wpa.org.uk

Flexible Health elite

A Guide to Your Policy

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

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.

Contents

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:

- Consultations and diagnostic tests needed to establish a diagnosis;
- 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 **elite** which provides comprehensive in-patient, day-patient and out-patient cover, including emergency abroad benefits and cash towards everyday expenses such as optical and dental.

There is also the option to include or exclude **premium hospitals** to tailor your cover. Note that each member of your family can choose different options to suit their individual requirements.

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

Shared Responsibility

With Shared Responsibility you will pay 25% of eligible claims up to your chosen Shared Responsibility maximum annual limit (£500, £1,000, £3,000 or £5,000). WPA will pay up to 75% of eligible treatment costs. Your contributions (i.e. 25% of each eligible claim) will be deducted from your maximum annual limit. Once your contributions total your chosen annual limit within one policy year, WPA will pay 100% of eligible claims (within your benefit limits) until your next policy year starts.

For any children covered by your policy we will pay 75% towards the cost of admissible claims and the remaining 25% will be paid by you and deducted from the maximum annual Shared Responsibility limit of the eldest person on the policy. Once the eldest person's Shared Responsibility limit has been paid, WPA will pay 100% of eligible claims (within the benefit limits) for the remainder of the policy year for any children covered, as well as for the eldest person.

Whether you have in-patient, day-patient or out-patient treatment, WPA will settle all eligible treatment costs directly with the provider and will inform you of your share which you will need to settle. We cannot accept payment of your share of the treatment costs. Please note that if your treatment takes place at the time of your renewal, your Shared Responsibility limit will start again on your renewal date for the forthcoming year.

Shared Responsibility does not apply to:

- NHS Cash Benefits;
- Hospice Donation; or
- Out of Pocket Expenses.

WPA will pay 100% of these eligible claims, within the benefit limits.

Self-employed or a Professional?

Please let us know if 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 as above.

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 the tests and investigations that your specialist needs to arrange so as to be able to make a diagnosis or decide on your treatment plan.

Your policy is primarily designed to cover Secondary Care. It only covers Primary Care as part of limited benefits available under the 'What is covered' section –'Out-patient consultations with a specialist and diagnostic tests' and 'Diagnostic scans' benefits.

elite

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.

In-patient & Day-patient Treatment *(see page 10)*	Cover	Notes
Hospital Treatment	✓	Choose from over 600 hospitals nationwide (also see Premium Hospitals option on page 6)
Specialists' Fees [1]	✓	In line with customary & reasonable fees whilst in hospital
Diagnostic Tests	✓	Such as blood tests, ultrasound and x-rays
Complex Diagnostic Scans	✓	MRI, CT and PET scans only
Psychiatric Treatment	✗	See page 30
Out-patient Treatment *(see page 11)*		
Consultations with a Specialist & Diagnostic Tests [1]	✓	Consultations with a specialist and tests such as x-rays, blood tests and ultrasound when referred by your specialist. A maximum of £500 is available for diagnostic tests arranged by your GP
Complex Diagnostic Scans	✓	MRI, CT & PET scans only at the request of a specialist and one MRI/CT scan requested by a GP
Physiotherapy (and other therapies) [2]	✓	
Psychiatric Treatment	✗	See page 30
Out-patient Procedures [1]	✓	In line with customary & reasonable fees
Pre-admission Tests	✓	In the 2 weeks prior to your operation
Cancer Care [3] *(see page 12)*		
Consultations with a specialist [1]	✓	In line with customary and reasonable fees
Radiotherapy/chemotherapy	✓	
Targeted/Biological Therapies [4]	✓	Advanced anti-cancer (Targeted/Biological Therapies) treatment

Other Benefits *(see page 17)*	**Cover**	**Notes**
Nursing at Home	✓	Up to 4 weeks
Private Ambulance Transport	✓	
Parent and Child	✓	Hospital accommodation charges
Prostheses	✓	
Out of Pocket Expenses	✓	Up to £10 per day
Hospice Donation	✓	£70 per day/night up to £700
Health Screening [5]	✓	£200
Optical Treatment [5]	✓	£200
General Dental Treatment [5 6]	✓	£450
Dental Emergencies [5 6]	✓	For a maximum of 4 episodes per year, up to £250 per dental emergency treatment; maximum £1,000 per policy year
Dental Injuries [1 5 7]	✓	Up to £20,000 where injury has been caused by an external blow to the face, teeth or jaw
Oral Cancer [1 3 7]	✓	Up to £10,000 towards restorative dental treatment
Emergency Abroad (not USA and its dependency Puerto Rico) [8]	✓	Treatment (including Evacuation/Repatriation and Family Assistance). Up to 70 days per trip. Maximum 180 days and £500,000 per policy year
Overseas Treatment		See page 24

✓ = Cover available subject to your chosen Shared Responsibility limit.
✗ = Not covered.

