

Company Health Insurance

Enterprise Flexible Benefits: A Guide to Your Group Policy

Effective from 1 March 2010



wpa.org.uk



ISO 9001
FS 28452



BS 25999
BCMS 538164



ISO 14001
EMS 505226



ISO 27001
IS 553152

CONTENTS

Section	Page
1 How To Use This Guide	1
2 Your Policy	2
3 Claims	5
4 Benefits	8
5 What Is Not Covered	36
6 Important Information (including cancellation rights)	41
7 Policy Administration	45
8 Directory	51

1. HOW TO USE THIS GUIDE

Welcome to WPA's Enterprise Flexible Benefits

This guide sets out your and our rights and obligations affecting your group policy membership/policy, and this contract of insurance.

For your own benefit you should take time to read through 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

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.

Visit our website at wpa.org.uk for service online and our iClaim facility at wpa.org.uk/claim

If you have any questions please call 01823 625270 (check our real-time telephone stats at wpa.org.uk and click on Phoning us?) or email ebd@wpa.org.uk and we'll be happy to help.

2. 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, 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 does not cover long term management or maintenance of incurable conditions.

The purpose of private medical insurance is to indemnify you for your medical costs in accordance with your prevailing benefits. If payment is made direct to providers it is made on your behalf.



It is important to note that private medical insurance is not designed to be a replacement for the NHS, but rather to complement it.



Your group policy covers acute 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.



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.



Your policy does not cover:

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

2.3

Secondary Care

This is treatment given by a specialist or therapist on the referral of your GP. 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 ultrasound scan/x-rays if you have the Therapy Option.

2.4

Critical Care

! We define Critical Care as 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 private Critical Care Unit following:

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

✗ We will not pay for:

- Treatment in a unit or facility which is not a dedicated Critical Care Unit;
- Admission as a private patient 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 following an emergency (unplanned/non elective) 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 a medical emergency, we advise you to consult your GP, call the NHS emergency services or attend your local NHS A & E department as they are best equipped to provide the emergency care.

Once the medical condition has been stabilised you may wish to arrange transfer to private facilities. The transfer to a private bed must be arranged by the specialist at the patient's own request and of his/her own free will; At this stage you must get authorisation from us as the transfer must be agreed in advance between the specialist and us-otherwise no funding will be available. The patient needs to complete and sign the hospital's appropriate authorisation form. Private treatment will only be covered with effect from the date the form was signed.

✗ **We will not pay benefit for emergency admission into a private hospital as private hospital admissions are for planned treatment only.**

3. CLAIMS

3.1 How To Make A Claim

3.2 Claims Processing

3.3 Personal Injury Claims

3.4 Dual Insurance

3.1

How to make a claim

- ! All claims must be pre-authorized. You can then be sure that we recognise your specialist or therapist, that we cover the hospital you have chosen and that your medical condition and the treatment you are to have are not excluded by any rules or personal medical exclusions.
- You may claim for treatment which relates to the benefits listed on your Benefit Table which apply to your policy at the date your treatment is given provided the policy is in force at the time of treatment and no personal exclusions apply.
- We will pay in line with the rules which are in force on the date of your treatment, not on the date that your condition was first noticed or diagnosed.
 - Start by visiting your GP - Primary Care. Your GP may refer you to a specialist or therapist for Secondary Care.
 - You must 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.
 - Based on the information you give us, we will let you know in writing whether the treatment is covered.
 - We will send you a claim form (declaration) to be signed by your GP, specialist or therapist.
 - Send the completed claim declaration (together with original receipts for relevant Top-Up or Dental option claims) to WPA, Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE.
 - For Dental, Worldwide or Top-Up claims please download a claim form from our website wpa.org.uk/claim

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

- You must first be referred by your GP to a specialist
- Your specialist needs to sign the declaration confirming the details of your claim for specialist or hospital treatment;
- Your therapist can sign the declaration for physiotherapy or other therapy treatment. After you have had a maximum of 8 sessions, we need your GP to confirm that any ongoing treatment is medically necessary.

If you have been covered by WPA for **less than two years** your GP needs to sign a declaration for all claims.

We can only pay your claim if:

- Your claim has been pre-authorised;
- We formally recognise the specialist/therapist/dentist you have been referred to;
- The hospital you use is on our list of recognised hospitals;
- Your treatment is not given by any provider of treatment who is related to you/the patient or recommended by a GP who is a member of your/the patient's family;
- You have sent us a fully completed declaration;
- Your treatment is for an acute condition;
- You continue to live in the UK for at least 6 months a year;
- Your policy is in force and/or the premiums are up to date at the time of treatment
- Your treatment took place within the UK (unless explicitly authorised by WPA);
- You do not accept any inducement (financial or otherwise) to have private treatment;
- The treatment was not carried out solely at your request.

The charges for any treatment must be customary and reasonable.

- If we make a claims payment in error we will explain this to you and we reserve the right to offset the value of the incorrect payment against the amount payable for other claims on your policy.

3.2

Claims Processing

- If you have paid for any part of your authorised treatment and wish us to repay you, you must send us the original invoice and proof of payment such as a valid credit card receipt.
- Hand written receipts will not be accepted.
- If we need medical evidence in support of your claim we will invite you to contact your doctor to provide it to us. If you refuse to co-operate fully, we may refuse your claim and may recover anything we have already paid in respect of that medical condition from you.

- We can also require your treatment provider to supply us with any information we feel reasonably necessary in relation to your treatment details, costs, bills submitted to us both for processing your claim and to minimise fraud.

3.3

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.

3.4

Dual Insurance

If you are making a claim on your policy, and you have insurance with an other insurer for healthcare, you must tell us. We may need to contact the other company as we are not liable to pay more than our proportionate share when split between the insurance companies.

4. BENEFITS

- 4.1 Essential
- 4.2 Cancer Care
- 4.3 Out-patient Option
- 4.4 Therapy Option
- 4.5 Emergency Worldwide Option
- 4.6 Dental Option
- 4.7 Helpline Services
- 4.8 Top-Up

4.1 Ess

Essential

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

In-patient & Day-patient Treatment	
Hospital charges including accommodation charges, operating theatre fees, drugs, dressings and medicines used whilst you are in hospital (There is an annual maximum limit of 28 days for any critical care unit (see important benefit note 4.1.2))	Full refund within and in accordance with our hospital agreements
Specialists' fees 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 (see important benefit note 4.1.3)	Full refund of customary and reasonable fees
Diagnostic tests such as blood tests, ultrasound, x-rays whilst in hospital receiving in-patient or day-patient treatment	Full refund of customary and reasonable fees
Diagnostic MRI, CT & PET Scans whilst in hospital receiving in-patient or day-patient treatment	Full refund of customary and reasonable fees
NHS Cash Benefit for any in-patient or day-patient treatment received as an NHS patient which is covered by your policy (see important benefit note 4.1.5)	£100 for each day/night max of £3,000 per person per group policy year
Psychiatric Treatment for in-patient or day-patient treatment for a maximum period of 28 days/nights in 5 consecutive policy years	Pre-authorisation is required
Out-Patient Treatment *	
Consultations with a private specialist we recognise	Up to £150 per person per group policy year
Single Post Operative Consultation within the 90 days following a surgical procedure	Full refund of customary and reasonable fees
Out-patient diagnostic MRI, CT & PET scans on the referral of your specialist only	Full refund of customary and reasonable fees
Out-patient surgical procedures carried out by a recognised specialist	Full refund of customary and reasonable fees
Pre-admission Tests 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
Cancer care	
Radiotherapy/Chemotherapy (please refer to Section 4.2 for full details)	Full refund of customary and reasonable fees
Consultations with a specialist (please refer to Section 4.2 for full details)	Full refund of customary and reasonable fees
Advanced Therapeutics (please refer to Section 4.2 for full details)	Pre-authorisation is required
NHS Cash Benefit 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	
Nursing at home 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 (see important benefit note 4.1.6)	Pre-authorisation is required
Private Ambulance Transport when medically necessary for transport to and from hospital for treatment which is covered by your policy	Full refund of customary and reasonable fees
Parent & Child 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
Prostheses which are medically necessary as an integral part of your operation however this excludes such items as artificial limbs (see important benefit note 4.1.4)	Pre-authorisation is required
Out of Pocket Expenses 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
Hospice Donation 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
Helpline Services (please refer to page 27 for full details)	24 hours, 365 days

* When as a private In or Day case patient

4.1.1

Recognition of provider

We reserve the right to withdraw or amend our list of recognised providers (without prior notice if necessary) in such a way as we feel is reasonable and commercially necessary - this may include hospitals, specialists, therapists etc.

