wpa.org.uk

Flexible Health essentials

A Guide to Your Policy

Effective for registration or renewal on or after 1st August 2015

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

Introduction

This Guide sets out your and our rights and obligations affecting your policy. Please read this Guide in conjunction with all your relevant literature. When you receive your policy documents you should check them carefully to be sure you understand them and keep them in a safe place. Email pcd@wpa.org.uk or telephone 01823 625230 if there is anything about which you are uncertain. Any information leaflets, such as the long term (chronic) leaflet, are for general guidance only.

Certain words in this Guide have special meaning. An explanation of these words can be found under Definitions.

We are continually investing in leading edge technology to improve our efficiency. Our website at wpa.org.uk/secure enables you to register to administer your policy 24 hours a day, 365 days a year.

If you have any questions please call 01823 625230 (check our real time call waiting times at wpa.org.uk/phone) or email pcd@wpa.org.uk and we'll be happy to help.

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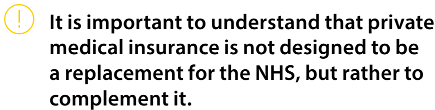
Your policy

Purpose

The purpose of your policy is to cover elective, short term, specialist care, 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, prolonged or lifelong conditions.

Private medical insurance indemnifies you for your medical costs in accordance with your prevailing benefits at the time of treatment. If payment is made direct to providers it is made on your behalf.



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

This policy is intended to cover acute treatment:

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

This may be:

- Surgery or medical treatment that has curative intent following the diagnosis;
- Treatment with curative intent for exacerbations or complications.

It does not include treatment that is:

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

This is called long term (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.

Your level of cover

Your chosen cover options are shown on your registration certificate.

You have chosen **essentials** which provides up to £50,000 benefit per person per year towards hospital and specialist charges when you have non-emergency (elective) surgery in hospital. It also includes post-operative physiotherapy and surgical consultations.

You can choose to add advanced cancer drugs to your cover.

Please advise us before your renewal if you would like to change your level of cover.

Self-employed or a Professional?

Please let us know if you or a person on your policy meets one of the following criteria. You may be able to benefit from further discounts on your premium if you do.

- A director of a private limited company; or
- A partner within a partnership; or
- Currently actively self-employed - i.e. as recognised by the HMRC; or
- A holder of a recognised franchise agreement; or
- A practising member of one of the WPA recognised professional bodies (see wpa.org.uk/qualify or contact WPA for a full list).

You should let us know immediately if there is a change in status, as failure to do so may render your policy void. We will be pleased to arrange alternative cover.

WPA reserve the right to request evidence of your status.

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.

Secondary Care

This is treatment given on the referral of your GP by a specialist or therapist. This includes surgical treatment in hospital.

Your policy only covers secondary care, in particular non-emergency (elective) surgery in hospital.

essentials

Benefits apply per person per policy year unless otherwise stated. Remember that all claims must be pre-authorised. Your documentation confirms which cover options you have chosen.

Your policy provides a benefit of up to £50,000 for each person per policy year, for planned (elective) surgical treatment of a diagnosed condition.

In-patient & Day-patient Treatment *(see page 8)*	Cover	Notes
Hospital Treatment	✓	Choose from over 600 hospitals for **planned (elective) surgical treatment of a diagnosed condition** [1]
Specialists' Fees [2]	✓	In line with customary & reasonable fees whilst in hospital
Prostheses	✓	
Emergency Surgery	✗	See page 14
Cancer Surgery	✗	Excludes surgical treatment of cancer conditions. See 'What is not covered'
Psychiatric Treatment	✗	See page 16

NHS Hospital Cash Benefit *(see page 9)*		
In-patient (less than 3 nights) or day-patient	£150 [3]	Benefit amounts shown are per person per day/night and there is an overall combined maximum benefit of £4,500 per person per policy year
In-patient stays (3 or more nights)	£200 [3]	

Out-patient Treatment – limited cover available as shown below *(see page 10)*		
Pre-admission Tests	✓	In the 2 weeks prior to your admission to hospital
Consultations with a Specialist [2]	✓ Up to £150	Pre-surgical consultations and tests in the 6 weeks prior to your surgery, in line with customary and reasonable fees
Post-hospital Consultation & Tests [2]	✓	One follow-up consultation within 90 days following a surgical procedure and associated tests carried out on the day of that consultation
Physiotherapy (and other therapies) [4]	✓ Up to £200	Within 90 days following a surgical procedure
Out-patient Procedures	✗	See page 15
Psychiatric Treatment	✗	See page 16

✓ = Cover available.
✗ = Not covered.

An extra to tailor your cover

Benefits apply per person per policy year unless otherwise stated. Please refer to your Certificate of Registration to check if you have chosen this option. Remember that all claims must be pre-authorised.

advanced cancer drugs *(see page 11)*	Cover	Notes
We cover cancer drugs which are licensed by the European Medical Agency (EMEA) and recommended by your cancer specialist but not yet approved by the National Institute for Health & Care Excellence (NICE) and therefore not available from the NHS	✓	Up to £50,000 **lifetime benefit** for the cost of these drugs (Targeted/Biological Therapies) and their administration

✓ = Cover available.

Important: this benefit will be removed at the renewal following your 66th birthday.

You will not be eligible for cover at the time of application (or at the time you are adding this extra from a future renewal date) if:

- You have had, or have, cancer or symptoms of cancer (by cancer we mean cancer, tumour or malignant condition) or you are on (or have been advised to take part in) a medically supervised health screening/review programme because you are considered to be at higher risk of developing cancer.
- Either your grandparents, parents or brothers/sisters have developed cancer under the age of 60.
- You may not be eligible for cover if any of your aunts/uncles developed breast cancer or colorectal/bowel cancer under the age of 60.

Cancers will not be covered which are diagnosed or for which symptoms develop within the first 90 days of the start of your policy (or the renewal date from which you add the advanced cancer drugs extra).

Footnotes relating to the essentials Benefit Table opposite.

