Freedom Healthnet

ELITE POLICY DOCUMENT

Freedom elite

CONTENTS

WELCOME

Welcome and thank you for choosing Freedom Elite Private Medical Insurance.

This document explains:

- how your policy works
- how to manage your policy
- what is and is not covered
- how to make a claim
- if in the unlikely event you are unsatisfied, how to make a complaint
- definitions and what we mean by the words throughout this document

It is therefore a valuable document and should be kept in a safe place.

Please read the policy document and certificate of insurance carefully to make sure all the details are correct. If you have any questions about the information in this policy document please contact us as soon as possible.

The application form and declarations completed by you, together with the policy document and certificate of insurance, create a contract between the policyholder, the underwriters and us.

In return for payment of the premium, we will pay charges for pre-authorised, appropriate and medically necessary treatment for eligible medical conditions. Payment of these charges will be subject to our reasonable and customary charges and fee schedule. All treatment must be authorised during the policy period.

This Policy is underwritten by Anahita Insurance Corporation on behalf of Freedom Healthnet Ltd. Freedom Healthnet Ltd is authorised and regulated by the Financial Conduct Authority, registration number 312282.

Nahid Salehi
Chief Executive Officer

Freedom Healthnet Ltd
Bourne Gate
25 Bourne
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2. UNDERWRITING

Your policy is subject to different types of underwriting and we have explained what these mean to you.

a) Full medical underwriting

This is a type of underwriting where we ask you to complete a number of questions about your health.

We will review this information and decide what cover we can offer you. If necessary we may ask your General Practitioner to provide more information to help us do this.

If you have any pre-existing conditions that may need treatment in the future, we will usually exclude it from the cover along with any condition related to it.

If you agree to the policy terms we are offering you, any exclusion we apply will be shown on your certificate of insurance and will start from your commencement date,. In some cases we will advise you that an exclusion can be reviewed at your request after a specific time period, after the policy has started. Please note that if we offer to review an exclusion, this does not automatically mean that the exclusion will be removed.

With full medical underwriting new acute medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

A fully medically underwritten policy does not cover medical conditions that you and your dependants already had prior to the policy commencement date, including any related conditions that have not been disclosed and accepted by us.

It is essential that you give us all the information we ask for, even if you have symptoms that have not been diagnosed. If you don't, we will not pay any claim that you make in the future, or may even cancel your policy. If you are not sure whether or not to mention something, you should do so.

b) Moratorium underwriting

If you choose this underwriting option, you do not need to complete any questions concerning your health at the point of application, however, you will not be covered for any claims made in respect of pre-existing conditions during the first two years of the policy, for which you have received treatment and/or medication, or asked advice on, or had symptoms of whether or not diagnosed, during the five years immediately before your policy started with us.

Conditions that arise after the policy commencement date, but are related to the pre-existing condition will also be excluded.

If you have:

- experienced symptoms,
- sought treatment,
- taken medication,
- asked for or gained advice, or
- needed treatment,

in the 2 years after the policy commencement date, then you will have to wait until you have completed a continuous 2 year period where you have not;

- experienced symptoms,
- sought treatment,
- taken medication,
- asked for or gained advice, or
- needed treatment,

in order for the medical condition or related medical condition will be considered for coverage.

c) Continued Personal Medical Exclusions (CPME) underwriting

If you have had previous medical insurance with another insurer and you were medically underwritten, you may be able to apply for a transfer to Freedom Healthnet Ltd.

We will ask you to complete a number of questions about your health and provide a copy of your certificate of insurance from the other insurer. If we agree to accept your application, any personal exclusions outlined on the insurers previous certificate of insurance will also be applied to your policy with Freedom Healthnet Ltd.

Please note that the terms and conditions of your Freedom Healthnet Ltd policy may be different to your previous insurance policy.

d) Continued Moratorium (CM or Switch Moratorium) underwriting

If you have had previous medical insurance with another insurer and you were underwritten on a moratorium, you may be able to apply for a transfer to Freedom Healthnet Ltd.

We will ask you to complete a number of questions about your health and provide a copy of your certificate of insurance from the other insurer. If we agree to accept your application, we will transfer your moratorium commencement date from your previous insurer to Freedom Healthnet Ltd.

Please note that the terms and conditions of your Freedom Healthnet Ltd policy may be different to your previous insurance policy. For information on the moratorium underwriting, please refer to the moratorium explanation in point 2 above.

e) Medical History Disregarded (MHD)

We do not apply any personal medical exclusion to your policy as a result of pre-existing conditions.

3. HOW TO MANAGE YOUR POLICY

Procedure for acceptance

All applications for cover are reviewed and validated by Freedom Healthnet Limited. Once your completed and signed application form has been submitted, cover will commences as soon as we have confirmed our acceptance of your application by issuing the policy documents. The commencement date will be shown on the certificate of insurance.

Premiums

In order for you to enjoy the benefits of your policy, you must pay your premiums on or before the due date. If you do not pay the premium by the due date, all claims will be suspended until the premium due is paid.

If the premiums remain unpaid after 30 days from the premium due date, the policy will be cancelled.

All premiums must be paid in pound sterling.

Cancellation

If you decide that this policy is not suitable for your needs, you can cancel the policy within 14 days (cooling off period) of receiving your policy documents or from your policy commencement date, whichever is the later. You will need to send the policy cancellation request in writing by letter, fax or email.

If you incur eligible claims costs within an insured period and cancel within that period we reserve the right to reclaim monies paid on an eligible claim.

We also reserve the right to cancel the policy if you:

- you fail to pay the premium,
- failed to observe the policy terms including a change of circumstances;
- misled us by mis-statement, deception or concealment;
- failed to act with utmost good faith;
- attempted, alone or with a third party, to obtain money unreasonably at our cost;
- cease to be a resident in the UK.

We may also cancel the policy if changes occur regarding the national health insurance law or other legal general regulations which affect the policy fundamentally and subsequently no further basis for the policy exist.

Change of circumstances

You must inform us as soon as possible of any changes in your circumstances or any insured person's circumstances for instance;

- change of name,
- change of address,
- change of occupation to a dangerous occupation,
- any material fact which may affect the premium or the terms of the agreement.

We reserve the right to cancel or amend the terms or premium of the policy upon notification of such changes.

If an insured person has a dangerous occupation, we will cancel the policy from the date you began to follow the dangerous occupation or the commencement date if later.

Adding and removing dependants

Subject to our acceptance, you can apply to add your dependant onto your policy. Any request must be made in writing by letter, fax or email and you must tell us about all material facts.

If the dependant is a new born child, born during the policy period then as long as you have notified us of the request before the child is 3 months old and you have told us of all material facts, which we accept, we will not apply a moratorium on pre-existing medical conditions.

At the renewal date, we will remove a dependant (child) on your policy if they are 21 years of age (or 25 if they are in full-time education). They may apply for the own policy and as long as there has been no break in coverage, their inception date will stay the same. Any application is subject to our acceptance.

