

# Enterprise Flexible Benefits<sup>®</sup>

## A Guide to Your Health Insurance Group Policy

Effective from 1st June 2008

Large print guides are available upon request



[wpa.org.uk](http://wpa.org.uk)

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Western Provident Association (WPA) has taken every care in the preparation of the material contained in this Guide, however this material may contain technical inaccuracies or typographical errors. WPA expressly excludes to the fullest extent permitted by law all liability howsoever arising from any such inaccuracies or errors.

# 1. How To Use These Rules

Welcome to WPA's Enterprise Flexible Benefits.

This Guide sets out your and our rights and obligations affecting your group policy membership.

Please take time to read through this Guide and keep it in a safe place.

When you receive your group policy documents you should check them carefully to be sure you understand them.

## **The benefits are illustrated as follows:**



This is covered by your policy



This is not covered by your policy



Very important information

**Visit our website at [wpa.org.uk](http://wpa.org.uk) for service on-line and our new iClaim facility.**

We are continually investing in leading edge technology to improve our efficiency. Our website – built by our staff for our customers – is very user-friendly, enabling you to access your group policy membership 24 hours a day, 365 days a year. Take a look at all the things it can do for you.

**If you have any questions please call 01823 625270 or e-mail [cbd@wpa.org.uk](mailto:cbd@wpa.org.uk) and we'll be happy to help.**

## 2. Purpose Of Your Policy

2.1 Purpose

2.2 Primary Care

2.3 Secondary Care

2.4 Critical Care

2.5 Emergency Treatment

## 2.1 Purpose

**The purpose of your policy is to cover elective, short term, specialist care that is provided with curative intent, in the reasonable expectation that it will restore you to the same or possibly even better health than you enjoyed before treatment. It is not to cover long term management or maintenance of incurable conditions.**



Your group policy is intended to cover treatment:

- For which your policy provides a benefit;
- Which is given by a provider of treatment at a centre we recognise;
- For a medical condition which is not excluded by the rules of your policy or by any personal medical exclusion;
- Which is established;
- Which is provided with curative intent.

**This may be:**

- Consultations and diagnostic tests needed to establish a diagnosis;
- Surgery or medical treatment that has curative intent following the diagnosis;
- Treatment that has curative intent for exacerbations or complications.

This is called acute treatment.



It does not include treatment that is:

- Recurrent, continuing or long-term;
- Monitoring or maintenance – that is routine follow up consultations, checkups, examinations or tests;
- Preventative – that is aimed at stopping a condition from developing or developing further;
- Solely to relieve symptoms, control pain or improve quality of life.

This is called chronic treatment.

To make a claim for treatment you must start by visiting your GP who provides **Primary Care**. If your GP cannot treat you they will refer you to a specialist or therapist for **Secondary Care**.

## 2.2 Primary Care

Your GP knows you and your medical history and may well be able to diagnose and/or treat the condition him/herself. This is Primary Care and it includes any tests or investigations that your GP needs to arrange so as to be able to treat the condition or refer you to the appropriate specialist/therapist for Secondary Care.



Primary Care does not cover:

- GP fees;
- Tests such as blood tests;
- Scans and x-rays (unless you have the Therapy Option);
- Drugs or dressings.

## 2.3 Secondary Care

This is treatment given on the referral of your GP by a specialist or therapist. This includes the tests and investigations that your specialist needs to arrange so as to be able to make a diagnosis or decide on your treatment plan.



You are not covered for tests or investigations arranged by a GP or therapist. However, benefit can be considered towards GP referred scans/x-rays if you have the Therapy Option.

## 2.4 Critical Care

We define Critical Care as including both:

### Level 1 – Intensive Care

Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex conditions requiring support for multi-organ failure.

## Level 2 – High Dependency

Patients requiring more detailed observation (than in an ordinary hospital bed) or intervention including support for a single failing organ system or postoperative care, and those stepping down from higher levels of care.



We will pay for up to **28 days** treatment each policy year in a dedicated Critical Care Unit following:

- A planned admission as a private patient to a private hospital
- A planned admission as a private patient to a private unit of an NHS hospital for an eligible procedure/treatment that then requires anticipated Critical Care.



We will not pay for:

- Critical care treatment in a unit or facility which is not a dedicated Critical Care Unit;
- Admission to an NHS Critical Care Unit following an unplanned/emergency admission to an NHS Hospital although we will pay the NHS Cash Benefit for such an admission;
- Admission to a private hospital Critical Care Unit or as a private patient to an NHS Critical Care Unit following a planned NHS admission;
- Treatment as a private patient in the Critical Care Unit of an NHS hospital following transfer from a private hospital.

## 2.5 Emergency Treatment

In the event of a medical emergency, we advise you to consult your GP, call the NHS emergency services or attend your local A & E department as they are usually best equipped to provide the required emergency care.

Once the medical condition has been stabilised (no longer requiring ITU or High Dependency Care) you may wish to arrange transfer to private facilities. At this stage you must get authorisation from us as the transfer must be agreed in advance between the specialist and us. Please call us on 01823 625270.

## 3. How To Make A Claim

3.1 How To Make A Claim

3.2 Claims Processing and Access to Medical Reports Act 1988

### 3.1 How to make a claim

If you wish to make a claim on your policy, following this guide will help you make the most of your cover. Please check your membership documents for full details of your cover.

#### Step 1

First visit your GP; they may then refer you to a specialist (who will then be in charge of your care) or a therapist.

#### Step 2

All claims must be pre-authorised so please contact us in advance to tell us about any proposed treatment, either, by phoning us on 01823 625270 or by visiting [wpa.org.uk/claim](http://wpa.org.uk/claim). We will then send you a claim declaration containing a unique claim number, or if you pre-authorise on our website, a claim declaration can be printed out at the end of the iClaim process.

#### Step 3

If you have been covered by WPA for **two years or more**:

- When seeking specialist or hospital treatment we require your specialist to sign the claim declaration confirming the details of your claim;
- When seeking physiotherapy or other therapy treatment we require your therapist to sign the claim declaration. After you have received a maximum of 8 sessions, we will request that you seek further advice from your GP;

or

If you have been covered by WPA for **less than two years**:

- Your GP is required to sign the claim declaration for all claims.

#### Step 4

Send the completed claim declaration together with original receipts for relevant cash plan or dental plan claims to WPA, Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE for us to authorise any future required treatment.

**For dental, worldwide or cash plan claims please download a claim form from our website [www.wpa.org.uk/claim](http://www.wpa.org.uk/claim)**

### **3.2 Claims Processing and Access to Medical Reports Act 1988**

Please note it may be appropriate to request a medical report and/or details of your full medical history from your GP to help us in processing your claim. If a report is needed we will write to you explaining the reason. We reserve the right in appropriate circumstances to require you to have a medical examination with a clinician of our choice and at our expense with a view to providing us with a medical report relevant to underwriting of your policy and/or processing of your claims. If you refuse to co-operate with our reasonable request to supply appropriate medical information then we reserve the right to decline your claim(s) to recoup any monies paid in respect of earlier claims and in appropriate circumstances may be obliged to terminate your insurance cover.

## 4. The Benefits Available

- 4.1 Essential Option . . . . . ●
- 4.2 Cancer Care . . . . . ●
- 4.3 Out-patient Option . . . . . ●
- 4.4 Therapy Option . . . . . ●
- 4.5 Emergency Worldwide Option . . . . . ●
- 4.6 Dental Option . . . . . ●
- 4.7 Corporate Cash Plan Option . . . . . ●
- 4.8 Helpline Services . . . . . ●

## 4.1 Essential Option

These benefits are available when you are referred by your GP to a specialist we recognise.

