



Freedom Benefit Guide

Your comprehensive guide to international health insurance plans for the UK

Welcome to Freedom Health Insurance

deel.

Welcome and thank you for choosing private medical insurance from Freedom Health Insurance. you and your family can rely on us to give you access to quality care, supported by our dedicated team.

Established 2003

Award-winning provider of affordable and flexible health insurance for individuals and companies

Award winning Customer Service

Our friendly and knowledgeable staff deliver the highest standards of customer service

Simple documentation

We've kept our documents simple and easy to follow so you always know what your plan includes

We are delighted that you have joined us and look forward to supporting your healthcare journey.

To make the most of your international healthcare plan, please read this guide together with your **Insurance Certificate** and **Table of Benefits**.

For more information, visit www.fhi.co.uk

About this Benefit Guide

This guide is designed to help you find everything you need to know about your Freedom Health Insurance plan.

The sections below give you a clear overview of the support available, how to use your cover, and the important terms that apply:

Overview

How we can help

How to make a claim

Additional benefits

Understanding how your cover works

Seeking treatment

Additional information about claiming

Terms & Conditions

Administration of your policy

Data protection

Complaints procedure

Health Insurance Definitions

Health Insurance Exclusions

How we can help

If your need to make a claim, the simplest and fastest way is through the Freedom claims portal.

Our team is here to support you with any questions about your cover, claims, or membership details. We suggest noting down your policy number and our contact details for quick reference.

General Enquiries

Phone: **0800 999 2013** or **01202 756 350**

Email:

Policy Administration enquiries: info@fhi.co.uk

Claims enquiries: claims@fhi.co.uk



Opening hours

Policy Administration:

9am to 6pm, Monday to Friday
(excluding public holidays)

Claims Administration:

24/7, 365 days a week



Call recording

Calls may be recorded and monitored
for training and quality purposes



Free calls

Calls to 0800 numbers are free from
consumer landlines and mobiles

If you ever have questions, please get in touch — we'll be happy to help.

Need immediate assistance? Call our Freedom Helpline: **0800 999 2013**

How to make a claim

Freedom Claims Portal *powered by Mayfair We Care*



Through the **Freedom Claims Portal**, available as a secure online platform and mobile app, you have convenient access to your cover wherever you are.



My Policy

View your insurance documents and digital membership e-card.



My Claims

Submit claims online in a few simple steps and track their progress in real time.



My Providers

Search for medical providers worldwide, with integrated maps and directions.



My Alerts

Receive claim updates and important notifications directly on your device.



My Support

Contact the Freedom Helpline 24/7 by phone, email or via the Freedom Claims Portal.

 All personal data within the Freedom Claims Portal is encrypted and GDPR compliant.

Getting Started

Download the app

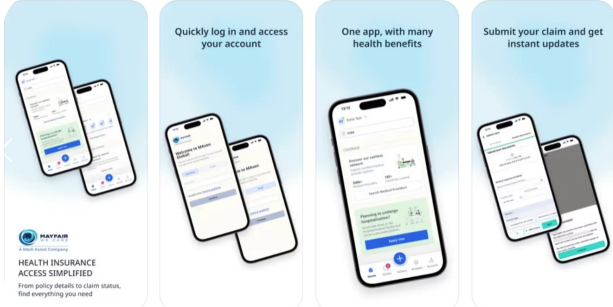
Get the **My Mayfair App** from the App Store or Google Play.



My Mayfair 17+
Medi Assist Healthcare Services
Free

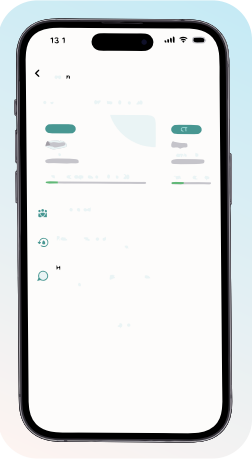
Register your account

Use your Freedom policy number and personal details to create your secure account.



Access your services

Log in to access your claims, policy and provider services all in one secure place.



A video tutorial is available at <https://www.youtube.com/watch?v=9lQlaBDjTYg> for step-by-step guidance.

Find out more about the Freedom Claims Portal [here](#)

Additional benefits

In this section, you'll find details of the extra services included with your Freedom Health Insurance plan, such as Freedom 360, Second Medical Opinion, and Travel Security Services, all designed to give you added support beyond your core cover.



Freedom 360 – Everyday support for your employees

Introducing Freedom 360, a powerful digital toolkit offering wellness support, expert care, and health and wellbeing discounts. All included in your core cover at no extra cost.

Freedom Partners

Freedom Digital GP

24/7 GP access via video or phone, with fast medical advice, prescriptions, and referrals - available in the UK.

1

2

Freedom Dermatology

Skin assessments to detect skin issues, including early signs of cancer, with fast, expert reviewed results - available in the UK.

Freedom Cancer Care

Personalised clinical, practical, and emotional support through every stage of diagnosis, treatment and recovery - available in the UK.

4

3

Freedom Wellness

In the moment support from experts helps you manage stress, anxiety, life challenges, and much more - available worldwide.

Freedom Favourites

A curated range of health and wellbeing discounts, offering valuable savings across fitness, nutrition, mental health, diagnostics, and lifestyle products.

Find out more about Freedom 360 [here](#)

How to access your Freedom 360 digital toolkit

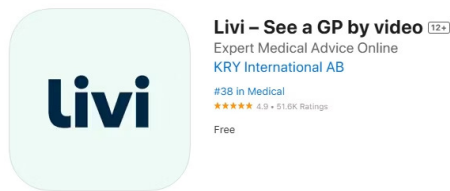
Freedom 360 gives you quick and easy access to four specialist partner services. Here's how to get started with each:

1

Freedom Digital GP

Partnered with eMed powered by Livi

- Download the Livi app from the App Store or Google Play



- Register using details that match your policy certificate. Registration will also require your Digital GP Membership code found on your welcome letter.
- Book a GP appointment 24/7 by phone or video consultation.

2

Freedom Dermatology

Partnered with Skin Analytics

To use Freedom Dermatology, please contact the Freedom Health Insurance Claims team:

- Email: claims@fhi.co.uk
- Phone: **0800 999 2013**

Choose from two simple pathways:

1. **Skin Lesion Pathway** – assess up to three lesions at once, with a response in three days. (*No GP referral needed*).
2. **General Dermatology Pathway** – GP referral required, app-based consultant support, with treatment and management plans provided within three days.

If your plan includes outpatient cover, the service is included. If cover is limited, fees will be deducted from your outpatient benefit.

Policies without outpatient cover cannot access this service.

3

Freedom Cancer Care

Partnered with Reframe Cancer

- If you receive a cancer diagnosis, call the Freedom Claims Helpline.
- You'll be connected to a member of the dedicated Cancer Care Team who will guide you through treatment, coordinate NHS and private pathways, and support you throughout your journey.
- Freedom Cancer Care Contact Details:
 - Email: cct@fhi.co.uk
 - Phone: **01202 283 592**

4

Freedom Wellness

- Choose from counselling, mindfulness, legal, financial or HR support
- Available 24/7 for employees and dependants
- Freedom Wellness is easy to contact via the following channels:
 - Call the Freephone line: **0800 243 458**
 - WhatsApp: **+1 984 920 6875**
 - Log in via the online portal. Code: FHI
 - Download the iConnectYou app. Code: 278086

Second medical opinion & Travel security services

Second Medical Opinion

Peace of mind when you need it most

If you're diagnosed with a serious illness or surgery is recommended, you can request a second medical opinion.

- A dedicated case manager will guide you through the process.
- Your case will be reviewed by an independent specialist.
- You'll receive expert advice on the best treatment options available.

Travel Security Services

Stay safe wherever you go

When travelling, you have access to 24/7 personal security information and advice.

- Emergency hotline for immediate safety concerns.
- Country intelligence reports with local safety guidance.
- Daily news alerts for high-risk events like terrorism or severe weather.

Please contact the Freedom Helpline if you have any queries.

Our third party providers

Certain services included within your plan are delivered by trusted third-party partners. Freedom partners included within Freedom 360 are Freedom Wellness, Freedom Dermatology (provided by Skin Analytics), Freedom Digital GP (provided by eMed, powered by Livi) and Freedom Cancer Care (provided by Reframe Cancer). Your policy also includes access to the Freedom Claims Portal, powered by Mayfair We Care.

