Solutions

Policy Wording 100–249 employees

| Retirement | Investments | Insurance | **Health** |

AVIVA

Welcome to Aviva

This booklet tells you about your policy and the cover your company provides for its members, including:

- what's covered
- what's not covered, and
- explanations of some of the terms used in this document so that you're fully aware of the cover that's being provided.

Throughout this booklet certain words are shown in **bold** type. These are defined terms and have specific meanings when used in this booklet. The meanings are set out in the definitions section which can be found in the back pages.

We've designed this booklet to be as easy to understand as possible, but if you've any questions or queries about your policy please call us on **0800 158 3333** and we'll be pleased to help you. Calls to and from Aviva may be monitored and/or recorded.

This policy is insured by Aviva Insurance Limited and administered by Aviva Health UK Limited.

Contents

Cover and benefits

The information on these pages details the benefits available under **your policy**.

Some important notes apply:

- This **policy** covers **treatment** of **acute conditions**. It does not cover **chronic conditions**.

  An **acute condition** is defined as a disease, illness or injury that is likely to respond quickly to **treatment** which aims to return a **member** to the state of health they were in immediately before suffering from it, or which leads to their full recovery.

- All **treatment** and **diagnostic tests** must be by, and under the care of, a **specialist** following referral by a **GP** unless otherwise stated.

Members are covered for eligible **treatment**. Eligible **treatment** is **treatment** of an **acute condition**:

- covered under the **policy**, including facilities, services and equipment
- shown by current best available clinical evidence to improve the **member's** health outcome, at the time the **member's treatment** takes place
- appropriate for the **member's** individual care, including how it is carried out, how long it continues and how often it occurs
- carried out by a health care professional, such as a **specialist**, who is qualified to provide the **member's treatment** and to care for their condition, and is recognised by **us**
- carried out at a **hospital** on the **member's** list, a facility recognised by **us** as part of a **network** or an NHS **hospital** recognised by **us** to provide the type of **treatment** undertaken
- carried out in facilities where appropriate clinical governance processes are in place at the time the **member's treatment** takes place, and
- undertaken because the **member** needs it for medical reasons.

All **treatment** and **diagnostic tests** must be carried out by providers (such as **hospitals,** facilities, **specialists**) recognised by **us**. If a **member** has **treatment** with a provider that **we** do not recognise, **we** will not pay that provider's fees.

Core cover

All benefit limits and excesses (if applicable) apply to each **member** every **policy year** unless otherwise stated.

Benefits	Amount payable	Notes
A. Hospital treatment as an in-patient or day-patient		**See networks and hospital charges benefit terms**
If a **member** has the six week option, they cannot claim for these benefits if their **treatment** is available on the NHS (including **accident or emergency admissions**) within six weeks from the date their **specialist** recommends it.		
Hospital charges	In full	Including accommodation and meals, nursing care, drugs and surgical dressings and theatre fees. See hospital charges benefit term
Specialists' fees	Up to the limits in **our** specialist fee schedule	See specialists' fees benefit term
Diagnostic tests	In full	Including blood tests, X-rays, scans and ECGs
Radiotherapy/chemotherapy	In full	
NHS cash benefit	£100 per night, up to 25 nights	See NHS cash benefit term
Hospital treatment as an in-patient or day-patient		**See networks benefit term**
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
B. Treatment as an out-patient		**See networks benefit term**
Consultations with a **fee approved specialist**	In full	See consultation fees benefit term
Treatment by a **specialist** as an **out-patient**	In full	Including **hospital** fees, equipment charges, anaesthesia. **Specialists'** fees are covered up to the limits in **our** fee schedule. See specialists' fees benefit term
Diagnostic tests	In full	CT, MRI and PET scans as an **out-patient** are only covered at a **diagnostic centre. Specialists'** fees for surgical procedures are covered up to the limits in **our** fee schedule. See specialists' fees benefit term
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	
Radiotherapy/chemotherapy	In full	

Benefits	Amount payable	Notes
B. Treatment as an out-patient		**See networks benefit term**
Specialist referred **treatment** by: • a **physiotherapist** • a **chiropractor** • an **osteopath** for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	
Psychiatric **treatment**	Up to £2,000	On **GP** referral to a **psychiatric therapist** or psychiatric **specialist.** See psychiatric benefit term
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
C. Additional benefits		**See networks benefit term**
Home nursing	In full	Immediately following **in-patient** or **day-patient treatment** that is covered by the **policy**. See home nursing benefit term
Private ambulance	In full	See private ambulance benefit term
Parent accommodation when staying with a child covered by the **policy**	In full	Child of 15 or under receiving **treatment** covered by the **policy**; one parent only
Hospice donation	£70 per day, up to 10 days	See hospice benefit term
Baby bonus	£100 for each baby	Payable to the **group member**. See baby bonus benefit term
Limited emergency overseas cover	In full	Emergency **treatment** as an **in-patient** or **day-patient** during overseas trips of up to 90 days in total each **policy year.** See overseas benefit term
Treatment for complications of pregnancy and childbirth	In full	See pregnancy complications and specialists' fees benefit terms
Investigations into the causes of infertility	In full	
Surgical procedures on the teeth performed in a **hospital**	In full	Specialists' fees are covered up to the limits in **our** fee schedule. See specialists' fees benefit term
Stress counselling helpline	Unlimited number of calls	This benefit is available to **members** aged 16 and over. See stress counselling helpline benefit term

Options

The following optional benefits will only apply if they have been chosen by **you** and will be shown on **your** accepted quotation. The options **you** have chosen will appear in the **group member** booklet.

The benefits and benefit terms that apply to each option add to, or amend benefits provided in core cover.

Benefits	Amount payable	Notes – see networks benefit term
1. Mental health treatment		
Treatment as an **in-patient** or **day-patient –** accommodation and nursing	Either 28 days or 45 days (as shown on the accepted quotation)	For each **member**, every **policy year.** See psychiatric benefit term
Specialists' fees for **in-patient treatment**	Up to £210 per week	

2. Routine and GP referred services	
Benefits are subject to a combined limit of £1,000 for each **member** every **policy year**	
Consultations with a **fee approved specialist** and **diagnostic tests**, for a chronic condition	Benefit is only available if the disease, illness or injury is not otherwise excluded by the **policy**. See consultation fees benefit term
Follow-up consultations with a **fee approved specialist** to monitor a **member** when they have finished **treatment** for an **acute condition**	
GP referred radiology and pathology for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions	CT, MRI and PET scans as an **out-patient** are only covered at a **diagnostic centre**
GP referred **treatment** by • a **physiotherapist** • a **chiropractor** • an **osteopath** • an **acupuncturist** for any condition other than pain in the back, neck muscles or joints – musculoskeletal conditions	Up to 10 sessions in combined total each **member**, each condition, every **policy year.** See therapies benefit term
GP referred **treatment** by • a **chiropodist/podiatrist** • a **homeopath** for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions	
GP minor surgery – £100 per procedure	For procedures appearing on **our GP** minor surgery list. For further details please see aviva.co.uk/gp-minor-surgery

Benefits	Amount payable	Notes – see networks benefit term
3. Hospital lists – members will have the Key hospital list unless **you** have chosen one of the following:		
Extended hospital list		See hospital charges benefit term
Signature hospital list – available to residents of Scotland and Northern Ireland only		See hospital charges benefit term
Fair + Square hospital list – available to existing Fair + Square hospital list holders only		See Fair + Square hospitals benefit term

4. Dental and optical		
Routine dental treatment	Up to £500, of which the **member** pays £50 excess	See routine dental treatment benefit term See dental and optical excess benefit term for details of how the excess works
Treatment by a dentist of an accidental dental injury	Up to £600	See accidental dental injury benefit term
Optical benefit	Up to £300, of which the **member** pays £50 excess	See optical benefit term. See dental and optical excess benefit term for details of how the excess works

5. Six week	
A **member** cannot claim for private **treatment** as an **in-patient** or **day-patient**, NHS cash benefit, NHS cancer cash benefit or for the cost of an NHS amenity bed, if their **treatment** is available on the NHS (including **accident or emergency admissions**) within six weeks from the date their **specialist** recommends it	

6. Member excess	
£50	Benefits covered under this **policy** will be subject to an excess payable for each **member** every **policy year.** See excess benefit term
£100	
£150	
£200	
£250	
£500	

7. Selected benefit reduction – the following additional benefits are removed from core cover	
Limited emergency overseas cover	
Treatment for complications of pregnancy and childbirth	
Investigations into the causes of infertility	
Surgical procedures on the teeth performed in a **hospital**	

Benefits	Amount payable	Notes
8a. Reduced cover for out-patient treatment £0 limit– core cover benefits section B is deleted and replaced with:		
B. Treatment as an out-patient		**See networks benefit term**
If this option has been chosen, the only **out-patient** benefits available on the **policy** are:		
CT, MRI and PET scans	In full	These scans will only be covered at a **diagnostic centre**
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	**We** cover pre-admission tests that are carried out up to 14 days before **in-patient** or **day-patient treatment** that is covered by the **policy**
Physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
Radiotherapy/chemotherapy	In full	
If **you** have chosen 8a. **members** will have no cover as an **out-patient** for: • consultations with a **specialist** whether **fee approved** or not • **treatment** by a **specialist**, including **hospital** fees, equipment charges, anaesthesia • **diagnostic tests** • **specialist** referred **treatment** by a **physiotherapist**, **chiropractor** or **osteopath** for non-musculoskeletal conditions • psychiatric **treatment** • **treatment** (other than physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions)		

The monetary limit does not apply to **out-patient cancer treatment** received after the **member** has been diagnosed with **cancer**.

Benefits	Amount payable	Notes
8b. Reduced cover for out-patient treatment £1,000 limit– core cover benefits section B is deleted and replaced with:		
B. Treatment as an out-patient		**See networks benefit term**
CT, MRI and PET scans	In full	These scans will only be covered at a **diagnostic centre**
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	**We** cover pre-admission tests that are carried out up to 14 days before **in-patient** or **day-patient treatment** that is covered by the **policy**
Physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
Radiotherapy/chemotherapy	In full	
The following benefits are subject to a combined limit of £1,000 for each **member** every **policy year**		
Consultations with a **fee approved specialist**		See consultation fees benefit term
Treatment by a **specialist** as an **out-patient**		Including **hospital** fees, equipment charges, anaesthesia. **Specialists'** fees are covered up to the limits in **our** fee schedule. See specialists' fees benefit term
Diagnostic tests		Including pathology, X-rays and physiological tests (such as ECG's)
Treatment other than physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions		See BacktoBetter benefit term
Specialist referred **treatment** by: • a **physiotherapist** • a **chiropractor** • an **osteopath** for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions		
Psychiatric **treatment**		On **GP** referral to a **psychiatric therapist** or to a psychiatric **specialist**. See psychiatric benefit term

The monetary limit does not apply to **out-patient cancer treatment** received after the **member** has been diagnosed with **cancer**.