1 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).
2 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.
3 Cancers will not be covered which are diagnosed or for which symptoms develop within the first 90 days of the start of a new policy (applies to new policyholders of WPA).
4 WPA will fund the use of advanced anti-cancer (targeted/biological therapies) treatment which are not readily available on the NHS with our prior approval and when given with curative intent.
5 There is a 1 month qualifying period for optical, general dental and health screening and a 14 day qualifying period for dental emergencies and injuries.
6 Benefit is only available for the removal of wisdom teeth if undertaken in a general practice (not hospital).
7 To be paid in line with the WPA Dental Schedule which is available in the 'dental schedule' section or by visiting wpa.org.uk/dentalschedule
8 Excludes treatment in the USA and its dependency Puerto Rico. Repatriation to the nearest country for treatment where it is medically necessary and the treatment cannot be obtained locally.

elite

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.

NHS Hospital Cash Benefit [1] *(see page 11)*		
In-patient (less than 3 nights) or day-patient	£150*	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*	
Out-patient complex diagnostic scans† and procedures	£150*	

NHS Hospital Cash Benefit (cancer) [1] *(see page 14)*		
In-patient or day-patient	£200*	Benefit amounts shown are per person per day/night and there is an overall combined maximum benefit of £6,000 per person per policy year
Out-patient complex diagnostic scans†, procedures, blood tests and radiotherapy/ chemotherapy	£150*	

The following relates specifically to the NHS Hospital Cash Benefits:

* 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

† MRI, CT and PET scans only.

1 Cancers will not be covered which are diagnosed or for which symptoms develop within the first 90 days of the start of a new policy (applies to new policyholders of WPA).

Extra to tailor your cover

Premium Hospitals *(see page 26)*

We provide an extensive choice of hospitals as standard, including BMI, Nuffield Health, Spire, Ramsay, independent private hospitals and private wings of NHS hospitals. By including Premium Hospitals you have access to treatment in these additional centres which are primarily based in Central London and listed below.

Include Premium Hospitals (shown below)

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 & Neurosurgery
University College London
Wellington Hospital

Exclude Premium Hospitals

If you do not choose cover in the Premium Hospitals, you will only be able to add this option at a future renewal date and you will not be able to claim for treatment in one of the centres until a qualifying period of 90 days has passed.

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 normal GP – Primary Care. Your GP may refer you to a specialist or therapist for Secondary Care;
- Once your GP refers you to a specialist or therapist for Secondary Care, you should contact us in advance 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 (together with original receipted invoices for relevant cash or dental benefit claims) 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;
- For emergency abroad claims you must contact the Worldwide Co-ordination Centre on (+44) 20 8680 3800. Please see Emergency Abroad Cover on page 24;
- For optical, dental, dental emergency, health screening or cash benefit claims please download a claim form from our website wpa.org.uk/claim
- 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 120 2322;
- 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/dentist/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 and covered based on your chosen premium hospital option;
- 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

Emergency treatment means unforeseen treatment that is due to a sudden, acute illness or injury that, for medical reasons, cannot be delayed.

Private hospital admissions are for planned treatment only and so we will not pay benefit for emergency admission into a private hospital unless we have authorised this and you have first had a consultation with a specialist who has decided to admit you.

- In a medical emergency, we advise you to consult your GP, call the NHS emergency services or attend your local NHS A&E department as they are best equipped to provide the emergency care;
- Once the medical condition has been stabilised you may wish to arrange transfer to private facilities. The transfer to a private bed must be arranged by the specialist at the patient's own request and of his/her own free will;
- At this stage you must get authorisation from us as the transfer must be agreed in advance between the specialist and us – otherwise no funding will be available. The patient needs to complete and sign the hospital's appropriate authorisation form;
- Private treatment will only be covered with effect from the date the form was signed.

