Solutions

Member booklet for group sizes of 2-99 employees

BacktoBetter
including the BacktoBetter musculoskeletal (MSK) case management service.

Extensive cover
Our cancer pledge
and support

Retirement
Investments
Insurance
Health

AVIVA

Welcome to Solutions from Aviva

This member booklet contains information about Solutions, your private medical insurance from Aviva. You'll find details about your cover and all the information you require should you need to make a claim. Please check what options are included on your policy and what these cover. If you have any questions, are unsure of the cover you have or if any of your personal details are incorrect, please contact your group administrator.

What's covered – summary of Solutions core cover

It's important to note that this benefit table is intended to provide you with only a summary of the core cover benefits offered by Solutions. If your company has decided to include any additional options on your policy then these core cover benefits may change. The full terms and conditions are provided in the policy wording which is available on request from your group administrator. Non-standard terms may apply.

A. Hospital treatment as an in-patient or day-patient		**Covered at a facility recognised by us as part of a network, at a hospital on the Key hospital list or an NHS hospital recognised by us**
Benefits	Amount payable	Notes
If you have the six week option, you can't claim for these benefits if your treatment is available on the NHS within six weeks from the date your specialist recommends it.		
Hospital charges	In full	Including accommodation and meals, nursing care, drugs and surgical dressings, theatre fees
Specialists' fees	In full	Specialists' fees are covered up to the limits in our fee schedule
Diagnostic tests	In full	Including blood tests, X-rays, scans and ECGs
CT, MRI and PET scans	In full	
Radiotherapy/ chemotherapy	In full	
NHS cash benefit	£100 each night, up to 25 nights	Not covered for the first 3 nights of an emergency admission
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	Managed through the BacktoBetter service

B. Treatment as an out-patient		At a network facility if we have a network for your symptoms or condition
Benefits	Amount payable	Notes
Consultations with a fee approved specialist	In full	If you have a consultation with a specialist who is not fee approved we'll only pay up to the limits we pay our fee approved providers
Treatment by a specialist as an out-patient	In full	Specialists' fees are covered up to the limits in our fee schedule
Diagnostic tests	In full	CT, MRI and PET scans as an out-patient are only covered at a diagnostic centre. Specialists' fees for surgical procedures are covered up to the limits in our fee schedule
Pre-admission tests (tests carried out at hospital before admission to check that you're fit to undergo surgery and anaesthesia. These can include ECG's and 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	In full	
Psychiatric treatment	Up to £2,000	On GP referral to a psychiatric therapist or psychiatric specialist
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	The most appropriate treatment for your condition, managed through the BacktoBetter service

C. Additional benefits		At a network facility if we have a network for your symptoms or condition
Benefits	Amount payable	Notes
Home nursing	In full	Immediately following in-patient or day-patient treatment that is covered by the policy
Private ambulance	In full	Where medically necessary for transportation to the nearest available hospital for eligible treatment
Parent accommodation when staying with a child covered by the policy	In full	Child of 11 or under receiving treatment covered by the policy; one parent only
Hospice donation	£70 each day, up to 10 days	
Baby bonus	£100 for each baby	Payable to the group member
Limited emergency overseas cover	In full	Emergency treatment as an in-patient or day-patient during overseas trips of up to a maximum of 90 days in total each policy year
Treatment for complications of pregnancy and childbirth	In full	For the conditions specified in the policy wording. Subject to a 10 month qualifying period for FMU or Mori underwriting
Investigations into the causes of infertility	In full	Subject to a 2 year qualifying period, for FMU or Mori underwriting
Surgical procedures on the teeth performed in a hospital	In full	Specialists' fees are covered up to the limits in our fee schedule
GP helpline	Unlimited number of calls	
Stress counselling helpline	Unlimited number of calls	Available to members aged 16 and over

Policy options explained

Your company may have chosen to add any of the following options to your core cover on your Solutions policy.

To see if your company has added any of these options please refer to the options listed on within your insurance certificate.