Benefits	Amount payable	Notes – see networks benefit term
8c. Reduced cover for out-patient treatment £1,500 limit– core cover benefits section B is deleted and replaced with:		
B. Treatment as an out-patient		**See networks benefit term**
CT, MRI and PET scans	In full	These scans will only be covered at a **diagnostic centre**
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	**We** cover pre-admission tests that are carried out up to 14 days before **in-patient** or **day-patient treatment** that is covered by the **policy**
Physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
Radiotherapy/chemotherapy	In full	
The following benefits are subject to a combined limit of £1,500 for each **member** every **policy year**		
Consultations with a **fee approved specialist**		See consultation fees benefit term
Treatment by a **specialist** as an **out-patient**		Including **hospital** fees, equipment charges, anaesthesia. **Specialists'** fees are covered up to the limits in **our** fee schedule. See specialists' fees benefit term
Diagnostic tests		Including pathology, X-rays and physiological tests (such as ECG's)
Treatment other than physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions		See BacktoBetter benefit term
Specialist referred **treatment** by: • a **physiotherapist** • a **chiropractor** • an **osteopath** for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions		
Psychiatric **treatment**		On **GP** referral to a **psychiatric therapist** or to a psychiatric **specialist**. See psychiatric benefit term

The monetary limit does not apply to **out-patient cancer treatment** received after the **member** has been diagnosed with **cancer**.

Benefit terms

The benefit tables tell **members** which benefit terms apply to them.

Accidental dental injury

We will pay for **treatment** required as a result of an injury which causes damage or deformity to teeth or gums which have not previously been decayed, diseased, repaired, restored or treated (other than scaling or polishing). This does not include damage to dentures or implants. The injury must be caused by an accident which occurs after the **member** joined the **policy.**

Baby bonus

We pay the **group member** a baby bonus of £100 for each baby born to or adopted (within a year of birth) by them or a **family member** during a **policy year.**

The baby bonus is only available if the baby is born or adopted more than ten months after the **group member** joins the **policy** and is payable once for each baby.

The above qualifying criteria applies to **members** with moratorium or full medical underwriting.

BacktoBetter

Muscukoskeletal conditions are

- pain
- stiffness
- weakness
- spasm
- a pull or strain, or
- other discomfort

in the back, neck, muscles or joints.

Members do not need to see a **GP** before making a claim for a musculoskeletal condition. **Members** should contact **us** before **treatment** begins and **our** recognised clinical providers will arrange the most appropriate **treatment** for the **member's** condition. **Treatment** may include, for example:

- telephone and/or online support
- **treatment** provided by **physiotherapists**
- referral to a **specialist**

If **we** have a musculoskeletal **network** for the **member's** condition, **treatment** must be carried out as part of that **network**. If the **policy** has the extended **hospital** list, **members** do not have to use **our networks**.

Treatment related to musculoskeletal conditions will not be an eligible claim under any other benefit on this **policy**, except for NHS cash benefit.

Please note:

- if the **member** is referred to an **osteopath** or **chiropractor**, **we** will check that they have been referred to a practitioner recognised by **us**. If the **member** receives **treatment** from an **osteopath** or **chiropractor** it will be limited to 10 sessions per condition per **policy year**
- physiotherapy for musculoskeletal conditions will not be subject to the **out-patient** limit (if one applies).

We are constantly reviewing the BacktoBetter service and may offer a different musculoskeletal claim pathway in the future where **we** identify opportunities to achieve the same or better clinical outcome for **members**, with the involvement of **our** recognised clinical providers.

For **members** aged 11 and under the BacktoBetter service is not available, however benefit is still available for **treatment** of musculoskeletal conditions. A **GP** referral should be obtained before contacting **us**.

Consultation fees

We will pay in full for consultations with a **fee approved specialist** or other **fee approved** practitioner. If the **member** has an eligible consultation with a **specialist** or other practitioner who is not **fee approved we** will only pay up to the limits **we** pay **our fee approved** providers. This could leave the

member with a shortfall that the **policy** does not cover. If the actual cost of the consultation is less than the amount **we** would have paid to a **fee approved** provider, **we** will pay for the consultation in full.

Dental and optical excess

Routine dental treatment and optical benefit each have a separate excess of £50. **We** will pay for the costs up to the limit covered by the **policy,** minus the excess.

For example if a claim is made for £220 for routine dental treatment covered by the **policy**, **we** will deduct the £50 excess from this sum and pay the balance of £170 to the **member.** The **member** is responsible for paying the £50 excess for the **treatment** received. This leaves a balance of £280 available to the **member** in this example for subsequent claims in the same **policy year.** The excess is only deducted once for each **member** every **policy year.**

If another excess has been chosen on the **policy** it will not apply to the dental and optical benefit.

Excess

If **you** have chosen an excess, **we** will pay for **treatment** covered by the **policy**, minus the amount of the excess.

The excess is applied to each **member**, each **policy year**. This means that if a claim or course of **treatment** continues from one **policy year** to the next, the excess will apply again.

For example, if there is a £500 excess on the **policy** and the **member's treatment** in a **policy year** costs £1,000, the **member** will pay the first £500 and **we** will pay the rest. If the **treatment** carries on into the next **policy year**, another excess will apply, so the **member** will again pay the first £500 of **treatment** received in that **policy year.**

If the **treatment** the **member** is claiming for costs £500 and the excess is also £500, the **member** will have to meet the full cost of that **treatment**. However, their excess will be paid and will not apply to other claims in that **policy year**.

The excess is applied on the date **treatment** takes place and not the date **we** pay the bill.

The excess does not apply to NHS cash benefit, the baby bonus, donations **we** make to a **hospice,** any benefit claims under the dental and optical benefit, NHS cancer cash benefit or the wigs benefit under benefits for **cancer treatment**.

If a **member** claims for a benefit that has a limit, and they have not already paid their excess for that **policy year**, the excess will count towards the benefit limit.

So if, for example, the **member's** excess was £200 and the **treatment** they are claiming for has a benefit limit of £1,000, they would have to pay the first £200 and **we** would only pay up to a further £800 for that benefit in that **policy year.**

If an excess applies, **we** will write to the **member** to advise who the excess should be paid to. The **member** is liable for the excess and this should be paid directly to the provider of **treatment** or services, for example the **specialist** or **hospital**.

Fair + Square hospitals

The Fair + Square hospital list is a closed list. It is not available as an option unless stated on **your** accepted quotation.

If a **member** has a condition or suspected condition for which **we** don't have a **network** and receives **treatment** as an **in-patient** or **day-patient** in a **hospital** that is not included on the Fair + Square hospital list but is recognised by **us, we** will calculate the average cost of equivalent **treatment** across all **hospitals** on the Fair + Square hospital list, and that average cost is the maximum **we** will pay. This could leave the **member** with a shortfall that the **policy** does not cover. If the actual cost of the **treatment** is less than the average cost, **we** will pay the **hospital** costs in full.

We will cover **specialists'** fees up to the limits in our fee schedule.

If a **member's treatment** is for a condition or suspected condition for which **we** have a **network, we** will only pay for that **treatment** if it is carried out at a facility and/or under the care of a **specialist** (or other practitioner) recognised by **us** as part of that **network.**

If a **member** receives **in-patient** or **day-patient treatment** in a **hospital** that is not included on the Fair + Square hospital list and is not recognised by **us, we** will not pay any **hospital** fees for their **treatment.**

Home nursing

We cover home nursing if this:

- is recommended and supervised by the **member's specialist**
- takes place in their home
- immediately follows **treatment** as an **in-patient** or **day-patient** that is covered by their **policy**
- is carried out by a **nurse** and is the type of **treatment** that only a **nurse** can provide, and
- is needed for medical reasons and is not to help with their mobility, personal care or preparation of meals.

Hospice

We will pay a donation directly to the **hospice** when:

- a **member** receives care as a patient of a **hospice**, and
- **we** have previously covered **treatment** for the condition.

Hospital charges

If a **member** has a condition or suspected condition for which **we** don't have a **network,** or has the extended hospital list, and receives **treatment** as an **in-patient** or **day-patient** in a **hospital** that is not:

- included on their **hospital** list, or
- an NHS pay-bed at an NHS **hospital**

but is recognised by **us, we** will calculate the average cost of equivalent **treatment** across all **hospitals** on the **member's** list and that average cost is the maximum **we** will pay. This could leave the **member** with a shortfall that the **policy** does not cover. If the actual cost of the **treatment** is less than the average cost, we will pay the **hospital** costs in full. **We** will cover **specialists'** fees up to the limits in **our** fee schedule.

If a **member's treatment** is for a condition or suspected condition for which **we** have a **network**, **we** will only pay for that **treatment** if it is carried out at a facility and/or under the care of a **specialist** (or other practitioner) recognised by **us** as part of that **network**. If the **policy** has the extended hospital list, **members** do not have to use **our networks**.

If a **member** receives **in-patient** or **day-patient treatment** in a **hospital** that is not included on their **hospital** list and is not recognised by **us, we** will not pay any **hospital** fees for their **treatment.**

If a **member** receives **treatment** as an NHS **in-patient** or **day-patient** whilst occupying an NHS amenity bed (a bed paid for by them in a single room or side ward in an NHS hospital where they receive NHS **in-patient** or **day-patient treatment**) and that **treatment** would have been covered by the **policy** if they had chosen to receive it as a private patient, **we** will reimburse them for the cost of the amenity bed.

We will pay the fixed cost for the amenity bed only; **we** will not pay for additional extras (such as visitor meals).

If they claim for the cost of an NHS amenity bed they cannot also claim NHS cash benefit or NHS cancer cash benefit for the same **treatment**.

Networks

If the **member** has **in-patient**, **day-patient** or **out-patient treatment** for a condition or suspected condition for which **we** have a **network** but their **treatment** isn't carried out at a facility recognised by **us** as part of that **network** or under the care of a **specialist** or other practitioner recognised by **us** as part of that **network we** will not pay for the **treatment**.

If the **policy** has the extended hospital list, **members** do not have to use **our networks**.

A list of the conditions or suspected conditions for which **we** have **networks** in place can be found at aviva.co.uk/health-network

NHS cash

We will pay NHS cash benefit if:

- the **member** receives **treatment** as an NHS **in-patient**, and
- that **treatment** would have been covered by the **policy** if they had chosen to receive it as a private patient.

When they make a claim for NHS cash benefit, **we** may ask for the discharge summary from the **hospital**.

NHS cash benefit is not available:

- if the **member** is a fee paying patient of any kind
- for the first three nights following an **accident or emergency admission**
- for **cancer treatment**
- for claims for psychiatric **treatment**, or
- if a **member** claims for the cost of an NHS amenity bed for the same **treatment**.

Optical

Optical benefit is payable for contact lenses and glasses bought as a result of a change in a **member's** prescription.

We do not cover the cost of eye tests, optical solutions and accessories (for example cases, cleaning cloths) or contract schemes (for example monthly disposable contact lens schemes).

