Solutions – Pre-renewal brochure

Flexible private medical insurance for small and medium sized companies, covering 2-99 employees

Retirement
Investments
Insurance
Health

AVIVA

Your Solutions policy has come up for renewal

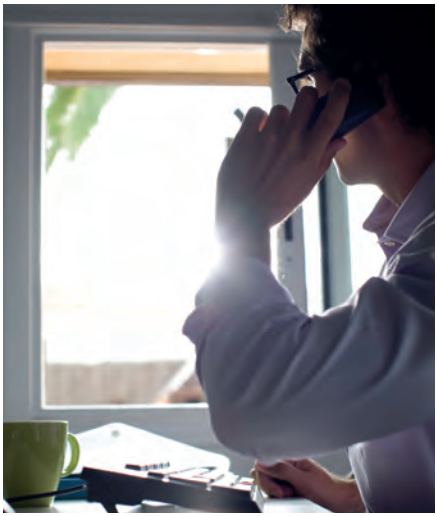
Solutions is our private medical insurance that's flexible enough to suit your business and helps you care for your employees.

This booklet provides a summary of the cover provided by our Solutions private medical insurance product so please check that it still meets the specific needs of your company. To identify which options are relevant to you, please refer to the options column on your policy statement.

Full details of cover and exclusions are set out in the policy wording which contains the terms and conditions. If you'd like a copy of these just ask and we'll send them to you. Non-standard terms may apply on your policy.

If your cover continues to meet your needs, take no action and we'll renew your policy. If not, please contact your usual healthcare insurance intermediary (if you use one) or contact us on 0800 015 1080 between 9.00am and 5.00pm Monday to Friday. Calls to and from Aviva may be monitored and/or recorded.

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



Why you still get **value for money with Solutions**

We include a range of helpful extra features at no extra charge with every Solutions policy.

Access to a 24-hour GP helpline
For over-the-phone consultations with a fully qualified GP when employees need reassurance about medical issues, day or night.

A 24-hour stress counselling helpline
When employees want to talk about a personal or professional issue that's causing them distress. This benefit is available to members aged 16 and over.

Aviva News & Guides
An online portal of tips and tools that can help your employees improve their health and fitness.

Up to 25% off gym membership
We offer up to 25% off membership fees at some of the UK's leading health and fitness clubs.

MyAviva
MyAviva helps members manage their Aviva policies, allows existing customers to get a 20% discount on selected new Aviva products, and access useful online tools, all in one place and at a time that suits them.

Awards and ratings

Defaqto 5 Star Rating

Rated 5 stars for quality of cover by independent financial researcher Defaqto.

Defaqto have given Solutions their highest rating, 5 stars, meaning that it is one of the most comprehensive products in its class within the private health insurance market.

2016 Health Insurance Awards

Best Group PMI Provider
(seventh year running)

Best Individual PMI Provider

Best Online Service to Intermediaries

Best Customer Services Provider

Health Insurance Company of the Year
(seventh year running)

What's covered – summary of **Solutions core cover**

It's important to note that this benefit table is only intended to provide you with a summary of the core cover benefits offered by Solutions. Full details can be found in your Solutions policy wording.

Benefits	Amount payable	Notes
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**
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		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	
Treatment for pain in the back, neck, muscles or joints – musculoskeletal conditions	In full	Managed through the BacktoBetter service

Benefits	Amount payable	Notes
B. Treatment as an out-patient		At a network facility if we have a network for your symptoms or condition
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 anesthesia. These can include ECGs 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	Managed through the BacktoBetter service

Benefits	Amount payable	Notes
Additional benefits		
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
Investigations into the causes of infertility	In full	
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

BacktoBetter

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

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

There is no need for your employees to see their GP before accessing BacktoBetter.

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

Networks

These are the specified group of facilities, specialists or other practitioners that we recognise to provide the treatment your employees require for their conditions or suspected conditions. If we have an appropriate network for your employees' conditions or suspected conditions, we'll tell them where they can have their 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

You can add any of the following options to your core cover and enhance the benefits available from your Solutions policy. Remember, if you choose any of these options your premium will increase.

Option 1: Mental health treatment

To complement the out-patient psychiatric benefit available under core cover, you can choose to add in-patient and day-patient psychiatric treatment to your policy. Your policy can provide a maximum of 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 a 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 you can add cover for out-patient monitoring of chronic conditions by adding option 2. This means that for extra peace of mind, your employees can undertake routine monitoring of these conditions, as long as they are not excluded under the policy, when they would usually have to use the NHS.

