



Solutions

Policy Wording - 2-49 employees

By choosing Aviva, the UK's largest insurance group, you benefit from our financial strength. Together with millions of customers worldwide you can feel certain of your choice whether you invest for the future, provide against the unexpected, or protect the things that are important to you.

Our size and efficiency give us the strength to deliver an extensive range of value-for-money, quality products - investments, retirement, protection and healthcare - designed and changing to meet your needs, both now and in the future.

Contents

Definitions	2
Core Cover	5
Benefit Terms	7
Exclusions from Cover	9
Options	11
Conditions	16
Personal Health Manager, GP Helpline and Stress Counselling Helpline	20
Chronic Conditions Explained	21
Important information	24

Welcome to Aviva

This booklet contains information about your private health insurance policy. It forms part of our contract of insurance with the policyholder, providing cover for the insured persons. Please read it carefully and then keep it somewhere safe.

The application, policy statement, financial statement and policy schedules which you have already received (as amended from time to time), all form part of your contract with us, they should be read and kept together with this document.

For any help with your policy please contact your sales advisor or your usual intermediary. For any advice on making a claim, please contact our customer service helpline whose telephone number is shown on each insured person's membership card.

We aim to give you the best customer service and claims administration possible. To assist us in delivering a high level of service, and sometimes for confidential training purposes, calls to and from Aviva may be monitored or recorded.

Signed on behalf of Aviva Health UK Limited.

A handwritten signature in black ink, appearing to read 'Gil Baldwin', with a horizontal line underneath.

Gil Baldwin
Managing Director UK Health

Definitions

To avoid repetition, the following words or expressions, wherever used in this **Policy**, have the specific meanings given below. To assist **you** in identifying the defined words or expressions they are shown in **bold** print throughout the **Policy**.

Accidental Dental Injury

An unexpected injury arising from an accident which occurs after **your Date of Entry** and causes damage or deformity to the teeth or gums. This does not include accidents to or disorders of the teeth or gums which have previously been decayed, diseased, repaired, restored or treated (other than scaling and polishing) before the accident, nor accidents causing damage to dentures or implants.

Acute Condition

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

Advice

Any consultation or advice from a **General Practitioner** or **Specialist** including the issue of any prescription or repeat prescription.

Application

The **Policyholder's** application for cover for the **Group** under the **Policy** and, where they are required by **us**, the individual applications made by **Group Members**.

Chronic Condition

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

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

Commencement Date

The date shown in the **Policy Statement** on which cover for the **Group** commences under this **Policy**.

Core Cover

The standard benefits available subject to the terms of the **Policy**.

Date of Entry

The date shown in the **Policy Schedule** on which **you** were included in the **Group**.

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 when **you** receive **your Treatment**.

Diagnostic Tests

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

Eligible Dependant(s)

A **Group Member's** spouse or partner and / or children under 24 years of age who are included in the **Group** pursuant to the **Application**.

Employee

An employee engaged for reward by the **Policyholder** on a contract of service for a minimum of 16 hours per week, being over the age of 16 and subject to PAYE.

Evacuation

The transport of an **Insured Person** from the country of incident to the next nearest appropriate facility for the sole purpose of receipt of **In-patient** or **Day-patient Treatment**.

Financial Statement

A statement addressed to the **Policyholder** giving details (amongst others) of the **Membership** and **Premium Rates**.

General Practitioner

A general medical practitioner holding a Certificate of General Practice Training and registered with the General Medical Council in the United Kingdom.

GP Helpline Consultation

The provision by one of **our** retained **General Practitioners** of such advice as it is reasonable and practical to give **you** over the telephone when symptoms presented by **you** are described during a telephone call to **our** GP Helpline (see Benefit Terms).

Group

All **Insured Persons** covered under the **Policy** pursuant to the **Policy Statement**.

Group Member(s)

Any of the following named in the **Policy Statement** who is, at the relevant time, in relation to the **Policyholder**:

- An **Employee**; or
 - The sole proprietor; or
 - A partner; or
 - A registered director
- } working for a minimum of 16 hours per week in the conduct of the **Policyholder's** business.

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 Treatment** or domiciliary basis.

Hospital

- A private hospital in the United Kingdom which is registered in accordance with United Kingdom legislation and which has specialist facilities for carrying out major surgical operations, or
- An NHS pay-bed, or
- Any hospital included on **our** list of **Select Hospitals**, or
- Any establishment which **we** agree is an appropriate facility for the provision of **Treatment** prior to **Treatment** being carried out

and which **we** recognise to provide the type of **Treatment** undertaken and for the condition that requires **Treatment**.

In-patient

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

Insured Person/you/your

A **Group Member** or an **Eligible Dependant**.

Membership

The number of **Group Members** on cover by category of risk, indicating level of cover, age, whether single, married, family or single parent family, as set out on the **Financial Statement**.

Minor Surgery

A surgical procedure classified in accordance with the list published by **us**.

Nurse

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

Option(s)

Benefits available subject to the terms of the **Policy** which add to or subtract from the **Core Cover**.

Out-patient

A patient who attends a **Hospital**, consulting room, or out-patient clinic and is not admitted as a **Day-patient** or an **In-patient**.

Period of Cover

The period set out in the **Policy Statement** during which cover is in place and for which the premium has been paid.

Policy

Our contract of insurance with the **Policyholder** providing cover for **Group Members** and their **Eligible Dependents**. The **Application**, **Policy Statement**, **Financial Statement**, **Policy Schedules** and list of **Select Hospitals** (current at the **Relevant Date**) all form part of the contract and must be read together with this policy document (as amended from time to time).

Policyholder

The business entity named in the **Policy Statement** and consisting of a sole proprietor or a partnership (which may be a registered LLP) or a registered company. In the case of a partnership, the policyholder consists jointly and severally of the partners at the **Commencement Date** (including but not limited to those named in the **Policy Statement** plus any partners joining from time to time (save as otherwise specifically agreed by **us** in writing).

Policy Schedule

A schedule addressed to each **Group Member** giving details of (amongst others) the **Date of Entry**, **Policyholder** and **Insured Persons** and endorsements (if any) and **Options** (if selected).

Definitions

Policy Statement

A statement sent to the **Policyholder** giving details of (amongst other things) the **Policyholder**, eligibility criteria to join the **Group**, type(s) of cover and endorsements (if any).

Pre-existing Condition

Any disease, illness or injury for which:

■ **you** have received medication, **Advice** or **Treatment**;
or

■ **you** have experienced symptoms;

whether the condition has been diagnosed or not before **your Date of Entry**.

Premium Rates

The rates payable for single, married, family and single parent family cover under the **Policy**.

Psychiatric Therapist

A practitioner

- i. who is employed to provide therapy sessions at a psychiatric **Hospital** or
- ii. who is:
 - an Accredited Member or Senior Accredited Member of the British Association of Counselling and Psychotherapy (BACP); or
 - a Chartered Psychologist registered with the British Psychological Society (BPS) or
 - a practitioner who has conditional registration with the BPS; or
 - an Accredited Member of the British Association for Behavioural and Cognitive Psychotherapies (BABCP);
 - a practitioner who is registered with the United Kingdom Psychotherapy Council (UKCP) under one of the following Modality Sections:
 - Behavioural & Cognitive Psychotherapies section
 - Humanistic & Integrative section
 - Psychotherapeutic Counselling section
 - Psychoanalytic & Psychodynamic section

and who is recognised by **us**.

Qualified 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**.

Qualified Chiropodist/Podiatrist

A practitioner who is included, as required by the Health Professions Order 2001, in the register of the Health Professions Council as a Chiropodist/Podiatrist, and who is recognised by **us**.