Overseas

This is not travel insurance and cover is restricted to the **treatment** of emergency conditions that are serious enough to need an immediate admission to **hospital** as an **in-patient** or **day-patient**. If a **member** feels this level of cover is not appropriate for them or that they may need more cover they should consider taking out a travel insurance policy.

Members should consider taking a European Health Insurance Card (EHIC) with them if they are travelling to countries covered by the EHIC scheme. Application forms can be obtained from the post office or online and should be completed and validated before the **member** travels. This will allow them to benefit from the reciprocal health arrangements which exist with these countries. They should take steps to use these arrangements where possible.

We have an overseas emergency assistance provider who deals with all aspects of overseas claims.

The telephone number is: +44 (0)2381 247290
Calls may be monitored and/or recorded.

Our overseas emergency assistance provider is available 24 hours a day. When a **member** calls, they should give them their name, **policy** number and a brief description of the problem.

We cover **treatment** as an **in-patient** or **day-patient** for an **acute condition** outside the **UK** if:

- a **member** is outside the **UK** temporarily for a maximum of 90 days during any **policy year**
- a medical emergency occurs that requires them to be admitted to an overseas medical facility for **treatment** immediately
- the **treatment** is carried out by a medical practitioner
- the **treatment** is required for the immediate needs of the medical emergency, and
- the **treatment** is **medically necessary**.

We do not cover **treatment** outside the **UK** if:

- it is planned ahead, including any elective surgical procedure, such as a caesarean section, or for therapy, such as physiotherapy
- it is carried out as an **out-patient**
- it could have been carried out by a **GP** if the **member** had been in the **UK**, they could have treated the condition themselves or they could have waited for **treatment** until they returned to the **UK**
- it consists of **out-patient** drugs and dressings (including medication that they are currently taking and medication which they can obtain 'over the counter'), or
- their medical condition and the **treatment** are not covered by the **policy**.

If a **member** is outside the UK for more than 90 days during any **policy year** there is no cover under the overseas benefit.

Evacuation

Evacuation is the transport of a patient from a medical facility to the nearest available medical facility for **treatment** of an overseas medical emergency**.** The nearest available medical facility for a **member's treatment** might not be in the **UK**.

We only cover **evacuation** to the nearest available medical facility if:

- the **member's evacuation** is **medically necessary**
- they contact **us** and **we** agree to their **evacuation** before this takes place, and
- their **evacuation** is undertaken by the emergency assistance company specified by **us** and all arrangements are made by them.

We do not cover a **member's** repatriation to the **UK** unless the nearest available **hospital** is in the **UK** and **we** have agreed to their repatriation before this takes place.

We do not cover travel or accommodation costs for relatives or friends who accompany the **member** during their **evacuation** or repatriation to the **UK**, whether or not they are covered by this **policy** (or another of **our** policies).

We will pay all costs in sterling at the rate ruling in London at the beginning of the month in which the **member's treatment** takes place.

Pregnancy complications

Cover will only be available for **treatment** directly or indirectly arising from or recommended by the **member's specialist** in connection with the following conditions once diagnosed:

- post-natal depression (only if the **policy** has mental health cover – please refer to the **financial statement** to see which options have been chosen)
- ectopic pregnancy (development of foetus outside the womb)
- miscarriage (but not investigations into the cause of miscarriage)
- still birth
- hydatidiform mole (cell growth abnormality in the womb)
- retained placenta (afterbirth retained in the womb)
- eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
- caesarean sections – in specific clinical circumstances (**we** require full clinical details from the **member's specialist** before **we** can make a decision about cover).

For **members** with moratorium or full medical underwriting - **We** will only pay for these conditions and **treatments** if they occur at least 10 months after the **member** joins the **policy**.

Private ambulance

We cover travel by a private ambulance to the nearest available facility if:

- it is needed in connection with **treatment** as an **in-patient** or **day-patient** that is covered by the **policy**, and
- the **member** travels between **hospitals** as part of their **treatment** as an **in-patient** or **day-patient**, and
- it is **medically necessary** for the **member** to travel by ambulance.

Psychiatric

We cover acute psychiatric conditions. This means **we** will cover **treatment** which aims to lead to a **member's** full recovery.

BUT:

We do not cover

- **treatment** that is given solely to alleviate symptoms, or
- chronic psychiatric conditions.

We consider a psychiatric condition to be chronic if:

- it meets the definition of a **chronic condition**, or
- **we** have paid for **treatment** for that condition or a **related** psychiatric condition during three separate **policy years**. This will apply to acute

flare-ups of a **chronic condition**, it will also apply if the **treatment** was not in consecutive **policy years**.

We do not cover **treatment**, including **diagnostic tests** to treat or assess learning difficulties or developmental or behavioural problems such as Attention Deficit Hyperactivity Disorder (ADHD) and Autistic Spectrum disorders.

Routine dental treatment

We cover dental **treatment** carried out by a dental practitioner in a dental surgery including examinations, tooth cleaning, white fillings (where appropriate), crowns, extractions and surgery. **We** do not pay for contract schemes (for example monthly dental plans).

Specialists' fees

We cover **specialists'** fees up to the limits in **our** fee schedule. If the fee is higher than the limit in **our** fee schedule, it is the **member's** responsibility to pay the **specialist** the difference.

Members can view the fee schedule online at aviva.co.uk/health/online-fee-schedule or call the customer service helpline on 0800 158 3333. Calls to and from Aviva may be recorded and/or monitored.

Stress counselling helpline

The stress counselling helpline service is designed to be available 24 hours per day but some reasonable delay may be experienced.

This is not an emergency service. A **member** may call on behalf of another **member** subject to any patient confidentiality requirements of the service provider. In using the helpline, the **member** (where applicable, on behalf of another **member**) automatically authorises the use and disclosure of any medical or other information, on a fully confidential basis as between **us** and any service providers **we** use in making the service available, for the sole purpose of **policy** and service administration.

We will not be responsible for any failure in the provision of the helpline service to the extent that it is due to circumstances beyond the reasonable control of **us** or any of **our** service providers.

Call charges are the responsibility of the caller.

Therapies

We cover up to ten sessions in combined total (for example five physiotherapy sessions and five osteopathy sessions) per **policy year** on referral from a **GP** for each separate condition.

Benefits for cancer treatment

This section explains what Aviva will pay for **cancer treatment**

Important:

If **you** have chosen one of the reduced **out-patient** options the monetary limit will not apply to **cancer treatment** received after the **member** has been diagnosed with **cancer.**

If the six week option has been chosen, **we** do not pay for **treatment** as an **in-patient** or **day-patient** if it is available on the NHS (including **accident or emergency admissions**) within six weeks from the date the **specialist** recommends it. If a **member** is diagnosed with **cancer** this may mean that the **treatment** will be available on the NHS and **we** will not pay for most of the **treatment** that the **member** needs.

If the six week option has been chosen and a **member** has **treatment** as an **out-patient**, **we** do not apply the six week rule to that **treatment**. However, if they need to be admitted for emergency **treatment**, for example a blood transfusion, **we** will not pay for that **treatment**.

If a **member's treatment** is for a condition for which **we** have a **network, we** will only pay for that **treatment** if it is carried out at a facility and/or under the care of a **specialist** (or other practitioner) recognised by **us** as part of that **network**. If the **policy** has the extended hospital list, **members** do not have to use **our networks**.

If **we** don't have a **network** for the **member's** condition or suspected condition they can have **out-patient treatment** at a **hospital** not on their list, but recognised by **us**, and **we** will pay in full. However, **in-patient** and **day-patient treatment** will only be covered in full at a **hospital** that is included on their **hospital** list and recognised by **us**. If a **member** has **in-patient** or **day-patient treatment** at any other **hospital** recognised by **us, we** will calculate the average cost of equivalent **treatment** across all **hospitals** on their list, and that average cost is the maximum **we** will pay. This could leave the **member** with a shortfall that the **policy** does not cover. If the actual cost of the **treatment** is less than the average cost, **we** will pay the hospital costs in full. **We** will cover **specialists'** fees up to the limits in **our** fee schedule. If a **member** receives **treatment** in a **hospital** that is not recognised by **us, we** will not pay any **hospital** fees for their **treatment**.

Benefits	Amount payable	Notes
Hospital charges for surgery and medical admissions	In full	Including accommodation and meals, nursing care, drugs and surgical dressings, theatre fees. See preventative treatment benefit term
Specialists' fees	Up to the limits in **our** specialist fee schedule	See consultation fees and specialists' fees benefit terms
NHS cash benefit for **cancer treatment**	£100 each day	See NHS cancer cash benefit term
Post-surgery services		For example, specialist nursing, feeding; see post-surgery services benefit term for details of services that the **policy** will pay for
Chemotherapy	In full	See chemotherapy benefit term
Radiotherapy	In full	See radiotherapy benefit term
Bone strengthening drugs (such as bisphosphonates)	In full	**We** pay for bone strengthening drugs when they are being used to treat metastatic bone disease
Treatment for side effects of **chemotherapy** and radiotherapy	In full	See side effects benefit term
Wigs	Up to £100	In total whilst a **member** is covered by the **policy** (not per **policy year**) See wigs benefit term
External prostheses	Up to £5,000	See prostheses benefit term
Stem cell and bone marrow transplants	In full	See stem cell transplants benefit term
Monitoring	Up to ten years	See monitoring benefit term
Ongoing needs	Up to five years	See ongoing needs benefit term
Preventative **treatment** for **cancer**		See preventative treatment benefit term
End of life care		See end of life care benefit term

The information on this page must be read in conjunction with the definitions, benefit terms, policy conditions and exclusions, and other documents forming the **policy.**

Benefit terms

Chemotherapy

We will pay for **chemotherapy** in full if a **member** has the **treatment** via **our** approved **networks**.

If **we** don't have a **network** for the **treatment** the **member** needs, or if the **policy** has the extended hospital list, **we** will still pay in full if they have the **treatment**:

- as a **day-patient** or an **in-patient** at a **hospital** on their list
- as an **out-patient**, or
- at home.

We do not pay for hormone therapy.

BUT: **We** will pay for hormone therapy if a **member** needs it to shrink a tumour before they have surgery or radiotherapy.

Consultation fees

We will pay in full for consultations with a **fee approved specialist** or other **fee approved** practitioner. If the **member** has an eligible consultation with a **specialist** or other practitioner who is not **fee approved we** will only pay up to the limits **we** pay **our fee approved** providers. This could leave the **member** with a shortfall that the **policy** does not cover. If the actual cost of the consultation is less than the amount **we** would have paid to a **fee approved** provider, **we** will pay for the consultation in full.

End of life care

We will pay for end of life care in a **hospital** if it is **medically necessary**.

If a **member** is admitted to a **hospice, we** will make a donation to the **hospice** of £100 each night, up to £10,000 (someone will need to tell **us** that the **member** has been admitted to the hospice).