Any change will be reflected on our website.

4.1.2

In-patient/Day-patient treatment

You are covered for accommodation charges, operating theatre fees, drugs, dressings and medicines used while you are in hospital as a day-patient or in-patient. The hospital will usually send the invoice straight to us. We will pay the hospital direct. If you are given a copy of the invoice before you leave hospital please check that it appears to be correct before you send it to us.



You are not covered for:

- Treatment in a hospital that is not on our hospital list and so is not currently recognised;
- Treatment in convalescent, nursing or residential homes, health-hydros, nature cure clinics or similar establishments;

- Private in-patient treatment following an accident and emergency admission to a hospital unless the transfer to a private bed is arranged by the specialist at the patient's own request and of his/her own free will. The patient needs to complete and sign the hospital's appropriate authorisation form. Private treatment will only be covered with effect from the date the form was signed.

4.1.3

Specialist Fees

We will cover treatment provided or requested by a medical practitioner currently registered and holding a licence to practice whose name appears on the current GMC Specialist Register and is certified as a specialist by its appropriate college or specialty body providing a regulatory function.

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.

4.1.4

Prostheses

Prostheses are internal permanent replacements for body parts.

They may be passive or active.

Passive prostheses

These are inert replacements of joints, blood vessels or other organs. Examples include a hip replacement or an aortic graft, but not an artificial limb or electronic device;



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 pre-authorisation by our Medical Advisory and Clinical Governance Committee;
- The customary and reasonable costs of insertion.



You are not covered for:

- Artificial limbs;
- Prostheses that are experimental or not in established use;

Active prostheses – electronic implantable medical devices

These electronic devices are usually implanted permanently within the body to correct or modify an abnormal bodily function caused by disease, illness or injury. Examples include muscle or nerve stimulators and pacemakers or defibrillators.

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.



We will pay for:

- The customary and reasonable cost of the initial supply and fitting of such a device to prevent the risk of potentially fatal organ failure e.g. cardiac pacemakers or defibrillators provided:
- The device is in established use and;
- The device has been approved by NICE and is accepted and recognised treatment within the NHS.



You are not covered for:

- Implantable muscle or nerve stimulators, cochlear implants or intracranial devices for neurological conditions;
- Any subsequent maintenance of the device. This includes battery replacement or replacement because of ageing or technological advance and any failure in the device due to manufacture, broken leads or misplacement. Battery replacement or renewal would be available on the NHS;
- Treatment with any device that has not been specifically authorised in advance.

Note: We will only fund the insertion of an active prosthesis once in a lifetime.

4.1.5

NHS Cash benefit

Where Essentials and Wellness have been chosen, the Essentials full benefit must have been claimed before the Wellness benefit can be paid.

4.1.6
















Nursing at home

We do not fund nurses for help with mobility or personal care.

- Treatment must be provided by a qualified nurse at your main address for up to four (4) weeks;
- This must be recommended by your specialist so that you can leave hospital early provided that you are able to have the same level of nursing care at home. The nursing should be arranged by your specialist and your specialist remains in charge of your treatment;
- You must contact WPA before nursing at home can be arranged.

4.2 Cancer Care

This is a summary of the cancer care cover that we offer. Remember that all claims must be pre-authorised.

Cover	
Place of treatment	 Established investigations and active treatments for cancer in the UK in hospital as an in-patient or day-patient or 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	 You are not covered for screening or tests to determine the existence of a condition for which you do not have any symptoms but may be at risk (including genetic tests) the removal of tissue (biopsy) or preventative treatment 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"> • Chemotherapy • Advanced Therapeutics (Targeted Therapies) that are not readily available to you as an NHS patient for a maximum of 12 consecutive months from the start of treatment with them. This benefit can be extended if the treating oncologist provides us with convincing clinical evidence that it continues to be given with curative intent, in which case we will continue to fund it, with a further review after 3 months. • Biological therapy e.g. hormone tablets when these can only be supplied by your specialist, not your GP.
	 You are not covered for 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)	 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 a maximum of 5 years 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.
	 You are not covered for new or experimental treatment outside these conditions.
Clinical trials	 We may pay for pre-authorised 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 in-patient or day-patient provided your claim is covered by the rules of your policy. A financial contribution to the cancer unit caring for you will be made if you ask us to do so to improve the service for others using the unit.
Bone marrow or stem cell treatment	 One complete procedure per lifetime for each individual person covered by the policy but only if not readily available on the NHS. You must contact us 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	 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.

4.2.1

Cancer Care

What do you need to do if cancer is diagnosed?

All claims must be pre-authorized before your treatment starts. We will work together with your oncologist to smooth your claim process.



We will pay:

Customary and reasonable charges for:

- Active, established investigations and treatments in the UK for cancer whether a new cancer or a recurrence ;
- Treatment in hospital as an in-patient or day-patient, as an out-patient or at home;
- Surgery, radiotherapy, chemotherapy and Advanced Therapeutics (see below) intended to remove or kill off cancerous cells.

Advanced Therapeutics (Targeted Therapies) if:

- Your oncologist confirms that they would not be readily available to you as an NHS patient; and
- They have been granted an European Medicines Agency (EMA) product licence for use in the particular clinical condition; 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 explicitly agree to cover their use in advance (as for all claims).

- We will pay for a course of treatment with Advanced Therapeutics (Targeted Therapies) for 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 will be extended subject to expert oncology advice if your oncologist gives us convincing objective evidence of continuing disease and clinical benefit and that the drug continues to be given with curative intent.
- Funding for Advanced Therapeutics will be reviewed at 3 monthly intervals.
- For blood cancers, for example leukaemia, it is more difficult to find objective evidence that cancer is no longer present. In these cases we will fund up to 12 months treatment with Advanced Therapeutics (Targeted Therapies). In special circumstances this will be extended subject to expert oncology advice.
- Adjuvant Therapy is sometimes given in order to clear any cancer cells not removed by the initial surgery or radiotherapy. We will fund up to 12 months treatment for Advanced Therapeutics (Targeted Therapies) when given as Adjuvant Therapy in line with currently acceptable international guidelines.
- Further funding for Advanced Therapeutics (Targeted Therapies) would be available to you if you were to develop a different (histologically distinct) cancer.

Follow up consultations

- Covered for up to 5 years from the completion of active treatment for your cancer.

Clinical trials

- We may help with some 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 UKCCR.
- Any side effects or complications that result directly or indirectly from the trial are not covered as they would be funded by the NHS.
- You are not covered for inclusion in clinical trials in the private sector or treatment for side effects or complications arising directly or indirectly from inclusion in such trials.
- Tell us before you volunteer to be included in any research trial.

Treatment outside the UK

- We may approve cancer investigations or treatment outside the UK up to the level of benefit of the nearest equivalent procedure or treatment regime in the UK. No treatment will be funded without prior authorisation.

Bone marrow or stem-cell transplants

- We will pay for one complete procedure per lifetime for each individual person covered by the policy if it is not readily available to you on the NHS. We must agree to cover this before your bone marrow or stem-cell treatment starts. Costs to the donor will not be covered.