These services are provided subject to the terms and conditions of your policy and those of each respective third-party provider. Availability may vary depending on your plan type and geographical location.

Freedom Partners available through Freedom 360 and the Freedom Claims Portal, powered by Mayfair We Care, along with any associated materials or resources, are provided by independent third-party professionals and organisations. Freedom Health Insurance does not provide clinical services, nor does it supervise or control third-party providers. Freedom Health Insurance accepts no responsibility or liability for any clinical advice, decisions, treatment or outcomes. Any guidance you receive is between you and the third-party professional, and you should always follow the advice of your treating clinician.

Freedom Health Insurance and its administrators are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of these third-party services.

Understanding how your cover works

Your health insurance provides comprehensive protection for you and your dependants, covering **medically necessary treatment and related costs**. This guide explains the key aspects of your coverage, including what's included, where you can receive treatment, and how benefit limits work. Cover is subject to:

Medically necessary treatment

Coverage for essential medical care and related costs, services, and supplies as detailed in your Table of Benefits.

Policy definitions and exclusions

Your cover is subject to the policy definitions and exclusions set out in this guide.

Reasonable and customary costs

These are charges that are usual within the country of treatment. We will only reimburse medical providers where their fees follow standard and generally accepted medical practice. If we consider a claim excessive or inappropriate, Freedom reserves the right to decline or reduce payment.

Pre-existing conditions (including chronic conditions) are covered unless otherwise excluded in your policy documents. Check your Table of Benefits to confirm coverage, and contact the Freedom Helpline if you're unsure about planned treatment.

Where can I receive treatment?

Your healthcare coverage extends across your designated **area of cover**, giving you flexibility in choosing where to receive medical treatment whilst maintaining comprehensive protection, as shown in your Insurance Certificate. The key principle is that all eligible medical costs are covered within your policy terms, regardless of location within your coverage area.

Within your coverage area

Treatment is available in any country shown on your Insurance Certificate. If local treatment is available but you prefer to travel elsewhere within your coverage area, we'll reimburse all eligible medical costs within policy terms.

Travel expenses are not covered when treatment is locally available

Medical evacuation coverage

When treatment is **not available locally** and your plan includes Medical Evacuation, we cover travel costs to the nearest suitable facility.

Pre-authorisation required for evacuation coverage

Home country treatment

Eligible treatment in your **home country** is fully covered, provided your home country falls within your designated area of cover.

Full coverage applies when home country is included

Understanding your benefit limits & payments

Your insurance plan is designed to give you comprehensive cover, with clear limits and cost-sharing rules to help manage expenses fairly. Below is an outline of your **Benefit Limits**:



Maximum plan limits

Your plan may be subject to a **maximum plan limit** – the most we will pay in total for all benefits per insured person, per Insurance Year.

This applies even where:

- The term **“Full refund”** appears next to a benefit.
- A **specific benefit limit** applies (e.g. £10,000).

Benefit limits may apply on a **per Insurance Year**, **per lifetime**, or **per event** basis (such as per trip, per visit, or per pregnancy).

In some cases, Freedom Health may also pay only a **percentage of costs** for certain benefits (e.g. 65% refund up to £4,150).



Maternity coverage limits

For "Routine maternity" and "Complications of pregnancy and childbirth", benefits are paid either **per pregnancy** or **per Insurance Year** (your Table of Benefits will confirm).

If maternity is covered on a **per pregnancy** basis and a pregnancy spans two Insurance Years, these rules apply:

- **Year 1** – limits apply to eligible costs incurred that year.
- **Year 2** – updated limits apply, less any amount already reimbursed in Year 1.
- If the limit decreases at renewal and we have already paid up to or above that level, no further benefit is payable in Year 2.

Limits for multiple birth babies, all babies born by surrogacy, adopted and fostered children:

- For in-patient treatment in the first three months following birth, a limit of **£24,900 per child** applies if the baby:
 - is a **multiple-birth baby** from assisted reproduction,
 - was **born by surrogacy**,
 - is **adopted**, or
 - is **fostered**.
- Outpatient treatment is covered under the outpatient Plan.

Co-payments & financial protections

What are co-payments?

A **co-payment** is when you pay a set percentage of eligible costs and Freedom pays the remainder. The percentage that applies to your plan is shown in your **Table of Benefits**.

What are deductibles?

A **deductible** (also called an excess) is a fixed amount you must pay each Insurance Year before Freedom begins to contribute towards eligible costs. Your **Table of Benefits** confirms whether a **deductible** applies and the amount.

Check your Table of Benefits to confirm if these apply to your specific plan

Key financial protections

Understanding your benefit structure ensures you can make informed decisions about your healthcare whilst maximising your coverage benefits.



Comprehensive limits

Maximum plan limits provide overall financial protection



Flexible payment options

Co-payments and deductibles offer cost-sharing arrangements



Specialised coverage

Enhanced protection for maternity and newborn care

Seeking treatment

We understand that seeking treatment can be stressful. Follow the steps below so we can look after the details – whilst you concentrate on getting better.

01

Check your cover

Verify that your plan covers the treatment you're seeking, using your Table of Benefits

03

Emergency care

Get immediate treatment and contact us within 48 hours if hospitalised

05

Outpatient claims

If you do not have direct settlement, pay your provider and submit claims via our Freedom Claims Portal

02

Pre-authorisation

Some treatments require approval before proceeding - check your Table of Benefits

04

In-patient treatment

Contact our claims team at least five working days before treatment

06

Evacuations

Contact Freedom Helpline immediately before arranging any evacuation services

The following cards will walk you through each step in detail.

Understanding your cover and pre-authorisation

Check your level of cover

- First, check that your plan covers the treatment you are seeking
- Your **Table of Benefits** will confirm what is included
- If you are unsure, contact the **Freedom Helpline** for support

Pre-authorisation requirements

Your Table of Benefits will show which treatments require **pre-authorisation**. This applies mainly to in-patient treatment and high-cost outpatient procedures.

Pre-authorisation allows us to assess your case, liaise with the hospital, and (where possible) arrange direct payment of your hospital bill.

If pre-authorisation is not obtained

- If treatment is later proven to be **medically unnecessary**, your claim may be declined
- If treatment is later proven to be **medically necessary**, Freedom will cover only **80% of in-patient benefits** and 50% of other benefits

Emergency and in-patient treatment

Emergency treatment

- Get the emergency treatment you need and call us if you require any advice or support
- If you are hospitalised, either you, your doctor, one of your dependants, or a colleague must call our Helpline **within 48 hours** of admission
- We can take pre-authorisation details over the phone when you call

In-patient treatment

To obtain pre-authorisation, use the Freedom Claims Portal to enter your claim details, making sure you submit your pre-authorisation form at least **five working days before treatment** .

If treatment is due within **72 hours**, you can provide details by speaking to a member of our claims team over the phone:

- Phone: **01202 756 350** (Monday–Friday, 9am–6pm)

Claims, evacuation and repatriation



Outpatient claims process

1. If you do not have direct settlement, receive your treatment and pay the provider.
2. Request an invoice including: patient's name, treatment date(s), diagnosis, date of symptom onset, details of treatment, and fees charged.
3. Submit your claim via the **Freedom Claims Portal powered by Mayfair We Care**.
4. Upload your invoices, enter the details, and submit your claim.



Evacuations and repatriations

If you may need medical evacuation or repatriation, call the **Freedom Helpline immediately**.

Phone: **+44 1202 756 350**

Email: **claims@fhi.co.uk**

Always contact us before speaking with providers directly. If evacuation or repatriation is not arranged through Freedom Health, costs may not be covered.

Additional information about claiming for your expenses

Medical claims

Prior to presenting a claim to us, kindly observe the subsequent considerations:

Claiming deadline

All claims (submitted via our Freedom Claims Portal) must reach us no later than six months after the conclusion of the Insurance Year. If coverage is terminated during the Insurance Year, your submission should be made within six months following the date your coverage ceased. After this period, we are not obligated to honor the claim.

Claim submission

A separate claim must be submitted for each individual seeking reimbursement and for every unique medical condition being claimed.

Supporting documents

When you send us copies of supporting documents (e.g., medical receipts), please ensure that you retain the original versions. We reserve the right to demand original supporting documentation/receipts for auditing purposes for up to twelve months after your claim has been settled. We may also ask for evidence of your payment (e.g., a bank or credit card statement) for healthcare expenses you have covered. We advise keeping duplicates of all communications with us, as we cannot be held accountable for correspondence that fails to reach us for reasons beyond our influence.

