Welcome to Aviva

This booklet tells you about your policy, including:

● what to do if you wish to claim
● what is covered
● what is not covered, and
● explanations of some of the terms used in this document so that you are fully aware of the cover you have bought.

When making a claim you will need to refer to the information in this booklet, so please keep it somewhere safe. We recommend that you also make a note of your policy number and our contact information separately in case this booklet is lost or mislaid.

Throughout this booklet certain words are shown in bold type. These are defined terms and have specific meanings when used in this guide. The meanings are set out in the definitions section at the back of this booklet.

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

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

Contents

Cover and benefits 1
Benefit terms 8
Benefits for cancer treatment 13
Exclusions 16
Underwriting 21
Policy conditions 23
How to claim 28
Hospital List 29
Use of personal information 30
Further information 33
Definitions 34
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 you to the state of health you were in immediately before suffering from it, or which leads to your full recovery.
- All treatment and diagnostic tests must be by, and under the care of specialists following referral by a GP.
- A no claim discount applies to this policy. For further details please see section 3 of the policy conditions.

You are covered for eligible treatment. Eligible treatment is treatment of an acute condition:
- covered under your policy, including facilities, services and equipment,
- shown by current best available clinical evidence to improve your health outcome, at the time your treatment takes place,
- appropriate for your 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 your treatment and to care for your condition,
- carried out at a hospital on your 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 your treatment takes place, and
- undertaken because you need it for medical reasons.
All benefit limits and excesses (if applicable) apply to each member every policy year unless otherwise stated.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Hospital treatment as an in-patient or day-patient</strong></td>
<td></td>
<td>See networks and hospital charges benefit terms</td>
</tr>
<tr>
<td>If you have the six week option, you cannot claim for these benefits if your treatment is available on the NHS within six weeks from the date your specialist recommends it.</td>
<td></td>
<td>Including accommodation and meals, nursing care, drugs and surgical dressings, theatre fees. See hospital charges benefit term</td>
</tr>
<tr>
<td><strong>Hospital charges</strong></td>
<td>In full</td>
<td></td>
</tr>
<tr>
<td><strong>Specialists’ fees</strong></td>
<td>Up to the limits in our specialist fee schedule</td>
<td>See specialists’ fees benefit term</td>
</tr>
<tr>
<td><strong>Diagnostic tests</strong></td>
<td>In full</td>
<td>Including blood tests, X-rays, scans, ECGs</td>
</tr>
<tr>
<td><strong>Radiotherapy/chemotherapy</strong></td>
<td>In full</td>
<td></td>
</tr>
<tr>
<td><strong>NHS cash benefit</strong></td>
<td>£100 each night, up to 30 nights</td>
<td>See NHS cash benefit term</td>
</tr>
<tr>
<td><strong>B. Additional benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home nursing</strong></td>
<td>In full</td>
<td>Immediately following treatment as an in-patient or day-patient that is covered by the policy. See home nursing benefit term</td>
</tr>
<tr>
<td><strong>Private ambulance</strong></td>
<td>In full</td>
<td>See private ambulance benefit term</td>
</tr>
<tr>
<td><strong>Parent accommodation when staying with a child covered by the policy</strong></td>
<td>In full</td>
<td>Child of 15 or under receiving treatment that is covered by the policy; one parent only</td>
</tr>
<tr>
<td><strong>Hospice donation</strong></td>
<td>£70 each day, up to 10 days</td>
<td>See hospice benefit term</td>
</tr>
<tr>
<td><strong>GP referred treatment by a speech therapist for children</strong></td>
<td>Up to 2 speech therapy sessions</td>
<td>For each child covered by the policy. See speech therapy benefit term</td>
</tr>
<tr>
<td><strong>Baby bonus</strong></td>
<td>£100 for each baby</td>
<td>Payable to the policyholder. See baby bonus benefit term</td>
</tr>
<tr>
<td><strong>GP helpline</strong></td>
<td>Unlimited number of calls</td>
<td>See helplines benefit term</td>
</tr>
<tr>
<td><strong>Stress counselling helpline</strong></td>
<td>Unlimited number of calls</td>
<td>This benefit is available to members aged 16 and over. See helplines benefit term</td>
</tr>
</tbody>
</table>

* Claims for these benefits will not affect the no claim discount.

The information on these pages must be read in conjunction with the definitions, benefit terms, policy conditions and exclusions and the policy schedule.
Over the next three pages there are five options for out-patient cover. If you have chosen one of the reduced out-patient options instead of C1 this will be shown on your policy schedule.

<table>
<thead>
<tr>
<th>C1. Treatment as an out-patient</th>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations with a fee approved specialist</td>
<td>In full</td>
<td>See consultation fees benefit term</td>
<td></td>
</tr>
<tr>
<td>Treatment by a specialist as an out-patient</td>
<td>In full</td>
<td>Specialists’ fees are covered up to the limits in our fee schedule. See specialists’ fees benefit term</td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>In full</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Pre-admission tests (tests carried out at hospital before your admission to check that you are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests).</td>
<td>In full</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiotherapy/chemotherapy</td>
<td>In full</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist referred treatment by: ● a physiotherapist ● a chiropractor ● an osteopath</td>
<td>In full</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric treatment as an out-patient</td>
<td>Up to £2,000</td>
<td>On GP referral to a psychiatric therapist or psychiatric specialist. See psychiatric benefit term</td>
<td></td>
</tr>
</tbody>
</table>

Other benefits – for members with C1 option only

| Treatment for complications of pregnancy and childbirth as an in-patient, day-patient, or out-patient | In full | See pregnancy complications benefit term |
| Surgical procedures on the teeth performed in a hospital as an in-patient, day-patient, or out-patient | In full | Specialists’ fees are covered up to the limits in our fee schedule. See specialists’ fees 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 |
C1000. Reduced out-patient cover – £1000 limit

If you have chosen option C1000 you are not covered for treatment for complications of pregnancy and childbirth and surgical procedures on the teeth performed in a hospital as an in-patient, day-patient, or out-patient and emergency overseas treatment.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT, MRI and PET scans</td>
<td>In full</td>
<td>These scans are only covered at a diagnostic centre</td>
</tr>
<tr>
<td>Pre-admission tests (tests carried out at hospital before your admission to check that you are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests).</td>
<td>In full</td>
<td>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</td>
</tr>
<tr>
<td>Radiotherapy/chemotherapy</td>
<td>In full</td>
<td></td>
</tr>
</tbody>
</table>

The following out-patient benefits are subject to a combined limit of £1,000 for each member every policy year:

- Consultations with a fee approved specialist
- Treatment by a specialist as an out-patient
- Diagnostic tests including blood tests, X-rays and ECGs
- Specialist referred treatment by:
  - a physiotherapist
  - a chiropractor
  - an osteopath
- Psychiatric treatment