What is not covered:

- Either long term monitoring or treatment given to maintain good health in the absence of symptoms and objective signs of active cancer, or for preventative use.
- Advanced Therapeutics (Targeted Therapies) or bone marrow or stem cell transplants that are readily available to you on the NHS as confirmed by your oncologist.
- Treatment or care for cancer which is 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.
- Treatment that we have not pre-authorized or treatment that is prescribed by a General Practitioner and not by a recognised specialist.

4.3 O/P

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

4.3.1

Consultations with specialist



We will cover treatment provided or requested by a specialist who is a medical practitioner holding a license to practise whose name appears on the current GMC Specialist Register and is certified as a specialist by the appropriate college or specialty body providing a regulatory function.

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 psychiatric specialist

Treatment must be pre-authorised. If your specialist refers you for any psychology/psychotherapy treatment you must have the therapy option. You can then claim for a maximum period of 3 consecutive months. Check the benefit available if you have the therapy option as there is an annual limit.



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

4.4 **Thpy**

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	
Acupuncture when treated by a member of the British Medical Acupuncture Society or Acupuncture Association for Chartered Physiotherapists	Up to a total of £1,000 per person per group policy year
Chiropody/Podiatry when treated by a practitioner who is on the Register of Chiropodists/Podiatrists of the Health Professions Council (see important benefit note 4.4.1)	
Chiropractic when treated by a practitioner who is on the Register of the General Chiropractic Council	
Dietary Services when treated by a dietician who is on the Register of Dieticians of the Health Professions Council	
Homeopathy when treated by a Fellow (FFHom) or a Member of the Faculty of Homeopathy (MFHom) (see important benefit note 4.4.2)	
Osteopathy when treated by a practitioner who is on the Register of the General Osteopathic Council	
Physiotherapy when treated by a practitioner who is on the Register of Physiotherapists of the Health Professions Council	
Psychology/psychotherapy A therapist must be a practitioner who is on the Register of Psychologists of the Health Professions Council, a member of the British Association of Psychotherapists (BAP), the United Kingdom Council of Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP), the British Association for Behavioural and Cognitive Psychotherapies (BABCP) or the British Psychoanalytic Council (BPC) (see important benefit note 4.4.3)	
Speech and Language Therapy when treated by a therapist who is on the Register of Speech and Language Therapists of the Health Professions Council	
GP referral for Ultrasound scans/X-rays 75% of the cost 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 - other than as set out below.



We will cover surgery to the forefoot by a WPA recognised NHS Consultant Podiatric Surgeon – if we agree this in advance.

4.4.2

Homeopathy



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

4.4.3

Psychology/Psychotherapy

Treatment must be 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 27).
- A therapist must be a practitioner who is on the Register of Psychologists of the Health Professions Council, a member of the British Association of Psychotherapists (BAP), the United Kingdom Council of Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP), the British Association for Behavioural and Cognitive Psychotherapies (BABCP) or the British Psychoanalytic Council (BPC)



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

4.5

Emergency Worldwide Option

The Worldwide Option provides cover for eligible emergency treatment whilst you are outside the UK up to the benefit limits of the cover your company have selected. Unless we explicitly tell you otherwise, the general rules in this Guide will apply unless this conflicts with your Certificate of Registration.




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 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.

Treatment must be given by locally recognised providers or in a locally recognised hospital.

-  **No treatment will be funded unless you have contacted the Worldwide Co-ordination Centre on (+44) 20 8680 3800 and cover has been agreed.**
-  **If you are taken ill during your trip before the end of 35/70 days (dependant on the limits of your cover), cover for eligible treatment will continue until such time as you are well enough to travel home.**
-  **Important note: in the USA Worldwide 70 will only give the same level of cover as Worldwide 35.**

WW35

Worldwide 35	
Emergency overseas treatment for a sudden acute illness or injury that for medical reasons cannot be delayed until your return to the UK	Overall annual maximum of £250,000
Evacuation/Repatriation including family members by air ambulance when local medical facilities are inadequate (see important benefit notes 4.5.1 & 4.5.2)	

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.

WW70

Worldwide 70	
Emergency overseas treatment for a sudden acute illness or injury that for medical reasons cannot be delayed until your return to the UK	Overall annual maximum of £500,000
Evacuation/Repatriation including family members by air ambulance when local medical facilities are inadequate (see important benefit notes 4.5.1 & 4.5.2)	

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.



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

4.5.1

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.

4.5.2

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 under the emergency worldwide option for treatment:

- Not authorised by the Worldwide Co-ordination Centre;
- That you can have using your European Health Insurance Card (EHIC) or if there is a reciprocal health agreement between the UK and the country where treatment takes place.
- 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.
- Either overseas or on your return to the UK for a medical condition contracted or injury sustained if you travelled against medical advice;
- You needed because you did not take the necessary precautions e.g. vaccinations;

- Not covered by the rules of your policy or outside the benefit limits;
- That you can also claim for under the terms of a Travel Insurance or other insurance policy. We will only pay our share of the claim;
- If you have a medical condition that is terminal.

Also:

- Trips outside the UK falling outside the limits set out in the Benefit Table.

How You Make a Claim

No treatment will be funded unless authorised by 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.



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 on your policy this will apply.

Elective Overseas Treatment

This is treatment overseas (outside the UK) where part or the whole reason for travelling or being abroad is to get that treatment. It applies only to treatment that is normally 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 Advisor for agreement 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 under Elective Overseas Treatment for:
- Treatment that we have not explicitly agreed in advance;
 - 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 if you have a medical condition that is terminal;
 - 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 Dent

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	
General Dental Treatment 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. (see important note 4.6.1)	75% of costs up to £250 per person per group policy year
Dental Emergencies 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 (see important note 4.6.2)	Up to £250 per person per course of treatment up to a maximum of £1,000 per group policy year
Dental injuries 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 (see important note 4.6.3)	Up to £20,000 per person per group policy year
Defined Oral Problems 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 (see important benefit note 4.6.4)	Up to £10,000 per person per group policy year
Other Dental Benefits	
Hospital Charges including accommodation charges, drugs, dressings and medicines used whilst you are in hospital (see important note 4.6.5)	In line with customary and reasonable fees
Specialist/Consultant Fees whilst you are in hospital (see important note 4.6.6)	In line with customary and reasonable fees
Hospital Cash Benefit for any in-patient or day-patient treatment received as an NHS patient which is covered by your policy (see important note 4.6.7)	£200 for each day/night you spend within an NHS hospital, payable as part of the maximum benefit allowed by either the Dental Injury or Defined Oral Problem benefits
Parent and Child cover for accommodation charges made by the hospital for one parent to accompany a child patient when recommended by the specialist (see important note 4.6.8)	In line with customary and reasonable fees

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).

We will need original, receipted accounts.

Children under the age of 18 are entitled to 50% of the benefit available and 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.

With the exception of General Dental Treatment you are not covered for dental problems that started on or before the date your cover started on the Dental Option.

4.6.1

General Dental Treatment

Treatment not classed as an Emergency Dental Injury or Defined Oral Problem

- Treatment must be by a **registered dental surgeon, registered hygienist or dental therapist** in general dental practice.
- ✔ We will pay 75% up to £250 for general Dental treatment.
- Original invoices and proof of payment such as a valid credit card receipt must be attached to all dental claims.
- ! If wisdom teeth are extracted this must be carried out in the dentist's chair in a dental surgery.
- ✘ You are not covered for:
 - Treatment outside the UK;
 - Treatment received within the first 3 months from your Dental cover start date;
 - Treatment that requires hospitalisation;
 - Implants, orthodontics, appliances (such as mouth guards);
 - Cosmetic/aesthetic treatment (e.g. veneers, bleaching etc.);
 - Treatment relating to periodontal disease.

4.6.2

Dental Emergencies

Treatment carried out in the UK and abroad not classed as a dental injury or defined oral problem.