<b>In-patient &amp; Day-patient Treatment</b>	
<b>Hospital charges</b> including accommodation charges, operating theatre fees, drugs, dressings and medicines used while you are in hospital	Full refund within and in accordance with our hospital agreements
<b>Specialists' fees</b> such as surgeons', physicians' and anaesthetists' fees whilst in hospital receiving in-patient or day-patient treatment provided we recognise the specialist and the charges are customary and reasonable ( <b>see important benefit note 4.1.1</b> )	Full refund of customary and reasonable fees
<b>Single Post Operative Consultation</b> and any tests carried out on the day of that consultation within the 90 days following a surgical procedure and associated tests	Full refund of customary and reasonable fees
<b>Diagnostic tests</b> such as blood tests, ultrasound, x-rays whilst in hospital receiving in-patient or day-patient treatment	Full refund of customary and reasonable fees
<b>Diagnostic MRI, CT &amp; PET Scans</b> whilst in hospital receiving in-patient or day-patient treatment	Full refund of customary and reasonable fees
<b>NHS Cash Benefit</b> for any in-patient or day-patient treatment received as an NHS patient which is covered by your policy	£100 for each day max of £3,000 per person per group policy year
<b>Psychiatric Treatment</b> for in-patient or day-patient treatment for a maximum period of 28 days/nights in 5 consecutive policy years	Pre-authorisation is required
<b>Out-Patient Treatment *</b>	
<b>Consultations with a specialist</b> we recognise	Up to £150 per person per group policy year
<b>Outpatient diagnostic MRI, CT &amp; PET scans</b> on the referral of your specialist only	Full refund of customary and reasonable fees
<b>Outpatient surgical procedures</b> carried out by a recognised specialist	Full refund of customary and reasonable fees
<b>Pre-admission Tests</b> necessary to assess your fitness for your planned operation which must be undertaken in the 2 weeks prior to your admission to hospital	Full refund of customary and reasonable fees
<b>Cancer care</b>	
<b>Radiotherapy/Chemotherapy</b> (please refer to Section 4.2 for full details)	Full refund of customary and reasonable fees
<b>Consultations with a specialist</b> (please refer to Section 4.2 for full details)	Full refund of customary and reasonable fees
<b>Advanced Therapeutics</b> (please refer to Section 4.2 for full details)	Pre-authorisation is required
<b>NHS Cash Benefit</b> for any in-patient or day-patient treatment received as an NHS patient which is covered by your policy	£200 for each day/night max of £6,000 per person per group policy year

\* Please note that tests and/or investigations performed on an out-patient basis are not covered unless you have the separate Out-patient Option (detailed on page 16).

Other Benefits	
<b>Nursing at home</b> for a maximum period of 4 weeks when recommended by your specialist for medical reasons and carried out by a nurse who is registered on the Nursing and Midwifery Council (NMC) register and holds a valid NMC personal identification number	Pre-authorisation is required
<b>Private Ambulance Transport</b> when medically necessary for transport to and from hospital for treatment which is covered by your policy	Full refund of customary and reasonable fees
<b>Parent &amp; Child</b> cover for accommodation charges made by the hospital for one parent to accompany a child patient when recommended by the specialist	Full refund of customary and reasonable fees
<b>Prostheses</b> which are medically necessary as an integral part of your operation however this excludes such items as artificial limbs ( <b>see important benefit Note 4.1.2</b> )	Pre-authorisation is required
<b>Out of Pocket Expenses</b> to help with charges made by the hospital for items such as telephone calls, newspapers and visitors' meals	Up to £5 per day whilst you are in hospital
<b>Hospice Donation</b> when you are admitted to a hospice. This contribution will be paid directly to the hospice on your behalf	£70 per day/night up to a maximum of £700 per person per group policy year
<b>Helpline Services</b> ( <b>please refer to page 25 for full details</b> )	24 hours, 365 days

#### 4.1.1 Specialist Fees



We will cover treatment provided or requested by a medical practitioner whose name appears on the current GMC Specialist Register (or overseas is locally recognised if you have the Worldwide Option).

##### Customary & Reasonable Charges

By customary and reasonable specialists' fees we mean the level of fees that are charged by the specialist's medical colleagues to the majority of our policyholders for the same treatment and which is considered reasonable and fair by our Medical Advisory and Clinical Governance Committee.

#### 4.1.2 Prostheses

Prostheses are internal permanent replacements for body parts. They may be:

**Passive** – by which we mean inert passive replacements of joints, blood vessels or other organs. Examples include a hip replacement or an aortic graft, but not an artificial limb);

**Active** – these are usually electronic devices implanted permanently within the body to correct or modify an abnormal bodily function caused by disease, illness or injury. Examples include spinal nerve stimulators and pacemakers.

or



##### Passive prostheses

We will pay for the reasonable cost of the prosthesis provided that it is in established common clinical practice and has been approved by NICE. Payment for other prostheses will only be made following preauthorisation by WPA's Medical Advisory and Clinical Governance Committee. The full costs of insertion will also be covered provided they are customary and reasonable.



You are not covered for:



Artificial limbs;



Prostheses that are not in established use.



### **Active electronic implantable medical devices**

WPA cover those that are used to prevent the risk of potentially fatal organ failure e.g. cardiac pacemakers or defibrillators.

Implantable spinal nerve stimulators, cochlear implants or intracranial devices for a variety of neurological conditions are not covered as these conditions are usually not acute and are therefore outside the terms of the policy.

Several new devices are currently in development for a variety of functional disorders but will not be covered unless passed by NICE as safe and efficacious and used in the treatment of potentially fatal organ failure.



### **Pre-authorisation is required before benefit will be paid for treatment with an active prosthesis**

Your specialist will need to provide full details of your proposed treatment for assessment prior to approval by our Medical Advisory and Clinical Governance Committee.

It is important that you discuss these particular conditions with your consultant/specialist.



With pre-authorisation we will then pay for the initial supply and fitting of an active electronic implantable medical device, provided that the device has been approved by NICE and is accepted and recognised treatment within the NHS.



You are not covered for:



Any subsequent maintenance, including battery replacement;



A further procedure/device unless the device fails because of a fault in its manufacture;



We do not cover revision surgery or faults in clinical benefit caused by mis-placement or misuse;



Treatment with active electronic implantable devices that have not been specifically authorised.

## 4.2 Cancer Care

This is a summary of the cancer care cover that we offer.

Cover		
Place of treatment	✓	Established investigations and active treatments for cancer in the UK in hospital as an in-patient or day-patient, as an out-patient or at home. We will also make a donation on your behalf if you are admitted to a hospice.
Diagnosis	✓	Consultations with your specialist including second opinions and diagnostic tests, scans and biopsies.
Surgery	✓	We will provide benefit for fees up to a level that is customary and reasonable.
Prevention	X	You are not covered for screening or tests to determine the existence of a condition for which you do not have any symptoms, including genetic tests, the removal of tissue or preventative treatment (e.g. vaccines) for it even if you have a family history of that condition (e.g. prophylactic mastectomy, vaccines etc).
Drug therapy	✓	<ul style="list-style-type: none"> <li>Chemotherapy</li> <li>Advanced Therapeutics that are not available to you as an NHS patient (see definitions) for a maximum of 12 consecutive months from the start of treatment with any form of Advanced Therapeutics. This benefit can only be extended if the treating oncologist provides us with convincing clinical evidence that it continues to be given with curative intent, when we will continue to fund it, with a further review after 3 months.</li> <li>Biological therapy e.g. hormone tablets when these are supplied by your specialist, not your GP.</li> </ul>
	X	Drugs given to maintain remission or prescribed by your GP
Radiotherapy	✓	This includes radiotherapy given for pain relief.
Terminal care (sometimes referred to as palliative care)	X	You are not covered for terminal care. We will however make a donation to a hospice on your behalf.
Monitoring	✓	Follow up consultations and reviews will be covered for 5 years within NHS protocols from the time when your active treatment for cancer has finished.
Established (not experimental) treatment	✓	You are covered for established treatment as defined in these rules.
	X	You are not covered for new or experimental treatment outside these conditions.
Clinical trials	✓	<b>Pre authorise</b> - We may pay for treatment given in certain recognised research trials approved by a local NHS Ethics and Research Committee.
NHS treatment	✓	If you choose to be treated as an NHS patient you will be entitled to a daily cash benefit whether you are being treated as a day-patient or in-patient provided your claim is covered by the rules of your policy. A financial contribution to the cancer unit caring for you to improve the service for others using the unit will be made if you ask us to do so.
Bone marrow or stem cell treatment	✓	<b>Pre authorise</b> - Such treatment must be pre-authorized before your bone marrow or stem-cell treatment starts. Please note that we will not contribute to the costs to the donor.
Treatment outside the UK	✓	<b>Pre authorise</b> - Benefit may be available based on the costs that would be incurred and regarded as customary and reasonable for the nearest equivalent investigation or treatment in the UK. Specific agreement is required from WPA before any treatment takes place. We will need to communicate with your oncologist in your chosen location as part of the pre-authorisation process.

## 4.2.1 Cancer Care


### What do you need to do if cancer is diagnosed?

You should read both these rules and our Cancer Care Leaflet right through so you know what is and what is not covered. You can view/download the Cancer Care leaflet from [wpa.org.uk/cancer](http://wpa.org.uk/cancer) or call us on 01823 625270.

You must contact us to **pre-authorise** your treatment. We will then contact your **oncologist** so that we can work together to smooth your claim process.



What is covered:

- **Active, established** investigations and treatments in the UK for **cancer**, as set out here, whether a new **cancer** or a recurrence of the original;
- Treatment in hospital as an in-patient or day-patient, as an outpatient or at home;
- Surgery, radiotherapy and chemotherapy which is intended to remove, suppress or kill off cancerous cells;
-  In addition you are covered for **Advanced Therapeutics** not available to you on the NHS as set out here.