If a **member** stays at home but is visited by a nurse from a registered charity, for example Macmillan Cancer Support or Marie Curie Cancer Care, **we** will donate £50 a day to one charity for each day they need to be with them, up to the £10,000 limit.

Monitoring

We will pay for monitoring for up to ten years after a **member's treatment** for **cancer** has finished. This includes **diagnostic tests** and consultations.

We do not pay for monitoring after **treatment** for non-melanoma skin **cancer.**

NHS cancer cash

We will pay NHS cancer cash benefit for **cancer treatment** if:

- a **member** receives **treatment** for **cancer** as an NHS patient and
- that **treatment** would have been covered by the **policy** if they had chosen to receive it as a private patient.

We will pay £100 for each day the **member** receives **treatment**:

- as an **in-patient**
- as a **day-patient**.

We will pay £100 for each day the **member:**

- receives **out-patient** radiotherapy, **chemotherapy** or blood transfusions
- undergoes **out-patient** surgical procedures.

We will pay £100 for:

- each day the **member** receives intravenous (IV) **chemotherapy** at home
- each week whilst the **member** is taking oral **chemotherapy** drugs at home.

We may need to contact the **member's specialist** for details of their **treatment** before **we** can pay their claim. When a **member** makes a claim for NHS cancer cash benefit, **we** may ask for the discharge summary from the **hospital.**

The **member** will not be able to claim more than £100 in any one day.

NHS cancer cash benefit for **cancer treatment** is not available:

- for claims for psychiatric **treatment**, or
- if a **member** claims for the cost of an NHS amenity bed for the same **treatment**.

Ongoing needs

If a **member** has any ongoing medical needs, such as regular replacement of tubes, drains or stents, **we** will pay for up to five years after their **treatment** for **cancer** has finished.

Post-surgery services

Medical services

Following surgery for **cancer** there are a number of different specialist services that a **member** may need, depending on the type of **cancer** they have and the surgery they have had. **We** will pay for consultations following surgery with, for example, a:

- **dietician** in order to stabilise a **member's** diet following surgery or **chemotherapy**
- stoma **nurse** to show them how to care for their stoma
- **nurse** to show them how to manage lymphoedema.

Artificial feeding

If, due to a **member's cancer** or **treatment** of their **cancer**, they have problems eating and need artificial feeding, **we** will pay for the insertion and replacement of a tube (for example, a central line, PICC line or PEG) to deliver the food (called nutrition). Whilst they are in **hospital** for **cancer treatment we** will pay for the nutrition itself, although once their **cancer treatment** has finished **we** will no longer pay for the nutrition itself, or maintenance of the line (for example cleaning of the line).

Preventative treatment

We will pay for surgery to prevent further **cancer** only if a **member** has already had **treatment** for **cancer** that **we** have paid for – for example, **we** will pay for a mastectomy to a healthy breast in the event that they have been diagnosed with **cancer** in the other breast.

We will not pay for surgery where a **member** has no symptoms of **cancer**, for example where they have a strong family history of **cancer** such as breast **cancer**, or bowel **cancer**.

Prostheses

We will pay in full for prostheses that are inserted into the body.

For external prostheses following surgery for **cancer** – for example arms, legs, breasts, ears – **we** will contribute up to £5,000 towards the cost of the first prosthesis after a **member's** surgery. This includes any cost for fitting the prosthesis.

Radiotherapy

We will pay for radiotherapy in full if a **member** has the **treatment** at a **network** facility. If **we** don't have a **network** for the **treatment** the **member** needs, or if the **policy** has the extended hospital list, **we** will still pay in full if they have the **treatment** as:

- a **day-patient** or an **in-patient** at a **hospital** on the **member's** list if they need it for medical reasons, or
- an **out-patient**.

Side effects

Whilst a **member** is receiving **chemotherapy** or radiotherapy, **we** will pay for **treatment** prescribed by their **specialist** that **they** need to deal with their side effects, for example:

- antibiotics
- anti-sickness drugs
- steroids
- pain killers
- drugs to boost their immune system, and
- blood transfusions.

Specialists' fees

We cover **specialists'** fees up to the limits in **our** fee schedule. If the fee is higher than the limit in **our** fee schedule, it is the **member's** responsibility to pay the **specialist** the difference.

Members can view the fee schedule online at aviva.co.uk/health/online-fee-schedule or call **our** customer service helpline on 0800 158 3333. Calls to and from Aviva may be recorded and/or monitored.

Stem cell transplants

We will pay for:

- the collection of
- storage of, and
- implantation of

stem cells and bone marrow if a **member** has this **treatment** at a **network** facility or, if **we** don't have a **network** for the **treatment** they need, or if the **policy** has the extended hospital list, at a **hospital** on their list.

If the stem cells or bone marrow comes from another person, **we** will pay for their collection. **We** do not pay for search costs, including compatibility testing, to find a donor for a transplant. **We** do not pay for courier charges.

We will pay for drugs for the **member** to take home at the time they are discharged from **hospital** following a stem cell or bone marrow transplant.

BUT: After they have been discharged from **hospital** following a stem cell or bone marrow transplant, they may need to take certain drugs (for example immunosuppressants, antibiotics, steroids) for a long period of time in order to prevent complications. **We** will not pay for these drugs.

Wigs

We will pay up to £100 towards the cost of a wig if a **member** needs one due to hair loss caused by **cancer treatment**.

Exclusions

1a. Pre-existing and related conditions

We do not cover **treatment** of any **pre-existing condition**, or any **related** or associated condition unless the **member** advised **us** of that condition in writing when they applied to be included on the **policy** and **we** did not apply an exclusion for it. If the **policy** has been underwritten on a Medical History Disregarded basis then this exclusion does not apply.

2. AIDS and HIV

We do not cover **treatment** of AIDS (acquired immune deficiency syndrome), HIV (human immunodeficiency virus) or any condition arising from or **related** to AIDS or HIV.

3. Addictions and substance abuse

We do not cover **treatment** for addictions (such as alcohol addiction or drug addiction) or substance abuse (such as alcohol abuse or solvent abuse), or **treatment** of any illness or injury needed directly or indirectly as a result of any such abuse or addiction.

4. Appliances and prostheses

We do not cover:

- surgical or medical appliances such as wheelchairs, hearing aids, false limbs, crutches and dentures and orthotics (supports), or
- neurostimulators or any **treatment** needed in connection with them.

BUT: **We** do cover:

- prostheses inserted into the body during a surgical procedure
- external prostheses following surgery for **cancer** (see benefits for cancer treatment section)
- hand, back and knee braces required immediately after a **related** surgical procedure, and
- heart pacemakers and implantable cardioverter defibrillators.

5. Birth control

We do not cover **treatment** directly or indirectly **related** to birth control.

6. Chronic conditions – please refer to the accepted quotation to see which options have been chosen

We do not cover **treatment** of a **chronic condition**.

In particular:

- regular planned check ups for a **chronic condition** where a **member** is likely to need **treatment**
- expected deterioration of a **chronic condition** which needs regular consultations, **diagnostic tests** or **treatment** from a **specialist.**

BUT:

- **We** do cover unexpected acute flare-ups of a **chronic condition** until the **member's** condition is re-stabilised (this does not apply to chronic psychiatric conditions – please see the psychiatric benefit term for further information).
- **We** do not apply this **chronic condition** exclusion to **treatment** for **cancer**. **We** will apply this exclusion to consequences of, or conditions **related** to **cancer treatment**.

OR

If the **policy** has the Routine and GP referred services benefit the exclusion that applies to the **member** is:

We do not cover **treatment** of a **chronic condition**.

In particular:

- expected deterioration of a **chronic condition** which needs regular consultations, **diagnostic tests** or **treatment** from a **specialist**, other than the benefit available under the Routine and GP referred services benefit.

BUT:

- **We** do cover unexpected acute flare-ups of a **chronic condition** until the **member's** condition is re-stabilised (this does not apply to chronic psychiatric conditions – please see the psychiatric benefit term for further information).
- **We** do not apply this **chronic condition** exclusion to **treatment** for **cancer**. **We** will apply this exclusion to consequences of, or conditions **related** to **cancer treatment**.

7. Cosmetic treatment

We do not cover **treatment,** or any consequence of **treatment,** that is intended to change a **member's** appearance (for example a tummy tuck, facelift, tattoo, body piercing), whether or not this is carried out for psychological or medical reasons.

We do not cover **treatment,** or any consequence of **treatment,** to remove undiseased tissue.

BUT: **We** will cover a surgical procedure to restore a **member's** appearance if:

- the surgical procedure immediately follows an accident, or **treatment** for **cancer**, and
- the accident or **cancer treatment** took place when the **member** was covered under the **policy** and they have had no break in cover since then.

If the **member** has an implant or implants following **treatment** for **cancer we** will pay for the removal and replacement of the implant or implants at the end of their lifespan providing the **member** was covered under the **policy** when the **cancer treatment** took place and the **member** has had no break in cover since then.

We advise the **member** to contact **us** before **treatment** begins so that **we** can confirm if they are covered.

8. Dental treatment – please refer to the accepted quotation to see which options have been chosen

We do not cover:

- **treatment** carried out by a dentist or dental surgeon
- **treatment** of gum disease or **treatment** carried out to help a **member** wear dentures
- removable bridges, or **treatment** carried out to insert or help a **member** wear removable bridges
- dental implants, or **treatment** carried out to insert or help a **member** wear dental implants
- orthognathic (bite correction) surgery, or
- orthodontic **treatment** and any associated extractions.

OR

If the **policy** has the dental and optical benefit the exclusion that applies to the **member** is:

We do not cover:

- dental **treatment** performed for cosmetic reasons such as teeth whitening
- removable bridges, or **treatment** carried out to insert or help a **member** wear removable bridges
- **treatment** carried out to facilitate the wearing of dentures
- dental implants, or **treatment** carried out to insert or help the **member** wear dental implants
- orthognathic (bite correction) surgery, or
- orthodontic **treatment** and any associated extractions.

9. Dialysis

We do not cover kidney dialysis as part of long-term **treatment** of a **chronic condition**.

BUT: **We** cover short-term kidney dialysis:

- if a **member** is admitted to **hospital** for eligible **treatment** as an **in-patient** for another condition and needs regular kidney dialysis during this admission
- if required as a result of secondary kidney failure during eligible **treatment** as an **in-patient**, or
- immediately before or after a surgical procedure to transplant a kidney as part of **treatment** as an **in-patient**.

10. Drugs and dressings

We do not cover drugs or dressings for a **member** to take home from **hospital**.

BUT: **We** do cover drugs and dressings that are needed during, and immediately related to, chemotherapy or radiotherapy.

11. Experimental treatment

We do not cover experimental **treatment**, unless it meets the criteria set out below.