Option 1: Mental health treatment

To complement the out-patient psychiatric benefit available under core cover, your company can choose to add in-patient and day-patient psychiatric treatment to your scheme. If they've added this option then you will also receive either 28 or 45 days combined in-patient and day-patient psychiatric treatment each member every policy year. This also includes benefit for specialists' fees for in-patient treatment of up to £210 each week.

We cover treatment that aims to lead to your full recovery. We do not cover chronic psychiatric conditions.

Option 2: Routine & GP referred services

This option has an overall benefit limit of £1,000 each member every policy year.

As with most health insurance policies, our core cover excludes long-term treatment for chronic conditions. However, with Solutions your company may have chosen to include cover for out-patient monitoring of chronic conditions. This means that you can undertake routine monitoring of these conditions, as long as they are not excluded under the policy, as shown within the what's not covered – summary section of this booklet.

In addition, we recognise that more and more people want to use complementary and alternative treatments and want to be able to access diagnostic services following a visit to their GP.

This option includes the following benefits up to a combined total of £1,000 each member every policy year:

- consultations with a fee approved specialist and tests, for chronic conditions and follow up consultations with a fee approved specialist to monitor you after you've finished treatment for an acute condition
- GP referred radiology/pathology for non-musculoskeletal conditions
- GP referred physiotherapy, chiropractic, osteopathy and acupuncture treatment for non-musculoskeletal conditions – up to 10 sessions in combined total each condition each member every policy year
- GP referred chiropody, podiatry and homeopathy for non-musculoskeletal conditions
- GP minor surgery – up to £100 each procedure (payable to the GP).

Option 3: Hospital lists

As part of your core cover you have access to our Key hospital list, this list gives you access to around 300 private hospitals across the UK. There are additional options that your company may have selected to either add more, or to remove hospitals from your cover. Your company may have added more hospitals by selecting:

- the Extended hospital list – which gives access to more hospitals, predominantly in the Greater London area.

However, your company may have decided that you didn't need to access all the hospitals within the Key hospital list so could have chosen one of the hospital lists below:

- the Signature hospital list – a great option for companies whose employees are solely based in Scotland or Northern Ireland, as this list excludes all hospitals in England and Wales from your cover.
- the Trust hospital list – an option that uses the excellent private patient units of NHS Trust and partnership hospitals.

Your insurance certificate will show which hospital list you're on and you can see what hospitals are included on your list and covered in your area at aviva.co.uk/hospital-list.

Remember that if you require treatment for a condition or suspected condition where we have a network, we'll tell you where you can have your treatment. Our networks may include hospitals that aren't on your hospital list.

Option 4: Dental & optical

Our core cover provides benefit for surgical procedures on the teeth performed in a hospital and ophthalmic procedures, however as with most health insurance policies, cover for routine dental treatment and optical expenses is excluded.

If your company has chosen the dental & optical option then you will receive the following benefits:

- £500 routine dental benefit, of which you pay £50 excess
- £600 accidental dental benefit
- £300 optical benefit, of which you pay £50 excess.

A £50 excess applies separately to both the routine dental benefit and optical benefits. This means that there will be a £50 excess applied to any dental claims and another £50 excess applied to any optical claims.

Option 5: Six week option

If your company has chosen the six week option, you will still have the benefit of prompt cover should a GP refer you to a fee approved specialist for a consultation. And, if subsequent eligible treatment as an out-patient is required, that is covered too, including out-patient treatment from BacktoBetter and out-patient treatment covered under the NHS cancer cash benefit.

The difference is that you will only be covered for in-patient or day-patient treatment if the wait for that treatment is longer than six weeks on the NHS. If the NHS waiting time for any in-patient or day-patient treatment is less than six weeks you will need to use NHS

facilities as a non-paying patient or self-fund any private treatment; you won't be able to claim for NHS cash benefit, NHS cancer cash benefit or the cost of an NHS amenity bed if your treatment is available on the NHS within six weeks from the date your specialist recommends it.

This option is usually taken so that you can avoid long NHS waiting lists as it means that the maximum amount of time you'll have to wait for an in-patient or day-patient procedure is six weeks.