1 Cover is available for admission to any hospital on our hospital list (see wpa.org.uk/hospital) with the exception of the following premium hospitals:

BUPA Cromwell Hospital • 30 Devonshire Street • Harley Street at Queens (Romford, Essex) • Harley Street at UCH • Harley Street Clinic • Lister Hospital • London Clinic • Portland Hospital • Princess Grace Hospital • Royal Marsden Hospital (London and Surrey) • The London Bridge Hospital • LOC – Leaders in Oncology Care • The National Hospital for Neurology and Neurosurgery • University College London • Wellington Hospital

2 For a guideline of customary and reasonable fees contact WPA or visit wpa.org.uk/guideline WPA actively manages your claims and most specialists' and anaesthetists' fees are within these limits. If their charges are higher, and they have advised you before the treatment takes place, they may require you to pay the difference (see How to make a claim - Consultant and Anaesthetist Fees).

3 If you receive treatment (as an NHS patient) in one of the defined Central London NHS Hospitals, the benefit limits shown on the table will increase by £100 per day/night, up to the same maximum annual limits shown. For a list visit wpa.org.uk/central

4 This benefit covers one or a combination of the following treatments: Acupuncture, Chiropody/Podiatry, Chiropractic Care, Dietary Services, Homeopathy, Osteopathy, Physiotherapy and Speech & Language Therapy.

How to make a claim

All claims must be pre-authorised. 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 is not excluded by any rules or personal medical exclusions.

If your claim has not been pre-authorised we will not pay it.

It is best medical practice both in the NHS and in the private sector that patients should only see a specialist with referral from their GP.

The authorisation and reimbursement of claims requires a formal referral, otherwise treatment costs may not be reimbursed.

- Start by visiting your GP – Primary Care. Your GP may refer you to a specialist or therapist for Secondary Care;
- Once your GP or specialist has diagnosed your condition and referred you for surgery please contact us by phoning us on 0345 122 3100 (National call rates apply);
- Let us know the name and practice address of your specialist or therapist;
- We will send you a claim form to be completed confirming the details of your claim for treatment;
- Send the completed claim form to WPA, Rivergate House, Blackbrook Park, Taunton Somerset, TA1 2PE;
- Based on the information you give us, we will let you know in writing whether the treatment is covered;
- You may claim for treatment which relates to the benefits listed on the Benefit Table which apply to your policy at the date your treatment is given – provided the policy is in force – and no personal medical exclusions apply;
- We will pay in line with the rules of your policy which are in force on the date of your treatment, not on the date that your condition was first noticed or diagnosed;
- We will only pay eligible claims to a valid UK bank account held in the policyholder's name at a bank regulated by the Prudential Regulation Authority (PRA);
- You should submit claims within 6 months from the date of treatment;
- Your policy does not cover any charges made by your GP (including charges for completing the claim form);

If you have been continuously covered by WPA for more than 10 years:

- You must first get your GP to refer you to a specialist/therapist;
- You must then contact us in advance by phoning us on 0345 122 3100;
- We will be able to advise you if your treatment can be authorised without the completion of a claim form.

We can only pay your claim if:

- We have pre-authorised it;
- We formally recognise the specialist/therapist/hospital you have been referred to;
  - We reserve the right to withdraw or amend our list of recognised providers (without prior notice) in such a way as we feel is reasonable and commercially necessary – including hospitals, specialists, therapists etc.
- The hospital you use is on our list of recognised hospitals except premium hospitals (these are listed on the Benefit Table);
- You have sent us a fully completed claim form;
- 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 paid up to date at the time of treatment;
- Your treatment took place in the UK unless explicitly authorised by WPA in advance;
- You do not accept any inducement (financial or otherwise) to have private treatment;
- The treatment was not carried out solely at your request;

- Fees payable for any treatment are customary and reasonable;
- You have provided any information we request.

We will not pay if your treatment:

- Is carried out by any provider of treatment who is related to you/the patient or we do not recognise or have ceased to recognise; or
- Is recommended by a GP who is a member of your/the patient's family; or
- Takes place at a facility in which you have a financial interest.

If we make a claims payment in error we will explain this to you and we reserve the right to recover the value of the claim from you. This may include offsetting the value of the incorrect payment against the amount payable for other claims on your policy.

Consultant and Anaesthetist Fees

When you receive treatment, a contract exists between you and the provider, be that a Private Hospital or a Consultant. We have cost agreements with almost every hospital, and we publish our schedule of fees for Consultants – these may be viewed at any time at wpa.org.uk/fees

Fee reimbursement levels are set at customary and reasonable levels by means of our continuing dialogue with the medical profession, and for the vast majority of our customers this results in professional fees being reimbursed in full. Very occasionally a consultant or anaesthetist may charge you more than we consider to be customary and reasonable and, where they have advised you in advance, if you decide to proceed with the treatment, then it is your responsibility to settle the difference (the shortfall).

Emergency Treatment

We will not pay for:

Surgical treatment associated with an injury or medical condition that was unforeseen, or of sudden occurrence, that demands immediate action as your policy only covers planned (elective) surgical treatment of a diagnosed condition.

- 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.

Claims Processing and Access to Medical Reports Act 1988

- All private treatment must be pre-authorised by WPA and we normally settle all bills directly with the provider of your treatment. In exceptional circumstances we can reimburse you your treatment costs, if you have 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 or your application for cover we will invite you to contact your doctor to provide it to us. This may be in the form of a medical report or access to your relevant medical records;
- We reserve the right to review your medical records in the event of a claim soon after the start of your policy;
- If you refuse to co-operate fully, and do not give us all the information we reasonably require, we may refuse your claim or decline your policy 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.

Personal Injury Claims including Clinical Negligence

In the event that WPA funds any treatment costs attributable to the fault or negligence of a Third Party (including accident, illness, clinical negligence), WPA has a right in law to recover all such medical expenses in the event that your litigation/claim is successful.

It is a condition of your policy that if WPA funds any treatment costs you agree to comply with the Claims Co-operation Procedure which can be viewed on our website at wpa.org.uk/injury

It is important that you understand the legal implication of these rules. If you are in any doubt as to the meaning of this, then you must contact us or take independent legal advice as soon as possible.

Dual Insurance

- If you are making a claim on your policy, and you have insurance with another provider for private medical insurance or a health cash policy, you must tell us and agree to our contacting them;
- We may then contact the other company as neither we nor they are liable to pay more than our proportionate share of the claim;
- The total claimed from both insurers must not exceed the total eligible cost incurred.

As a matter of general legal principle no one can be paid more than once for the same expense under one or more insurance indemnity policies (i.e. may not make a profit from claims).

Claim Settlement

All claims settlements payable to the patient will be sent to the policyholder for all family members covered.

