Solutions

Policy Wording (age rated)

Welcome to Aviva

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

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

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

When we refer to 'you' or 'your' in this policy document, we mean the person or business named as policyholder in the financial statement and which is actively trading in the UK.

When we refer to 'we', 'our', or 'us', we mean Aviva Health UK Limited, which administers the policy on behalf of Aviva Insurance Limited, which underwrites and provides your contract of insurance. We are a wholly owned subsidiary of Aviva Insurance Limited and act as its agent for the purposes of: (i) receiving premium from our clients; and (ii) receiving and holding claims money and premium refunds prior to transmission to our client making the claim or entitled to the premium refund.

Throughout the policy document, the words 'such as', 'including' and 'for example' are illustrative only and are not intended to define an exhaustive list.

We've designed this booklet 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'll be pleased to help you. Calls to and from Aviva may be monitored and/or recorded.

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

Contents

Cover and benefits

The information on these pages details the benefits available under your **policy**. If you are a resident in the Channel Islands or Isle of Man additional cover and benefits apply (please refer to the additional benefits document).

Some important notes apply:

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

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

A **chronic condition** is defined as a disease, illness or injury that has one or more of the following characteristics:

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

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

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

- covered under the **policy**, including facilities, services and equipment
- shown by current best available clinical evidence to improve the **member's** health outcome, at the time the **member's treatment** takes place
- appropriate for the **member's** individual care, including how it is carried out, how long it continues and how often it occurs
- carried out by a health care professional, such as a **specialist**, who is qualified to provide **the member's treatment** and to care for their condition, and is recognised by us, and
- undertaken because the **member** needs it for medical reasons.

We take our obligations under the Equality Act 2010 seriously, and do not exclude cover generally for people on the basis of their protected characteristics. The cover and exclusions detailed in your **policy** apply to everyone and are a reflection of the commercial risk we are prepared to accept as an insurance company.

Key

☐ Expert Select option

☐ Hospital lists option

In the Exclusions section, we've used orange and grey boxes to show when different exclusions apply, depending on the options chosen. The options chosen will appear on your financial statement and the **member's insurance certificate**.

Where are members covered for treatment?

Expert Select

If a **member** has the Expert Select hospital option, **treatment** will be covered when it's carried out by the **specialist** and at the **hospital** confirmed by us.

If a **member's GP** decides they need to be referred for further **diagnostic tests** or **treatment**, they must obtain an **open referral** and contact us. We will then use our clinical knowledge and independent quality data to locate a **specialist** and **hospital** suitable for them. **Members** must also obtain an **open referral** if they are referred for further **diagnostic tests** or **treatment** following NHS **treatment**. This includes **treatment** at an accident & emergency department.

We will only accept a named referral from a **GP** or a **specialist** if we agree there is a medical need for it. We maintain the right to request a report from the **GP** or **specialist** to get full details before we consider **treatment** under a named referral.

If a **member** has **treatment** with a **hospital** or **specialist** that has not been agreed by us, we will not pay that provider's fees.

Hospital lists

If a **member** has a hospital list, **in-patient** and **day-patient treatment** will be covered when it takes place at a **hospital** on the chosen hospital list or a facility within one of our **networks**. All **treatment** and **diagnostic tests** must be carried out by providers (such as **hospitals**, facilities, or **specialists**) recognised by us. If a **member** has **treatment** with a provider that we do not recognise, we will not pay that provider's fees.

Networks

We've set up **networks** of treatment units, specialising in managing certain conditions. We only work with clinicians and medical facilities that meet our quality care standards. These facilities measure their outcomes using patient reported outcome measures (known as PROMs), condition-specific clinical outcome scores and service user satisfaction scores.

More information on **networks** and a list of the conditions for which we have a **network** in place can be found at **aviva.co.uk/health-network**

If a **member** has Expert Select, they will always benefit from our **networks** as we will guide them to a **network** facility if we have one for their condition, following the **open referral** from their **GP**.

If a **member** has a hospital list and they need **treatment** for a condition for which we have a **network**, they can benefit from our **networks** by obtaining an **open referral** and allowing us to confirm a **treatment** facility for them, or they can choose to use a **hospital** on their hospital list.

Core cover

All benefit limits and excesses (if applicable) apply to each **member** every **policy year** unless otherwise stated. The options you have chosen will be shown on your financial statement.

Benefits	Amount payable	Notes
A. Hospital treatment as an in-patient or day-patient		**See hospital charges benefit term**
If a **member** has the six week option, they cannot claim for these benefits if their **treatment** is available on the NHS (including **accident or emergency admissions**) within six weeks from the date their **specialist** recommends it.		
Hospital charges	Including accommodation and meals, nursing care, drugs and surgical dressings and theatre fees	
	If a **member** has Expert Select: we will pay charges in full for **treatment** carried out at the **hospital** confirmed by us. See hospital charges benefit term	
	If a **member** has a hospital list: we will pay charges in full for **treatment** carried out at a **hospital** on their list or a **network** facility. See hospital charges benefit term	
Specialists' fees	If a **member** has Expert Select: we will pay fees in full for **treatment** carried out by the **specialist** confirmed by us. See specialists' fees benefit term	
	If a **member** has a hospital list: we will pay up to the limits in our fee schedule. See specialists' fees benefit term	
Diagnostic tests	In full	Including blood tests, X-rays, scans and ECGs
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
Radiotherapy/chemotherapy	In full	
NHS cash benefit	£100 per night, up to 25 nights	See NHS cash benefit term
B. Treatment as an out-patient		**Expert Select – see hospital charges benefit term**
Consultations with a **specialist**	If a **member** has Expert Select: we will pay charges in full for consultations with the **specialist** confirmed by us. See specialists' fees benefit term	
	If a **member** has a hospital list: we will pay up to the limits in our fee schedule. See specialists' fees benefit term	
Treatment by a **specialist** as an **out-patient**	In full	Including **hospital** fees, equipment charges, anaesthesia
		If a **member** has Expert Select: we will pay **specialist** fees in full for **treatment** carried out by the **specialist** confirmed by us. See specialists' fees benefit term
		If a **member** has a hospital list: we will pay **specialist** fees up to the limits in our fee schedule. See specialists' fees benefit term