Option 6: Member excess

Another option that your company may have chosen is a £50, £100, £150, £200, £250 or £500 member excess. We apply the excess once each member every policy year, irrespective of the number of claims that you make during that policy year.

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

If you claim for a benefit that has a limit, the excess will count towards the benefit limit. So if, for example, the treatment you were claiming for had a benefit limit of £1,500 and you have an excess of £250, you would have to pay the first £250 and we would only pay up to a further £1,250 for that benefit in that policy year.

Option 7: Selected benefit reduction

Your company may decide that they only require cover for in-patient, day-patient and out-patient costs and not the less essential extras.

If your policy includes the selected benefit reduction option, it means that you don't have cover for the costs associated with infertility, complications of pregnancy, surgical procedures on the teeth and limited emergency overseas cover.

Option 8: Reduced out-patient cover

Another option your company may have included on your policy is to reduce the out-patient cover it provides. This option limits out-patient diagnostics and treatment to £0, £1,000 or £1,500 each member every policy year – your insurance certificate will show which (if any) of these limits apply to your policy.

The following out-patient benefits will be taken out of your out-patient cover limit (if one applies on your policy):

- consultations with a fee approved specialist
- treatment by a specialist as an out-patient
- diagnostic tests
- treatment other than physiotherapy for pain in the back, neck, muscles or joints (musculoskeletal conditions) claimed through BacktoBetter
- specialist referred treatment by a physiotherapist, osteopath or chiropractor for any condition other than pain in the back, neck, muscles or joints
- psychiatric treatment on GP referral to a psychiatric therapist or psychiatric specialist.

As some out-patient diagnostics and treatment can be more expensive, it does however provide cover in full for CT, MRI and PET scans at a diagnostic centre that we

recognise, cancer treatment, radiotherapy and chemotherapy for pain in the back, neck, muscles or joints (musculoskeletal conditions) claimed through BacktoBetter.

In addition we will also cover any costs for pre-admission tests required within 14 days of admission to enable you to proceed into hospital for eligible in-patient or day-patient treatment.

This is a summary of the policy options. Full details of cover and exclusions are given in the policy wording, a copy of which is available on request from your group administrator. Non-standard terms may apply.

If you are unsure about the cover provided by your policy, or any of these options (and if they apply), speak with your group administrator or call the customer service helpline on **0800 158 3333.**

Underwriting

Your company will have chosen one, or more, of the following types of underwriting. You should refer to your insurance certificate to see which type of underwriting applies to you and any dependants included in your cover - your dependants may have different underwriting to you.

Full Medical Underwriting (FMU) – we ask you to fill in an application form detailing your past health. Pre-existing conditions and any related conditions are excluded unless we've agreed to accept them.

Continued Medical Exclusions (CME) – is used if your company has transferred from an existing fully medically underwritten insurance plan. The same personal medical exclusions (if any) that were applied to your previous policy will apply to this policy.

Moratorium (Mori) – we automatically exclude any disease, illness, injury or any related condition that you had symptoms of, medication for, diagnostic tests for, treatment for, or advice about, within five years before joining the policy. And, after joining the policy, where there has not been a clear two year period where you have been free of medication for, diagnostic tests for, treatment for, or advice about such a disease, illness, injury or related condition.

Continued Moratorium (CMori) – is used where a company transfers from an existing plan which is underwritten on a moratorium basis. Our moratorium wording applies with effect from each member's original moratorium start date.

Medical History Disregarded (MHD) – any pre-existing medical conditions are covered providing they fall within the terms and conditions of the policy.

Summary of cancer cover with **Solutions**

Our cancer pledge

We understand the importance of providing extensive cover and support at every stage of cancer treatment. Our cancer pledge means we'll cover the cancer treatment and palliative care you need, as recommended by your specialist.

We also want to make things as comfortable as possible for you following cancer treatment, so we'll provide extensive cover for aftercare, including consultations with a dietician, as well as money towards prostheses and wigs.