Death

If the insured person dies, there will be no premium refund under the policy, although valid claims will still be paid in accordance with the terms and conditions of this policy. Subject to our agreement and if requested, we can transfer the policy to the insured spouse or dependants, if over the age of 18.

Renewal

Your policy is an annual contract and renewable each year subject to our acceptance.

We reserve the right to change the terms and conditions of the policy and such changes will be advised to you when we invite you to renew one month prior to your policy expiry date.

Premiums are reviewed annually and are always based on the insured person's age, medical considerations, benefits chosen and general inflation.

4. GENERAL POLICY CONDITIONS

1. This policy provides benefit for reasonable and customary costs of eligible acute medical conditions as outlined in the benefits you have chosen. Your policy does not provide cover for chronic medical conditions unless you have chosen Elite Option 5, Executive Benefits.
2. We will pay benefit for eligible new medical conditions that arise after the acceptance and commencement of cover, as stipulated in the certificate of insurance. The basis of underwriting acceptance is stated on the certificate of insurance.
3. All treatment and diagnostic tests must be by and under the care of specialists following referral by a GP.
4. All claim requests must be made within 60 days of the initial visit to the referring GP.
5. Benefits will be paid net of any excess agreed under the terms of the Policy.
6. If we agree to pay for a claim, all payments will be made by cheque, unless otherwise specified and in pound sterling only.
7. We reserve the right to require you to get a second opinion from a Specialist of our choosing. We will be responsible for the Specialist's costs for the second opinion.
8. All correspondence about this policy, will be sent to the policyholder at your last known address. If you do not receive this any changes we have made will still be valid.
9. When dealing with a claim, we will always correspond and communicate directly with the claimant, if aged 18 years or over. If the clamant is under 18 years of age, we will communicate directly with the policyholder.
10. It is a condition of this policy that all material facts must be disclosed to us before we accept an application, make any changes to the policy or renew the policy. If you are unsure that a fact is material, then we recommend that you advise us for your own protection.

    Please note, if you choose moratorium underwriting at the time of your application and advise us about any pre-existing medical conditions you may have, the moratorium underwriting terms will still apply to any pre-existing condition.

    Failure to disclose a material fact, which would have affected our assessment of the risk, may lead us to cancel the policy and not pay any benefits in respect of a claim.

    If we cancel the policy due to you not disclosing a material fact, we will refund the premium amount paid, less any benefit paid out on a claim. If the amount of benefit paid on a claim is more than the premium paid, you will need to reimburse us the additional amount we have paid.
11. If there is or has been any fraud, untrue statements or concealment of facts either before or after the policy started, we will cancel the policy and any benefit paid on a claim must be returned to us.

    If we have evidence that you have made a claim, which is false, fraudulent or intentionally exaggerated, we will not pay any benefits for that claim.

    If you suspect fraud, then you must notify us immediately.
12. If we ask for more information to support a claim, this must be provided or we may not pay your claim. If we require any medical certificates, information, evidence and receipts, these must be obtained by the Insured Person at their expense. We reserve the right to ask for additional information from your GP, Specialist, other physician and/or request third party opinions as often as we may reasonably require.
13. We reserve the right to re-evaluate a claim already pre-authorised should new information be received or disclosed.

14. If any other insurance or indemnity covers the treatment for which the Insured Person is claiming benefit, we will only pay our share after that cover has been exhausted.

15. You must inform us as soon as possible if the medical condition for which a claim is being made, is, or may be, the fault of a third party. In these circumstances:

    a) We may start legal proceedings in the Insured Person's name but at our expense to recover any benefits paid under this Policy.

    b) The Insured Person must give us all the necessary assistance and information to start legal proceedings or to settle or defend the claim.

    c) The Insured Person must refund to us any compensation received or due relating to your claim up to the benefit amount paid by us.

16. If we decline a claim under the policy, the onus to prove the claim is covered is the responsibility of the insured person.

17. We do not accept proof of posting an application form, claim form or premium payment as proof that we have received it.

18. The issuance of the policy document and certificate of insurance is evidence that the contract is in force.

19. If you lose your policy documents, we may charge an administration fee to re-issue.

20. Your Policy is bound by English Law.

5. DATA PROTECTION

We will use your personal information, including information provided about your dependants, to underwrite, administer and service your policy. By taking out a policy with us, you consent us to using your personal information and sensitive personal information. We will also use your personal information for statistical data analysis, to prevent fraud and for audit purposes.

In carrying out your instructions, processing and administering your claims, we may disclose your personal information to other companies in the Freedom group, our business associates, agents, service providers or third parties acting on our behalf inside and outside the EU, which may not have the same standard of data protection as in the UK. We will ensure appropriate safeguards are in place to protect your information. All information will be used outside the EU and laws will be subject to the United States of America.

If required to do so, we will pass your personal information and information about your policy to a legal or a regulatory body.

We may advise you of certain products and services that may be of interest to you. This normally involves using information that you have provided us. Please advise us if you prefer not to receive such information.

We will continue to hold information about you and your policy for a reasonable period of time after it may have ended. After this time period, we will dispose of your personal information in a responsible way to maintain your confidentiality.

6. YOUR GUIDE TO CANCER COVERAGE

Cancer treatment

We want you to have a clear understanding on what is covered and what is not covered for cancer treatment under your policy and have provided guidance below. However, if you need treatment for cancer then please call our Claims Helpline and one of our claims team will be able to help guide you through the coverage available.

What is covered for cancer?

The following treatment is covered to achieve a cure or reach remission:

- Consultations, diagnostic tests to establish the diagnosis.
- Surgery. Surgery must be widely recognised as a safe and effective treatment.
- Chemotherapy and radiotherapy drugs provided that these are used within normal clinical practice. Acceptable chemotherapy drugs are drugs that have been approved for use in the NHS by NICE (National Institute for Health & Clinical Excellence), are used within their licensed indications, as licensed by EMEA (European Medicines Agency) or MHRA (Medicines & Healthcare products Regulatory Agency) and for combinations of drugs, the drugs must have been shown to be effective in actively treating the type of cancer the patient has.
- Hormonal and biological therapies, e.g. Monoclonal antibodies, such as Herceptin, if licensed with the EMEA. They must be approved by the National Institute of Health and Clinical Excellence (NICE) and be used for the purpose for which they are currently licensed and widely available within the NHS. If used in combination with other drugs, hormonal and biological therapies will only be considered if these combinations are widely recognised for use within the NHS.
- Follow-up consultations and monitoring for a period of 5 years once treatment to achieve a cure or to reach remission has ceased.
- Breast reconstruction and surgery to improve symmetry, following a mastectomy or lumpectomy. We will pay for such operations for a period of up to 24 months following initial surgery.

What is not covered for cancer?