**WPA will pay for** a course of treatment with **Advanced Therapeutics** for your cancer lasting up to a total of 12 consecutive calendar months starting from the date on which the first treatment with

them is given. This may be extended if your oncologist can provide us with convincing clinical evidence that it continues to be given with curative intent. Funding will continue, provided clinical evidence continues to justify its use at 3 monthly intervals. This is payable only in line with the policy benefits and when the policy is in force.

Further funding for **Advanced Therapeutics** would be available to you if you were to develop a different (**histologically distinct**) cancer.



WPA will provide benefit for **Advanced Therapeutics** provided that:

- They have been granted an European Medicines Agency (EMA) product licence and;
- Their use is justified by a substantial body of published evidence specific to the particular clinical situation and;
- They are being given with **curative intent** in the acute, active phase of cancer treatment and;
- We formally pre-authorise their use and;
-  Your oncologist states that they are not available to you as an NHS patient under any circumstances.

**Follow up consultations** - Visits to your specialist to monitor your condition once your treatment has finished may be important to you. These will normally

be covered for up to 5 years from the completion of **active** treatment for your cancer. The frequency of consultations we fund will be agreed within NHS protocols for the particular cancer.

**Clinical trials** - Cover may be available for certain expenses if you volunteer to be included in a NHS based research trial that has local research and ethical approval and is registered by a non-commercial organisation such as the Medical Research Council or UKCCCR. Any consequential side effects or complications would not be covered as they are funded by the NHS.

WPA will not cover any cost incurred by policyholders when included in clinical trials in the private sector. Further we will not fund any treatment for side effects or complications arising from inclusion in such trials.

You should seek clarification before volunteering to be included in any research trial.

**Treatment overseas** – Although you are not automatically covered for investigations or treatment outside the UK, approval may be given up to the level of benefit of the nearest equivalent procedure or treatment regime in the UK. You need to seek **pre-authorisation** for this before any treatment will be funded.

**Bone marrow or stem-cell transplants** may occasionally be recommended as part of your **cancer** treatment. You need **pre-authorisation** for this before your bone marrow or stem-cell treatment starts. Please note that the costs to the donor will not be covered.



What is not covered:

- We do not pay for treatment for **cancer** with **Advanced Therapeutics** to maintain or prolong **remission**, to maintain good health in the absence of symptoms of **active cancer**, or for preventative use;
- You are not covered for Advanced Therapeutics that are available to you on the NHS. We will need your oncologist to confirm whether this applies to you or not;
- Treatment with Advanced Therapeutics beyond twelve months unless clinically justified by your Consultant Oncologist, or for treatment that does not work;
- We do not cover treatment or care for **cancer** described by your oncologist as **terminal**. (sometimes described as palliative care) whether carried out in a hospital, at home or in a hospice. If you are admitted to a hospice we will make a contribution to the hospice if you ask us to do so;
- We do not cover treatment that has not been **pre-authorized** where this is required or treatment that is prescribed by a General Practitioner and not your specialist.



## Cancer related definitions

**Active treatment** - treatment that is of **curative intent**.

**Advanced Therapeutics** - are drugs that target specific sites on cells so stopping them from multiplying or developing a blood supply to sustain themselves and spread. These are new agents which usually cause fewer side effects than chemotherapy but which are extremely expensive to develop and to use. Examples of these agents are Herceptin, Avastin, Gleevec and Tarceva.

**Cancer** - a malignant process of tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

**Curative intent** applies to treatment that is administered with a reasonable expectation that it will restore the patient close to the state of health enjoyed prior to the disease being diagnosed, and the patient will be alive and disease free 5 years after commencement of the treatment.

### Established treatment –

That it is approved by NICE for routine use in the NHS:

- For which there is substantial clinical evidence of benefit;

- That is accepted and practiced by more than one group of specialists in the field in the UK;
- That involves the use of drugs that are recognised and licensed in the UK for safe use and for the stage of the condition being treated;
- That is considered to be acceptable recognised clinical practice by WPA's Medical Advisors in the particular circumstances.

Please note: particular terms apply to **Advanced Therapeutics** as set out above.

**Histologically Distinct** - Every **cancer** has a unique 'footprint' that can be identified by histological pathology demonstrating if it is a spread of an existing cancer or a new disease. Histology is the microscopic study of tissues and cells.

**Oncologist** – Oncology is the specialist **treatment of cancer**, which includes radiotherapy and chemotherapy. WPA provides benefit for Consultant oncologists. Best Clinical Practice expects that your Consultant Oncologist will form part of a Multi-disciplinary Team overseeing your cancer care.

**Pre-authorisation** – you need to contact us to tell us about your treatment before your treatment starts so that we can confirm whether it will be covered.

**Remission** - a clinical state where the effects of the cancer are suppressed or under control.

**Terminal care (sometimes referred to as palliative care)** - treatment that concentrates on controlling pain and other symptoms connected with cancer when the patient is near or approaching the end of life and active treatment is no longer considered effective or appropriate.

**All treatment for cancer requires pre-authorisation.**

### 4.3 Out-patient Option

You can claim these benefits if your company has chosen this option and you are referred to a recognised specialist by your GP. Please check your Certificate of Registration to see if you have this option.

Out-Patient Treatment	
<b>Consultations with a specialist</b> we recognise including benefit for a second opinion if required ( <b>see important benefit note 4.3.1</b> )	No Annual Limit
<b>Diagnostic tests, x-rays, pathology and scans</b> at the request of your specialist ( <b>see important benefit note 4.3.2</b> )	No Annual Limit
<b>Consultations with a psychiatric specialist</b> for a maximum period of 6 consecutive calendar months ( <b>see important benefit note 4.3.3</b> )	Pre-authorisation required

#### 4.3.1 Consultations with a specialist



We will cover treatment provided or requested by a specialist who is a medical practitioner and appears on the GMC Specialist Register (or overseas is locally recognised if you have the Worldwide Option) when the charges made are customary and reasonable.

##### Customary & Reasonable Charges

By customary and reasonable specialist's fees we mean the level of fees that are charged by the specialist's medical colleagues to the majority of our policyholders for the same treatment and which is considered reasonable and fair by our Medical Advisory and Clinical Governance Committee.



You are not covered when treatment is provided by a specialist we do not recognise or have ceased to recognise or is related to you.

#### 4.3.2 Diagnostic Tests, x-rays, pathology and scans



You are not covered for any of these tests if they are arranged at the request of your GP.

#### 4.3.3 Consultations with a psychiatric specialist



Treatment is only available once it has been pre-authorised.



If your specialist refers you for any psychology/psychotherapy treatment you must have the therapy option and can claim for a maximum period of 3 consecutive months.

You are recommended to check the benefit available if you have the therapy option as there is an annual limit which applies.



**You are not covered for any out-patient drugs or dressings, cancelled or missed appointments.**

## 4.4 Therapy Option

You can claim these benefits if your company has chosen this option. Please check your Certificate of Registration to see if you have this option. We have listed useful websites at the back of this guide for your information.

GP Referred Services	
<b>Acupuncture</b> when treated by a member of the British Medical Acupuncture Society	<b>Up to a total of £1,000 per person per group policy year</b>
<b>Chiropody/Podiatry</b> when treated by a practitioner who is on the Register of Chiropodists/Podiatrists of the Health Professions Council ( <b>see important benefit note 4.4.1</b> )	
<b>Chiropractic</b> when treated by a practitioner who is on the Register of the General Chiropractic Council	
<b>Dietary Services</b> when treated by a dietician who is on the Register of Dieticians of the Health Professions Council	
<b>Homeopathy</b> when treated by a Fellow (FFHom) or a Member of the Faculty of Homeopathy (MFHom) ( <b>see important benefit note 4.4.2</b> )	
<b>Osteopathy</b> when treated by a practitioner who is on the Register of the General Osteopathic Council	
<b>Physiotherapy</b> when treated by a practitioner who is on the Register of Physiotherapists of the Health Professions Council	
<b>Psychology/psychotherapy</b> when treated by a member of the British Psychological Society (BPS) or a psychotherapist who is a member of the British Association of Psychotherapists (BAP), a member of the United Kingdom Council for Psychotherapy (UKCP) or a member of the British Association for Counselling and Psychotherapy (BACP) for a maximum period of 3 consecutive months ( <b>see important benefit note 4.4.3</b> )	
<b>Speech and Language Therapy</b> when treated by a therapist who is on the Register of Speech and Language Therapists of the Health Professions Council	
75% of the cost for <b>GP referral for Scans/X-rays</b> for eligible medical conditions (when the results are interpreted by a Consultant Radiologist)	

### 4.4.1 Chiropody/Podiatry



You are not covered for:



Any surgery carried out by a chiropodist/podiatrist.



We will cover surgery to the forefoot by a WPA recognised NHS Consultant Podiatric Surgeon – this must be pre-authorized.



**You are not covered for fees charged for cancelled or missed appointments.**

### 4.4.2 Homeopathy



You are not covered for any remedies (for example medicines, lotions, supplements and herbs).