The following table provides a summary of the cancer cover available on Solutions. It doesn't contain the full standard terms and conditions. These are provided in the policy wording, which is available on request from your group administrator. Non-standard terms may apply.

If you have reduced out-patient cover, the monetary limit for out-patient treatment will not apply to cancer treatment received after you've been diagnosed with cancer.

In-patient and day-patient treatment is covered at a hospital on your hospital list unless we have a network in place for the treatment required, in which case we will tell you where you can have your treatment.

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

Summary of cancer cover with Solutions

This table provides a summary of the cancer cover available on Solutions.
Full terms and conditions are available on request.

Benefits	Amount payable
Hospital charges for surgery and medical admissions	✓
Specialists' fees	✓
NHS cancer cash benefit	£100 each day
Post surgery services	✓
Radiotherapy and chemotherapy	✓
Bone strengthening drugs (such as bisphosphonates)	✓
Treatment prescribed by a specialist for side effects while you're receiving chemotherapy or radiotherapy	✓
Wigs	Up to £100
External prostheses	Up to £5,000
Stem cell and bone marrow transplants	✓
Monitoring	Up to ten years
On-going needs, such as regular replacement of tubes or drains	Up to five years
Preventative treatment for cancer	
End of life care: • in a hospital if it is medically necessary • donation to a hospice • donation to a registered charity	 ✓ £100 each night, up to £10,000 £50 each day, up to £10,000

Notes
Covered at a facility recognised by us as part of a network, a hospital on the Key hospital list or an NHS hospital recognised by us
Up to the limits in our specialist fee schedule
We pay £100 a day for treatment received as an in-patient or day-patient, £100 for each day you receive out-patient radiotherapy, chemotherapy or blood transfusions or out-patient surgical procedures. £100 for each day you receive intravenous (IV) chemotherapy at home and £100 for each week you're taking oral chemotherapy at home. You won't be able to claim more than £100 in any one day
Includes specialist services immediately following surgery, such as consultations with a dietician or stoma nurse
We pay for bone strengthening drugs when they are being used to treat metastatic bone disease
We'll pay towards the cost of a wig if one is needed due to hair loss caused by cancer treatment. This is payable once each member, not every policy year
We'll pay towards the cost of the first external prosthesis following surgery for cancer
Includes collection, storage and implantation
Only if you've already had treatment for cancer that we've paid for. For example, we'll pay for a mastectomy to a healthy breast in the event that you've been diagnosed with cancer in the other breast
Each night you're admitted Each day that you're visited at home by one of the charities nurses

Networks

These are the specified group of facilities, specialists or other practitioners that we recognise to provide treatment for particular conditions or suspected conditions.
If we have an appropriate network for your condition or suspected condition, we'll tell you where you can have your treatment which may not be at a hospital on your chosen list. We will however only pay for that treatment if it is carried out within our networks. A list of the conditions or suspected conditions for which we have networks in place can be found at aviva.co.uk/health-network

BacktoBetter

If you experience back, neck, muscle or joint pain, our BacktoBetter service should be your first point of contact.

Solutions includes BacktoBetter, our musculoskeletal case management service, as standard for everyone covered on the policy, helping you get better and back to work quicker. BacktoBetter offers rapid access to a clinical case manager who can help you deal with the pain and disruption of a musculoskeletal injury.

There's no need to see your GP before accessing BacktoBetter

Clinical case managers will make sure you get the very best advice and organise any necessary treatment quickly.

Hospital lists

To find out which hospitals on your list are in your area, please visit: aviva.co.uk/hospital-list

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: phin.org.uk

NHS amenity beds

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

Calling us

For claims and enquiries, please call our customer service helpline on 0800 158 3333.

If you're calling with a question, you'll just need your policy number and company name. If you're phoning to make a claim, you'll also need:

- details of your condition, including symptoms, dates and diagnosis if known; and
- information about your consultation or treatment, including the place and date of any upcoming appointments and whether this will be as an in-patient, day-patient or out-patient.

Our helpline is open 8am – 8pm Monday to Friday, 8am – 1pm Saturday and calls may be recorded and/or monitored.