We only pay for **treatment** that is:

- approved by European Medicines Agency (EMA) and Medicines & Healthcare products Regulatory Agency (MHRA) and is used within the terms of its licence,

or

- part of a nationally approved clinical guideline (The National Institute for Health and Care Excellence or Scottish Intercollegiate Guidelines Network),

or

- supported by best quality evidence (prospective randomised controlled trials that have been published in peer reviewed journals, independent of conflicts of interest and applicable to the **member's** clinical condition), and offered by a **specialist** with documented evidence of positive clinical and patient reported outcomes within a **hospital** that is equipped with staff, equipment and processes to provide it.

If the **member's treatment** meets these requirements, **we** will not exclude **treatment** on the basis that it is experimental. Before **we** can decide if the **member's** proposed **treatment** is eligible, **we** must receive all the clinical details **we** need from their **specialist**, including a completed 'Treatment Request Form'. **We** must confirm the **member's** cover in writing before any **treatment** begins.

BUT:

Even if **we** consider the **member's treatment** to be experimental because it does not satisfy the requirements listed above, **we** will still pay for the lowest cost of either:

- the experimental **treatment** or
- the equivalent established **treatment** usually provided for the **member's** condition, if this is available.

Please note: No payment will be made if there is no established **treatment** available for the **member's** condition (for which the experimental **treatment** is being proposed). If the **member** undergoes experimental **treatment** that is not successful, **we** will not pay towards further **treatment** of the **member's** condition or for any other condition that the **member** develops as a result of undergoing experimental **treatment**.

12. Eyesight – please refer to the accepted quotation to see which options have been chosen

We do not cover **treatment** for short-sight or long-sight, such as glasses, contact lenses or laser eyesight correction surgery.

OR

If the **policy** has the dental and optical benefit the exclusion that applies to the **member** is:

We do not cover **treatment** for short sight or long sight, such as laser eyesight correction surgery.

13. GP charges and treatment – please refer to the accepted quotation to see which options have been chosen

We do not cover:

- **treatment** provided by a **GP**
- **treatment** or **diagnostic tests** requested by a **GP**, such as X-rays, blood tests and scans unless covered by the BacktoBetter benefit term, or
- **GP** charges or fees, including those for completing a claim form if the claim is not covered by the **policy.**

OR

If the **policy** has the Routine and GP referred services benefit the exclusion that applies to the **member** is:

We do not cover:

- **treatment** provided by a **GP**, other than minor surgery from **our** published list
- **treatment** requested by a **GP**, other than **treatment** by a **physiotherapist**, **osteopath**, **chiropractor**, **acupuncturist**, **chiropodist**, **podiatrist** or **homeopath** – for conditions other than pain in the back, neck, muscles or joints – musculoskeletal conditions
- **GP** charges or fees, including those for completing a claim form if the claim is not covered by the **policy**
- **diagnostic tests** requested by a **GP** other than: - radiology or pathology for conditions other than pain in the back, neck, muscles or joints, or
  - radiology or pathology covered by the BacktoBetter benefit term.

14. Hearing loss

We do not cover hearing aids or devices, cochlear implants or any **treatment** related to their implantation or continued care.

BUT**: We** will cover **diagnostic tests** to investigate the cause of a **member's** deafness.

15. Infertility treatment – please refer to the accepted quotation to see which options have been chosen

We do not cover infertility **treatment**.

BUT: **We** will cover investigations into the causes of infertility.

OR

If the **policy** has selected benefit reduction removing the investigations into infertility benefit the exclusion that applies to the **member** is:

We do not cover investigations into the causes of infertility or infertility **treatment**.

16. Lipoedema

We do not cover **treatment** of lipoedema (the abnormal build-up of fat cells usually in the legs, thighs, buttocks or arms).

17. Musculoskeletal

We do not cover **treatment** for back, neck, muscle or joint pain (musculoskeletal conditions) that has not been pre-authorised by **us**.

18. Non-medical admissions

We do not pay for **hospital** charges if the reason a **member** has been admitted to **hospital** is that they need help with mobility, personal care or preparation of meals. **We** only pay if a **member** has been admitted to **hospital** for medical reasons.

19. Overseas treatment – please refer to the accepted quotation to see which options have been chosen

We do not pay for **treatment** outside the **UK** other than provided under the limited emergency overseas cover.

OR

If the **policy** has selected benefit reduction removing limited emergency overseas cover the exclusion that applies to the **member** is:

We do not pay for **treatment** outside the **UK**.

20. Pregnancy and childbirth – please refer to the accepted quotation to see which options have been chosen

We do not cover pregnancy and childbirth or **treatment** required as a result of pregnancy or childbirth. **We** do not cover termination of pregnancy.

BUT: **We** do cover the specific complications listed under the pregnancy complications benefit term.

OR

If the **policy** has selected benefit reduction removing **treatment** for complications of pregnancy and childbirth the exclusion that applies to the **member** is:

We do not cover pregnancy or childbirth or any **treatment** related to pregnancy or childbirth in any circumstances.

21. Psychiatric treatment – please refer to the accepted quotation to see which options have been chosen

We do not cover **treatment** of psycho-geriatric conditions of any kind.

BUT: **we** do cover **out-patient** psychiatric **treatment** from the psychiatric benefit in section B.

If option 1 (Mental health treatment) has been chosen, **we** also cover the **in-patient** and **day-patient** psychiatric **treatment** detailed in this option only.

Psychiatric **treatment** is not available under any other benefit.

OR

If the **policy** has benefit 8a (reduced out-patient cover – £0 limit) but not the mental health benefit the exclusion that applies to the **member** is:

We do not cover **treatment** of psychiatric, psycho-geriatric or mental health illnesses or conditions of any kind, such as stress.

22. Rehabilitation, convalescence and nursing home care

We do not cover rehabilitation, convalescence or nursing home care.

BUT: **We** do not apply the exclusion for rehabilitation to **treatment** for **cancer**. **We** will apply this exclusion to consequences of, or conditions **related** to **cancer treatment**.

23. Routine medical examinations, screening and preventative treatment – please refer to the accepted quotation to see which options have been chosen

We do not cover:

- routine medical examinations (such as sight tests), medical screening, health check-ups or vaccinations
- **treatment** to prevent a disease or illness, or
- any **treatment** to discover the presence of a potential disease or illness if symptoms are not present, such as genetic tests.

If **we** have paid for a **member** to have **treatment** for **cancer**, this exclusion will not apply with regard to routine monitoring for **cancer**. This exclusion does not apply to molecular profiling used to determine a **member's cancer treatment**.

OR

If the **policy** has the dental and optical benefit the exclusion that applies to the **member** is:

We do not cover:

- routine medical examinations (other than routine dental **treatment**), medical screening, health check-ups or vaccinations
- **treatment** to prevent a disease or illness, or
- any **treatment** to discover the presence of a potential disease or illness if symptoms are not present, such as genetic tests.

If **we** have paid for a **member** to have **treatment** for **cancer**, this exclusion will not apply with regard to routine monitoring for **cancer**. This exclusion does not apply to molecular profiling used to determine a **member's cancer treatment**.

24. Self-inflicted injury

We do not cover **treatment** directly or indirectly arising as a result of self-inflicted injury.

25. Sexual dysfunction

We do not cover **treatment** of sexual dysfunction such as impotence.

BUT: **We** do cover investigations, including **diagnostic tests**, to find the cause of sexual dysfunction.

26. Sleep disorders and sleep problems

We do not cover **treatment** directly or indirectly **related** to sleep disorders and sleep problems, such as snoring, insomnia or sleep apnoea (when breathing stops temporarily during sleep).

27. Sports related treatment

We do not cover **treatment** of an injury sustained whilst a **member** is training for or taking part in sport for which they are:

- paid
- personally funded by sponsorship or grant (including equipment and any kit).

This exclusion does not apply if the **member** is coaching the sport or receiving travel costs only.

28. Treatment by providers that are not recognised

If a **member** sees a practitioner, **specialist** or other healthcare professional that **we** do not recognise, **we** will not pay for that provider's fees.

If a **member** attends a **hospital**, facility or any other **treatment** centre that **we** do not recognise, **we** will not pay for that provider's charges.

29. Treatment outside of a specified network

We do not cover **treatment** for a condition or suspected condition for which **we** have a **network** unless that **treatment** is carried out at a facility recognised by **us** as part of that **network** or under the care of a **specialist** or other practitioner recognised by **us** as part of that **network**.

If the **policy** has the extended hospital list, this exclusion does not apply.

30. Treatment that is not eligible

We do not pay for **treatment** that is not covered by the **policy** or the consequences of such **treatment**. For example, **we** do not cover **treatment** of an infection or corrective surgery needed as a result of ineligible cosmetic surgery.

31. Undiseased tissue

We do not cover **treatment**, or any consequence of **treatment**, to remove undiseased tissue.

32. Varicose veins

We do not cover **treatment** of varicose veins of the leg.

BUT: **we** will cover **treatment** when:

The varicose veins are greater than 3mm in diameter and any of the following also applies:

- there is established lipodermatosclerosis or progressive skin changes
- there have been recurrent episodes of superficial thrombophlebitis
- there is active or healed venous ulceration.

We will need to contact a **member's GP** or **specialist** for details of their condition before we can confirm their claim.

33. War and hazardous substances

We do not cover **treatment** required as a direct or indirect result of:

- war (declared or not), military, paramilitary or terrorist activity (such as the effects of radiological, biological or chemical agents), or
- use, misuse, escape or the explosion of any gas or hazardous substance (such as explosives, radiological, biological or chemical agents).

34. Warts/verrucas/skin tags

We do not cover **treatment** of warts, verrucas or skin tags.

35. Weight loss surgery

We do not cover **treatment** that is directly or indirectly **related** to:

- bariatric surgery (weight loss surgery), such as gastric banding or a gastric bypass, or
- the removal of surplus or fat tissue.

Underwriting

This **policy** is subject to one, or more, of five different types of underwriting. The group administrator will be able to advise which underwriting applies to each **member**.

Full Medical Underwriting (FMU)

We do not cover **treatment** of any **pre-existing condition**, or any **related** or associated condition unless the **member** advised **us** of that condition in writing when they joined the **policy** and **we** did not apply an exclusion for it.

Any medical exclusions **we** have applied are available online at aviva.co.uk/myaviva or on request by calling 0800 158 3348.

We may review the **member's** personal medical exclusion(s) at the **renewal date**, if the **member** asks **us** to. If **we** have recently applied an exclusion when the **member** joined the **policy** or reviewed a medical exclusion at the **renewal date**, **we** will let the **member** know when the medical exclusion may be reviewed again, if they ask **us**.

We will not alter or remove a medical exclusion if the excluded medical condition (or any **related** conditions) is likely to need **treatment** in the future. There are some medical exclusions that **we** will not review, for example, if it is a **chronic condition**.

Moratorium (this is sometimes known as mori)

We do not cover **treatment** of any **pre-existing condition**, or any **related** condition, if the **member** had:

- symptoms of
- medication for
- **diagnostic tests** for
- **treatment** for, or
- **advice** about

that condition in the five years before they joined the **policy**.