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). There are separate rules for treatment outside the UK. Please see Emergency Abroad Cover;
- 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 plan, 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).

Emergency Abroad Claims

If you fall ill whilst abroad you must call the Worldwide Co-ordination Centre on (+44) 020 8680 3800 who will be able to give you valuable help and advice (see page 24).

- **Please note cover is not available in the USA and its dependency Puerto Rico.**

Dental claims

Visit our website at wpa.org.uk/claim to obtain a claim form online or call us on 0345 122 3100 before you visit your dentist.

For further details regarding dental claims please see page 18.

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 cover options you have 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.

Your policy only covers treatment in the UK except where the Emergency Abroad cover applies.

In-patient & day-patient

Hospital Treatment
Accommodation charges, operating theatre fees, drugs, dressings and medicines used while you are in hospital as a day-patient or in-patient.

The hospital will usually send the invoice straight to us. We will pay the hospital direct. If you are given a copy of the invoice before you leave hospital please check that it appears to be correct before you send it to us.

Critical Care cover is defined as follows:

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.

Diagnostic Tests
Investigations, such as x-rays, blood tests or ultrasounds requested by your specialist whilst in hospital receiving in-patient or day-patient treatment to help find the cause of your symptoms.

Complex Diagnostic Scans
MRI, CT and PET scans requested by your specialist whilst in hospital receiving in-patient or day-patient treatment.

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);
- £150 per day for one or more NHS out-patient diagnostic scan (MRI, CT or PET scans) or out-patient procedure (see Definitions);

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

Consultations and Diagnostic Tests
We will provide benefit with no overall limit for consultations with a specialist and tests such as x-rays, blood tests or ultrasound arranged by your specialist as long as charges are customary and reasonable. There is a maximum of £500 per person per policy year available towards diagnostic tests arranged by your GP.

Complex Diagnostic Scans
MRI, CT and PET scans, only on your specialist's referral. You are also covered for a maximum of one MRI or CT scan arranged by your GP.

Physiotherapy and other therapies
You must be referred by your GP or specialist.

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:

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 consultations with 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.

Out-patient Procedures

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

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

We will pay for these in line with customary and reasonable charges.

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).

Overseas Treatment

Your policy only covers treatment in the UK except where the Emergency Abroad Cover applies.

Cancer cover

What do you need to do if cancer is diagnosed? These rules set out what is and what is not covered.

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.

We cover:

Customary and reasonable charges for:

- Active, established investigations and treatments in the UK for cancer whether a new cancer or a recurrence;
- Treatment in hospital as an in-patient, day-patient, out-patient or at home, including consultations and physiotherapy;
- Surgery, radiotherapy, chemotherapy and Targeted/Biological Therapies intended to remove or kill off cancerous cells.

Reconstructive surgery
We will pay for:

- One procedure for breast reconstruction following removal of one or both breast(s) as part of the treatment for cancer of the breast. This might be either immediate or delayed and carried out in up to 3 stages and may be applicable to one or both sides;
- One procedure to restore symmetry following cancer surgery in the opposite breast;
- As an alternative to reconstruction surgery, following removal of one or both breast(s) we will cover one (or two if both breasts have been removed) non-surgical breast insert(s) once per policy lifetime;
- After reconstruction has been completed we will not cover complications arising from or related to the surgery and/or insertion of a prosthesis;
- WPA will cover this up to the end of the 5 year follow up period, following the completion of the active treatment of the cancer condition.

Targeted/Biological Therapies (Advanced Therapeutics) if:

- Your oncologist confirms that they would not be readily available to you as an NHS patient; and
- They have been granted a European Medicines Agency (EMEA) product licence for use in the particular clinical condition; and
- Their use is justified by a substantial body of published evidence specific to the particular clinical situation; and
- They are being given with curative intent in the acute, active phase of cancer treatment; and
- We explicitly agree to cover their use in advance (as for all claims);
- We will pay for treatment with Targeted/Biological Therapies for cancer, as per the EMEA product licence. This will be extended for active treatment and not for maintenance of remission, subject to expert advice from your oncologist that there is evidence of continuing disease and clinical benefit and the drug continues to be given with curative intent;
- For blood cancers, for example leukaemia, it is more difficult to find objective evidence that cancer is no longer present. In these cases we will fund up to 12 months treatment with Targeted/Biological Therapies and we will extend this subject to expert advice from your oncologist that there is evidence of continuing disease and clinical benefit and that the drug continues to be given with curative intent;
- Adjuvant Therapy is sometimes given in order to clear any cancer cells not removed by the initial surgery or radiotherapy. We will fund treatment for Targeted/Biological Therapies (Advanced Therapeutics) when given as Adjuvant Therapy in line with currently acceptable international guidelines – typically up to 12 months;
- Further funding for Targeted/Biological Therapies would be available to you if you were to develop a different (histologically distinct) cancer.

Follow up consultations

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

Genetic tests

- We will pay for genetic tests of the cancer where these are done in the UK to identify the most appropriate cancer drug treatment of Targeted/Biological Therapies approved by the EMEA for the particular cancer condition.

Bone marrow or stem cell transplants

- We will pay for one complete procedure per lifetime for each individual person covered by the policy if it is not readily available to you on the NHS. We must agree to cover this before your bone marrow or stem cell treatment starts. We reserve the right to ask for a second clinical opinion as to the evidence of efficacy of the proposed treatment for each particular case. Costs to the donor will not be covered.

What is not covered (applicable to all Cancer Care):

- Cancers occurring before or within the first 90 days of the policy starting whether the cancer has been formally diagnosed or not;
- Either long term monitoring or treatment given to maintain good health in the absence of symptoms and objective signs of active cancer, or for preventative use;
- Targeted/Biological Therapies (Advanced Therapeutics) or bone marrow or stem cell transplants that are readily available to you on the NHS as confirmed by your oncologist;
- Treatment or care for cancer which is described by your oncologist as end of life care (sometimes described as terminal), whether carried out in a hospital, at home or in a hospice. If you are admitted to a hospice we will make a contribution to the hospice if you ask us to do so;
- Treatment that we have not pre-authorised or treatment that is prescribed by a GP and not by a recognised specialist.

Wigs

We will pay up to £250 per lifetime for each individual person covered by the policy, towards the cost of a wig when hair loss has occurred due to treatment for cancer. You will need to provide a receipted invoice and we will make payment direct to you.

NHS Hospital Cash Benefit (Cancer)

We will pay a cash benefit per day/night (as illustrated on your Benefit Table and below) up to a combined maximum benefit of £6,000 per person per policy year, when treated as an NHS patient for an eligible cancer condition.

- £200 per day/night for each NHS day-patient admission OR for each night spent as an NHS patient when receiving treatment for cancer;
- £150 per day for one or more sessions of NHS out-patient cancer treatment:
  - radiotherapy or chemotherapy or treatment with Targeted/Biological Therapies drugs;
  - complex diagnostic scans (MRI, CT or PET scans);
  - out-patient procedures (see Definitions);
  - out-patient blood tests.
- 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 £6,000 annual benefit limit. For a list of the Central London NHS hospitals please visit wpa.org.uk/central
- Your 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 claim for NHS cash benefit that does not have a NHS discharge summary in support of the claim;
- Any other out-patient treatment which falls outside the above treatments, for example consultations and planning of radiotherapy or out-patient diagnostic tests (such as ultrasounds or x-rays);
- 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 including the specific cancer rules and any personal medical exclusions.
- A&E admissions only (without a subsequent in-patient stay).

Please also refer to the Appendix on page 45 for examples to further illustrate cancer cover.

Summary of cancer cover

This is a summary of the full range of cancer cover that we offer. All claims must be pre-authorised.