Types of referral

With Solutions we don't mind which type of referral you receive, you'll get great service either way. If a GP recommends that you need to see a specialist for further assessment or treatment, they will give you a referral. This may either be in the form of an open referral or a named referral.

- An open referral is where the GP just states which type of specialist you need to see or the type of treatment you need, without giving a specific named specialist.

  If you receive an open referral, our claims team will help you to find a specialist and hospital. In most cases, we'll connect you directly with the hospital to book your appointment over the phone.
- A named referral is where the GP recommends a particular specialist.

  If you receive a named referral, you'll need to call us to check whether we have a network for your condition or suspected condition. If we do, we'll tell you where you can have your treatment. If we don't have a network in place we'll check to make sure the specialist is recognised by us. However, even if your GP provides a named referral, we can still offer to find other suitable specialists when you call us, as this may provide more choice and convenience for your particular circumstance.

MyAviva – manage Aviva polices at the touch of a button

Because everything we do is full of good thinking for you, we created MyAviva. Our online platform will help you manage your Aviva policies in a secure and easy-to-use place – at a time that suits you. There's a whole host of benefits at your fingertips.

You can:

- check your policy information
- change your personal details
- track your policy limits and excess
- get access to useful online tools
- get a 20% discount for existing customers off selected new Aviva products
- download our smartphone app to view your policies on the go.

Your group administrator

Your group administrator is located within your company and is the main point of contact for your company's health insurance policy.

The group administrator knows about this policy and is responsible for your company's administration of the policy; they will also be able to advise you on the claims process.

If you have any queries about your cover, please speak to your group administrator who can help you. For certain queries they may refer you to the customer service helpline.

Summary of **what isn't covered**

Solutions doesn't cover you for:

- long term or chronic conditions (except as provided for under option 2 – 'Routine and GP referred services'). This exclusion does not apply to treatment for cancer
- treatment for pregnancy or childbirth although certain complications may be covered (as detailed in the policy wording) unless you have option 7 – 'Selected benefit reduction'
- infertility treatment (except as provided for under the benefit for investigations into the causes of infertility)
- HIV/AIDS and related conditions
- alcoholism, alcohol abuse, solvent abuse, drug abuse and other addictive conditions
- health hydros or similar establishments
- treatment undertaken without GP referral to a specialist (unless through BacktoBetter)
- any musculoskeletal treatment that has not been pre-authorised by us
- psychiatric or mental health illnesses as an in-patient or day-patient (except as provided for in option 1 – 'Mental health treatment')
- treatment by a GP (except as provided for in option 2 – 'Routine and GP referred services')
- kidney dialysis
- cosmetic treatment (except following an accident or surgery for cancer)
- take home drugs and dressings
- surgical or medical appliances such as neurostimulators (for example, cochlear implants) and crutches
- professional sports injuries
- experimental treatment (limited benefit may be available – please contact us)
- self-inflicted injury
- treatment required as a result of war, terrorism, contamination by radioactivity, biological or chemical agents
- routine medical examinations (except as provided for in option 4 – 'Dental and optical'), we don't apply this exclusion to routine monitoring for cancer where we have paid for your treatment for cancer
- treatment for psycho-geriatric conditions
- varicose veins of the leg, unless they meet the criteria detailed in the policy wording
- sleep disorders and sleep problems such as snoring and sleep apnoea
- sexual dysfunction
- treatment for warts, verrucas and skin tags
- treatment outside of networks (for any condition or suspected condition for which we have a network)
- weight loss surgery.

This is a summary of the policy exclusions. Full details of standard cover and exclusions are given in the policy wording, a copy of which is available from your group administrator. Non-standard terms may apply.

Chronic conditions explained

A chronic condition is a disease, illness or injury which 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.

Chronic psychiatric conditions explained

If your policy includes cover for psychiatric treatment, we cover treatment that aims to lead to your full recovery.