- Drugs that are still under trial or trials of combination drug therapies. These can be defined as experimental.
- Surgical and non-surgical treatment of cancer that is not recognised for treating that particular type of cancer.
- Maintenance or long-term treatment where the condition is stable, remains in remission, or remission and a cure cannot be achieved.
- Treatment of cancer where the intent is to provide relief of symptoms.
- Treatment costs that exceed the procedure limits or policy limits (if applicable).
- Where you have a recurrence of cancer, we will ask your specialist for specific information about the intent of treatment to determine whether your claim remains eligible for benefit.

Guidance

If your cancer comes back, we will assess your medical condition and proposed treatment as a new episode of treatment and will follow the same process in assessing the eligibility of your claim.

Where the intent of treatment is to provide relief of symptoms, rather than attempting to cure the cancer, benefit will cease. We will always talk to you and your specialist if this situation arises to ensure a smooth transition from private to NHS healthcare and that you do not experience a break in treatment.

We have provided you some examples in order to help explain further. All examples assume that the medical condition is eligible under the policy and benefit is available.

Example 1

Beverley has been with Freedom for five years when she is diagnosed with breast cancer. Following discussion with her specialist she decides to have the breast removed followed by breast reconstruction. Her specialist also recommends a course of radiotherapy and chemotherapy. In addition she is to have hormone therapy tablets for several years.

Will her insurance cover this treatment plan and are there any limits to the cover?

We would cover the cost of mastectomy and breast reconstruction.

We would then cover the course of radiotherapy and chemotherapy drugs provided that these are used within normal clinical practice. The hormone tablets would not be eligible for benefit as these are outpatient drugs and she would need to obtain these by prescription from her GP.

Example 2

Cara has previously had a breast cancer, which was previously treated by lumpectomy, radiotherapy and chemotherapy under her existing policy. She now has a recurrence in her other breast and has decided to have a mastectomy, radiotherapy and chemotherapy.

We would cover her for the mastectomy, radiotherapy and chemotherapy. The course of radiotherapy and chemotherapy drugs would be covered provided that these are used within normal clinical practice.

Example 3

Monica, who was previously treated for breast cancer under her existing policy, has a recurrence which has spread to other parts of the body. Her specialist has recommended the following treatment plan:

- A course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months.
- Monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years).
- Weekly infusions of a drug to suppress the growth of the cancer. These infusions are to be given for as long as they are working (hopefully years).

Will her insurance cover this treatment plan and are there any limits to the cover?

We will provide benefit for the six cycles of chemotherapy provided that these are used within normal clinical practice and where the treatment is given with curative intent and is not experimental.

We do not provide benefit for preventative treatments such as the monthly infusions as described. However, whilst undertaking chemotherapy we would provide funding as necessary.

We would not provide benefit for the weekly infusion under the terms and conditions of the policy as the drug is not being given with curative intent.

Example 4

John has been diagnosed with end stage cancer and would like to be admitted to a hospice for care aimed solely at relieving symptoms.

Will his insurance cover this and are there any limits to the cover?

As the admission to the hospice is aimed solely at relieving symptoms, and not at curing his cancer, We will be unable to provide benefit for his admission to the hospice.

7. YOUR GUIDE TO CHRONIC MEDICAL CONDITIONS COVERAGE

It is important to understand that your policy is designed to cover treatment for acute medical conditions where the purpose of the treatment is to cure the medical condition. Acute medical conditions respond quickly to treatment and the aim of the treatment is to return you to the state of health you were in immediately before suffering the medical condition, or which leads to your full recovery.

The core policy is not designed to cover chronic medical conditions where the purpose of treatment is to keep the symptoms under control and a cure is not possible. However, please note if you have chosen Elite Option 5, Executive Benefits, you do have a £500 limit for eligible chronic medical conditions per person, per policy year, where the purpose of treatment is to keep the symptoms under control and a cure is not possible.

Guidance

What do we mean by a chronic condition?

We define a chronic medical condition as:

a disease, illness, or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

What does this mean in practice?

When you become ill with a medical condition for the first time, we will provide coverage for the treatment (if eligible under the policy) to stabilise your medical condition. Once your condition has stablised and the treatment you are receiving appears only to be monitoring you, or controlling your medical condition, rather than curing it, then we will no longer be able to offer you coverage. If this happens, we will discuss this with you. We may also need to obtain further medical information from your GP or Specialist when making a decision on coverage.

What if your chronic condition gets worse or becomes unstable?

Although we may not be covering you for the routine monitoring and control of your chronic medical condition, if your chronic medical condition becomes unstable and gets worse, we may be able to provide cover in order that your chronic medical condition can be stabalised.

We have provided you some examples in order to help explain further. All examples assume that the medical condition is eligible under the policy and benefit is available.

Example 1

Alan has been with Freedom for many years. He develops chest pain and is referred by his GP to a specialist. He has a number of investigations and is diagnosed as suffering from angina. Alan is placed on medication to control his symptoms.

Will Alan be covered?

We will cover Alan's initial consultations and tests to obtain the diagnosis. We will also cover further consultations with his specialist until his symptoms are under control and being maintained.

Two years later, Alan's chest pain recurs more severely and his specialist recommends that he has a heart bypass operation.

We will provide a monetary benefit amount for the recognised procedure. We will also cover the post-operative check-ups for one year to ensure that the medical condition has been stabilised.

Example 2

Eve has been with Freedom for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges for a number of tests. These reveal that Eve has asthma. Her specialist puts her on medication and recommends a follow-up consultation in three months to see if her condition has improved. At that consultation Eve states that her breathing has been much better, so the specialist suggests she have check-ups every four months.

We will cover the consultations and tests and will also agree to pay for the three-month check-up. We would be unable to cover the check-ups every four months as the condition has stablised and is being controlled.

Eighteen months later, Eve has a bad asthma attack.

If Eve was admitted to an Accident and Emergency department, then we would be unable to provide any cover for this treatment, as the policy is not designed to cover accident and emergency treatment.

If after her discharge from accident and emergency a specialist follow-up appointment is needed, we may agree to cover the cost of one follow-up consultation to make sure that the symptoms are being controlled again.

Example 3

Deirdre has been with Freedom for two years when she develops symptoms that indicate she may have diabetes. Her GP refers her to an endocrinology specialist who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments to the medication regime, the specialist confirms that the condition is now well controlled and explains that he would like to see her every four months to review the condition.

We will pay for the treatment of the diabetes up to the point where the specialist confirms that the condition is well controlled and only needs to see the Deirdre every four months. We will be unable to consider the regular four month follow-ups as this would be considered routine monitoring.

One year later, Deirdre's diabetes becomes unstable and her GP arranges for her to go into hospital for treatment.

If Deirdre was admitted to an Accident and Emergency department, then we would be unable to provide any cover for this treatment, as the policy is not designed to cover accident and emergency treatment.

If after her discharge from accident and emergency a specialist follow-up appointment is needed, we may agree to cover the cost of one follow-up consultation to make sure that the symptoms are being controlled again.