What is covered

When reading the benefits available please refer to the Benefit Tables at the start of this Guide and your policy documentation that confirms the options chosen.

We use the following symbols to illustrate what is and what is not covered.

This is covered by your policy

This is not covered by your policy

Very important information

Important: New WPA policyholders are not covered for pre-existing conditions (see Definitions) and are also not covered for any medical conditions/symptoms, whether diagnosed or not, which arise in the first 14 days of cover.

Overseas Treatment
Your policy only covers treatment in the UK.

Please note that your policy provides a benefit of up to £50,000 per person per policy year.

In-patient & day-patient

Hospital Treatment
Accommodation charges, operating theatre fees, drugs, dressings and medicines used while you are in hospital having an elective planned day-patient or in-patient or surgical procedure of a diagnosed condition. The admission to hospital as an in-patient or day-patient must be medically necessary. Your specialist may be required to confirm this.

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.

Critical Care cover is defined as follows. Please note that this is only available within the overall £50,000 benefit limit:

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 post operative 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 in any Critical Care Unit of an NHS hospital following transfer from a private hospital.

Specialists' Fees
Only treatment provided by a specialist (see Definitions) and in line with customary and reasonable charges will be covered.

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 hip or knee replacements 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;
- For lens replacement see page 14;
- Payment for other prostheses will only be made following pre-authorisation by WPA's Medical Advisory and Clinical Governance Committee;
- The customary and reasonable costs of insertion;
- **For knee or hip replacements:** After a hip or knee joint replacement operation, cover will be available for routine follow up within the 90 days Post-Hospital Consultation and Tests benefit. Any in-patient surgery required as a direct result of the initial operation itself will be covered within the terms of your policy for a period of one year after the conclusion of the initial surgery. After 10 years, conventional wear and tear on the joint replacement may make further intervention necessary and funding will be considered once your specialist confirms surgery is required.

We will not pay 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 pacemakers or defibrillators.

We will pay for:

- The customary and reasonable cost of the initial supply and fitting of such a device only 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; and
  - Your specialist has provided full details of your proposed treatment to our Medical Advisory and Clinical Governance Committee whose approval has been given.

This policy has a maximum benefit of £50,000 payable in each policy year in respect of each person on your policy. Please note that the insertion of pacemakers or defibrillators can be very expensive. In light of the overall £50,000 benefit limit, we may only be able to pay a contribution towards these before the policy limit is reached.

We will not pay 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 we have not specifically authorised in advance.

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

NHS Hospital Cash Benefit

We will pay a cash benefit per day/night (as illustrated on your Benefit Table and below) up to the maximum benefit of £4,500 per person per policy year, when you are treated as an NHS patient.

- £150 per day for each NHS day-patient admission;
- £150 per night for each night spent as an NHS patient during an in-patient admission of less than 3 nights;
- £200 per night for each night spent as an NHS patient during an in-patient admission of 3 or more nights (from the first night);

We will not pay for:

- Any other out-patient treatment which falls outside the above treatments, for example consultations or out-patient diagnostic tests such as x-rays, pathology or ultrasounds.

- If your NHS treatment takes place in one of the defined Central London NHS Hospitals, we will pay an additional £100 per day/night, up to the overall benefit limit of £4,500. For a list please visit wpa.org.uk/central
- The hospital, GP or specialist will need to confirm the dates that you were in hospital.
- When we calculate the amount we will pay the day you are admitted to hospital and the day you are discharged count, together, as one day.
  - If your NHS in-patient stay is preceded by an A&E admission, we will count the first night in A&E towards your NHS Cash Benefit as the first night as an NHS patient.

We will not pay for:

- Any other out-patient treatment not listed above;
- Treatment received as a private patient;
- Treatment as a private patient in an NHS hospital, even if your bed was not in a private ward;
- Treatment you receive in a hospital outside the UK;
- Treatment that is excluded by these rules or any personal medical exclusions;
- A&E admissions only (without a subsequent in-patient stay).

Out-patient

Pre-admission Tests
Tests carried out in hospital to check your fitness for your admission to hospital up to 2 weeks before your admission (such as blood tests, ECGs and chest x-rays) – elective (non emergency) surgical in- and day-patient admissions only.

Consultations with a Specialist
Consultations with a specialist and associated tests carried out on the day of the consultation, provided it takes place in the 6 weeks prior to your elective surgical procedure which you are having as an in-patient or day-patient.

We will pay up to £150 per person per policy year provided charges are customary and reasonable.

Post-hospital Consultation & Tests
One follow-up consultation with your specialist AND associated tests carried out on the day of that consultation, provided it takes place within 90 days following a surgical procedure which you are having as an in-patient or day-patient. We will pay for these in line with customary and reasonable charges.

Physiotherapy and other therapies
You must be referred by your specialist as part of your post-surgery recuperation.

We will not pay for:

- Fees charged for cancelled or missed appointments;
- Drugs or remedies prescribed by your homeopath or other therapist;
- Diagnostic tests and scans undertaken on the referral of your therapist.

We will pay for the following therapies up to £200 per policy year, provided the treatment takes place within 90 days following the elective surgical procedure which you are having as an in-patient or day-patient:

Acupuncture

We will pay for treatment by an acupuncturist who is a member of the British Medical Acupuncture Society or Acupuncture Association for Chartered Physiotherapists or the British Acupuncture Council.

Chiropody/Podiatry

We will pay for treatment by a chiropodist/podiatrist who is on the Register of Chiropodists/Podiatrists of the HCPC.

We will not pay for:

- Medical appliances, such as insoles or orthoses, but if these are being fitted we will cover the podiatrists' consultation fees;
- Any procedure carried out by a chiropodist/podiatrist. However, with pre-authorisation we will cover surgery to the forefoot by a WPA recognised NHS Consultant Podiatric Surgeon.

Chiropractic Care

We will pay for treatment by a chiropractor who is on the Register of the General Chiropractic Council.

Dietary Services

We will pay for treatment by a dietician who is on the Register of Dieticians of the HCPC.

Homeopathy

We will pay for treatment by a homeopath who is a Fellow of the Faculty of Homeopathy (FFHom) or a Member of the Faculty of Homeopathy (MFHom) or a member of the British Institute of Homeopathy.

We will not pay for:

- Any remedies (for example medicines, lotions, supplements and herbs).

