Cover guide

Summary

Optimum Referral for Pearson Plc - Core Policy Number - 961BMD

This summary has been designed to provide you with the key information about the product and it is important that you read this section. The summary does not, however, contain the full standard terms and conditions that apply to the product. These are contained in the policy wording, a copy is available from your group administrator. Non-standard terms may apply.

What is covered

Benefit limits shown below apply per person per policy year and all treatment must be referred by, and under the care of, a specialist (see definitions in the policy wording under specialist) unless otherwise stated.

In-patient or day-patient treatment of acute conditions by the specialist and hospital selected by us

- Hospital accommodation charges
- Prescribed medicines, drugs and dressings
- Operating theatre fees
- Nursing care including intensive/high dependency care
- Specialists' fees including surgeons', anaesthetists' and physicians' fees
- Diagnostic tests, for example X-rays, CT, MRI and PET scans, blood tests and ECGs
- Radiotherapy and chemotherapy
- Treatment for pain in the back, neck, muscles or joints (musculoskeletal conditions) through the BacktoBetter service

Out-patient treatment of acute conditions by the specialist and hospital selected by us

- Radiotherapy/chemotherapy
- CT, MRI and PET scans at a diagnostic centre recognised by us
- Treatment for cancer (specialists' fees are covered up to the limits in our fee schedule)
- Physiotherapy for pain in your back, neck, muscles or joints (musculoskeletal conditions) - see member guide
- Pre-admission tests required within 14 days of an admission to check that you are fit to undergo surgery and anaesthesia

The following benefits are subject to an overall combined maximum of £2,000

- Consultations with a specialist (specialists fees are covered up to the limits in our fee schedule)
- Treatment by a specialist as an out-patient (including hospital fees and equipment charges.) Specialists fees are covered up to the limits in our fee schedule
- Charges for diagnostic tests, for example X-rays, blood tests and ECGs (specialists' fees are covered up to the limits in our fee schedule)
- Treatment (other than physiotherapy) for pain in your back, neck, muscles or joints (specialists' fees are covered up to the limits in our fee schedule). Osteopathy and chiropractics (if agreed) up to 10 sessions per condition, per person, per policy year (practitioner fees are covered up to the limits in our fee schedule)
- Physiotherapy, chiropractics, osteopathy and acupuncture for conditions other than pain in your back, neck, muscles or joints (if directly referred by your GP), up to 10 sessions in combined total, per condition, per person, per policy year (practitioner fees are covered up to the limits in our fee schedule)

Additional benefits

- Level 3 cancer benefit (please see attached leaflet for full details of your benefits)
- Nursing at home following eligible in-patient or day-patient treatment
- Private ambulance where medically necessary for transportation to the nearest available hospital in connection with eligible in-patient or day-patient treatment
- Parent accommodation costs when staying with a child of 11 or under receiving eligible treatment, one parent only
- Minor surgery by a GP up to £100 per procedure (payable to the GP)
- Hospice donation of £70 per day up to 10 days' care maximum; donation to the hospice
- Treatment for complications of pregnancy and childbirth as detailed in the policy wording
- NHS cash benefit of £100 per night where eligible NHS in-patient treatment takes place as an NHS patient without charge. Benefit is limited to 35 nights. Cash benefit is not payable where you have been admitted to an NHS hospital as a fee-paying patient of any kind, if you claim for the cost of an NHS amenity bed for the same treatment or for cancer treatment.
- Stress counselling helpline - available to members aged 16 and over
- Mental health benefits, through the mental health pathway, consisting of
  - In-patient and day-patient treatment up to 28 days per person per policy year
  - Out-patient treatment by a psychiatric specialist or psychiatric therapist
  - Mental health treatment is not available under any other benefit on this policy except for gender identity benefit. If private in-patient treatment is not available where the member lives, (such as the Channel Islands, Isle of Man, Isle of Wight or Northern Ireland), support will be provided by clinical transfer to a state in-patient facility in their local area
- The out-patient limit doesn't apply to treatment received through the mental health pathway or gender identity benefit
- Gender Identity benefit - see separate leaflet
- If you have family cover, your children can be covered up to 21 years of age or up to 24 years of age if in full time education.

Excess

An excess of £50 per person per policy year applies to all members. Benefits will only be paid once the excess amount has been exceeded and this should be settled directly with the relevant provider (for example the hospital or specialist). The excess does not apply to physiotherapy for pain in the back, neck, muscles or joints (musculoskeletal conditions) managed through BacktoBetter, to treatment received through the mental health pathway, to treatment for gender dysphoria received through the mental health provider or to out-patient therapy received under the Talking Through Cancer benefit.

The excess is applied on the date treatment takes place and not on the date we pay the bill. If you claim for a benefit that has a monetary limit, the excess amount will not contribute to the monetary limit.

Medical History Disregarded

This means that any pre-existing conditions you have will be covered providing they fall within the terms and conditions of the policy.

What isn't covered?

There are some things which aren't covered by your policy, so it's important that you speak to the customer service helpline before receiving any treatment. Some examples of what is not covered by the policy are:

- Long term or chronic conditions
- Treatment undertaken by a specialist without GP referral (except through BacktoBetter, the Mental Health Pathway or under the Gender Identity benefit)
- Seeing a GP privately
- Prescription charges
- Charges by a GP, medical practitioner or specialist for completion of a claim form if the claim is not covered by the policy
- Take home drugs and dressings
- Cosmetic treatment (except following an accident, or surgery for cancer)
- Routine medical examinations including eye tests, health screens etc
- Sports related treatment (if you are paid or personally funded/sponsored)
- Convalescence
- Experimental treatment (limited benefit may be available - please contact us)
- Incidental hospital expenses such as newspapers and telephone calls
- Varicose veins of the leg, unless they meet the criteria specified in the policy wording
- Surgical and medical appliances such as neurostimulators (for example cochlear implants) and crutches
- Kidney dialysis
- Self-inflicted injury
- Sleep disorders and sleep problems such as snoring and sleep apnoea
- Treatment for warts, verrucas and skin tags
- Weight loss surgery and non-surgical treatment such as injections, medications or drugs
- Any musculoskeletal, mental health or gender identity treatment that has not been pre-authorised by us
- Routine dental treatment
- Treatment for pregnancy and childbirth, but we do cover related conditions that can also be experienced outside of pregnancy and childbirth, and the specific complications detailed in the policy wording
- Alcoholism, alcohol misuse, solvent misuse, drug misuse and other addictive conditions
- Psychiatric, psycho-geriatric or mental health illnesses or conditions
- Overseas treatment
- Treatment required as a result of war, terrorism, or contamination by radioactivity, biological or chemical agents
- Treatment that is not by a specialist and hospital selected or authorised by us
- Treatment for lipoedema
- Treatment by providers (such as specialists, practitioners, hospitals and/or facilities) that are not recognised by us