On GP referral to a psychiatric therapist or psychiatric specialist

OR

C500. Reduced out-patient cover – £500 limit

If you have chosen option C500 you are not covered for treatment for complications of pregnancy and childbirth and surgical procedures on the teeth performed in a hospital as an in-patient, day-patient, or out-patient and emergency overseas treatment.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT, MRI and PET scans</td>
<td>In full</td>
<td>These scans are only covered at a diagnostic centre</td>
</tr>
<tr>
<td>Pre-admission tests (tests carried out at hospital before your admission to check that you are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests).</td>
<td>In full</td>
<td>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</td>
</tr>
<tr>
<td>Radiotherapy/chemotherapy</td>
<td>In full</td>
<td></td>
</tr>
</tbody>
</table>

The following out-patient benefits are subject to a combined limit of £500 for each member every policy year:

- Consultations with a fee approved specialist
- Treatment by a specialist as an out-patient
- Diagnostic tests including blood tests, X-rays and ECGs
- Specialist referred treatment by:
  - a physiotherapist
  - a chiropractor
  - an osteopath
- Psychiatric treatment

On GP referral to a psychiatric therapist or psychiatric specialist

The information on these pages must be read in conjunction with the definitions, benefit terms, policy conditions and exclusions and the policy schedule.
C0. Reduced out-patient cover (£0 limit) and selected benefit removal

If you have chosen option C0 there is no cover as an out-patient for any consultations with a specialist whether fee approved or not, diagnostic tests (other than pre-admission tests) or treatment by a specialist, specialist referred treatment by a physiotherapist, chiropractor or osteopath, or psychiatric treatment as an out-patient.

You are also not covered for treatment for complications of pregnancy and childbirth and surgical procedures on the teeth performed in a hospital as an in-patient, day-patient, or out-patient, and emergency overseas treatment.

If you have chosen option C0 the only out-patient benefits available on your policy are:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT, MRI and PET scans</td>
<td>In full</td>
<td>These scans are only covered at a diagnostic centre</td>
</tr>
<tr>
<td>Pre-admission tests (tests carried out at hospital before your admission to check that you are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests).</td>
<td>In full</td>
<td>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</td>
</tr>
<tr>
<td>Radiotherapy/chemotherapy</td>
<td>In full</td>
<td></td>
</tr>
</tbody>
</table>

C2. Reduced out-patient cover and selected benefit reduction.

Available to existing C2 option holders only

If you have chosen option C2 you are not covered for specialist referred treatment by a physiotherapist, chiropractor or osteopath as an out-patient, or psychiatric treatment as an out-patient.

You are also not covered for treatment for complications of pregnancy and childbirth and surgical procedures on the teeth performed in a hospital as an in-patient, day-patient, or out-patient, and emergency overseas treatment.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two consultations with a fee approved specialist</td>
<td>In full</td>
<td>See consultation fees benefit term</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>In full</td>
<td>Only if they:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• lead directly to treatment as an in-patient or day-patient that is covered by the policy, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• take place within six months after treatment as an in-patient or day-patient that is covered by the policy and are required for the same condition.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In addition, 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</td>
</tr>
<tr>
<td>Radiotherapy/chemotherapy</td>
<td>In full</td>
<td></td>
</tr>
</tbody>
</table>
Please see your policy schedule to see which options apply to you.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D. Other treatment and therapies.</strong> Claims for the benefits in option D will not affect your no claim discount</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GP referred treatment by:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• a physiotherapist</td>
<td>In full</td>
<td></td>
</tr>
<tr>
<td>• a chiropractor</td>
<td>Up to 10 sessions in combined total each member, each condition, every policy year. See therapies benefit term</td>
<td></td>
</tr>
<tr>
<td>• an osteopath</td>
<td>Up to 10 sessions in combined total each member, each condition, every policy year. See therapies benefit term</td>
<td></td>
</tr>
<tr>
<td>• an acupuncturist</td>
<td>Up to 10 sessions in combined total each member, each condition, every policy year. See therapies benefit term</td>
<td></td>
</tr>
<tr>
<td>Minor surgery by a GP</td>
<td>Up to £100 for each procedure</td>
<td>For procedures appearing on our GP minor surgery list. Details are available on request</td>
</tr>
<tr>
<td><strong>E. Dental and optical benefits.</strong> Claims for the benefits in option E will not affect your no claim discount</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment</strong> by a dentist of an accidental dental injury</td>
<td>Up to £600</td>
<td>For each member, each condition, every policy year. See accidental dental injury benefit term</td>
</tr>
<tr>
<td>Routine dental treatment</td>
<td>Up to £300, of which you pay £50 excess</td>
<td>See routine dental treatment benefit term. See dental and optical excess benefit term for details of how the excess works</td>
</tr>
<tr>
<td>Optical benefit</td>
<td>Up to £200, of which you pay £50 excess</td>
<td>See optical benefit term. See dental and optical excess benefit term for details of how the excess works</td>
</tr>
<tr>
<td><strong>F. Mental health treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Treatment</strong> as an in-patient or day-patient – accommodation and nursing</td>
<td>In full up to 28 days</td>
<td>For each member, every policy year. See psychiatric benefit term</td>
</tr>
<tr>
<td><strong>Specialists’ fees for treatment as an in-patient</strong></td>
<td>Up to £210 each week</td>
<td></td>
</tr>
<tr>
<td><strong>G. Hospital list options.</strong> You will have the Key hospital list unless you have chosen one of the following.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended hospital list</td>
<td>See hospital charges benefit term</td>
<td></td>
</tr>
<tr>
<td>Trust hospital list</td>
<td>See hospital charges and Trust hospitals benefit terms</td>
<td></td>
</tr>
<tr>
<td>Signature hospital list – available to residents of Scotland and Northern Ireland only</td>
<td>See hospital charges benefit term</td>
<td></td>
</tr>
<tr>
<td>Fair+Square hospital list – available to existing Fair+Square hospital list holders only</td>
<td>See Fair+Square hospitals benefit term</td>
<td></td>
</tr>
</tbody>
</table>

The information on these pages must be read in conjunction with the definitions, benefit terms, policy conditions and exclusions and the other documents forming the policy.
Please see your policy schedule to see which options apply to you.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount payable</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H. Excess options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£100</td>
<td></td>
<td>Benefits covered under this policy will be subject to an excess payable for each member every policy year.</td>
</tr>
<tr>
<td>£200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£1,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£3,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£5,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **I. Six week option**                |                |                                                                      |
| **You** 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 your treatment is available on the NHS within six weeks from the date your specialist recommends it |                |

| **J. Protected no claim discount**    |                |                                                                      |
| **Your** no claim discount (NCD) is protected. Your discount will remain at its current level and not reduce at the next renewal date if a claim that would have caused your NCD to reduce by three levels is paid. |                | Eligibility criteria apply. See protected NCD benefit term |
Benefit terms

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 you join the policy.