Deductibles

If the sum you are seeking is less than the deductible amount specified in your policy, you may either:

- Collect all outpatient receipts until the total reaches an amount that surpasses this deductible figure.
- Forward each claim to us every time you receive treatment. Once you reach the deductible sum, we will begin reimbursing you. Please attach all supporting receipts and/or invoices with your submission.

Currency

We will reimburse you in the same currency as your premiums are paid. On rare occasions, we may be unable to make a payment in that particular currency due to international banking rules. If this situation arises, we will identify an appropriate alternative currency. Should we need to convert from one currency to another, we will apply the exchange rate that was in effect on the date the invoices were issued.

Reimbursement

We will only compensate (within the limitations of your policy) eligible expenditures after considering any pre-authorisation requirements, deductibles, or co-payments as detailed in the Table of Benefits.

Reasonable and customary cost

We will only cover charges that are considered fair and typical in accordance with standard and generally accepted medical practices. If we deem a claim to be inappropriate, we maintain the right to refuse your claim or decrease the sum we pay.

Deposits

If you are required to make an initial payment prior to any medical treatment, we will compensate this cost exclusively after the treatment has been completed.

Providing information

You and your dependants agree to assist us in acquiring all the necessary data to process a claim. We reserve the right to access all medical records and to engage in direct discussions with the healthcare provider or the attending physician. We may, at our own expense, request a medical assessment by our doctors if we deem it essential. All details will be handled with discretion. We reserve the right to withhold benefits if you or your dependants do not support us in obtaining the required information.

Claims for accidental death

Should the "accidental death" provision be part of your health coverage, notification of the claim is required within 90 business days subsequent to the date of the policyholder's passing.

Please send us:

A fully completed life and <u>accidental death benefit</u> application form	A death certificate
A medical report indicating the cause of death	A written statement outlining the date, location and circumstances of the <u>accident</u>
Official documentation proving the <u>insured person's</u> family status (e.g., their marital status or parental responsibilities)	For the beneficiaries, proof of identity as well as proof of their relationship to the <u>insured person</u>

Beneficiaries are, unless otherwise specified by the insured:

- 1 The insured person's spouse or partner**
Provided there is no legal separation
- 2 If there is no spouse, the insured person's surviving children**
Comprising step-children, adopted or foster children, and offspring born within 300 days following the policyholder's demise; to be divided equally among them
- 3 If there are no children, the insured person's father and mother**
To be shared equally by both, or to the surviving parent should one precede the other in death
- 4 Failing any of the above, the insured person's estate**

Should you desire to designate a beneficiary not enumerated above, kindly get in touch with our Freedom Helpline.

Kindly be aware that in the event the policyholder and any or all beneficiaries perish in the same occurrence, the policyholder shall be presumed to have died last.

Treatment needed as a result of someone else's fault

If you are submitting a claim for medical care necessitated by the fault of another individual, you must inform us in writing without delay. For instance, if you require treatment after being involved in a road accident as a victim. Please take any reasonable measures we request to acquire the insurance information of the responsible party. We can then seek reimbursement from the other insurer for the cost of treatment we have covered. If you manage to directly recover the expense of any treatment we have paid for, you will be obligated to repay that amount (plus any accrued interest) to us.

Terms and Conditions

This section outlines the benefits and regulations of your health insurance policy. Please review it alongside your Insurance Certificate and Table of Benefits.

1

Insurance Certificate

Your Insurance Certificate provides details of the plan(s) and geographical coverage area that your company has selected for you and your dependants (where applicable). It also indicates the commencement date and renewal date of your coverage. For policies where your medical history is evaluated (underwritten policies) this document will specify any special conditions that may apply to your coverage. Please be aware that we will issue you a new Insurance Certificate if we need to record any modifications to your policy. These may be changes that your company requests or changes we are entitled to make. They may also be changes that you request (such as adding a dependant) – provided your company approves and we accept.

2

Table of Benefits

Your Table of Benefits details the plan(s) chosen by your company and the benefits available to you. It also identifies any benefits/treatments which require you to submit a Pre-authorisation Form. It confirms any benefits to which specific benefit limits, waiting periods, **deductibles** and/or co-payments apply. Your Table of Benefits will be in the currency agreed with your company (or with you, if you pay the insurance premium).

For complete details of your company's insurance contract, please contact your company's Group Scheme Manager. Please note that the terms and conditions of your coverage may be amended from time to time by agreement between your company and us.

Administration of your policy

Understanding the administrative aspects of your healthcare insurance policy is essential for ensuring continuous coverage and making the most of your benefits. This comprehensive guide covers everything from when your cover begins to how premiums are managed, providing you with the knowledge needed to navigate your policy effectively.

When cover commences for you and your dependants

Policy validity period

Your insurance becomes valid from the start date displayed on the Insurance Certificate and continues until the group renewal date (also stated on the Insurance Certificate). Typically, this spans one Insurance Year, unless we and your company agree otherwise or if you commenced your policy mid-year.

Renewal terms

At the conclusion of this period, your company may renew the insurance based on the policy terms and conditions applicable at that time. You will be bound by those terms.

Dependant coverage

Cover for dependants (if applicable) commences on the effective date shown on the most recent Insurance Certificate which lists them as your dependants. Their membership may continue for as long as you remain part of the group scheme and, for children, as long as they remain under the defined age limit.

Child age limits

Child dependants can be covered under your policy up until the day before their 18th birthday or up until the day before their 24th birthday if they are in full-time education. At that time, they may apply for cover in their own right under one of our plans for individuals and families.

Adding dependants to your policy

You may apply to include any member of your family as a dependant if you are permitted to under the agreement between your company and us.

How do I add a newborn to my policy?

Newborn infants (including multiple birth babies, babies born by surrogacy, adopted and fostered children) will be accepted for cover from birth, provided that we are **notified within four weeks** of the **date of birth**.

To have a newborn added to the policy, you must ask your company to submit a request in writing, including a copy of the birth certificate, to its usual contact person for membership changes.

Certificate updates

Following acceptance, we will issue a new Insurance Certificate to reflect the addition of a dependant.

This new certificate will replace any earlier version(s) you may have from the start date shown on it.

What happens if I don't notify my company within four weeks?

If we are notified four weeks or more after the date of birth, newborn children will be accepted for cover from the date of that notification.

There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- was born by surrogacy
- is adopted
- is fostered
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is **£24,900 per child**. Outpatient treatment is paid under the terms of the Outpatient Plan.

Important administrative changes

Changing country of residence

It is important that you contact our **Freedom Helpline** and notify your **Group Scheme Manager** to let us know when you change your country of residence. This may affect your cover or premium, even if you are moving to a country within your geographical area of cover, as your existing plan may not be valid there.

Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Changing your postal address or email address

We will send all correspondence to the address we have on record for you unless requested otherwise. You need to inform us in writing as soon as possible of any change in your home, business or email address.

Correspondence

When you write to us, please use email or post (with the postage paid). We do not usually return original documents to you, but if you ask us to, we will.

Renewal of cover

If your company pays for your premium, the renewal of your cover (and that of your dependants, if applicable) is the decision of your company.

If you pay your premium and your company renews your cover (and that of your dependants, if applicable), your policy will automatically renew for the next Insurance Year, if:

- We can continue to provide cover in your country of residence
- All premiums due to us have been paid
- The payment details we have for you are still valid on the policy renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

Policy termination and premium management

Ending your cover

Your company can end your cover or that of any of your dependants by notifying us in writing. We cannot backdate the cancellation of your cover. It will automatically end:

Policy agreement termination

At the end of the Insurance Year, if the agreement between your company and us is terminated.

Company decision

If your company decides to end or not to renew your cover.

Payment issues

If your company does not pay premiums or any other payment due to us.

Individual payment default

If you are an individual payer and you do not pay premiums or any other payment due to us.

Employment changes

When you stop working for your company.

Death of employee

Upon the death of the insured employee.

We can end your cover and that of your dependants if there is reasonable evidence that you or they have misled or attempted to mislead us. For example giving us false information, withholding information, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

- Whether you (or they) can join the scheme
- What premiums your company has to pay
- Whether we have to pay any claim

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends. For up to six months after the expiry date, we will reimburse any eligible expenses incurred during the period of cover.