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 a member when they have 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 and your employees have access to our Key hospital list, this list gives you and them access to around 300 private hospitals across the UK.
There are additional options that you can select to either add more, or to remove hospitals from your cover. You can add more hospitals by selecting:

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

However, you can also lower your costs by choosing one of the reduced hospital lists below:

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

Please note that the Trust hospital list is only available on Solutions policies covering 2-99 employees which are priced on an age related basis.

Remember, if we have a network for your employees' conditions or suspected conditions, they will need to use our network facility for their treatment. Our networks may include hospitals or other facilities that aren't on your chosen 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.

With Solutions this needn't be the case – our dental & optical option can provide the following benefits:

- £500 routine dental benefit (a £50 excess applies)
- £600 accidental dental benefit
- £300 optical benefit (a £50 excess applies)

A £50 excess applies separately to both the routine dental benefit and optical benefit. This means that there will be a £50 excess applied to any dental claims and another £50 excess applied to any optical claims, meaning that employees will need to pay the first £50 of any claim and we will pay a further £450 for dental expenses or up to a further £250 for optical expenses.

If you want to reduce your premium to help meet your budget, you can do this by choosing from the following cost containment options.

Option 5: Six week option

If you choose the six week option, your employees will still have the benefit of prompt cover should a GP refer them to a 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 your employees 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 they will need to use NHS facilities as a non-paying patient or self-fund any private treatment; members won't be able to claim for NHS cash benefit, NHS cancer cash benefit or the cost of an NHS amenity bed if their treatment is available on the NHS within six weeks from the date their specialist recommends it.

This option can be taken so that your employees avoid long NHS waiting lists as it means that the maximum amount of time they'll have to wait for a procedure is six weeks.

Option 6: Member excess

Another way you can reduce your premium is by choosing a £50, £100, £150, £200, £250 or £500 member excess. We apply our excess once each member every policy year, irrespective of the number of claims made 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.

Option 7: Selected benefit reduction

You may feel that you require cover for only in-patient, day-patient and out-patient costs and not the less essential extras.

That's why Solutions includes the selected benefit reduction option, which lets you remove cover and costs associated with infertility, complications of pregnancy, surgical procedures on the teeth and limited emergency overseas cover.

Option 8: Reduced out-patient cover

Another cost saving option is to reduce your out-patient cover. This option limits out-patient cover to £0, £1,000 or £1,500 each member every policy year.

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

The monetary limit does not apply to out-patient cancer treatment received after members have been diagnosed with cancer. In addition we will also cover any costs for pre-admission tests required within 14 days of admission to check that members are fit to undergo surgery and anaesthesia.

This is a summary of the options Solutions offers. If you'd like a copy of the full terms and conditions, just ask and we'll send them to you.

Chronic conditions explained

A chronic condition is 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.

Examples of chronic conditions are diabetes or crohn's disease.

Like most insurers we do not cover chronic conditions. However, if you choose Option 2: Routine and GP referred services, we will cover consultations with a fee approved specialist and tests for chronic conditions and follow up consultations with a fee approved specialist to monitor a member when they have finished treatment for an acute condition, up to the overall benefit limit.

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.

A 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 your employees need, as recommended by their specialist.

We also want to make things as comfortable as possible for them 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. Full terms and conditions are available on request.

If you choose the reduced out-patient cover, the monetary limit for out-patient treatment will not apply to cancer treatment received after they have 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 your employees where they can have their 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 your employees are diagnosed with cancer, this may mean that treatment will be available on the NHS and we will not pay for most of the treatment that's needed.

Benefits		Notes
Hospital charges for surgery and medical admissions	✓	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
Specialists' fees	✓	Up to the limits in our specialist fee schedule
NHS cancer cash benefit	£100 each day	We pay £100 a day for treatment received as an in-patient or day-patient, £100 for each day your employees receive out-patient radiotherapy, chemotherapy or blood transfusions or out-patient surgical procedures. £100 for each day they receive intravenous (IV) chemotherapy at home and £100 for each week they are taking oral chemotherapy at home. They won't be able to claim more than £100 in any one day

Benefits		Notes
Post surgery services	✓	Includes specialist services immediately following surgery, such as consultations with a dietician or stoma nurse
Radiotherapy and chemotherapy	✓	
Bone strengthening drugs (such as bisphosphonates)	✓	We pay for bone strengthening drugs when they are being used to treat metastatic bone disease
Treatment prescribed by a specialist for side effects while your employees are receiving chemotherapy or radiotherapy	✓	
Wigs	Up to £100	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
External prostheses	Up to £5,000	We'll pay towards the cost of the first external prosthesis following surgery for cancer
Stem cell and bone marrow transplants	✓	Includes collection, storage and implantation
Monitoring	Up to ten years	
On-going needs, such as regular replacement of tubes or drains	Up to five years	
Preventative treatment for cancer		Only if they have already had treatment for cancer that we have paid for. For example, we'll pay for a mastectomy to a healthy breast in the event that they have been diagnosed with cancer in the other breast
End of life care: • in a hospital if it is medically necessary	✓	
• donation to a hospice	£100 each night, up to £10,000	Each night they are admitted
• donation to a registered charity	£50 each day, up to £10,000	Each day that they are visited at home by one of the charities nurses