Qualified Chiropractor

A practitioner who is included as required by the Chiropractors Act 1994 in the Register of Chiropractors kept by the General Chiropractic Council and who is recognised by **us**.

Qualified Homeopath

A homeopath who is a Fellow of the Faculty of Homeopathy (FFHOM) or a Member of the Faculty of Homeopathy (MFHOM), the UK Homeopathic Medical Association (UKHMA), the Society of Homeopaths or the Alliance of Registered Homeopaths.

Qualified Osteopath

A practitioner who is included as required by the Osteopaths Act 1993 in the Register of Osteopaths kept by the General Osteopathic Council and who is recognised by **us**.

Qualified Physiotherapist

A Practitioner who is included, as required by the Health Professions Order 2001, in the register of the Health Professions Council as a physiotherapist, 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.

Relevant Date

The actual date of the **Treatment**.

Review Date

The annual anniversary of the **Commencement Date**.

Routine Dental Treatment

Dental treatment carried out by a dental practitioner in a dental surgery including examinations, tooth cleaning, white fillings (where appropriate), crowns, extractions and surgery.

Select Hospital

A **Hospital** appearing on the Hospital list chosen by the **Policyholder** for the **Period of Cover** and issued by **us** and current at the **Relevant Date**.

Specialist

A registered medical practitioner who:

- a. has at any time held and is not precluded from holding a substantive consultant appointment in the relevant specialty in an NHS hospital, or
- b. holds a Certificate of Higher Specialist Training in the relevant specialty issued by the Higher Specialist Training Committee of the relevant Royal College or faculty, or
- c. is included as required by the European Specialist Medical Qualifications Order 1995 in the Specialist Register kept by the General Medical Council in respect of the relevant specialty

and who is recognised by **us** to provide the **Treatment you** require for **your** condition.

Treatment

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

We/our/us

Aviva Health UK Limited on behalf of the underwriter Aviva Insurance UK Limited.

Core Cover

The purpose of this **Policy** is to cover **you** during a **Period of Cover** for the **Treatment** of **Acute Conditions** of brief duration on a short-term basis. Except as otherwise stated below, all **Treatment** must be by **Specialists** following referral from **your General Practitioner**.

We will pay for eligible **Treatment** subject to the benefit terms, conditions and exclusions contained in this **Policy** under the following **Core Cover** benefits subject to the additional **Options** chosen by the **Policyholder** as shown on the **Policy Statement**.

Benefits available for **Treatment** under this **Policy** shall be limited to **Hospital** charges, professional fees and **Hospice** donations for the following:

Benefits	Amount Payable	Notes - see also Benefit Terms
A. In-patient or Day-patient Treatment at a Hospital in the Key section of the Select Hospital list or in an NHS pay-bed; see Benefit Term 3		
i. Hospital charges Consisting of accommodation and meals; nursing care, drugs and surgical dressings; operating theatre; intensive and high dependency care; prostheses inserted into the body during an operation; physiotherapy	In full	
ii. Specialists' fees Consisting of surgeons', anaesthetists' and physicians' fees	See Benefit Term 2b	Subject to Aviva's fee guidelines for Specialists
iii. Diagnostic Tests Including pathology, X-rays, physiological tests such as ECGs; CT, MRI and PET scans	In full	
iv. Radiotherapy/chemotherapy	In full	
B. Out-patient Treatment		
i. Consultations with a Specialist	In full	Any procedures included are subject to Aviva's fee guidelines for Specialists ; see Benefit Term 2b
ii. Diagnostic Tests Including pathology, X-rays, physiological tests such as ECGs; CT, MRI and PET scans	In full	Out-patient CT, MRI or PET scans will only be covered at a Diagnostic Centre
iii. Radiotherapy/chemotherapy	In full	
iv. Treatment by a Qualified Physiotherapist, Qualified Chiropractor or Qualified Osteopath	In full	On Specialist referral
v. Psychiatric Treatment	Up to £1,000	Reasonable fees up to £1,000 per Insured Person per one year Period of Cover ; on referral by a General Practitioner to a Psychiatric Therapist or to a Specialist ; see Benefit Term 4

The information on this page must be read in conjunction with the Definitions, Benefit Terms, Conditions, Exclusions and the other documents forming the **Policy**.

Core Cover

Benefits	Amount Payable	Notes - see also Benefit Terms
Additional Benefits		
C. Nursing at home by a Nurse	In full	Immediately following eligible In-patient or Day-patient Treatment ; see Benefit Term 5
D. Private ambulance	In full	Reasonable charges; see Benefit Term 6
E. Parent accommodation when staying with a child covered by the Policy	In full	Child under 12 undergoing eligible Treatment ; one parent only
F. Hospice care	£70 per day	Donation to the Hospice , up to 10 days' care maximum; see Benefit Term 7
G. NHS cash benefit	£100 per night	For each night spent as an NHS patient undergoing eligible In-patient Treatment ; up to 25 nights per Insured Person per one year Period of Cover , see Benefit Term 8
H. Maternity cash benefit	£100 per child	For each child born within a Period of Cover ; see Benefit Term 9
I. Emergency overseas cover	In full	Emergency In-patient or Day-patient Treatment when temporarily abroad for a period of up to 90 days; see Benefit Term 10
J. Treatment for complications of pregnancy and childbirth	In full	Subject to the condition arising at least 10 months after the Date of Entry , see Benefit Term 11
K. Investigation into the causes of infertility	In full	Reasonable costs of investigation into the cause of infertility; see Benefit Term 12
L. Oral surgical procedures	In full	Subject to Aviva's fee guidelines for Specialists ; see Benefit Term 2b
M. GP Helpline	Unlimited number of calls	See Benefit Term 13
N. Stress Counselling Helpline	Unlimited number of calls	See Benefit Term 14
O. Personal Health Manager	Unlimited use	See Benefit Term 15

The information on this page must be read in conjunction with the Definitions, Benefit Terms, Conditions, Exclusions and the other documents forming the **Policy**.

Benefit Terms

1. The date for determining the benefits available for **Treatment** shall be the **Relevant Date**.
- 2a. All costs for which benefit is claimed must:
 - i. be reasonable and be necessarily incurred; and
 - ii. unless otherwise specified in this **Policy** be wholly and exclusively for the purpose of **Treatment** of **Acute Conditions** of brief duration on a short term basis. Benefit is only payable in respect of **Treatment** that aims to return **you** to the state of health **you** were in immediately before suffering the disease, illness or injury or which leads to **your** full recovery.
- 2b. **We** produce a list of fee guidelines for **Specialists** based on factors such as the complexity and duration of each procedure, which sets out the limits of what **we** consider to be a reasonable payment for **Specialists'** fees. Any amount above the relevant guideline figure will not usually be covered by this **Policy** and will be **your** responsibility. A copy of **our** fee guidelines for **Specialists** is available on request.
3. If **you** use a **Hospital** that is not either
 - an NHS pay-bed; or
 - included on **your Select Hospital** list,**we** will only pay **Hospital** charges for that **Treatment** up to:
 - £200 for each admission for **Day-patient Treatment** or
 - £250 per night for **In-patient Treatment**.**Hospital** charges include accommodation and nursing costs, but also any other charge made by any **Hospital**, facility or service provider if it is related to **your Day-patient** or **In-patient Treatment**. **Specialists'** fees will be covered according to **our** fee guidelines for **Specialists**.
4. Benefit B(v) (Psychiatric **Treatment**) must be authorised by **us** in writing before **Treatment** is taken.
5. Benefit C (Nursing at home) is only available for nursing on **Specialist** recommendation which takes place in **your** home. It is payable only when all the charges are reasonable and necessary, and are exclusively for exercising nursing skills of a nature of which only **Nurses** are capable, and must immediately follow **Treatment** which has been the subject of a valid claim under this **Policy**.
6. Benefit D (Private ambulance) will only be available where medically necessary for transportation of an **Insured Person** to the nearest appropriate **Hospital** for the purpose of eligible **Treatment**.
7. Benefit F (**Hospice** care) is payable only in relation to care received as a patient of a **Hospice** recognised by **us**, and must relate to a medical condition which has been the subject of a prior valid claim under this **Policy**.
8. Benefit G (NHS cash benefit) will not be available where **you** have been admitted to the NHS hospital as an Accident or Emergency case, or as a fee-paying patient of any kind.
9. Benefit H (Maternity cash benefit) is only available if the birth takes place more than ten months after the mother's **Date of Entry**. This benefit is only available to the mother.