Your questions answered

How to claim

Making a claim

Once your GP has recommended you see a specialist, all you need to do is call the customer service helpline on 0800 092 7774. Further details can be found in your member guide. Calls may be monitored and/or recorded

BacktoBetter and mental health claims

For back, neck, muscle or joint pain and for mental health claims, the claims journey is even easier than the standard process. You don’t need to see your GP, just contact the customer service helpline and describe your symptoms.
Further details can be found in your member guide.
Members aged 11 and under should obtain a GP referral and contact the customer service helpline.

For all other claims

For all other conditions you need to consult your GP. Once they've recommended you see a specialist, just call the customer service helpline. Further details can be found in your member guide.

Can the policy be cancelled?

The policy can only be terminated by the policyholder. There's no cooling off period.

Schedule 2
Optimum Referral Policy Wording

Cover and benefits - Medical Insurance

The purpose of this **policy** is to cover **you** during a **period of cover** for the **treatment** of **acute conditions** on a short-term basis. Except as otherwise stated all **treatment** must be by, and under the care of, **specialists** following an **open referral** from **your GP**.

If **your GP** decides **you** need to be referred for further tests or **treatment**, **you** must obtain an **open referral** and contact **us**. **We** will then locate a **specialist** and **hospital** for you. **Your policy** will only cover **treatment** undertaken by the **specialist** and **hospital** confirmed by **us**.

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

- covered under **your policy**, including facilities, services and equipment
- shown by current best available clinical evidence to improve **your** health outcome, at the time **your treatment** takes place
- appropriate for **your** individual care, including how it is carried out, how long it continues and how often it occurs
- carried out by a health care professional, such as a **specialist**, that **we** have confirmed is eligible to provide **your treatment**, before that **treatment** takes place
- carried out at a facility that **we** have confirmed is eligible to provide **your treatment**, before that **treatment** takes place
- undertaken because **you** need it for medical reasons.

An **acute condition** is defined as:
A disease, illness of 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.

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.

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

Benefits

Benefit under this **policy** is subject to an excess of £50 per **insured person** per one year **period of cover**. The does not apply to physiotherapy for pain in the back, neck, muscles or joints (musculoskeletal conditions) managed by **our** case management provider, to **treatment** received through the mental health pathway, to **treatment** for gender dysphoria received through the mental health provider or to **out-patient** therapy received under the Talking Through Cancer benefit managed by **our** mental health provider. Full details of how the excess is applied are given in Condition 6a. excess

Benefits available for **treatment** under this **policy**, subject to the benefit terms, 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** by the **specialist** and **hospital** confirmed by **us**. See benefit term 3		
i.	**Hospital** charges	In full	Including accommodation and meals, nursing care, drugs and surgical dressings and theatre fees. See benefit term 3
ii.	**Specialists'** fees	In full	
iii.	**Diagnostic tests**	In full	Including pathology, X-rays, physiological tests such as ECGs; CT, MRI and PET scans
iv.	Radiotherapy/chemotherapy	In full	
v.	**Treatment** for pain in **your** back, neck, muscles or joints – musculoskeletal conditions	In full	See benefit term 4

B.	**Out-patient treatment** by the **specialist** and **hospital** confirmed by us. See benefit term 3		
i.	CT, MRI and PET scans	In full	**Out-patient** CT, MRI or PET scans will only be covered at a **diagnostic centre**
ii.	Radiotherapy/chemotherapy	In full	
iii.	**Treatment** for **cancer**	In full	
iv.	**Treatment** by a **qualified physiotherapist** for pain in **your** back, neck, muscles or joints – musculoskeletal conditions	In full	See benefit term 4
v.	Pre-admission tests (tests carried out at **hospital** before **your** admission to check that **you** are fit to undergo surgery and anaesthesia. These can include ECGs, blood tests)	In full	**We** cover pre-admission tests that are carried out up to 14 days before **in-patient** or **day-patient treatment** that is covered by the **policy**
The following benefits are subject to an overall benefit limit of £2,000 per **insured person**, per one year **period of cover**			
vi.	Consultations with a **specialist**		
vii.	**Treatment** by a **specialist** as an **out-patient**		Including **hospital** fees and equipment charges.
viii.	**Diagnostic tests** including pathology, X-rays and physiological tests such as ECGs		
ix.	**Treatment** (other than physiotherapy) for pain in **your** back, neck, muscles or joints – musculoskeletal conditions		See benefit term 4.
x.	**Treatment** by a • **qualified physiotherapist** • **qualified chiropractor** • **qualified osteopath**, or • **qualified acupuncturist** on referral by **your GP** (for conditions other than pain in **your** back, neck, muscles or joints – musculoskeletal conditions)		Up to 10 sessions in combined total, per condition. This limit to be taken from the overall **out-patient** benefit limit of £2,000.