Osteopathy

We will pay for treatment by an osteopath who is on the Register of the General Osteopathic Council.

Physiotherapy

We will pay for treatment by a physiotherapist who is on the Register of Physiotherapists of the HCPC.

Speech and Language Therapy

We will pay for treatment by a therapist who is on the Register of Speech and Language Therapists of HCPC.

Extra

advanced cancer drugs

Important: New WPA policyholders are not covered for cancers occurring before or within the first 90 days of the policy starting whether formally diagnosed or not.

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

advanced cancer drugs is available as an extra on your essentials policy. Please check your Certificate of Registration to remind yourself whether you have selected this extra.

Recent and dramatic advances in medical technology make treatments ever more effective – such as Avastin for those with metastatic bowel or breast cancer – advanced cancer drugs can help fund the cost of such advanced drugs where the NHS may deny use of them.

Advanced cancer drugs provides:

- Each person on cover with up to £50,000 lifetime benefit (up to the age of 66) towards the cost of cancer drugs not available from the NHS. The drugs – Targeted/Biological Therapies (Advanced Therapeutics) – 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 policy (not per policy year) and they are aged 66 and under.**
- Cover is only available for cancer drugs that have been licensed and approved by the European Medicines Agency (EMEA). In addition the drugs 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/cancer

Further information is available at www.emea.europea.eu

WPA will fund customary and reasonable private sector charges for the administration of the drug and any directly related costs within the lifetime benefit 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).

What is not covered:

- Cancers occurring before or within the first 90 days of the policy starting (or the renewal date from which you add advanced cancer drugs cover) whether the cancer has been formally diagnosed or not;
- Maintenance or remission of cancer, where these agents are used to maintain good health in the absence of symptoms and objective signs of active cancer, or for preventative use;
- Treatment or care for cancer which is described by your oncologist as end of life care (sometimes described as terminal), whether carried out in a hospital, at home or in a hospice;
- Accommodation charges;
- Treatment that we have not pre-authorised or treatment that is prescribed by a GP and not by a recognised specialist;
- Cancer treatment where there is no objective evidence of improvement or evidence of clinical benefit/curative intent.
- Treatment undertaken solely at your request.

We will not pay your claim if:

- You have had, or at the time of application (of adding this cover) have cancer or symptoms of cancer (by cancer we mean cancer, tumour or malignant conditions);
- Your grandparents, parents or brothers/sisters have developed cancer under the age of 60;
- You are on a medically supervised health screening review programme (or have been advised to take part in one) because you are considered to be at higher risk of developing cancer;
- You may not be eligible for cover if any of your aunts/uncles developed breast or colorectal/bowel cancer under the age of 60.

The advanced cancer drugs cover will cease from the renewal date following your 66th birthday.

Some conditions and types of treatment are not covered by your policy, whether or not you have any personal medical exclusions. Please also see 'How to make a claim' section.

What is not covered

Some conditions and types of treatment are not covered by your policy, whether or not you have any personal exclusions. The following exclusions apply to all the benefits in this Guide and on the Benefit Table. Please note that there is no cover for care and/or treatment arising from or related to the exclusions in this section unless stated otherwise. Please also see 'How to make a claim' section.

Your policy does not cover

Alcohol/Drug/Substance Abuse/ Dependency

- Treatment required, directly or indirectly, as a result of dependency on or abuse of alcohol, drugs or other addictive substances;
- Oral cancer (and related NHS hospital cover) arising directly or indirectly from your chewing tobacco and/or consuming alcohol, having been advised by your doctor to reduce alcohol intake.

Allergic conditions

- Care and/or treatment related to or arising from neutralising/desensitising these.

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 following cancer surgery.

Cancer surgery

- Surgery associated with cancer conditions.

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 taking part in winter sports of any kind, or any accident or injury that occurs whilst on a winter sports holiday and whilst staying in a winter sports resort;
- Scuba diving and motor sports of any kind;
- Care and/or treatment either overseas or on your return to the UK for a medical condition contracted or injury sustained while taking part in dangerous activities or 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;
- Medical conditions arising out of war, invasion, riot, revolution, act of terrorism, act of piracy, nuclear, biological or chemical contamination or any similar event.

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

We reserve the right to decline claims from family members where the claim results from what can reasonably be considered a dangerous/high risk occupation unless we were made aware of this when the family member joined and agreed in writing to waive this clause.

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

This means treatment of a condition which involves any teeth, their roots and surrounding tissue attachments where this forms part of the dental procedure.

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

- Care and/or treatment arising from or related to these.

- Full psychological or educational assessments are not covered.

Diagnostic tests
- Diagnostic tests and scans, investigations and treatment, including procedures such as (but not limited to) endoscopies with biopsies in order to confirm a diagnosis.

Dialysis

Drooping Eyelids (ptosis) – We will only provide benefit for ptosis (drooping eyelids), if your optometrist identifies visual impairment and you are in turn referred by your General Practitioner to a consultant opthalmologist. We will only fund surgery if your field detects as identified by the optometrist are at risk of threatening the ability to achieve the DVLA requirements for visual field testing for safe driving.

Emergency treatment
- Emergency treatment means unforeseen treatment that is due to a sudden, acute illness or injury that, for medical reasons, cannot be delayed;
- We will not pay benefit for emergency admission into a private hospital.

Eye surgery

Refractive eye surgery for the correction of imperfect sight.
To consider cataract surgery for customers age 65 or less, we will require retro-illuminate photographs from your specialist for our Medical Advisers to review.

For cataract surgery, we will fund the cost of monofocal lenses only, but will allow the customer to pay the difference where toric or multifocal lenses are considered clinically appropriate.

Please note we will not provide benefit for complications which arise specifically from the insertion of a toric or multifocal lens.

Fees that are over and above those of customary and reasonable levels.

Genetic tests

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.

Hospital treatment
- Treatment taking place in a hospital that is not on our hospital list;
- Treatment taking place in one of the Premium Hospitals is excluded from cover (these are listed on the Benefit Table);
- 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;
- NHS hospital treatment;
- Private fees whilst being treated in hospital as an NHS patient;
- In a hospital overseas;
- That is excluded by these rules or any personal medical exclusions.

We reserve the right to withdraw or amend the list of recognised hospitals (without prior notice if necessary) in such a way as we feel is reasonable and commercially necessary.