Benefit Term 10 is amended where Option 7 has been selected.
10. Benefit I (Emergency overseas cover) Benefit may only be claimed for the medical services specified in this **Policy** if they are provided:
 - a. in the United Kingdom, Channel Islands or Isle of Man;
 - b. overseas when temporarily overseas for a period of up to 90 days during any annual **Period of Cover** and incidental to the intended purpose of travel a medical emergency arises requiring immediate admission to **Hospital** for the sole purpose of receipt of **Treatment** in respect of an **Acute Condition** of brief duration. **We** shall decide whether or not there is any medical necessity for **Evacuation** and will make all arrangements concerning such **Evacuation**. In the event of a medical **Evacuation**, **you** will be moved to the next nearest appropriate facility for the **Treatment** **you** require which may not be in the United Kingdom, Channel Islands or Isle of Man. Benefits under this **Policy** will extend to reasonable transport and accommodation costs incurred by **you** during an **Evacuation** and in any event only following specific authorisation of such **Evacuation** by **us**. Benefits under this **Policy** will not extend to the costs incurred on behalf of any person (whether or not another **Insured Person**) accompanying **you**. For the purpose of assessing benefit for **Treatment** received overseas, all reference in this **Policy** to expressions which relate specifically to the United Kingdom will be interpreted by **us** as the appropriate local equivalent. Wherever possible the emergency assistance company designated by **us** from time to time should be contacted prior to any **In-patient** or **Day-patient Treatment** costs being incurred to advise **you** of the benefits available whilst

Benefit Terms

you are overseas. Details of the emergency assistance company designated by **us** and contact telephone numbers are listed in the Group Member Booklet.

11. Benefit J (complications of pregnancy and childbirth) will only be available for **Treatment** directly or indirectly arising from or requested in connection with complications of pregnancy and childbirth arising at least 10 months after the **Date of Entry**.

The following conditions will be considered complications for the purposes of this benefit:

- Ectopic pregnancy (development of foetus outside the womb)
- Miscarriage (if **you** have miscarried, but not investigations into the cause of repeated miscarriages)
- Still birth
- Hydatidiform mole (cell growth abnormality in the womb)
- Retained placenta (afterbirth retained in the womb)
- Pre-eclampsia (a condition with a number of symptoms, including high blood pressure and fluid retention)
- Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
- Diabetes (if diabetes begins in pregnancy, but not before)
- Caesarean sections - in specific clinical circumstances (**we** require full clinical details from **your Specialist** before **we** can make a decision about **your** cover)

12. Benefit K (Investigation into infertility) will only be available for **Treatment** directly or indirectly arising from or required in connection with the reasonable costs of investigations into the causes of infertility where both husband and wife;
- i. have been continuously covered by **us** for at least two years at the time of incurring such costs, and
 - ii. have been unaware of the existence of infertility at the relevant **Date of Entry**.

13. Benefit M (GP Helpline). Each **GP Helpline Consultation** is intended to deal with one call per **Insured Person** to a **General Practitioner** on **our** GP Helpline lasting up to 15 minutes per consultation as required by the **General Practitioner** in respect of one set of symptoms presented; but each such consultation may at the discretion of the **General Practitioner** involve a longer call or more than one call.

The GP Helpline service is designed to be available 24 hours per day but some reasonable delay may be experienced. It is not an emergency service. Call charges are the responsibility of the caller.

You may call on behalf of another **Insured Person** subject to any patient confidentiality requirements of the **General Practitioner**. In using the GP Helpline, **you** (where applicable, on behalf of another **Insured Person**) automatically authorise the use and disclosure of any medical or other information, on a fully confidential basis as between **us**, the **General Practitioners** and any service providers **we** use in making the service available, for the sole purpose of policy and service administration.

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

14. Benefit N (Stress Counselling Helpline). The Stress Counselling Helpline aims to give such advice as it is reasonable and practical to give to **you** over the telephone.

The Stress Counselling Helpline is designed to be available 24 hours per day but some reasonable delay may be experienced. It is not an emergency service. Call charges are the responsibility of the caller. **You** may call on behalf of another **Insured Person** subject to any patient confidentiality requirements of the service provider. In using the Stress Counselling Helpline, **you** (where applicable, on behalf of another **Insured Person**) automatically authorise 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 shall not be responsible for any failure in the provision of the Stress Counselling Helpline service to the extent that it is due to circumstances beyond the reasonable control of **us** or any of **our** service providers.

15. Benefit O (Personal Health Manager) entitles each **Group Member** to a code giving access to the Personal Health Manager web service. Use of the web service is subject solely to the terms and conditions contained on the website itself. Once on the site users will be asked to read and accept the terms and conditions of the service and these will then apply, as amended from time to time, throughout any use of Personal Health Manager. Access to the GP Helpline service via Personal Health Manager will be subject to the terms in Benefit Term 13.

Note: Benefit Terms relating to **Options** 1-7 can be found underneath the applicable **Option**.

Exclusions from Cover

Benefits will not be available for:

1. Treatment

- a. of any **Pre-existing Condition** or any **Related** condition unless the **Pre-existing Condition** or any **Related** condition was fully disclosed to **us** in writing on the **Group Member** application in the form prescribed by **us** and **we** have not expressly excluded **Treatment** relating to it;

(**We** may alter the above exclusion 1a, and if **we** do, **we** will confirm this to the **Policyholder** and each **Group Member** on the **Policy Statement** and **Policy Schedule** respectively).

- b. of any condition that is not an **Acute Condition** of brief duration, except that **we** will pay for **Treatment** to the point of diagnosis of a **Chronic Condition**. Any condition which is an **Acute Condition** of brief duration but which also falls within the definition of **Chronic Condition** will be deemed to be an **Acute Condition** of brief duration;
- c. attributable directly or indirectly to infection by Human Immunodeficiency Virus (HIV) and/or any related illness including but not limited to Acquired Immune Deficiency Syndrome (AIDS);
- d. for alcoholism, alcohol abuse, solvent abuse, drug abuse or addictive conditions of any kind and **Treatment** of any illness or injury arising directly or indirectly from any such abuse or addiction;
- e. received in health spas, nature cure clinics or similar establishments, or private beds registered as a nursing home attached to such establishments;
- f. by a **Specialist** without referral from **your General Practitioner** except for **Treatment** of **Acute Conditions** in an emergency but only if **your General Practitioner** is kept fully informed of the **Treatment** so he/she is able to support a claim for benefit;
- g. of myopia.