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

- A dental emergency is an incident of acute pain, swelling or dental haemorrhage requiring an emergency dental appointment.
- Treatment must be carried out in a dentist's chair (general dental surgery) by a registered dentist or A&E department only.
- An episode/course of treatment starts from the date of the initial emergency appointment and continues up to the completion of treatment which must take place within 3 consecutive months.
- ! Wisdom teeth are covered only when carried out as a dental emergency (or under the General Dental Treatment benefit if carried out in the dentist's chair in a dental surgery).
- ✘ You are not covered for:
 - Treatment received within the first 14 days from your Dental Option cover start date;
 - Treatment that requires hospitalisation;
 - Treatment relating to periodontal disease;
 - Implants, dentures and orthodontics.

4.6.3

Dental Injuries

This is treatment required for dental injuries received as a result of an injury to the patient's teeth and support structures caused by an extra oral impact (an external blow to the face, teeth or jaws).

We must explicitly agree any treatment plan following a dental injury before it starts or no claims can be paid.

- You must inform us and have the emergency appointment with a dentist or at a hospital Accident & Emergency (A&E) department within 72 hours of the injury.
- You can only claim this benefit if you have had an emergency appointment first.
- Should the injury occur outside the UK and you need an emergency appointment abroad, we will cover the cost of your emergency treatment abroad up to the limit shown on the Benefit Table. All subsequent treatment relating to this injury will be subject to the normal limits and must be undertaken in the UK only;
- Your dentist must provide a treatment plan for any treatment that cannot be undertaken at the emergency appointment with:
 - A full report on the incident and all injuries sustained, including
 - Photographic evidence of the facial injury and x-rays to show the injuries sustained;
 - Evidence that the injury is not related to chronic periodontal disease;
 - The type of treatment;
 - The date the treatment will begin and finish;
 - The name of the recognised treatment provider who will undertake the treatment;
 - Detailed treatment costs.

We will consider your claim on the basis of this information and let you know if you are covered. Your claim will not be valid until this has been done.



- You are not covered for:
- Treatment outside the UK except as detailed above;
 - Treatment following an accident if you did not inform us and if you did not have an emergency appointment with a dentist or at a hospital Accident & Emergency (A&E) department within 72 hours;
 - Treatment for dental injuries sustained while participating in any contact sport (e.g. American Football, Boxing, Hockey, Ice Hockey, Lacrosse, Martial Arts, Rugby) when the appropriate mouth protection was not worn at the time of injury. We will ask for evidence that a mouth protector was worn at the time the injury was sustained.
 - Treatment given more than 12 months after the date of the extra oral impact to which the treatment relates unless we have agreed in writing to cover it;
 - Treatment relating to periodontal disease;
 - Veneers unless the original was damaged as a result of the dental injury;
 - Orthodontic treatment, except the repair of orthodontic appliances as a result of a the dental injury;
 - Treatment resulting from accidents to dentures or implants;
 - More than 2 implants per policy year;
 - Treatment arising as a result of a road traffic accident / collision where you were not wearing a seat belt or a suitable child restraint.

4.6.4

Defined Oral Problems

These are:

- Treatment of oral cancer including reconstructive plastic surgery;
- Treatment of bone cyst of the jaw (i.e. not tooth or gum cysts);
- Treatment of tumour of the mouth or jaw;
- Treatment of conditions of the salivary glands;
- Surgical removal of retained buried roots under general anaesthetic (extraction of roots which can be done in a dentist's chair are not included in this benefit);
- Surgery to the temporomandibular joint;
- Treatment must be carried out by a Consultant Oral/Maxillo-Facial Surgeon/ recognised specialist in hospital and not carried out by a dentist unless part of follow-up treatment agreed by us;
- Before your treatment starts we need a detailed treatment plan including costs and x-rays from your Consultant Oral/Maxillo-Facial Surgeon/ recognised Specialist to show the diagnosis of the defined oral problem and that the treatment is not needed because of chronic periodontal (gum) disease;
- If you need to claim you must contact us within 72 hours of the diagnosis of a defined oral problem so that we can confirm the extent of your cover.



- You are not covered for:
- Treatment given following diagnosis if you did not inform us within 72 hours of the diagnosis;
 - Treatment relating to periodontal (gum) disease;
 - Treatment of tooth-related cysts;
 - Orthodontic treatment and appliances (such as mouthguards);
 - More than 2 implants per defined oral claim.

4.6.5

Hospital Charges

This benefit is payable within the maximum benefit allowed by either the Dental Injury benefit or the Defined Oral Problems benefit.

4.6.6

Specialists'/Consultants' fees whilst you are in hospital

This benefit will be payable as part of the maximum benefit allowed by either the Dental Injury benefit or the Defined Oral Problems benefit.

4.6.7

Hospital Cash Benefits (applies to Dental Injuries & Defined Oral Problems)

Payable as part of the maximum benefit allowed by either the Dental Injury Benefit or the Defined Oral Problem benefit.

- A cash benefit for each night you spend as a non-private (NHS) patient or as a day-patient in an NHS hospital, without charge or overseas in a hospital where no charge is made by the hospital or Consultant Oral/Maxillo-Facial Surgeon/ recognised Specialist instead of being admitted to hospital as a private patient;
- Up to a maximum of 10 nights;
- The hospital will need to confirm the dates you were in hospital.

4.6.8

Parent and Child

Payable as part of the maximum benefit allowed by either the Dental Injury Benefit or the Defined Oral Problem benefit.

- The accommodation charge made by the hospital for one parent/child to stay in hospital with your child/parent, on the specialist's recommendation and provided the patient is covered by this policy.

WPA Dental Schedule

The WPA Dental Schedule is available by contacting us or by visiting wpa.org.uk/dental-schedule. This schedule shows the maximum amount we will pay for treatment under the Dental Injury and Defined Oral Problems benefits.

4.7 HS

Helpline Services

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

Benefits	
Health and Medical Information – 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	Simply call: 0800 915 8082
Counselling – 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: 0800 915 8082
Emergency Domestic Repair Assistance – this service will help you find approved and vetted contractors to cover emergency domestic repairs which includes plumbing, electricians, locksmith, heating engineers, carpenters and roofing specialists (you will be responsible for the payment of any fees incurred for these services).	Simply call: 0800 915 8082

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

4.8 Top-Up

You can claim these benefits if your company has chosen this option. It provides cover for medical expenses.

Wellness	
Prescription Charges	We pay 100% of each bill up to £40 per plan year
Specialist/Second Opinion	We pay 100% of each bill up to £250 per plan year
Eye Test	We pay 100% of each bill up to £40 per plan year
Optical Treatment	We pay 75% of each bill up to £150 per plan year
Routine Dental Treatment	We pay 75% of each bill up to £150 per plan year
Physiotherapy and other therapies	We pay 75% of each bill up to £300 per plan year
GP Services	We pay 75% of each bill up to £150 per plan year
Health Screening	We pay for 75% of 1 health screen each plan year up to £200
NHS Hospital In/Day patient Admission	We give you £65 per day/night for up to 20 days per plan year
Post Hospital Recovery Bonus	We give you £400.00 after 7 consecutive nights in hospital
A&E Attendance *	We give you £40 for each emergency attendance up to £80 per plan year
Maternity/Paternity	We give you £200 each time you have a child
Health & Medical Information *	We provide 24/7 telephone support
Confidential Stress Counselling Service *	We provide 24/7 telephone support

Wellness - Important note:

Important - Please note: there is a 10 month qualifying period for maternity/paternity benefit, 6 months for health screening and 1 month for all other benefits unless marked *. Maternity/paternity benefit is only available for persons over the age of 18 years. Health screens for employment reasons are excluded.

* No qualifying period.

4.8 Top-Up Your plan

The purpose of Top-Up is to complement the charges made by the National Health Service (NHS) which, although generally free at the point of care, can involve an element of self funding.