Additional benefits		Amount payable	Notes - see also benefit terms
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	See benefit term 6
E.	Parent accommodation when staying with a child covered by the **policy**	In full	Child aged 11 or under receiving eligible **treatment**; one parent only
F.	**Minor surgery** by a **GP**	Up to £100 per procedure	For procedures appearing on **our** minor surgery list; payable to the **GP**. For further details please see aviva.co.uk/gp-minor-surgery
G.	**Hospice** donation	£70 per day, up to 10 days	Donation to the **hospice**; see benefit term 7
H.	**Treatment** for complications of pregnancy and childbirth	In full	See benefit term 8
I.	NHS cash benefit	£100 per night	For each night spent undergoing eligible NHS **in-patient treatment**; up to 35 nights per **insured person** per one year **period of cover**; see benefit term 9
J.	Mental health benefit Mental health **treatment** as an **in-patient** or **day-patient** consisting of accommodation, nursing and **specialists'** fees Fees for mental health **out-patient treatment** such as counselling by a **psychiatric therapist** or psychiatric **specialist**	 Up to 28 days In full	As managed by **our** third-party mental health provider; see benefit term 10 Per **insured person** per one-year **period of cover.**

K.	Gender identity benefit		See benefit term 11
	Counselling by a **psychiatric therapist** for mental health conditions directly **related** to gender identity	In full	As managed by **our** third party mental health provider; see benefit term 10
	Assessment with a gender identity **specialist**	In full	
	Initiation and monitoring of hormone **treatment**	Up to two years	Per **insured person**
	Consultations with a hormone **specialist** if required to re-stabilise medication	In full	
	Female to male genital surgery	In full	On **specialist** referral
	Male to female genital surgery	In full	On **specialist** referral
	Mastectomy and creation of a male chest	In full	On **specialist** referral
	Breast augmentation and creation of a female chest	In full	On **specialist** referral
	Facial feminisation surgery	In full	Including Adam's Apple shaving
	Facial masculinisation surgery	In full	Including Adam's Apple enhancement
	Voice surgery	In full	
	Voice therapy	Up to 20 sessions	In total whilst **you** are an **insured person** of the **policy**
	Hair transplantation	Up to £30,000	In total whilst **you** are an **insured person** of the **policy**
	Hair removal	Up to £20,000	In total whilst **you** are an **insured person** of the **policy**
	Wig	Up to £100	In total whilst **you** are an **insured person** of the **policy**

L.	Family planning and fertility benefit consisting of: Fertility **treatment** Fertility preservation for **insured persons** where the **treatment** they are undergoing will detrimentally impact their future fertility Fertility advice and family building support	Up to £20,000	Per **insured person**, for the lifetime of the **policy**. See benefit term 12 Via our third party provider with no charge to **insured persons**
M.	Stress Counselling helpline	Unlimited number of calls	This service is available for **insured persons** aged 16 and over. See benefit term 13

The information on the cover and benefits pages must be read in conjunction with the definitions, benefit terms, conditions and 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**.

2. All costs for which benefit is claimed must:
   - be **medically necessary** and
   - unless otherwise specified in this **policy**, be wholly and exclusively for the purpose of **treatment** of **acute conditions** 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.

3. All **treatment** must be carried out by the **specialist** and **hospital** confirmed by **us**. If **you** receive **treatment** at a **hospital** or with a **specialist** that has not been confirmed by **us**, **we** will not pay that provider's fees.

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

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

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

4. Benefit A (v), B (iv) and B (ix) (**treatment** for pain in **your** back, neck, muscles or joints – musculoskeletal conditions).

Claims for musculoskeletal conditions are managed through **our** BacktoBetter service. Musculoskeletal conditions are:

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

in the back, neck, muscles or joints.

You do not need to see a **GP** before making a claim for a musculoskeletal condition. **You** should contact **us** before **treatment** begins and **our** third party clinical providers will arrange the most appropriate **treatment** for **your** condition.

Treatment may include, for example:

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

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

Please note:

- if **you** are referred to an **osteopath** or **chiropractor**, **we** will check that **you** have been referred to a practitioner recognised by **us**. If **you** receive **treatment** from an osteopath or chiropractor it will be limited to 10 sessions per condition per one year **period of cover**, fees will be paid in full.
- BacktoBetter is not a **network**. All **treatment** for musculoskeletal conditions must be managed and received through the BacktoBetter pathway.
- Physiotherapy for musculoskeletal conditions will not be subject to the excess,
- Physiotherapy for musculoskeletal conditions will not be subject to the **out-patient** benefit limit.

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

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

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 charges 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**. It must be needed for medical reasons and not to help with **your** mobility, personal care or preparation of meals.

6. Benefit D (private ambulance). **We** cover travel by a private ambulance to the nearest available facility if:
    - it is needed in connection with **treatmen**t as an **in-patient** or **day-patient** that is covered by **your policy**, and
    - **you** travel between **hospitals** as part of **your treatment** as an **in-patient** or **day-patient**, and
    - it is **medically necessary** for **you** to travel by ambulance.

7. Benefit G (**hospice** donation) 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 H (**treatment** for complications of pregnancy and childbirth) will only be available for **treatment** directly or indirectly arising from or recommended by **your specialist** in connection with the
following conditions once diagnosed:
    - ectopic pregnancy (development of foetus outside the womb)
    - miscarriage (if you have miscarried, but not investigations into the cause of miscarriage or **treatment** to prevent miscarriage)
    - still birth
    - hydatidiform mole (cell growth abnormality in the womb)
    - retained placenta (afterbirth retained in the womb)
    - eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
    - caesarean sections - in specific clinical circumstances (**we** require full clinical details from **your specialist** before **we** can make a decision about **your** cover).

9. Benefit I (NHS cash benefit) isn't available:
    - where **you** have been admitted to the **hospital** as a fee-paying patient of any kind, or
    - if **you** claim for the cost of an NHS amenity bed for the same **treatment**.
    - for **cancer treatment**

10. Benefit J (mental health benefit). **We** provide benefit for acute mental health conditions. This means **we** will pay for **treatment** which aims to lead to **your** full recovery.

    BUT:
    We do not cover
    - **treatment** that is given solely to alleviate symptoms, or
    - chronic mental health conditions.

    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 autism spectrum disorder.