However, we will no longer cover any on-going or further treatment that is required after the expiry date of your policy.

Applying for cover if group membership ends

If your cover comes to an end, you can apply for cover under one of our Plans for Individuals and Families, by simply sending us an email (info@fhi.co.uk). You need to submit your application within one month of leaving the group scheme. You may be subject to underwriting. If we accept your application, cover will start on the first day after you leave the group scheme.

Paying Premiums

If your company pays your insurance premium

In most cases, your company is responsible for paying the premiums for you and your dependants. Your company may also pay other taxes and charges associated with your cover (such as Insurance Premium Tax). However you may be liable to pay tax in respect of the premiums paid by your company. For details, please check with your company.

If you pay your insurance premium

If you are responsible for paying your insurance premium, you need to pay us in advance for the duration of your cover. Your Insurance Certificate shows the amount your company has agreed with us and your selected payment frequency. The initial premium or first premium installment is payable immediately after we accept your application. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third-parties. Subsequent premiums are due on the first day of the chosen payment period.

Additional taxes and charges if you pay your insurance premium

If applicable, you may also need to pay the following taxes in addition to your premium:

- Insurance Premium Tax (IPT).
- Other taxes, levies or charges relating to your cover that we may have to pay or collect from you by law.

These charges may already be in effect when you join but they could be introduced (or change) afterwards. Your invoice will show these taxes. If they change or if new taxes are introduced, we will write to inform you. If you do not accept the changes, you can choose to end your cover. We will not apply any of the changes if you end your membership within 30 days of the date they take effect, or within 30 days of us telling you about the changes (whichever is later).

In some countries you may also be required to apply withholding tax. If that is the case, it is your responsibility to calculate and pay this amount to the relevant authorities in addition to payment of your full premium to us.

Annual renewal and premium changes

Each year on the renewal date, we may change how we calculate your premiums and taxes, the amount you have to pay and/or the method of payment. If so, we will inform you of these changes and they will only apply from your renewal date. If you wish, you can change the way you pay at policy renewal. Please write to us to request this at least 30 days before the renewal date.

Important: If you are unable to pay your premium for any reason, please contact us so that we can discuss this with you, as if you don't pay your premiums on time you may lose your cover.

Additional terms that apply to your cover

Understanding the key provisions and conditions that govern your insurance policy

Applicable law

Your policy is governed by the laws of England and Wales, unless local law requires otherwise.

Sanctions suspension clause

No (re)Insurance Provider shall be deemed to provide cover and no (re)Insurance Provider shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)Insurance Provider to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America and/or any other applicable national economic or trade sanction law or regulations.

Who is covered

Only those group members (and their dependants) named in your Insurance Certificate are eligible for cover.

Amounts payable

Our liability is limited to the amounts shown in your **Table of Benefits** and any endorsements. Reimbursement under this policy, a public medical scheme, or any other insurance will never exceed the invoiced amount.

Changes to your policy

Only an appointed representative or your Group Scheme Manager can request changes on your behalf. Changes are only valid once agreed by your company and Freedom.

Coverage limitations and administrative provisions



When cover is provided elsewhere

We may **decline a claim** if you or your dependants can claim benefits from:

- a public scheme,
- another insurance policy, or
- another third party.

You must inform us and provide the necessary details. You and the third party cannot agree a settlement or waive our right to recover expenses without our written consent. If you do, we may recover from you any amount we have paid and cancel your cover.

We are entitled to recover from a third party any costs we have paid if those costs should have been met by them. We may take legal action in your name, at our expense, to do this (known as **subrogation**).

We will not share costs with another insurer if their policy fully or partly covers them. If our plan provides a higher level of cover, we will pay the balance not covered by the other insurer.



Circumstances outside our control (force majeure)

We will always act in your best interests, but we are not liable for delays or failures caused by **events outside our reasonable control**.

Examples include: extreme weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, war or hostilities, riots, explosions, strikes, labour unrest, civil disturbances, sabotage, or actions by government authorities.

Cancellation and Fraud

- For policies with full medical underwriting, the information you and your dependants provide (e.g. on application forms or supporting documents) must be accurate and complete. If it is incorrect, incomplete, or you fail to disclose something relevant, your policy may be invalid from the start date. You must also tell us about any medical conditions that arise between submitting the application and the start of the policy. Undisclosed conditions are unlikely to be covered. If you are unsure whether something is relevant, please call us for guidance.
- We will not pay benefits for any claim that is:
 - false, fraudulent or intentionally exaggerated, or
 - supported by fraudulent means used by you, your dependants, or anyone acting on your behalf.

Any claims paid before discovery of a fraudulent act or omission will become immediately repayable to us. We reserve the right to notify your company of fraudulent activity.

Contacting dependants

To administer your policy, we may need further information. Where this relates to a dependant (e.g. requesting an adult dependant's email address), we may contact you, as the policyholder, to provide that information if it is not sensitive. Likewise, for claims administration we may send you non-sensitive information about a family member.

Data protection & Privacy Policy

Freedom Health Insurance Privacy Information

Our **Freedom Health Insurance Privacy Policy** explains how we protect your privacy and process your personal data. You must read it before sending us any personal information.

To read our Privacy Policy, visit: www.fhi.co.uk/privacy-policy

Freedom Helpline

Phone: **0800 999 2013**

Data Queries

Email: info@fhi.co.uk

Need a paper copy? Call our Freedom Helpline for a printed version delivered to your address.

Your privacy matters to us. We're committed to transparency in how we collect, use, and protect your personal information throughout your healthcare journey.

How we use your personal information

If you have any queries concerning our data protection policy, write to the Chief Operating Officer at Freedom Health Insurance.

Confidentiality and protecting your information

Freedom Health Insurance will deal with all personal information supplied to us in the strictest confidence. We will comply with all requirements of current data protection legislation.

We may appoint a third party to assist with the administration of claims. Any third party we appoint will only process personal information for the sole purpose of administering a claim and in line with our instructions and all processing carried out on our behalf is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by current data protection legislation.

From time to time, it may be necessary to process personal information outside of the European Economic Area (EEA) – for example, in order to guarantee payment of medical treatment costs in an overseas hospital. We will take reasonable steps to ensure personal information is protected.

How we will use personal information

The information we receive in connection with a policy, including any claims made under that policy, will be held by us, on behalf of the underwriter, for the purpose of providing and managing the insurance cover available under that policy. This includes:

- processing claims and making payments on behalf of an insured person;
- obtaining further information about an insured person's condition and treatment plan from their GP, specialist, hospital or any other medical practitioner involved in their treatment;
- sharing information with another insurer to recover our proportionate share of treatment costs in relation to a 'dual insurance' claim;
- sharing information with a solicitor or another third party to recover our costs in relation to a 'third party' claim;
- producing statistics to help us assess how our policies are used to enable us to develop future products and services.

To help the policyholder review a group scheme, we may include details of claims paid in anonymised statistical reports we send to the group secretary and any broker appointed by the policyholder.

We will not give medical information to anyone unless we have been given permission or we are allowed to by law.

Information about family members

If a member gives us personal information about another insured person for the purpose of administering a policy or making a claim, we will assume that the member has the insured person's consent to do so.

Most correspondence about a policy, including claims correspondence, will be sent to the member because the policy will be in their name. If any insured person over 18 years of age does not want us to do this, they should let us know. It may be preferable for that insured person to apply for their own policy in their own name.

Preventing and detecting fraud

To protect the interests of all our customers, we will share information with external fraud prevention agencies to enable the detection and prevention of fraudulent and improper claims. This may include:

- sharing information about an insured person with other organisations and public bodies including the police where we have reasonable grounds to suspect that fraudulent claims may have been made;
- checking the details fraud prevention agencies hold about an insured person; and
- carrying out credit searches and searches of databases set up by the insurance industry to identify fraud.

If we are given false or inaccurate information and we suspect fraud, we will pass details to fraud prevention agencies. In addition, the policy may be cancelled, we will not pay the claim and we may report the matter to the policyholder and the police.

Requesting information

An insured person can ask for a copy of the information we hold about them and ask us to correct any mistakes in the information.

Passing information to other third parties

Other than for the sole purpose of administering a policy, or as required by law, we do not pass any personal information on to any third party for marketing purposes.

Destruction of personal information

We will hold information for a reasonable period of time (usually no more than two years) after a policy has ended. It will then be destroyed in a secure and confidential manner.