### 4.4.3 Psychology/Psychotherapy

The treatment is only available once it has been pre-authorized.



Benefit for psychology/psychotherapy is limited to 3 consecutive months if you are under the care of a psychiatrist or if you are referred to a therapist by your GP



You are not covered for:



Group therapy sessions;  
Counselling sessions - however we do provide a 24 hour counselling helpline service (see page 25).

## 4.5 Emergency Worldwide Option

Your Certificate of Registration confirms whether your company has chosen this option.

This is not a full travel insurance policy but an additional benefit of your policy which offers restricted cover for emergency medical treatment abroad. However, unlike most travel insurance, it covers eligible medical conditions that arise after you take out your WPA policy. You must let us have the details of any travel or any other relevant insurance cover you have so that we can pay our proper share of your claim.

**Emergency treatment** means unforeseen treatment that is due to a sudden, acute illness or injury that, for medical reasons, cannot be delayed until your return to the UK. Overseas in this context means outside the UK, Channel Islands and the Isle of Man.

**If you are travelling in the EU and you are entitled to a European Health Insurance Card (EHIC) you must get one before you travel. Also contact the Department of Health or visit their website at [www.dh.gov.uk](http://www.dh.gov.uk) to understand the reciprocal health agreements in place between the UK and other countries before travelling.** Where you receive treatment in a European state funded facility we will only pay for eligible treatment costs that are over and above those covered by the EHIC or reciprocal health agreements in the country where treatment occurs. If you undergo private treatment where the EHIC is not valid or a reciprocal health agreement is not in place, we will pay the claim under the terms of your policy.



**No treatment will be funded unless you have contacted the Worldwide Co-ordination Centre on (+44) 20 8680 3800 and your treatment has been pre-authorised. Overseas means outside the UK.**



**Important note: in the USA Worldwide 70 will only give the same level of cover as Worldwide 35.**

Worldwide 35	
<b>Emergency overseas treatment</b> for a sudden acute illness or injury that for medical reasons cannot be delayed until your return to the UK ( <b>see important benefit note 4.5.1</b> )	Overall annual maximum of £250,000
<b>Evacuation/Repatriation</b> to the nearest suitable medical facility ( <b>see important benefit note 4.5.2</b> )	
<b>Family Assistance</b> to cover the cost of immediate family members travelling with the patient who needs to be evacuated or repatriated. ( <b>see important benefit note 4.5.3</b> )	

**Cover is for trips abroad for up to 35 days per trip starting on the day you leave the UK, for up to an overall maximum of 90 days per person per group policy year.**

Worldwide 70	
<b>Emergency overseas treatment</b> for a sudden acute illness or injury that for medical reasons cannot be delayed until your return to the UK ( <b>see important benefit note 4.5.1</b> )	Overall annual maximum of £500,000
<b>Evacuation/Repatriation</b> to the nearest suitable medical facility ( <b>see important benefit note 4.5.2</b> )	
<b>Family Assistance</b> to cover the cost of immediate family members travelling with the patient who needs to be evacuated or repatriated. ( <b>see important benefit note 4.5.3</b> )	

**Cover is for trips abroad for up to 70 days per trip starting on the day you leave the UK, for up to an overall maximum of 180 days per person per group policy year.**

#### 4.5.1 Emergency Overseas Treatment



Trips abroad for up to 35 or 70 days each (with the calculation starting on the day of outward travel) subject to an annual maximum of 90 days and an annual maximum benefit of £250,000 or £500,000.

Should you be taken ill during your trip before 35 or 70 days have elapsed, cover for eligible treatment will continue until such time as medical advice indicates you are well enough to travel home.

We have a 24-hour co-ordination service offering a translation service for all major languages. To use this you need to phone the Worldwide Co-ordination Centre on (+44) 20 8680 3800.

#### 4.5.2 Evacuation/Repatriation



If you are outside the UK and need eligible medical treatment that in our opinion is not available in the country you are in, we will, through the Worldwide Co-ordination Centre, evacuate you to the nearest suitable medical facility where the treatment you need is available.

We may, in extreme circumstances, repatriate you to the UK for treatment where this is medically necessary and the treatment cannot be obtained locally.

In the event of the death of an insured person, our Worldwide Co-ordination Centre will make arrangements (including the completion of any documentation) for the return of the deceased to the UK. Cover does not include funeral expenses.

#### 4.5.3 Family Assistance



In the event of evacuation or repatriation of an insured person we will cover the cost of immediate insured family members (i.e. partner/children) who are overseas with the patient at the time of the illness or injury to travel with the patient or return to the UK by the most appropriate means and by economy class.



You are not covered for:

- Treatment that you have not advised to and has not been authorised with the Worldwide Co-ordination Centre;
- Treatment that is available to you using your European Health Insurance Card (EHIC) or where a reciprocal health agreement exists between the UK and the country where the treatment takes place – see first section of the Emergency Worldwide rule;
- Trips outside the UK falling outside the limits set out in the Benefit Table;
- Elective overseas treatment – but see next section on page 20;
- Any costs which you can also claim under the terms of a Travel Insurance or other

insurance policy. We will only pay our share of the claim;

- Treatment relating to general or personal exclusions that is not covered by your policy in the UK for example **winter or professional sports**;
- Treatment either overseas or on your return to the UK for a medical condition contracted or injury sustained whilst in a location to which you travelled (during the period of the advice) against advice issued by the Foreign and Commonwealth Office (FCO) either as **all travel or all but essential travel**. Please check their website [www.fco.gov.uk](http://www.fco.gov.uk) before you travel, alternatively call their advice line on 0845 850 2829;
- Treatment either overseas or on your return to the UK for a medical condition contracted or injury sustained if you travelled against medical advice;
- Any costs incurred where the necessary precautions were not taken, for example vaccinations.

#### How You Make a Claim

**No treatment will be funded unless you have contacted the Worldwide Co-ordination Centre and your treatment has been authorised so you must call the Worldwide Co-ordination Centre on (+44) 20 8680 3800 who will be able to give you valuable help and advice.**

In exceptional situations, such as an emergency admission to hospital, you must still contact the Worldwide Co-ordination Centre straight away or as soon as you are able to do so.



**We will cover you, under the Worldwide Cover but not under the general policy benefits, against Acts of Terrorism as long as you are not in a country or part of a country explicitly warned against travel by the Foreign and Commonwealth Office (FCO) either as all travel or all but essential travel. Please check their website [www.fco.gov.uk](http://www.fco.gov.uk) before you travel, alternatively call their advice line on 0845 850 2829.**



Payment for your treatment:

- Payment will be co-ordinated by the Worldwide Co-ordination Centre or WPA;
- **We will always pay bills totalling more than £300 directly to the provider of your treatment – not to you or your representative**, so do not make payment for your treatment in cash if the total payment is over £300 as we will not be able to refund it to you. If payment is under £300, please keep a copy of the invoice and a receipt demonstrating proof of payment;
- If you have a Shared Responsibility element (see page 31) on your policy this will apply.

## Elective Overseas Treatment

**Elective overseas treatment** is treatment overseas (outside the UK) that is not an emergency, and where part or the whole reason for travelling or being abroad is to get that treatment.

It applies only to treatment that is otherwise covered by your policy.



What is covered:



We will contribute to the cost of elective overseas treatment to no greater extent than if you had your treatment in the UK, but only if:



The proposed treatment overseas has been recommended or is supported in writing by the specialist who is treating you in the UK and the specialist or your GP writes to us to confirm this at your expense; and



You send us a written quotation of the full cost before you arrange the treatment. We will refer this and the letter from your specialist/GP to our Medical Adviser for pre-authorisation and approval. We will then consider the extent to which we can contribute to the cost of your elective treatment overseas. and



We confirm the extent to which we will assist you in writing before you undertake the treatment.



**We will make an administration charge for authorising your elective overseas treatment which will be 5% of the cost of treatment with a minimum fee of £250;**



Please note that we will be in direct contact with the hospital and consultant who will be providing your treatment before the treatment takes place.



Payment for your treatment:



Once we have authorised your treatment we will be happy to fund it in advance to the agreed level - however we will only make payment direct to the provider of your treatment by international fund transfer;



**Do not make any payment for your treatment in cash as we will not be able to refund it to you;**



We will need all the original accounts and medical reports before we can make any payment.



You are not covered for:



Treatment that we have not pre-authorised;



Treatment that costs more than the contribution we have agreed;



Treatment not normally covered in the UK by your policy, for example treatment that is not established;

- Treatment either overseas or on your return to the UK for a medical condition contracted or injury sustained whilst in a location to which you travelled (during the period of the advice) against advice issued by the Foreign and Commonwealth Office (FCO);
- Any travel costs relating to your treatment abroad;
- Any cost relating to companion(s) travelling with you;
- The cost of accommodation except for the charges made for your hospital admission;
- Any cost relating to evacuation or repatriation in the event of complications or death;
- Any additional charges made by the hospital in the event of complications. **We therefore strongly advise you** to seek a package deal with the hospital abroad that includes treatment of unforeseen complications.

