Solutions policy update

At Aviva we are constantly reviewing our products to ensure they continue to meet your needs. We are making a number of changes to your Solutions policy that will apply from your renewal date, so please read the information below carefully.

Full details of the changes listed here and all other changes can be found in the policy wording booklet. If you have any questions about these changes, please contact the customer management team if your policy is direct, or your usual healthcare intermediary.

Removal of a benefit

Limited emergency overseas cover

Following a review of the limited emergency overseas cover, we've decided to remove it from all our private medical insurance products that have it. This provides limited cover for in-patient or day-patient treatment and evacuation if a member is taken ill abroad in an emergency situation. From renewal, if members previously had limited emergency overseas cover, it will no longer be available under your policy. If members are travelling abroad in future they should give consideration to their travel insurance needs.

Other changes

Mental health treatment

We have introduced the Mental Health Pathway into core cover for out-patient mental health treatment. All treatment for mental health conditions must be managed and received through the mental health pathway. Members no longer need a GP referral for mental health treatment, they just need to call our claims team and we'll route them through to our clinical provider for assessment and treatment if required. The £2,000 limit for out-patient treatment has been removed so treatment will be covered in full.

We have also changed the way we assess chronic psychiatric conditions. We no longer consider a psychiatric condition to be chronic if we have paid for treatment for that condition during three separate policy years. We now only consider a psychiatric condition to be chronic if it meets the definition of a chronic condition.

If your policy includes a reduced out-patient option, this amends your out-patient cover. Please see your policy documentation to see which options you have selected:

- If you have reduced out-patient cover with a £1,000 or £1,500 limit, mental health treatment as an out-patient is now covered in full through the mental health pathway and is not subject to the limit.
- If you have reduced out-patient cover with a £0 limit, there remains no cover for mental health treatment.

Cancer cover

We're removing the time limit for monitoring after treatment for cancer has finished, so the 10 year limit will no longer apply.

We've increased the cover for bone strengthening drugs (bisphosphonates) and we'll now pay for these drugs in full, regardless of whether they're being used to treat metastatic bone disease or not.

We've also added wording to clarify that we do pay for genetic testing in full when being used to aid a diagnosis or to help determine the type of treatment required.

Also, molecular profiling is paid for in full when being used to determine the most appropriate treatment.

Networks

If you've chosen a hospital list option, and we have a network for the treatment a member needs, they can now choose whether to use the network, or to use a hospital on their list instead. If a member has the Extended hospital list, they won't be affected by this change.

A list of the conditions or suspected conditions for which we have networks in place can be found at **aviva.co.uk/health-network**

Practitioner fees

We've updated the terms and conditions to show that in the same way as we pay specialists' fees up to the limits in our fee schedule, we will now pay all practitioners' fees (such as physiotherapists, chiropractors, or osteopaths) up to the limits in our fee schedule.

The new 'Practitioner fees' benefit term explains that if a member receives treatment from a practitioner who charges above the fee guideline, it will be the member's responsibility to pay the difference. The fee schedule can be found at **aviva.co.uk/pmifees**

BacktoBetter

We've added wording to clarify that BacktoBetter is not a network. All treatment for musculoskeletal conditions must be managed and received through the BacktoBetter pathway.

Consultation fees

We've removed the reference to fee approved specialists to make it clear that all fees charged by a specialist will be paid up to our fee guidelines.

Changes to options

please see your policy documentation to see which options you have selected

Reduced out-patient cover

We've enhanced the cover available on policies that have a monetary limit for out-patient treatment. We'll now pay for out-patient surgical procedures in full, instead of taking them out of the out-patient limit. These are procedures carried out by a specialist in a clinical and sterile setting, including surgical treatment, guided injections and complex diagnostic procedures.

We've also added wording to clarify that if a member has a reduced out-patient option, the limit doesn't apply to out-patient treatment received through some of our networks. A list of the conditions for which we have a network in place and details of how the out-patient limit is applied can be found at **aviva.co.uk/health-network**

Excess

We're changing the way that excesses are applied to benefits that have a monetary limit. From your renewal, if a member claims for a benefit that has a monetary limit and an excess applies, the excess amount will not be deducted from the benefit limit. This means that if, for example, a member has a £100 excess and a benefit has a £500 limit, they would pay £100 and Aviva would pay up to £500 for that benefit.

Mental health upgrade

In-patient and day-patient treatment for mental health is now available through the mental health pathway. Members no longer need a GP referral for mental health treatment, they just need to call our claims team and we'll route them through to our clinical provider for assessment and treatment if required. If in-patient or day-patient treatment is necessary, it is available up to your chosen limit of either 28 days or 45 days as shown on your policy documentation.