Top-Up provides valuable cash benefits towards everyday medical expenses. We will settle all claims directly with you once you have received and paid for the treatment with the exception of treatment abroad, cosmetic surgery or cancer drugs, which are paid to the provider.



Important

Receipt requirements - all receipts must:

- Be unaltered originals and not copies;
- Show the full name and address of the treatment provider;
- Show the patient's full name;
- Show a description of the treatment given, including dates and amounts paid;
- Please note: we do not accept invoices or treatment plans;
- Receipts will not be returned.

We will carefully review the contents of your application. We reserve the right to decline cover to applicants in appropriate circumstances (e.g. people with high BMI, people on a supervised health screening or review programme for cancer or other circumstance in our absolute discretion).

How to make a claim

- For **Wellness** please visit wpa.org.uk and complete the online claim form. All claims for **A&E Abroad**, **Cosmetic Surgery** and **mycancerdrugs** must be pre-authorised;
- You must contact us in advance to tell us about any proposed treatment;
- **For A&E Abroad** call our Worldwide Co-ordination Centre on (+44) 20 8680 3800;
- **For Cosmetic Surgery** call your helpdesk (see page 51);
- **For mycancerdrugs** call your helpdesk (see page 51).

Alternatively, phone us using the numbers shown on page 51 which is appropriate for your scheme. You will need your customer number which is shown on your Certificate of Registration.

Please note it may be necessary to request a medical report from your GP and if one is needed we will write to tell you why. If you refuse to provide such access, we reserve the right to refuse your claim and will recoup from you any previous monies that we paid in respect of that medical condition.

4.8.1 Optical Treatment



We will pay 75% of each bill up to £150 per plan year towards the cost of new prescription glasses (reading, distance or bi/varifocals) or new prescription contact lenses. There is a 1 month qualifying period for this benefit.



You are not covered for:
Replacement of disposable contact lenses (by disposable we mean daily or monthly).

4.8.2 Physiotherapy and Other Therapies

All therapists must be members of one of the following:

- Physiotherapists - Register of Physiotherapists (HPC);
- Osteopathy - Register of General Osteopathic Council;
- Homeopathy - when treated by a Fellow (FFHom) or a Member of the Faculty of Homeopathy (MFHom);
- Psychotherapy - when treated by a therapist who is a member of the British Psychological Society (BPS), the British Association of Psychotherapists (BAP), the United Kingdom Council for Psychotherapy (UKCP), the British Association for Counselling and Psychotherapy (BACP), the British Association for Behavioural and Cognitive Psychotherapies (BABCP) or the British Psychoanalytic Council (BPC);
- Chiropractic - Register of General Chiropractic Council;
- Acupuncture - British Medical Acupuncture Society.

4.8.3

Health Screening

- ✔ We will pay 75% towards one health screen every plan year up to £200. There is a 6 month qualifying period for this benefit.
- ✘ You are not covered for:
Any health screening required for employment reasons.

4.8.4

Post Hospital Recovery Bonus

- ✔ We will pay a cash benefit of £400 per plan year after 7 consecutive nights in hospital. There is a 1 month qualifying period for this benefit.

A&E Abroad	
GP/medical fees and medically referred x-rays, tests and prescription medication	We pay up to £150 per plan year
Routine Dental Treatment	Your £150 Dental benefit under Wellness can also be claimed when abroad
Hospital treatment for medical emergencies overseas (injury or sudden acute illness) including Evacuation/Repatriation	We pay up to £100,000 per plan year
Worldwide network of medical professionals with valuable local knowledge	We provide 24/7 telephone support

A&E Abroad - Important note:

Important - Please note: Benefits apply to trips abroad no more than 21 days and a maximum total of 90 days in each plan year.

Cancer Drugs	
We cover cancer drugs which are licensed by the European Medical Agency (EMA) and recommended by your cancer specialist but not yet approved by the National Institute for Health and Clinical Excellence (NICE) and therefore not available on the NHS	Up to £50,000 Lifetime benefit where these drugs are administered in the NHS or in the private sector

Cancer Drugs - Important note:

Important: This benefit will be removed at the renewal following your 65th birthday. You will not be eligible for this option if you, your parents, brothers or sisters (under the age of 60) have had, or at the time of application have, any form of Cancer or are on a medically supervised health screening or review programme because you/they are considered to be at higher risk of developing cancer or for pre-existing conditions. There is a 90 day deferment period for this option. This option is not available if you already have Private Medical Insurance either with WPA or an alternative provider.

A&E Abroad

This is not a full travel insurance plan but an additional benefit which offers restricted cover for emergency medical treatment abroad (except USA or where the FCO advises against travel).

GP/Medical Fees

- ✔ You are covered for GP/Medical fees and medically referred x-rays, tests, and prescription medications.

Hospital Treatment for Medical Emergencies

- ✔ You are covered for trips abroad for up to 21 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 £100,000.

Should you be taken ill during your trip before 21 days have elapsed, cover for eligible treatment will continue until such time as medical advice indicates you are well enough to travel home - subject to overall £100,000 limit.

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.

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. 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.

Mycancerdrugs

- ✔ Mycancerdrugs provides each person on cover with up to £50,000 lifetime benefit towards the cost of providing you with cancer drugs not available from the NHS. The drugs must be prescribed by the UK consultant in charge of your cancer treatment with curative intent. The £50,000 benefit limit is applied across the lifetime of each person whilst they are insured by this plan (not per plan year) and under the age of 65 years. Cover is only available for cancer drugs that have been licensed and approved by the European Medicines Agency (EMA). In addition they must be used to treat the specific stage and type of cancer (i.e. the therapeutic indications) that the drugs are authorised for. The drugs that WPA authorise are constantly updated and are available on our website at wpa.org.uk/topup Further information is available at www.emea.europa.eu/htms/human/epar/a.htm. Where it is not possible for an NHS hospital to administer the drug, WPA will fund customary and reasonable private sector charges for the administration of the drug and any directly related costs within the lifetime benefit limit of £50,000. Funding for these drugs will only be provided where objective evidence of clinical benefit and curative intent is available (typically reviewed every 3 months).
- Cancer drugs that are not readily available on the NHS.

- ✘ You are not covered for:
 - Cancers diagnosed for which symptoms develop before or within the first 90 days of your plan starting;
 - Maintenance or remission of cancer, where these agents are used to maintain good health in the absence of symptoms;
 - Cancer treatment where there is no objective evidence of improvement or evidence of clinical benefit/curative intent;
 - Treatment undertaken solely at your request.

Treatment Denial

If your local NHS will not allow you to top-up your NHS treatment with privately funded cancer drugs under the Cancer Drugs option, the benefit funds the administration of these drugs in the private sector.

- ✘ We cannot pay your claim if:
 - You have not obtained pre-authorisation in advance of treatment (see contact numbers on page 51);
 - Your plan is not in force and/or the premiums are not up to date at the time of treatment;
 - This specific cancer treatment is covered by another Private Medical Insurance plan and/or a cash/dental plan;
 - Your treatment took place outside the UK.

- ✘ You will not be eligible for cover if:
 - You have had, or at the time of application have, cancer or symptoms of cancer;
 - Either your parents, brothers or sisters have developed or died from cancer under the age of 60;

- You are on a medically supervised health screening or review programme because you are considered to be at higher risk of developing cancer.
- You have Private Medical cover either with WPA or an alternative provider. All cancer cover will cease from the date of renewal following your 65th birthday.

- ✘ You are not covered for:
 - Maintenance or remission of cancer, where these agents are used to maintain good health in the absence of symptoms;
 - Cancer treatment where there is no objective evidence of improvement or evidence of clinical benefit/curative intent;
 - Treatment undertaken solely at your request;

Cosmetic Surgery	
Option 1: Upper Body includes: Arms, Face, Neck & Breasts	We pay up to £20,000 per plan year towards treatment
Option 2: Lower Body includes: Stomach & Legs	We pay up to £20,000 per plan year towards treatment
Option 3: Total Body	We pay up to £20,000 per plan year towards treatment

Cosmetic Surgery - Important note:

Important - Please note: Hands and feet are excluded from cover. There is a 1 month qualifying period for Cosmetic Surgery. Benefits are only available for scars in excess of 1cm in length that have been caused by accidents and injuries. Deliberately self-inflicted injuries are not covered. We will not pay for any treatment which results from accident or injury sustained which has, or may be, the subject of a criminal proceeding or conviction, including road traffic offences.