Long term (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, Crohn's disease and recurrent urinary tract infections;

Natural causes
- We do not pay for treatments intended to relieve symptoms arising from or related to any natural cause which are not due to any underlying disease, illness or injury.

Newborn/congenital disorders

- Treatment for unborn babies/foetuses/embryos;
- Any birth defect or congenital abnormality whether identified at birth or later in life. This includes, but not limited to, conditions such as a Patent Foramen Ovale (PFO) and genetic disorders such as Down's syndrome.

Non-disclosed conditions/symptoms

- Conditions and symptoms which you have not told us about when asked to do so when applying for cover or pre-authorising a claim. Please see 'Ending the Policy' under the policy administration section.

Non-established treatment

Treatment that does not fulfil the following criteria:

Treatment that is considered to be acceptable recognised clinical practice by WPA's medical advisors and which falls into one or more of the following categories:

- It is approved by NICE for routine use in the NHS;
- It is an established clinical practice in the UK, supported by peer reviewed published evidence of significant clinical benefit;
- It involves the use of drugs that are licensed by EMEA for safe use for the stage of the condition being treated.

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;
- Bone marrow and stem-cell transplants.

We will however cover:

- Cornea transplants, skin grafts and blood transfusions if these are performed as part of an elective (non-emergency) surgical in-patient and day-patient procedure (but only within the £50,000 benefit limit).

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 (e.g. antibiotics).

Out-patient procedures

Where a procedure or surgery is performed on an out-patient basis.

Pre-existing medical conditions (if fully medically underwritten)

Pre-existing medical conditions are defined as 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;
- Any symptom or condition which occurred in the first 14 days of cover unless declared and accepted in writing by WPA;
- If you have chosen moratorium underwriting you will not be covered for at least 2 years for any pre-existing conditions (including any related conditions) which you had during the five years before cover starts or which occurred in the first 14 days of cover. If you do not have symptoms, treatment, medication or advice for pre-existing conditions for two continuous years after the policy starts, cover will then become available.

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.

Professional sports

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

Psychiatric conditions

- Care and/or treatment arising from or related to mental illness or disorder (including stress).

Rehabilitation

- Treatment helping towards improving physical and/or mental capacities, following illness or injury.

Removal of healthy tissue

- Care and/or treatment arising from or related to the removal of healthy tissue from any part of the body even if this is for medical or psychological reasons. Examples including but not limited to surgery for gynaecomastia, labiaplasty and circumcision.

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. The exception to this rule is treatment for the following specified medical conditions when they occur during pregnancy:
  - Ectopic pregnancy (where the foetus grows outside the womb).
  - Hydatidiform mole (abnormal cells growing in the womb).

Road traffic collision/illegal activity

- Treatment arising as a result of a road traffic incident/collision where you were not suitably restrained and/or wearing/using appropriate protection, e.g. seat belt, helmet or suitable child restraint;
- If your claim for treatment results from an incident or injury which is or may be subject to criminal proceedings against you or conviction, including road traffic offences, then you must provide all relevant details and we will suspend payment of your claim pending the outcome of proceedings. If you are convicted then no benefit will be paid.

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.

Sex change/gender reassignment

- Care and/or treatment arising from or related to sex change/gender reassignment.

Sleep disorders (including snoring)

- Care and/or treatment arising from or related to sleep disorders, including sleep studies or corrective surgery. Examples include: sleep apnoea and snoring.

Terminal care – (sometimes referred to as end of life 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

- 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 long term (chronic) problem.

But your policy covers:

- Treatment after you have been a policyholder for 2 years;
  - If this treatment is excluded by a personal medical 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 simple injections of residual veins after treatment to the main veins, covered up to 6 months after the main procedure.

Policy administration

You and your family members

Please note that this is an annual contract of insurance.

You and your family members can join this policy if you or they are aged 65 and under. After 65 you can renew your policy each year. You must reside in the UK for at least 6 months of the year and must have been registered with an NHS GP for at least 6 months. You and your family must all live at your permanent address in the UK. Cover will automatically cease or become void if this is not true or if you leave the UK to live elsewhere for more than 6 months a year.

Whilst a person aged under 18 years can benefit from cover under this policy as a primary policyholder, in such circumstances the parent or guardian of the minor will be deemed to be the policyholder, being responsible for paying premiums to WPA and for submitting claims, until the person insured reaches the age of 18.

If you should die your partner may take over your policy, providing they are already on cover, and will be bound by its rules as long as the premium is paid.

You can apply to join if you are a private individual or joining as part of a group but paying for your own cover.

We reserve the right to undertake credit checks on you and any adult covered by the policy during the term of your cover and further to require you to arrange for your doctor to supply us with appropriate medical information. By applying you are consenting to this.

We reserve the right to request appropriate medical information as part of your application or during the term of your cover, any costs for which will be at your expense.

We reserve the right to decline cover to applicants in appropriate circumstances (e.g. people with high Body Mass Index, people on a supervised health screening or review programme for cancer or other circumstances in our absolute discretion).

If you have declared that you meet one of the Self-employed/Professional criteria as stated on page 1 you may be asked to provide proof of your self-employed or franchise status or professional body membership at application, renewal or point of claim (for criteria see 'Your policy' section).

Children

A child may join your policy as a family member. He or she cannot remain on the policy if they leave the main residence except if going to higher education. You can add your baby to the policy without the need for medical underwriting providing you send us a copy of the birth certificate within 6 months of the birth. The baby's premiums will then not be included on your invoice until the next renewal date following the date of birth.

Please note that although your child will then be covered by your policy, no claims will be paid for treatment before their birth. They will also be excluded for any condition that is present at birth.

If you add your child more than 6 months after their birth they will need to be fully medically underwritten and premiums will apply.

Underwriting Explained

When you and your family members apply to join this policy you may join in one of the following ways:

- Moratorium Underwriting; or
- Full Medical Underwriting (FMU) – Detailed Medical History.

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.

Moratorium Underwriting
If you have chosen moratorium underwriting you will not be covered for at least two years, for any pre-existing medical condition(s) (including any related conditions) which you had during the five years before your cover starts or which occurred in the first 14 days of your cover.

If you do not have symptoms, treatment, medication or advice for pre-existing conditions for two continuous years after the policy starts, cover will then become available.

Although you do not have to provide medical details on application, we may request more detailed information from your GP/specialist for each new condition you claim for.