Place of treatment	✓	Established investigations and/or active treatment for cancer (new/recurrence) in a UK hospital either as an in-patient, day-patient, out-patient or at home. We will also make a donation on your behalf if you are admitted to a hospice.
Diagnosis	✓	Consultations with your specialist including second opinions and diagnostic tests (including certain diagnostic genetic tests), scans including ultrasound and biopsies up to a level that is customary and reasonable as well as scans and screens within the 5 year follow up period (covered for a maximum of 5 years from the time when your active treatment for cancer has finished).
Surgery	✓	We will provide benefit for fees up to a level that is customary and reasonable. This includes treatment of primary and secondary cancer and reconstructive surgery as defined in the cancer care section.
Preventative	✗	You are not covered for: • screening or tests to determine the existence of a condition for which you do not have any symptoms but may be at risk (including genetic tests) • the surgical removal of asymptomatic tissue; or • preventative treatment (e.g. prophylactic mastectomy, vaccines etc.).
Drug therapy	✓	Chemotherapy
	✓	Targeted/Biological Therapies that are not readily available to you as an NHS patient as per the EMEA product licence. This benefit can be extended if the treating oncologist provides us with convincing clinical evidence that it continues to be given with curative intent, in which case we will continue to fund with quarterly reviews.
	✗	You are not covered for Targeted/Biological Therapies (Advanced Therapeutics) to maintain remission.
	✓	Hormone tablets when supplied by your specialist, not your GP.
	✗	You are not covered for drugs prescribed by your GP.
Genetic tests	✓	Genetic tests where done in the UK to identify the most appropriate cancer drug treatment of Targeted/Biological Therapies approved by the EMEA for the particular cancer.
Radiotherapy	✓	This includes radiotherapy given for pain relief.
Maintenance and palliative treatment (to relieve cancer symptoms)	✓	You are covered for active treatment, treatment that is of curative intent, treatment to relieve symptoms or supress disease progression such as treatment to remove or destroy cancerous cells.
End of life care (terminal care)	✗	You are not covered for treatment 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. This follows dialogue with your cancer specialist. We will however make a donation to a hospice on your behalf.

Wigs	✓	When hair loss has occurred due to treatment for cancer (see Cancer Care section).
Monitoring	✓	Follow up consultations, tests and reviews will be covered for a maximum of 5 years from the time when your active treatment for cancer has finished.
Limits	✗	You are not covered for cancers occurring before or within the first 90 days of the policy join date, whether the cancer has been formally diagnosed or not.
Established (not experimental treatment)	✓	You are covered for established treatment as defined in these rules.
	✗	You are not covered for new, non-established or experimental treatment outside these conditions.
Physiotherapy	✓	When treated by a practitioner who is on the Register of Physiotherapists of the HCPC
NHS treatment	✓	If you choose to be treated as an NHS patient we will be pleased to pay you a cash benefit for specified day-patient, in-patient or out-patient treatment provided your claim is covered by the rules of your policy. A financial contribution to the cancer unit caring for you will be made if you ask us to do so.
Bone marrow or stem cell treatment	✓	One complete procedure per lifetime for each individual person can be covered by the policy provided the treatment is not readily available to you on the NHS. You must contact us before your bone marrow or stem cell treatment starts. We reserve the right to ask for a second clinical opinion as to the evidence of efficacy of the proposed treatment for each particular case. Please note that we will not contribute to the costs to the donor.

✓ = Covered (Shared Responsibility applies)
✗ = Not covered.

Other benefits

Nursing at Home
This must immediately follow an in-patient admission that has been covered by your policy. Treatment must be provided by a qualified nurse, at your main address, for up to four (4) weeks;

- This must be recommended by your specialist so that you can leave hospital early provided that you are able to have the same level of nursing care at home. The nursing care should be arranged by your specialist and your specialist remains in charge of your treatment.
- You must contact WPA before nursing at home can be arranged.

We will not pay for:
Nurses for help with mobility or personal care.

Private Ambulance Transport
Transport by private ambulance when this is needed for medical reasons to go to, from or between hospitals for treatment which is covered by your policy.

Medical reasons in the context of this benefit means that you have to be medically supervised during the journey.

Parent and Child
The hospital accommodation charge for one parent to stay in hospital with a child if the specialist says this is necessary, provided that the patient (parent or child) is covered by the policy.

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 28;
- 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 and problems relating directly to the operation itself for a period of one year from the conclusion of the initial surgery. Between the second and fifth year of the initial surgery, we will cover in total one consultation and one x-ray. No further follow up or any treatment including reactions or complications relating to the replacement, or a new replacement, will be funded until 10 years after the initial surgery. After 10 years, conventional wear and tear on the joint replacement may make further intervention necessary and funding will be within the benefit limits of the chosen level of cover.