Baby bonus
We pay the policyholder a baby bonus of £100 for each baby born to or adopted (within a year of birth) by a member during a policy year. The baby bonus is only available if the baby is born or adopted more than ten months after the policyholder joins the policy and is payable once for each baby. The above qualifying criteria applies if you have moratorium or full medical underwriting.

Consultation fees
We will pay in full for consultations with a fee approved specialist or other fee approved practitioner. If you have 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 you 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 an excess of £50. We will pay for the costs up to the limit covered by the policy, minus the amount of 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 you. You are responsible for paying the £50 excess for the treatment received. This leaves a balance of £80 available to you in this example for subsequent claims in the same policy year. The excess is only deducted once for each member every policy year. If you have chosen another excess on this policy it will not apply to option E (Dental and optical benefits).

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 you have a £5,000 excess and your treatment in a policy year costs £10,000, you will pay the first £5,000 and we will pay the rest. If the treatment carries on into the next policy year, another excess will apply, so you will again pay the first £5,000 of treatment received in that policy year.

If the treatment you were claiming for cost £1,000 and your excess was also £1,000, you would have to meet the full cost of that treatment yourself. However, your excess would be paid and would 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, NHS cancer cash benefit, the baby bonus, donations we make to a hospice, any benefit claimed under option E (dental and optical benefits), or to the wigs benefit under benefits for cancer treatment.

If you claim for a benefit that has a limit, and you have not already paid your excess for that policy year, the excess will count towards the benefit limit.

So if, for example, your excess was £200 and the treatment you were claiming for had a benefit limit of £500, you would have to pay the first £200 and we would only pay up to a further £300 for that benefit in that policy year. If we do not pay a claim because the amount due is less than the excess, the no claim discount will not be affected.

If an excess applies, we will write to the policyholder to advise who the excess should be paid to. The policyholder 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 policy schedule.
If you receive treatment as an
• in-patient or
• day-patient
for a condition or suspected condition for which we don’t have a network, in a hospital that is not:
• included on the Fair + Square hospital list, and
• recognised by us for the treatment that you need
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 you 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 your 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.

Helplines
The GP helpline and stress counselling helpline services are designed to be available 24 hours a day but some reasonable delay may be experienced. They are not emergency services. You may call on behalf of another member subject to any patient confidentiality requirements of the GP or service provider.
In using the helplines, you (where applicable, on behalf of another member) automatically authorise the use and disclosure of any medical or other information, on a fully confidential basis as between us, the GPs and any service providers we use in making the services available, for the sole purpose of policy and service administration. We will not be responsible for any failure in the provision of the helplines to the extent that it is due to circumstances beyond the reasonable control of us or any of our service providers.
A GP helpline consultation is advice which it is practical for one of the retained GPs to give you over the telephone when your symptoms are described. It is intended to deal with one call per member lasting up to 15 minutes in respect of one set of symptoms presented. The consultation may, at the discretion of the GP, involve a longer call or more than one call.
Call charges are the responsibility of the caller.

Home nursing
We cover home nursing if this:
• is recommended and supervised by your specialist
• takes place in your home
• immediately follows treatment as an in-patient or day-patient that is covered by your 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 your mobility, personal care or preparation of meals.

Hospice
We will pay a donation directly to the hospice when:
• you receive care as a patient of a hospice, and
• we have previously covered treatment for the condition.

Hospital charges
If you receive treatment as an
• in-patient or
• day-patient
for a condition or suspected condition for which we don’t have a network, in a hospital that is not:
• an NHS pay-bed at an NHS hospital recognised by us, or
• included on your hospital list and recognised by us for the treatment that you need
we will calculate the average cost of equivalent treatment across all hospitals on your list and that average cost is the maximum we will pay. This could leave you 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 your 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 **you** receive **treatment** as an NHS **in-patient** or **day-patient** whilst occupying an NHS amenity bed (a bed paid for by **you** in a single room or side ward in an NHS **hospital** recognised by **us** where **you** receive NHS in-patient or day-patient **treatment**) and that **treatment** would have been covered by the **policy** if **you** had chosen to receive it as a private patient, **we** will reimburse **you** 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 **you** claim for the cost of an NHS amenity bed **you** cannot also claim NHS cash benefit or NHS cancer cash benefit for the same **treatment**.

**Networks**

If **you** have **in-patient**, **day-patient** or **out-patient** **treatment** for a condition or suspected condition for which **we** have a **network** but **your 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 **your treatment**.

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

**NHS cash**

**We** will pay NHS cash benefit if:

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

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

NHS cash benefit is not available:

- if **you** are 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**
- if **you** claim 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 **your** 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 **you** feel this level of cover is not appropriate for **you** or that **you** may need more cover **you** should consider taking out a travel insurance policy.

**You** should consider taking a European Health Insurance Card (EHIC) with **you** if **you** are travelling to countries covered by the scheme. Application forms can be obtained from the post office or online and should be completed and validated before **you** travel. This will allow **you** to benefit from the reciprocal health arrangements which exist with these countries. **You** 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 **you** call, please give them **your** 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:

- **you** are outside the UK temporarily for a maximum of 90 days during any **policy year**
- a medical emergency occurs that requires **you** 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 you had been in the UK, you could have treated the condition yourself or you could have waited for treatment until you returned to the UK
- it consists of out-patient drugs and dressings (including medication that you are currently taking and medication which you can obtain ‘over the counter’), or
- your medical condition and the treatment are not covered by your policy.

If you are 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 appropriate medical facility for treatment of an overseas medical emergency. The nearest appropriate medical facility for your treatment might not be in the UK.

We only cover evacuation to the nearest appropriate medical facility if:
- your evacuation is medically necessary,
- you contact us and we agree to your evacuation before this takes place, and
- your evacuation is undertaken by the emergency assistance company specified by us and all arrangements are made by them.

We do not cover your repatriation to the UK unless the nearest appropriate hospital is in the UK and we have agreed to your repatriation before this takes place.

We do not cover travel or accommodation costs for relatives or friends who accompany you during your 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 your treatment takes place.

Pregnancy complications
Cover will only be available for treatment directly or indirectly arising from or recommended by your specialist in connection with the following conditions once diagnosed:
- ectopic pregnancy (development of foetus outside the womb)
- miscarriage (if you have miscarried, but not investigations into the cause of repeated miscarriages)
- 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 your specialist before we can make a decision about cover).

If you have moratorium or full medical underwriting – We will only pay for these conditions and treatments if they occur at least 10 months after you have joined 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 your policy
- you travel between hospitals as part of your treatment as an in-patient and
- it is medically necessary for you to travel by ambulance.

Protected NCD
If you have not already selected no claim discount (NCD) protection, it can only be added at your renewal date.