2. Supportive **Treatment** of renal failure including dialysis. However **we** may at **our** discretion pay for the cost of renal dialysis incurred:

- a. immediately pre- and post-operatively during any kidney transplant or attempted transplant;
- b. in connection with acute secondary failure when the dialysis is part of intensive care.

3. Cosmetic treatment, whether or not for psychological purposes, and any consequence of such treatment.

4. Drugs and dressings other than:

- a. those prescribed by a **Specialist** for use during the course of **In-patient** or **Day-patient Treatment**; and
- b. those prescribed by a **Specialist** for a surgical procedure during the course of **Out-patient Treatment**.

5. **Hospital** charges:

- a. if for any reason the **Hospital** has effectively become or could be treated as being **your** home or permanent abode; or
- b. where admission to the **Hospital** is arranged wholly or partly for domestic reasons.

6. **Treatment** required as a consequence of an injury sustained whilst training for, or participating in, sport for which **you** receive payment or sponsorship (other than travel costs).

7. **Treatment** directly or indirectly required as a result of any of the following, unless the **Insured Person** sustains bodily injury covered by the **Policy** whilst an innocent bystander;

- a. war (declared or not), military, paramilitary or terrorist activity (including the effects of radiological, biological or chemical agents)
- b. criminal activity and, or public disorder (including but not limited to assault, use of offensive weapons, violent disorder or riot)
- c. use, misuse, escape or explosion of any gas or hazardous substance (including explosives or radiological, biological or chemical agents).

8. **Treatment**, including drug therapy, which **we** decide, based on established medical practice in the United Kingdom, is experimental or unproven.

9. Any treatment or surgical procedure carried out for the purpose of removing undiseased body tissue, and any consequence of such treatment.

10. **Treatment** directly or indirectly arising from or required as a consequence of self-inflicted injury.

Exclusions from Cover

Exclusions 11 to 15 apply to the **Core Cover** but may be amended subject to any **Options** selected:

- 11 a. Neurostimulators (such as cochlear implants) and any **Treatment** related to their implantation or continued care.
This exclusion does not apply to heart pacemakers or implantable cardioverter defibrillators.
- b. Spectacles; contact lenses; hearing aids; dentures; other optical, dental, surgical or medical appliances or equivalent appliances (other than prostheses inserted into the body during the course of a surgical procedure).
12. **Treatment** of psychiatric, psycho-geriatric or mental illnesses or conditions of any kind except as provided by Benefit B(v).
- 13 a. **Treatment** by a **General Practitioner**.
 - b. Any **Diagnostic Tests**, which are specifically requested by a **General Practitioner**.
 - c. Routine medical examinations including sight testing.
14. Any dental **Treatment** not involving an oral surgical operation.
15. **Treatment** directly or indirectly arising from or required in connection with any of the following;
 - pregnancy or childbirth other than as specified in Benefit J
 - male and female birth control
 - termination of pregnancy
 - infertility except as specified in Benefit K and any form of assisted reproduction.

Note. Exclusions relating to **Options** 1-7 can be found underneath the applicable **Option**.



Options

The following optional benefits only apply to the **Policy** if selected by the **Policyholder** and shown on the **Policy Statement**.

The Benefit Terms and Exclusions that apply to each **Option** must be read in conjunction with, or as amendments to, the Benefit Terms, Exclusions and Conditions of this **Policy** document.

Any combination of **Options** can be selected in conjunction with the **Core Cover**.

Option 1 - Psychiatric Cover	Amount Payable	Notes
Benefits		
In-patient or Day-patient Treatment consisting of accommodation and nursing	In full	Either 28 days or 45 days, as selected per Insured Person , per one year Period of Cover ; see Benefit Term 16
In-patient Treatment consisting of Specialist's fees	Up to £210 per week	See Benefit Term 16

Benefit Term

16. Claims for Benefit **Option 1** must be authorised by **us** in writing before **Treatment** is undertaken.

Exclusions

Exclusion 12 is deleted and replaced with the following: **Treatment** of psychiatric, psycho-geriatric or mental illnesses of any kind except as provided by Benefit B(v) and **Option 1**.

Option 2 - GP Referred Services	Amount Payable	Notes
Benefits - Overall Benefit Limit of £1,000 per one year Period of Cover		
i. Treatment of Acute Conditions by a Qualified Physiotherapist, Qualified Chiropractor, Qualified Osteopath, Qualified Acupuncturist	Up to 10 sessions in combined total	Per Insured Person per condition, per one year Period of Cover ; see Benefit Term 17
ii. Treatment of Acute Conditions by a Qualified Chiropracist/Podiatrist, Qualified Homeopath	In full	Per Insured Person per one year Period of Cover
iii. General Practitioner referred radiology/pathology	In full	Per Insured Person per one year Period of Cover
iv. Minor Surgery by a General Practitioner	Up to £70 per procedure	For procedures appearing on our Minor Surgery List, payable to the GP
v. Specialists' fees for other consultations and Diagnostic Tests	In full	Per Insured Person per one year Period of Cover ; see Benefit Term 18

Benefit Term

17. **Option 2** (i) is available for a maximum of ten sessions in combined total for all these benefits. If **you** require more than ten sessions in combined total for the medical condition in the same **Period of Cover** then they must be requested by and under the control of a **Specialist**.

18. **Option 2** (v) is available for consultations and **Diagnostic Tests** with **Specialists** which relate to a disease, illness or injury which is not an **Acute Condition**, and for follow-up consultations as required by a **Specialist** for a past disease, illness or injury which was an **Acute Condition**. This benefit is only available for treatment of a disease, illness or injury not otherwise excluded by the **Policy**.

Exclusions

Exclusion 13 a. and b. are deleted and replaced with:

- Treatment** by a **General Practitioner** (other than **Minor Surgery**)
- Except as permitted by **Option 2** Benefit (iii) any **Diagnostic Tests** which are specifically requested by a **General Practitioner**.

The information on this page must be read in conjunction with the Definitions, Benefit Terms, Conditions, Exclusions and the other documents forming the **Policy**.

Options

Option 3 - Hospital Lists

Option 3a - Extended Hospital List

Core Cover Benefits A, **In-patient** or **Day-patient Treatment** can be received at any **Hospital** on the Key or Extended Hospital List or in an NHS pay-bed; see Benefit Term 3

Option 3b - Signature Hospital List

Core Cover Benefits A, **In-patient** or **Day-patient Treatment** can be received at any **Hospital** on the Signature Hospital List or NHS pay-bed in Scotland or Northern Ireland; see Benefit Term 3

Option 3c - Trust Care Hospital List

Core Cover Benefits A, **In-patient** or **Day-patient Treatment** can be received at any **Hospital** on the Trust Care Hospital List or NHS pay-bed. See Benefit Terms 19 and 20

Option 3d - Fair+Square Hospital List

Core Cover Benefits A, **In-patient** or **Day-patient Treatment** can be received at any **Hospital** on the Fair+Square Hospital List. See Benefit Term 21.

When **Option 3b** is selected Benefit Term 6 is replaced with

- Benefit D (Private Ambulance) will only be available where medically necessary for transportation of an **Insured Person** to the nearest appropriate **Signature Hospital** for the purpose of eligible **Treatment**.

Definition

Where **Option 3c** is selected the definition of **Hospital** is deleted and replaced with:

Hospital

- An NHS pay bed, or
- An NHS facility included on **our** Trust Care hospital list current at the **Relevant Date**, or
- An NHS establishment which **we** agree is an appropriate facility for the provision of **Treatment** prior to **Treatment** being carried out

and which **we** recognise to provide the type of **Treatment** undertaken and for the condition that requires **Treatment**.

