Out-patient Limit - Key Facts

Individual policies

As you selected an **out-patient limit** when choosing your cover, we will pay a contribution towards the cost of your eligible **out-patient** treatment rather than paying for that treatment in full.

You will have chosen one of these options:

- C1000 – £1,000 contribution
- C500 – £500 contribution
- C0 – There is no **out-patient** benefit other than where indicated below
- C2 – see box below.

Choosing one of these options has reduced the premium that you pay for your cover.

C1000, C500 or C0 – whichever of these options you have selected, we will pay the full cost of the following treatments as an out-patient:

- CT, MRI & PET scans (at a recognised diagnostic centre)
- pre-admission tests (carried out up to 14 days before an admission to check that you're fit to undergo surgery as an in-patient or day-patient)
- radiotherapy and chemotherapy, and
- out-patient surgical procedures by a specialist in a clinical, sterile setting. If you have a hospital list, specialists' fees are covered up to the limits in our fee schedule.

In addition, if you selected C500 or C1000 we will contribute up to a combined total of £500 or £1000 each person every policy year (depending on your option choice) towards the costs of the following treatment as an out-patient:

- consultations with a specialist (specialists' fees are covered up to the limits in our fee schedule)
- non-surgical treatment by a specialist as an out-patient (if you have a hospital list, specialists' fees are covered up to the limits in our fee schedule)
- diagnostic tests such as blood tests, x-rays, ECGs and ultra-sounds
- specialist referred treatment by a physiotherapist, chiropractor, osteopath
- mental health treatment on GP referral to a psychiatric therapist or psychiatric specialist.

If you have the C2 option then you will only be covered for the following out-patient benefits:

- two consultations with a specialist each person every policy year (specialists' fees are covered up to the limits in our fee schedule)
- diagnostic tests only if they:
  - lead directly to eligible in-patient or day-patient treatment
  - take place within six months after eligible in-patient or day-patient treatment, for the same condition
- radiotherapy and chemotherapy.

Cancer treatment

We won't apply your **out-patient limit** to cancer treatment received after you have been diagnosed with cancer, so your treatment will be paid in full.

My Aviva

Did you know, you can view and track your **out-patient** and **excess** benefit limits online through MyAviva? To activate or view your account just visit **aviva.co.uk/myaviva**

Consultations

If your specialist suggests conducting a test during your consultation please tell them that you have an **out-patient limit** and ask how much it will cost

All of these out-patient limit options also remove the benefits below from your policy:

- surgical procedures on the teeth as an in-patient, day-patient and out-patient and any treatment related to that surgical procedure, including consultations and diagnostic tests
- treatment for complications of pregnancy and childbirth as an in-patient, day-patient and out-patient.

Treatment charges will vary and Aviva cannot tell you exactly how much your treatment will cost – it's **important** that you always check the cost of your **out-patient treatment** with the hospital and/or specialist beforehand.

These figures are a guide to what some **out-patient treatments** could cost (November 2021) – these will vary, check with your treatment provider

Consultation	Ultrasound	X-ray	1 Physiotherapy session	Blood tests
£150–£250	£200–£450	£150–£300	£42–£140	can vary greatly, please check the costs with your specialist

Any Questions

For more information please visit the **Aviva website**

aviva.co.uk/health

Or alternatively contact us on

0800 092 4590

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