Cover Guide
Summary

AVIVA

Retirement
Investments
Insurance
Health

Transocean

Optimum for the Transocean Scheme Policy Number - 961BFW

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 at any hospital on the Key hospital list, any facility recognised by us as part of a network, or an NHS hospital recognised by us for your treatment or condition

- 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 (subject to Aviva's fee guidelines for specialists)
- 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 at a facility or hospital recognised by us

- Radiotherapy/chemotherapy
- CT, MRI and PET scans at a diagnostic centre recognised by us
- Treatment for cancer
- Physiotherapy for pain in your back, neck, muscles or joints (musculoskeletal pain) – 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 £1500

- Consultations with a fee approved specialist
- Treatment by a specialist as an out-patient (including hospitals fees, equipment charges, anaesthesia. 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 for surgical procedures are covered up to the limits in our fee schedule)
- Treatment (other than physiotherapy) for pain in your back, neck, muscles or joints (see member guide for details). Osteopathy and chiropractics (if agreed) is limited to 10 sessions per condition per person per policy year.
- Physiotherapy, osteopathy, chiropractics and acupuncture for conditions other than pain in your back, neck, muscles or joints (if directly referred by your GP, limited to 10 sessions in combined total per condition per person per policy year).

Additional benefits

- Targeted drug therapies for cancer (for example Herceptin or Avastin) are covered in full when being used to achieve a cure or up to 36 months per condition in all other instances, for example disease control. The time limit starts from when you first start receiving the targeted therapy.
- Bone strengthening drugs (such as bisphosphonates) that are being used to treat metastatic bone disease are covered for up to 6 months. The time limit starts from when you first start taking bone strengthening drugs.
- 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
- 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
- Cash benefit of £200 per night where eligible NHS in-patient treatment takes place as an NHS patient without charge. Benefit is limited to 28 nights.
  Cash benefit is not payable where you have been admitted to an NHS hospital as a fee-paying patient of any kind, for the first three nights following an accident or emergency admission, for cancer treatment, or if you claim for the cost of an NHS amenity bed for the same treatment
  Cash benefit of £100 per day where eligible treatment as an NHS day-patient takes place in a hospital without charge. NHS cash benefit will not be available:
  if you claim for the cost of an NHS amenity bed for the same treatment or for cancer treatment.
- NHS cash benefit for cancer treatment
  We will pay £100 for each day you receive treatment as an in-patient, as a day-patient, out-patient radiotherapy, chemotherapy or blood transfusions, or undergo out-patient surgical procedures.
  We will also pay £100 for each day you receive intravenous (IV) chemotherapy at home, or for each week whilst you are taking oral chemotherapy drugs at home.
  You won't be able to claim more than £100 in any one day, but there is no limit on the amount of days you can claim.
  NHS cancer cash benefit is not 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.
  The limits applied to your policy for cancer treatment, will still apply and you will only be able to claim up to the specified limit whether this is privately, as an NHS patient or a combination of both.
- 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
  Psychiatric treatment is not available under any other benefit on this policy.
- Parent accommodation costs when staying with a child of 11 or under receiving eligible treatment, one parent only
- If you have family cover, your children can be covered up to 26 years of age if unmarried.
- Baby bonus of £100 for each baby born or adopted (within a year of birth) during a policy year

Excess

An excess of £100 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 a hospital or specialist). The excess does not apply to physiotherapy for pain in the back, neck, muscles or joints (musculoskeletal conditions) managed through BacktoBetter.

The excess and out-patient limit doesn't apply to treatment received through the mental health pathway

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
- 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
- HIV/AIDS and related conditions
- 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
- Any musculoskeletal or mental health treatment that has not been pre-authorised by us
- Routine dental treatment
- Treatment for pregnancy and childbirth other than the complications specified in the policy wording
- Alcoholism, alcohol abuse, solvent abuse, drug abuse and other addictive conditions.
- Psycho-geriatric conditions
- Overseas treatment other than where provided for in the guide to limited emergency overseas cover (see page 4)
- Treatment required as a result of war, terrorism, or contamination by radioactivity, biological or chemical agents
- Treatment outside of a network (for any condition or suspected condition for which we have a network)
- 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 158 3315

Further details can be found in your member guide

Calls may be monitored and/or recorded

Back to Better 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 as above

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.

Guide to limited emergency overseas cover

Your corporate healthcare policy includes an overseas benefit which is available when temporarily overseas for a period of up to 90 days in any one policy year. The 90 days are accrued on a cumulative basis. If you are outside the UK for more than 90 days during any policy year there is no cover available under the limited emergency overseas benefit.

Cover is restricted to the treatment of emergency conditions serious enough to require immediate admission to hospital as an in-patient or day-patient. The medical emergency must arise incidental to the intended purpose of the visit.

In the event that the country of incident does not have adequate facilities to treat the condition, Aviva will evacuate the patient only, to the nearest available facility, which may not be the UK. After release from hospital following evacuation, Aviva will meet the cost of the journey either to the country evacuated from, or the UK, if this is of comparable cost.
Cover does not extend to costs incurred on behalf of any person who accompanies the patient.

This is a summary of the overseas benefit available under your corporate healthcare policy. Full details are given in the policy wording.

Please note this is not travel insurance and cover is restricted to the treatment of emergency conditions that are serious enough to need an immediate admission to hospital as an in-patient or day-patient. If you feel this level of cover is not appropriate for you or that you may need more cover you should consider taking out travel insurance.

You may also want to consider the European Health Insurance Card (EHIC) scheme which allows you to benefit from the reciprocal health arrangements when travelling to countries covered by the scheme. Application forms can be obtained from the post office or online and should be completed and validated before you travel. You should take steps to use these arrangements where possible.

Assistance Company Services
We've an emergency assistance provider who deals with all aspects of overseas claims.

Before you travel you should give your policy number and the emergency assistance provider's telephone number to a family member or a travelling companion who can contact them on your behalf should you become involved in an emergency and be unable to contact them directly.

In an emergency – members should go immediately to the nearest physician or hospital without delay, then contact the emergency assistance provider.

The telephone number is: +44 (0)2381 247290

Calls may be monitored and/or recorded

Our overseas emergency assistance provider is available 24 hours a day.
When you call, please give them your name, policy number and brief description of the problem.