To be eligible for the NCD protection you must:
- have not had any form of cancer, heart disease or stroke in the last five years
- have not had any consultations, diagnostic tests or treatment in the last 12 months
- have no consultations, treatment or diagnostic tests pending with a GP, specialist or hospital and
- not be aware of any conditions for which you may need diagnostic tests or treatment in the next six months, whether or not you have consulted a medical practitioner.
The NCD protection takes effect if a member makes any claims that would have caused the NCD to reduce by three levels on the scale (these are new claims or claims that haven’t yet caused the member to drop down the NCD scale which total more than £250). Instead of the NCD reducing by three levels:
- that member will remain at their current NCD level,
- we will calculate their premium from the next renewal date based on their current NCD level, and
- we will remove that member’s NCD protection and the NCD rules will apply. For details of these see section 3 of the policy conditions.

We will remove the NCD protection if you ask us at any renewal date.

If we remove a member’s NCD protection for any reason, we will reinstate it after a period of 12 months with no claims paid if the policyholder asks us to and the member satisfies the protected NCD eligibility rules.

Psychiatric

We cover acute psychiatric conditions. This means we will cover treatment which aims to lead to your 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 your treatment for that condition or a related psychiatric condition during three separate policy years. This will apply even 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 will pay for dental treatment carried out by a dental practitioner in a dental surgery including examinations, tooth cleaning, white fillings (where appropriate), crowns, extractions and surgery.

**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 your responsibility to pay the specialist the difference.

You 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.

**Speech therapy**

This benefit is available for each child covered by the policy, until the renewal date following their 18th birthday and includes cover for speech therapy needed for developmental delay.

**Therapies**

We cover up to ten sessions in combined total (for example five physiotherapy sessions and five osteopathy sessions) each policy year on referral from a GP for each separate condition. If either C2 (Reduced out-patient cover and selected benefit reduction) or C0 (Reduced out-patient cover (£0 limit) and selected benefit reduction) options have also been chosen, there is no cover for specialist referred treatment by a physiotherapist, osteopath, chiropractor or acupuncturist in any circumstances.

**Trust hospitals**

If the Trust hospital nearest to you is removed from the Trust hospital list and there is no other hospital on the Trust hospital list within 30 miles, of your address, we will review your hospital list option at your next renewal date.

We may change your hospital list option to either the Key hospital list or the Signature hospital list, to make sure that you have a hospital available to you within a reasonable distance. If we change your hospital list option, the Trust hospital list will no longer be available to you.

A change of hospital list may affect your premium.
Benefits for cancer treatment

This section explains what Aviva will pay for cancer treatment.

Important:

If you have chosen a monetary limit for out-patient treatment (C0, C500 or C1000) the monetary limit will not apply to cancer treatment received after you have been diagnosed with cancer.

If you have chosen the reduced out-patient cover and selected benefit reduction option (C2), we will still cover in full any consultations and diagnostic tests required as part of your cancer treatment.

If you have the six week option, we do not pay for treatment as an in-patient or day-patient if it is available on the NHS within six weeks from the date your specialist recommends it. If you are diagnosed with cancer, this may mean that your treatment will be available on the NHS and we will not pay for most of the treatment that you need.

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

If your 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 we don’t have a network for your condition or suspected condition, you can have out-patient treatment at a hospital not on your list 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 your hospital list and recognised by us for the treatment that you need. If you have in-patient or day-patient treatment at any other hospital we will calculate the average cost of equivalent treatment across all hospitals on your list, and that average cost is the maximum we will pay. This could leave you 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.

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

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 you have the treatment via our approved networks. If we don’t have a network for the treatment you need we will still pay in full if you have the treatment:

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

We do not pay for hormone therapy.

BUT: We will pay for hormone therapy if you need it to shrink a tumour before you have surgery or radiotherapy.

Consultation fees

We will pay in full for consultations with a fee approved specialist or other fee approved practitioner. If you have 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 you 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 you are 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 you have been admitted to the hospice).

If you stay at home but are 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 you, up to the £10,000 limit.

Monitoring

We will pay for monitoring for up to ten years after your 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 cash benefit for cancer treatment if

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

We will pay £100 for each day you receive treatment:

- as an in-patient
- as a day-patient

We will pay £100 for each day you:

- receive out-patient radiotherapy, chemotherapy or blood transfusions
- undergo out-patient surgical procedures.

We will pay £100 for

- each day you receive intravenous (IV) chemotherapy at home
- each week whilst you are taking oral chemotherapy drugs at home.

We may need to contact your specialist for details of your treatment before we can pay your claim. When you make a claim for NHS cancer cash benefit, we may ask for the discharge summary from the hospital.

You will not be able to claim more than £100 in any one day.

NHS cancer cash benefit is not available:

- for claims for psychiatric treatment, or
- if you claim for the cost of an NHS amenity bed for the same treatment.

Ongoing needs

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

Post-surgery services

Medical services

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

- dietician in order to stabilise your diet following surgery or chemotherapy
Benefit terms

- dietician in order to stabilise
- surgery with, for example, a:
  - pay for consultations immediately following
  - have had.
  - have and the surgery
  - We
  - you
  - cancer you
  - need, depending on the type of
  - different specialist services that
  - you
  - may
  - Following surgery for
  - cancer
  - there are a number
  - Medical services
  - treatment
  - for
  - cancer
  - has finished.
  - we
  - regular replacement of tubes, drains or stents,
  - Ongoing needs
  - ●
  - if
  - for claims for psychiatric
  - ●
  - undergo
  - receive
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  - ●
  - as an
  - ●
  - if
  - We
  - will pay NHS cash benefit for
  - NHS cancer cash
  - will not be able to claim more than £100
  - You
  - discharge summary from the
  - hospital
  - we
  - NHS cancer cash benefit,
  - may ask for the
  - pay
  - we
  - can
  - We
  - may need to contact
  - for
  - We
  - will pay £100 for
  - We
  - will pay for radiotherapy in full if
  - Radiotherapy
  - This includes any cost for fitting the prosthesis.
  - Artificial feeding
  - If, due to your cancer or treatment of your
cancer, you 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 you are receiving
treatment for cancer we will pay for the
nutrition itself, although once your 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 you have 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 you have been diagnosed with
cancer in the other breast.
  - We will not pay for surgery where you have no
symptoms of cancer, for example where you
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 your surgery.
  - This includes any cost for fitting the prosthesis.
  - Radiotherapy
  - We will pay for radiotherapy in full if you have
the treatment at a network facility.
  - If we don’t have a network for the treatment
you need we will still pay in full if you have
the treatment:
  - ● as a day-patient or an in-patient at a
hospital on your list if you need it for
medical reasons, or
  - ● as an out-patient.
  - Side effects
  - Whilst you are receiving chemotherapy or
radiotherapy, we will pay for treatment
prescribed by your specialist that you need to
deal with the side effects, for example:
  - ● antibiotics
  - ● anti-sickness drugs
  - ● steroids
  - ● pain killers
  - ● drugs to boost your 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 your responsibility
to pay the specialist the difference.
  - You 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 you have this
treatment at a network facility or, if we don’t
have a network for the treatment you need,
at a hospital on your 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 to find a donor
for a transplant.
  - We will pay for drugs for you to take home
at the time you are discharged from hospital
following a stem cell or bone marrow transplant.
  - BUT: After you have been discharged from
hospital following a stem cell or bone marrow
transplant, you 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 you need one due to hair loss caused by
cancer treatment.
Exclusions

**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.

**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.

**Appliances and prostheses**

*We* do not cover:

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

**BUT:** *We* do cover:

- prostheses inserted into the body during a surgical procedure
- hand, back and knee braces required immediately after a related surgical procedure, and
- heart pacemakers and implantable cardioverter defibrillators.