We do not cover:

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

We consider a psychiatric condition to be chronic if:

- it meets the definition of a chronic condition, or
- we have paid for treatment for that condition or a related psychiatric condition during three separate policy years. This will apply even if the treatment was not in consecutive policy years.

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

How to make a claim – **three simple steps**

When you feel unwell, the last thing you want to face is a difficult claims journey. So we've made ours as easy and as hassle free as possible.

BacktoBetter claims

For back, neck, muscle or joint pain (musculoskeletal conditions), the claims journey is even easier than the standard process – you don't even need to see your GP.

1. For musculoskeletal pain

There's no need to wait to see a GP.

Just contact the customer service helpline on 0800 158 3333 and describe your symptoms. Calls to and from Aviva may be monitored and/or recorded.

If you've already seen your GP, you can move to step 2 of the standard claim process if:

- your GP has recommended osteopathy or chiropractic treatment, or
- your condition does not relate to your back or neck (spine), and
- your GP has recommended radiology, pathology, or referral to a specialist.

Otherwise you can continue to follow the BacktoBetter pathway.

2. Telephone clinical assessment

Our advisers will assess your claim and, if eligible, they'll arrange for a clinical case manager from one of the independent clinical case management providers to contact you at a convenient time to assess your symptoms.

All other claims

For non-musculoskeletal claims you'll need to follow the standard claims process

1. Consult your GP

If you're unwell you'll need to see a GP, where you may be referred for further assessment or treatment. This could be an open referral or a named referral.

It's really important that you get in touch with us before attending any appointments so we can make sure your claim is covered under the terms and conditions of the policy before you incur any costs.

Before calling, please have the following information:

- your policy number and company name
- details of your condition, including symptoms, dates and diagnosis if known
- information about your consultation or treatment, including the place and date of any upcoming appointments and whether this will be as an in-patient, day-patient or out-patient.

2. Contact Aviva on 0800 158 3333

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

After you've been referred by your GP you'll need to call us to set up your claim.

If we have a network for the treatment you need, we'll let you know where you can have your treatment. Our network facilities may be different to the hospitals on your chosen hospital list.

If we don't have a network for your condition or suspected condition:

- and you've been given a named referral, we'll check to make sure the specialist is recognised by us, or
- you've been given an open referral, we'll use our specialist finder database to select an appropriate specialist and/or hospital for you.

3. Treatment

The clinical case manager will conduct a thorough assessment of your problem and recommend the most effective course of treatment. If clinically appropriate, this will include being referred to an approved physiotherapist from one of the clinical case management providers' networks for treatment within two working days and/or onward referral to a specialist.

The clinical case manager will provide advice to help you manage symptoms and pain, how best to remain active with a tailored home exercise programme and will monitor your progress throughout your claim.

3. Diagnosis, treatment or surgery

After you attend an appointment, your specialist may recommend hospital treatment – this is where you need to ask for a procedure code (CCSD code).

Once you've called us with these details, we can confirm whether or not the treatment is covered and provide information about where you can receive treatment, whether this is through our networks, at a hospital on your list or at other facilities recognised by us.

Payment of bills?

All eligible bills will be settled by us directly with the treatment provider. If you do receive a bill for your treatment, please send us a copy together with your policy number, so that we can arrange payment.

Please send this to:

Bill Payment Team
Aviva Health UK Limited
Chilworth House
Hampshire Corporate Park
Templars Way
Eastleigh
Hampshire
SO53 5RY

We'll contact you to advise if you need to pay any part of the bills – for example if you have an excess.

If you don't contact the customer service helpline and continue with any recommended diagnostics or treatment, you may have to pay the costs for these services if they aren't covered by your healthcare policy.

Your questions **answered**

Can the policy be cancelled?

Your company may cancel the policy by giving us the appropriate notice. If you have any queries, please contact your group administrator.

What's the duration of the policy?

Your company's private medical insurance policy is a one year contract.

What about tax?

Under current UK tax rules, the contribution that's paid to us for your inclusion on the policy arises from your employment and is therefore a taxable benefit. Please contact your group administrator if you require further information.

Are you covered by the Financial Services Compensation Scheme (FSCS)?