If you (or a family member covered by the policy) suffers from a pre-existing long term medical condition that requires regular monitoring/advice/medication, such as (but not only) high blood pressure, these conditions will not be covered by your policy. This is because you/the patient will not have a two year period clear of medical advice/ symptoms and cover is limited within the policy terms.

Other examples of long-term (chronic) conditions are: Atypical haemolytic uraemic syndrome; Chronic fatigue syndrome; Crohn's disease; Diabetes type 1 or 2; Fibromyalgia; Lupus (SLE); ME (myalgic encephalomyelitis); MS (multiple sclerosis); Polymyalgia rheumatica; Rheumatoid arthritis, Sjögren's syndrome; and Ulcerative colitis. This is not an exhaustive list.

We strongly advise you not to delay seeking medical advice or treatment for a pre-existing condition during the moratorium period.

Full Medical Underwriting (FMU) – Detailed Medical History
A fully medically underwritten policy does not cover medical conditions that you (and your family) already have (including any related conditions) when you join the policy, unless declared to and accepted in writing by WPA. You are also not covered for any medical conditions/symptoms, whether diagnosed or not, if these arise in the first 14 days of cover.

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, we will not pay any claim that you make in the future, or may even cancel your policy. 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.

Any such condition will be shown on your Certificate of Registration as a personal medical exclusion. If we exclude a specific pre-existing condition at the time when your policy starts we may, in some cases, review the exclusion at our discretion when you request us to do so.

Policy documents
We will send you a Certificate of Registration when you join and when we renew your cover.

When you receive your policy documents you should check them carefully to be sure you understand them – if you have any questions please let us know. Email our Customer Support Team at pcd@wpa.org.uk or phone us on 01823 625230.

Paying your premiums
Your premium depends on:
- The cover you have chosen;
- Your age;
- The number of enrolled family members and their age(s);
- Whether you smoke;
- How you pay your premiums;

- Where you live;
- Whether you meet WPA's self-employed criteria or you are a member of a WPA recognised profession or trade body (up to the age of 65);
- The percentage of Insurance Premium Tax applicable.

You will be entitled to the benefit provided by the policy, and will be bound by its rules, as long as the premium is paid.

All premiums must be paid via a valid UK bank account held at a bank regulated by the Prudential Regulation Authority (PRA). We will also only pay eligible claims to such a valid UK bank account held in the policyholder's name.

You may pay the full annual premium by cheque, direct debit, with a debit card or an acceptable credit card. Please note payments made by credit card will attract a surcharge of 1.5%. You can also pay by 12 separate monthly payments. Direct debit and credit card payments are accepted on a continuous authority. We will advise in writing when collections will take place. You must let us know straightaway if your card has expired or been replaced.

Please note that if you pay by debit card this is a one-off payment option and your policy will automatically revert to a cheque payment method the following year.

It is your responsibility to make sure the premium reaches us when it is due even if you pay through someone else. If you arrange for someone else to pay the premium on your behalf we will only send information about premiums and other correspondence about the administration of the policy to you (the policyholder).

You are then responsible for passing this to the person who pays the premium. You retain ultimate responsibility for all matters concerning the payment of the premium. If you have 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 you have chosen to pay in advance each month you must make each payment on time for that period.

It is your responsibility to ensure that your premium is paid to us when it is due. If you fail to pay your premium to us your Policy will lapse and any claim you make will be void. If you cancel your Policy then no further premiums will be due.

Neither you or your family members will then have an automatic right to rejoin this policy, or take out another policy with us.

If you cancel your policy we reserve the right to make a reasonable charge to reflect the cost to us.

Cancellation of the policy cannot be backdated. If your cover is cancelled no premiums will be refunded to you.

If you cancel cover within 14 days of joining we will refund premiums paid as long as you have not submitted any claims. In the case of premium refunds we reserve the right to withhold £25 as an administration fee. Premium refunds will be made to the payment method used to pay the premium, be it a valid UK bank account held at a bank regulated by the PRA or the credit card used.

Making changes

- You 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 family members and cancellations cannot be backdated;
- If you change your name or address you must tell us 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 online**. We will issue you a new Certificate of Registration within 4 working days to confirm the change;
- If you would like to add the advanced cancer drugs extra you will only be able to do so when you first join the policy, or from a future renewal date (i.e. not part way through the policy year);
  - You will be asked to complete a cancer specific medical questionnaire.

    - You will not be covered for any cancers or symptoms later diagnosed as cancerous if these occur before, at or within 90 days of that date.
- You will not be eligible for advanced cancer drugs cover at the time of application (or at the time you are adding this extra from a future renewal date) if:
    - You have had, or have, cancer or symptoms of cancer or you are on (or have been advised to take part in) a medically supervised health screening or review programme because you are considered to be at higher risk of developing cancer.
    - Your grandparents, parents or brothers/sisters have developed cancer under the age of 60;
    - You may not be eligible for cover if any of your aunts/uncles developed breast or colorectal cancer under the age of 60.

Renewing the policy

- Your policy is an annual contract of insurance and runs for a period of 12 months from the start date shown on your Certificate of Registration;
- At least 21 days before the contract expires we will advise you that we will renew your policy for a further 12 months and will send you the relevant information including any changes to the policy for the forthcoming year. This may include changes to rules and terms of the contract and your premium. After your renewal date, the new rules and premiums will apply but you will benefit from the same medical underwriting terms;
- Please note, the provisions set out in "Ending the Policy" will apply.

Ending the policy

We may at any time end or change the terms of your policy or stop providing benefit:
If you or your family members:

- Fail to act honestly in relation to your policy and WPA;
- Recklessly or negligently mislead us, either intentionally or carelessly including giving us incorrect information or leaving out something that might influence whether we accept you as a customer or agree to pay a claim;
- 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 premium.

We reserve the right to discontinue all or part of the policy and may not pay claims you have made. 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; or
- If a resolution or an order has been passed for the winding up of WPA.

If you transfer to another of our private medical insurance policies, we may need to request your detailed medical history and and apply personal medical exclusions.

Key information

WPA and our services to you

Regulation

WPA is a company registered in England number 475557. Our registered office is at Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE. We are authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority. We are authorised to arrange and underwrite general insurance contracts. Our FCA registration number is 202608. Our authorisation can be checked at fca.org.uk/register WPA promotes its policies through distribution channels which include WPA Appointed Representatives.