**Birth control**

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

**Chronic conditions**

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

In particular:

- regular planned check ups for a chronic condition where *you* are 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 *your* condition is re-stabilised
- *we* do not apply this chronic condition exclusion to treatment for cancer.

**Cosmetic treatment**

*We* do not cover treatment, or any consequence of treatment, that is intended to change *your* 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 *your* appearance if:

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

If *you* have 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 *you* were covered under the policy when the cancer treatment took place and *you* have had no break in cover since then.

*We* advise that *you* contact *us* before treatment begins so that *we* can confirm if *you* are covered.

**Dental treatment – please see your policy schedule 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 you wear dentures or bridges
● dental implants, or treatment carried out to insert or help you wear dental implants, or
● orthodontic treatment and any associated extractions.

**OR**

If you have chosen option E (dental and optical benefits) the exclusion that applies to you is:

**We** do not cover

● dental treatment performed for cosmetic reasons such as teeth whitening
● treatment carried out to help you wear dentures or bridges
● dental implants, or treatment carried out to insert or help you wear dental implants, or
● orthodontic treatment and any associated extractions.

**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 you are admitted to hospital for eligible treatment as an in-patient for another condition and you need your 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.

**Drugs and dressings**

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

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

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

**BUT:**

Even if we consider your 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 your condition, if this is available.

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

**Eyesight – please see your policy schedule 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 you have chosen option E (dental and optical benefits) the exclusion that applies to you is:

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

**GP charges and treatment – please see your policy schedule 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 (other than two speech therapy sessions per child), or
- GP charges or fees, including those for completing a claim form if the claim is not covered by the policy.

**OR**

If you have chosen option D (other treatment and therapies) the exclusion that applies to you 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 or acupuncturist, and two speech therapy sessions per child
- diagnostic tests requested by a GP, such as X-rays, blood tests and scans, or
- GP charges or fees, including those for completing a claim form if the claim is not covered by the policy.

**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 your deafness.

**Infertility treatment**

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

**Non-medical admissions**

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

**Out-patient treatment**

If you have chosen option C2 (reduced out-patient cover and selected benefit reduction), we do not cover treatment as an out-patient.

BUT: we do cover up to two consultations with a specialist each policy year, and limited diagnostic tests.

If you have chosen option C0 (Reduced out-patient cover – £0 limit) we do not cover treatment as an out-patient, including consultations and diagnostic tests.

BUT: we do cover CT, MRI and PET scans, pre-admission tests and radiotherapy/chemotherapy.

**Overseas treatment – please see your policy schedule 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 you have chosen option C2, C0, C500 or C1000 (a reduced out-patient option) the exclusion that applies to you is:
We do not pay for treatment outside the UK.

Pregnancy and childbirth – please see your policy schedule 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 you have chosen option C2, C0, C500 or C1000 (a reduced out-patient option) the exclusion that applies to you is:
We do not cover pregnancy and childbirth as an in-patient, day-patient, or out-patient, or any treatment related to pregnancy or childbirth as an in-patient, day-patient, or out-patient, in any circumstances.

Psychiatric treatment – please see your policy schedule 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 sections C1, C1000 or C500.
If option F (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 you have chosen option C2 (reduced out-patient cover and selected benefit reduction) or C0 (reduced out-patient cover – £0 limit) but not option F (Mental health treatment) the exclusion that applies to you is:
We do not cover treatment of psychiatric, psycho-geriatric or mental health illnesses or conditions of any kind, such as stress.

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.

Routine medical examinations, screening and preventative treatment – please see your policy schedule 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, for example genetic tests.
If we have paid for you to have treatment for cancer, this exclusion will not apply with regard to routine monitoring for cancer.

OR
If you have chosen option E (dental and optical benefits) the exclusion that applies to you 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, for example genetic tests.
If we have paid for you to have treatment for cancer, this exclusion will not apply with regard to routine monitoring for cancer.
Self-inflicted injury
We do not cover treatment directly or indirectly arising as a result of self-inflicted injury.

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.

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).

Sport – professional sports
We do not cover treatment of an injury sustained whilst you are:
● training for, or
● taking part in sport for which you are paid or funded by sponsorship or grant (unless you receive travel costs only). This exclusion does not apply if you are coaching the sport.

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.

Treatment that is not eligible
We do not pay for treatment that is not covered by your 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.

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

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 your GP or specialist for details of your condition before we can confirm your claim.

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).

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

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

Your policy is subject to one of five different types of underwriting. Your policy schedule will show which type of underwriting applies to you.

Full Medical Underwriting (FMU)
If you were covered on a policy that was updated to Healthier Solutions, the following wording applies to you:

Any medical exclusions we have applied are shown on your policy schedule.

If you do not have any personal medical exclusions applied to a medical condition, the wording that applies to your cover is:

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

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

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

that condition in the five years before you joined the policy.

However, we will cover a pre-existing condition if you do not have:

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

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

Any medical exclusions we have applied are shown on your policy schedule.

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

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

that condition in the five years before you joined the policy.

However, we will cover a pre-existing condition if you do not have:

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

that condition during a continuous two year period after you join the policy.
**Continued Medical Exclusions (CME)**

For members who were fully medically underwritten on another policy and then transferred to Healthier Solutions.

We apply the personal medical exclusions for pre-existing conditions that were applied by your previous insurer, if any. These are shown on your policy schedule. The terms and conditions of this policy may be different to those of your previous policy.

**Continued moratorium**

For members who were insured on a moratorium basis on another policy and then transferred to Healthier Solutions.

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

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

that condition in the five years before your initial date of cover. Your initial date of cover is the date you 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 you do not have:

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

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

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

**Medical History Disregarded (MHD)**

For members who have left a company scheme and who were insured on a MHD basis.

We do not apply any personal medical exclusions to your policy 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?
All those named on the policy schedule will be covered on this policy.
- The policyholder
- the policyholder’s spouse, partner or civil partner and
- their children
can all be members.
Members must permanently live in the UK.
Adding members
The policyholder may add new members to the policy at any time by contacting us.

Newborn babies
If a member has a baby while they are covered by the policy, they can add their baby to the policy without underwriting if the policyholder applies to us within three months of the baby’s birth. No premium will be required either:
- for three months from the date of the baby’s birth, or
- until the next renewal date whichever happens sooner.
Before we can include a newborn baby on your policy we need a copy of the baby’s birth certificate.
Please also see Child rates under Premiums section.