We now pay specialists' fees for in-patient treatment up to the limits in our fee schedule.

Dental and optical benefits

We're changing the way the excess is applied to the routine dental and optical benefits, but the excess amounts remain the same for both benefits. From your renewal, the excess amounts will not be deducted from the benefit limits. To reflect this change, we've amended the published amount that we will pay towards treatment under these benefits.

For the routine dental benefit, members will pay £50 excess, and we will then pay up to £450.

For the optical benefit, members will pay £50 excess, and we will then pay up to £250.

Trust hospitals

We've changed the wording under this option, and made it clear what we will pay for. We'll pay in full if a member has eligible in-patient or day-patient treatment at a hospital on the Trust list, or through one of our networks, or in an NHS pay-bed at an NHS hospital, or at a hospital we have chosen if the treatment they need is not available at a hospital on the Trust list.

If a member has in-patient or day-patient treatment at a hospital that we recognise, but which doesn't fall into one of the categories above, we'll only pay the average cost of treatment across all the hospitals on the list. This could leave the member with a shortfall that they would have to pay.

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

Hospital option

We've added a new guided hospital option called Expert Select. With this option, if a member's GP refers them for treatment, they would need to ask for an open referral. An open referral would detail the type of specialist they need to see, but it wouldn't name a specific specialist or hospital.

For a member's treatment, we'll offer them a choice of specialists and hospitals which meet our quality standards. With Expert Select, we guarantee no shortfalls on any eligible hospital or specialist charges for consultations, tests or treatment.

At renewal your policy will remain on your current hospital list(s), but if you'd like to move to Expert Select please contact us, or your usual adviser.

Changes to exclusions

Addictive conditions

We've amended the exclusion for addictive conditions and conditions relating to alcohol, drugs or solvents. We do not cover treatment for misuse of these substances (we previously referred to the 'abuse' of these substances).

Undiseased body tissue

We've amended this exclusion to clarify that we do cover surgery to prevent further cancer if we've paid for you to have cancer treatment.

Treatment outside the UK

For clarity, as we're removing the limited emergency overseas cover, we're adding an exclusion to show that there's no cover for treatment received outside the UK. If your policy doesn't have limited emergency overseas cover, you won't be affected by this change.

Changes to underwriting

In the Full Medical Underwriting section we've added wording relating to pre-existing conditions, to clarify that even if a member advises us of a condition and we don't apply an exclusion for it, they would not be covered if the condition is excluded under the policy.

Changes to conditions

Who can be a member?

The terms have been updated to make it clearer as to what the residency requirements are for a person to be eligible to be covered under the policy. Members must lawfully reside in the UK and intend to continue to reside in the UK for the duration of the policy year. If this changes,

then we may need to cancel their cover as it may not be lawful for us to continue to cover them and if this is the case then any cancellation will be effective from the time their circumstances changed. If a member is considering changing their residency whether on a temporary or permanent basis, they need to bear this in mind particularly if they have an ongoing claim.

Number of employees

Solutions is now available to companies covering 1 – 249 employees (previously 2 – 249 employees). If you have an age rated policy, we have removed the wording which stated we may cancel the policy if the number of employees covered by the policy falls below two. We also now state that if the number of employees covered by an age rated policy exceeds 199 we reserve the right to cancel the policy.

Changes to your circumstances

We've amended this condition to state that we may alter the premiums or policy terms, cancel cover for a member of the policy or cancel the policy following a change of risk.

Cancelling the policy

This condition has been updated to show that reinstatement after a failure to pay the premium is subject to claims experience and the approval of our underwriters.

Third party claims

We've updated this condition to explain what information we need from members, and how claims are handled if someone else is at fault.

If you have other insurance

We've updated this condition to be clear that it's our share of costs which may be recovered.

Law

In the legal jurisdiction section we have amended the wording to state that the contract is governed by and shall be construed to the exclusive jurisdiction of the courts of England and Wales.

We have also included additional wording to ensure we are only obliged to meet our obligations under the policy, including settling claims, if it is lawful for us to do so. This is particularly relevant in the context of Brexit, to ensure we comply with the local laws and regulations of other jurisdictions outside the UK, and is also connected to the change to the residency wording noted above.

Changes to definitions

Advice

We've amended the definition of 'advice'. It now applies to advice from all practitioners, not just a GP or specialist.

Network

We've updated the definition of 'network' to reflect that members can now choose whether to use networks and to provide more information on the benefits of using our networks.

Specialist

We've amended the definition of 'specialist' to be clear that the criteria shown in all three bullet points must be met.

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