Cosmetic Surgery



We will pay up to £20,000 per plan year towards reconstructive cosmetic surgery following an accident or injury resulting in a scar of over 1cm in length which happened after you took out the plan to any part of:

Option 1: your arms, face, neck and breasts excluding your hands.

Option 2: your stomach and legs excluding your feet.

Option 3: your body excluding your hands and feet. There is a 1 month qualifying period for this benefit.



You are not covered for:

- Any treatment which results from injury or accident sustained which has or may be the subject of a criminal proceedings or conviction (including Road Traffic Offences);
- Birth defects;
- Dangerous activities (see page 37)
- Deliberately self inflicted injuries or attempted suicide;
- Scars that are less than 1cm;
- Treatment given without our prior written approval;
- Treatment given following an accident or injury if you did not inform WPA at the earliest opportunity after the accident/injury.

Note: it often takes over a year for injury to settle before reconstructive plastic surgery can take place. Benefit is available up to 2 years after reporting the injury/accident. Surgery must be conducted under the care of a surgeon who is a member of The British Association of Aesthetic Plastic Surgeons. You must receive initial medical treatment, GP or hospital (e.g. A&E) attendance within 72 hours of the accident or injury which resulted in the scarring of over 1cm in length and you must inform WPA at the earliest opportunity after the accident or injury.

Medical and Legal Helpline

Expert Legal Helpline

Legal guidance and information provided by experienced legal advisors

Medical Legal Helpline



Experienced solicitors who are selected for their skill in explaining complex legal matters in everyday language provide personal legal guidance and information. This service is available 24 hours a day, 7 days a week. Due to the technical nature of some enquiries it may be necessary to arrange a call back. **Simply call: 0800 915 8082**

The Helpline is provided by the Validium Group Ltd. The Validium Group Ltd will not accept responsibility if the helpline services are unavailable for reasons they cannot control. The territorial limits of the legal advice service are under the laws of the member countries of England, Scotland and Northern Ireland.

5. WHAT IS NOT COVERED

5.1 General Exclusions

5.1

General Exclusions

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

Your Policy Does Not Cover

Allergic conditions

- Treatment related to or arising from neutralising/desensitising these.

Babies

- Treatment for babies/foetuses/embryos before or within 90 days of birth.
- Any condition that is present at birth or detected in the first 90 days of life.

Breast surgery

Care and/or treatment arising from or related to breast modification whether for medical or psychological reasons for example gynaecomastia (breast enlargement in men) except as shown here:

We will pay for:

- 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.

Cosmetic/aesthetic treatment

- Treatment intended to improve the patient's appearance 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 reduction or enlargement;
- Further treatment arising from or related to cosmetic surgery;
- Any form of cosmetic dentistry (e.g. bleaching, veneers or implants).


Dangerous activities/circumstances.

- Care and/or treatment arising from or related to you or any family members covered on your policy who take part in winter sports of any kind, or any accident or injury that occurs whilst on a winter sports holiday;
- Scuba diving and motor sports of any kind;
- Any extreme sports;
- If you are not sure whether an activity you plan to do falls within this rule you should check with us first.
- You are strongly advised to take out the appropriate specialist insurance if you are undertaking a particular sport or activity and that this insurance covers you for treatment whilst in the UK or abroad.
- 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;
- Medical conditions arising out of war, invasion, riot, revolution, act of terrorism, act of piracy, nuclear, biological or chemical contamination or any similar event.

Care and/or 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.


Deliberately self-inflicted injuries or attempted suicide


- Care and/or treatment arising from or related to deliberately self inflicted injuries or attempted suicide.

 **Dental Treatment (unless covered by the Dental Option).** This means treatment of a condition which involves any teeth, their roots and surrounding tissue attachments.

Developmental, behavioural or educational problems (or speech problems arising from these)

- Care and/or treatment arising from or related to these;
- We will however pay for an initial consultation with a consultant, specialist or with a psychologist we recognise to diagnose the cause of the symptoms. Full psychological or educational assessments are not covered.

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

 **Drooping Eyelids (ptosis)** - (we only cover surgery for this if the visual field is obstructed by more than 50%).

✘ Drug/substance dependency or abuse of alcohol

- Care and/or treatment arising from or related to dependency on or abuse of alcohol, drugs or other addictive substances.

✘ Fees that are over and above those of customary and reasonable levels;

✘ HIV, AIDS

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

✘ Hormone replacement therapy (HRT)

- We do not pay for Hormone Replacement Therapy (HRT) or other treatments intended to relieve symptoms arising from or related to any natural cause such as the menopause which are not due to any underlying disease, illness or injury.

✘ Hospital treatment

- Treatment taking place in hospitals that are not on our hospital list
- We reserve the right to withdraw or amend the hospital list (without prior notice if necessary) in such a way as we feel is reasonable and commercially necessary.
- If we take this action we will advise customers on our website.

✘ Long term conditions – also called **chronic conditions**.

- Your policy covers short-term, not long-term, treatment of acute medical conditions which start after you have taken out your policy.
- Your policy does not cover treatment for conditions that keep on coming back or need long term monitoring and management. Examples include: diabetes, glaucoma, Alzheimer's disease, macular degeneration, ulcerative colitis, rheumatoid or juvenile arthritis and Crohn's disease.
- We may provide cover for initial investigations needed to diagnose a new condition and the initial short term treatment up to the point of stabilisation - a period not exceeding 3 months. You should contact us in these circumstances for pre-authorisation.
- We do not consider cancer as a chronic condition. For advice on cover for cancer please see pages 13-15.

! Advanced Therapeutics (Targeted Therapies) for chronic conditions

- Advanced Therapeutics (Targeted Therapies) are now being used for some long term chronic conditions. If your specialist considers that you may respond to a short term course of an Advanced Therapeutic (Targeted Therapy) you must contact us and your specialist must confirm that the treatment is not readily available to you as an NHS patient.
- We will then cover the authorised treatment to allow your specialist to find out if it will be effective and can stabilise your condition for a period not exceeding 3 months.

We have an advisory leaflet about cover for long term/ chronic conditions. If you would like a copy of this, please contact us on 01823 625270 – or it is available on our website wpa.org.uk/chronic

✘ Non disclosed conditions/symptoms

- Conditions or symptoms which you have not told us about when asked to do so.

✘ 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;
- Involving 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.

✘ Nursing at home

- Not provided by a qualified nurse and not pre-authorised;
- Simply for help with mobility or personal care.

✘ Obesity

- Investigations and/or treatment either medical or surgical arising from or related to obesity including bariatric surgery.

- Care and/or treatment arising from or related to the removal of fat or surplus healthy tissue from any part of the body even if this is for medical or psychological reasons.

✘ Organ transplant(s)

- A transplant is where a patient receives an organ or tissue from another person (surgically implanted or infused).
- Operations including investigations done before the operation or treatment needed as a result of the operation;
- We will however cover cornea transplants or skin grafts, blood transfusion and bone marrow or stem cell transplants where this forms part of treatment for cancer (see page 13-15 for full details).

✘ 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 (i.e. antibiotics).

✘ Pre-existing medical conditions

- Any disease, illness or injury for which:
- You have received medication, advice or treatment;
- You have experienced symptoms whether the condition has been diagnosed or not before the start of your cover.

✘ Preventative tests or operations

- Tests to rule out the existence of a condition for which you do not have any symptoms, even if you have a family history of that condition

- Removal of tissue for a condition for which you do not have any symptoms, even if you have a family history of that condition.