2. Premiums
The policy schedule shows you how much must be paid, when and by which payment method. We will advise the policyholder if the premium changes.
We will collect premiums in advance of the date they are due. We will collect any premiums due unless the policyholder tells us to cancel the policy in time for us to stop collecting the payment.

We do not pay any claims if premiums are not paid to date at the time your treatment takes place.
If you pay monthly, each monthly premium payment is for one month’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 policy during the policy year, any change to your premium will only take effect from the renewal date. See section 5, changes to your circumstances.

Child rates
A premium is payable for all members on the policy aged 20 and over.
A premium is payable for the eldest member aged under 20 on the policy.
All other members aged under 20 on the policy are covered free. (This will only apply if there is at least one member aged 20 or over on the policy).

MyHealthCounts
If you choose to participate in our MyHealthCounts programme, you may receive a discount on your premium. This discount on your premium can go up or down at your renewal date, depending on the Q score you achieve.
The premium discount will depend on you completing your online Q score in full and on time. Please refer to the MyHealthCounts website for full details of when the final Q score is required.
We may change or remove all or any part of the MyHealthCounts offer at any time and we will advise the policyholder of any changes.
Full details are available on request or online at www.aviva.co.uk/myhealthcounts.
### 3. No claim discount

**Your policy** includes a no claim discount (NCD) which is reviewed at each **renewal date**.

The NCD cannot fall below level 0.

An NCD applies to each **member** of the **policy**. This means that if a **member** makes a claim on the **policy** which affects the NCD, only the premium for that **member** will change.

The NCD is affected on the date **we** pay the bill that arises from the claim, rather than the date the **treatment** takes place.

Before each renewal **we** will review the claims that **we** have paid for each **member** in the year before the **renewal date** to determine the NCD that will be used to calculate their premium for the next **policy year**:

a) If no claims have been paid for a **member** during the year before the **renewal date**, their no claim discount will increase by one level on the scale.

b) If the claims **we** have paid for a **member** are all new claims, or claims that have not yet caused the **member** to drop down the NCD scale, and the total combined amount **we** have paid towards those claims is £250 or less, that **member** will remain at their current NCD level. New claims are those that are for a disease, illness or injury which is not related to an existing claim.

c) If **we** have paid claims for a **member** that are new claims, or claims that have not yet caused the **member** to drop down the NCD scale, and the total combined amount **we** have paid towards those claims is more than £250, that **member’s** NCD will reduce by three levels on the scale.

d) The NCD will not reduce by more than three levels on the scale in any one **policy year**.

e) If **we** have paid bills for a claim that caused the **member** to drop three levels down the NCD scale in a previous year, and **we** pay further bills for the same claim in another **policy year**, it will not cause the NCD to reduce again at the end of that **policy year**. Instead, that **member** will remain at their current NCD level (unless other claims that do cause the **member** to drop down the scale have been paid).

f) Claims under the following will not affect the NCD:

- NHS cash benefit
- NHS cancer cash benefit
- hospice donation
- baby bonus
- GP referred **treatment** by a speech therapist for children
- other treatment and therapies
- dental and optical benefits
- **if** **we** do not pay a claim because the amount due is less than an excess.

The NCD is applied after any other premium discounts or reductions.

A claim paid after the renewal premium has been calculated will not affect the NCD at that renewal, instead it will affect the NCD the following year.

**We** may change the structure of the NCD and will advise the **policyholder** before any changes take effect. **We** may remove the NCD from a future **renewal date** by giving at least one years notice to the **policyholder**.

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#### No claim discount scale

<table>
<thead>
<tr>
<th>Level</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>11</th>
<th>12</th>
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<td>% discount off level 0 premium</td>
<td>0</td>
<td>9</td>
<td>18</td>
<td>25</td>
<td>32</td>
<td>39</td>
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<td>59</td>
<td>63</td>
<td>66</td>
<td>69</td>
<td>72</td>
<td>75</td>
</tr>
</tbody>
</table>
4. Payments for ineligible treatment
If we agree to pay for treatment that is not normally eligible on your 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 your policy terms and conditions, your no claim discount and your excess (if you have an excess).

5. Changes to your circumstances
The policyholder must tell us as soon as possible about any changes relating to members, for example a change of name, address, if somebody works for the diplomatic service or a foreign embassy.
You must tell us as soon as possible if any member no longer permanently lives in the UK. Cover for that member will end immediately.
The following changes can be made to your policy at any time during the policy year, but this could result in your premium changing before your renewal date:
● changes relating to members, for example a change of name, title, address
● the correction of any information shown on the policy schedule
● removing members from the policy
● changes to the underwriting terms.
Any changes made during the policy year will be treated as a continuation of your contract of insurance.
We reserve the right to alter the premiums or policy terms or cancel cover for a member of the policy following a change of risk.
We will always write to your last known address with details of any changes to your cover.

6. Renewing the policy
The policy lasts for one year and (if we still offer Healthier Solutions) we will automatically renew it unless you notify us that you do not wish to renew.

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 let us know in writing.
Only Aviva can make changes to the terms and conditions of the policy.
If you wish to make any changes to your policy, for example adding or removing options, please contact us. We will review the claims that we have paid for each member when deciding whether you can make these changes.

7. Cancelling the policy
When the policyholder may cancel the policy:
The cooling off period
The policyholder may cancel the policy for any reason within 14 days of purchasing the policy or receiving the policy documents, whichever is the later (this is called the ‘cooling off period’). Provided no claims have been made during the cooling off period we will refund any premium already paid during that time.
After the cooling off period
The policyholder may cancel the policy after the cooling off period, but we will not refund any premiums that have been paid for cover up to the cancellation date.
If the policyholder has paid an annual premium, we will refund the premium that has been paid for the time that the policy is no longer in place (from the cancellation date to the end of the policy year).
If you wish to cancel your policy, you can do so by notifying our customer service department in writing at:
Aviva Health UK Limited
Chilworth House
Hampshire Corporate Park
Templar’s Way
Eastleigh
Hampshire
S053 3RY

or by calling us on 0800 092 4590.

You are advised to call our customer service helpline to discuss your options before taking this step. Calls to and from Aviva may be recorded and/or monitored.

Important note
The Consumer Insurance (Disclosure and Representations) Act 2012 sets out situations where failure by a policyholder to provide complete and accurate information requested by an insurer allows the insurer to cancel the policy, sometimes back to its start date and to keep any premiums paid.

The policyholder must take reasonable care to 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 the policyholder has not taken reasonable care to provide complete and accurate answers to the questions we ask (see Important note above):

- we may cancel the policy 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, the policyholder 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 Consumer Insurance (Disclosure and Representations) Act 2012.

If a claim made by, or on behalf of, the policyholder 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, the policyholder, we may cancel the policy back to the date of the fraudulent act and keep all premiums. This will end the cover of the policyholder 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 the policyholder (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 Healthier Solutions product at your renewal date. If this happens, we will contact you to advise you of your options.
8. If the policyholder dies
We will not automatically cancel the policy if the policyholder dies. The policy will transfer to the policyholder’s spouse or partner or the eldest child over the age of 18, subject to their agreement to continue the policy and accept its terms and conditions.