Benefits	Amount payable	Notes
B. Treatment as an out-patient		**Expert Select – see hospital charges benefit term**
Diagnostic tests	In full	CT, MRI and PET scans as an **out-patient** are only covered at a **diagnostic centre** If a **member** has Expert Select: we will pay **specialists'** fees for surgical procedures in full with the **specialist** confirmed by us. See specialists' fees benefit term If a **member** has a hospital list: we will pay **specialists'** fees for surgical procedures up to the limits in our fee schedule. See specialists' fees benefit term
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	
Radiotherapy/chemotherapy	In full	
Specialist referred **treatment** by: • a **physiotherapist** • a **chiropractor** • an **osteopath** for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions	Up to the limits in our fee schedule	See practitioner fees benefit term
Mental health **treatment**	In full	Such as counselling by a **psychiatric therapist** or psychiatric **specialist,** as managed by our mental health provider. See mental health pathway benefit term
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
C. Additional benefits		
Home nursing	In full	Immediately following **in-patient** or **day-patient treatment** that is covered by the **policy**. See home nursing benefit term
Private ambulance	In full	See private ambulance benefit term

Benefits	Amount payable	Notes
C. Additional benefits		
Parent accommodation when staying with a child covered by the **policy**	In full	Child of 15 or under receiving **treatment** covered by the **policy**; one parent only
Hospice donation	£70 per day, up to 10 days	See hospice benefit term
Baby bonus	£100 for each baby	Payable to the **group member**. See baby bonus benefit term
Treatment for complications of pregnancy and childbirth	In full	See pregnancy complications and specialists' fees benefit terms
Investigations into the causes of infertility	In full	See investigations into infertility benefit term
Surgical procedures on the teeth performed in a **hospital**	In full	See specialists' fees benefit term
Stress counselling helpline	Unlimited number of calls	This benefit is available to **members** aged 16 and over. See stress counselling helpline benefit term

Options

The following optional benefits will only apply if they have been chosen by you and will be shown on your financial statement. The options you have chosen will appear on the **member's insurance certificate.**

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

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

Benefits	Amount payable	Notes
1. Mental health upgrade		
Treatment as an **in-patient** or **day-patient –** accommodation and nursing	Either 28 days or 45 days (as shown on the financial statement)	Through the mental health pathway. See mental health pathway benefit term
Specialists' fees for **in-patient treatment**	Up to the limits in our fee schedule	

This option cannot be selected for members that have option 8a (Reduced out-patient cover £0 limit). This option is not available to **members** who live in the Channel Islands, the Isle of Man, the Isle of Wight, or Northern Ireland.

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

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

4. Dental and optical		
Routine dental treatment	Up to £450. A £50 excess applies	See routine dental treatment benefit term. See dental and optical excess benefit term for details of how the excess works
Treatment by a dentist of an accidental dental injury	Up to £600	See accidental dental injury benefit term
Optical benefit	Up to £250. A £50 excess applies	See optical benefit term. See dental and optical excess benefit term for details of how the excess works

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

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

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

Benefits	Amount payable	Notes
8a. Reduced cover for out-patient treatment £0 limit – core cover benefits section B is deleted and replaced with:		
B. Treatment as an out-patient		**Expert Select – see hospital charges benefit term**
If this option has been chosen, the only **out-patient** benefits available on the **policy** are:		
CT, MRI and PET scans	In full	These scans will only be covered at a **diagnostic centre**
Surgical procedures by a **specialist** in a clinical, sterile setting	In full	Including surgical **treatment**, guided injections and complex diagnostic procedures. If the surgical procedure is for a musculoskeletal condition, see BacktoBetter benefit term If a **member** has Expert Select: we will pay **specialist** fees in full with the **specialist** confirmed by us. See specialists' fees benefit term If a **member** has a hospital list: we will pay **specialist** fees up to the limits in our fee schedule. See specialists' fees benefit term
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs and blood tests)	In full	We cover pre-admission tests that are carried out up to 14 days before **in-patient** or **day-patient treatment** that is covered by the **policy**
Physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
Radiotherapy/chemotherapy	In full	

If you have chosen 8a. **members** will have no cover as an **out-patient** for:

- consultations with a **specialist**
- non-surgical **treatment** by a **specialist**
- **diagnostic tests** such as pathology, X-rays
- **specialist** referred **treatment** by a **physiotherapist**, **chiropractor** or **osteopath** for non-musculoskeletal conditions
- mental health **treatment**
- **treatment** (other than physiotherapy) for pain in the back, neck, muscles or joints – musculoskeletal conditions.

Members that have option 8a cannot have option 1, mental health treatment. This means that they will have no mental health cover on the policy.

This £0 limit does not apply to **out-patient cancer treatment** received after the **member** has been diagnosed with **cancer**. The limit will still apply to consequences of **cancer treatment** and conditions **related** to **cancer treatment**.

The £0 limit does not apply to **out-patient treatment** received through some of our **networks**. A list of the conditions for which we have a **network** in place and details of how the **out-patient** limit is applied can be found at **aviva.co.uk/health-network**

Benefits	Amount payable	Notes
8b. Reduced cover for out-patient treatment £1,000 limit – core cover benefits section B is deleted and replaced with:		
B. Treatment as an out-patient		**Expert Select – see hospital charges benefit term**
CT, MRI and PET scans	In full	These scans will only be covered at a **diagnostic centre**
Surgical procedures by a **specialist** in a clinical, sterile setting	In full	Including surgical **treatment**, guided injections and complex diagnostic procedures. If the surgical procedure is for a musculoskeletal condition, see Backtobetter benefit term If a **member** has Expert Select: we will pay **specialist** fees in full with the **specialist** confirmed by us. See specialists' fees benefit term If a **member** has a hospital list: we will pay **specialist** fees up to the limits in our fee schedule. See specialists' fees benefit term
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	We cover pre-admission tests that are carried out up to 14 days before **in-patient** or **day-patient treatment** that is covered by the **policy**
Physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
Mental health **treatment**	In full	Such as counselling by a **psychiatric** therapist or psychiatric **specialist**, as managed by our mental health provider. See mental health pathway benefit term
Radiotherapy/chemotherapy	In full	