Benefit Term

19. When **Option 3c** is selected **Core Cover** Benefit G and Benefit Term 8 are deleted.
20. When **Option 3c** is selected Benefit B (**Out-patient Treatment**) will be available other than at a **Select Hospital** where facilities are not reasonably available at a **Select Hospital**. This does not apply to out-patient CT, MRI or PET scans which will only be covered at a **Diagnostic Centre**. Please contact **our** Customer Service Helpline. Benefit Term 3 is deleted.

Exclusion

16. **In-patient**, **Day-patient** and **Out-patient Treatment** received other than at a **Hospital** on the Trust Care Hospital List except as stated in Benefit Term 20.

Definition

Where **Option 3d** is selected the definition of **Hospital** is deleted and replaced with:

Hospital

- A hospital in the United Kingdom which is registered in accordance with United Kingdom legislation and which has specialist facilities for carrying out major surgical operations, or
- Any establishment which **we** agree is an appropriate facility for the provision of **Treatment** prior to any **Treatment** being carried out

and which **we** recognise to provide the type of **Treatment** undertaken and for the condition that requires **Treatment**.

Benefit Term

When **Option 3d** is selected Benefit Term 3 is replaced with:

21. If eligible private **Treatment** is not within the range of services reasonably available from a **Hospital** on the Fair+Square Hospital List but is available at one or more other **Hospitals**, **we** will at **our** reasonable discretion after being requested to do so nominate one or more such other **Hospitals** for the purpose of private **Treatment** covered by this **Policy**. The **Treatment** at such other **Hospital** must be pre-authorized by **us** in writing.

Exclusion

17. **In-patient**, **Day-patient** and **Out-patient Treatment** received other than at a **Hospital** on the Fair+Square Hospital List except as stated in Benefit Term 21.

The information on this page must be read in conjunction with the Definitions, Benefit Terms, Conditions, Exclusions and the other documents forming the **Policy**.

Option 4 - Dental and Optical	Amount Payable	Notes
Benefits		
i. Routine Dental Treatment	£300 benefit limit £50 excess	Per Insured Person per one year Period of Cover . For details of how the excess applies see Excess
ii. Treatment by a Dentist in respect of an Accidental Dental Injury	Up to £600	Per Insured Person per one year Period of Cover
iii. Optical Benefit	£200 benefit limit £50 excess	Per Insured Person per one year Period of Cover ; see Benefit Term 22. For details of how the excess applies see Excess

Excess

The excess applies separately to **Routine Dental Treatment** and the Optical Benefit under this **Option**, per **Insured Person** per one year **Period of Cover** and is deducted from the benefit available. Payment of benefit will only be available to an **Insured Person** when total eligible expenditure incurred by an **Insured Person** during a **Period of Cover** exceeds the amount of the excess. For example, if a claim is made for £220 for eligible **Routine Dental Treatment (Option 4i)**, we will deduct the £50 excess from this sum and pay the balance of £170 to the **Insured Person**. This leaves a balance of £80 available to that **Insured Person** in this example for subsequent claims in the same **Policy** year (£300-£220). This excess is only deducted once for each **Insured Person** in each one-year **Period of Cover**. This means that where total expenditure for **Treatment** continues from one one-year **Period of Cover** to another the excess will apply again even if a new claim is not submitted.

Benefit Term

22. Benefit **Option 4(iii)**, Optical Benefit is payable for contact lenses or spectacles obtained as a result of a change of prescription. The contact lenses or spectacles must be obtained within three months of the eye test which discovered the change in prescription. In order to claim benefit under **Option 4(iii)** the date of the change in

prescription and the relevant section of the claim form must be completed and signed by the dispensing Optician. This benefit excludes the cost of optical solutions and sundries or optical care contract schemes.

Exclusions

Exclusion 11b is deleted and replaced with:

Hearing aids; dentures; other optical, dental, surgical or medical appliances or equivalent appliances (other than prostheses inserted into the body during the course of a surgical procedure).

Exclusion 13 c. is deleted and replaced with:

C. Routine medical examinations except as permitted under **Option 4(i)**

Exclusion 14, if **Option 7** is not also selected, is deleted and replaced with;

14. Any dental **Treatment** not involving an oral surgical operation except as permitted under **Option 4(i)** and 4(ii).

If **Option 7** is also selected, Exclusion 14 is deleted and replaced with:

14. Any dental **Treatment** whether or not involving an oral surgical operation except as permitted under **Option 4(i)** and 4(ii).

Option 5 - Six Week Option	Notes
Benefits	
Six Week Option	Benefits for In-patient or Day-patient Treatment and for NHS Cash Benefit will only be available if Treatment is not available at an NHS Hospital within six weeks. See Benefit Term 23

Benefit Term

23. By opting for the Six Week **Option**, benefits for **In-patient** or **Day-patient Treatment** and for NHS Cash benefit (**Core Cover** Benefit G) will only be available if that **Treatment** is not available (except for reasons of country of residence or of nationality) to **you** at an NHS hospital within six weeks after the date on which the **Specialist** recommends that **Treatment** (at or following a consultation between that **Specialist** and **you**). The NHS waiting period must be determined and advised by the **Specialist** in charge of **your Treatment**.

NB: If **Option 3c** is also selected **Core Cover** Benefit G is deleted.

The information on this page must be read in conjunction with the Definitions, Benefit Terms, Conditions, Exclusions and the other documents forming the **Policy**.

Options

Option 6 - Member Excess	Notes
Benefit	
Benefit under this Policy is subject to an excess per Insured Person per one year Period of Cover	Either £50, £100, £150 or £200 as selected. For details of how this is applied see Conditions 7a. This excess does not apply to Option 4 if selected, and benefit claimed under Option 4 does not count towards this excess.

Option 7 - Selected Benefit Reduction	Notes
Benefits	
The following additional benefits are removed from Core Cover .	
I. Emergency overseas cover	See Benefit Term 24
J. Treatment for complications of pregnancy and childbirth	Benefit Term 11 is deleted
K. Investigation into the causes of infertility	Benefit Term 12 is deleted
L. Oral surgical procedures	

Benefit Term

24. Benefit Term 10 is deleted and replaced with:
Benefit may only be claimed for the medical services specified in this **Policy** if they are provided in the United Kingdom, Channel Islands or Isle of Man.

Exclusions

Unless **Option 4** is also selected, Exclusion 14 is deleted and replaced with:

Any dental **Treatment** whether or not involving an oral surgical operation.

If **Option 4** is also selected, Exclusion 14 is deleted and replaced with:

Any dental **Treatment** whether or not involving an oral surgical operation except as permitted under **Option 4**(i) and 4(ii).

Exclusion 15 is deleted and replaced with:

Treatment directly or indirectly arising from or required in connection with any of the following:

- pregnancy or childbirth whether complicated or not
- male and female birth control
- termination of pregnancy
- infertility including investigations into the causes of infertility and any form of assisted reproduction.

The information on this page must be read in conjunction with the Definitions, Benefit Terms, Conditions, Exclusions and the other documents forming the **Policy**.