However, **we** will cover a **pre-existing condition** if the **member** does not have:

- medication for
- **diagnostic tests** for
- **treatment** for, or
- **advice** about

that condition during a continuous two year period after they join the **policy**.

Continued Medical Exclusions (CME)

We apply the personal medical exclusions for **pre-existing conditions** that were applied by **your** previous insurer, if any. These are available online at aviva.co.uk/myaviva or on request by calling 0800 158 3348.

The terms and conditions of this **policy** may be different to those of **your** previous policy.

Continued moratorium

We do not cover **treatment** of any **pre-existing condition**, or any **related** conditions, if the **member** had:

- symptoms of
- medication for
- **diagnostic tests** for
- **treatment** for, or
- **advice** about

that condition in the five years before their initial date of cover. The initial date of cover is the date they started cover with **your** first insurer (provided there has been no break in cover since then).

However, we will cover a **pre-existing condition** if the **member** does not have:

- medication for
- **diagnostic tests** for
- **treatment** for, or
- **advice** about

that condition during a continuous two year period after their initial date of cover.

The terms and conditions of this **policy** may be different to those of **your** previous policy.

Medical History Disregarded (MHD)

We do not apply any personal medical exclusions to **members** as a result of **pre-existing conditions**.

The terms and conditions of this **policy** may be different to those of **your** previous policy.

Policy conditions

1. Who can be a member?

Our company policies are intended to provide cover for **employees**, directors and other designated **members** of an actively trading business, based in the **UK**. All those named on the member listing will be covered on this **policy**.

- The **group member**
- the **group member's** spouse, partner, civil partner and
- their children

can all be **members**.

Members must permanently live in the **UK**, this means living in the **UK** for 6 months or more of every year.

We reserve the right to decline to provide cover for businesses that **we** believe do not meet **our** Corporate Responsibility requirements or which **we** believe may cause **us** to contradict **our** Corporate Responsibility policies. Information relating to **our** Corporate Responsibility position can be found at Aviva.com/responsible-sustainable-business

You must tell **us** if a **member** joins or leaves the **policy. We** will then amend the premium and advise **you** of the new amount due.

Adding members

If **you** want to add a new **member** to the **policy you** will need to contact **us** up to 30 days before the date **you** want cover to start. **We** will not backdate the start date of any new **members** prior to the date that **we** received the request. If **we** need the **member** or **you** to complete an application form **we** will advise.

Newborn babies

If a **member** has a baby while they are covered by the **policy**, they can add their baby to the **policy** from the baby's birth date, if the **policyholder** applies to **us** within three months of the baby's birth date. This means that at the point of claim their medical history will be disregarded, and no personal medical exclusions will apply.

Before **we** can include a newborn baby on the **policy we** require the baby's birth certificate.

Removing members

We will remove a **member** from the policy when **you** tell **us** to. This means that:

- if a **member** is due to leave the **policy** from a date in the future we will remove them from that date
- if a **member** left the **policy** at a date in the past, **we** will remove the **member** from the date **you** contact **us** to advise.

If a **group member** is removed from the **policy**, their spouse, partner, civil partner and any children will also be removed from the **policy**.

We will not refund any premiums to **you** because of a delay in **you** telling **us** that a **member** has left the **policy**.

Children who are **members** can stay on the policy up to the age of 24. They will be removed from the **policy** at the next **renewal date** following their 24th birthday.

2. Premiums and policy duration

The invoice and financial statement shows **you** how much must be paid, when and by which payment method. **We** will advise **you** if the premium changes.

The premium will be payable in full by **you** without any deduction or set-off in respect of any amounts owed, (or which are alleged to be owed), by Aviva to **you**.

We will collect premiums in advance of the date they are due. **We** will collect any premiums due unless **you** tell **us** to cancel the **policy** in time for **us** to stop collecting the payment.

If any amounts paid under this **policy** need to be refunded to **you**, (for whatever reason), they will be paid into the account from which **we** received the original funds.

We do not pay any claims if premiums are not paid to date at the time a **member's treatment** takes place.

All premiums should be paid for by the **policyholder/company** itself, from a **UK** business bank account and the **company** should not attempt to recover premiums from individuals (including cash or services provided). **We** may ask for proof of account status such as a copy of **your** business bank statement.

On or before the first day of the **policy year you** need to provide us with an **opening membership** figure including the names of all **members** to be covered by the **policy**. **You** must also tell **us** within 30 days, of any **member** joining or leaving the **policy**.

The premium rates are calculated based on the membership information provided to **us** for quotation purposes prior to the **start date** or, if later, the appropriate **review date**.

The premium payable will be calculated based on the membership multiplied by the premium rates for the different categories of risk, as set out on the financial statement.

At each **review date** the premium for the **policy year** will be recalculated retrospectively by **us** on the simple average of the **opening membership** and the membership at the **review date**. **You** will be liable to pay any additional premium or will be entitled to a refund of premium accordingly.

If during a **policy year** a **major fluctuation** occurs the method by which **we** will determine the membership figures for the purposes of recalculating the premium will be as follows: First **we** will take the simple average of the **opening membership** as at the **start date** and the membership immediately before the **major fluctuation** occurs. This amount will be multiplied by the number of days from the **start date** up to and including the day immediately prior to the day the **major fluctuation** occurs, and then divided by the number of days in the **policy year**.

The amount calculated according to the previous paragraph is then added to the weighted projected membership for the remainder of the **policy year**, which is calculated by taking the membership immediately after the **major fluctuation** occurs, multiplying this figure by the number of days remaining in the **policy year** as at (and including) the day the **major fluctuation** occurs, and then dividing by the number of days in the **policy year**.

If a further **major fluctuation** occurs during the **policy year we** will determine the membership figures for the purposes of recalculating the premium as above but by taking the simple average of the membership numbers at the beginning and end of each discreet period ending with a **major fluctuation** and weighting according to the number of days in that period.

We reserve the right to invoice for any additional premium required as a result of any recalculation whether immediately or at the next **review date**, and **you** will be liable to pay any additional premium.

If one or more **major fluctuations** have occurred during the **policy year**, then at the next r**eview date**, the premium for the **policy year** ending at the **review date** will be recalculated by **us** by taking the simple average of the membership at the last **major fluctuation** and the membership at that **review date**, and weighting according to the number of days from the last **major fluctuation** to the end of the **policy year**. This amount is then added to the premium calculated at the time of the last **major fluctuation** weighted according to the number of days from the **start date** to the day immediately before the last **major fluctuation** occurred. **You** will be liable to pay any additional premium or will be entitled to a refund accordingly.

If the number of **group members** covered by the **policy** falls below 100, this constitutes a change in risk and **we** shall be entitled to charge premium for a minimum of 100 **group members** (and their **family members**) for the whole of the **policy year**.

If **you** pay monthly, each monthly premium payment is for one month's cover. If **you** pay quarterly, each quarterly payment is for one quarter's cover, if **you** pay annually, each annual premium payment is for one year's cover. If **you** wish to change the way **you** pay the premium (for example from monthly to annually) **you** can do this at the **renewal date**. If there are no changes to **your** premium during the **policy year**, any change to **your** premium will only take effect from the **renewal date**. See section 4, changes to your circumstances.

If a **member** moves into a higher age band the increase will not take effect until the next **renewal date.**

3. Payments for ineligible treatment

If **we** agree to pay for **treatment** that is not normally eligible on the **policy**, this does not mean that **we** will make another payment for **treatment** in the same or similar circumstances.

Any payments **we** do make towards the cost of ineligible **treatment** will count towards any benefit limit listed in the **policy** terms and conditions and the excess (if one has been chosen).

4. Changes to your circumstances

You must tell **us** as soon as possible about:

- changes to **your** company, for example a change of company name, trading status, company structure, company number
- any changes relating to **members**, for example a change of name, address, if somebody works for the diplomatic service or a foreign embassy
- any other changes which affect information given in connection to the application for cover under this **policy**, for example liquidation, insolvency or bankruptcy procedures.

We reserve the right to alter the premiums, **policy** terms or cancel cover for a **member** of the **policy** following a change of risk. Changes will not be backdated to before the date on which **we** receive the notice.

We will always write to the **policyholder's** last known address with details of any changes to the cover.

You cannot give any of the **policy** benefits or **your** responsibilities under the **policy** to anyone else without receiving permission from **us.**

5. Renewing the policy

The **policy** lasts for one year. Renewal requires the agreement of **us** and the **policyholder**.

We will give **you** reasonable notice when **your policy** is due to renew in order to give **you** time to decide whether to renew the **policy** or cancel it.

Changes to your cover

We may change the terms and conditions of the **policy** at the **renewal date**. If there are changes to the **policy, we** will let **you** know before the next **renewal date.** If **you** decide to cancel the **policy** as a result of such changes, **you** must contact **us**.

Only Aviva can make changes to the terms and conditions of the **policy.**

If **you** wish to make any changes to **your policy** at renewal, for example adding or removing options, please contact **us** or speak to **your** financial adviser.

6. Cancellation

Important note

The Insurance Act 2015 sets out the duty on a policyholder to provide complete and accurate information to an insurer, and the potential consequences if the policyholder does not do so.

As part of this duty, the **policyholder** must provide complete and accurate answers to any questions **we** ask either in an application form, over the telephone or by any other means when the **policyholder** takes out, makes changes to or renews the **policy**.

When we may cancel the policy

If **you** have failed to provide complete and accurate information to **us** (see Important note above) then, depending on the nature of that failure:

- **we** may cancel the **policy** back to its start date and refuse to pay any claim, or
- **we** may not pay any claim in full, or
- **we** may revise the premium, or
- the extent of cover may be affected.

If **we** cancel the **policy** for this reason, **you** will be entitled to a refund of the premium paid in respect of the cancelled cover, less a proportionate deduction for the time **we** have provided cover, unless **we** are legally entitled to keep the premium under the Insurance Act 2015.

If a claim made by, or on behalf of, **you** or a **member** is in any way fraudulent or fraudulently exaggerated or supported by a false statement or fraudulent evidence, **we** may:

- refuse to pay the claim, and
- recover any sums paid by **us** in respect of the claim.

In addition:

- where the claim is made by, or on behalf of, **you**, **we** may cancel the **policy** back to the date of the fraudulent act and keep all premiums. This will end the cover for **you** and all **members** listed on the **policy schedule**, or
- where the claim is made by, or on behalf of, a **member**, **we** may cancel that **member's** cover back to the date of the fraudulent act and keep premiums in respect of that **member's** cover. Alternatively, **we** may apply different terms (in line with reasonable underwriting practice) to that **member's** cover.

If **we** cancel the **policy** or any **member's** cover for these reasons **we** will notify **you** (and the relevant **member**) in writing by first class post or by hand to their last known address.

If any premium is not paid, the **policy** will automatically be cancelled. **We** will reinstate the cover if the premium is paid within 45 days of its due date and there are no claims pending.

We will not cancel the **policy** because of eligible claims made by any **member**.