Continued on next page

Benefits	Amount payable	Notes
The following benefits are subject to a combined limit of £1,000 for each **member** every **policy year**		
Consultations with a **specialist**		If a **member** has Expert Select: we will pay in full (subject to the £1,000 limit) with the **specialist** confirmed by us. See specialists' fees benefit term If a **member** has a hospital list: we will pay up to the limits in our fee schedule. See specialists' fees benefit term
Non-surgical **treatment** by a **specialist** as an **out-patient**		If a **member** has Expert Select: we will pay **specialist** fees in full (subject to the £1,000 limit) with the **specialist** confirmed by us. See specialists' fees benefit term If a **member** has a hospital list: we will pay **specialist** fees up to the limits in our fee schedule. See specialists' fees benefit term
Diagnostic tests		Including pathology, X-rays and physiological tests (such as ECGs)
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions (other than physiotherapy and surgical procedures above which are paid in full)		See BacktoBetter benefit term
Specialist referred **treatment** by: • a **physiotherapist** • a **chiropractor** • an **osteopath** for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions		We will pay up to the limits in our fee schedule. See practitioner fees benefit term

The monetary limit does not apply to **out-patient cancer treatment** received after the **member** has been diagnosed with **cancer**. The limit will still apply to consequences of **cancer treatment** and conditions **related** to **cancer treatment**.

The monetary limit does not apply to **out-patient treatment** received through some of our **networks**. A list of the conditions for which we have a **network** in place and details of how the **out-patient** limit is applied can be found at **aviva.co.uk/health-network**

Continued on next page

Benefits	Amount payable	Notes
8c. Reduced cover for out-patient treatment £1,500 limit – core cover benefits section B is deleted and replaced with:		
B. Treatment as an out-patient		**Expert Select – see hospital charges benefit term**
CT, MRI and PET scans	In full	These scans will only be covered at a **diagnostic centre**
Surgical procedures by a **specialist** in a clinical, sterile setting	In full	Including surgical **treatment**, guided injections and complex diagnostic procedures. If the surgical procedure is for a musculoskeletal condition, see Backtobetter benefit term
		If a **member** has Expert Select: we will pay **specialist** fees in full with the **specialist** confirmed by us. See specialists' fees benefit term
		If a **member** has a hospital list: we will pay **specialist** fees up to the limits in our fee schedule. See specialists' fees benefit term
Pre-admission tests (tests carried out at **hospital** before a **member's** admission to check that they are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	We cover pre-admission tests that are carried out up to 14 days before **in-patient** or **day-patient treatment** that is covered by the **policy**
Physiotherapy for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	See BacktoBetter benefit term
Mental health **treatment**	In full	Such as counselling by a **psychiatric** therapist or psychiatric **specialist**, as managed by our mental health provider. See mental health pathway benefit term
Radiotherapy/chemotherapy	In full	

Continued on next page

Benefits	Amount payable	Notes
The following benefits are subject to a combined limit of £1,500 for each **member** every **policy year**		
Consultations with a **specialist**		If a **member** has Expert Select: we will pay in full (subject to the £1,500 limit) with the **specialist** confirmed by us. See specialists' fees benefit term If a **member** has a hospital list: we will pay up to the limits in our fee schedule. See specialists' fees benefit term
Non-surgical **treatment** by a **specialist** as an **out-patient**		If a **member** has Expert Select: we will pay **specialist** fees in full (subject to the £1,500 limit) with the **specialist** confirmed by us. See specialists' fees benefit term If a **member** has a hospital list: we will pay **specialist** fees up to the limits in our fee schedule. See specialists' fees benefit term
Diagnostic tests		Including pathology, X-rays and physiological tests (such as ECGs)
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions (other than physiotherapy and surgical procedures above which are paid in full)		See BacktoBetter benefit term
Specialist referred **treatment** by: • a **physiotherapist** • a **chiropractor** • an **osteopath** for any condition other than pain in the back, neck, muscles or joints – musculoskeletal conditions		We will pay up to the limits in our fee schedule. See practitioner fees benefit term

The monetary limit does not apply to **out-patient cancer treatment** received after the **member** has been diagnosed with **cancer**. The limit will still apply to consequences of **cancer treatment** and conditions **related** to **cancer treatment**.

The monetary limit does not apply to **out-patient treatment** received through some of our **networks**. A list of the conditions for which we have a **network** in place and details of how the **out-patient** limit is applied can be found at **aviva.co.uk/health-network**

Benefit terms

The benefit tables in the previous section tell **members** which of the following benefit terms apply to them.

Accidental dental injury

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

Baby bonus

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

The baby bonus is payable once for each baby. For **members** with moratorium or full medical underwriting, the baby bonus is only available if the baby is born or adopted more than ten months after the **group member** joins the **policy**.

BacktoBetter

Claims for musculoskeletal conditions are managed through our BacktoBetter service.

Musculoskeletal conditions are

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

in the back, neck, muscles or joints.

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

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

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

Please note:

- if the **member** is referred to an **osteopath** or **chiropractor**, we will need to check that they have been referred to a practitioner recognised by us. If the **member** receives **treatment** from an **osteopath** or **chiropractor** it will be limited to 10 sessions per condition per **policy year** and we will pay up to the limits in our fee schedule for each session
- physiotherapy for musculoskeletal conditions will not be subject to the **out-patient** limit (if one applies)
- BacktoBetter is not a **network**. All **treatment** for musculoskeletal conditions must be managed and received through the BacktoBetter pathway.

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

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

Dental and optical excess

Routine dental treatment and optical benefits each have a separate excess of £50. The **member** must pay the first £50 themselves and we will then pay for costs up to the limit covered by the **policy**.