Option 8 – Reduced Cover for Out-patient Treatment	Amount Payable	Notes
Benefits		
Core Cover Benefits Section B is deleted and replaced with:		
B. Out-patient Treatment of Acute Conditions		
i. CT, MRI and PET scans	In full	These scans will only be covered at a Diagnostic Centre
ii. Radiotherapy / chemotherapy	In full	
The following benefits are subject to a combined limit of £1,000 per Insured Person per one year Period of Cover :		
		Notes
iii. Consultations with a Specialist		Any procedures included are subject to Aviva's fee guidelines for Specialists ; see Benefit Term 2b
iv. Diagnostic Tests including pathology, X-rays and physiological tests (such as ECGs)		
v. Treatment by a Qualified Physiotherapist, Qualified Chiropractor or Qualified Osteopath		On Specialist referral
vi. Psychiatric Treatment		Reasonable fees; on referral by a General Practitioner to a Psychiatric Therapist or to a Specialist ; see Benefit Term 4

The information on this page must be read in conjunction with the Definitions, Benefit Terms, Conditions, Exclusions and the other documents forming the **Policy**.



Conditions

1. Compliance with Policy Terms

Our liability under this **Policy** will be conditional upon the **Policyholder** and each **Insured Person** complying with its terms and conditions.

2. Change of Risk

- a. The **Policyholder** must inform **us**, as soon as reasonably possible, of any changes relating to **Insured Persons** (such as change of address, occupation or marital status) or of any other material changes which affect information given in connection with the application for cover under this **Policy**, for example liquidation, insolvency or bankruptcy procedures. In line with reasonable underwriting practice **we** reserve the right to alter the premiums or **Policy** terms or cancel cover for an **Insured Person** following a change of risk. In any event changes will not be backdated to before the date on which **we** receive such notice.
- b. The **Policyholder** may not assign the benefit of nor any of its or any **Insured Person's** obligations under the **Policy** without **our** prior written consent.
- c. In addition, the **Policyholder** must inform **us**, as soon as possible and in any event within 30 days, of an **Insured Person** joining or leaving the **Group**. **We** will then increase or decrease the premium accordingly and will notify the **Policyholder** of the new amount. Notification of an **Insured Person** joining the **Group** must be accompanied by a completed **Group Member Application** in the form prescribed by **us**.

3. Policy Duration and Premiums

- a. This **Policy** shall be for one year. Renewal requires the agreement of both parties.
- b. The premium will be payable without deduction or set off.
- c. The **Policyholder** shall be responsible for paying the premium for all **Insured Persons** and must not recover any part of the premium relating to **Group Members** from those **Group Members**.
- d. The **Policyholder** shall elect prior to or at the **Commencement Date** or **Review Date** to pay the premium annually, quarterly or monthly.

- e. The premium payable may be changed by **us** from time to time. However this **Policy** will not be subject to any alteration in **Premium Rates** until the next **Review Date**. In any event if a **Group Member** moves to a higher age band the premium will increase at the next **Review Date**.
- f. All premiums are payable in advance of any cover under this **Policy** being provided. Each monthly premium relates to one month's cover. Each quarterly premium relates to one quarter's cover. Each annual premium relates to one year's cover.
- g. If at any time the number of **Group Members** covered by the **Policy** falls below two **we** reserve the right to cancel cover for the **Group**. If **we** cancel cover under this **Policy** **we** may at **our** discretion offer cover under an alternative product. If **we** continue cover for the **Group** **we** shall be entitled to charge premium for a minimum of two **Group Members** (and their **Eligible Dependants**) for the whole of the **Period of Cover**.
- h. If at any time the number of **Group Members** covered by the **Policy** exceeds 49 **we** reserve the right to cancel cover for the **Group**. If **we** cancel cover under this **Policy** **we** may at **our** discretion offer cover under an alternative product.

4. Children

- a. **Insured Persons** being children will at the next **Review Date** following the earlier of their 24th birthday or their marriage cease to be **Eligible Dependants**.
- b. A child born to an **Insured Person** during the **Period of Cover** and whose birth has been notified to **us** (in writing and including a birth certificate) within three months of birth will be accepted for full cover from the date of birth regardless of health.

5. Continuation Terms

Group Members and **Eligible Dependants** who are no longer eligible for the **Policy** will be entitled to transfer to an individual policy nominated by us with no further medical underwriting.

Please note that:

- benefits, terms and exclusions on another policy may be different to those on this **Policy**
- if **you** choose to have improved benefits **you** may need to declare **your** medical history and be re-underwritten.

These terms will only apply if **you** take out another policy within 30 days of **your** cover on this **Policy** ending.

6. Cancellation

- a. This **Policy** will stand cancelled and the **Period of Cover** will cease automatically upon non-payment of the premium although **we** may at **our** discretion reinstate the cover if the premium is paid within 30 days of its due date.
- b. If any premium due from the **Policyholder** remains unpaid **we** may in addition defer payment of all or any claims until such time as the premiums outstanding are paid in full.
- c. Whilst **we** shall not cancel this **Policy** because of eligible claims made by any **Insured Person**, **we** may at any time (with retrospective effect where appropriate) cancel this **Policy** or terminate a **Group Member's** and/or **Eligible Dependant's** membership of the **Group** or subject their membership to different terms in line with reasonable underwriting practice if the **Policyholder** or **Group Member/Eligible Dependant** has at any time:
 - i. misled **us** by mis-statement or concealment;
 - ii. knowingly claimed benefits for any purpose other than as are provided for under this **Policy**;
 - iii. agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to **our** detriment;
 - iv. otherwise failed to observe the terms and conditions of this **Policy** or failed to act with utmost good faith.

If **we** do cancel this **Policy** or terminate cover for any of the reasons i to iv above **we** shall give the **Policyholder** written notice sent by first class post or delivered by hand to the **Policyholder's** last known address, to take effect as specified in the notice.

If **we** do so **we** will not be obliged to give a refund of premium.

- d. Cover for a **Group Member** and his/her **Eligible Dependants** (if any) shall cease forthwith upon the **Group Member** ceasing to be included in the **Group**.
- e. The **Policyholder** must, as soon as reasonably possible after each event, notify each **Group Member** of:
 - i. the termination of his/her cover and that of his/her **Eligible Dependants** under the **Policy** if the **Group Member** ceases to be included in the **Group**; and
 - ii. the termination of his/her cover and that of his/her **Eligible Dependants** under the **Policy** if the **Policy** is cancelled.

7. Claims Procedure

- a. If an excess applies to this **Policy** then payment of the benefits under this **Policy** will only be available to **you** to the extent that the total expenditure for **Treatment** covered by this **Policy** incurred by **you** during any one-year **Period of Cover** exceeds the amount of the excess. The excess is applied once per **Insured Person** for each one-year **Period of Cover**. This means that where total expenditure for **Treatment** continues from one one-year **Period of Cover** to another the excess will apply again even if a new claim is not submitted.
You will be liable for the amount of the excess and the excess will be re-applied for each one-year **Period of Cover**. The excess amount should be settled by **you** directly with the relevant provider (for example a **Hospital** or **Specialist**) and not with **us**.

Conditions

- b. Before undertaking any **Treatment** (unless a medical emergency) covered by this **Policy**, **you** must notify **us** of its proposed nature and the name and address of the **Specialist** and **Hospital** concerned. **We** advise that where possible claims should be authorised in advance of **Treatment**, but this will obviously not apply to emergency admissions. In order to confirm cover before claiming **we** must receive all necessary medical information at least five working days prior to any proposed **Treatment**. Usually this will include a completed claim form but dependent upon the **Policyholders** service arrangements with **us** and at **our** discretion **we** may sometimes be able to take the necessary information over the telephone; if this is the case **we** will tell **you** at the time. **You** will then receive written confirmation from **us** if **your** condition is covered.
- c. **We** reserve the right to reject any claim which is not submitted within a reasonable time period.
- d. Many of the **Hospitals** on **our Select Hospital List** operate direct billing arrangements with **us**. This means that the accounts for **In-patient Treatment** or **Day-patient Treatment** covered under the **Policy** will be settled directly with **us**. Direct billing may not be possible at other **Hospitals** and in any event will not normally be possible for **Out-patient Treatment** at any **Hospital** whether a **Select Hospital** or otherwise. In addition to the direct billing arrangements that **we** have with some **Hospitals** **we** may also settle eligible claims directly with the providers of other services or with any other person.
- e. All documents or material (including but not limited to accounts, certificates and X-rays) that **we** require to support a claim, an application for cover or a change in cover shall be provided without expense to **us** (including if requested by **us** a medical report from **your General Practitioner** or **Specialist**).
- f. Claims may only be made for **Treatment** actually received by **you** during a **Period of Cover** and benefit will be available only for expenditure incurred prior to the expiry or termination of such a **Period of Cover**.
- g. Where **Treatment** continues over an extended period of time, updated claim information may be required at regular intervals, which may include a claim form.