## 4.6 Dental Option

You can claim this benefit if your company has chosen this option. Please check your Certificate of Registration to see if you have this option.

Dental Treatment	
<b>General Dental Treatment</b> performed by a registered dentist or dental hygienist in general practice. There is a 3 month qualifying period from the start date of this option. (A breakdown of costs will be required for all invoices over £120)	75% of costs up to £250 per person per group policy year
<b>Dental Emergencies</b> for any incidence of acute pain or swelling requiring an emergency appointment. There is a 14 day qualifying period from the start date of this option. <b>(see important benefit note 4.6.1)</b>	Up to £250 per person per course of treatment up to a maximum of £1,000 per group policy year
<b>Dental injuries</b> caused by an external blow to the face, teeth or jaw. We need evidence that an emergency appointment with your dentist or Accident & Emergency department has taken place. You must advise us within 72 hours of the injury and all treatment will need pre-authorisation on receipt of a detailed treatment plan and must be completed within 12 months of the initial injury. <b>(see important benefit note 4.6.2)</b>	Up to £20,000 per person per group policy year
<b>Defined Oral Problems</b> when treated by a recognised Consultant Oral/Maxillo-Facial Surgeon where fees are customary and reasonable. You must advise us within 72 hours of the problem being diagnosed and all treatment will need pre-authorisation once we receive a detailed treatment plan <b>(see important benefit note 4.6.3)</b>	Up to £10,000 per person per group policy year

**Cover is provided for dental treatment in the UK only with the exception of dental emergencies.**

**We will pay in line with the WPA Dental Schedule (available by visiting [wpa.org.uk/dentalschedule](http://wpa.org.uk/dentalschedule)).**

**We will pay cash benefit towards original, receipted accounts.**

**Children under the age of 18 are entitled to free treatment under the terms and conditions of the NHS and are therefore excluded from benefit for General Dental Treatment (including hygienist treatment) and Dental Emergencies.**



**Please note benefit for the removal of wisdom teeth is only available when undertaken in general practice in a dentist's chair.**

#### 4.6.1 Dental Emergencies

If you require emergency assistance you can call the WPA Emergency Denteline (020 8666 9222) or when overseas (+44 20 8666 9222) anytime night or day.



You will be covered for treatment undertaken at the emergency appointment and any subsequent appointments within 3 months for any treatment that could not be completed at the initial emergency appointment.



You are not covered for the provision of dentures, artificial teeth, veneers or work involving the use of precious metals.

#### 4.6.2 Dental Injuries



You are not covered for any dental injuries sustained whilst participating in any contact sport where the appropriate mouth protection was not worn at the time of the injury.



We will only provide benefit for the cost of a replacement veneer if the original is damaged as a result of a dental injury.

#### 4.6.3 Defined Oral Problems



Benefit will be available for the following defined serious oral problems:



Oral Cancer, including reconstructive plastic surgery;



Treatment of cysts, odontoma or tumours of the mouth or jaw;



Treatment of conditions of the salivary glands;



Surgical removal of buried roots and not simply extraction of teeth;



Surgery to remove temporomandibular joint.



You are not covered for adhesive bridges of the Maryland or Rochette type or orthodontic treatment.

## 4.7 Corporate Cash Plan Option

You can claim these benefits if your company has chosen this option. It provides cover for medical expenses incurred in the UK only. Please check your Certificate of Registration to see if you have this option.



**You cannot claim for treatment on the Corporate Cash Plan if it is also covered by your Enterprise Flexible Benefits policy.**

Treatment	75% of bills up to:
<b>Dental</b>	Up to £150 per person per group policy year
<b>Optical</b> (Except for disposable lenses)	Up to £150 per person per group policy year
<b>Specialist Consultations</b>	Up to £250 per person per group policy year
<b>Chiropody</b>	Up to £125 per person per group policy year
<b>Therapy</b> on referral by your GP	Up to £300 per person per group policy year
<b>GP Fees</b>	Up to £60 per person per group policy year
<b>Health Screening</b> for one health screen per group policy year (excluding health screenings required for legal, insurance or employment reasons)	Up to £200 per person per group policy year
Cash Benefits	Full Re-imbusement:
<b>Maternity/Paternity</b> (Not available to child dependants)	£200 per birth
<b>Post Hospital Recovery Bonus</b> (A bonus of £400 after a hospital inpatient stay of 14 consecutive nights or more)	£400 per person per group policy year
<b>Hospital In-patient Admission</b> (when admitted to an NHS hospital for treatment)	£65 per night up to a maximum of 50 nights per group policy year
<b>Day-patient Admission</b> (when admitted to hospital for treatment for which you occupy a bed)	£65 per day up to a maximum of 5 days per group policy year
<b>Accident &amp; Emergency (A&amp;E) Attendance</b> (Excludes any follow up visits)	£40 per day
<b>Helpline Services</b> (please refer to page 25 for full details)	24 hours, 365 days

There is a 6 month qualifying period for all benefits except maternity/paternity which has a 10 month qualifying period.

To claim the Maternity benefit the mother of the child must hold a Corporate Cash Plan and to claim the Paternity benefit the father must hold a Corporate Cash Plan.

Immediate cover is available for Accident & Emergency (A&E) Attendance.

We will pay cash benefit towards original, receipted accounts.

Benefit is calculated at half the above rates for child family members.

## 4.8 Helpline Services

These services are available 24 hours a day, 7 days a week whilst your cover remains in force.

Benefits	
<b>Health and Medical Information</b> – a wide range of health information and non-diagnostic advice on medical matters, including side effects of drugs, self help groups, waiting lists, general health and fitness, childhood illnesses and vaccinations, and travel health and immunisation (These advice lines are available from 9am until midnight – 7 days a week)	Simply call: 0117 934 0486
<b>Counselling</b> – administered by counselling professionals who can provide confidential counselling over the phone on personal issues including bereavement including where appropriate onward referral to relevant voluntary or professional services	Simply call: 0117 934 0476
<b>Childcare Assistance/Homecare Assistance</b> – the advice service will help you find cleaning staff, au pairs, cooks, housekeepers, qualified child minders or nannies (You will be responsible for the payment of any fees incurred for these services)	Simply call: 0117 934 0486

We do not accept any responsibility if the Helpline Services are unavailable for reasons we cannot control. The Helpline Services are provided by DAS Assistance Ltd.

## 5. What Is Not Covered

5.1 General Exclusions

5.2 Specific Exclusions

5.3 Non-Established Treatment

## 5.1 General Exclusions

Some conditions and types of treatment are not covered by your group policy, whether or not you have any personal medical exclusions.

We cannot pay your claim if:

- You have not been referred by your GP to a specialist/therapist we recognise;
- Your treatment is carried out by any provider of treatment who is related to you/the patient or is recommended by a GP who is a member of your/the patient's family;
- You cease to live in the UK;
- Your group policy is not in force and/or the premiums are not up to date at the time of treatment;
- Your company terminates your group policy;
- Your claim has not been pre-authorised;
- Your treatment is covered by a private medical insurance policy with a different insurer or healthcare cash plan provider which you have not told us about;
- As a matter of general legal principle no one can be paid more than once for the same expense under one or more insurance indemnity policy (ie an insured may not make a profit from claims).
- Private Medical Insurance is an indemnity policy. If you or your family members hold more than one indemnity policy you must tell us (for example if you also have travel insurance or hold an individual policy but are also covered by your own or a partner's company medical insurance). If you make

a claim we will contact the other insurer and share the claim between us.

- Your treatment took place outside the UK (unless you have Worldwide cover or pre-authorisation);
- You accept or have accepted any inducement (financial or otherwise) to have private treatment.

## 5.2 Specific Exclusions

### Allergic conditions

Treatment related to or arising from neutralising/desensitising these.

### Cosmetic/aesthetic treatment

This is treatment intended to improve the patient's appearance.

- Cosmetic or aesthetic treatment whether or not for psychological purposes except when needed as a direct result of an accident or injury;
- Care and/or treatment arising from or related to breast modification except for one reason as below;
  - One procedure for breast reduction following cancer surgery in the opposite breast
  - One procedure for breast reconstruction on one or both sides after removal of one or both breast(s) as part of the treatment for cancer.
- Further treatment arising from or related to cosmetic surgery;
- Any form of cosmetic dentistry (eg bleaching, veneers or implants).



### **Dangerous activities/circumstances**

Care and/or treatment arising from or related to you or any family members taking part in winter sports of any kind, scuba diving and motor sports of any kind. You are strongly advised to take out the appropriate specialist insurance if you are undertaking a particular sport or activity.