8. TABLE OF BENEFITS

In-patient and day-patient hospital costs at a hospital on your chosen hospital list	
Annual in-patient limit, per person, per policy year	**No annual limit**
Hospital charges – accommodation, nursing, dressings and prescribed medicines and drugs used during an in-patient or day patient stay	Full cover within at a hospital within your chosen hospital list. All charges for a hospital not within your list will be limited to £250 per night for private treatment as an in-patient or £200 per private treatment as a day-patient.
Operating theatre charges, surgical drugs and dressings	Covered in full
Surgeon's, anaesthetist's, physician's fees.	Full cover within the limits of our fee schedule. If charges exceed those stated in our fee schedule, the difference will need to be paid by you.
Surgical appliances which form a permanent and integral part of the body, apart from neurostimulators and pacemakers as outlined in the exclusions	Covered in full
Diagnostic tests, including pathology and radiology	
MRI, CT/PET scans	
Oncology tests, drugs, consultant's fees including cover for chemotherapy and radiotherapy, when the treatment is aimed to cure the medical condition.	
Physiotherapy during an in-patient stay	
Oral surgical procedures as specified in our definition	
Rehabilitation therapy during an in-patient stay	Up to 3 hours per day for a maximum of 7 days
Private road ambulance	Covered in full
Accommodation for parent if child 14 or under	
NHS in-patient benefit where you receive treatment over night as a non-paying in-patient in an NHS Hospital. Please refer to exclusion 34 to see what is not covered	£200 per night, up to a maximum of 10 nights and on receipt of a discharge summary from the NHS Hospital
NHS day-patient benefit where you receive treatment as non-paying day-patient in an NHS Hospital. Please refer to exclusion 34 to see what is not covered	£100 per night, up to a maximum of 5 days and on receipt of a discharge summary from the NHS Hospital
Home nursing benefit	Full cover up to a maximum of 13 weeks
Core out-patient cover	
MRI/CT/PET Scans	Covered in full
Oncology tests, drugs, consultant's fees including cover for chemotherapy and radiotherapy, when the treatment is aimed to cure the medical condition	

Option 1 – Out-Patient Cover

Specialist consultation and treatment fees	**A)** Covered to £1,500 per person, per policy year	**B)** No annual limit - covered in full
X-rays, pathology, diagnostic tests and procedures		
Physiotherapy (6 visit maximum from GP referral)		

Option 2 – Alternative Therapies

Treatment by a registered osteopath, chiropractor, acupuncturist, homeopath, podiatrist and chiropodist after referral from a GP or Specialist (6 visit maximum from a GP referral)	**A)** Covered to £750 per person, per policy year	**B)** Covered to £1,500 per person, per policy year

Option 3 – Psychiatric Care

Inpatient treatment	Covered up to £10,000 at a hospital within your chosen hospital list or agreed in advance of admission
Out-patient treatment	Covered up to £1,000 (Treatment must be by a registered specialist psychiatrist or psychologist)

Option 4 – Private GP, Dental & Optical

£50 compulsory excess subject to a 6 month qualifying period

Routine dental treatment – check-ups, examinations, investigations and tests such as x-rays, scale and polish and hygienist fees	Covered up to £300
Clinically necessary dental treatment to restore your teeth, such as fillings, crowns, bridges, inlays, extractions at a dental practice.	
Accidental damage to teeth or emergency dental treatment – following a covered accident, the restoration of your oral health to its pre-accident state or the relief of severe pain which cannot be controlled by over the counter pain medications	Covered up to £600
Private GP consultations, investigations and minor surgery	Covered up to £300 per year. Minor surgery Covered up to £70 per procedure within the £300 limit.
Optical – routine eye sight checks, prescription spectacles and contact lenses	Covered up to £200

8. TABLE OF BENEFITS (CONTINUED)

Option 5 – Executive Benefits

External prosthesis as recommended by a specialist	Covered up to £200 per policy year following an in-patient stay
Chronic benefit – treatment of eligible chronic medical conditions where the treatment is to maintain and monitor symptoms	Covered up to £500 per policy year upon first diagnosis following the policy commencement date
Wellbeing benefit – routine health and screening checks	Covered up to £300 per lifetime following a two year qualifying period
Ante-natal and post-natal care where no complications arise – specialist consultations, diagnostic tests and investigations. Please note that we will only pay for two 2D ultrasound scans during a pregnancy. There is no coverage for 3D ultrasound scans.	Covered up to £3,000 lifetime benefit following a two year qualifying period
Routine delivery for a natural birth	
Pregnancy complications within listed procedures outlined in our definition	Covered up to £3,000 lifetime benefit
Maternity cash benefit	£150 per pregnancy following an 11 month qualifying period
Investigations into infertility. No cover available for assisted reproduction. Please refer to exclusions	Covered up to £1,500 lifetime benefit following a two year qualifying period
Charged NHS prescriptions	Covered up to 6 per policy year with a maximum of benefit of £50 available
Specialist second opinions	1 second opinion per policy year
London Premier Hospitals	Cover for reasonable and customary charges within the London premier hospital list as shown in our hospital guide

Please Note: All limits above are per Policy year unless otherwise specified.

9. WHAT IS NOT COVERED?

Unless otherwise specified in your table of benefits or agreed by us, the policy does not cover claims arising from or connected with the following policy exclusions:

1. A benefit not available on your policy.
2. A benefit where you have not satisfied the waiting or qualifying period.
3. A medical or related condition resulting from you being under the influence of alcohol, drugs or any other intoxicating substance.
4. Accident and Emergency services.
5. Alcohol, drug, or any other intoxicating substance abuse or dependency, and any medical condition arising directly or indirectly from any such abuse or dependency.
6. Amounts claimed in excess of the overall maximum annual limit for any given policy year. Any continuing treatment or other medical conditions are excluded thereafter.
7. Allergic conditions that the Insured is aware of or for which medical treatment or advice has been sought.
8. Assisted reproduction including in vitro fertilisation (IVF).
9. Birth control of any form for both male and female (e.g. vasectomy, sterilisation) or reversing the process.
10. Charges made by a specialist/consultant or hospital that we do not regard as reasonable or customary.
11. Childbirth complications arising from a pre-existing anatomical abnormality.
12. Chiropractic, osteopathy, homeopathy or any other alternative therapy treatment. This exclusion does not apply to chiropractic, osteopathy, acupuncture, homeopathy consultations, if you have purchased Option 2 benefit. Please refer to your table of benefits to see the coverage terms that apply.
13. Chronic and non-acute medical conditions. If you have purchased Option 5 benefit, then you do have benefit for treatment in respect of eligible chronic conditions. Please refer to your table of benefits to see the coverage terms that apply.
14. Congenital birth defects, including the correction of congenital abnormalities. This includes surgery and/or investigations carried out on the mother, unborn child/ or children.
15. Cosmetic surgery or any treatment - benefit is not payable under this policy for cosmetic treatment, including any treatment as a result of cosmetic treatment, whether or not for psychologial or personal reasons, except when needed to restore appearance after treatment for cancer.
16. Dental treatment and/or investigation including periodontal treatment or malocclusions other than covered in-patient oral surgery procedures. If you have purchased Option 4 benefit, then you do have benefit for dental treatment. Please refer to your table of benefits to see the coverage terms that apply.
17. Dialysis for renal failure, other than acute, reversible kidney failure.
18. Disease, illness or injury directly or indirectly arising as a result of your occupation.
19. Eating disorders.
20. Eye surgery for the corrective purpose of refracting defects of the eye or routine sight testing. If you have purchased Option 4 benefit, then you do have benefit for sight testing. Please refer to your table of benefits to see the coverage terms that apply.