8. Claims – Our Rights

- a. The **Policyholder** must without delay give **us** or procure that the relevant **Insured Person** gives **us** without delay written notification of any claim or right of action against any party arising out of any circumstances which gave rise to the claim under this **Policy** and must continue to keep **us** fully informed in writing and take all steps **we** reasonably require in making a claim upon that other party. **We** shall be entitled to prosecute in any **Insured Person's** name for **our** own benefit any claim for indemnity or damages or otherwise, which relates to any benefits and costs paid or payable under this **Policy** but **we** shall have no responsibility for any claim for uninsured losses in respect of which the **Policyholder** and each **Insured Person** should ensure that legal advice is taken.
- b. **We** shall have full discretion in the conduct of any such proceedings and in the settlement of any such claim.

9. Distribution of Information to Group Members

The **Policyholder** must distribute to each **Group Member** on joining the **Group** the Group Member Booklets (including any inserts) summarising the benefits under this **Policy**, his/her **Policy Schedule** (if applicable) and must distribute to **Group Members** any subsequent member literature **we** send to the **Policyholder** thereafter without delay.

10. Other Insurance

If there is any other insurance or fund covering any of the same benefits the **Policyholder** must disclose or procure that the relevant **Insured Person** discloses the same to **us** and **we** shall not be liable to pay or contribute more than **our** rateable proportion.

11. Alterations

We may alter any of the terms of this **Policy** at any **Review Date**. A copy of the current **Policy** terms will be sent to the **Policyholder** at such time.

12. Records, Consents and Confirmations

- a. **We** shall be entitled at all reasonable times and on reasonable notice to inspect the **Policyholder** records relating to the **Policy**.

On behalf of itself and each person covered, the **Policyholder** agrees and consents on a continuing basis to the computer and other processing and use of all personal and medical details received by **us** from time to time. This includes processing by the data controllers and relevant third parties (which may include the **Policyholder**, medical and other service providers and relevant intermediaries) for the purposes of Policy administration, service provision, reinsurance, claims validation and fraud prevention. The **Policyholder** also agrees to provide or procure the provision of such confirmations of consent (if any) as **we** may require from time to time. Processing may be in any part of the world. Processing will be carried out in such a manner as to ensure adequate standards of data protection within the meaning of English law apply. The data controllers are Aviva Health UK Limited, Aviva Insurance UK Limited and Aviva Life & Pensions UK Limited.

- c. The **Policyholder** will, at its cost, on request by **us**, from time to time provide (or facilitate the provision by third parties of) all such evidence and confirmations as **we** reasonably require to verify that one or more individuals are eligible for cover as **Insured Persons** and/or that the definition of **Policyholder** is satisfied.

This may include (but is not limited to);

- Management accounts
- PAYE, NI, Inland Revenue records and returns
- Employee records
- Employee contracts
- VAT records and returns

13. Fraudulent/Unfounded Claims

If any claim under this **Policy** is in any respect fraudulent or unfounded all benefit paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable.

14. Waiver

Waiver by **us** of any term or condition of this **Policy** will not prevent **us** from relying on such term or condition thereafter.

15. Settlement of Claims

All settlements will be made in sterling at the rate ruling in London at the beginning of the month in which the **Relevant Date** occurred.

16. Jurisdiction

The **Policy** is governed by and shall be construed in accordance with English Law and shall be subject to the exclusive jurisdiction of the courts of England and Wales.

17. Enforcement

Only the **Policyholder** and **us** are parties to this **Policy**. Other persons including **Insured Persons** will have no right under the Contracts (Rights of Third Parties) Act 1999 to enforce this **Policy** or any part of it. This will not effect any third party right or remedy if available apart from that Act.

Additional benefits - Personal Health Manager

www.aviva.co.uk/personalhealthmanager

Personal Health Manager

Aviva isn't just about helping your employees and their families get the best treatment when they are unwell. We can help them to learn how to take control of their health, so they can get more out of life. Our online Personal Health Manager is an integral part of your Policy that provides your employees with help, advice and information to improve their well being and that of their family, day or night.

Regularly reviewed by medical experts, Personal Health Manager covers many aspects of medicine and healthcare. Your employees and their families can access the Symptom Assessment and get fast, accurate advice. Alternatively they can use the Health Planner to carry out a full health and lifestyle assessment. The Medical Information section includes a medical encyclopaedia sourced from the *Complete Family Health Guide* published by Dorling Kindersley which provides access to an extensive online medical reference whenever they come across a term they don't fully understand. Also, in conjunction with Dr Foster, the medical research organisation, they have access to a range of NHS Trust waiting list times.

Our excellent 24 hour GP Helpline and Stress Counselling Helpline complement the entire Personal Health Manager service by providing your employees and their families with a service where they can answer any medical or health questions raised from using Personal Health Manager.

With any element of Personal Health Manager, there is no limit to the number of times that they can use the service and the only cost is that of the internet use and any calls to the Helplines.

GP Helpline: 0800 158 3112*

The GP Helpline gives your employees fast access to medical advice from a qualified GP about symptoms, or fast access to more general medical information from a Nurse, any time of the day or night, 365 days a year. This service is available to your employees as often as they want and for as long as they want.

The GP Helpline can save your employees and their families trips to the doctors, unnecessary worry and anxiety and provide advice on everything from viruses to vitamin supplements.

Stress Counselling Helpline: 0800 158 3349*

The Stress Counselling Helpline provides 24 hours a day, 365 days a year access to experienced counsellors providing counselling as well as advice and information on how to overcome stress.

Your employees and their families can call our Stress Counselling Helpline any time of the day or night. They can talk for as long as they wish - there will be no pressure to bring the call to an end. The counsellors are always ready to listen, help and advise.



There is no limit to the number of calls that can be made to the GP Helpline or Stress Counselling Helpline and the only cost will be that of the calls themselves. Please note that medical or other details given to the GP Helpline or Stress Counselling Helpline may be used and disclosed on a confidential basis between us and our retained service providers and General Practitioners, if appropriate, for policy and service administration purposes.

*Calls may be monitored and/or recorded.

Chronic conditions explained

If you are familiar with Private Health Insurance, or already have a Policy, you may have heard the term 'chronic medical condition'.

This section of your booklet explains how Aviva manages those insured persons whose medical condition becomes a 'chronic condition'.

Private Health Insurance is intended to cover short term treatment of acute conditions, which start after your date of entry. It does not provide cover for chronic conditions.

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

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

What is a chronic condition?

A chronic condition is defined as:

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

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

At Aviva we cover the cost of treatment for acute conditions of brief duration, subject to the terms of your Policy Wording. An acute condition is a disease, illness or injury that is likely to respond quickly to treatment, the aim of which is to return you to the state of health you were in immediately before suffering the condition, or which leads to your full recovery.

