Product Oversight and Governance Report – Fair Value Assessment

Product Name: Advantage Voluntary
Product Type: Health Cash Plan
Date of review: October 2024

- This guide is for distributor reference only
- It does not contain the full terms and conditions of the contract of insurance
- The information provided within this document should be sufficient for distributors in the chain to understand the value of the product, the intended target market and those to whom the product should not be marketed

Assessment

Date of the last review	November 2023
Status	Open and actively marketed.
Manufacturer / Co-manufacturer	Manufacturer – Westfield Health
Customer	
Target Market Who is this product designed for?	Advantage Health Cash Plan is an individual voluntary product provided by any company/organisation with more than five employees/members with payment available via direct debit, payroll deduction or pension deduction. Pension deduction is only available to those who have a pension and deductions are made to the British Health Care Association

	(BHCA) and South Yorkshire Pensions Authority and employers deducting from pension. The plan is ideally suited to situations where companies don't want to pay for cover themselves but want to offer employees/members extra cover or partner cover for instance alongside another corporate paid plan. The direct debit version of the plan has been offered where companies/organisations do not want to offer a payroll deduction facility. The policyholder must be aged between 16 and 65, not yet 66 at application. Dependent children are covered up to 18, so cover finishes once they become 18. Individuals must be resident for 180 days or more each year in the UK (England, Scotland, Wales and Northern Ireland), Jersey and Isle of Man. Distributors: Please inform us where you identify that you have consistently distributed our products to customers outside of the intended target market.
Negative Target Market Who is this product NOT designed for?	The product is not designed/suitable for: • Professional sports people • B2C Consumers • Dependent children over the age of 18 • A company with <5 employees General exclusions include: • Any claim that is not submitted in accordance or in breach with General Terms and Conditions. • Pre-existing medical conditions are not covered for some benefits. Additional information can be found in the Terms & Conditions. • Any charges that a hospital/treatment centre, practitioner or any other organisations makes for filling in a claim form or providing information we ask for relating to the claim • Any claim or expense of any kind directly or indirectly arising as a result of war, invasion, rebellion, revolution or terrorism including chemical or biological terrorism. • We don't cover claims arising directly or indirectly from, or as a consequence of: o professional sports injuries* o participating in a criminal act o an accident while you were under the influence of alcohol or drugs o drug, alcohol or solvent abuse, or taking drugs (unless told to do by a registered medical practitioner) o suicide or deliberate self-inflicted injury o participation of dangerous activities and sports

	○ flying as a pilot or crew member (that is, aircraft, gliders, hang-gliders, microlights, parachuting, paragliding and ballooning) ○ a pandemic illness ○ ionising radiation or contamination by any nuclear fuel, or the radioactive, toxic explosive or other dangerous properties of any explosive nuclear machinery or part of it. • Any treatment or service that you receive from a: ○ member of your immediate family – a parent, child, brother or sister, or your partner ○ business that you own • We cannot pay benefits for any claims directly related to the following: ○ any health-screening checks, medical examinations, consultations or reports for employment, emigration, legal or insurance reasons ○ contraceptives ○ cosmetic reasons ○ vasectomies or sterilisation ○ GP fees for private treatment • This policy does not cover fees or charges for: ○ missing an appointment ○ completing a claim form or providing a medical report ○ providing further information in support of a claim ○ administration or referral costs, joining fees or registration fees ○ postage and packing costs * Exclusion for professional sports injuries – this is any injury sustained whilst training for, or participating in, sport for which the policyholder receives payment or non-charitable sponsorship. Distributors: Please inform us where you identify that you have consistently distributed our products to customers outside of the intended target market.
Knowledge and experience of and within the target market	Westfield Health is an FCA/PRA regulated company that has been established for over 100 years. Westfield Health have dedicated teams including Propositions and Sales working predominantly in the health insurance market. The product has been designed to take account of those who: • have no insurance purchasing experience, interest, or knowledge • have some insurance purchasing experience, interest, or knowledge • have insurance purchasing experience, interest, and knowledge.

	In dealing with the target audience and the evolving marketplace, Westfield Health seek to provide access to relevant insurance products, and will provide appropriate information concerning the policy type, details of the relevant product features, and the likely outcomes from the product, so that prospective customers can select the products they require based on an informed judgement. Westfield Health will not provide advice nor recommend a product.
Identifying and dealing with vulnerable customers	Westfield Health have a Vulnerable Customer Policy and provide colleagues with annual training to support identifying and interacting with customers who show characteristics of vulnerability and ensure that good customer outcomes are delivered. Training is provided to our IDD group on an annual basis, and ad-hoc where there is a need, and those colleagues who interact with our customers also have access to a toolkit which provides them with additional information on how to identify and deal with a vulnerable customer. A good customer outcome does not just relate to the avoidance of financial detriment, it could also include instances which cause, or could cause, distress, inconvenience, or harm. Our over-riding principle when dealing with vulnerable customers is that good outcomes are achieved throughout the customer journey, and any barriers are removed to allow access and utilisation of our products and services. We take a flexible approach which allows us to provide additional support where needed and interact with our customers in a way which meets their needs.
Any circumstances which may cause a conflict of interest to the detriment of the customer	Limited conflicts of interest have been identified. Except; • Pre-existing medical conditions are not covered across most benefits. • If receiving treatment; the practitioner cannot be a family member (as stated in the T&Cs).
Product	
The main features and characteristics of the product	Advantage Health Cash Plan is a voluntary paid product, with multiple payment options including direct debit, payroll or BHCA sold direct or via intermediaries. The plan has five levels of cover and claim values to select from.