We are covered by the Financial Services Compensation Scheme (FSCS). If we cannot meet our obligations, the owner of the plan may be entitled to compensation under the scheme. For this type of plan, the scheme covers 90% of the total amount of the claim. For further information, see fscs.org.uk or telephone 0800 678 1100 or 020 7741 4100.

How do I make a complaint?

If you ever need to complain, you can contact us at:

Aviva Health UK Ltd
Complaints Department
PO Box 540
Eastleigh
SO50 0ET
Telephone: 0800 051 7501
E-mail: hcqs@aviva.com

If you are not satisfied with our response, you may be able to take your complaint to the Financial Ombudsman Service.

The Financial Ombudsman Service can look at most complaints and is free to use. You do not have to accept their decision and will still have the right to take legal action. Their contact details are:

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR
Telephone: 0800 023 4567
E-mail:
complaint.info@financial-ombudsman.org.uk
Website: financial-ombudsman.org.uk

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

How do you use my personal information?

We'll use the information you give us to:

- administer your policy and handle any claims
- help detect and prevent fraudulent activity.

Other companies from across the Aviva group, or third parties who provide services to us, in any country (including those outside the European Economic Area) could also use your information in this way. If they do, we'll make sure they agree to treat your information with the same level of protection as we would.

We may share your information with regulatory bodies, your employer, other insurers (directly or using shared databases), your insurance intermediary, or third parties providing services to them.

To keep our products and services competitive and suitable for customers' needs, we may also use your information for research and customer profiling.

From time to time, we may tell you about other products or services which may be of interest. If you don't want us to, please write to us at: Aviva, FREEPOST, Mailing Exclusion Team, Unit 5, Wanlip Road Industrial Estate, Wanlip Road, Syston, Leicester, LE7 1PD

Who can help me at work?

Your group administrator is located within your company and is the main point of contact for your company's health insurance policy.

If you have any queries about your cover, please speak to your group administrator. For certain queries they may refer you to our customer service helpline.

What if my personal details change?

Please advise your group administrator in writing immediately should any of your personal details change e.g. address, name, etc. If you have family cover and wish to add new dependants, for example, a newborn baby, please notify your group administrator.

Do I have cover overseas?

All policies that don't include Option 7: Selected benefit reduction, have limited emergency overseas cover as standard. This is available for a maximum of 90 days spent overseas on a temporary basis in any one policy year. The 90 days are accrued on a cumulative basis. If you are outside the UK for more than 90 days during any policy year the limited emergency overseas benefit is not available to you.

The policy covers treatment of emergency conditions that require immediate admission to hospital as an in-patient or day-patient, including patient evacuation to the nearest available facility.

It doesn't cover any treatment related to the intended purpose of the visit.

In an emergency – go immediately to the nearest physician or hospital. Then contact our emergency assistance provider on: +44 (0)2381 247290

Calls may be monitored and/or recorded

Please note this is not travel insurance. If you feel this level of cover isn't appropriate, you should consider taking out a travel insurance policy. Full details are given in the policy wording.

What happens if I leave?

If you leave your company, your cover will cease immediately. However, having been a member of an Aviva policy you're entitled to benefit from continued medical cover on an individual product without further medical underwriting. Benefits, exclusions, terms and conditions on an individual policy may be different to those on this policy.

If you'd like to discuss this further, please contact your group administrator or our sales advice line on: 0800 015 2470. Calls to and from Aviva may be monitored and/or recorded.

Please note that to qualify for continued cover you need to apply within 45 days from the date your cover ceases. If more than 45 days elapse you'll be required to complete a member health declaration which may affect your underwriting.

Useful contacts

Customer service helpline

0800 158 3333

8am - 8pm Monday to Friday

8am - 1pm Saturday

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

GP helpline

To talk to a qualified GP at any time, phone

0800 158 3112

Calls to the GP helpline may be recorded for quality and training purposes.

Stress counselling helpline

To talk to an experienced counsellor, phone

0800 158 3349

This benefit is available for members aged 16 and over.

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