For example if a claim is made for £220 for routine dental treatment covered by the **policy**, we will deduct the £50 excess from this sum and pay the balance of £170 to the **member**. The **member** is responsible for paying the £50 excess for the

treatment received. This leaves a balance of £280 available to the **member** in this example for subsequent claims in the same **policy year**. The excess is only deducted once for each **member** every **policy year**.

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

Excess

If you have chosen an excess, we will pay benefits up to the amounts shown after the excess has been paid.

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

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

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

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

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

If a **member** claims for a benefit that has a monetary limit, the excess amount will not contribute to the monetary limit.

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

If an excess applies, we will write to the **member** to advise who the excess should be paid to. The **member** is liable for the amount of 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 no longer available to new or existing customers who haven't already selected this list. It is only available to existing customers who currently have this list included on their policy, as shown on their financial statement.

Hospital charges for **in-patient** and **day-patient treatment** are covered in full if a **member** has **treatment** at a **hospital** on the Fair + Square hospital list, or a facility on one of our **networks**.

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

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

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

Home nursing

We cover home nursing if this:

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

Hospice

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

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

Hospital charges

Expert Select

If a **member** has Expert Select, we cover **treatment** that is carried out at the **hospital** confirmed by us. If a **member** receives **in-patient**, **day-patient** or **out-patient treatment** at a **hospital** that has not been confirmed by us, we will not pay the **hospital** fees.

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

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

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

Hospital lists

If a **member** has a hospital list, **hospital** charges for **in-patient** and **day-patient treatment** are covered in full if a **member** has **treatment** at a **hospital** on their hospital list, a facility on one of our **networks** or an NHS pay-bed at an NHS hospital.

If the **member** receives **treatment** as an **in-patient** or **day-patient** in a **hospital** or facility that is not:

- included on their hospital list, or
- included on one of our **networks**, or
- an NHS pay-bed at an NHS **hospital**

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

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

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

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

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

Investigations into infertility

We pay for **treatment** at a **hospital** that is covered under the **member's** hospital option.

We will pay for **treatment** directly or indirectly related to the costs of investigations into the causes of infertility.

If a **member** has moratorium or full medical underwriting, we will pay where the **member**:

- has been covered by the **policy** for a continuous period of two years or more at the time the costs are incurred, and
- was unaware of the infertility when they joined the **policy**.

Mental health pathway

Claims for mental health conditions are managed through the mental health pathway. We cover **treatment** for acute mental health conditions. This means we will pay for **treatment** which aims to lead to a **member's** full recovery.

Members aged 12 and over do not need to see a **GP** before making a claim for a mental health condition. **They** should call us before **treatment** begins and our independent mental health provider will arrange the most appropriate **treatment** for their condition. **Treatment** may include for example:

- online CBT (Cognitive Behavioural Therapy)
- remote talking therapies (telephone or video)
- face to face **treatment**
- psychiatrist/psychiatric **specialist** assessment and **treatment**.

We do not cover:

- **treatment** that is given solely to alleviate symptoms
- **chronic conditions**, or
- **treatment**, including **diagnostic tests** to treat or assess learning difficulties or developmental or behavioural problems such as attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder.

For **members** aged 11 and under the mental health pathway is not available, however benefit is still available for **treatment** of acute mental health conditions. These **members** should see a **GP** for a referral then contact us with the details of the claim.

Please note:

- **treatment** related to mental health conditions will not be covered under any other benefit on this **policy**
- if **members** using the mental health pathway do not provide 24 hours' notice for cancellation of an appointment, or do not attend a scheduled appointment, they will be charged a cancellation fee
- the mental health pathway is not a **network**. All **treatment** for mental health conditions must be managed and received through the mental health pathway.

We are constantly reviewing the mental health pathway and may offer a different claim pathway in the future where we identify opportunities to achieve the same or a better clinical outcome for **members**, with or without the involvement of our independent mental health provider.

NHS cash

We will pay NHS cash benefit if:

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

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

NHS cash benefit is not available:

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

Optical

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

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

Practitioner fees

We cover practitioner's fees (such as physiotherapists, osteopaths) up to the limits in our fee schedule.

If the fee is higher than the limit in our fee schedule, it is the **member's** responsibility to pay the practitioner the difference.

Members can view the fee schedule online at **aviva.co.uk/health/online-fee-schedule** or call the customer service helpline on 0800 158 3333.

Calls to and from Aviva may be recorded and/or monitored.

Pregnancy complications

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

- ectopic pregnancy (development of foetus outside the womb)
- miscarriage (but not investigations into the cause of miscarriage)
- still birth
- hydatidiform mole (cell growth abnormality in the womb)
- retained placenta (afterbirth retained in the womb)
- eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
- caesarean sections – but only in specific clinical circumstances (we require full clinical details from the **member's specialist** before we can make a decision about cover).

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

Private ambulance

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

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

Routine dental treatment

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

Specialists' fees

Expert Select

If a **member** has Expert Select, we cover **treatment** that is carried out by a **specialist** confirmed by us. If a **member** receives **in-patient**, **day-patient** or **out-patient treatment** by a **specialist** that has not been confirmed by us, we will not pay the **specialists'** fees.

If a **specialist** decides a **member** needs to be referred to another **specialist** for tests and/or **treatment** they should ask for the specialism and the sub-specialism of the person they need to see and contact us. We will then confirm the **specialist** that the **policy** will cover.

We will only accept a named referral from a **GP** or a **specialist** if we agree there is a medical need for it. We maintain the right to request a report from the **GP** or **specialist** to get full details before we confirm we will cover **treatment** under a named referral.

If a **member** has received **treatment** and is discharged from the **specialist's** care but needs further **treatment** for the same condition within three months of their discharge, the **policy** will cover further eligible **treatment** with the same **specialist**.

If a **member** has been discharged from the **specialist's** care but needs further **treatment** for the same condition more than three months after their discharge, they must obtain an **open referral** from their **GP** and we will confirm the **specialist** that the **policy** will cover.

We will only cover further **treatment** with the same **specialist** more than three months after a **member's** discharge if we agree there is a clinical need. We maintain the right to request a report from the **GP** or **specialist** to get full details before we confirm cover.