	Advantage Health Cash Plan provides the customer with nineteen different cash benefits and value- added services; ranging from money towards the cost of glasses, dental appointments, or prescription charges, plus access to key wellbeing services; including 24/7 telephone access to a prescribing UK GP, from anywhere in the world or Telephone Care Advisory Services and care after hospital for you/ your/ your partner's elderly relatives. Please refer to benefit table attached below for additional information.
How the product meets the needs of the customer and provides benefits	The Advantage Health Cash Plan provides a wide range of benefits and services to the policyholder (and eligible children), with five levels of cover to select from depending on budget and affordability, plus upgrade levels and voluntary payment options available. The policyholder has access to eighteen different benefits and services (as documented in the benefit table), consisting of cash reimbursement and third-party wellbeing services. Each benefit or service has been purposely selected to meet the needs of our diverse customer base. Benefit table:  **Advantage Voluntary - Benefit** 1
Is the product considered complex?	A health cash plan is an insurance product provided by an employer or selected by an individual which helps cover the cost of routine medical costs, such as eye tests and dental appointments. Depending on the benefits available within the product they can also include over the phone assistance with things like mental health and financial support, as well as physiotherapy and prescriptions charges. Some of our corporate Health Cash Plan products have fixed cash back and wellbeing benefits included while others have benefits that can be selected by the employer within set criteria to allow for a more bespoke offering in line with their needs. The consumer products have fixed cash back and wellbeing benefits based on our experience within the market. Customers are required to submit their bill and receipt to Westfield Health for any medical expense they have paid for which is covered by the product. Westfield Health will refund a

	percentage of the cost; the maximum refund is determined by the terms of the policy. The pre- and post-sale documentation is designed to be clear and concise for customers ensuring we don't use jargon. Terms and Conditions are issued to all customers at the start of the plan or when any amendments that impact them are made, these explain the claims process and benefit periods for each benefit. How the services can be used are explained within the documentation. When scheme changes are done, we ensure all customers are brought up to the level of new customers ensuring we do not carry complexity internally and allow us to manage all our customers on the same level. When changes are made, these are communicated to customers. Moreover, we are also actively seeking to rationalise our book of products for simplicity internally and understanding of our offering externally. Given there is no underlying investment and no life cover elements, the individual or employer pays a premium and then the customer is able to claim against cash back elements or access wellbeing benefits we do not consider the product complex.
The risk of harm/customer detriment associated with the product?	There is minimal risk or harm/customer detriment associated with the product. As an organisation we only partner with 'Best in Class' Suppliers who have been selected via rigorous selection processes and full sign off from executive management level. Our contracts all include clear and concise SLAs and duty of care standards expected from our third- party suppliers. We have an internal Procurement team and full time employed third party supplier manager who consistently works and reviews all contracts and service standards from those we partner with. The product Terms and Conditions (T&Cs) also state that any treatment received via a practitioner must be provided by an accredited / professional organisation as standard. Our DoctorLine service is provided by clinically approved advisors and have affiliation with NHS services. The EAP operates to their industry standards and work closely with the NHS. To ensure that the customer receives fair value for this product, care must be taken to ensure that no duplicate cover exists or if it does, the implications to proceed on that basis was highlighted to the customer.

How much information about the product is publicly available?	General Health Cash Plan information is available on the Westfield Health website. Specific product information can be provided by our dedicated sales function at request.
Service	
What are the end user product Service Level Agreements (SLAs) and are these being met?	Our current SLAs are outlined below, these are reviewed regularly with a monthly meeting to discuss in greater detail. We meet the set SLA target 98% of the time. Claims: Postal – 4 days Online – 2 days Voice – 60% of calls answered within 40 seconds. This SLA typically results in customers waiting on average around 65 seconds for us to answer their call and we answer approximately 95% of all calls. Emails –98% in 1 day Policies (This relates to all membership applications, company queries and all payments that companies make.) 98% – 4 days. In addition to the SLA's, we send surveys out to all our customers who contact us through voice, where we've paid a claim and where we've cancelled a claim to get a Net Promoter Score (NPS)* and Customer Satisfaction score (CSAT) to gather feedback from customers on their interaction with us. The NPS has a target score of 70 and the CSAT has a target score of 4.7 out of 5. The scores are reported monthly and form part of the board pack. Colleagues handling calls do discuss their survey feedback / results each month with their line manager. Should any theme's become apparent that's impacting any of their scores adversely this would be passed on to the quality coach who would arrange for coaching sessions to address any concerns. If required increased call monitoring may take place for a period until any issues have been addressed. The Year-to-Date (Apr 24 – September 24) scores are below. NPS – 73.88 CSAT - YTD – 4.9 **NPS – This is our net promoter score and how likely our customers are to recommend us to others. They have the option to select a score between 0-10. 0-6 are classed as detractors and these deduct points from your NPS score. 7-8 are passives, this doesn't impact your score at all. 9-10 are promoters who add to your NPS score.*

<table>
<tr><td></td><td>CSAT – Is made up of, ease of the process and if an advisor is knowledgeable, friendly & helpful. This score is out of 5.</td></tr>
<tr><td>Complaints data relating to this product</td><td>We monitor our complaints data closely and it is presented quarterly to the board with any actions required closely monitored to ensure any issues are addressed in a timely manner.