If you are suffering symptoms for which diagnostic tests are undertaken we would generally pay for such investigations. If, as a result of the tests, you are diagnosed as suffering with a chronic condition, benefit would not usually be payable for subsequent treatment. Some conditions may satisfy both the definition of a chronic condition and an

acute condition, in these circumstances we would view it as an acute condition and pay accordingly.

What does this mean in practice?

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

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

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

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

What if my condition gets worse?

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

Some chronic conditions are likely to have acute flare-ups or to worsen substantially for a short period of time.

Treatment for such episodes will generally be covered if they are likely to respond quickly to treatment which aims to return you to your previous state of health. Once your condition is stabilised, we would follow the same procedures as set out in the previous section.

Examples of chronic conditions

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

Chronic conditions explained

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

Example A

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

Aviva covers the investigations and tests needed to diagnose Alan's chest pain. We also cover the Specialist reviews until his condition has been stabilised, although we would not pay for any medication.

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

Aviva provides full cover for the surgery and eligible aftercare needed by Alan because its aim is to relieve his symptoms and stabilise his condition. We also advise him that we will cover his post-operative check-ups for one year, to ensure that his surgery has been successful.

Example B

Bob has been with Aviva for three years when he develops hip pain. His GP refers him to an osteopath who treats him every other day for two weeks, then recommends that he return once a month for additional treatment to prevent a recurrence of his original symptoms.

Aviva explains that, although benefit is payable for the initial two week course of treatment, the monthly visits are not covered by Bob's policy. If his condition should worsen to the point where a hip replacement is needed, this would be covered if his GP refers him to a suitable Specialist. Aviva agrees to provide cover for the first monthly visit to the osteopath, to allow Bob to make alternative arrangements.

(Please note, many of our policies do not include benefit for osteopathy treatment.)

Example C

Carole develops a lump in her left breast which is diagnosed as breast cancer. Her Specialist recommends that she has a mastectomy (breast removal) followed by a course of chemotherapy and radiotherapy.

Aviva provides cover for the diagnosis of this condition, the surgery required to remove the affected breast and for the chemotherapy and radiotherapy to treat the cancer, for as long as this is required. Our experienced cancer case management team are able to ensure that Carole has access to the treatment she needs, when it is needed and in a venue that suits her circumstances. For example, it may be possible to arrange for her chemotherapy treatment to be given at home. In addition, we may be able to pay for the costs of reconstructive surgery to her breast because we recognise that this is often a very important part of the overall treatment programme.

Once Carole's course of treatment has been completed, her Specialist recommends that she has regular check-ups to ensure that she remains free from a recurrence of the disease.

Provided that Carole's policy includes out-patient benefit, we will normally pay for follow-up checks after cancer treatment of this type, for up to five years after the treatment is completed.

Unfortunately, after just three years Carole discovers that she has developed cancer of the lung, secondary to her breast cancer.

In these circumstances Aviva provides benefit for the diagnostic tests, and for treatment of her new illness. This would include payment for any eligible surgery, radiotherapy and chemotherapy, together with check-ups for a further five years after this course of treatment is completed.

Example D

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

Aviva covers the cost of the investigations and consultations until Deirdre's condition is controlled. We then explain that we cannot continue to provide benefit for the four monthly review consultations, but agree, on this occasion, to provide benefit for the first one to allow her to make alternative arrangements for the routine follow-ups.

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

Aviva provides benefit for this admission, until her condition is back under control.

Example E

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

Aviva covers Eve's consultations and tests until the diagnosis is made. We also agree, on this occasion, to pay for her first routine check-up. However, we advise her that we will not be able to cover the regular check-ups after this, because the condition is now well controlled, and has become a chronic condition.

18 months later, Eve has a bad asthma attack.

As this is an acute flare-up which is likely to respond quickly to treatment aiming to return her to her previous state of health, we agree to cover the cost of the hospital treatment to stabilise her condition. We also agree to cover the cost of one follow-up consultation with the Specialist to make sure that her symptoms are again well controlled.

We would ask you to note that this explanation has been produced to help you to understand how Aviva may handle a claim involving a chronic condition. The examples given are for illustration purposes only. You should always contact our Customer Service Helpline before receiving treatment. This will enable us to explain to you how we can help in your particular circumstances.

Important information

If you have any cause for complaint

Our aim is to provide an excellent standard of service to our policyholders, and to do everything we can to ensure that you are satisfied. However, should you feel that we have fallen short of this standard and that you have cause to make a complaint, please contact your insurance adviser, if you used one to arrange your policy.

Otherwise, please write with full details to:

The Customer Relations Team
Aviva Health UK Limited
Chilworth House
Hampshire Corporate Park
Templars Way
Eastleigh
Hampshire SO53 3RY

In the unlikely event that the matter is not resolved, then your complaint can be referred to the Customer Experience Manager at the same address.

It is very rare that matters cannot be resolved amicably, however if you are still unhappy with the outcome, you may ask the Financial Ombudsman Service to investigate by writing to:

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR

Telephone: 0845 080 1800

Email: complaint.info@financial-ombudsman.org.uk

Website: www.financial-ombudsman.org.uk

Please note that the Financial Ombudsman Service will not consider your complaint until you have given us the opportunity to resolve the matter directly with you.

We have every reason to believe that you will be totally satisfied with your Aviva policy, and with our service.

Nevertheless, we have provided the above information to assist you should you ever feel that you have cause to make a complaint.

Referring your complaint to any of the above will not affect your right to take legal action.

The Financial Services Compensation Scheme (FSCS)

We are covered by the FSCS. You may be entitled to compensation from the scheme if we cannot meet our obligations. This depends on the type of business and the circumstances of the claim.

Where you are entitled to claim, insurance advising and arranging is covered for 100% of the first £2,000 and 90% of the remainder of the claim, without any upper limit.

Further information about compensation scheme arrangements is available from the FSCS at:

Financial Services Compensation Scheme
7th Floor, Lloyds Chambers
Portsoken Street

London

E1 8BN

Website: www.fscs.org.uk

Language

All our communications with you in connection with this policy will be written in English.

About Aviva

The Financial Services Authority (FSA) is the independent watchdog that regulates financial services. It requires us to give you this information. Use this information to decide if our services are right for you.

Aviva Health UK Limited, Chilworth House, Hampshire Corporate Park, Templars Way, Eastleigh, Hampshire, SO53 3RY is authorised and regulated by the Financial Services Authority. Our FSA registration number is 308139. Our permitted business is advising on, arranging and administering general insurance and pure protection contracts. You may check this on the FSA's website www.fsa.gov.uk/register or by contacting the FSA on 0845 606 1234.

Aviva Health UK Limited is a wholly owned subsidiary of Aviva Plc, which includes within its group a number of insurers.

Aviva offers a range of products. You may have your own insurance intermediary who will provide you with information about their permitted business and the range of products they offer.

You only need pay the premium; you do not otherwise have to pay us for our services to you.

Aviva Health UK Limited. Registered in England Number 2464270. Registered Office 8 Surrey Street Norwich NR1 3NG.
This insurance is underwritten by Aviva Insurance UK Limited. Registered in England Number 99122,
Registered Office 8 Surrey Street Norwich NR1 3NG.
Authorised and regulated by the Financial Services Authority.
Aviva Health UK Limited, Head Office: Chilworth House Hampshire Corporate Park Templars Way Eastleigh Hampshire SO53 3RY.
www.aviva.co.uk/health