    Under 12s
    Insured persons aged 11 or under will need to see a **GP** for a referral. **You** should then contact **us** with the details of the claim so that **we** can confirm that **we** will pay for that **treatment**.

    Insured persons aged 12 and over do not need to see a **GP** before making a claim for a mental health condition. **You** should call **us** before **treatment** begins and **our** third party mental health provider will arrange the most appropriate **treatment** for **your** condition. **Treatment** may include for example:
    - online CBT (Cognitive Behavioural Therapy)
    - remote talking therapies (telephone or video)
    - face-to-face **treatment**
    - psychiatrist/psychiatric **specialist** assessment and **treatment.**

Please note:

- if **you** do not provide 24 hours' notice for cancellation of an appointment, or do not attend a scheduled appointment, **you** will be charged a cancellation fee
- if private mental health **in-patient** facilities are not available where the **insured person** lives (such as the Channel Islands, Isle of Man, Isle of Wight or Northern Ireland) support will be provided by clinical transfer to a state **in-patient** facility in their local area.
- the excess does not apply to **treatment** received through the mental health pathway
- the out-patient limit does not apply to **treatment** received through the mental health pathway

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

Mental health **treatment** is not available under any other benefit on this **policy** apart from gender identity benefit or the Talking Through Cancer benefit.

11. Benefit K (Gender identity benefit). Gender identity benefit provides cover for the **treatment** of gender dysphoria. Gender dysphoria is a sense of unease where a person experiences discomfort or distress because there's a mismatch between the sex assigned to them at birth and the gender with which they identify.

You do not need to see a **GP** before making a claim for gender dysphoria, just contact **us** before **treatment** begins.

Counselling by a **psychiatric therapist** is available to **insured persons** aged 12 and over. All other **treatment** is only available to **insured persons** aged 18 and over, except the wig benefit which has no minimum age requirements and must be carried out by a **specialist** at a **hospital** that **we** recognise unless otherwise stated.

Counselling

To make a claim for counselling, call **us** before **treatment** begins and **our** third party mental health provider will arrange the most appropriate **treatment** for **your** condition. **Treatment** may include for example:

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

We provide benefit for acute mental health conditions. This means **we** will pay for **treatment** which aims to lead to **your** full recovery.

BUT:
We do not cover

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

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

Assessment and initiation of hormone treatment

To make a claim for assessment with a gender identity specialist, call **us** before **treatment** begins. **We** will cover the initial assessment with a Health and Care Professions Council (HCPC) and General Medical Council (GMC) registered clinician and, if clinically appropriate, a consultation to initiate hormone **treatment** with a GMC registered clinician.

We will cover the cost of consultations to monitor **you** while taking hormone **treatment** for up to two years. During hormone **treatment**, regular blood tests will be required which can usually be obtained through **your GP**. If **you** cannot obtain blood tests through **your GP**, **we** will cover the cost during the two year period. **We** do not cover the cost of the hormones themselves; these will be issued by prescription via **your** NHS **GP**.

We will also cover the cost of consultations with a GMC registered clinician if required to re-stabilise medication, for example before and after surgery.

Genital surgery

We also cover hair removal from a donor site, which is necessary to facilitate the genital surgery.

Voice therapy

Voice therapy must be carried out by a HCPC registered speech and language therapist

Hair transplantation

Hair transplantation must be carried out by a GMC registered surgeon and at a facility registered with one of the following UK regulators:

- Care Quality Commission (England)
- Healthcare Improvement Scotland (Scotland)
- Healthcare Inspectorate Wales (Wales)
- Regulation and Quality Improvement Authority (Northern Ireland)

Hair removal

We cover hair removal by laser or electrolysis.
Hair removal by laser must be carried out by a specialist recognised by **us**, or a clinician registered with the Joint Council for Cosmetic Practitioners, Save Face, or British College of Aesthetic Medicine.

Hair removal by electrolysis must be carried out by a **specialis**t recognised by **us**, or a clinician registered with the British Institute & Association of Electrolysis.

Please note:

- **we** do not cover any other **treatment** related to gender dysphoria
- **we** do not cover reversal of any previous gender affirmation surgery
- **treatment** related to gender dysphoria will not be covered under any other benefits on this **policy.**
- the out-patient limit does not apply to **treatment** for gender dysphoria
- the excess does not apply to **treatment** for gender dysphoria received through the third party mental health provider

12. Benefit L (Family planning and fertility benefit) is covered up to £20,000 per **insured person** for the lifetime of the **policy**. Benefit is available for **insured persons** who satisfy one of the following criteria:

- they have received a confirmed diagnosis of specific reproductive pathology,
- in the absence of known reproductive pathology, they are unable to conceive naturally through regular sexual intercourse for a period of 2 years,
- in the absence of known reproductive pathology, where attempting to conceive by regular sexual intercourse is not possible (for example for same sex couples, single women, people with a physical disability or people with psychosexual disorders).

Fertility preservation (for example egg or sperm freezing) is available for **insured persons** where **treatment** they are undergoing will detrimentally impact their future fertility. This includes annual storage costs to support fertility preservation while the **insured person** is a member of the **policy**, to be taken from the overall benefit limit.

We will pay for fertility **treatment** and fertility preservation if the **insured person** uses a clinic licensed by the Human Fertilisation and Embryology Authority. **Treatment** is only available on a reimbursement basis. **Insured persons** must pay for their **treatment** and **we** will reimburse the costs that the **policy** covers. **Insured persons** will need to send **us** receipts for any **treatment** they claim for.

We will only pay for pre-implantation genetic testing where there is clear evidence of a serious inherited disease in the family, it is being undertaken in accordance with HFEA guidelines and is being undertaken as part of eligible treatment.

We do not pay for:

- surrogacy or associated costs
- egg, embryo or sperm freezing if it is not either part of the **insured person's** current course of IVF or available under the fertility preservation benefit
- complementary therapies
- reversal of voluntary sterilisation or **treatment** required in connection with voluntary sterilisation

Sometimes clinics may offer optional add-on **treatments**, on top of the standard fertility **treatment**. **We** will assess the use of any add-on **treatments** to ensure their effectiveness and clinical appropriateness before **we** will pay benefit.

