

The **Orchard** Healthcare Plan



Benefit Rules Terms and Conditions



Cutting the cost of staying healthy



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1 Dental Benefit

We will pay 50% of the total cost of treatment up to the maximum amount in any 12-month period, within your chosen plan cover.

What is covered

Check-ups, treatment, hygienist's fees, dentures, bridges, crowns, fillings and root canal treatment.
Treatment provided by a dental surgeon, orthodontist or periodontist.

What is not covered

Charges incurred as a member of a dental healthcare scheme
Registration or administration fees
Cancelled or missed appointments
Teeth whitening
Cosmetic dentistry
Prescription charges
Sundry items (toothbrushes, toothpaste, floss etc)

2 Optical Benefit

We will pay 100% of the cost treatment up to the maximum amount in any 12-month period, within your chosen plan cover.

What is covered

The cost of a sight test
One pair of prescription spectacles or contact lenses, provided an itemised receipt is given
Prescription lenses to an existing spectacle frame
Re-glaze of lenses
Repairs of frames

What is not covered

Cancelled or missed appointments
Purchase of frames
Contact lens solutions
Laser treatment
Sundry items
Goggles used for leisure activities

3 Hearing Aids

We will pay 50% of the total cost of the hearing aid up to the maximum amount in any 24-month period within your chosen plan cover. Adults only. A recognised audiologist must supply the aid.

4 Surgical Appliances

We will pay 50% of the total cost of the appliance, up to the maximum amount paid in any 24-month period, within your chosen plan cover. For more information about which items are covered please contact the WHCA office. Members must be referred by a doctor or consultant. If requested a copy of your GP's referral letter must be provided.

5 Physiotherapy, Osteopathy, Chiropractic, Acupuncture Benefit

We will pay 50% of the cost of treatment up to a combined maximum amount in any 24-month period, within your chosen plan cover.

Treatment for adults only. Treatments must be given by a relevant registered practitioner and referred by your GP. You must provide written evidence of this, if requested, at your own expense.

What is covered

Treatment administered by a qualified person registered with an organisation recognised by WHCA

What is not covered

Treatment given by someone who is not a registered practitioner,
Cosmetic treatment
Missed or cancelled appointments

6 Chiropody and Podiatry

We will pay 50% of the total cost of treatment up to the maximum amount in any 24-month period, within your chosen plan cover. Treatment must be carried out with a registered chiropodist/podiatrist. Treatment is for adults only.

What is covered

Chiropody and podiatry consultations and treatments

What is not covered

Any treatment that is not chiropody or podiatry
Cosmetic pedicures
X-rays
Surgical footwear
Missed or cancelled appointments
Sundry items

7 Complementary Therapies (Gold Plan Only)

We will pay 50% of the cost of treatment in any 24-month period. For adult members only.

The following treatments are acceptable but only with referral from a GP: Reflexology, Bowen Technique,

Aromatherapy (clinical use only) Homeopathy and Shiatsu Massage. Proof of referral must be provided if requested.

8 Specialist Consultation Fees

We will pay 50% of the fee charged up to a maximum amount in any 12-month period, within your chosen plan cover. Payable for consultations only. X-ray, blood and other diagnostic tests are not covered. Members must be referred to the consultant by their GP.

9 Health Screening

We will pay 50% of the fee charged up to the maximum in any 24-month period, subject to your chosen plan cover. The screening must be carried out by qualified medical staff and is available for adults only.

What is covered

- Full health screen
- Mammography screening
- Well man screening
- Well woman screening
- Bone density scan
- Heart disease screening

What is not covered

- Any screening test or check that is not listed above
- Any screening test that is for employment, legal or insurance purposes
- Missed or cancelled appointments

10 Occupational Health Screening (Gold Plan Only)

We will pay 50% of the total cost of the consultation in any 12-month period. Consultation must be carried out with a nursing sister or doctor specialising in this field.

11 Diagnostic Procedures (Gold Plan Only)

We will pay for 50% of the total cost of treatment in any 24-month period. Payable for blood tests, x-rays, MRI, CT and Dexascan, and other approved procedures following a consultation with a GP or consultant.

12 Day Surgery

Payment is for Day Surgery Procedures carried out in a NHS or private registered hospital. You must sign a consent form and be allocated a bed. Members are able to claim for one two-day or two one-day procedures in any 12-month period.

Treatment will involve a surgical procedure involving the use of an operating theatre.

You must be referred for treatment by a doctor or consultant.

The benefit is subject to a daily maximum rate for each level of cover.

Proof of referral letter must be provided if requested.

13 Hospital In-Patient Benefit

Payable for a maximum of 50 nights in hospital at a fixed nightly rate for the level of cover applicable, in respect of admission to an NHS or Private Registered Hospital.

What is covered

- A fixed nightly rate dependent on the level of cover of your plan
- In all cases written confirmation of your in-patient stay is required from the hospital to process the claim.