Hospital lists

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

Members can view the fee schedule online at **aviva.co.uk/health/online-fee-schedule** or call the customer service helpline on 0800 158 3333.

Calls to and from Aviva may be recorded and/or monitored.

Stress counselling helpline

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

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

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

Stress Counselling helpline: **0800 158 3349**

This service is available to **members** aged 16 and over. Call charges are the responsibility of the caller.

Therapies

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

Trust hospitals

The Trust hospital list is only available to policies with up to 99 **group members**.

If a **member** has the Trust list, **hospital** charges for **in-patient** and **day-patient treatment** are covered in full if a **member** has **treatment** at a **hospital** on the Trust list, a facility on one of our **networks**, an NHS pay-bed at an NHS hospital, or at a **hospital** that we have chosen if the **treatment** they need is not available at a **hospital** on the Trust list.

If the **member** receives **treatment** as an **in-patient** or **day-patient** in a hospital or facility that is not:

- included on the Trust list, or
- included on one of our **networks**, or
- an NHS pay-bed at an NHS hospital, or
- a **hospital** that we have chosen for their **treatment**

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

If a **member** receives **treatment** in a hospital that is not recognised by us, we will not pay any hospital fees for their **treatment**.

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

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

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

Benefits for cancer treatment

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

Important:

If a **member** has one of the reduced **out-patient** options the monetary limit will not apply to **cancer treatment** received after the **member** has been diagnosed with **cancer**. The out-patient limit will still apply to consequences of **cancer treatment** and conditions **related** to **cancer treatment**.

If a **member** has the six week option, we do not pay for **treatment** as an **in-patient** or **day-patient** if it is available on the NHS (including **accident or emergency admissions**) within six weeks from the date the **specialist** recommends it. The NHS can often treat cancer patients within 6 weeks, which means that we will not pay for most of the **treatment** a **member** needs.

However, if a **member's specialist** recommends **treatment** that is not available on the NHS, but is covered by the **policy**, we will pay for that **treatment**.

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

We cover **treatment** that is carried out at a **hospital** covered under the **member's** hospital option. We also cover **treatment** at home if the **member's specialist** agrees this is possible and it can be supported by a homecare provider recognised by us.

Benefits	Amount payable	Notes
Hospital charges for surgery and medical admissions	Including accommodation and meals, nursing care, drugs and surgical dressings and theatre fees	
	If a **member** has Expert Select: we will pay charges in full for **treatment** carried out at the **hospital** confirmed by us. See hospital charges benefit term	
	If a **member** has a hospital list: we will pay charges in full for **treatment** carried out at a **hospital** on your list or a **network** facility. See hospital charges benefit term	
Specialists' fees	If a **member** has Expert Select: we will pay charges in full for **treatment** carried out by the **specialist** confirmed by us. See specialists' fees benefit term	
	If a **member** has a hospital list: we will pay up to the limits in our fee schedule. See specialists' fees benefit term	
NHS cash benefit for **cancer treatment**	£100 each day	See NHS cancer cash benefit term
Post-surgery services		For example, specialist nursing, feeding; see post-surgery services benefit term for details of services that the **policy** will pay for
Chemotherapy	In full	See chemotherapy benefit term
Radiotherapy	In full	See radiotherapy benefit term
Bone strengthening drugs (such as bisphosphonates)	In full	

Treatment for side effects of **chemotherapy** and radiotherapy	In full	See side effects benefit term
Genetic testing to support **treatment**	In full	See genetic testing benefit term
Molecular profiling	In full	See molecular profiling benefit term
Wig	Up to £100	In total whilst a **member** is covered by the **policy** (not per **policy year**) See wig benefit term
External prostheses	Up to £5,000	See prostheses benefit term
Stem cell and bone marrow transplants	In full	See stem cell transplants benefit term
Monitoring	In full	See monitoring benefit term
Ongoing needs	Up to five years	See ongoing needs benefit term
Preventative **treatment** for **cancer**		See preventative treatment benefit term
End of life care		See end of life care benefit term

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

Benefit terms

Chemotherapy

We will pay for **chemotherapy** in full if a **member** has **treatment** at a **hospital** covered under their hospital option.

We also cover **chemotherapy** at home if the **member's specialist** agrees this is possible and it can be supported by the homecare provider.

We do not pay for hormone therapy.

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

End of life care

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

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

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

Genetic testing

We will pay for genetic testing in full if it is requested by a **specialist** to aid a diagnosis or to help determine the type of **treatment** required and is carried out at a facility recognised by us.

But, we will not pay for genetic testing carried out:

- for screening purposes
- where there are no symptoms, or
- when the outcome of the test will not determine a **treatment** pathway.

Molecular profiling

During molecular profiling, the profile of the cancerous tissue is studied to help determine the most accurate and effective **treatment**. We pay for these tests in full when they are being used to determine the most appropriate **treatment** and are carried out at a facility recognised by us.

Monitoring

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

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

NHS cancer cash benefit

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

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

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

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

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

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

We will pay £100 for:

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

We may need to contact the **member's specialist** for details of their **treatment** before we can pay their claim. When a **member** makes a claim for NHS cancer

cash benefit, we may ask for the discharge summary from the **hospital**.

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

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

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

Ongoing needs

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

Post-surgery services

Medical services

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

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

Artificial feeding

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

Preventative treatment

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

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

Prostheses

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

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

Radiotherapy

We will pay for radiotherapy in full if a **member** has **treatment** at a **hospital** covered under their hospital option.

Side effects

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

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

Specialists' fees

Expert Select

If a **member** has Expert Select, we cover **treatment** that is carried out by a **specialist** confirmed by us. If a **member** receives **in-patient**, **day-patient** or **out-patient treatment** by a **specialist** that has not been confirmed by us, we will not pay the **specialists'** fees.

If a **specialist** decides a **member** needs to be referred to another **specialist** for tests and/or **treatment** they should ask for the specialism and the sub-specialism of the person they need to see and contact us. We will then confirm the **specialist** that the **policy** will cover.

We will only accept a named referral from a **GP** or a **specialist** if we agree there is a medical need for it. We maintain the right to request a report from the **GP** or **specialist** to get full details before we confirm we will cover **treatment** under a named referral.