Fertility advice and family forming support is available through our independent provider's app, with no charge to **insured persons**. When an **insured person** contacts us with an eligible claim, our claims team will provide information on how to download the app and register. The service provides clinically led fertility support, as well as advice and support around family forming. The **insured person** has access to an initial video call with a fertility patient care advisor, followed by in-app messaging support 5 days a week. If recommended by the fertility patient care advisor, the **insured person** also has access to a remote consultation with a fertility nurse or doctor.

13. Benefit M (Stress Counselling helpline). The Stress Counselling helpline aims to give such practical 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.

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.

Call charges are the responsibility of the caller.

Benefits for cancer treatment – Level 3

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

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

Out-patient, day-patient and **in-patient treatment** by the **specialist** and **hospital** confirmed by **us**.

Benefits	Amount payable	Notes
Hospital charges for surgery and medical admissions	In full	Including accommodation and meals, nursing care, drugs and surgical dressings and theatre fees. See benefit term C1
Specialists' fees	In full	
NHS cancer cash benefit for **cancer treatment**	£100 each day	See benefit term C2
Post-surgery services		For example, specialist nursing, feeding. See benefit term C3 for details of services that the **policy** will pay for
Chemotherapy	In full	See benefit term C4
Radiotherapy	In full	
Hormone therapy	In full	See benefit term C5
Treatment for side effects of **chemotherapy** and radiotherapy	In full	See benefit term C6
Stem cell and bone marrow transplants	In full	See benefit term C7
Targeted therapies being used to achieve a cure	In full	
Targeted therapies, **treatments** and drugs used to maintain and control metastatic disease	In full	
Bone strengthening drugs (such as bisphosphonates)	In full	
Wig	Up to £100	In total whilst **you** are an **insured person** of the **policy** (not per one year **period of cover**). See benefit term C8
Mastectomy bra	Up to £100	In total whilst **you** are an **insured person** of the **policy** (not per one year **period of cover**). See benefit term C9
External prostheses	Up to £5,000	See benefit term C10
Genetic testing to support **treatment**	In full	See benefit term C11
Molecular profiling	In full	See benefit term C12

Talking Through Cancer	In full	See benefit term C13
Monitoring	In full	See benefit term C14
Ongoing needs	Up to five years	See benefit term C15
Preventative **treatment** for **cancer**		See benefit term C1
End of life care		See benefit term C16

Benefit terms

C1. Preventative treatment

We will pay for surgery to prevent further **cancer** only if **you** have already had **treatment** for **cancer** and the **treatment** took place when you were covered under the **policy** and there has been no break in cover since then (unless your underwriting provides cover for pre-existing conditions) – for example, **we** will pay for a mastectomy to a healthy breast if **you** have been diagnosed with **cancer** in the other breast.

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

C2. NHS cancer cash benefit

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

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

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

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

We will pay £100 for each day **you**:

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

We will pay £100 for:

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

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

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

NHS cancer cash benefit for **cancer treatment** is not available if **you** claim for the cost of an NHS amenity bed for the same **treatment**.

C3. Post-surgery services

Medical services

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

- **dietician** to stabilise **your** diet following surgery or **chemotherapy**
- stoma **nurse** to show **you** how to care for **your** stoma
- **nurse** to show **you** how to manage lymphoedema.

Artificial feeding

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

C4. Chemotherapy

We will pay for **chemotherapy** in full if the **treatment** is carried out:

- by the **specialist** and **hospital** confirmed by **us**, or
- at home.

C5. Hormone therapy

We will pay for hormone therapy:

- if **you** need it to shrink a tumour before **you** have surgery or radiotherapy, or
- where it is available under **specialist** use and only within the licensing indications in the **UK**.

We will pay for hormone therapy in full if the **treatment** is carried out:

- by the **specialist** and **hospital** confirmed by us, or
- at home.

We do not pay for:

- hormones given to prevent recurrence of disease unless they're only available under **specialist** use and only within the licensing indications in the **UK**.

C6. Side effects

Whilst **you** are receiving **chemotherapy**, radiotherapy or targeted therapy **we** will pay for **treatment** prescribed by **your specialist** that **you** need to deal with their side effects, for example:

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

C7. Stem cell transplants

We will pay for:

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

stem cells and bone marrow if **you** have this **treatment** by the **specialist** and **hospital** confirmed by **us**.

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

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

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

C8. Wig

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

C9. Mastectomy bra

We will pay up to £100 towards the cost of a mastectomy bra if **you** need one because of **cancer treatment**.

C10. Prostheses

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

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

C11. Genetic testing

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

BUT: **We** will not pay for genetic testing carried out:

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

C12. Molecular profiling

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

C13. Talking Through Cancer

We provide a mental health assessment and therapy benefit for an **insured person** who is diagnosed with **cancer** and is receiving **treatment** that would be covered by the **policy**.

Insured persons do not need to see a **GP** before making a claim. **You** should call **us** and **we** will pass **you** to **our** third party mental health provider who will arrange the most appropriate **out-patient** therapy for **your** needs.

Therapy may include for example:

- online CBT (Cognitive Behavioural Therapy)
- remote talking therapies (telephone or video)
- face-to-face counselling or therapy
- face-to-face CBT (Cognitive Behavioural Therapy)
- play therapy

Please note:

- if **you** don't provide 24 hours' notice for cancellation of an appointment, or don't attend a scheduled appointment, **you** will be charged a cancellation fee
- therapy for children, aged 11 or under, isn't available in the Channel Islands, Isle of Wight, Isle of Man or Northern Ireland. If **you** choose to have therapy in mainland **UK**, **we** won't pay any travel or accommodation costs
- if an excess applies to the **policy**, it won't apply to the Talking Through Cancer benefit
- if an **out-patient** limit applies to the policy it won't apply to the Talking Through Cancer benefit
- this benefit is available for **insured persons** aged five and over.