If you are not sure whether an activity you plan to do falls within this rule you should check with us first.

### Professional sports

- Care and/or treatment arising from or related to engaging in professional sport that is a sport where any fee, donation or benefit in kind is received either directly or indirectly for playing, training or coaching;

### War, invasion, riot, revolution, act of terrorism

- Medical conditions arising out of war, invasion, riot, revolution, act of terrorism (unless covered under the Emergency Worldwide Option – see page 18), act of piracy, nuclear, biological or chemical contamination or any similar event.



### **Deliberately self-inflicted injuries or attempted suicide**



### **Dental treatment (unless this is covered by the Dental Option)**

**Developmental, behavioural or learning problems (or speech problems arising from these)**

**Dialysis for chronic kidney failure, unless we agree to cover as part of emergency treatment**

**Drug/substance dependency or abuse of alcohol, drugs or other addictive substances**

**Genetic tests**

**HIV, AIDS or similar infections**

Care and/or treatment arising from or related to HIV, AIDS or similar infections or illnesses and injuries or medical conditions arising from these;

**Neonatal treatment for babies within 91 days of birth**

**Obesity**

Investigations and/or treatment either medical or surgical for obesity.

**Optical treatment (unless this is covered by the Cash Plan Option)**

**Organ transplant**

Operations including investigations done before the operation or treatment needed as a result of the operation;

A transplant is where a patient receives an organ or tissue from another person

(surgically implanted or infused). This does not include blood transfusion. We will however cover cornea transplants or skin grafts, and bone marrow or stem cell transplants where this forms part of treatment for cancer.

**Out-patient drugs/dressings**

This includes drugs and dressings you are given to take home from hospital unless they are needed to complete a short course of treatment (eg antibiotics).

**Pre-existing medical conditions**

Any disease, illness or injury for which: you have received medication, advice or treatment

or

you have experienced symptoms whether the condition has been diagnosed or not before or on the date cover started.

**Pregnancy, fertility problems, assisted conception, contraception, miscarriage, sterilisation or hormone replacement therapy (HRT)**

Any investigations, care or treatment arising from or related to the above conditions.

**Preventative tests or operations even if there is a family history of that condition**

**Receipted accounts**

We will not cover cash plan or dental plan claims where we have not been sent the original receipts.

**Rehabilitation**

→ You are not covered for rehabilitation, unless the rehabilitation immediately follows an in-patient admission that has been covered by your policy and we specifically agree the extent of the cover before the rehabilitation starts;

- We will then agree to cover only a short course of rehabilitation (normally 2 weeks) which will not be extended.

**Routine medical examinations, health screening or medical appliances**, such as:

- Hearing aids;
- Wheelchairs;
- Crutches;
- Orthoses;
- Braces.

**Sexual problems**

- Sexual dysfunction (however caused);
- Sexually transmitted diseases;
- Care and/or treatment arising from or related to sex change/gender reassignment.

**Snoring or sleep disorders**

- Sleep apnoea including sleep studies or corrective surgery.

**Terminal care**

Treatment that concentrates on controlling pain and other symptoms when the patient is near or approaching the end of life and active treatment is no longer considered effective or appropriate.



### **Varicose veins**

- In the first 2 years of cover;
- Micro-sclerotherapy for thread veins and other superficial veins.

## **5.3 Non-Established Treatment**

### **Established treatment is treatment:**

- Approved by NICE for routine use in the NHS;
- For which there is substantial clinical evidence of benefit;
- Accepted and practised by more than one group of specialists in the field in the UK;
- Involves the use of drugs that are recognised and licensed in the UK for safe use and for the stage of the condition being treated;
- Considered to be acceptable recognised clinical practice by WPA's Medical Advisors in the particular circumstances.

Treatments which do not meet these criteria will be deemed non-established.

## 6. Important Information

- 6.1 Underwriting Explained
- 6.2 Shared Responsibility Explained
- 6.3 Long Term Conditions (also called chronic conditions)
- 6.4 Excess Payments
- 6.5 The Contract
- 6.6 Cancellation
- 6.7 Complaints
- 6.8 Fraud
- 6.9 Data Protection
- 6.10 Personal Injury Claims

## 6.1 Underwriting Explained

When you and your family members apply to join an Enterprise Flexible Benefits scheme you may join in one of two ways – Fully Underwritten or Continued Personal Medical Exclusions (known as CPME for short).

When we refer to medical conditions in this section we also mean symptoms, diseases, illnesses or injuries that are linked to the medical conditions you have.

### Fully Underwritten

Your policy does not cover medical conditions that you (and your family) already have, or any related conditions, when you join the company scheme. So on the application form we ask you to give us details of your (and your family's) medical history and if necessary, we may write to your doctor for more information.

It is essential that you give us all the information we ask for, even if you have symptoms that have not been diagnosed. If you don't, you may find that we may not be able to pay any claim that you make in the future, or may even cancel your group scheme membership. If you are not sure whether or not to mention something, you should do so.

If you have a medical condition which our underwriters feel is likely to come back, we will issue a policy, but that condition (and

any related to it) will not be covered, either indefinitely, or for a set period of time.

### Continued Personal Medical Exclusions (CPME)

If you and your family already have medical insurance and were fully underwritten by your last insurer, we may be able to offer you CPME cover. We will still ask you to fill in the application form with your medical history so that we can decide this.

If we accept you for CPME cover, you will continue to have the same medical exclusions you had with your previous policy but in any case you will not be covered for medical conditions that started before you took out your previous policy.

It is important to note that the rules of Enterprise Flexible Benefits may be different from those of your previous policy.

## 6.2 Shared Responsibility Explained

If you have a Shared Responsibility option you will pay 25% of admissible claims up to the Shared Responsibility annual maximum limit (£250, £500, £1,000, £3,000 or £5,000). WPA will pay 75% of eligible treatment costs and 100% of admissible costs once you have reached your maximum annual limit until your next renewal date.

→ Your Shared Responsibility personal annual limit applies once per person, per group

- policy year and will be allocated to the group policy year in which you had the treatment; When you have treatment, please arrange for the provider of the treatment to send the bill straight to us. We will pay 75% of the eligible expenses to the provider of your treatment and advise you how much you need to pay direct to the provider. Once you have paid your Shared Responsibility personal annual limit we will meet all further eligible costs within the group policy limits;
- Please note that we cannot accept payment to us of your share of the treatment costs. You must pay this directly to the provider of your treatment;
- Please note that Shared Responsibility does not apply to any Dental or Cash Plan claims;
- Shared Responsibility annual limits can only be reduced by one step at a time and only at renewal.

## 6.3 Long Term Conditions (also called chronic conditions)

**You can download the leaflet from our website at [wpa.org.uk](http://wpa.org.uk)**

Your policy is intended to cover short-term, not long-term treatment of acute medical conditions (which start after you have taken out your policy). An acute medical condition is defined by most medical insurers as '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.'

It is not intended to cover treatment for conditions that keep on coming back or need long term monitoring and management or conditions that can only be controlled by repetitive treatment or medicines. These are called chronic conditions for which continuing treatment or repeated operations are often necessary. Examples are diabetes, glaucoma, ulcerative colitis, rheumatoid or juvenile arthritis and Crohn's disease.

### What is a chronic medical condition?

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 will only decide that your condition is chronic once we have received a report from the doctor who is in charge of your treatment and taken that advice into account. We will give you time to make other arrangements for your future treatment, such as asking your doctor to transfer you to NHS care.

### What does this mean in practice?

If your illness or medical condition requires recurring consultations over a long period (normally more than a year), checks on your medication or long term therapy or treatment to ease symptoms, your condition may have become chronic. If you are having therapy such as osteopathy, physiotherapy or chiropractic treatment, we would normally consider treatment that has been ongoing for more than 6 months to be long-term.

It may not always be clear when you first have your treatment that your condition may become chronic. We will try to let you know as soon as we are aware your claim is for a condition that may become chronic. However, the fact that we have paid for such treatment in the past does not mean that we are liable to continue to cover it.

So if your treatment has been ongoing for some time, or if it seems that it is intended to only manage your condition or keep your symptoms in check then we may need to review your condition with your doctor to establish whether or not it has, in fact, become chronic.

### What happens next?

- First, we will write to you and explain why we think your condition may have become chronic;
- We will ask your permission to contact your specialist or GP who knows your particular

circumstances. We will explain to them that we think your condition may have become chronic and ask whether we are correct and if not, why;

- Your doctor's reply will be put before our Medical Advisor if there is any doubt as to the decision we should make;
- If we then feel that your condition has become chronic we will let you know, and give you time to make other arrangements for your continued treatment, such as asking your GP to transfer you to NHS care;
- We will always take note of your particular circumstances and look at your case on an individual basis;
- If we establish that your condition is not currently chronic, we may need to review it again, after a period of time. In this event we will advise you and your specialist when we will need an update on your condition.