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

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

If we have paid any costs for your treatment then you must not settle your personal injury claim unless we have given our agreement to you or your lawyers.

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

If we want to, we can take proceedings in your 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 your policy.

We cannot offer you legal advice.

10. If you have other private medical insurance
If you have any other insurance covering any of the benefits covered by your Aviva policy, such as other private medical insurance or travel insurance, you must let us know and we may recover these costs from that other insurer.

11. 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 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 the policyholder and us. No other person shall have any rights to rely on any terms under the policy.
How to claim

When you are referred by your GP, please call us on 0800 158 3333. Calls to and from Aviva may be recorded and/or monitored.

If your claim is for treatment for a condition for which we have a network in place, we will tell you where you can have your treatment and/or which specialist (or other practitioner) we recognise to carry out the treatment that you need.

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

For all other conditions, if you have an open referral, with no specialist name, we can help to name the specialists in your area that work out of a hospital on your list. This sometimes means you can get an appointment quicker, as you can arrange an appointment with the specialist that can see you at a time that suits you.

If your GP has given you a named referral, we will check that the specialist is recognised by us.

Whenever possible we will assess your claim over the telephone but we may require the completion of a claim form. Our experienced claims staff will then talk you through the claims process and advise you what to do next.

We strongly recommend that you call before any planned treatment or diagnostic tests take place so that we can tell you if:

- the treatment is covered
- you must use our network for the treatment you need for your condition
- your specialist or hospital is recognised by us
- there are any limits that apply to your cover, or
- you need to complete a claim form.

It will help if you can give us the following information:

- your symptoms and the date when they began
- details of your treatment, when and where it is due to take place and how long it is expected to last, and
- your specialist’s full name and address.

You need to give us all the information we need to assess your claim, for example:

- a completed claim form if we ask for one (we need 5 working days to assess claim forms)
- any medical reports relating to your treatment
- previous medical records
- a doctor’s report if we need one, and
- original bills and receipts where appropriate (not copies).

Please remember, we do not cover GP charges or fees for completing a claim form if the claim is not covered by the policy.

If your claim continues for some time or the symptoms re-occur, we may ask for more details.

Claims payments

We pay all costs in sterling.

Most hospitals on your list or facilities within our networks will settle charges directly with us, although some may ask you to pay and then reclaim the money from us. You should check the bill on leaving the hospital or facility. The hospital or facility will then forward it to us for payment.

Sometimes you might be sent the bills first. All you need to do is forward them to us with your full name, address and policy number and we will pay the provider (for example the hospital or specialist) direct for eligible costs.

If you have paid a bill, send the original receipt to us and we will reimburse you for all eligible costs.

If you do not have internet access and need to check the list and call us on 0800 015 1013.

Sometimes hospitals close or change ownership we transfer hospitals between lists or in the event hospitals close or change ownership we sometimes remove them. For this reason please check the list and call us on 0800 015 1013 before arranging any treatment.

If you would like details of the bills we have paid for your treatment, please call us on 0800 158 3333 and we will send you a summary.

We do not pay any claims if premiums are not paid up to date at the time your treatment takes place.

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: www.phin.org.uk
Hospital lists

If your claim is for treatment for a condition for which we have a network in place, we will tell you where you can have your treatment. This may or may not be at a hospital included on your list.

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

Details of our hospital lists are available online at www.aviva.co.uk/hospital-lists. From here you can view the latest list on a PDF, which can be downloaded or printed.

Hospital lists are updated frequently as we work to ensure we get the best possible service for our customers. We regularly add new hospitals, transfer hospitals between lists or in the event hospitals close or change ownership we sometimes remove them. For this reason please check the list and call us on 0800 015 1013 before arranging any treatment.

If you do not have internet access and need to know whether or not a hospital is on your list, please call 0800 015 1013.

Most of the hospitals on the list send bills directly to us. However, sometimes the bills might be sent to you first. If this happens, just forward them to us with your full name, address and policy number and we will pay the provider direct for eligible treatment costs.

If you have paid a bill, send the original receipt to us and we will reimburse you for all eligible costs. The address for all bills and receipts is:

Aviva Health UK Limited
Chilworth House
Hampshire Corporate Park
Templars Way
Eastleigh
Hampshire
SO53 3RY

**Children**

Only a limited number of hospitals in the UK are able to admit children for private treatment. Please contact our customer service helpline on 0800 158 3333 if you have any queries about cover for children on your policy.

Calls to and from this number may be monitored and/or recorded.

**Accommodation**

Many of the hospitals on the list will normally provide private en suite facilities to Aviva members. It is likely that variations will exist with respect to the size and quality of these rooms so if you have any queries of the accommodation that will be available to you, please check with your specialist or the hospital before you are admitted.
Use of personal information

Personal Information
We collect and use personal information about you so that we can provide you with a policy that suits your insurance needs. This notice explains the most important aspects of how we use your information but you can get more information about the terms we use and view our full privacy policy at www.aviva.co.uk/privacypolicy or request a copy by writing to us at Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD

The data controller(s) responsible for this personal information is Aviva Insurance Limited as the insurer of the product. Additional controllers include Aviva UK Digital Limited if you took your policy out online and Aviva Health UK Limited/your intermediary (as applicable), who are responsible for the sale and distribution of the product and any applicable reinsurers.

Personal information we collect and how we use it
We will use personal information collected from you and obtained from other sources:-

● to provide you with insurance: we need this to decide if we can offer insurance (to you) and if so on what terms and also to administer your policy, handle any claims and manage any renewal;

● to support legitimate interests that we have as a business:
  - we need this to manage arrangements we have with reinsurers and for the detection and prevention of fraud
  - we also use personal information about you to help us better understand our customers and improve our customer engagement. This includes profiling and customer analytics which allows us to make certain predictions and assumptions about your interests, make correlations about our customers to improve our products and to suggest other products which may be relevant or of interest to customers, which includes marketing products and services to you

● to meet any applicable legal or regulatory obligations: we need this to meet compliance requirements with our regulators (e.g. Financial Conduct Authority), to comply with law enforcement and to manage legal claims; and

● to carry out other activities that are in the public interest: for example we may need to use personal information to carry out anti-money laundering checks.

As well as collecting personal information about you, we may also use personal information about other people, for example family members you wish to insure on a policy. **If you are providing information about another person we expect you to ensure that they know you are doing so and are happy to have their information shared with us. You might find it helpful to show them this privacy notice and if they have any concerns please contact us in one of the ways described below.**

The personal information we collect and use will include name, address, date of birth, current state of health and any existing conditions of each person included in the application. If a claim is made we will also collect personal information about the claim from you and any relevant third parties. We may also need to ask for details relating to the unspent offences or criminal convictions of you or somebody else covered under your policy. We recognise that information about health and offences or criminal convictions is particularly sensitive information. Where appropriate, we will ask for consent to collect and use this information.