9. WHAT IS NOT COVERED? (CONTINUED)

21. Experimental, unproven treatment or drug therapy.
22. Failure to follow medical advice, prescribed care and complications arising from ignoring such advice.
23. Foetal surgery including treatment on mother or unborn child.
24. GP charges (including administration costs such as providing medical reports or the completion of claim forms) If you have purchased Option 4, then you do have benefit for GP consultations, investigations and minor surgery. Please refer to your table of benefits to see the coverage terms that apply.
25. Growth hormone treatment.
26. HIV/AIDS related conditions.
27. HRT (Hormone Replacement Therapy) and any treatment for menopausal symptoms.
28. Hazardous activities.
29. Injuries sustained whilst participating in professional sports.
30. Investigations into infertility and sub-fertility. If you have purchased Option 5, then you do have benefit for investigations into infertility. Please refer to your table of benefits to see the coverage terms that apply.
31. Investigations of and treatment for sexually transmitted diseases.
32. Invoices, medical information or claim forms that have been amended or altered.
33. Learning difficulties, behavioural and development problems, dyslexia and ADHD (Attention Deficit Hyperactivity Disorder).
34. NHS cash benefit is not available for:

a. The first three nights following an accident or emergency admission.

b. Psychiatric treatment.

35. Organ transplant procedures, organ donations procedures, including stem cell and bone marrow transplants. We will pay benefits for corneal and skin grafts.
36. Out-Patient drugs or dressings. If you have purchased Option 5, then you do have benefit for charged NHS prescriptions. Please refer to your table of benefits to see the coverage terms that apply.
37. Pace makers and neurostimulators.
38. Palliative care and treatment.
39. Pandemics.
40. Personal Medical Exclusions
41. Phobias.
42. Placing yourself in needless danger.
43. Podiatry and chiropody. This exclusion does not apply, if you have purchased Option 2 benefit. Please refer to your table of benefits to see the coverage terms that apply.

44. Pre-existing medical or related conditions (unless we have accepted to underwrite you on a Medical Histories Disregarded (MHD) basis):

    a. If you are underwritten on a moratorium, also known as (MORI), the following applies:

    We exclude any medical conditions or related conditions for which you have:

    - received treatment and/ medication,
    - asked advice, or
    - you have experienced signs or symptoms,

    whether the condition has been diagnosed or not in the five years before the start of the insured persons cover.

    If you have:

    - experienced symptoms,
    - sought treatment,
    - taken medication,
    - asked for or gained advice, or
    - needed treatment,

    in the two years after the policy commencement date, then you will have to wait until you have completed a continuous two-year period where you have not;

    - experienced symptoms,
    - sought treatment,
    - taken medication,
    - asked for or gained advice, or
    - needed treatment,

    in order the medical condition or related medical condition will be considered for coverage.

    b. If you are underwritten on Full Medical Underwriting also known as (FMU), the following applies:

    We exclude any pre-existing condition, or any related condition unless you have notified us of the condition when you applied for cover and we did not apply an exclusion on the insured persons certificate of insurance. Any medical exclusion we have applied is shown on the certificate of insurance.

    c. If you are underwritten on a Continuous Personal Medical Exclusion (CPME) or Switch Moratorium, the following applies:

    Members who are previously Insured and have transferred to us without a break in cover are subject to the pre-existing conditions applied by the previous insurer or the moratorium date applied by your previous insurer. Please refer to points a or b above.

45. Routine and/or complications of pregnancy and childbirth. If you have purchased Option 5, then you do have benefit for pregnancy and childbirth. Please refer to your table of benefits to see the coverage terms that apply.

46. Placing yourself in needless danger.

47. Pregnancy termination.

48. Preventative treatment or procedures.

49. Primary care treatment. If you have purchased Option 4, then you do have benefit for some primary care treatment from your GP. Please refer to your table of benefits to see the coverage terms that apply.

9. WHAT IS NOT COVERED? (CONTINUED)

50. Psychiatric Care, psychological or mental illness, or any other condition normally treated by a psychiatrist or psychologist. If you have purchased Option 3, then you do have benefit for psychiatric treatment. Please refer to your table of benefits to see the coverage terms that apply.
51. Removal of fat or healthy tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).
52. Routine monitoring or occupational check-ups carried out over a long period of time or for screening purposes whether or not they have been approved by a GP or Specialist (e.g. routine mammogram or prostate specific antigen tests). If you have purchased Option 5, then you do have benefit for routine health checks and screening. Please refer to your table of benefits to see the coverage terms that apply.
53. Second opinions. If you have purchased Option 5, then you do have benefit for a second opinion. Please refer to your table of benefits to see the coverage terms that apply.
54. Self-inflicted conditions or any injury incurred from attempted suicide.
55. Services or treatment at any long term care facility, nursing home, spa, hydro-clinic, sanatorium or hospice that is not a hospital.
56. Sex change or gender reassignment whether or not for psychological reasons.
57. Sexual problems: Impotence, psycho-sexual dysfunction, whether or not for psychological reasons.
58. Sleep apnoea, snoring, or other sleep disorders and sleep-related breathing disorders.
59. Speech therapy
60. Surgical /medical appliances, such as aids or equipment, including optical and hearing aids, dentures and dental appliances. Artificial apparatus or prostheses inserted during a surgical procedure are covered unless specifically excluded. If you have purchased Option 5, then you do have benefit for external prosthesis. Please refer to your table of benefits to see the coverage terms that apply.
61. Terrorism which involves the use or release or threat there of any nuclear weapon or any chemical or biological agents.
62. Treatment and diagnosis received outside the UK and not within your chosen hospital list.
63. Treatment that has taken place:

a. before your commencement date;

b. after your end date unless you have renewed with us and paid your premium due and the medical condition is eligible;

c. if you have not paid the premium due.

64. Treatment undertaken solely at your request.
65. Treatment undertaken without the referral of a GP.
66. Treatment as a consequence of criminal activity.
67. Warts and verrucas.
68. Varicose vein treatments.
69. War invasion, acts of foreign enemies, hostilities (whether war declared or not), civil war, terrorism, rebellion, revolution, insurrection, military or usurped power (whether war be declared or not).
70. Weight control surgery, treatment of obesity, special diets, weight loss prescription medicines and weight loss programmes.
71. Winter sports, including all injuries sustained whilst participating in a winter sport.