### What if my condition gets worse?

- If your condition flares up again, we will cover further short-term treatment to stabilise it;
- We will never limit your cover if you suddenly become dangerously ill; and
  - we have paid for the condition in the past;
  - general medical opinion supports further treatment and;
  - your doctor(s) can confirm that the treatment will be likely to stabilise your condition so you can resume a normal life.

## 6.4 Excess Payments

If your group policy membership has an excess this will be deducted just once per person each policy year from the first admissible claim and any subsequent claim until the excess has been exhausted. It will not be deducted from any Cash Plan or Dental Plan claim. We cannot accept cheques in payment of your excess – you will need to send payment of any shortfall to the provider of your treatment.

You will still need to send us a claim form, even if you have an excess and need to pay all or part of the fees you are claiming yourself, so that we can deduct the excess correctly.

## 6.5 The Contract

This contract can only be enforced by WPA and/or the policyholder. No rights of enforcement or any other rights are given to any third parties, including family member(s).

## 6.6 Cancellation

If you are not satisfied with your policy and the benefit it provides you have the right to cancel your policy provided you notify us within 14 days of receiving your policy documents. If you purchased your policy on-line you can cancel within 28 days of receiving your policy documents. If you do not exercise this right within the 14/28 day period then you are committed to the

cover and premium for the rest of the cover period. You must return your Certificate of Registration with your notice to cancel.

## 6.7 Complaints

If you have a complaint you can write, e-mail or telephone the member of staff/Appointed Representative you have been dealing with and ask them to refer the matter to the appropriate level of management. The manager will send you a decision letter. If you are not satisfied with this, the Independent Review Team will independently review your case. If at any stage you feel your complaint has not been satisfactorily resolved, please do not hesitate to contact the Director of Best Practice at WPA. We have a free leaflet, which explains our complaints procedure and we will be pleased to send you a copy if you ask for one.

### Financial Ombudsman Service (FOS)

WPA is a member of the FOS. This provides an independent and impartial method of resolving complaints. The Ombudsman will need to know that you have given us the chance to put things right. If we are unable to resolve a complaint we will send you a leaflet setting out details of the service the FOS provides.

### The Ombudsman's address is:

The Financial Ombudsman Service  
South Quay Plaza, 183 Marsh Wall, London  
E14 9SR  
(Telephone: 0845 080 1800)

The laws of England will apply in the event of any dispute.

### Financial Services Compensation Scheme (FSCS)

WPA customers are covered by the FSCS which can provide entitlement to compensation to customers where an insurer cannot meet its obligations. Further information about compensation scheme arrangements is available from the FSCS ([www.fscs.org.uk](http://www.fscs.org.uk)).

## 6.8 Fraud

We have a duty to all our customers to take all reasonable measures to detect and prevent fraudulent claims.

You and any family members have a right to the details of the fraud prevention agencies we use. For information contact [RiskReviewGroup@wpa.org.uk](mailto:RiskReviewGroup@wpa.org.uk)

We reserve the right to check the details of your claim with the provider(s) of your treatment. We always refer suspicious or fraudulent claims to the police.

We may request access to your medical records including any medical referral letters so as to establish the eligibility of any claim. If you refuse to provide such access, we reserve the right to refuse your



claim and will recoup any previous monies that we paid in respect of that medical condition.

You must tell us if you have any unspent conviction evidencing fraud, theft or dishonesty when you complete your WPA group policy application form. You have a continuing duty to tell us of any such unspent conviction that you may acquire while your group policy is in force.

We reserve the right to ask you for proof of identity when you apply for a WPA group policy and at any time thereafter when appropriate.

It is important that you also read 'How we may use your personal data or disclose it to third parties' below.

## 6.9 Data Protection

We take our responsibility regarding the confidentiality of our customers' personal information very seriously. Any information you give to us (your name, address, bank details and medical history) will be processed accurately and held securely in accordance with the Data Protection Act 1998.

Except where stated below we will never disclose any information about customers to third parties.

### **How we may use your personal data or disclose it to third parties:**

- To process your claims and administer your policy;
- To liaise with your treatment provider regarding treatment details and costs;
- To process claims that are also covered by another insurer or other party;
- To help us to develop services that we think may be in your interest;
- For statistical analysis to help us to assess how the scheme you belong to is used;
- To detect and prevent fraud or improper claims. We may check your details with a fraud prevention agency/agencies and if you give us false or inaccurate information and we suspect fraud, we will record and investigate this. Please note that WPA works with other organisations to pool information about applications or claims which are believed to be fraudulent. Where potential fraud is notified to us, or identified by us, we will investigate this. For more information about our fraud prevention policy contact [riskreviewgroup@wpa.org.uk](mailto:riskreviewgroup@wpa.org.uk)

### **In the course of administering your policy we will disclose administration and claims data to:**

- The staff of WPA and its subsidiaries, FSA registered appointed representatives, agents and medical advisors;
- Countries outside the EEA (European Economic Area) which may not have data protection legislation in place. However a contract will be in place to ensure that your

information is protected and we will remain bound by our obligations under the Data Protection Act.

By becoming a WPA customer you are consenting to the use and disclosure of your data as set out above for yourself and your family members.

### **Giving you information**

We may advise you by letter, telephone, electronic mail or otherwise of services or products which we believe you may be interested in. If you do not wish to receive such information please tell us at any time.

Neither we, nor our FSA Appointed Representatives will pass your details on to other companies or to any third party for marketing purposes.

You have a right to know what information we hold about you. We may request a small administration fee for supplying a copy of any personal information and for amending any inaccuracies.

### **Communication**

We may monitor any communication we have with you, including telephone conversations, to assist with the administration of your policy;

You should notify us of any changes to your personal information such as a change to your name or address to ensure your personal information is correct and up to date.

E-mails are a useful way for you to contact us and for us to communicate with you – but please remember that the e-mail address you give us must be secure and not accessible by anyone else (e.g. a work e-mail address).

## **6.10 Personal Injury Claims**

WPA has a right in law to recover any medical expenses within the rules of your policy membership if you make a claim for treatment for an accident or illness that was the fault of someone else (a third party).

You will not be entitled to claim for these expenses unless you comply with the requirements of the Claims Co-operation procedure. Please contact us on 01823 625270 and we will be pleased to send you a leaflet.

## 7. Policy Administration

- 7.1 Joining And Re-purchasing
- 7.2 Retired Employees
- 7.3 Payment Of Premiums
- 7.4 Making Changes
- 7.5 Ending Your Group Policy Membership
- 7.6 Definitions

## 7.1 Joining and Re-purchasing

The group must consist of a minimum of 3 employees (not including family members) who are actively involved with the company and at least 2 must reside at different addresses.

You can apply to join if you are a director, partner, proprietor or employee of the company and are 16 years of age or over. However, if you are aged 65 or over, you must be fully underwritten. A compulsory Shared Responsibility of £3,000 will also apply.

Child dependants may remain on the policy up to the age of 21 or 25 if in full time education.

If 2 employees working for the company are both eligible to join the group policy then they must do so as separate policyholders regardless of the status of their relationship.

Family dependants may apply to be included on the group policy with the consent of the company/employer. A family member may be a partner/spouse and/or any unmarried children who are under 21 years of age and living with you or 25 and in full time education when joining the policy or at any renewal.

We have the right to refuse cover to anyone who does not meet our criteria.

A group policy member is a member of staff who is principally insured under the group policy. This does not confer any rights in relation to the affairs of WPA, but confirms the right to the benefits of the group policy. The group policy member may sometimes be referred to as you/your. With the consent of your company/ employer, family members maybe included in your group policy membership.

The Group Policy is an annual contract of insurance and we will automatically offer to renew it and will send you the relevant information including any changes to the Group Policy for the forthcoming year at least twenty-one (21) days before the contract expires, unless you advise us otherwise.

## 7.2 Retired Employees

Retired employees can apply to be included as members of a group policy as long as they represent no more than 25% of the group's policyholders. They will only be taken on as fully underwritten joiners with a compulsory Shared Responsibility of £3,000.



Care should be taken when including retired members over the age of 65 into this group policy as more favourable terms are often available within individual policies.

We strongly recommend the company seeks professional advice before offering private medical insurance to retired employees and including it on a contractual basis.

## 7.3 Payment of Premiums

Your group policy membership is for a whole policy year and is an annual contract of insurance, however you are personally insured for the cover period. This is a year if the whole premium is paid at the beginning of the policy year, 3 months if it is paid quarterly or a month if it is paid monthly.

Your company is responsible for paying the premiums to us and can only recover from you premiums which relate to your family member(s).

If your company has chosen to pay the full annual premium at the start of the policy year this must be paid before you are entitled to any benefits. If your company has chosen to pay each quarter or each month they must make each payment on time for that period. Your cover will end if your premium is not paid when it is due or your company terminates your group policy membership. Neither you nor your family members will then have an automatic right to re-join this policy, or take out another policy with us.