Support Circle

The **insured person,** diagnosed with **cancer,** can nominate up to four additional people to be part of their support circle. Benefit for the support circle is available for the **insured person** from the point of their **cancer** diagnosis and whilst they are receiving or waiting for **treatment** for **cancer**. Referral will be made by **our** third party mental health provider if clinically appropriate.

If the **insured person** is 18 and over, they can include their child/children/stepchildren and/or any other adults. If the **insured person** claiming for **cancer** is a child, they can include their sibling(s) or any adult over the age of 18. Members of a support circle do not need to be insured members on the **policy** but must be resident in the **UK**.

Our provider will arrange the most appropriate **out-patient** therapy for **your** needs.

Therapy may include for example:

- family therapy

Please note:

- **you** should contact **us** before the date of **your** last active t**reatmen**t for **cancer** to claim for this benefit family therapy must consist of at least one adult (either the **insured person** with **cancer** or a nominated adult) and a minimum of two children under the age of 18 (if there is only 1 child an alternative therapy will be offered as clinically appropriate)
- family therapy is not available in the Channel Islands, Isle of Wight, Isle of Man or Northern Ireland for children under the age of 16. If **you** choose to have therapy in mainland **UK**, **we** will not pay any travel or accommodation costs
- this benefit is available for **insured persons** aged five and over.

The Talking Through Cancer benefit will not be available for an **insured person** or nominated person who is already receiving mental health **treatment** or for whom **our** provider deems this benefit would not be clinically appropriate.

C14. Monitoring

We will pay for monitoring in full after **your treatment** for **cancer** has finished. This includes **diagnostic tests** and consultations.

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

C15. Ongoing needs

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

C16. End of life care

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

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

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

Exclusions from cover

Benefits will not be available for:

1. **Treatment**

a. subject to the underwriting of this **policy**. This **policy** has been written on a Medical History Disregarded (MHD) basis. This means that any pre-existing conditions **you** have will be covered provided they are within the terms and conditions of the **policy**;

b. of any condition that is a **chronic condition**.

In particular:

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

BUT:

- **We** do cover unexpected acute flare-ups of a **chronic condition** until **your** condition is re-stabilised (this does not apply to chronic mental health conditions, please see Benefit term 10 mental health benefit for further information);
- **We** do not apply this **chronic condition** exclusion to **treatment** for **cancer**. **We** will apply this exclusion to consequences of, or conditions **related** to, **cancer treatment**;

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

- pregnancy or childbirth (other than for complications and **related** conditions that can also be experienced outside of pregnancy and childbirth)
- male and female birth control
- termination of pregnancy

d. for alcoholism, alcohol misuse, solvent misuse, drug misuse or addictive conditions of any kind and **treatment** of any illness or injury arising directly or indirectly from any such misuse or addiction;

e. received in health hydros, nature cure clinics or similar establishments, or private beds registered as a nursing home attached to such establishments;

f. by a **specialist** without a referral from **your GP** except for **treatment** as specified under the BacktoBetter benefit, the mental health benefit, the gender identity benefit or **treatment** of **acute conditions** in an emergency but only if **your GP** is kept fully informed of the **treatment** so that they are able to support a claim for benefit;

g. of psycho-geriatric conditions of any kind;

h. of myopia or hyperopia, such as laser eyesight correction surgery;

i. directly or indirectly related to sleep disorders and sleep problems, such as snoring, insomnia or sleep apnoea (when breathing stops temporarily during sleep);

j. of warts, verrucas or skin tags;

k. that is directly or indirectly related to:
- bariatric surgery (weight loss surgery), such as gastric banding or a gastric bypass and non-surgical **treatment** such as injections, medications or drugs, or
- the removal of surplus or fat tissue;

l. of varicose veins of the leg.

BUT: **We** will cover **treatment** when the varicose veins are greater than 3mm in diameter, and any of the following also applies:
- there is established lipodermatosclerosis or progressive skin changes
- there have been recurrent episodes of superficial thrombophlebitis
- there is active or healed venous ulceration.

We will need to contact **your GP** or **specialist** for details of **your** condition before **we** can confirm **your** claim;

m. of lipoedema (the abnormal build-up of fat cells usually in the legs, thighs, buttocks and arms);

n. for back, neck, muscle or joint pain (musculoskeletal conditions) or **treatment** through Talking Through Cancer that has not been pre-authorised by **us**;

o. by a **specialist** or **hospital** that has not been confirmed by **us.** If **you** receive **treatment** at a **hospital** or with a **specialist** that has not been confirmed by **us**, **we** will not pay that provider's fees.

2. Supportive **treatment** of renal failure including dialysis. However, **we** will pay for the cost of renal dialysis incurred:
- immediately pre- and post-operatively during any kidney transplant or attempted transplant
- in connection with acute secondary failure when the dialysis is part of intensive care, or
- if **you** are admitted to **hospital** for eligible **treatment** as an **in-patient** for another condition and **you** need **your** regular kidney dialysis during this admission.

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

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

BUT: **We** will cover a surgical procedure to restore **your** appearance if:
- the surgical procedure immediately follows an accident or **treatment** for **cancer**, and
- the accident or **cancer treatment** took place when **you** were covered under the **policy** and **you** have had no break in cover since then (unless **your** underwriting provides cover for pre-existing conditions).

If **you** have an implant or implants following **treatment** for **cancer we** will pay for the removal and replacement of the implant or implants at the end of their lifespan providing **you** were covered under the **policy** when the **cancer treatment** took place and **you** have had no break in cover since then (unless **your** underwriting provides cover for pre-existing conditions).

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

4. Drugs or dressings for **you** to take home from **hospital** or any prescriptions charges.

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

5. **Treatment** provided by a **GP** (other than **minor surgery**). **Treatment** or **diagnostic tests** requested by a **GP**, such as X-rays, blood tests and scans (unless covered under the BacktoBetter benefit and benefit B(x)) or **GP** charges or fees, including those for completing a claim form if the claim is not covered by the **policy.**

6. Routine medical examinations (such as sight tests) medical screening, health check-ups or vaccinations. If **we** have paid for **you** to have **treatment** for **cancer**, this exclusion will not apply with regard to molecular profiling used to determine **your cancer treatment** or to routine medical examinations needed as part of **your cancer treatment**.