If a **member** has received **treatment** and is discharged from the **specialist's** care but needs further **treatment** for the same condition within three months of their discharge, the **policy** will cover further eligible **treatment** with the same **specialist**.

If a **member** has been discharged from the **specialist's** care but needs further **treatment** for the same condition more than three months after their discharge, they must obtain an **open referral** from their **GP** and we will confirm the **specialist** that the **policy** will cover.

We will only cover further **treatment** with the same **specialist** more than three months after a **member's** discharge if we agree there is a clinical need. We maintain the right to request a report from the **GP** or **specialist** to get full details before we confirm cover.

Hospital lists

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

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

Stem cell transplants

We will pay for:

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

stem cells and bone marrow if a **member** has **treatment** at a **hospital** covered under their hospital option.

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

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

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

Wig

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

Exclusions

1a. Pre-existing and related conditions

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

2. AIDS and HIV

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

3. Addictions and substance misuse

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

4. Appliances and prostheses

We do not cover:

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

BUT: We do cover

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

5. Birth control

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

6. Chronic conditions – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover **treatment** of a **chronic condition**, including:

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

BUT:

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

OR

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

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

Including:

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

BUT:

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

7. Cosmetic treatment

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

We do not cover procedures, or any consequence of a procedure, to remove undiseased tissue.

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

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

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

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

8. Dental treatment – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover:

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

OR

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

We do not cover:

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

9. Dialysis

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

BUT: We cover short-term kidney dialysis:

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

10. Drugs and dressings

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

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

11. Experimental treatment

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

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

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

or

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

or

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

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

BUT:

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

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

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

12. Eyesight – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

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

OR

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

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

13. GP charges and treatment – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover:

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

OR

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

We do not cover:

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

14. Hearing loss

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

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

15. Hospital charges – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover hospital charges if a **member** receives **treatment** at a hospital that has not been confirmed by us.

OR

If the **policy** has a hospital list option, the exclusion that applies to the **member** is:

We do not cover charges from a hospital, facility or any other treatment centre if we do not recognise that provider.

16. Infertility treatment – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover infertility **treatment**.

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

OR

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

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

17. Lipoedema

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

18. Mental health treatment – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover mental health **treatment** that has not been authorised by us.

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

BUT: we do cover **out-patient** mental health **treatment** authorised by us from the mental health benefit in section B.

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

Mental health **treatment** is only available from the mental health benefits, it is not available under any other benefit.

OR

If the **policy** has benefit 8a (reduced out-patient cover – £0 limit) the exclusion that applies to the **member** is:

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

19. Musculoskeletal

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

20. Non-medical admissions

We only cover **hospital** charges if a **member** has been admitted to **hospital** for medical reasons. We do not cover **hospital** charges if a **member** has been admitted to **hospital** for any other reason, including help with mobility, personal care or preparation of meals.

21. Overseas treatment

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

22. Pregnancy and childbirth – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover pregnancy and childbirth, or **related** conditions that can only be caused by pregnancy or childbirth.

BUT: We do cover:

- **related** conditions that can also be experienced outside of pregnancy and childbirth, and
- the specific complications listed under the pregnancy complications benefit term.

OR

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

We do not cover pregnancy and childbirth, or **related** conditions that can only be caused by pregnancy or childbirth.

BUT: We do cover **related** conditions that can also be experienced outside of pregnancy and childbirth.

23. Rehabilitation, convalescence and nursing home care

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

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

24. Routine medical examinations, screening and preventative treatment – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover:

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

BUT: We do cover:

- routine monitoring for **cancer** after a **member** has finished **treatment** for **cancer**
- genetic tests and molecular profiling to determine the type of **treatment** required for **cancer**.

OR

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

We do not cover:

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

BUT: We do cover:

- routine monitoring for **cancer** after a **member** has finished **treatment** for **cancer**
- genetic tests and molecular profiling to determine the type of **treatment** required for **cancer**.

25. Self-inflicted injury

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

26. 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.

27. 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).

28. Specialist and practitioner fees – please refer to the financial statement to see which options have been chosen. This will determine which exclusion applies

We do not cover specialists' fees if a **member** receives **treatment** by a specialist that has not been confirmed by us. We do not cover practitioners' fees (such as **physiotherapists**, **acupuncturists**, **chiropodists**) if a member sees a practitioner that we do not recognise.

OR

If the **policy** has a hospital list option, the exclusion that applies to the **member** is:

We do not cover fees from a practitioner, **specialist** or other healthcare professional if we do not recognise that provider.

29. Sports related treatment

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

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

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

30. Treatment that is not eligible

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

31. Undiseased tissue

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

BUT:

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

32. Varicose veins

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

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

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

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

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

33. War and hazardous substances

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

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

34. Warts/verrucas/skin tags

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

35. Weight loss surgery

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

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

Underwriting

Your **policy** is subject to one, or more, of five different types of underwriting. Your financial statement and the **insurance certificate** will show which type of underwriting applies to each **member**.

Full Medical Underwriting (FMU)

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

A **member** is able to view any medical exclusions we have applied online at **aviva.co.uk/myaviva** or on request by calling 0800 158 3348.

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

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

Moratorium (this is sometimes known as mori)

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

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

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

However, we will cover that condition if the **member** does not have:

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

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

With mori underwriting the claims process may take a bit longer, as each time a **member** makes a claim we'll look at their medical history, and may ask for information from their **GP**, to understand if their symptom or condition is new or pre-existing.

Continued Medical Exclusions (CME)

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

The terms and conditions of this **policy** (including excesses payable, benefit limits and exclusions) may be different to those of your previous policy.

Continued Moratorium

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

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

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

However, we will cover that condition if the **member** does not have:

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

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

The terms and conditions of this **policy** (including excesses payable, benefit limits and exclusions) may be different to those of your previous policy.

Medical History Disregarded (MHD)

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

The terms and conditions of this **policy** (including excesses payable, benefit limits and exclusions) may be different to those of your previous policy.