Ownership

WPA is a company limited by guarantee with no shareholders.

The policies we offer

We offer only our own medical insurance, dental insurance and cash policies. Our policies can be renewed annually.

The service we will provide

We look to provide all the information you need to choose a policy for your needs. If you require advice or a recommendation please contact your Independent Financial Advisor or contact WPA on 0800 783 3 783. We can advise you on our range of medical insurance and cash policies, but not those of other providers. All our staff and Appointed Representatives receive full training in their role. In the course of their discussions with you, our staff/Appointed Representatives will discuss whether they can offer appropriate policies and services to meet your needs. You will be sent a letter/Customer Needs Questionnaire confirming any recommendations we make.

No fees

You will not be charged any fees by WPA for arranging cover.

Treating customers fairly

We will endeavour to:

- Make sure you receive all the documents you need;
- Make sure all the information we give you is clear, fair and not misleading;
- Protect any personal information or money we hold for you;
- Handle claims fairly and promptly;
- Act fairly and reasonably when we deal with you.

Our standard of service is that we will:

- Process properly presented claims within 7 working days.

In addition:

- We promise that we will never cancel your policy or raise your premiums on the grounds that you have made too many claims;
- You may make as many eligible claims up to any annual benefit limit.

What are my 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 (28 days if you purchased online) of receiving your policy documents as long as you have not submitted any claims. In the case of a premium refund we reserve the right to withhold £25 as an administration fee.

Cancellation of the policy cannot be backdated.

If you cancel your policy and wish to rejoin you will be required to rejoin as a new customer.

How do I make a complaint?

This process is overseen by the Director of Best Practice.

If you have a complaint you can write, email or telephone the member of staff or Appointed Representative you have been dealing with and ask them to refer the matter

to the appropriate level of management. Once a complaint has been made a manager will carry out a full review of your concerns and then issue a response letter detailing our findings and decision on your complaint.

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

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 and cannot investigate your complaint if you haven't contacted us to let us try to resolve your complaint or if the matter is already the subject of legal proceedings or arbitration. The Ombudsman's address is:

The Financial Ombudsman Service
Exchange Tower, London
E14 9SR

Consumer helpline open 8am to 8pm Monday to Friday, 9am-1pm Saturday.

0800 0234 567 normally free for people phoning from a "fixed line" (for example, a landline at home). 0300 123 9 123 – calls to this number are charged at the same rate as 01 or 02 numbers on mobile phone tariffs.

Email:
complaint.info@financial-ombudsman.org.uk

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. The maximum level of compensation is 90% of the claim with no upper limit. Further information about compensation scheme arrangements is available from the FSCS (fscs.org.uk).

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).

How we use your information

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 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 believe you have committed fraud (or attempted to do so) then we reserve the right to notify the person who pays your premium which may include your employer or family member.

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. If this happens, 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 use your information to administer your policy including underwriting, claims processing, assessment and analysis and to improve our services.

We take great care in the safe custody and use of your personal data. We are one of the few insurance companies to hold the ISO 27001:2013 Standard – the International and British Standard for Information Security.

We never share any information about customers with third parties other than to a limited number of essential people including those who provide a service to us, or act as agents, including our Appointed Representatives and our wholly owned subsidiary located outside the European Economic Area. We may also share medical information with those involved in a patient's care or treatment, e.g. their GP, specialist, therapist. We may also share your information with someone reasonably acting on your behalf, if you are incapacitated. We may require your treatment provider to supply us with any information we feel reasonably appropriate in relation to the administration of the policy.

We never share any information about customers with third parties for marketing purposes.

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

When your cover ceases we may contact you to check whether you want to arrange continuation cover with us.

Giving you information

We may advise you by letter, telephone, email or otherwise of our 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 and record any communication we have with you, including telephone conversations, for the purpose of ensuring an accurate record of discussions. You should notify us of any changes to your personal information, such as a change to your name, address or email to ensure your personal information is correct and up-to-date.

We use email as our primary method of communication when we need to communicate with you on claims, medical or administrative matters. We also maintain a secure personal web based account where you can view your correspondence with us, track your claims and make changes to your policy (wpa.org.uk/secure).

By providing your email address you are consenting to its use as described above, which may include claim and medical information as well as the administration of your policy.

Claim Settlement

All claims settlements payable to the patient will be sent to the policyholder for all family members covered.

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 or to relieve acute symptoms, arrest disease progression or remove/destroy cancer cells.

Acute condition
A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

Cancer
A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

CCSD Schedule
Operations/procedures carried out by your specialist are classified using the industry standard CCSD (Coding, Classification and Schedule Development) codes. For information visit ccsd.org.uk

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

Cover period
Your cover period is a year if the whole premium is paid in advance at the beginning of the policy year, or a month if it is paid each month.

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

Customary and reasonable
The level of fees that we deem to be customary and reasonable are set to reflect the complexity of a procedure, the time and skill involved in its performance and that which is customary and reasonable and a fair return for services rendered. The benefit levels for each procedure are regularly reviewed by WPA's Medical Advisory and Clinical Governance Committee, whose medical members have both private and NHS consultant experience. We take professional advice from our specialist advisers and through continuing dialogue with both the medical profession and professional specialist bodies.

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.

Dependant/family member
A person covered by the policy who is related to the policyholder and lives at the same address (unless in full-time education).

Diagnostic Tests
Investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms. For the purposes of this policy, diagnostic tests also include ultrasound scans.

Elective surgery
Treatment that is not an emergency but is planned and is medically necessary and is typically where NHS waiting times are longer. It applies only to treatment that is covered by your policy.

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

EMEA
European Medicines Agency.

Established treatment
Treatment that is considered to be acceptable recognised clinical practice by WPA's medical advisors and which falls into one or more of the following categories:

- It is approved by NICE for routine use in the NHS;
- It is an established clinical practice in the UK, supported by peer reviewed published evidence of significant clinical benefit;
- It involves the use of drugs that are licensed by EMEA for safe use for the stage of the condition being treated.

HCPC
Health and Care Professions Council

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.

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

Insurance Premium Tax (IPT)
IPT is a tax levied by the UK 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.

Long term (chronic) condition
A disease, illness, or injury that has one or more of the following characteristics:
- It needs on-going or long term monitoring through consultations, examinations, check-ups, and/or tests;
- It needs on-going 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.

NICE
National Institute for Health & Care 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.