✘ Rehabilitation

- Treatment helping towards improving physical and/or mental capacities, following illness or injury.
- You are not covered for rehabilitation unless:
 - It immediately follows an inpatient admission that has been covered by your policy.
 - And we specifically agree the extent of the cover before rehabilitation starts.
- We will then cover only a short course of rehabilitation (not to exceed 2 weeks) which will not be extended.

We do not cover treatment in convalescent, nursing or residential homes, health hydros, nature cure clinics or similar establishments.

✘ Refractive eye surgery for the correction of imperfect sight.

✘ Reproductive system.

- You are not covered for any investigations, care or treatment arising from or related to pregnancy, fertility problems, assisted conception, contraception, miscarriage, sterilisation and child birth.

✘ Road traffic accident/collision

- Treatment arising as a result of road traffic accident/collision where you were not wearing a seat belt or suitable child restraint.

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

- Hearing aids;
- Wheelchairs;
- Crutches;
- Braces;
- Surgical orthoses.

✘ Sexual problems

- Care and/or treatment arising from or related to investigating and /or treating sexual dysfunction however caused;
- Care and/or treatment for 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 - (sometimes referred to as palliative care)

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

✘ Tests/investigations

- Tests or investigations arranged by your GP or therapist even if they are carried out and reported by a consultant radiologist who is not the specialist in overall charge of your treatment.



Varicose veins

- Care and/or treatment during the first 2 years of cover;
- Micro-sclerotherapy for thread veins and other superficial veins;
- Treatment of recurrent varicose veins, which is regarded as a chronic problem.



But your policy covers:

- Treatment after you have been a policyholder for 2 years; If this treatment is excluded by a special term (exclusion) as detailed on your registration certificate this will continue to apply after the first two years of your policy;
- One admission per leg for an operative laser or foam injection procedure for varicose veins for the duration of your membership;
- One visit only for injections of residual veins after treatment to the main veins.

6. IMPORTANT INFORMATION

- 6.1 Underwriting Explained
- 6.2 Shared Responsibility Explained
- 6.3 Excess Payments
- 6.4 The Contract
- 6.5 Cancellation Rights
- 6.6 Complaints
- 6.7 Data Protection

6.1

Underwriting Explained

When you and your family members apply to join an Enterprise Flexible Benefits scheme you may join in one of three ways – Fully Underwritten, External Transfers on Continued Personal Medical Exclusions (CPME) or Medical History Disregarded (MHD).

When we refer to medical conditions in this section the term also includes 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 (including any related conditions), when you join the company scheme. 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 will not 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.

External Transfers on 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 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 on transfer terms, 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.

Medical History Disregarded terms

Medical History Disregarded (MHD) is usually offered on the basis that the Group Secretary is not aware of any employee or dependant who has previous, pending or on-going treatment for any of the following conditions:

- Heart/stroke conditions; any forms of cancer; organ failure or transplants; psychiatric, mental or nervous conditions;
- Any medical condition likely to result in an in-patient stay.

If you are accepted on MHD terms you will still be bound by the general exclusions applied to this scheme.

6.2

Shared Responsibility Explained

- You will pay 25% of eligible claims up to your chosen Shared Responsibility maximum annual limit (£250, £500, £1,000, £3,000 or £5,000).
- WPA will pay up to 75% of eligible treatment costs. Your contributions will be deducted from your maximum annual limit.
- Once your contributions total your chosen annual limit within one group policy year, WPA will pay 100% of eligible claims until the next group policy year starts.
- Ask the provider of your treatment to send the bill straight to us.
- We will pay our share directly to the provider of treatment. We will then tell you the amount which you will need to settle. We cannot accept payment of your share of the treatment costs.
- If your treatment takes place at the time of your renewal, your Shared Responsibility limit will start again on your renewal date for the forthcoming year.
- Shared Responsibility does not apply to Dental or Top-Up claims.

You can increase the Shared Responsibility limit, however you can only reduce it by one level at a time e.g. £5,000 to £3,000 and at renewal only (unless you have joined on MHD terms when a minimum Shared Responsibility of £500.00 applies per policy year).

6.3

Excess Payments

- If your group policy membership has an excess we deduct this just once per person each policy year from the first admissible claim and any subsequent claim until the excess has been used up.
- It will not be deducted from any Top-Up or Dental Plan claim.
- We cannot accept payment of your excess – you need to pay any shortfall to the provider of your treatment.

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

6.4

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).

6.5

Cancellation rights

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 do not exercise this right within the 14 day (or 28 days if purchased on-line) 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.

Cancellation/lapse of policy

- Cancellation of the policy cannot be backdated.
- If cover is cancelled or lapses mid-term for any reason we will not refund the premium which relates to the rest of the year, unless you cancel within 14 days of joining (or 28 days if purchased on-line).
- If you reapply for cover you will be re-underwritten.

6.6

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 are available from the FSCS (fscs.org.uk).

6.7

Data Protection

How we use information about you

- We will hold and process your personal information in accordance with the Data Protection Act 1998.
- To detect and prevent fraud or improper claims we may check your details and application with a fraud prevention agency/agencies. If you give us false or inaccurate information and we reasonably suspect fraud, we will record and investigate this. We work with other organisations including other insurers 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.
- If we obtain evidence of fraud or reckless or deliberate misrepresentation in relation to your policy we will take legal action for recovery of all losses to us, the interest on these sums and all associated costs. This will involve recovery of any claims we have paid to you.
- We reserve the right to make the policy void from the date it started and will not refund any premiums you have paid to us.
- We may use and disclose your information to provide our services, to administer your policy including underwriting, claims processing, assessment and analysis, to improve our services and to protect our interests.

- We may share customer information, including medical information, in strict confidence, with other persons who provide a service to us, or act as agents, including our FSA registered Appointed Representatives and companies located outside the EEA.
- We may also share medical information with those involved in a patient's care or treatment e.g. their GP, specialist or therapist.
- We may require your treatment provider to supply us with any information we feel reasonably necessary in relation to your treatment details and costs/bills submitted to us etc.

By becoming a WPA customer you are consenting to the use and disclosure of your data as set out above for both yourself and your family members, and further to the release of any appropriate information as above to us by your treatment provider.

Giving you information

- We may advise you by letter, telephone, e-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.
- 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.

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).
- If you select this mode of contact, we will attach all correspondence to the e-mail for you to view or download.
- By providing your e-mail address you are consenting to its use for services which may include claim and medical information as well as the administration of your policy.

7. POLICY ADMINISTRATION

- 7.1 Joining and Renewing
- 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 Renewing

- A group policy member is a member of staff who is principally insured under the group policy whether employed, a director, partner or proprietor (employee).
 - Group membership does not confer any general rights in relation to the affairs of WPA, but carries the right to the benefits of the group policy. The group policy member may sometimes be referred to as you/ your.
 - The group must contain a minimum of 3 employees (not including family members) on either Essentials or Wellness apart from groups choosing to have the stand alone dental option only where a minimum of 3 employees on Dental applies.
 - You can apply to join if you are an 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.
 - If two 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.
 - You may apply for family members 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 when joining the policy or at any renewal.
 - Child family members may remain on the policy up to the age of 21 (or 25 if in full time education).
- They cannot stay on the policy if they marry, leave the main residence (except if going to higher education) or cease to be financially dependent on you. We will welcome them applying for separate registration in an appropriate WPA scheme.
 - We have the right to obtain all relevant information from you and/or the group as to eligibility of any individual to join, including asking you to arrange for your doctor to provide us with appropriate medical information.
 - With the consent of your company/employer, family members may be 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 21 days before the contract expires, unless you advise us otherwise.