10. HOW TO MAKE A CLAIM

1. How to claim under your:

- Core benefits (excluding hospital cash benefit),
- Option 1 Out-patient cover benefit (if purchased),
- Option 2 Alternative therapies benefit (if purchased), or
- Option 3 Psychiatric care (if purchased)

Stage 1

a) Firstly, visit your General Practitioner (GP). If your GP considers it is medically appropriate to refer you for specialist treatment, then advise your GP that you have private health insurance with Freedom Healthnet Ltd.

b) Call our dedicated Claims Helpline where one of the claims team will be able to assist you. Please have your policy number ready.

c) We will check your policy details and ask you some questions about your medical condition and what the GP has advised you.

d) We will then send you a Medical Consent form for completion and ask you to obtain a copy of the referral letter that your GP sends to the specialist.

e) In some cases we may need to obtain further information from your GP in order we can advise you on coverage. We will advise you if this is the case and keep you informed of the progress of obtaining the necessary information. We will be unable to confirm any coverage whilst we are awaiting the additional information requested. We may also request your help to obtain this.

f) When we have all the required information in order to make a decision on your claim, we will inform you in writing of what we are able to cover and any limitations that may apply.

Stage 2

a) Go and see your specialist if we have agreed treatment.

b) You may pay for your treatment upfront and send the itemised invoices and receipt to the Claims Department, at the contact details shown in order we can reimburse you under the terms of your policy. However, where practical, we can also settle your pre-authorised medical expenses direct to the hospital or treatment provider. You will be responsible to pay any excess applicable.

c) If your specialist recommends further treatment or a surgical procedure, we will need to be sent a copy of the clinic letter which will provide us the necessary information in order we can further assess your claim.

d) In some cases we may need to obtain further information from your specialist in order we can advise you on coverage. We will advise you if this is the case and keep you informed of the progress of obtaining the necessary information. We will be unable to confirm any coverage whilst we are awaiting the additional information requested. We may also request your help to obtain this.

e) Once we have all the necessary information we will advise you if your treatment is covered and if any limits apply to the treatment.

2. How to make a claim under your Core benefits for NHS in-patient or day-patient benefit:

a) When you get discharged from your NHS admittance, please obtain a discharge note.

b) Send the discharge note to The Claims Department at the contact details shown, in order we can consider your NHS cash benefit claim.

10. HOW TO MAKE A CLAIM (CONTINUED)

c) In some cases we may need to obtain further information from your GP. We will advise you if this is the case and keep you informed of the progress of obtaining the necessary information. We will be unable to confirm any coverage whilst we are awaiting the additional information requested. We may also request your help to obtain this.

d) Once we have all the necessary information we will advise you if your treatment is covered and if any limits apply to the treatment.

3. How to claim under Option 4, Private GP, dental and optical benefit (if purchased):

a) Private GP benefit:

- Visit your GP for treatment.
- Pay for the treatment and obtain an itemised invoice which shows the services provided.
- Send the itemised invoices and receipts to the Claims Department at the contact details shown, in order we can make an assessment on coverage.

If you intend to use this benefit to be referred under the core benefit, option 1,2 or 3 you must follow the procedures outlined in Section 1, stage 1 and stage 2.

b) Dental treatment:

- Visit your dentist for treatment.
- Pay for the treatment and obtain an itemised invoice which shows the services provided.
- Send the itemised invoices and receipts to the Claims Department at the contact details shown, in order we can make an assessment on coverage.

c) Optical care:

- Visit your optician for treatment.
- Pay for the treatment and obtain an itemised invoice which shows the services provided.
- Send the itemised invoices and receipts to the Claims Department at the contact details shown, in order we can make an assessment on coverage.

4. How to claim under Option 5, Executive benefits (if purchased):

a) External prosthesis

- If your specialist recommends you need an external prosthesis, we will need to be sent a copy of the clinic letter which will provide us the necessary information on what prosthesis is being proposed, in order we can fully assess your claim.
- Once we have all the necessary information we will advise you if your prosthesis is covered.

b) Chronic benefits

- Follow the procedures outlined in Section 1, stage 1 and stage 2.

c) Wellbeing benefit

- Visit your Specialist for routine health and screening checks.
- Pay for the treatment and obtain an itemised invoice which shows the services provided.
- Send the itemised invoices and receipts to the Claims Department at the contact details shown, in order we can make an assessment on coverage.

d) Pregnancy benefit – Ante-natal or post natal care/Routine delivery:

- If you are scheduled to go into a private hospital within your chosen hospital list for a routine normal delivery, follow the procedures outlined in Section 1, stage 1 and stage 2.

e) Pregnancy complications within the listed procedures outlined in our definitions:

- If you have a pregnancy complication and one of the listed procedures outlined with the pregnancy complications definition is going to take place, then you or a personal representative of yours needs to call our dedicated Claims Helpline as soon as reasonably possible.

f) Maternity cash benefit and Charged NHS prescriptions

- Please call our dedicated Claims Helpline as soon as reasonably possible and we will explain what is required to claim the cash benefit.

g) Investigations into infertility

- Follow the procedures outlined in Section 1, stage 1 and stage 2.

h) Specialist second opinion:

- If you consider a specialist second opinion is required, please call our dedicated Claims Helpline on +44 (0) 1202 756350 as soon as reasonably possible.

Claims Department contact details

Claims helpline:	+44 (0) 1202 756350 (Open Monday to Friday 09:00 to 18:00)
Fax:	+44 (0) 1202 756351
Post:	Claims Department Freedom Healthnet Ltd Bourne Gate 25 Bourne Valley Road Poole BH12 1DY

11. COMPLAINTS

Our commitment to you

At Freedom Healthnet Ltd each of our customers is important to us, and we believe you have the right to a fair, swift and courteous service at all times.

We are committed to providing you with excellent service and exceeding our customers expectations.

If for any reason you are not entirely satisfied with any aspect of our service, please let us know.

We shall work to correct matters as quickly as possible and where appropriate, take steps to prevent the problem happening again. We value our customers and your feedback can help us improve the products and services we offer to you.

Your complaint will be investigated by an employee of competence not involved in the subject matter of the complaint.

We shall aim to resolve all complaints by close of business on the business day following receipt of the complaint. If we cannot resolve the complaint within this time due to us needing to carry out more in-depth investigations, we shall:

1. Acknowledge your complaint in writing within 5 working days with either a full response or information about the progress of the matter and a contact name for future reference.

2. Provide you with a final response and redress (if appropriate), within 4 weeks of receipt of your complaint.

Please note in some circumstances, a complaint may require more in-depth investigations and therefore a longer timeline to resolve will apply. We shall aim to resolve such in-depth complaints within 8 weeks. We shall advise you if this is the case with your complaint.