Oncologist
Oncology is the specialist treatment of cancer, which includes radiotherapy and chemotherapy.

Out-patient
A patient who attends a hospital, consulting room, or out-patient clinic and is not admitted as a day-patient or an in-patient.

Partner
The person you are married to or who you live with as if you were married.

Permanent address
The address where you live regularly and where you expect to have treatment.

Personal medical exclusions
Exclusions or conditions that we may apply to your policy if you declare your detailed medical history on taking out your policy or on transfer. These will appear on your Certificate of Registration. If you are joining on a moratorium underwriting basis you will also see your moratorium terms outlined in the Personal Medical Exclusions section on your Certificate of Registration.

Policy
The cover WPA provides as shown on your Certificate of Registration, together with this Guide, subject to its terms and conditions. Sometimes referred to as plan.

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 with no further signs and symptoms of cancer. Remission can be temporary or permanent.

Specialist
A medical practitioner holding a licence 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.

Surgery
Surgery is a medical specialty that uses operative, manual and instrumental techniques on a patient to treat a disease, illness or injury.

Targeted/Biological Therapies (Advanced therapeutics)
Drugs that stop cells from multiplying and spreading or developing a blood supply to sustain themselves. Targeted/Biological therapies (Advanced Therapeutics) also include immunotherapies which use your own immunological system to treat the underlying condition. Further information on Targeted/Biological Therapies (Advanced Therapeutics) for cancer and long term (chronic) conditions can be found on our website at wpa.org.uk/tt

Terminal or end of life care
Treatment which 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 policyholder or family member(s) changes level of cover or moves from one 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.

Appendix – cancer cover explained

The examples below illustrate the cancer cover available as an extra on this policy. Please refer to your Certificate of registration to confirm if you have chosen the advanced cancer drugs extra.

This particular WPA policy does not provide benefit towards surgery, consultations, tests, investigations, radiotherapy or chemotherapy as a treatment of cancer conditions.

Please note that example questions are set by industry standards and are not based on any individual customer scenario. Remember that all claims must be pre-authorised; WPA will be in contact with the specialist in charge of your treatment to obtain a full treatment plan including time scales.

Example 1

Customer A has been with WPA for five years when she is diagnosed with breast cancer. Following discussion with her specialists she decides:

- To have the tumour removed by surgery. As well as removing the tumour, her treatment will include a reconstruction operation.
- To undergo a course of radiotherapy and chemotherapy.
- To take hormone therapy tablets for several years after the chemotherapy has finished.

Will her policy cover this treatment plan, and are there any limits to the cover?

The advanced cancer drugs extra on this policy will not cover her treatment.

Example 2

During the course of chemotherapy Customer A suffers from anaemia. Her resistance to infection is also greatly reduced. Her specialist:

- Admits her to hospital for a blood transfusion to treat her anaemia.
- Prescribes a course of injections to boost her immune system.

Will her policy cover this treatment plan, and are there any limits to the cover?

The advanced cancer drugs extra on this policy will not cover her treatment.

Example 3

Despite the injections to boost her immune system, Customer A develops an infection and is admitted to hospital for a course of antibiotics.

Will her policy cover this treatment, and are there any limits to the cover?

The advanced cancer drugs extra on this policy will not cover her treatment.

Example 4

Five years after Customer A's treatment finishes, the cancer returns. Unfortunately it has spread to other parts of her body. Her specialist has recommended a treatment plan:

- A course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months.
- Monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years).
- Weekly infusions of a drug to suppress the growth of the cancer. These infusions are to be given for as long as they are working (hopefully years).

Will her policy cover this treatment plan, and are there any limits to the cover?

We would need her oncologist to send us a detailed treatment plan including the type of drugs to be used.

- Standard EMEA licenced chemotherapy is not covered;
- Treatment with drugs classed as Targeted/Biological Therapies (Advanced Therapeutics) which are:
  - EMEA approved;
  - NOT available to you on the NHS; and
  - Given by the oncologist with curative intent, under the terms of the EMEA product licence. Lifetime benefit of £50,000.

  We would not pay for Targeted/Biological Therapies (Advanced Therapeutics) drugs which are readily available to you on the NHS.

- Drugs given to maintain remission of cancer, where the drugs are used to maintain good health and there are no symptoms, would not be covered;
- All cover ceases on the renewal following Customer A's 66th birthday.

Example 5

Customer B has been with WPA for seven years when he is diagnosed with cancer. Following discussion with his specialist he decides to undergo a course of high dose chemotherapy, followed by a stem cell (sometimes called a 'bone marrow') transplant.

Will his policy cover this treatment plan, and are there any limits to the cover?

The advanced cancer drugs extra on this policy does not cover chemotherapy, stem-cell or bone marrow transplants.

Example 6

When Customer B's treatment is finished, his specialist tells him that his cancer is in remission. He would like him to have regular check-ups for the next five years to see whether the cancer has returned.

Will his policy cover this treatment plan, and are there any limits to the cover?

The advanced cancer drugs extra on this policy will not cover consultations and check-ups.

Drugs used to maintain remission of cancer, where the drugs are used to maintain good health and there are no symptoms, would not be covered.

Example 7

Customer C has been diagnosed with cancer. Her policy has a limit and she decides to commence private treatment.

What help will be available if the policy limit is reached and she needs to transfer into the NHS?

The advanced cancer drugs extra on this policy does not cover consultations, diagnostic scans and tests, hospital treatment or radiotherapy and chemotherapy. Customer C would therefore need to use the NHS for their cancer treatment, or alternatively, fund their own private treatment.

The advanced cancer drugs extra on this policy provides cover towards Targeted/Biological Therapies (Advanced Therapeutics) which are EMEA approved and which are not available on the NHS, up to a lifetime limit of £50,000. Once this benefit limit is reached, or from the renewal following their 66th birthday, they would need to fund the continuation of their treatment with the advanced cancer drug.

Example 8

Customer D would like to be admitted to a hospice for care aimed solely at relieving symptoms.

Will his policy cover this, and are there any limits to the cover?

We do not cover end of life care (sometimes referred to as terminal care) i.e. 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.

WPA has a history of over 110 years of helping our policyholders fund the very best healthcare and is committed to providing excellent customer service.

WPA is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and Prudential Regulation Authority.

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.

wpa.org.uk

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Western Provident Association Limited
Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE
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