We reserve the right to close the Solutions product at **your renewal date**. If this happens, **we** will contact **you** to advise **you** of **your** options.

7. Continuation terms

If a **group member** or **family member** no longer meet the eligibility requirements of the **policy** (e.g. if they leave the company) they will be entitled to transfer to an individual product nominated by **us** with no further personal medical exclusions.

If a **member** does take out one of **our** individual policies the benefits, terms and exclusions on the new policy may differ from those on this **policy.** If the **member** wants to have enhanced benefits they may have to complete a health declaration and may have any **pre-existing** conditions excluded.

These terms will only apply if the **member** gets a quote on one of **our** individual products within 45 days of their cover ending on this **policy,** and accepts the quote within 30 days of receiving it, Premiums must be paid in full from the date the **member** leaves this **policy** to have continued cover on the individual policy.

If the **member** does not ask for a quote within 45 days or accept the quote within 30 days of receiving it, they will not get continued cover and **pre-existing conditions** may be excluded.

8. Claims procedure

Members should contact **us** before going ahead with any **treatment,** (unless a medical emergency). **We** need to know what **treatment** they are having and the name and address of the **specialist** and the **hospital. We** will tell the **member** if **we** have a **network** for the condition or suspected condition for which the **treatment** is required.

We need to receive all necessary medical information at least five working days prior to the proposed **treatment. We** can usually take the information over the phone but in some cases **we** may still require a claim form, if so **we** will tell the **member**.

Many of the **hospitals** on **our** list or facilities within **our networks** operate direct billing arrangements with **us** and payment for eligible **in-patient** or **day patient treatment** will be settled directly with **us.** This isn't always the case for **out-patient treatment** and other **hospitals**. **We** may also settle eligible claims direct with the provider of other services or with any other person.

Documents that **we** need to support a **member's** claim may incur an expense; the **member** will be responsible for any of these expenses.

Claims will only be paid for **treatment** whilst a **member** is covered by the **policy.**

If a **member's treatment** continues for a long period of time **we** may require updated information on a regular basis, this may include a claim form.

Full details of the claims procedure are given in the **member** guide.

9. Third party claims

The **member** must let **us** know if **treatment** was needed because someone else was at fault – for example, if they were injured as a result of a road traffic accident. **We** may be able to recover the cost of their **treatment** that **we** have paid for. **We** call this a third party claim.

They must keep **us** informed of any claim that they are making against the person at fault and take whatever steps **we** reasonably require.

If **we** have paid any costs for their **treatment** then they must not settle their personal injury claim unless **we** have given **our** agreement to them or their lawyers.

If they recover costs **we** have paid for their treatment, including any interest on any payments **we** have made, they must forward these sums to **us** immediately.

If **we** want to, **we** can take proceedings in the **member's** name for **our** own benefit to recover any costs **we** have incurred.

We will not pay for any costs or claim against any third party for costs that are not covered by the **policy.**

We shall have full discretion in the conduct of any such proceedings and in the settlement of any such claim.

We cannot offer a **member** legal advice.

10. Distribution of information

You are responsible for ensuring that **group members** receive their group member booklet along with any inserts when they join the **policy** and any other literature whilst they remain a **member** of the **policy.**

11. If a member has other private medical insurance

If a **member** has any other insurance covering any of the benefits covered by their Aviva **policy**, such as other private medical insurance or travel insurance, they, or **you,** must make sure that they let **us** know and **we** may recover these costs from that other insurer.

12. Law

The law of England and Wales will apply to this contract unless:

- the **policyholder** and **we** agree otherwise, or
- at the date of the contract, the **policyholder** is a resident of (or, in the case of a business, the registered office or principal place of business is situated in) Scotland, Northern Ireland, Channel Islands or the Isle of Man, in which case (in the absence of agreement to the contrary) the law of that country will apply.

If **we** decide to waive any term or condition of this **policy, we** may still rely on that term or condition at a later time.

Third party rights

This **policy** does not give any rights to any person other than **you** and **us.** No other person shall have any rights to rely on any terms under the **policy.**

13. Records, consents and confirmations

We shall be entitled at all reasonable times and on reasonable notice to inspect **your** records relating to the **policy.**

You will need to provide, on **our** request, (or facilitate the provision by third parties of) evidence and confirmations as **we** reasonably require to verify that one or more individuals are eligible for cover as **members** and/or the definition of **policyholder** is satisfied.

This may include (but is not limited to):

- management accounts
- NI, Inland Revenue records and returns
- employee records
- employee contracts
- VAT records and returns.

Chronic conditions explained

You may have heard the term 'chronic medical condition' before.

This section of the booklet explains how we manage those members whose medical condition becomes 'chronic'.

Private health insurance is intended to cover short term treatment of acute conditions, which start after a member's date of entry. It does not provide cover for chronic conditions.

This section of the policy wording contains important information about the cover available from our Solutions product. This information is set out for you in an industry standard format. Solutions can, however, extend beyond the usual scope of benefits offered by private medical schemes by including cover for some non-acute and chronic conditions, for example routine dental treatment.

There are benefit limitations and exclusions on all policies and members should contact us before incurring any costs.

What is a chronic condition?

A chronic condition is defined as:

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

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

At Aviva we cover the cost of treatment for acute conditions, subject to the terms of this policy wording. An acute condition is a disease, illness or injury that is likely to respond quickly to treatment, the aim of which is to return a member to the state of health they were in immediately before suffering the condition, or which leads to their full recovery.

If a member is suffering symptoms for which diagnostic tests are undertaken we would generally pay for such investigations. If, as a result of the tests, a member is diagnosed as suffering with a chronic condition, benefit would not usually be payable for subsequent treatment. However, we would pay for unexpected acute flare-ups of a chronic condition until a member's condition is stabilised.

What does this mean in practice?

If we think that a member's condition may have become a chronic condition, we will carefully consider the information available, including any medical information provided by their General Practitioner or the specialist in charge of their care.

We will always consider their individual situation, based on their particular circumstances, and we may consult our medical advisors for further assistance as appropriate.

Where we feel their condition has become a chronic condition, we will write to them to explain why. We will also give them time to make other arrangements for their continued treatment, such as asking their doctor to transfer them to NHS care.

If we establish that their condition is not currently a chronic condition, we may need to review it again in the future. If this happens we will advise them and indicate when we will need an update on their medical condition.

What if their condition gets worse?

Although we may withdraw cover because a member's condition has become a chronic condition, it does not necessarily mean that cover is permanently withdrawn.

Some chronic conditions are likely to have unexpected acute flare-ups or to worsen substantially for a short period of time. Treatment for such episodes will generally be covered if they are likely to respond quickly to treatment which aims to return a member to their previous state of health. Once their condition is stabilised, we would follow the same procedures as set out in the previous section.

Example A

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

We will pay for the diagnostic tests needed to find out the cause of Alan's chest pain. We will also pay for consultations with his specialist until his condition has been stabilised, although we would not pay for any medication.

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

We will pay for the heart by-pass operation. We will also pay for:

- *a pre-operative consultation and diagnostic tests, and*
- *a post-operative consultation, and diagnostic tests that Alan's specialist needs to do to ensure that the operation has been successful.*

Examples of chronic conditions

These examples help to show the cover a member might expect to have from us if they develop a medical condition that may become a chronic condition. Please bear in mind that these are illustrations only and are specific to the circumstances described, and members should always contact us prior to receiving any treatment to ensure that they do not incur any costs which they cannot recover.

Please note that these examples are based on a policy which includes full cover for in-patient, day-patient and out-patient treatment. If the policy you select does not have full out-patient cover members may not be covered as an out-patient for diagnostic consultations and tests, nor for follow-up consultations.

Example B

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

We will pay for the diagnostic tests and consultations until the diagnosis is made. We will pay for the first follow-up consultation to allow Eve to make alternative arrangements (for example using the NHS) if she needs to, but we will not pay for further consultations because these are routine, and so are not covered by the policy.

Eighteen months later, Eve has a bad asthma attack.

As this is an unexpected acute flare-up we will pay for the cost of the hospital treatment to re-stabilise Eve's condition. We will pay for one follow-up consultation with the specialist to make sure that her symptoms are well controlled.

Example C

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

We will pay for the diagnostic tests and consultations until Deirdre's condition is more stable and she is comfortable managing it. We will pay for the first follow-up consultation to allow Deirdre to make alternative arrangements (for example using the NHS) if she needs to, but we will not pay for further consultations because these are routine, and so are not covered by the policy.

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

As this is an unexpected acute flare-up we will pay for the cost of the hospital treatment to re-stabilise Deirdre's condition. We will pay for one follow-up consultation with the specialist to make sure that her symptoms are well controlled.

Example D

Beverley has been with Aviva for five years when she is diagnosed with breast cancer. Following discussion with her specialist she decides:

- to have the tumour removed by surgery. As well as removing the tumour, Beverley's treatment will include a reconstruction operation
- to undergo a course of radiotherapy and chemotherapy, and
- to take hormone therapy tablets for several years after the chemotherapy has finished.

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

We would pay for the surgery to remove the tumour and surgery to reconstruct the breast. We would also pay for radiotherapy, and chemotherapy. We will pay for hormone therapy only if it is needed to shrink a tumour before surgery or radiotherapy.

As Beverley's hormone treatment is not being used for this purpose we would not provide cover. Beverley's GP will be able to prescribe the tablets.

During the course of chemotherapy Beverley suffers from anaemia. Her resistance to infection is also greatly reduced. Her specialist:

- admits her to hospital for a blood transfusion to treat her anaemia
- prescribes a course of injections to boost her immune system.

Will her policy cover this treatment and are there any limits to cover?

We would pay for the blood transfusion which is intended to treat the anaemia and also the injections to boost her immune system.

Despite the injections to boost her immune system, Beverley develops an infection and is admitted to hospital for a course of antibiotics. Will her policy cover this treatment and are there any limits to cover?

We would pay for the admittance to hospital and the course of antibiotics which is intended to treat the infection.

Five years after Beverley's treatment finishes the cancer returns. Unfortunately it has spread to other parts of her body. Her specialist recommends a treatment plan:

- a course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months,
- monthly infusions of a drug to help protect the bones against pain and fracture which is to be given for as long as it continues to work (hopefully years), and,
- weekly infusions of a drug to suppress the growth of the cancer which is to be given for as long as it continues to work (hopefully years).

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

We would pay for chemotherapy recommended by Beverley's specialist. We would also pay for the weekly infusions of the drug used to suppress the growth of the cancer, for as long as her specialist recommends them. We will not pay for monthly infusions of a drug to help protect the bones against pain and fracture under these circumstances.

Example E

David has been with Aviva for two years when he is diagnosed with cancer. Following a discussion with his specialist he decides to undergo a course of high dose chemotherapy, followed by a stem cell (sometimes called a "bone marrow") transplant. Will his policy cover this treatment plan and are there any limits to cover?