How to complain:

You can raise your concerns in writing to:
Claims Manager or the Managing Director
Freedom Healthnet Ltd,
Bourne Gate,
25 Bourne Valley Road,
Poole
BH12 1DY
United Kingdom

Email: complaints@freedomhealthinsurance.co.uk

If you remain dissatisfied with the outcome of your complaint and you are an eligible complainant, you can refer your complaint to the Financial Ombudsman Service (FOS) within 6 months of our final response.

An eligible complainant is one who is:

- a private policyholder or an enterprise that employs less than 10 people and has a turnover of less than €2 million at the time the complaint is made:
- a charity which has an annual income of less than £1 million at the time the complaint is made:
- a trustee of a trust which has a net asset value of less than £1 million at the time the complaint is made.

We shall send you a copy of the Financial Ombudsman Service's explanatory leaflet with our final response letter. Copies can also be obtained from us or directly from the Financial Ombudsman Service at the address below:
South Quay Plaza
183 Marsh Wall
London
E14 9SR

Telephone: 0845 080 1800

Website: www.financial-ombudsman.org.uk

If for any reason you are unhappy with our underwriters please write to our Compliance officer, at:
Anahita Insurance Corporation
CGI Tower
2nd Floor, Warrens
St Michael
BB22026
Barbados

If you take any of the action mentioned above, it will not affect your right to take legal action.

12. FINANCIAL SERVICES COMPENSATION SCHEME

Freedom Healthnet Ltd is covered by the Financial Services Compensation Scheme (FSCS). This means that you may be entitled to compensation from the scheme if we cannot meet our obligations. This depends on the type of business and the circumstances of the claim and would provide cover 90% of the claim without any upper limit. Further information about compensation is available from the FSCS at www.fscs.org.uk or telephone 020 7892 7300.

13. DEFINITIONS

Abuse

Improper or excessive use of alcohol, drugs or any other intoxicating substance. This includes the use of drugs in quantities other than as directed or prescribed on medical authority or for a reason other than it is originally intended.

Accident and Emergency services

Services carried out;

- in an Accident and Emergency department, or
- services carried out following admission into a hospital via an Accident and Emergency department,
- or services carried out following emergency referral to the hospital by a General Practitioner or Specialist or any other person

as a result of an accident, or for urgent or unplanned treatment, or when immediate treatment or diagnostic tests are medically necessary.

Acupuncturist

A registered medical practitioner with full current registration with the General Medical Council and who is an accredited member of the British Medical Acupuncture Society, and from 1 January 2005, holds a licence to practice medicine issued by the General Medical Council.

Accidental dental injury

A sudden unforeseen external blow to the face, teeth or jaw, which occurs at an identifiable place and time resulting in dental injury.

Acute medical condition

A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

Advice

Any consultation regarding any symptoms or abnormalities that you have experienced from a General Practitioner, Specialist, therapist or allied healthcare Specialist, or otherwise, including the issue of any prescription or repeat prescription.

Appropriate

a) The type, level, length of service, and setting needed to provide safe and adequate care.

b) Rendered in accordance with generally accepted medical practice and professionally recognised standards.

c) Not generally regarded as experimental, investigational or unproven by recognised medical professionals or appropriate government agencies.

d) Specifically allowed by laws which apply to the provider who renders service.

If there is any doubt as to the appropriateness of treatment in respect of a claim, appropriateness shall be decided by our Chief Medical Officer.

Benefit

The maximum amount we will pay under the policy and as shown in the table of benefits and schedule of fees. The charges must be reasonable and customary.

Cancer

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue. Please refer to our cancer guide to understand the coverage provided for the treatment of cancer.

Certificate of Insurance

The document accompanying this policy, which lists the insured persons, the Commencement Date and any endorsements.

Chiropodist

An individual whose name appears on the practice register of The Society of Chiropodists and Podiatrists.

Chiropractor

An individual whose name appears on the practice register of the General Chiropractic Council, holding full registration.

Chronic medical condition

A disease, illness or injury that has at least one of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests;
- it needs ongoing or long-term control or relief of symptoms;
- it requires your rehabilitation or for you to be specially trained to cope with it;
- it continues indefinitely;
- it has no known cure;
- it comes back or is likely to come back.

Claim

The costs incurred relating to a course of treatment undergone in relation to a specific acute medical condition that we have authorised in writing as an eligible claim under the policy.

Claimant

An insured person who had made a claim under the policy.

Commencement date

This is the date of the commencement of the contract with us, as stipulated on your certificate of insurance.

Dangerous occupations

Including but not limited to:

a) Armed forces

b) Working at heights, underground, with explosives/dangerous chemicals/firearms

c) Working as a journalist or news cameraman in a war zone

d) Foreign embassy employee

e) Stuntmen, fairground, circus workers

f) Professional dancers

g) Any occupation involving working at sea

Day-Patient

A patient who is admitted to a hospital or Day-Patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

Dependant

Your husband, wife, partner or unmarried child included on your Policy. By partner we mean a person with whom you are cohabiting on a permanent basis. By child we mean you or your partner's unmarried own, adopted or step children who are under 21 (or 25 in the case of students enrolled in full-time education).

Diagnostic test

Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

Eating disorder

Any psychological disorder such as anorexia nervosa or bulimia that involves insufficient or excessive food intake.

Eligible

We have agreed coverage as the claim has satisfied the appropriate terms and conditions of the policy.

Emergency dental treatment

Dental treatment required for the immediate relief of severe pain, trauma, swelling or haemorrhage.

Excess

The amount of money shown on your certificate of insurance you must pay towards an eligible claim. The excess is payable once per year.

Experimental treatment

A diagnostic, medical or surgical procedure, treatment or drug therapy that is considered experimental or unproven, or not based on established medical practice in the UK.

External prosthesis

Surgical/medical appliances external and not integral to the body, such as aids or equipment, that are required following an in-patient stay and Option 5 has been selected.

General Practitioner (GP)

A registered medical practitioner with full current registration with the General Medical Council, working in the UK and recognised by us.

Hazardous activities

- Flying (including hot-air ballooning, hang gliding, gliding and micro-lighting) other than as a fare-paying passenger in a licensed passenger aircraft.
- Martial arts, boxing, wrestling or judo.
- Mountaineering, abseiling or rock climbing requiring the use of ropes and/or guides.
- Parachuting, free-fall parachuting, parasailing or parascending.
- Pot-holing.
- Bungee-jumping.
- Professional sporting activities of any kind.
- Gymnastics.
- Any form of swimming/diving at a depth of 30 metres or more.
- Any form of swimming using breathing apparatus.
- Water-skiing
- Use of a weapon or firearm.

13. DEFINITIONS (CONTINUED)

Health Screening or Routine Check

An examination or diagnostic test that are performed by a primary care provider or a specialist where no symptoms or medical conditions are present.