Cancellation of the policy cannot be backdated. WPA will not refund premiums where cover is cancelled or lapses mid-term.

If your company pays your premiums by instalments and your cover is cancelled or lapses part way through the policy year we reserve the right to collect the premiums which are outstanding for the remainder of the policy year or deduct them from any outstanding claims.

We may alter premiums to reflect any changes in the tax charged on them or the services for which benefit is paid, provided we give at least 3 weeks' written notice of the change to your company.

## 7.4 Making Changes

Your company can only renew the policy or change the cover it offers on the annual renewal date. The new terms, benefits and premiums will then apply.

### **Changes, including the addition of new group policyholders and cancellations, cannot be backdated.**

If you change your name or address you must tell us and your company straightaway, in writing, by telephone or by e-mail, and give us the new name or address and the date of the change or you may visit our website at [wpa.org.uk](http://wpa.org.uk) to make these changes yourself on-line. We will issue you a new Certificate of Registration

within 4 working days to confirm the change.

## 7.5 Ending your group policy membership

We may at any time end or change the terms of your group policy membership or stop providing benefit in any of the following circumstances:

### **If you or your family members or your company:**

- Fail to act honestly in relation to your group policy and WPA;
- Recklessly or negligently mislead us or give incorrect information;
- And/or fail to pay premiums.

In any of these circumstances you must return any benefit we have paid as a result of misleading information and we will not refund any part of your premiums.

If you transfer to another of our private medical insurance schemes, we may need to fully underwrite your policy and apply special terms.

### **If we:**

- Decide to discontinue all or part of the policy or it ceases to comply with current legislation;
- Discover the group policy doesn't cover at least 3 employees, partners or proprietors of the company (not including family members) at inception of the policy and at the beginning of any policy year.

In these circumstances we will refund the part of the premiums that applies to the period after the policy is discontinued or offer registration in another suitable WPA policy.

### **The policy will end if:**

- You leave the UK to live elsewhere;
- A resolution or an order has been passed for the winding up of WPA;
- You cease to be employed by your company.

## 7.6 Definitions

Some words and phrases used in WPA policies have a particular meaning and this is explained below. These definitions may not all apply to your particular policy, depending on the cover it offers.

### **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;

### **Cancer**

A malignant process of tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue;

**Chronic condition**

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;

**Contract**

The group policy consists of your completed, signed and dated application, this Guide, your Certificate of Registration and any other document setting out information affecting the rights and obligations of each of us concerning group policy membership. Your family members will also be treated as party to the group policy and so are bound by its terms;

**Curative intent**

Curative intent applies to when treatment that is administered with a reasonable expectation that it will restore the patient close to the state of health enjoyed prior to the disease being diagnosed, and the patient will be alive and disease free 5 years after commencement of the treatment;

**Day patient treatment**

Treatment which, for medical reasons, means you are admitted to a hospital or day patient unit because you need a period of medically supervised recovery but you do not occupy a bed overnight;

**Diagnostic tests**

Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms;

**Eligible treatment**

Treatment for which your group policy provides a benefit, given by a provider of treatment we recognise for a condition which is not excluded by the rules of your group policy or by any personal medical exclusion;

**In-patient treatment**

Treatment which, for medical reasons, means that you are admitted to hospital and you occupy a bed overnight or longer, for medical reasons;

**Nurse**

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

**Out-patient treatment**

Treatment given when attending a hospital, consulting room, or outpatient clinic and is not admitted as a day patient or an inpatient.

**Pre-existing condition**

Any disease, illness or injury for which:

- You have received medication, advice or treatment; or
- You have experienced symptoms (whether the condition has been diagnosed or not before the start of your cover);

**Related condition**

Any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury;

**Transfer**

When a group policy member or family member(s) moves from one group policy or level of cover or from one group policy to another;

**Treatment**

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

**UK**

England, Wales, Scotland, Northern Ireland, the Channel Islands and the Isle of Man;

**Us, we, our**

This association, the Western Provident Association Limited (WPA);

**Western Provident Association (WPA) Limited**

Rivergate House, Blackbrook Park,  
Taunton, Somerset TA1 2PE;

**You/your/yourself**

The person named on the Certificate of Registration and any registered family members.

## 8. Directory

### Useful Contact Numbers:

Customer Service Team:	01823 625270
Customer Service Team Fax:	01823 625380
Worldwide Co-ordination Centre (with Worldwide Option):	(+44) 20 8680 3800
WPA Emergency Dentaline (with Dental Option):	0208 6669222 (or when overseas, +44 20 8666 9222)
Foreign and Commonwealth Office for travel information:	0845 8502829
Financial Ombudsman Service	0845 0801800
Health and Medical Information:	0117 9340486 *
Counselling:	0117 9340476 *
Childcare Assistance/Homecare Assistance:	0117 9340486 *

\*Helpline services are provided by DAS Assistance Ltd

### WPA Weblinks and Email Addresses:

<a href="http://www.wpa.org.uk">www.wpa.org.uk</a>	WPA's Website - full service and claim facility online
<a href="mailto:cbd@wpa.org.uk">cbd@wpa.org.uk</a>	Customer Service Team Email Address
<a href="http://www.wpa.org.uk/products/efb">www.wpa.org.uk/products/efb</a>	Enterprise Flexible Benefits Scheme Details
<a href="http://www.wpa.org.uk/general/claim.html">www.wpa.org.uk/general/claim.html</a>	Online iClaim service
<a href="http://www.wpa.org.uk/guideline">www.wpa.org.uk/guideline</a>	Fee Guidelines
<a href="http://www.wpa.org.uk/dentalschedule">www.wpa.org.uk/dentalschedule</a>	Dental Fee Guidelines
<a href="http://www.wpa.org.uk/cancer">www.wpa.org.uk/cancer</a>	Full Details of Cancer Cover
<a href="http://www.wpa.org.uk/complaint">www.wpa.org.uk/complaint</a>	Complaint procedure details
<a href="mailto:riskreviewgroup@wpa.org.uk">riskreviewgroup@wpa.org.uk</a>	Email for details of our fraud prevention policy

### Other Useful Websites:

<a href="http://www.fco.gov.uk">www.fco.gov.uk</a>	Foreign and Commonwealth Office
<a href="http://www.drfooster.co.uk">www.drfooster.co.uk</a>	Consultant details
<a href="http://www.medical-acupuncture.co.uk">www.medical-acupuncture.co.uk</a>	British Medical Acupuncture Society
<a href="http://www.osteopathy.org.uk">www.osteopathy.org.uk</a>	General Osteopathic Council
<a href="http://www.gcc-uk.org">www.gcc-uk.org</a>	General Chiropractic Council
<a href="http://www.feetforlife.org">www.feetforlife.org</a>	Society of Chiropractors and Podiatrists
<a href="http://www.truhomeopathy.org">www.truhomeopathy.org</a>	British Homeopathic Association
<a href="http://www.bacp.co.uk">www.bacp.co.uk</a>	British Association for Counselling and Psychotherapy
<a href="http://www.bps.org.uk">www.bps.org.uk</a>	British Psychological Society
<a href="http://www.psychotherapy.org.uk">www.psychotherapy.org.uk</a>	UK Council for Psychotherapy
<a href="http://www.hpc-uk.org">www.hpc-uk.org</a>	Health Professions Council

WPA is authorised and regulated by the Financial Services Authority (FSA). The FSA website may be checked at [www.fsa.gov.uk/register](http://www.fsa.gov.uk/register) for WPA number 202608.



FS 28452

WPA is one of very few insurance companies world-wide to have been certified to the ISO 9001:2000 Quality Standard. In addition Western Provident was awarded the British Standard Institute's 'Gold Standard' of Company Wide Registration in May 1997 – the 24th company in the world to achieve this accolade. So the standards of service that you can expect are truly world class.



WPA is a member of the Financial Ombudsman Service, so you can be assured that any complaints are addressed seriously and objectively. Details of WPA's commitment to resolving customer complaints are included in your group policy literature.

WPA customers are covered by the Financial Services Compensation Scheme (FSCS) which can entitle customers to compensation should an insurer become insolvent. Further information can be found at [www.fscs.org.uk](http://www.fscs.org.uk)



EMS 505226

WPA is one of the first UK companies to achieve the environmental quality standard.



[wpa.org.uk](http://wpa.org.uk)

**Enjoy life. Insure health.**

**Western Provident Association Limited**

Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE

E-mail: [cbd@wpa.org.uk](mailto:cbd@wpa.org.uk)

Registered in England No. 475557

WPA is a registered service mark of Western Provident Association Limited.

The member state of the insurer is the United Kingdom.

To help protect your interests, and those of the Association, telephone conversations may be recorded for the purpose of ensuring an accurate record of discussions.

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