We would pay for the chemotherapy. We would also pay for the stem cell transplant. This includes the collection, storage and implantation of the stem cells. We will pay for drugs David needs to take home at the time he is discharged from hospital following the stem cell transplant but he may need to take certain drugs (for example immunosuppressants, antibiotics, steroids) for a long period of time in order to prevent complications. We will not pay for these drugs.

When his treatment is finished David's specialist tells him that the cancer is in remission but he would like him to have regular check ups for the next five years to see whether the cancer has returned. Will his policy cover these and are there any limits to cover?

We will pay for regular check ups needed for the next ten years to see whether the cancer has returned.

Example F

Eric would like to be admitted to a hospice for care aimed solely at relieving symptoms. Will his insurance cover this and are there any limits to the cover?

If Eric is suffering from cancer and is admitted to a hospice, we will make a donation to the hospice of £100 per day up to a maximum limit of £10,000.

If Eric is admitted to a hospice with a condition other than cancer and we have previously covered treatment for that condition, we will pay a donation to the hospice of £70 per day for up to 10 days.

These explanations have been produced to help members understand how we may handle a claim involving a chronic condition. The examples given are for illustration purposes only. Members should always refer to the policy wording for details of their cover and contact our customer service helpline before receiving treatment. This will enable us to explain to them how we can help in their particular circumstances.

Further information

If you have any cause for complaint

Our aim is to provide a first class standard of service to our customers, and to do everything we can to ensure you are satisfied. However, if you ever feel we have fallen short of this standard and you have cause to make a complaint, please let us know, our contact details are:

Aviva Health UK Ltd
Complaints Department
PO Box 540
Eastleigh
SO50 0ET

Telephone: 0800 051 7501
Email: hcqs@aviva.com

We have every reason to believe that you will be totally satisfied with your Aviva policy, and with our service. It is very rare that matters cannot be resolved amicably. However, if you are still unhappy with the outcome after we have investigated it for you and you feel that there is additional information that should be considered, you should let us have that information as soon as possible so that we can review it. If you disagree with our response or if we have not replied within eight weeks, you may be able to take your case to the Financial Ombudsman Service to investigate. Their contact details are:

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Telephone: 0300 123 9123 or 0800 023 4567
Email: complaint.info@financial-ombudsman.org.uk
Website: financial-ombudsmand.org.uk

If you have taken a product out online with Aviva and are unhappy with this product or the service you received, you can also use the European Commission's Online Dispute Resolution (http://ec.europa.eu/odr) service to make a complaint. The purpose of this platform is to identify a suitable Alternative Dispute Resolution (ADR) provider and we expect that this will be the Financial Ombudsman Service.

Please note that the Financial Ombudsman Service will only consider your complaint if you have given us the opportunity to resolve the matter first. Making a complaint to the Ombudsman will not affect your legal rights.

Clinical complaints

Clinical complaints are not regulated by the Financial Conduct Authority (FCA) and are not subject to our complaint process set out before.

For clinical complaints relating to the conduct or competency of your specialist or the facilities at which they practise, these need to be directed to the specialist and hospital or clinic directly.

For your information, the responsibility for investigating and responding to clinical complaints is as follows:

- If your complaint is about a hospital/clinic or specialist, whether through a network or otherwise, it will be investigated in accordance with the complaints process in force at the relevant hospital/clinic, please contact the hospital directly.
- If your complaint relates to a third party clinical case manager, this will be investigated by the clinical provider who employs that case manager.

- If your complaint is about a network therapist (e.g. physiotherapist, counsellor, psychologist) this will be investigated by the independent clinical provider responsible for the therapist network.

Once you have contacted the provider who is responsible for investigating and responding to your clinical complaint, they should advise you of the full complaints process which will also include any escalation details should you require these.

While Aviva do not have a role in investigating and responding to clinical complaints, Aviva do record clinical complaint volumes and investigation outcomes. If you would like to inform us of a clinical complaint outcome please contact us using the details provided before.

Financial Services Compensation Scheme (FSCS)

We are covered by the FSCS. You may be entitled to compensation from the scheme if we cannot meet our obligations. This depends on the type of business and the circumstances of the claim. Where you are entitled to claim, insurance advising and arranging is covered for 90% of the claim, with no upper limit.

Further information about compensation scheme arrangements is available from:

Financial Services Compensation Scheme
10th Floor
Beaufort House
15, St Botolph Street
London
EC3A 7QU

Website: fscs.org.uk
Telephone: 0800 678 1100 or 020 7741 4100

Private Healthcare Information Network

You can find independent information about the quality and cost of private treatment available from doctors and hospitals from the Private Healthcare Information Network:

Website: phin.org.uk

Language

All documents or letters relating to this policy will be written in English.

Definitions

Accident or emergency admission

An admission to:

- **hospital** directly following an accident
- a **hospital** ward directly from the emergency department for urgent or unplanned **treatment**, or
- a **hospital** ward on the same day as a referral for **treatment** is made either by a **GP** or **specialist**, when immediate **treatment** or **diagnostic tests** are **medically necessary**.

Acupuncturist

A doctor registered with the General Medical Council (GMC) who is also either:

- a Medical Member or
- Accredited Member

of the British Medical Acupuncture Society, and who is recognised by **us**, or

a registered member of the British Acupuncture Council, who is recognised by **us**.

Acute condition

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

Advice

Any:

- consultation
- advice or
- prescription

from a **GP** or **specialist**.

Cancer

A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chemotherapy

Drugs that are used to treat **cancer**. These include drugs used to destroy cancer cells or prevent tumours from growing (these could be cytotoxic drugs, targeted or biological therapy drugs).

For this **policy**, hormone therapy is not chemotherapy.

Chiropodist/podiatrist

A practitioner who is included in the register of the Health and Care Professions Council as a Chiropodist/Podiatrist, and who is recognised by **us**.

Chiropractor

A practitioner who is:

- included in the Register of Chiropractors kept by the General Chiropractic Council, and
- recognised by **us**.

Chronic condition

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

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

Day-patient

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

Diagnostic centre

A

- **hospital** or
- facility

recognised by **us** to carry out a CT, MRI or PET scan.

Diagnostic tests

Investigations, such as X-rays or blood tests, to find or to help to find the cause of a **member's** symptoms.

Dietician

A practitioner who is:

- included in the register of the Health and Care Professions Council as a dietician, and
- recognised by **us**.

Employee

An individual regularly and actively engaged for reward by the **policyholder** on a contract of service being over the age of 16.

Evacuation

The transport of a **member** from the country of incident to the next nearest available facility for **treatment** as an **in-patient** or **day-patient**.

Family member

A **group member's** partner, spouse, civil partner and/or children covered by the **policy.**

Fee approved

A **specialist** or other practitioner who at the time of the **member's treatment**:

- is recognised by **us**, and
- has agreed to **our** guidelines for consultation fees.

GP

A general medical practitioner included in the GP Register kept by the General Medical Council.

Group member(s)

Any of the following named on the member listing who is, at the relevant time, in relation to the **policyholder**:

- an **employee**; or
- the sole proprietor; or
- a partner; or
- a registered director

actively and regularly working in the conduct of the **policyholder's** business.

Homeopath

A practitioner who is:

- a member of the UK Homeopathic Medical Association (UKHMA)
- a member of the Society of Homeopaths
- a member of the Alliance of Registered Homeopaths (MARH)
- a member of the Faculty of Homeopathy (MFHOM), or
- a Fellow of the Faculty of Homeopathy (FFHOM).

Hospice

A **hospital** or part of a **hospital** recognised as a hospice by **us** which is devoted to the care of patients with progressive disease (where curative **treatment** is no longer possible) on an **in-patient** or domiciliary basis.

Hospital

- A hospital included on **your** chosen hospital list, as shown on **your** accepted quotation, or
- an NHS pay-bed

which **we** recognise to provide the type of **treatment** undertaken, or:

- any establishment which **we** agree is an appropriate facility for the provision of **treatment**, prior to **treatment** being carried out.

In-patient

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

Major fluctuation

Any change in the membership of 10% or more from the membership applicable on the start date or, if later, the appropriate **renewal date** or last preceding major fluctuation.

Medically necessary

Treatment or a medical service which is needed for a **member's** diagnosis and is appropriate in the opinion of a qualified medical practitioner or **specialist.** By generally accepted medical standards, if it is withheld the **member's** condition or the quality of medical care they receive would be adversely affected.

Member

A **group member** or **family member.**

Network

The specified group of facilities and/or **specialists** or other practitioners that are the only providers that **we** recognise to provide the **treatment** required for a **member's** particular condition or suspected condition.

Nurse

A qualified nurse who:

- is on the register of the Nursing and Midwifery Council (NMC), and
- holds a valid NMC personal identification number.

Opening membership

The membership on the first day of the **policy year**.

Osteopath

A practitioner who is:

- included in the Register of Osteopaths kept by the General Osteopathic Council, and
- recognised by **us**.

Out-patient

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

Physiotherapist

A practitioner who is:

- included in the register of the Health and Care Professions Council as a physiotherapist, and
- recognised by **us**.

Policy

Our contract of insurance with the **policyholder** providing the cover as detailed in this policy document. The invoice and financial statement, **hospital** list and accepted quotation form part of the contract and must be read together with this policy document (as amended from time to time).

Policyholder/Company

The person or business (must be actively trading in the **UK**) named as policyholder on the accepted quotation.

Policy year

The period of time from the date the **policy** began until the day before the first **renewal date** or, if the **policy** has been renewed, from one **renewal date** to the next.

Pre-existing condition

Any disease, illness or injury for which:

- the **member** has received medication, **advice**, or **treatment**; or
- the **member** has experienced symptoms;

whether the condition has been diagnosed or not before the **member** joined the **policy.**

Psychiatric therapist

A practitioner who is:

i. employed to provide therapy sessions at a psychiatric **hospital**, or

ii. a fully qualified and accredited member of any counselling register overseen by the Professional Standards Authority (PSA).

and who is recognised by **us**.

Related

Diseases, illnesses or injuries are related if, in **our** reasonable medical opinion, one is a result of the other or if each is a result of the same disease, illness or injury.

Renewal date

The annual anniversary of the date on which this **policy** began.

Specialist

A registered medical practitioner who:

- has at any time held and is not precluded from holding a substantive consultant appointment in an NHS hospital, or
- holds a Certificate of Higher Specialist Training issued by the Higher Specialist Training Committee of the relevant Royal College or faculty, or
- is included in the Specialist Register kept by the General Medical Council

and who is recognised by **us** to provide the **treatment** to the **member** required for the **member's** condition.

Treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

UK

Great Britain and Northern Ireland, the Channel Islands and the Isle of Man (for the purposes of this **policy**).

We/our/us

Aviva Health UK Limited, who administers the **policy** on behalf of Aviva Insurance Limited, who underwrites and provides **your** contract of insurance.

You/Your

The person or business (must be actively trading in the **UK**) named as **policyholder** on the accepted quotation.

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