Home nursing

Skilled nursing services given by a qualified nurse at your home, immediately after qualifying in-patient treatment. The nursing must be under the supervision of a specialist and for medical not domestic purposes.

Homeopath

A registered medical practitioner with full current registration with the General Medical Council who:

- Has the qualification MFHom, and
- From the 1 January 2005, holds a full licence to practice medicine issued by the General Medical Council.

Hospital

- Listed hospital: A private hospital registered under the UK's Care Standards Act 2000. Details of your chosen hospital list will be shown on your Certificate of Insurance.
- NHS hospital: hospitals run by the National Health Service which provides Specialist facilities for treatment.

In-Patient

A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

Insured person/member

Anyone of the individuals specified on the Certificate of Insurance.

Main insured person

The person who is named first on a valid certificate of insurance.

Material fact

Information which is likely to influence us in the assessment, acceptance or renewal of the policy, or in making any changes to it. For example, information:

- about you or your dependants, your lifestyles, health or medical conditions, that we may have asked you questions about;
- that you have chosen to give to us; or
- that we have not asked you any questions about, but which you must disclose to us.

If you are in any doubt about whether or not a fact is material please tell us.

Maternity cash benefit

A benefit payable to the policyholder for a new born child. Benefit is payable upon receipt of the birth certificate within the first three months of the child's birth. This cannot be used if any other option has been utilised.

Medical condition

Any signs, symptom, illness, sickness, disease or injury.

38 Medically necessity/necessary

Services or supplies which are:

- Appropriate for the signs, symptoms, diagnosis or treatment of the medical condition.
- Provided for the diagnosis or direct care and treatment of the injury or disease.
- Within standards of good medical practice within an organised medical community.
- Not primarily for the convenience of the Insured Person or any other participating supplier providing appropriate covered services to the insured person.
- An appropriate supply and level of service needed to provide safe and adequate care.

If there is any doubt as to the medical necessity of treatment in respect of a claim, medical necessity shall be decided by our Chief Medical Officer.

National Health Service (NHS)

The NHS provides healthcare to anyone normally resident in the United Kingdom (excluding the Channel Islands and Isle of Man). Most services are free at the point of use for the patient though there are charges associated with eye tests, dental care, prescriptions, and many aspects of personal care.

Oral surgical procedures

- Replantation of tooth/teeth following trauma
- Surgical removal of impacted/ buried tooth/ teeth
- Surgical removal of complicated buried roots
- Surgical drainage of dental abscess
- Apicectomy
- Enucleation of cyst of jaw
- Treatment of mandibular, zygomatic or maxillary fractures including internal or external fixation
- Excision or resection of mandible or maxilla, including removal of malignancy
- Maxillary osteotomy and prosthetic surgery
- Open operations of the jaw including the temporo-mandibular joint.
- Hospitalisation for dental treatment where anti-coagulant therapy requires management.

Osteopath

An individual whose name appears on the practice register of the General Osteopathic Council (GOsC) and holds full registration.

Out-Patient

A patient who attends a hospital, consulting room, or out-patient clinic and is not admitted as a day-patient or an in-patient.

Palliative Treatment

Any treatment given for the sole purpose of relieving symptoms rather than attempting cure of a medical condition.

Patient

An insured person being treated for a medical condition.

Personal Medical Exclusion

Exclusion(s) applied on the insured person's certificate of insurance and in addition to the policy exclusions.

Phobia

A persistent, irrational, intense fear of a specific object, activity or situation.

Physiotherapist

A person who is qualified to practice and is a member of the Chartered Society of Physiotherapists.

Podiatrist

An individual whose name appears on the practice register of The Society of Chiropodists and Podiatrists holding full registration.

Policy

The application form, declaration, policy document, schedule of fees, certificate of insurance, hospital lists, table of benefits, and any endorsements.

Policy period

The period shown on the certificate of insurance.

Pre-existing condition

Any medical condition or related medical condition for which:

- you have received medication, advice or treatment; or
- you have experienced symptoms;

whether the medical condition has been diagnosed or not in the five years before the commencement date.

Pre-authorisation

A process through which an insured person seeks approval from us prior to undertaking treatment or incurring costs.

13. DEFINITIONS (CONTINUED)

Pregnancy Complications

We consider the following list as a complication in pregnancy:

- Abnormal presentation
- Ectopic pregnancy
- Miscarriage
- Missed abortion
- Still birth
- Post partum haemorrhage
- Retained placental membrane

Premiums

The amount you must pay us each year as a premium for the policy insurance.

Primary Care

The advice, treatment and investigations provided by your General Practitioner, optician or dentist without any involvement of a Specialist.

Private road ambulance

A vehicle operated under the registration of the National Association of Private Ambulance Services.

Professional Sport

A sport where an income is received.

Psychiatric illness

An acute mental illness treated by a psychiatrist following a referral by a general practitioner.

Reasonable and customary

What we consider to be acceptable treatment charges as either outlined in our schedule of fees or based on our experience and knowledge.

Recuperative/Rehabilitation Care

The process of restoring an individual to normal or the highest possible near normal function, following the treatment of a medical condition.

Registered/Qualified Nurse

A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.

Related medical condition

Any medical condition, which is medically considered to be associated with another medical condition.

Routine dental treatment

Any treatment required which is not as a result of an emergency or accidental dental injury.

Second Opinion

Obtaining an alternative opinion of a medical condition from a second Specialist chosen by you.

Specialist

A medical practitioner who is currently registered under the Medical Acts and:

- Holds relevant and higher qualifications that are accepted and approved by us; and
- Holds or has held a consultants appointment in an NHS hospital and holds a Specialist Accreditation issued by the General Medical Council.

Third party opinion

Obtaining an alternative opinion of a medical condition from a second specialist chosen by us.

Treatment

Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a medical condition.

UK

The United Kingdom of Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

We/us/our

The appointed agents (Freedom Healthnet Ltd) acting on behalf of Anahita Insurance Corporation.

Winter sports

Skiing of any form (including snow skiing, dry-slope skiing, cross country skiing, alpine skiing, glacier skiing, land skiing, mono-skiing, langlauf or Nordic skiing, ski-racing, ski-jumping, ski-flying, ski-bobbing, ski-acrobatics, stunting and heli-skiing), ice-skating and use of sledges, skeletons, snow boards, snow mobiles, bobsleighs, toboggans or luge.

You/your

The Policyholder and each Insured Person who is listed on the Certificate of Insurance.

CONTACT DETAILS

Contact us

Freedom Healthnet Ltd
Bourne Gate
25 Bourne Valley Road
Poole BH12 1DY

Tel: **+44 (0)1202 756350**
Fax: **+44 (0)1202 756351**
Email: **info@freedomhealthinsurance.co.uk**
Web: **www.freedomhealthinsurance.co.uk**

Please note telephone calls may be recorded.

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Freedom elite