What is not covered

- Pre-existing conditions.
- Single night, but the first night will be included for admissions of two nights or more.
- Nights of home leave.
- When the maximum number of nights has been reached, no further claim will be payable until six months after the discharge date. (i.e. no repeat payments for continuous hospitalisation)
- Any type of in-patient admission where the hospital is regarded as your permanent residence.
- Admissions for rehabilitation, geriatric care or psychiatric treatment will be restricted to a maximum of 20 nights.
- Payments for pre-natal admissions.
- Payments under the family plan will only be payable in respect of new-born babies if the baby remains in hospital after the mother's discharge date and from that date only.
- For normal confinements in maternity cases this is not payable until 14 days after the birth (i.e. only applies to re-admission).
- Payments for admission resulting from alcohol or drug abuse or intentional self-inflicted injury).

14 Hospital In-Patient – Child (Family Plan Only)

Please see the rules governing hospital in-patient. Applies to the family plan only.

15 Hospital Parental Stay (Family Plan Only)

Applies to one parent who is required to stay with their child in hospital overnight. Not payable for the first night but payable for consecutive nights following. Claims must be supported by written confirmation from the hospital authorities of the period that the parent accompanied the child in hospital. Maximum 50 nights.

16 **Recuperation Grant**

A one-off payment for members who spend 14 or more continuous nights in hospital care, subject to the maximum limit applicable to your plan.

We will pay

A one-off payment once you have spent more than 14 continuous nights in hospital. Payable once in any 12-month period.

Not payable for

- Any nights home leave from hospital.
- We will not pay if you are not discharged.
- Rehabilitation, geriatric or psychiatric treatment.

17 **Maternity/Paternity/Adoption Grant– Payable for each child up to a maximum of triplets**

If both parents contribute to the scheme benefit is paid to each parent.

A full birth certificate is required.

An adoption grant will be paid for children aged five years or younger.

Benefit will only be payable for children born or adopted to members at least 12 months after membership to the scheme has commenced.

SPECIFIC RULES, TERMS AND CONDITIONS

1 Conditions of Joining and Membership

- We are unable to advise you personally regarding the suitability of specific policies
- You must be between the ages of 16 – or 18 if in full-time education – and 65 years. Membership can be maintained beyond the age of 65.
- You reside in the United Kingdom.
- You and your partner's children, and children born to you during the duration of cover can be covered in the family plan.
- A child will cease to be covered by your policy (family plan only) when
 - i they reach the age of 16 (18 if in full-time education)
 - ii they cease to be in full-time education between 16 and 18.
- A child member can join in his own right on reaching the age of 16 with no waiting limits incurred (if they transfer from the family plan).
- You must complete the approved application form to become a member.
- All information supplied to WHCA must be true and accurate.
- Any changes to your plan and level of cover must be notified to us in writing
- We do not issue renewal notices; renewals are ongoing as long as subscriptions are paid up to date.
- Upgrades to higher plans are immediate for Corporate Plan members and are subject to only a 3 month (13 weeks) waiting period for Personal Plan members.
- You may cancel your membership at any time provided you do so by letter. Cancellation will take effect immediately upon receipt of your letter. No further claims will be paid and any subscriptions already paid by you will not be refunded.
- We reserve the right to refuse any application for membership without explanation.
- We reserve the right to terminate a policy without explanation.

2 Subscriptions

Subscriptions may be paid by:

- Deductions from payroll (Corporate Members)
- Direct Debit
- Cheque payment half yearly or annually

- Your level of subscription determines the level of benefits
- Claims will not be paid if your subscriptions are not up to date
- Arrangements can be made for members leaving company schemes who wish to remain in the plan as personal members.
- Subscriptions are subject to Insurance Premium Tax (IPT). A change in the rate of IPT may affect your level of subscription.

3 How to make a claim

All claims must be submitted on a WHCA Orchard Claim Form which can be obtained either by telephoning 01905 729090 or by visiting our website www.whcaorchard.com

- The amounts shown in the benefit table are the amounts that you can claim for each benefit within the benefit year under the rules of the scheme.
- All claims must be submitted on a WHCA Orchard Claim Form completed in full.
- Claims must be made within 12 weeks of the date that treatment was received.
- For audit purposes we will carry out checks on the information provided to us. The submission of a false claim will lead to termination of your membership.
- No payments will be made for pre-existing conditions.
- All dates for treatment must be clearly stated.
- Only original receipts are acceptable. These will not be returned. Photocopies, credit or debit card slips are not acceptable.
- Additional medical information may be required to support your claim. Any charges incurred will be the responsibility of the member.
- Benefits will be paid to the member at their registered home address.

4 How we will pay your claim

We will endeavour to pay your claim within five working days of receipt of your completed claim form.