HDI Global Specialty SE privacy notice

HDI Global Specialty SE is a joint data controller. You can get a copy of its privacy notice at www.hdi.global/legal/privacy

How to make a complaint

At Freedom Health Insurance, our customers have the right to expect excellent customer service at all times. However, from time to time, things can go wrong and, when they do, we want you to tell us.

How to contact Freedom Health Insurance

Phone: **0800 999 2013 or 01202 756 350**

Email: complaints@fhi.co.uk

Post: **County Gates House, 300 Poole Road, Poole, Dorset BH12 1AZ**

We will investigate your complaint and provide you with our final decision within no more than eight weeks.

If you remain unhappy with our response, or if we have not replied within eight weeks, you may have the right to refer your complaint to the Financial Ombudsman Service.

About the Financial Ombudsman Service (FOS)

The Financial Ombudsman Service provides a free and independent service for resolving complaints with financial services firms. The FOS will only consider your complaint if you have given us the opportunity to resolve the matter first and you must refer your complaint to the FOS within six months of our final decision letter.

If you do not refer your complaint in time, the FOS will not have our permission to consider your complaint and so will only be able to do so in very limited circumstances. For example, if the FOS believes the delay was as a result of exceptional circumstances.

How to contact the Financial Ombudsman Service

Phone: **0800 023 4567 or 0300 123 9123**

Post: **Exchange Tower, Harbour Exchange, London, E14 9SR**

More information about the Financial Ombudsman Service is available on its website at www.financial-ombudsman.org.uk

If you contact the FOS, this does not affect your right to take legal action if you are dissatisfied with, and do not accept, the outcome of the review.

Financial Services Compensation Scheme

The Insurer is covered by the Financial Services Compensation Scheme, which means you may be entitled to compensation if the Insurer is unable to meet their obligations to you.

For further information, please visit www.fscs.org.uk or contact:

Phone: **0800 678 1100 or 020 7741 4000**

Post: **Financial Services Compensation Scheme, PO Box 300, Mitcheldean, GL17 1DY**

Email: enquiries@fscs.org.uk

Health Insurance Definitions

A comprehensive guide to understanding your health insurance terms and benefits. This glossary provides clear definitions of key terms, coverage details, and important conditions that affect your healthcare coverage.

If your plan includes any benefit not listed below, the definition will appear in the "Important Policy Information" section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy they will always have the following meanings:

A

Accident

Sudden, unexpected event that causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy.

Accidental death benefit

Amount shown in the Table of Benefits which becomes payable if an insured person (aged 18 to 70) dies during the period of insurance as a result of an accident (including an industrial injury).

A

- **Accommodation costs for one parent staying in hospital with an insured child** - Hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.
- **Acute** - 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.
- **Allergy testing** - A visit to a licensed practitioner to test for and discover if your symptoms are related to an allergy. If included in your plan as a specific benefit, cover is limited to the amount shown in your Table of Benefits.

B

Burial expenses

The cost of burials or cremation that take place outside the home country or principal country of residence. It doesn't include related ceremonial costs such as food and beverage, travel, accommodation, flowers and sympathy cards.



Cancer screening

Health checks, tests and examinations for the early detection of illness or disease, which are performed at appropriate age intervals and undertaken without any clinical symptoms being present. Please refer to your Table of Benefits to confirm what tests and checks are covered under this benefit.



Child hearing exam

It provides a contribution towards the services of a suitably qualified and recognised hearing care professional in the country of treatment. To be eligible for this benefit, your child must be 16 years or younger and covered at the time they receive the service. When submitting a claim, please attach a dated invoice from the provider.

C

- **Chronic condition** - Sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics: is recurrent in nature; is without a known, generally recognised cure; is not generally deemed to respond well to treatment; requires palliative treatment; leads to permanent disability. Please refer to the "Important Policy Information" section of your Table of Benefits to confirm whether chronic conditions are covered.
- **Company** - Your employer through which you and your dependants are insured with us. We and your company set out who can be covered, when cover begins, how it is renewed and how premiums are paid.
- **Complementary treatment** - Therapeutic and diagnostic treatment that exists outside of traditional Western medicine. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practised by approved therapists.
- **Complications of childbirth** - Post-partum haemorrhage and retained placental membrane only. Where your plan also includes a routine maternity benefit, complications of childbirth includes medically necessary caesarean sections.
- **Complications of pregnancy** - It relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.
- **Co-payment** - The percentage of the costs which you must pay. E.g. if a benefit has an 80% refund, this means that a co-payment of 20% applies, therefore we will pay 80% of the costs of each eligible treatment per insured person, per Insurance Year.

D

Day-care treatment

Planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductible

Also referred to as 'excess' in health insurance. It is the part of the cost that is payable by you and that we deduct from the amount we will pay. Where deductibles apply, they are payable per person per Insurance Year, unless your Table of Benefits states otherwise.

D

- **Dental prescription drugs** - Drugs prescribed by a dentist for the treatment of dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. They do not include mouthwashes, fluoride products, antiseptic gels and toothpastes.
- **Dental prostheses** - Crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.
- **Dental surgery** - Surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.
- **Dental treatment** - An annual check-up, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

D

- **Dependant** - Your spouse or partner and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 24th birthday if they are in full-time education.
- **Diagnostic tests** - Investigations such as x-rays or blood tests, carried out for diagnostic purposes. These tests are covered when you are already displaying symptoms or when needed following other medical test results. This benefit does not cover annual check-ups or routine screenings.
- **Dietician fees** - Charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practise in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.
- **Direct family history** - It exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.
- **Doctor** - A person who is licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

E

Emergency

The onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency_event will be covered.

Emergency in-patient dental treatment

Acute emergency dental treatment for the relief of pain that is due to a serious accident and requires admission to hospital. The treatment must take place within 24 hours of the emergency_event. Cover does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

E

- **Emergency outpatient dental treatment** - Treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. However, if your policy also includes a Dental Plan, it will cover dental treatment in excess of the limit on 'Emergency outpatient dental treatment' benefit. In that case, the Dental Plan terms will apply.
- **Emergency outpatient treatment** - Treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes an Outpatient Plan, it will cover you for outpatient treatment in excess of the limit on 'Emergency outpatient treatment' benefit. In that case, the Outpatient Plan terms will apply.
- **Emergency treatment outside area of cover** - Treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided for up to six weeks per trip within the maximum benefit amount. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. Please tell your company's Group Scheme Manager if you are going to be outside your area of cover for more than six weeks.
- **Expenses for one person accompanying an evacuated/repatriated person** - Travel costs for one person accompanying the evacuated/repatriated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation/repatriation started from. Cover is not provided for hotel accommodation or other related expenses.

F

Family history

It exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

Full medical underwriting

The assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

G

1

Gender dysphoria

The distress a person feels due to a mismatch between their gender identity and their sex assigned at birth.

2

Gender dysphoria services

Any of the following medically necessary treatments: Behavioural health services such as counselling for gender dysphoria and related psychiatric conditions (e.g. anxiety, depression). Treatment must be prescribed by a psychiatrist or PhD clinical psychologist; Hormonal therapy; Age-related and gender-specific preventive health checks such as cervical, breast, prostate cancer screenings, as appropriate to the individual's biological anatomy; Gender reassignment and related surgery, if you are diagnosed as having gender dysphoria, and the following criteria are met:

- You are at least 18 years old.
- You have one letter of recommendation for surgery from a mental health professional for breast/chest surgery or two letters of recommendations from two separate mental health professional for genital surgery, including an extensive report. We will also accept a letter from a master's degree-level professional (it refers to anyone working in the mental health field – psychiatrist, mental health nurse or psychologist who has done a relevant master's degree in this medical area) if the second letter is from a psychiatrist or PhD clinical psychologist.

The recommendation must be based on assessments conducted within the last 24 months and must indicate that your decision is current and not due to any other treatable condition or disorder. Each recommendation must state that the surgery is medically necessary according to evidence-based clinical guidelines.



G

- **Group Scheme Manager** - The designated representative of your company, who acts as the point of contact between the company and us for matters relating to the administration of the plan such as enrolment, premium collection and renewal.
- **Groups with full medical underwriting** - Groups where members' medical history is assessed.

H



Health and wellbeing checks including screening for the early detection of illness or disease

Health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present. Please refer to your Table of Benefits to confirm what tests and checks are covered under this benefit.