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.

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.

Out of Pocket Expenses

We will pay towards charges made by a private hospital, or private facilities of an NHS hospital, for telephone calls, newspapers and visitors' meals, up to £10 per day. We will need the original invoice to be able to pay this benefit.

Hospice Donation

We will pay £70 a night, up to £700 per policy year for each night you spend as a patient in a hospice. We will pay this direct to the hospice as a donation.

Health Screening

We will pay up to £200 per policy year towards the cost of health screens which are carried out by a medically qualified practitioner we approve.

We cover full body health screens, wellman, wellwoman, bone density screening, breast screening and heart disease screening, which must be carried out by medically qualified staff in a hospital or clinic.

We will not pay for:

- Health screens needed for legal, pension, insurance, emigration or employment reasons;
- A screen undertaken during the first month of cover (i.e. a one month qualifying period applies).

Optical Treatment

We will pay up to £200 per person per policy year towards the cost of sight tests and new prescription glasses (reading, distance or bifocals) or new prescription contact lenses and refractive eye surgery up to £200 each policy year.

We will not pay for:

- Replacement glasses needed because of damage or wear and tear;
- Treatment undertaken during the first month of cover (i.e. a 1 month qualifying period applies);
- Optical consumables, for example contact lens cases, spectacle cases and spectacle chains/cords or cleaning materials;
- Non-prescription glasses;
- Lenses supplied under an optical insurance plan;
- Optical insurance premiums;
- Ophthalmic consultant charges;
- Complications arising from refractive eye surgery.

General Dental Treatment

- We will pay up to a maximum of £450 each policy year towards preventative care or general dental treatment provided by a registered dentist or dental hygienist in general dental practice.

We will not pay for:

- Treatment outside the UK;
- Treatment that requires hospitalisation;
- Implants, veneers, orthodontics and appliances (such as mouth guards);
- Removal of wisdom teeth (unless carried out in the dentist's chair in a dental surgery);
- Treatment received within the first month of cover (i.e. a 1 month qualifying period applies);
- Dental consumables, for example toothpaste, toothbrushes, dental floss, interdental brushes or mouthwash;
- Treatment relating to periodontal disease.

Dental Emergencies

- We will pay treatment costs up to a maximum of £250 for each new episode/course of treatment required for dental emergencies up to 4 episodes and £1,000 each policy year;
- A Dental Emergency is defined as an incident of acute pain, swelling or dental haemorrhage requiring an emergency dental appointment;
- Treatment must be performed by a registered dentist in general dental practice or A&E department only;
- An episode/course of treatment starts from the date of the initial emergency appointment and continues up to the completion of treatment which must take place within 3 consecutive months;
- This benefit is available for treatment carried out in the UK and abroad and it covers treatment not classed as a dental injury or oral cancer.

We will not pay for:

- Treatment received within the first 14 days of the date your dental cover started;
- Pre-existing conditions.

The following exclusions apply to both General Dental and Dental Emergency Treatment:

We will not pay for:

- Treatment that requires hospitalisation;
- Implants, orthodontics, appliances (such as mouth guards);
- Dental consumables, for example toothpaste, toothbrushes, dental floss, interdental brushes or mouthwash;
- Removal of wisdom teeth (unless carried out by a General Dental Practitioner under local anaesthetic);
- Cosmetic/aesthetic treatment (e.g. veneers, bleaching, etc.);
- Treatment relating to periodontal disease;
- Fees which are recoverable from other indemnity schemes;
- Dental practice plan premiums and dental insurance premiums.

Dental Injuries

- We will pay up to £20,000 each policy year for treatment required for dental injuries received as a result of an injury to the patient's teeth caused by an extra oral impact (an external blow to the face, teeth or jaws);
- You must inform us and have the emergency appointment within **72 hours of the injury**. You can only claim this benefit if you have had an emergency appointment first;
- Should the injury occur outside the UK and you need an emergency appointment abroad, we will cover the cost of your emergency treatment abroad up to a maximum of £250. All subsequent treatment relating to this injury will be subject to the normal limits and must be undertaken in the UK only;
- **WPA must grant prior approval for any restorative treatment plan following a dental injury (this is for any treatment that cannot be undertaken at the emergency appointment).**

Your dentist must provide:

- A fully completed claim form which will be sent to you when you contact WPA;
- A treatment plan for any treatment that cannot be undertaken at the emergency appointment and to tell us:
  - The type of treatment;
  - The date the treatment will start and the date treatment will be completed;
  - The name of the recognised provider who will undertake the treatment;
  - Detailed treatment costs;
- A full report on the incident and all injuries sustained; including:
  - Photographic evidence of the facial injury and x-rays to show the injuries sustained including pre and post injury x-rays;
  - Evidence (dental records) that the injury is not related to chronic periodontal disease;
- On the basis of this information, WPA will give prior written approval (pre-authorisation) of your treatment and associated costs. Cover will not commence until this pre-authorisation has been sought and given and the extent of cover will be limited to the treatment detailed on the plan provided by your dentist;

- Benefit will be paid in line with the WPA Dental Schedule (see page 22) or the WPA Schedule for customary and reasonable fees (see wpa.org.uk/guideline) as appropriate.

We will not pay for:

- Treatment given if you did not inform us within 72 hours of the injury;
- Treatment carried out or completed within the qualifying period (which is 14 days);
- Treatment given more than 12 months after the date of the extra oral impact to which the treatment relates unless we have agreed in writing to cover it;
- Orthodontic treatment except the repair or replacement of orthodontic appliances as a result of a dental injury;
- Treatment for dental injuries sustained while participating in any contact sport (e.g. American Football, Boxing, Hockey, Ice Hockey, Lacrosse, Martial Arts, Rugby) when the appropriate mouth protection was not worn at the time of injury;
  - We reserve the right to ask for evidence of a mouth protector being worn at the time the injury was sustained.
- We will not pay for any treatment which results from accident or injury sustained which has or may be the subject of a criminal proceeding against you or conviction including road traffic offences;
- Dental practice plan premiums and dental insurance premiums.

Oral Cancer

- We will pay up to £10,000 each policy year for restorative dental treatment when this is required as a direct result of oral cancer treatment. For oral cancer cover see Cancer Care section;
- Treatment must be carried out by a Consultant Oral/Maxillo-Facial Surgeon in hospital and will not qualify for benefit when carried out by a dentist unless part of follow up treatment agreed by us;
- Oral cancer is defined as the diagnosis of cancer of the lips, tongue, major salivary glands, gums, from the mouth or pharynx down to the top of the oesophagus, supported by a specialist's letter and histology (microscopic study);
- You must provide a fully completed claim form which will be sent to you when you contact WPA;
- Before your treatment starts we require a detailed treatment plan including costs and x-rays from your Consultant Oral/Maxillo-Facial Surgeon or recognised specialist to show the diagnosis and that the treatment is not needed because of chronic periodontal (gum) disease and/or material dental neglect;
- Benefit will be paid in line with the WPA Dental Schedule (see page 22) or the WPA Schedule for customary and reasonable fees (see wpa.org.uk/guideline) as appropriate.

We will not pay for:

- Orthodontic treatment; appliances (such as mouth guards);
- Treatment in convalescent, nursing or residential homes, health-hydros, nature cure clinics or similar establishments;
- Oral cancers diagnosed or for which symptoms or signs develop within the first 90 days of cover (90 day deferment period);
- Dental practice plan premiums and dental insurance premiums.

The following benefits apply to both Dental Injury and Oral Cancer benefits and will be payable within the maximum sum allowed under this benefit.

Hospital Charges

- We will pay the cost of your room, food, nursing, operating theatre fees, drugs and medical supplies while you are in a WPA recognised hospital as an in-patient or day-patient.

Specialist/Consultant Fees while you are in hospital

- We will pay for treatment provided or requested by a specialist, provided their fees are customary and reasonable. The specialist must not be related to you/the patient or recommended by a dentist/specialist who is a member of your/the patient's family.

NHS Hospital Cash Benefits

- We will pay a cash benefit of £200 for each day-patient admission OR each night you spend as an NHS patient in an NHS hospital, without charge, instead of being admitted to hospital as a private patient (up to a maximum of £2,000 per policy year). The hospital or specialist will need to confirm the dates 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.

Parent and Child

- We will pay the accommodation charge made by the hospital for one parent/child to stay in hospital with your child/parent, on the specialist's recommendation and provided the patient is covered by this policy and for a maximum of 10 nights.