The WHCA will not accept any of the following:

- Claims not submitted on a WHCA Claim Form
- Receipts where only a deposit has been paid
- Photocopied receipts
- Receipts that have been altered
- Visa, Mastercard, and debit card slips without accompanying original receipt
- Any invoice that does not show that it has been paid by the member
- Claims that are submitted after 12 weeks following the date of treatment
- Claims from injuries gained from participation in **professional** sports
- Claims made through another healthcare scheme

5 What is not covered

Any pre-existing medical conditions
Infertility treatment
Psychiatric conditions
HIV/AIDS
Drug abuse
Cosmetic surgery
Injuries resulting from professional sporting activities
Neonatal treatment
Pre-natal treatment

GENERAL TERMS AND CONDITIONS

- 1 The WHCA reserves the right to amend the subscription rates, benefits and terms and conditions of the Orchard Healthcare Plan at any time.
- 2 All claims are paid at the discretion of the WHCA.
- 3 Contributions are non-refundable.
- 4 Claims are not payable under the personal accident policy if the injury is as a result of:
 - i Flying other than as a passenger.
 - ii Active participation in armed conflict.
 - iii Suicide or intentional self-inflicted injury.
- 5 No member, spouse, partner or child will be entitled to claim benefit in respect of an illness or condition which existed at the time of enrolment.
- 6 The date of joining is deemed to be the date the first direct debit or cheque payment is received.
- 7 The date of joining for corporate members is deemed to be the date the first deduction is made from the members' weekly wages/salaries.
- 8 There is a waiting period of 13 weeks (3 months) before a claim may be submitted for Personal Plan members. Corporate members may claim immediately.
- 9 Any complaints concerning the payment of claims should be made by letter to the Chief Executive at the WHCA office. If this matter is not resolved satisfactorily, the complaint will then be referred to the WHCA Executive Committee. If you are still not happy with the decision, you are able to contact the British Healthcare Association (BHCA) complaints panel and/or the Financial Ombudsman Service (FOS) who will consider your complaint.
- 10 Members are not eligible to transfer to a higher scheme after the age of 65.
- 11 The family plan provides benefits for the contributor, their spouse/partner and any children under the age of 16 (18 if in full-time education).
- 12 When a child reaches the age of 16 (18 if in full-time education) they are eligible to become a member in their own right. Membership will be carried over from the family plan into an individual plan and no waiting period will be applied.
- 13 If treatment for which a claim is made is also covered by a similar scheme or by travel insurance, the WHCA reserves the right to pay a reduced benefit or withhold benefit in total.
- 14 Members transferring to a higher scheme must wait for the 13 weeks qualifying period (no wait in the Corporate Plan), and one year (12 months) in the case of Maternity/Paternity Benefit to claim at the higher rate.
- 15 The detection of any fraudulent claims will result in termination of membership and possible legal action.

- 16 Membership will cease if payments are in arrears. Entitlement to benefits will cease immediately.
- 17 Payment will only be made for treatment carried out in the UK and Eire.
- 18 The benefit year follows a 12- or 24-month rolling period as specified in your plan with entitlement to benefit calculated retrospectively for each claim.
- 19 Maternity/Paternity Benefit will only be paid following the 12-month qualifying period.
- 20 For hospital admissions the appropriate section of the form must be completed by the hospital authorities. Your claim form must have the hospital stamp and discharge notice.
- 21 Annual Limit – This is the maximum amount payable for the relevant benefit in the year. Your Claim Date will be the date on which your qualifying treatment was received.
- 22 **All claims must be submitted within 12 weeks of treatment, or they will be refused.**

OTHER TERMS

Personal Accident Plan

This plan applies to persons over the age of 16.

The personal accident plan is provided by the WHCA.

Please contact the WHCA if you would like to make a claim under this plan.

Language

We will always communicate with you using the English Language.

Data Protection Act

We endeavour to ensure that all personal information you supply to us is correct and maintained in accordance with the Data Protection Act 1988. Any medical information we hold on you will be treated with the strictest confidence. You may request a copy of the information by writing to us, and may ask us to correct any inaccuracies. We reserve the right to charge an administration fee.

Law to be applied

Both you and the scheme underwriter have a choice as to which country's law applies to your participation in this health benefits plan. The scheme's underwriters have opted for English Law. Should you wish to choose another country's law this would need to be discussed with and agreed by the scheme's underwriters in advance of your participation.

Complaints Procedure

It is always the underwriter's intention to provide a first-class service. However, if you have any cause for complaint, a procedure has been put in place which you may care to use, without prejudice to your legal rights. The name, address and telephone number of the contact are given below.

You should in the first instance contact:

The Chief Executive
WHCA, Worcester House, 9 St Mary's Street, Worcester WR1 1HA
Tel: 01905 729090

If the matter is not resolved it will be referred to the WHCA's Executive Committee. Should you remain dissatisfied, the following agencies are available to you: (FOS) The Financial Ombudsman's Service and/or the (BHCA) British Healthcare Association.

Statutory Compensation Arrangements

You are protected by the Financial Services Compensation Scheme (FSCS). Under this scheme the maximum level of compensation for claims against firms declared in default is 90% of the claim with no upper limit.

WHCA

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