HIV or AIDS treatment

A benefit that covers consultations, investigations, in-patient and outpatient treatment related to a diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). If included in your plan as a specific benefit, cover is limited to the amount shown in your Table of Benefits.

H

- **Home country** - A country for which you hold a current passport or which is your principal country of residence.
- **Hormone replacement therapy** - The use of female hormones for the relief of symptoms resulting from cessation of ovarian function, either at the time of the natural menopause or following surgical removal of the ovaries. Cover is provided for medical practitioner fees, specialists fees as well as prescription drug expenses.
- **Hospital** - Any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a doctor. The following are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.
- **Hospital accommodation** - Standard private or semi-private accommodation as shown in the Table of Benefits - deluxe, executive rooms and suites are not covered. The hospital accommodation benefit only applies when the hospitalisation is not related to any other in-patient benefit shown on the Table of Benefits. For example, if a member is hospitalised for cancer treatment, the hospital accommodation will be covered under the oncology benefit, and not under the hospital accommodation benefit. Examples of benefits that already include hospital accommodation (if included in your plan) are Psychiatry and psychotherapy, Organ transplant, Oncology, Routine maternity, Palliative care and Long-term care.



Infertility treatment

All invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. It also covers treatment such as InVitro Fertilisation (IVF), for diagnosed cases of infertility. We will cover the cost of treatment for the insured member who receives it, up to the limit indicated in the Table of Benefits. You can't claim under an insured spouse/partner's cover for costs that exceed your benefit limit.

All non-invasive investigative procedures undertaken to establish the cause of infertility are covered within the relevant benefit limits of the Outpatient Plan (if you have one). Examples of benefits that cover non-invasive investigations procedures are 'Diagnostic tests', 'Medical practitioner fees' and 'Specialist fees'.

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to £24,900 per child for the first three months following birth. Outpatient treatment is paid under the terms of the Outpatient Plan.

In-patient cash benefit

It is payable when you receive in-patient treatment for a medical condition that is covered by us but is free of charge for you, i.e. when the full cost of your treatment is funded by your national health service and no claim is made or paid by us under any section of this policy. In-patient cash benefit is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital.



- **In-patient treatment** - Treatment received in a hospital where an overnight stay is medically necessary.
- **Insurance Certificate** - A document we issue that outlines the details of your cover. It confirms that your company has a group insurance policy with us.
- **Insurance Year** - It applies from the effective date of your policy, as shown on the Insurance Certificate and ends at the expiry date of that shown on your Insurance Certificate or that which your company informs you of. The following Insurance Year coincides with the year that is agreed between us and your company.
- **Insured person** - You and your dependants as stated on your Insurance Certificate.





Laser eye treatment

The surgical improvement of the refractive quality of the cornea using laser technology, including the necessary pre-operative investigations.

Local ambulance

Ambulance transport that is required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

Long-term care

Care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.



Medical evacuation

It applies in the following scenarios:

- If the necessary treatment you are covered for is not available locally
- If adequately screened blood is unavailable in an emergency.

We will evacuate you to the nearest appropriate medical centre (which may or may not be in your home country) by ambulance, helicopter or aeroplane. The medical evacuation should be requested by your doctor, and will be carried out in the most economical way that is appropriate to your medical condition. Following completion of treatment, we will also cover the cost of your return trip at economy rates to your principal country of residence.

If you can't travel or be evacuated for medical reasons following discharge from an in-patient episode of care, we will cover the reasonable cost of hotel accommodation in a private en-suite room for up to seven days. We do not cover costs for hotel suites, four or five-star hotel accommodation or hotel accommodation for an accompanying person.

If you are evacuated to the nearest appropriate medical centre for ongoing treatment, we will cover the reasonable cost of hotel accommodation in a private en-suite room. This cost must be more economical than the cost of a series of journeys between the nearest appropriate medical centre and your principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, try to locate and transport screened blood and sterile transfusion equipment, if this is advised by the treating doctor and our own medical experts. We and our agents accept no liability if we are unsuccessful or if contaminated blood or equipment is used by the treating authority.

You must contact us at the first indication that you need an evacuation. From this point onwards, we will organise and coordinate the evacuation until you arrive safely at your destination of care. If evacuation services are not organised by us, we reserve the right to decline all costs incurred.



Medical necessity

Medical treatment, services or supplies that fulfil all of the following:

- a) Essential to identify or treat your condition, illness or injury
- b) Consistent with your symptoms, diagnosis or treatment of the underlying condition
- c) In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover)
- d) Required for reasons other than the comfort or convenience of you or your doctor
- e) Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover)
- f) Considered to be the most appropriate type and level of service or supply
- g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition
- h) Provided only for an appropriate duration of time

In this definition, the term “appropriate” means taking patient safety and cost effectiveness into consideration. In respect to in-patient treatment, “medically necessary” also means that diagnosis can't be made or treatment can't be safely and effectively provided on an outpatient basis.

M

- **Medical practitioner fees** - Fees charged for non-surgical treatment performed or administered by a medical practitioner.
- **Medical practitioners** - Doctors who are licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.
- **Medical repatriation** - An optional level of cover and where provided will be shown in the Table of Benefits. If the necessary treatment for which you are covered isn't available locally you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is within your geographical area of cover. Following completion of treatment, we will also cover the cost of your return trip at economy rates, to your principal country of residence. The return journey must take place within one month after treatment has been completed. You must contact us at the first indication that repatriation is required. From this point onwards we will organise and coordinate all stages of the repatriation until you arrive safely at your destination of care. If the repatriation is not organised by us, we reserve the right to decline all costs incurred.
- **Mental health professional** - A practitioner working in health care, counselling or social services who offers services for the purpose of treating mental health conditions.
- **Midwife fees** - Fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has completed the necessary training and passed the necessary state examinations.

N

Newborn care

Customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth.

Cover doesn't include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant).

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to £24,900 per child for the first three months following birth. Outpatient treatment is paid with in the terms of the Outpatient Plan.

Non-prescribed physiotherapy

Treatment provided by a registered physiotherapist without being referred by a doctor in advance. Cover is limited to the number of sessions indicated in your Table of Benefits. A doctor must prescribe any additional sessions over this limit, which will be covered under the Prescribed physiotherapy benefit. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta.

- **Non-underwritten groups** - Groups where the members' health information is not assessed.
- **Nursing at home or in a convalescent home** - Nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will pay the benefit listed in the Table of Benefits if the treating doctor decides that it is medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. This benefit also needs to be approved by our Medical Officer. This benefit doesn't cover spas, cure centres, health resorts, palliative care or long-term care.

O

Obesity

It is diagnosed when a person has a body mass index (BMI) of over 30.

Occupational therapy

Treatment that helps you develop skills needed for daily living and interactions with other people and the environment. These refer to:

- Fine and gross motor skills (how you perform small, precise tasks and whole-body movement).
- Sensory integration (how the brain organises a response to your senses).
- Coordination, balance and other skills such as dressing, eating and grooming.

We will need to see a progress report after every 20 sessions.

Oculomotor therapy

A specific type of occupational therapy that aims to synchronise eye movement when there is a lack of coordination between eye muscles.

Oncology

Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis. We also cover the cost of an external prosthetic device for cosmetic purposes, for example a wig for hair loss or a prosthetic bra after breast cancer treatment.

Oral and maxillofacial surgical procedures

Surgical treatment on the mouth, jaws, face or neck performed in a hospital by an oral and maxillofacial surgeon for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours.

Unless you hold a Dental Plan, we do not cover the following procedures even if they are performed by an oral and maxillofacial surgeon:

- Surgical removal of impacted teeth
- Surgical removal of cysts

Orthognathic surgeries for the correction of malocclusion

Organ transplant

The following organ or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea. We do not reimburse the costs of acquiring organs.

Orthodontics

The use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria is very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria.

Medical necessity criteria:

1. Increased overjet > 6mm but <= 9 mm
2. Reverse overjet > 3.5 mm with no masticatory or speech difficulties
3. Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
4. Severe displacements of teeth > 4
5. Extreme lateral or anterior open bites > 4 mm
6. Increased and complete overbite with gingival or palatal trauma
7. Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
8. Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
9. Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
10. Partially erupted teeth, tipped and impacted against adjacent teeth
11. Existing supernumerary teeth

You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/or standard removable appliances. However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the 'Orthodontic treatment' benefit limit.