Policy conditions

1. Who can be a member?

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

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

can all be **members**, if the **policyholder** has chosen to include cover for them.

Only one spouse, partner or civil partner can be included on the **policy** for each **group member**.

Children who are **members** can stay on the policy until the next renewal date following their 24th birthday, at which time they will be removed from the **policy**.

If the **policyholder** wants to apply any exceptions to these criteria, they need to be agreed with us. Exceptions should be consistently applied across membership of the **policy**, for example if you provide cover for one child over 24 or one retired **group member**, then you should offer cover to all children over 24 or all retired **group members**.

Each **member** must be a **UK resident** for the duration of the **policy year**. You must notify us as soon as possible if:

- at any time a **member** ceases to be a **UK resident** during the **policy year**, or
- it might reasonably be expected that a **member** may cease to be a **UK resident** following any renewal of the **policy**.

If a **member** ceases to be a **UK resident**, we may cancel cover for that **member** from up to 14 days after we become aware, as the **policy** does not provide cover for any **members** who cease to be a **UK resident** and the relevant **member** will need to arrange alternative cover if they wish to continue their underwriting terms with another provider. If we cancel a **member's** cover for this reason:

- the **policyholder** will be entitled to a proportionate refund of the premium paid in respect of the cancelled cover (if applicable), less a proportionate deduction for the time we have provided cover, and
- we will notify the **policyholder** in writing by post to your last known address or appointed intermediary.

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

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

Adding members

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

Newborn babies

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

Removing members

We will remove a **member** from the policy when you tell us to (including your notification of a change to their **UK resident** status). This means that:

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

We will not refund any premiums to you because of a delay in you telling us that a **member** has left the **policy**, or that they are no longer a **UK resident**.

If a **group member** or retired group member is removed from the **policy**, their spouse, partner or civil partner and any children will also be removed from the **policy**. If we had allowed an exception to provide cover for children over 24, these children will also be removed when the **group member** is removed. You must advise us if the **group member** had any children over 24 on the **policy**.

If the number of **group members** covered by the **policy** exceeds 199 we may cancel the **policy**, either immediately or at the **renewal date**. If we cancel cover we will offer cover under an alternative product if available.

2. Premiums and policy duration

The financial statement shows you how much must be paid, when and by which payment method. We will advise you if the premium changes as a result of any agreed changes to the **policy**.

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

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

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

We can set off any amount that we owe to you against any amount due to us from you, and will give you written notice if we do this.

We will not pay any claims if premiums are not paid to date at the time a **member's treatment** takes place. It is your responsibility to advise **members** if the premiums are not paid when due as this may effect any claims that are underway.

All premiums should be paid for from the **policyholder's UK** business bank account and the **policyholder** should not attempt to recover premiums from individuals by any means (including cash or services provided). You agree to provide us with any documentation we may require to verify your account status, such as a copy of your business bank statement.

If you pay monthly, each monthly premium payment is for one month's cover. If you pay quarterly, each quarterly payment is for one quarter's cover, if you pay annually, each annual premium payment is for one year's cover. If you wish to change the frequency with which 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 circumstances during the **policy year**, any change to your premium rate will only take effect from the **renewal date**. See section 4, changes to your circumstances.

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

We act as agent of Aviva Insurance Limited for the purposes of receiving premium, receiving and holding claims money and premium refunds. Once a premium is received by us it is treated as if it has been paid directly to Aviva Insurance Limited and claims money and premium refunds will only be treated as received by you when they are actually paid over by us.

3. Payments for ineligible treatment

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

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

4. Changes to your circumstances

We reserve the right to alter the premiums or **policy** terms, cancel cover for a **member** of the **policy** or cancel the **policy** following a **change of risk**.

You or the relevant **member** must tell us as soon as possible about:

- changes to your company, for example a change of company name, trading status, business activity, company structure, company number
- any changes relating to **members**, for example a change of name or address, or if they cease to be a **UK resident**.

You must also tell us as soon as possible of any other changes which affect information given in connection with the application for cover under this **policy**, for example liquidation, insolvency or bankruptcy procedures.

We will decide from when any changes will take effect.

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

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

5. Renewing the policy

The **policy** lasts for one year and (if we still offer 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 contact us.

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

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

6. Cancellation

Important note

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

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

When we may cancel the policy

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

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

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

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

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

In addition:

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

If we cancel the **policy** or any **member's** cover for these reasons we will notify you (and the relevant **member**) of the cancellation in writing by first class post or by hand to your (and the relevant **member's**) 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, subject to claims experience and the approval of our underwriters.

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

We reserve the right to close the Solutions product at your **renewal date**. We will contact you to advise you if this happens.

7. Continuation terms

When a **group member** or **family member** no longer meet the eligibility requirements of the **policy** they may be entitled to transfer to an individual product nominated by us with no further personal medical exclusions.

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

These continuation terms will only apply if the **member** gets a quote on one of our individual products within 45 days of their cover ending on this **policy,** and accepts the quote within 30 days of receiving it. To have continued underwriting on the individual policy, the **member's** cover on the individual policy must start immediately after the **member** leaves this **policy** and the **member** must ensure that premiums for the individual policy are paid from this start date.

The **member** must still be a **UK resident**.

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

8. Claims procedure

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

Many **hospitals** operate direct billing arrangements with us and payment for eligible **in-patient** or **day patient treatment** will be settled directly with us. This isn't always the case for **out-patient treatment** and some **hospitals**. In those instances, the **member** will need to pay the bill themselves, and send us the receipt so that we can reimburse eligible costs. We may also settle eligible claims direct with the provider of other services or with any other person.

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

Claims will only be paid for **treatment** received by a person who is a **member** at the time the **treatment** takes place.

If a **member's treatment** continues for a long period of time we may require updated information on a regular basis to check that the claim is still valid, this may include a claim form.

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

9. Third party claims

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

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

If we have made any payment under the **policy** including a payment for their **treatment** then the member must not settle their personal injury claim unless we have given our agreement to them or their lawyers.

If the **member** recovers any payments that we have made under the **policy** including any payment for their **treatment** and including any interest on any payments we have made, they must forward these sums to us immediately.