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

8. 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 a prosthesis inserted into the body during the course of a surgical procedure and external prostheses following surgery for **cancer**, see benefit term C10).

9. **Treatment** of an injury sustained whilst **you** are training for or taking part in sport for which **you** are:
   - paid
   - personally funded by sponsorship or grant (including equipment and any kit).

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

10. **Treatment** directly or indirectly required as a result of:
    - war (declared or not), military, paramilitary or terrorist activity (including the effects of radiological, biological or chemical agents)
    - use, misuse, escape or explosion of any gas or hazardous substance (including explosives or radiological, biological or chemical agents).

11. Experimental **treatment**, unless it meets the criteria set out below:

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

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

or

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

or

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

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

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

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

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

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

13. **Treatment** of sexual dysfunction such as impotence.

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

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

15. Any dental **treatment** including:

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

BUT: **We** do cover an oral surgical procedure on the teeth performed in a **hospital**.

16. **Treatment**, or any consequence of **treatment**, to remove undiseased tissue.

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

17. **Treatment** outside the **UK**.

Conditions – Medical Insurance

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. Eligibility requirements and change of risk

Each **member** must be a **UK resident** for the duration of the **period of cover**. They must notify **us** as soon as possible if:

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

If either of these things do change, this constitutes a **change of risk** and **we** may cancel cover for that **insured person**. **Insured persons** must be enrolled under a **UK** residential address, which **we** are able to verify.

The **policyholder** must inform **us**, as soon as possible of any **change of risk**.

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

3. Policy duration and premiums

a. This **policy** shall be for one year. Renewal requires the agreement of both parties, and terms may differ.

b. The **policyholder** shall be responsible for paying the premium for all **insured persons** and shall be prohibited from recovering any part of the premium relating to **group members** from those **group members**.

c. All premiums should be paid for by the **policyholder**/company itself, from a **UK** business bank account. **We** may ask for proof of account status such as a copy of the business bank statement.

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

4. Children

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

5. Cancellation

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

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

a. When **we** may cancel the **policy**:
If the **policyholder** has failed to provide complete and accurate information to **us** (see Important note above) then, depending on the nature of that failure:

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

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

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

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

In addition:

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

If **we** cancel the **policy** or any **insured person's** cover for these reasons, **we** will notify the **policyholder** (and the relevant **insured person**) in writing by post to the **policyholder's** (and the relevant **insured person's**) last known address or to the email address we have on record.

b. If any premium is not paid, the **policy** will automatically be cancelled. **We** will reinstate the cover if the premium is paid within 30 days of its due date subject to claims experience and underwriters' approval.

c. **We** will not cancel the **policy** because of eligible claims made by any **insured person**.

d. This **policy** will be cancelled automatically upon the termination of the **agreement** for any reason.

e. 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**.

f. The **policyholder** must, as soon as 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.

6. Claims procedure

a. As an excess applies to this policy, payment of the benefit 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 annual period of cover exceeds the amount of the excess. The excess does not apply to physiotherapy for pain in the back, neck, muscles or joints (musculoskeletal conditions) managed by our case management provider, to treatment received through the mental health pathway, to treatment for gender dysphoria received through the mental health provider or to out-patient therapy received under the Talking Through Cancer benefit managed by our mental health provider.

The excess is applied once per person for each **period of cover**. This means that where the total expenditure for **treatment** continues from one **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 should settle the excess amount directly with the relevant provider (e.g. **hospital** or **specialist)** and not with **us**.

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

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

b. The **policy** covers **treatment** carried out by a **specialist** and **hospital** confirmed by **us**.

Unless otherwise stated, **insured persons** should always follow the **open referral** claim process detailed in this section. Any **treatment** with a **specialist** or **hospital** that has not been confirmed by **us** will not be covered by the **policy**.

If **your GP** decides **you** need to be referred for tests or **treatment**, **you** must obtain an **open referral** and contact **us**. **We** will then locate a **specialist** and **hospital** for eligible **treatment**. **You** must also obtain an **open referral** if **you** are referred for further tests or **treatment** following NHS **treatment**. This includes **treatment** at an accident & emergency department.

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

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

If **you** have received **treatment** and are discharged from the **specialist's** care but need further **treatment** for the same condition within three months of **your** discharge, the **policy** will cover further eligible **treatment** with the same **specialist**.

If **you** have been discharged from the **specialist's** care but need further **treatment** for the same condition more than three months after **your** discharge, **you** must obtain an **open referral** from **your GP** and **we** will confirm the **specialist** that the **policy** will cover.

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

To confirm cover before claiming **we** must receive all necessary medical information at least 5 working days prior to any proposed **treatment**. This may include a completed claim form but **we** may be able to take the necessary information over the telephone; if this is the case **we** will tell **you** at the time.

c. Most **hospitals** operate direct billing arrangements with **us**. This means that accounts for **in-patient treatment** or **day-patient treatment** covered under this **policy** will be settled directly with **us**. Direct billing may not be possible at all **hospitals** and in any event will not normally be possible for accounts for **out-patient treatment**. 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.

d. All documents or material (including but not limited to accounts, certificates and X-rays) that **we** require to support a claim shall be provided without expense to **us** (including if requested by **us** a medical report from **your GP** or **specialist**).

e. Claims may only be made for **treatment** given 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**..

f. Where **treatment** continues over an extended period of time updated claim information may be required at regular intervals, which may include a claim form.

g. **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

7. Claims - our rights

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

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

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

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

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

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

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

We cannot offer an **insured person** legal advice.

8. Distribution of information to group members

The **policyholder** must distribute to each **group member** on joining the **group** the member guide (including its 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.