Orthomolecular treatment

Alternative treatment that aims to restore the individual biochemical balance through supplements using natural substances such as vitamins, minerals, enzymes and hormones.

Outpatient surgery

Surgical procedure performed in a surgery, hospital, day-care facility or outpatient department that does not require you to stay overnight out of medical necessity.

Outpatient treatment

Treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

P

Palliative care

Ongoing treatment that aims to alleviate the physical/psychological suffering associated with progressive, incurable illness and to maintain quality of life. It includes in- patient, day-care and outpatient treatment following the diagnosis of a terminal condition. We will pay for physical care, psychological care, hospital or hospice accommodation, nursing care and prescription drugs.

Partner

A person you have lived with in a conjugal relationship for a continuous period of 12 months.

Periodontics

Dental treatment related to gum disease.

Post-natal care

Routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions

Medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

- The date we issued your Insurance Certificate or
- The start date of your policy

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered. Please refer to the “Important Policy Information” section of your Table of Benefits to confirm if pre-existing conditions are covered.

Pregnancy

The period of time when you are expecting a baby, from the date of the first diagnosis until delivery.

Pre-natal care

Common screening and follow-up tests required during pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and, if directly linked to an eligible amniocentesis, DNA-analysis.

Prescribed drugs

Over the counter drugs when prescribed by a doctor to:

- Treat a confirmed diagnosis or medical condition
- Compensate a lack of vital bodily substances

Examples are aspirins, vitamins and hypodermic needles. Prescribed drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by the pharmaceutical regulator in the country where you use the prescription. Even if you can legally buy a medication without a doctor's prescription in that country, you must get a prescription for these costs to be covered.

Prescribed glasses and contact lenses including eye examination

Cover for a routine eye examination carried out by an optometrist or ophthalmologist (one check-up per Insurance Year) and for lenses and glasses to correct vision.

Prescribed medical aids

Any device which is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
- Hearing and speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long-term wound aids such as dressings and stoma supplies.

We do not cover costs for medical aids that form part of palliative care or long-term care.

Prescribed physiotherapy

Treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report after every set of 12 sessions, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescription drugs

Products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily substances. Examples are antibiotics, sedatives, etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by internationally accepted medical guidelines. You can claim for a supply of up to a 3 months from the prescription date, subject to length of time remaining on the policy.

Preventative surgery

Prophylactic mastectomy or prophylactic oophorectomy. We will pay for preventative surgery when:

- You have a direct family history of a disease which is part of a hereditary cancer syndrome (for example, breast cancer or ovarian cancer) and
- Genetic testing has established the presence of a hereditary cancer syndrome.

Preventive treatment

Treatment you receive without any clinical symptoms being present at the time of treatment (e.g. the removal of a pre-cancerous growth). This benefit is covered when the 'Preventive treatment' benefit is listed in your Table of Benefits.

Principal country of residence

The country where you and your dependants (if applicable) live for more than six months of the year.

Professional sports

Training for or taking part in any sport for which you:

- are paid;
- receive a grant or sponsorship (excluding travel costs); or
- are competing for prize money.

Psychiatry and psychotherapy

The treatment of mental, behavioural and personality disorders, including autism spectrum and eating disorder. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary.

All day-care or in-patient admissions must include prescription medication related to the condition.

Outpatient psychotherapy treatment (where covered) requires referral by a doctor and is limited for 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Counselling is available through our Freedom 360 Toolkit and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This is not meant for longer-term situations or the treatment of clinical disorders. Freedom Wellness can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition, coping with isolation and loneliness.

R

Reasonable and customary

Treatment costs that are usual within the country of treatment. We will only reimburse the cost of medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures.

Rehabilitation

Treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery.

Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment.

Repatriation of mortal remains

The transportation of the insured deceased remains from the principal country of residence to the country of burial. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

Routine maternity

Medically necessary costs incurred during pregnancy and childbirth. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction). We do not cover costs of complications of pregnancy and childbirth under the 'Routine maternity' benefit. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

In case of home deliveries, we will pay up to the amount specified in the Table of Benefits if your plan includes the 'Home delivery' benefit.

S

1 Sleep apnoea

A sleep disorder characterised by pauses in breathing or periods of shallow breathing during sleep. If this benefit is indicated in your Table of Benefits, we will provide cover for the medically necessary treatment and diagnostic procedures related to a confirmed or suspected sleep apnoea diagnosis. The costs which are covered under this benefit include professional fees, a medically necessary sleep study, other necessary diagnostic tests, medical aids and drugs, up to the limits indicated on your Table of Benefits. Please note that proof of medical necessity is required.

2 Specialist

A licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.

3 Specialist fees

Non-surgical treatment performed or administered by a licensed doctor. This benefit does not include cover for psychiatrist, psychologist fees or any treatment that is already covered by another benefit under your Table of Benefits. We don't cover specialist treatment that is excluded under your policy.

4 Speech therapy

Treatment carried out by a qualified speech therapist to treat diagnosed physical impairments. This includes conditions such as nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

5 Surgical appliances and materials

Those required for surgeries. They include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

T

Therapist

A chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs of insured family members in the event of an evacuation/repatriation

The reasonable transportation costs of all insured family members of the evacuated or repatriated person, including minors who might otherwise be left unattended. If all family members can't travel in the same vehicle with the evacuated/repatriated person, we will pay for their round- trip transport at economy rates.

The 'Travel costs of insured family members in the event of a repatriation' benefit is covered if you have a repatriation plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of the repatriation of mortal remains

The reasonable transportation costs of any insured family members who had been living abroad with the insured person who died, to travel to the country of burial of the deceased. Reasonable transportation costs are considered to be round trip transport costs at economy rates. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured members to be with a family member who is at peril of death or who has died

The reasonable transportation costs of insured family members to be with a first-degree relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). In the case of a deceased relative, travel must commence within 6 weeks of their date of death.

Reasonable transportation costs are considered to be round trip transport costs at economy rates. A first-degree relative is a spouse or partner, parent, brother, sister or child, including adopted children, fostered children or step-children. When claiming, please include copies of the travel tickets and the death certificate or a doctor's certificate supporting the reason for travel. Cover does not include hotel accommodation or other related expenses.

Treatment

Medical procedure needed to cure or relieve illness or injury.

Treatment of autism spectrum disorder

A range of therapies to improve the skills of an insured person with autism. This includes specialist medical treatment and accredited behavioural programmes. Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Outpatient Plan, if you have one. Check your Table of Benefit for any limits that may apply. We don't cover admissions, stays or day care treatment at specialised educational facilities.

Treatment of eating disorders

A combination of psychotherapies, including cognitive behavioural therapy, medical monitoring, prescribed medication and nutritional counselling to treat anorexia nervosa, bulimia nervosa and binge-eating disorder.

All day-care or in-patient admissions must include prescription medication related to the condition.

Outpatient therapy (where covered) requires referral by a doctor and is limited for 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

V, W, Y

Vaccinations

- All basic immunisations and booster injections that are required by law in the country in which they are administered.
- Vaccination against COVID-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

We cover the cost of consultation for administering the vaccine and the cost of the drug.

*We cover any COVID-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) which demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.
- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

We cover the reasonable and customary cost of the COVID-19 vaccine, including the administration of the injection, in line with local public health policies related to the allocation of vaccines. We do not pay towards the travel cost if you decide to travel to a different country from where you normally reside in order to get the vaccination. Please note that cover is not intended to give you priority access to vaccines.

Video consultation services

They provide direct access to a doctor via a telecommunication platform. This benefit covers the costs of video consultations, as indicated in your Table of Benefits and offers medical advice, diagnosis and issuance of a prescription, if needed, for non-urgent medical care. Access to teleconsultation services and prescriptions will depend on your geographical location and local country regulations. You can make an appointment to speak to a medical practitioner in English, subject to availability. Some third party providers may offer additional core languages. Cost of medicines are not included, but delivery of medicine or referrals may or may not be included under this benefit, even when prescribed or recommended during the video consultation.

Waiting period

A period of time that begins on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits shows which benefits are subject to waiting periods.

We/Our/Us

Freedom Healthnet Limited (trading as Freedom Health Insurance) in its role as insurance provider and administrator.

This group scheme is underwritten by HDI Global Specialty SE, Starr International (Europe) Limited (SIEL) and HCC International Insurance Company plc ('HCCII') trading as Tokio Marine HCC.