If we need consent to use personal information for a specific reason, we will make this clear to you when you complete an application or submit a claim. If you give us consent to using personal information, you are free to withdraw this at any time by contacting us – refer to the “Contacting Us” details below. Please note that if consent to
use this information is withdrawn we will not be able to continue to process the information you gave us for this/these purpose(s). This would not affect our use of the information where consent is not required.

Of course, you don’t have to provide us with any personal information, but if you don’t provide the information we need we may not be able to proceed with your application or any claim you make.

Some of the information we use as part of this application may be provided to us by a third party. This may include information already held about you within the Aviva group, including details from previous quotes and claims, information we obtain from publicly available records, our trusted third parties and from industry databases, including fraud prevention agencies and databases.

Credit Searches

To ensure we have the necessary facts to assess your insurance risk, verify your identity, help prevent fraud and provide you with our best premium and payment options, we may need to obtain information relating to you at quotation, renewal and in certain circumstances where policy amendments are requested. We may undertake checks against publicly available information (such as electoral roll, county court judgements, bankruptcy orders or repossession(s)). Similar checks may be made when assessing claims.

Automated decision making

We carry out automated decision making and customer profiling to decide whether we can provide insurance to you and on what terms, deal with claims or carry out fraud checks. In particular we use an automated underwriting engine to provide a quote for this product, using the information we have collected.

On-line information

When you visit one of our websites, we may record your device information including hardware and software used, general location, when and how you interact with our websites. This information is retained and used to note your interest in our websites, improve customer journeys, determine pricing and/or offer you available discounts.

How we share your personal information with others

We may share your personal information:-

- with the Aviva group, our agents and third parties who provide services to us, your intermediary (if applicable) and other insurers (either directly or via those acting for the insurer such as loss adjusters or investigators) to help us administer our products and services;
- with clinicians, including hospitals, and third party case managers from whom you and others covered under your policy receive insured treatment or who manage your care or treatment pathway;
- with regulatory bodies and law enforcement bodies, including the police, e.g. if we are required to do so to comply with a relevant legal or regulatory obligation;
- with other organisations including insurers, public bodies and the police (either directly or using shared databases) for fraud prevention and detection purposes;
- with reinsurers who provide reinsurance services to Aviva and for each other. Reinsurers will use your data to decide whether to provide reinsurance cover, assess and deal with reinsurance claims and to meet legal obligations. They will keep your data for the period necessary for these purposes and may need to disclose it to other companies within their group, their agents and third party service providers, law enforcement and regulatory bodies

Some of the organisations we share information with may be located outside of the European Economic Area (“EEA”). We’ll always take steps
to ensure that any transfer of information outside of Europe is carefully managed to protect your privacy rights. For more information on this please see our Privacy Policy or contact us.

**Marketing**

We may use personal information we hold about you across the Aviva Group to help us identify and tailor products and services that may be of interest to you. We will do this in accordance with any marketing preferences you have provided to us. We may continue to do this after your policy has ended.

If you wish to amend your marketing preferences please contact us:

By phone: 01603 622200 or +44 1603 604999 (from abroad)

By email: helpdesk@aviva.co.uk

By Post: Aviva, Freepost, Mailing Exclusion Team, Unit 5, Wanlip Road Ind Est, Syston, Leicester, LE7 1PD

To see how you can change your preferences in MyAviva or view your choices for online advertising visit our full Privacy Policy at www.aviva.co.uk/privacypolicy

**How long we keep your personal information for**

We maintain a retention policy to ensure we only keep personal information for as long as we reasonably need it for the purposes explained in this notice. We need to keep information for the period necessary to administer your insurance and deal with claims and queries on your policy. We may also need to keep information after our relationship with you has ended, for example to ensure we have an accurate record in the event of any complaints or challenges, carry out relevant fraud checks, or where we are required to do so for legal, regulatory or tax purposes.

**Your rights**

You have various rights in relation to your personal information, including the right to request access your personal information, correct any mistakes on our records, erase or restrict records where they are no longer required, object to use of personal information based on legitimate business interests, ask not to be subject to automated decision making if the decision produces legal or other significant effects on you, and data portability. For more details in relation to your rights, including how to exercise them, please see our full privacy policy or contact us – refer to the “Contacting Us” section below.

**Contacting us**

If you have any questions about how we use personal information, or if you want to exercise your rights stated above, please contact our Data Protection Team by either emailing them at dataprt@aviva.com or writing to the Data Protection Officer, Level 4, Pitheavlis, Perth PH2 9NH.

If you have a complaint or concern about how we use your personal information, please contact us in the first instance and we will attempt to resolve the issue as soon as possible. You also have the right to lodge a complaint with the Information Commissioners Office at any time.
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
E-mail: 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.

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

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

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

(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.

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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: www.financial-ombudsman.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
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 you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

**Advice**
Any
- consultation
- 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.

**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 your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

**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 your symptoms.
Definitions

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

Fee approved
A specialist or other practitioner who at the time of your 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.

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 policy schedule, 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.

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

Member
A person named as an insured person in the policy schedule.

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 your 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.

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 application and policy schedule form part of the contract and must be read together with this policy document (as amended from time to time).
Policyholder
The person named as policyholder in the policy schedule.

Policy schedule
The schedule giving details of (amongst others):
• the policyholder
• members
• amendments, and
• exclusions that apply to specific members (if any).

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:
• you have received medication, advice or treatment, or
• you have experienced symptoms whether the condition has been diagnosed or not before you joined the policy.

Psychiatric therapist
A practitioner who is:
1. employed to provide therapy sessions at a psychiatric hospital, or
2. a 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
• 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 you require for your condition.

Speech therapist
A practitioner who is:
• included in the register of speech and language therapists kept by the Health and Care Professions Council and
• recognised by us.

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 your policy on behalf of Aviva Insurance Limited, who underwrites and provides your contract of insurance.

You/Your
A person named as an insured person in the policy schedule.
A registered medical practitioner who:

- has at any time held and is not precluded from holding a substantive consultant appointment in an NHS hospital
- 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 you require for your condition.

A practitioner who is:

- included in the register of speech and language therapists kept by the Health and Care Professions Council and
- recognised by us.

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 your policy on behalf of Aviva Insurance Limited, who underwrites and provides your contract of insurance.

You/Your A person named as an insured person in the policy schedule.
Any questions?  
Call us on  
0800 092 4590

Need to make a claim?  
Call us on  
0800 158 3333  
Calls to and from Aviva may be monitored and/or recorded.

GP helpline  
24 hours a day, 7 days a week  
0800 158 3112  
Calls to the GP Helpline may be recorded for quality and training purposes.

Stress counselling helpline  
24 hours a day, 7 days a week  
0800 158 3349  
This benefit is available to members aged 16 and over.