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

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

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

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

10. Distribution of information

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

11. If a member has other insurance

If a **member** has any other insurance covering any of the benefits they are entitled to from this **policy**, they must make sure that they let us know and provide us with any information we may require, as we may recover our share of these costs from the other insurer.

12. Law

This contract is governed by and will be construed in accordance with English law and will be subject to the exclusive jurisdiction of the courts of England and Wales.

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.

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

Notwithstanding any provisions of this **policy**, we will not be obliged to exercise or comply with any of our rights and/or obligations under this **policy** if to do so would cause (or may be reasonably likely to cause) us to breach any law or regulation in any jurisdiction.

13. Records, consents and confirmations

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

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

This may include:

- Management accounts
- NI and/or HMRC records and returns
- Employee records
- Employee contracts
- VAT records and returns.

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, including all relevant information. Our contact details are:

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

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

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

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

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

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

Clinical complaints

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

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

The responsibility for investigating and responding to clinical complaints is as follows:

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

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

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

Financial Services Compensation Scheme (FSCS)

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

Further information about compensation scheme arrangements is available from:

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

Website: fscs.org.uk

Private Healthcare Information Network

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

Website: phin.org.uk

Language

All documents and correspondence relating to this policy will be written in English.

Definitions

Accident or emergency admission

An admission to:

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

Acupuncturist

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

- a Medical Member, or
- Accredited Member

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

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

Acute condition

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

Advice

Any:

- consultation
- advice, or
- prescription.

Cancer

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

Change of risk

Any event or circumstance which we determine affects or is likely to affect the risk profile of the **policy**, including:

- changes to your company, for example a change of company name, trading status, business activity,company structure, company number, or any insolvency, liquidation or bankruptcy procedures
- a **member** no longer having the lawful right to reside in the **UK** or the intention to do so for the duration of the **policy year**
- any other changes relating to **members**, for example a change of name or address, and
- any other changes which affect information given in connection with the application for cover under the **policy**.

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 the purposes of this **policy**, hormone therapy is not chemotherapy.

Chiropodist/podiatrist

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

Chiropractor

A practitioner who is:

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

Chronic condition

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

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

Day-patient

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

Diagnostic centre

A

- **hospital** or
- facility

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

Diagnostic tests

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

Dietician

A practitioner who is:

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

Employee

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

Family member

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

GP

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

Group member(s)

Any of the following named in the financial statement as covered by the **policy** who is, at the relevant time, in relation to the **policyholder**:

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

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

A majority shareholder is not considered a group member unless they are actively engaged for reward on a contract of service. No other shareholders will be considered.

In addition, Aviva may consider upon referral, group member status for the following:

- retired **employees** who were group members of the scheme at the date of their retirement
- proprietors or majority shareholders not subject to PAYE but receiving shares
- over-aged dependants, who fall outside Aviva's maximum child age (24) providing they were aged 24 or under when their cover started
- **employees** of a charity, who are paid a salary by the charity. The charity must be a registered company and be able to provide their Charity Registration number, and
- self employed sub-contractors, providing they have a contract of service with the **policyholder** for the duration of their cover.

Homeopath

A practitioner who is:

- a member of the UK Homeopathic Medical Association (UKHMA)
- a member of the Society of Homeopaths

- a member of the Alliance of Registered Homeopaths (MARH)
- a member of the Faculty of Homeopathy (MFHOM), or
- a Fellow of the Faculty of Homeopathy (FFHOM).

Hospice

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

Hospital

If a **member** has the Expert Select hospital option:

The hospital or facility that we confirm is eligible for a **member's treatment** before the **treatment** goes ahead.

If a **member** has a hospital list:

- A hospital included on the **member's** hospital list, as shown on your financial statement and the **member's insurance certificate** 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.

Insurance certificate

The certificate giving details of (amongst others):

- the **group member** and any eligible **family members**
- the benefit options you have chosen.

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

Member

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

Network

A group of treatment units, specialising in managing specific conditions.

We only work with clinicians and medical facilities that meet our quality care standards. These facilities use the most modern treatment approach and measure their outcomes using patient reported outcome measures (known as PROMs), condition-specific clinical outcome scores and service user satisfaction scores.

More information on networks can be found at **aviva.co.uk/health-network**

Nurse

A qualified nurse who:

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

Open referral

A referral for tests or **treatment** that details the type of specialist a **member** needs to see but does not name a specific specialist or hospital.

An open referral should include:

- the **member's** medical condition/symptoms
- the specialism and sub-specialism of consultant that the **member** needs to see.

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, financial statement, **hospital** list (if applicable) and **insurance certificate** form part of the contract and must be read together with this policy document (as amended from time to time).

Policyholder

The person or business named as policyholder in the financial statement and which is actively trading in the **UK**.

Policy year

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

Pre-existing condition

Any disease, illness or injury for which:

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

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

Psychiatric therapist

A practitioner who is:

- employed to provide therapy sessions at a psychiatric **hospital**, or
- a fully qualified and accredited member of any counselling register overseen by the Professional Standards Authority (PSA)

and who is recognised by us.

Related

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

Renewal date

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

Specialist

If a **member** has the Expert Select hospital option:

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, and
- is included in the Specialist Register kept by the General Medical Council

and who we confirm is eligible for cover before the **member's treatment** goes ahead.

If a **member** has a hospital list:

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, and
- is included in the Specialist Register kept by the General Medical Council

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

Treatment

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

UK

For the purposes of this **policy**, being Great Britain and Northern Ireland, the Channel Islands and the Isle of Man.

UK resident

- Having the legal right to reside in the **UK** (ie. holding **UK** citizenship or an appropriate visa) for the duration of the **policy year**; and
- physically living in the **UK** for the duration of the **policy year** (other than for trips abroad totalling no more than 3 months during the **policy year**).

Need this in a different format?

Please get in touch if you would prefer this brochure **(GEN6901)** in large print, braille or as audio.

How to contact us

0800 158 3348

contactus@aviva.com

aviva.co.uk

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

aviva.co.uk/health

GEN6901 03/2023 REG001 © Aviva plc