HDI Global Specialty SE. HDI Global Specialty is authorised and regulated by BaFin. Authorised by the Prudential Regulation Authority. Subject to regulation by the Financial Conduct Authority and limited regulation by the Prudential Regulation Authority. Details about the extent of our regulation by the Prudential Regulation Authority are available from HDI Global Specialty SE on request. (FRN: 659331) HDI Global Specialty SE is registered in Germany (commercial register number HRB 211924) and has its registered office at HDI Platz 1, 30659 Hannover, Germany, and its UK branch office at 20 Gracechurch Street, London, EC3V 0BA, United Kingdom.

HCC International Insurance Company plc ('HCCII') trading as Tokio Marine HCC. HCCII is registered in England and Wales, (Company Reg No: 01575839) with its registered office at 1 Aldgate, London EC3N 1RE. HCCII is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority (Firm Reference Number 202655).

Starr International (Europe) Limited, registered office address 30 Fenchurch Avenue, London EC3M 5AD, United Kingdom. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Firm reference Number: 676783.

This group scheme is administered on behalf of the underwriter by Freedom Health Insurance

You/Your

The person working for the company and any dependants named on the Insurance Certificate.

Health Insurance Exclusions

Understanding what your health insurance policy does not cover is crucial for making informed healthcare decisions. These exclusions represent specific circumstances, treatments, and conditions that fall outside the scope of your coverage, unless otherwise listed in the Table of Benefits.

1

Accidental death benefit

If the death of an insured person has been caused directly or indirectly by:

- Active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.
- Intentionally caused diseases or self-inflicted injuries, including suicide, within one year of the enrolment date of the policy.
- Active participation in underground or underwater activity such as underground mining or deep-sea diving.
- Above-water activity (such as on oil platforms or oil rigs) and aerial activity, unless specifically agreed by us.
- Chemical or biological contamination, radioactivity or any nuclear material contamination, including the combustion of nuclear fuel.
- Passive war risk:
 - Being in a country where the British government has recommended that their citizens leave (this condition will apply regardless of the insured person's nationality) and has advised against “all travel” to that location or
 - Travelling to or staying, for more than 28 days per stay, in a country or an area where the British government advises “against all but essential travel”.

The passive war risk exclusion applies regardless of whether the claim arises directly or indirectly as a consequence of war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.

- Being under the influence of drugs or alcohol.
- Death that takes place more than 365 days after the occurrence of the accident.
- Deliberate exposure to danger, except in an attempt to save human life.
- Intentional inhalation of gas or intentional ingestion of poisons or legally prohibited drugs.
- Flying in an aircraft, including helicopters, unless the insured person is a passenger and the pilot is legally licensed, or is a military pilot and has filed a scheduled flight plan when required by local regulations.
- Active participation in extreme or professional sports including, but not limited to:
 - Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).
 - Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
 - Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
 - Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
 - Car and motorcycle sports such as motorcycle riding and quad biking.
 - Combative sports.
 - Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
 - Various other sports such as bungee jumping.

2

Acquisition of an organ

Expenses for the acquisition of an organ such as, but not limited to donor search, typing, harvesting, transport and administration costs.

Benefits that are not included in your Table of Benefits

The following benefits or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:

- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses. The only exception is oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Dietician fees.
- Emergency dental treatment.
- Expenses for one person accompanying an evacuated/repatriated person.
- Health and wellbeing checks including screening for the early detection of illness or disease.
- Home delivery.
- Infertility treatment.
- In-patient psychiatry and psychotherapy treatment.
- Medical repatriation.
- Organ transplant.
- Outpatient psychiatry and psychotherapy treatment.
- Outpatient treatment.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity.
- Travel costs of insured family members in the event of an evacuation/repatriation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.
- Travel costs of insured members to be with a family member who is at peril of death or who has died.
- Vaccinations.

C

1 **Chemical contamination and radioactivity**

Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

2 **Complementary treatment**

Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

3 **Complications caused by conditions not covered under your plan**

Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

4 **Consultations performed by you or a family member**

Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

D - F

Dental Veneers

Dental veneers and related procedures.

Developmental delay

Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified medical professionals and documented as a delay in development of at least 12 months.

Drug addiction or alcoholism

Care and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments to stop smoking), death associated with drug addiction or alcoholism, or the treatment of any condition that in our reasonable opinion is related to, or is a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

Experimental or unproven treatment or drug therapy

Any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

Failure to seek or follow medical advice

Treatment required as a result of failure to seek or follow medical advice.

Family therapy and counselling

Costs in respect of a family therapist or counsellor for outpatient psychotherapy treatment.

Fees for the completion of a claim form

Doctor's fees for the completion of a Claim Form or other administration charges.

G - I

Genetic Testing

Genetic testing, except:

- a) Where specific genetic tests are included within your plan.
- b) Where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
- c) Where testing for genetic receptor of tumours is covered.

Home visits

Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

Infertility treatment

Infertility treatment including medically assisted reproduction or treatment for any medical problems arising from it, unless you have a specific benefit for infertility treatment or have an Outpatient Plan. If you have an Outpatient Plan we will only cover non-invasive investigations into the cause of infertility (within the limits of your Outpatient Plan).

Injuries caused by professional sports

Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

Intentionally caused diseases or self-inflicted injury

Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

L - O

Laser eye treatment

Treatment to change the refraction of one or both eyes (laser eye correction).

Loss of hair and hair replacement

Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

Medical error

Treatment required as a result of medical error.

Obesity treatment

Investigations into and treatment for obesity.

Orthomolecular treatment

Please refer to the definition of 'Orthomolecular treatment'.

Participation in war or criminal acts

Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

- War
- Riots
- Civil disturbances
- Terrorism
- Criminal acts
- Illegal acts
- Acts against any foreign hostility

Plastic surgery

Treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes, and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exceptions are approved gender dysphoria and reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during your period of cover.

Pre- and post-natal

Pre- and post-natal classes.

Pre-existing conditions

For underwritten groups, pre-existing conditions (including pre-existing chronic conditions) when:

- Indicated on a Special Conditions Form that we issue before your policy starts
- Conditions were not disclosed on the application form
- Conditions arise between completing the application form and the later of the following:
 - The date we issue your Insurance Certificate or
 - The start date of your policy

Such conditions will also be subject to medical underwriting and if not disclosed, will not be covered.

Products sold without prescription

Products that can be purchased without a doctor's prescription, except where a specific benefit covering these costs appears in the Table of Benefits.

1

Sex change

Sex change related operations and related treatments such as:

- Blepharoplasty
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Face/forehead lift
- Facial bone reduction (osteoplasty)
- Hair removal/hair transplantation
- Jaw reduction
- Laryngoplasty
- Rhinoplasty
- Skin resurfacing (e.g., dermabrasion, chemical peels)
- Thyroid reduction chondroplasty
- Neck tightening
- Lip enhancement
- Botox and filler injections

2

Sleep disorders

Treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.

3

Speech therapy

Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

4

Stays in a cure centre

Stays in a cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.

5

Sterilisation, sexual dysfunction and contraception

Investigations into, treatment of and complications arising from:

- Sterilisation.
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

6

Surrogacy

Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.

T

Termination of pregnancy

Termination of pregnancy, except where the life of the pregnant woman is in danger.

Travel costs

Travel costs to and from medical facilities (including parking costs) for treatment, except when covered under 'Local ambulance', 'Medical evacuation' and 'Medical repatriation' benefits.

Treatment in the USA

Treatment is not covered in the USA.

Treatment outside the geographical area of cover

Treatment outside the geographical area of cover unless for emergencies or authorised by us.

Triple/bart's, quadruple or spina bifida tests

Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

Tumour marker testing

Tumour marker testing, unless you have been previously diagnosed with the specific cancer in question, in which case the cover is covered in the "Oncology." benefit.

V

Vessel at sea

Medical evacuation/repatriation from a vessel at sea to a medical facility on land.

Vitamins or minerals

Products classified as:

- Vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes).
- Supplements such as, infant formula and cosmetic products.

These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

Thank you

for choosing Freedom Health Insurance

Together, we make healthcare simpler, faster, and more personal.

Simpler

Streamlined processes and digital tools make managing your health insurance effortless

Faster

Quick claims processing and direct settlement get you the care you need without delay

More Personal

Dedicated support and tailored solutions designed around your unique healthcare needs

Taking care of tomorrow.