In Q1 2024 (April-June) we received 24 complaints relating to this product.

In Q2 2024 (July – September) we received 25 complaints relating to this product.

27 of these complaints have been service related and 16 have been upheld.

32 have been product related complaints and 5 have been upheld to date.

1 complaint is still being processed.

<table>
<tr><td colspan="4">Year to Date (Apr 24 – Sept 24)</td></tr>
<tr><td>Total Complaints</td><td>Total Upheld</td><td>Total Not Upheld</td><td>Still being processed</td></tr>
<tr><td>49</td><td>21</td><td>27</td><td>1</td></tr>
</table>

The total number of complaints equates to 0.13% of the policyholders.

A total of £30 redress has been paid in relation to a product complaint and a total of £462.15 has been paid across 4 service complaints as a gesture of goodwill.</td></tr>
<tr><td colspan="2">Distribution</td></tr>
<tr><td>The distribution strategy for this product (does the distribution arrangement mean that customers may be at a greater risk of not receiving fair value from the insurance product?)</td><td>The product is available direct and through intermediaries although it is predominantly direct sales.

The price is fixed, transparent and reviewed at product level and therefore demonstrates fair value for all customers.

Deductions through BHCA and a small number of council employers have an additional administration fee applied at the premium collection end before payment is made to Westfield Health.

The premium is inclusive of any commission paid to intermediaries for selling the product.</td></tr>
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	Distributors are remunerated by commission payable by Westfield Health for the sale of Health Cash Plans and PHI contracts. Our fair value assessment has factored in the cost of commission, and the clarity of end price paid by the consumer. Westfield Health rely on distributors to inform them if there are any additional fees and charges levied in respect of arranging contracts that are paid by consumers, so that this can be factored into fair value assessments.
Testing	
What product testing has taken place?	The product is regularly reviewed by a dedicated team internally assessing the performance of the plan. The last scheme change review was implemented in August 2023 with all changes considered within this review.
What product monitoring occurs?	The product oversight and governance are reviewed on an annual basis. In addition, Propositions and Underwriting & Insight teams review the products performance and shortfalls considering customer needs and manage the third-party suppliers to ensure the product remains competitive in the market. The summary of fair value included a review of the following MI: • Loss ratio (Including third party usage) • Policy cancellations • Claims acceptance rate • Net Promoter Score (NPS) • Customer Satisfaction Score (CSAT) • Number of complaints • Complaints as a percentage of policyholders • Redress inc. Gestures of goodwill payments made. The product has a 94% claim acceptance rate which exceeds the set business threshold.
Is remedial action taken if necessary?	Yes. Where any changes in the product or service are required, we ensure these are investigated and prioritised as necessary. Propositions monitor our core competitors, market, customer, and sales insight. In response to this analysis, we review and make changes when required.

Fair Value Findings	
How the product provides fair value to the customer and whether it will continue to do so for a reasonably foreseeable period (including following renewal) We must not market the product or permit the product to be distributed (whether directly or through another person), unless appropriate changes are made so that fair value will be provided	The product has been in force for over 25 years and has some long-established customers. The level of cover required can be selected based on the needs of the customer and their budget, offering a range of suitable benefits. New and existing business has a fixed, community rated price and is regularly reviewed at product level using underwriting data and competitor analysis to ensure the product is suitable and meets the customer's needs. The price at renewal is fixed and businesses can choose to accept the price, transfer to an alternative provider, or cancel the policy.
Statement	As part of the review, we have assessed the cost of the product to the customer against the benefits available for use including additional wellbeing benefits available to them and the distribution of the product. The fair value measures assessed are all within business appetite and the product is deemed suitable for the intended target market, with no material issues raised in relation to distribution or service. We would like to remind distributors that any fees charged (whether this relates to new business, renewals, mid-term adjustments, or cancellations) should not reduce nor negatively impact the intended product value and should always reflect the work and services provided by you for which the fees charged.

Product Governance report completed by:

Name:	Gareth Owen
Position:	Channel & Proposition Development Manager
Date:	10 October 2024
Date of next review:	October 2025

Product Governance report reviewed by Compliance Function to ensure it meets the requirements of the FCA Product Intervention and Product Governance (PROD) Sourcebook, our regulatory requirements in relation to fair value assessments and the consumer duty good outcomes for customers:

Name:	Sarah Ratcliffe
Position:	Compliance Manager
Date:	11 October 2024
Date of next review:	October 2025