CPME Transfers only:


- A group policy member's cover shall not commence until WPA has received and fully processed the detail's from the External Transfer application form and the previous Certificate of Registration. No claims can be made until the cover commences.
- The company agrees that all future new joiners will be on a fully underwritten basis and full medical histories disclosed at the point of joining.
- If the membership falls below 25 adult employees on cover the company agrees for all existing members or CPME to disclose medical history and will be transferred to fully underwritten terms.

MHD Transfers only:

- The company is responsible for ensuring the data provided such as membership and claims history is comprehensive and accurate. The company is responsible for ensuring the membership database is accurate and up-to-date at all times. WPA must be advised in a timely and prompt manner of any material changes in the companies constitution, structure or business which may have an adverse affect on membership.
- The company agrees that all future new joiners will be on a fully underwritten basis and full medical histories disclosed at the point of joining.
- If the membership falls below 30 adult employees on cover the company agrees for all existing members on MHD to disclose medical history and will be transferred to fully underwritten terms.

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 policy members. 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 a group policy as more favourable terms are often available from an individual policy.
- 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. You are 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).
- All premiums must be paid via a valid company or business bank account.
- 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.
- 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.

The premiums for the group will be priced on the Companies Registered Head office address.

- Insurance Premium Tax (IPT) is a tax levied by the government on the value of insurance premiums and is applied on this policy. Irrespective of the date your policy starts, the rate of IPT that applies to your premium is that prevailing at the date your payment is due. We may alter premiums to reflect any changes in the tax charged on them or services for which benefit is paid, provided we give you at least 3 weeks written notice of the change.

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/family members and cancellations, cannot be backdated.

If you change your name or address you must tell us and your company straightaway, and give us the new name or address and the date of the change or you may visit our website at 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 policy or stop providing benefit:

If you or your family members or your employer

- Fail to act honestly in relation to your 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;
 - We reserve the right to discontinue all or part of the policy. Any insurance policy may cease to comply with current legislation. In these events we will refund the premium on a pro rata basis;
 - Your policy will automatically become void and no claims will be payable;
 - If you leave the UK to live elsewhere for over 6 months;
 - If a resolution or an order has been passed for the winding up of WPA or you cease to be employed by your company.
- 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;

- If you transfer to another of our private medical insurance policies, we may need to fully underwrite your policy and apply personal medical exclusions.

If we:

- 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.

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.

Active treatment

Treatment that is of curative intent.

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;

Advanced Therapeutics (Targeted Therapies)

Drugs that target specific receptors on cells so stopping them from multiplying or developing a blood supply to sustain themselves and spread. These new agents usually cause fewer side effects than traditional chemotherapy. WPA will provide benefit for Advanced Therapeutics provided that:

- They are being given in the acute, active phase of your treatment;
- They have been granted an European Medicines Agency (EMA) product licence for use in the particular clinical condition and are registered in the product licence for use in the particular clinical condition;
- Their use is justified by a substantial body of published evidence specific to the particular clinical situation;
- Your specialist confirms that they are NOT readily available to you from the NHS.

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;

Claim

A request for payment of a benefit for which qualifying expenses have been incurred under the terms of the policy and in line with its rules.

Claim declaration

The document that you and the provider of your treatment sign telling us the details of your claim which we will use to confirm that it is covered.

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 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;

Customary and reasonable

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.

Day patient

A patient who is admitted to a hospital or day patient unit because they need a period of medically supervised recovery but does 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;

Established Treatment

Treatment that is:

- 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;
- Involving 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 our Medical Advisory and Clinical Governance Committee in the particular circumstances.

Employee

Director, partner, proprietor or employed member of staff.

Group policy

An annual contract of insurance which must consist of a minimum membership of 3 employees (not including family members) who are actively involved

with the company and of whom at least 2 must reside at different addresses.

Group leaver

An employee who leaves a Group Policy because he/she is no longer employed by the company (the Group policyholder) but where the Group Policy remains in force.

Hospital

A hospital included in our list of recognised hospitals that is:

- a private hospital which charges fees for its services with facilities for providing private medical and surgical treatment or;
- an NHS hospital in the UK which is registered in accordance with United Kingdom legislation which is not a nursing home which provides convalescence or geriatric care;
- or overseas is locally recognised.

In-patient

A patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons;

Locally recognised

If you have the Worldwide cover option, locally recognised means recognised by the appropriate authority in the country outside the UK in which the hospital is situated or the specialist or therapist practices;

NHS Consultant Podiatric Surgeon

A Fellow of the Surgical Faculty of the College of Podiatrists whose qualification is registered under the Health Professions Council and who is employed as a consultant by the NHS.

NICE

National Institute for Health and Clinical Excellence;

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

A patient who attends a hospital, consulting room, or outpatient clinic and is not admitted as a day patient or an inpatient;

Out-patient Procedure

An out-patient procedure is a procedure that involves one of the following:

- Making a cut or hole to gain access to the inside of a patient's body;
- Using an instrument (such as an endoscope) to gain access to and view the inside of a patient's body;
- Using electromagnetic energy to treat a condition for example lithotripsy to treat kidney stones.

Personal medical exclusions

Exclusions or conditions that we may apply to your policy if you are fully medically underwritten on taking out your policy or on transfer. These will appear on your Certificate of Registration;

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;

Remission of cancer

A clinical state in which there is no objective evidence of disease or the disease is under control and the patient is symptom free and apparently cured;

Specialist

A medical practitioner holding a license to practise whose name appears on the current GMC Specialist Register and is certified as a specialist by the appropriate college or specialty body providing a regulatory function;

Terminal

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

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

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 Denteline (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:	0800 915 8082 *
Counselling:	0800 915 8082 *
Emergency Domestic Repair Assistance:	0800 915 8082 *

**Helpline services are provided by the Vailidium Group Ltd*

Email Addresses:

ebd@wpa.org.uk	Customer Service Team Email Address
riskreviewgroup@wpa.org.uk	Email for details of our fraud prevention policy

WPA Weblinks

wpa.org.uk	WPA's Website - full service and claim facility online
wpa.org.uk/enterprise	Enterprise Flexible Benefits Scheme Details
wpa.org.uk/general/claim.html	Online iClaim service
wpa.org.uk/guideline	Fee Guidelines
wpa.org.uk/dentalschedule	Dental Fee Guidelines
wpa.org.uk/cancer	Full Details of Cancer Cover
wpa.org.uk/complaint	Complaint procedure details

Other Useful Websites:

fco.gov.uk	Foreign and Commonwealth Office
drfoster.co.uk	Consultant details
medical-acupuncture.co.uk	British Medical Acupuncture Society
osteopathy.org.uk	General Osteopathic Council
gcc-uk.org	General Chiropractic Council
feetforlife.org	Society of Chiroprodists and Podiatrists
trusthomeopathy.org	British Homeopathic Association
bacp.co.uk	British Association for Counselling and Psychotherapy
bps.org.uk	British Psychological Society
psychotherapy.org.uk	UK Council for Psychotherapy
hpc-uk.org	Health Professions Council
nice.org.uk	National Institute for Health and Clinical Excellence

WPA is a not for profit health insurer with a history of over 100 years of helping our policyholders fund the very best healthcare and is committed to providing excellent customer service.

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

WPA is one of very few insurance companies world-wide to have been certified to the ISO 9001:2008 Quality Standard. So the standards of service that you can expect are truly world class.

WPA is one of the first organisations in the UK to achieve full accreditation for business continuity.

WPA is one of the first insurance companies to achieve the internationally recognised certification for Information Security Management Systems (ISO 27001) – the benchmark for protecting customers' valuable and sensitive information.

WPA is one of the first UK companies to achieve the environmental quality standard. The paper we use is made up of fibre sourced from well-managed forests independently certified according to the rules of the Forest Stewardship Council (FSC).

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 policy literature.

Western Provident Association Limited

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

E-mail: ebd@wpa.org.uk

Phone: 01823 625270 Fax: 01823 625380

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.

© Western Provident Association Limited 2010

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of Western Provident Association Limited. 02/10123



Enjoy life. Insure health.