What isn't covered – **a summary**

Solutions doesn't cover you for:

- long term or chronic conditions (except as provided for under option 2 – 'Specialists' fees for other consultations and tests'). 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 is not 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 cover')
- treatment by a GP (except as provided for in option 2 – 'Routine & 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 do not apply this exclusion to routine monitoring for cancer where we have paid for your treatment for cancer
- 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
- weight loss surgery
- treatment outside of networks (for any condition or suspected condition for which we have a network).

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 on request. Non-standard terms may apply.

How to claim – **three simple steps**

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

BacktoBetter claims

For pain in the back, neck, muscles or joints (musculoskeletal (MSK) conditions), the claims journey is even easier for your employees than the standard process – they don't even need to see their GP

1. ### For musculoskeletal pain

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

The employee just needs to contact the customer service helpline on 0800 158 3333 and describe their symptoms. Calls to and from Aviva may be monitored and/or recorded.

If an employee has already seen their GP, they can move to step 2 of the standard claim process if:

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

Otherwise the employee can continue to follow the BacktoBetter pathway.

2. ### Telephone Clinical assessment

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

All other claims

For non-musculoskeletal claims your employees will need to follow the standard claims process

1. ### Consult your GP

If an employee is unwell they will need to see a GP, where they may be referred for further assessment or treatment. This could be an open referral or a named referral.

A named referral is where the GP recommends a particular specialist. An open referral is where the GP just states which type of specialist they need to see or the type of treatment they need, without giving them a specific named specialist.

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

2. ### Contact Aviva on 0800 158 3333

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

After your employee has been referred by their GP they'll need to call us to set up their claim.

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

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

– and they've been given a named referral, we'll check to make sure the specialist is recognised by us, or

– if it's an open referral, we'll use our specialist finder abase to select an appropriate specialist and/or hospital for them.

3. Treatment

The clinical case manager will conduct a thorough assessment of the employee's problem and recommend the most effective course of treatment. If clinically appropriate, this will include being referred to a physiotherapist from their networks and/or onward referral to a specialist.

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

3. Diagnosis, treatment or surgery

After the employee attends an appointment, their specialist may recommend hospital treatment – this is where they need to ask for a procedure code (CCSD code).

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

Your questions **answered**

Who pays the bill?

All eligible bills will be settled by us directly with the treatment provider. If your employee receives a bill for treatment, they should send us a copy together with their policy number, so that we can arrange payment.

Bills should be sent to:
Bill payment Team,
Aviva Health UK Limited,
Chilworth House,
Hampshire Corporate Park, Templars Way,
Eastleigh, Hampshire, SO53 5RY

We'll contact the employee to advise if they need to pay any part of the bill - for example if they have an excess.

If the employee doesn't contact the customer service helpline and continues with any recommended diagnostics or treatment, they may have to pay the costs for these services if they are not covered by their healthcare policy.

Can I cancel my policy?

The policy can be cancelled by the policyholder. Your documentation will include details about your rights to cancel the policy.

What is the duration of my policy?

Your Solutions policy is a one year contract. Your level of cover should be reviewed now as you're at renewal to make sure that it is still appropriate to help meet both your needs and requirements and the needs of your employees.

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.

Data Protection

Details you supply may be processed in order to tell you from time to time (by post, telephone, email, fax or other means) about products or services which may be of interest from Aviva Group and connected providers. Any person not wishing to receive such contact may write to: Aviva, Mailing exclusion team, Unit 5, Wanlip Road Industrial Estate, Wanlip Road, Syston, Leicester, LE7 1PD.

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.

What do you **need to do next?**

Aviva continually aims to offer the best level of support to our customers. We believe that with the trust that employers and employees place in us, there is a responsibility to provide access to the best care and most appropriate medical procedures.

And in order for us to maintain this high level of support for you and your employees, we have to review our premiums on an annual basis. We hope you'll agree that our products continue to offer tremendous value.

If you would like to discuss your renewal terms or any aspect of our healthcare cover with us, please do not hesitate to call your usual insurance intermediary or the Customer Management Team on 0800 015 1080.

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

GEN5940 REG001 05/2017