9. Other insurance

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

10. Alterations

We may alter any of the terms of this **policy** at any **review** d**ate**. A copy of the current **policy** terms will be sent to the **policyholder** at such time.

11. Records

We are entitled to inspect the **policyholder** records relating to the **policy** at any time if **we** give reasonable notice.

12. 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.

13. Waiver

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

14. 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.

Payments for ineligible treatment

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

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

15. Jurisdiction

This contract 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.

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

16. Enforcement

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

17. Language

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

18. Corporate Responsibility

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

SCHEDULE 3

SPECIAL CONDITIONS

1. **Group members** and **eligible dependants** who no longer meet the eligibility requirements of the **policy** will be entitled to transfer to an individual policy nominated by **us** with no further personal medical exclusions being applied.

   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** apply for another policy within 45 days of **your** cover on this **policy** ending.

Definitions – Medical Insurance

To avoid repetition, the following words or expressions, if 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**. **Your policy** may not include all of the words and expressions listed here.

Accident or emergency admission

An admission to:

- **hospital** directly following an accident
- a **hospital** ward directly from the emergency department for urgent or unplanned **treatment**, or
- a **hospital** ward on the same day as a referral for **treatment** is made either by a **GP** or **specialist**,

when immediate **treatment** or **diagnostic tests** are **medically necessary**.

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.

Advice

Any

- consultation,
- advice or
- prescription.

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.

Agreement

The agreement between **us** and the **policyholder** including details of (amongst other things) eligibility criteria for inclusion in the **group**, level(s) of cover and details of financial, administration and service arrangements which apply between **us** and the **policyholder**.

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**.

Cancer

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

Change of risk
An event or circumstance which **we** determine affects or is likely to affect the risk profile of the **policy**, including but not limited to:

- changes to the **policyholder,** for example a change of company name, trading status, business activity, company structure, company number, or any liquidation, insolvency or bankruptcy procedures
- an **insured person** no longer having the lawful right to reside in the **UK** or the intention to do so for the duration of the **period of cover**
- any other changes relating to **insured persons** (such as change of name, address, occupation or marital status), or
- other changes which affect information given in connection with the application for cover under this **policy**.

Chemotherapy
Drugs that are used to treat **cancer**. These include drugs used to destroy cancer cells or prevent tumours from growing (e.g., cytotoxic drugs).

For this **policy**, hormone therapy and targeted therapy are not chemotherapy.

Chronic condition
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.

Commencement date
The date shown in the **agreement** on which cover for the **group** commences under this **policy**.

Date of entry
The date on which **you** were included in the **group**. This will be shown in the **policy schedule** (if issued).

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

Diagnostic centre
A **hospital** or facility recognised by **us** to carry out a CT, MRI or PET scan.

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

Dietician
A practitioner who is:

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

Eligible dependant(s)
A group member's

- spouse, civil partner or partner and/or
- children under 21 years of age (or 24 years of age if in full time education) who are included in the **group** pursuant to the **agreement.**

Children cannot remain as **eligible dependants** after the first **review date** following their 21st birthday or, if they remain in full-time education, their 24th birthday. The **group member** must tell us if a child is in full-time education after their 24th birthday.

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

Group
All **insured persons** covered under the **policy** pursuant to the **agreement**.

Group member(s)
An employee or former employee (as applicable) of the **policyholder** who is designated as being eligible for inclusion in the **group** in accordance with the terms of the **agreement**.

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

Hospital
The hospital or facility that **we** confirm is eligible for **your treatment** before **your treatment** goes ahead.

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**.

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

Minor surgery
A surgical procedure appearing on **our GP** minor surgery list published by **us**. Details are available on request.

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

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

An open referral should include:
- **your** medical condition/symptoms
- the specialism and sub-specialism of consultant that **you** need to see.

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 **agreement** 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 dependants**. The **application, agreement** and **policy schedules** (if applicable) all form part of the contract and must be read together with these policy terms (as amended from time to time).

Policyholder
The company or business (must be actively trading in the **UK**) which enters into the **agreement** with **us**.

Policy schedule
The schedule addressed to each **group member** giving details of (amongst others) the **date of entry**, **policyholder** and **insured persons** and personal medical exclusions (if any).

A policy schedule will usually only be issued if **your** membership is medically underwritten.

Pre-existing condition
Any disease, illness or injury for which:
- **you** have received medication, **advice, diagnostic tests** or **treatment**, or
- **you** have experienced symptoms,

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

Psychiatric therapist
A practitioner who is:
- employed to provide therapy sessions at a psychiatric **hospital**, or
- a fully qualified and accredited member of any counselling register overseen by the Professional Standards Authority (PSA).

and who is recognised by **us**.

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**

or

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

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

Qualified chiropractor
A practitioner who is:
- included in the Register of Chiropractors kept by the General Chiropractic Council, and
- and who is recognised by **us**.

Qualified homeopath
A practitioner who is:
- a member of the UK Homeopathic Medical Association (UKHMA)
- a member of the Society of Homeopaths
- a member of the Alliance of Registered Homeopaths (MARH)
- a member of the Faculty of Homeopathy (MFHOM), or

a Fellow of the Faculty of Homeopathy (FFHOM).

Qualified osteopath
A practitioner who is:
- included in the Register of Osteopaths kept by the General Osteopathic Council, and
- who is recognised by **us**.

Qualified physiotherapist
A practitioner who is
- included in the register of the Health and Care 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**.

Renewal date / 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, fixed bridges extractions and surgery. **We** do not pay for removable bridges, dentures or contract schemes (for example monthly dental plans)

Speech therapist
A practitioner who is:

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

Specialist
A registered medical practitioner who:

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

and who **we** confirm is eligible for cover before **your treatment** goes ahead.

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

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

UK resident

- having the legal right to reside in the **UK** (i.e., holding UK citizenship or an appropriate visa) for the duration of the **period of cover**; and
- physically living in the **UK** for the duration of the **period of cover** (other than for trips abroad totalling no more than 3 months during the **period of cover**).

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