The following exclusions apply to both Dental Injury and Oral Cancer benefits:

We will not pay for:

- Treatment given without our prior written approval;
- Extraction of wisdom teeth;
- Consumables; appliances (such as mouth guards);
- Cosmetic/aesthetic treatment (e.g. bleaching, etc.) except when needed as a direct result of an accident or injury as part of a Dental Injury claim or when directly related to treatment of oral cancer;
  - Veneers: We will only provide benefit for the cost of a replacement veneer if the original is damaged as a result of a dental injury or oral cancer;
- More than 2 implants per policy year;
- Treatment relating to:
  - periodontal (gum) disease;
  - material dental neglect;
- Pre-existing conditions including any treatment that was planned or recommended by your dentist, or known about by you before the policy start date;
- Private in-patient treatment following an accident and emergency admission to an NHS hospital unless the transfer to a private bed is arranged by the specialist at the patient's own request and of his own free will. The patient needs to complete and sign the hospital's appropriate authorisation form. Private treatment will only be covered with effect from the date the form was signed;
- Specialists' fees when the patient receives treatment as an NHS patient in an NHS hospital;
- Treatment outside the UK;
- Charges made by the dentist/specialist for completing the claim form;
- Fees which are recoverable from other indemnity schemes.

Dental schedule

This schedule shows the maximum amount we will reimburse you for treatment you are claiming for under the Dental Injury and Oral Cancer benefits.

Out of hours attendance fee	Reimbursement limit
Out of hours telephone consultation	Up to £40
Registered dentist	Up to £200
Registered dental surgery assistant	Up to £75
Miscellaneous	
Consultation, examination & report	Up to £60
X-ray (small)	Up to £25
X-ray (full mouth)	Up to £55
Prescription antibiotics/pain killers	Up to £30
Sedative dressings – 1st tooth	Up to £45
Sedative dressings – multiple	Up to £75
Intravenous sedation	Up to £140
Abscess drainage	Up to £40
Arrest of haemorrhage	Up to £70
Root canal treatment, opening and dressing: single	Up to £45
Root canal treatment, opening and dressing: multiple	Up to £75
Temporary crown	Up to £55
Temporary bridge	Up to £120
Fillings	
One filling	Up to £45
Two fillings	Up to £75
Multiple fillings	Up to £95
Pin retention	Up to £25
Root fillings	
Incisor/canine	Up to £130
Pre-molar	Up to £160
Molar	Up to £295
Apicectomy (root filling)	Up to £165

Extractions	Reimbursement limit
One tooth	Up to £55
Multiple	Up to £75
Surgical extraction	Up to £145
Crown & bridges	
Pin retention for crown	Up to £25
Ceramic crown	Up to £350 per unit
Bonded crown – precious metal	Up to £390 per unit
Cast gold crown	Up to £370 per unit
Gold/ceramic inlay	Up to £320 per unit
Bridgework – precious metal	Up to £360 per unit
Re-cement crown/bridge/inlay	Up to £55
Dentures	
Complete set acrylic resin	Up to £625
Full upper or lower resin	Up to £360
Partial resin	Up to £240
Partial metal	Up to £545
Repairs	Up to £45
Repairs – emergency out of hours	Up to £85
Dental implants	
Implants and associated restorative treatment	£2,000 per implant £4,000 overall maximum per policy year
NHS dental fees	
Band 1 course of NHS treatment	NHS charges as applicable at the point of treatment
Band 2 course of NHS treatment	
Band 3 course of NHS treatment	

Overseas Treatment
Your policy only covers treatment in the UK except where the Emergency Abroad Cover applies.

Emergency Abroad Cover (not USA)
This is not a full travel insurance policy but an additional benefit of your policy which offers restricted cover for emergency medical treatment abroad. However, unlike most travel insurance, it covers eligible medical conditions that arise after you take out your WPA policy where you have not undergone treatment for the condition in the 6 months prior to travel.

Emergency treatment means unforeseen treatment that is due to a sudden, acute illness or injury that, for medical reasons, cannot be delayed until your return to the UK.

This benefit provides cover for eligible emergency treatment whilst you are outside the UK, subject to Shared Responsibility and up to the benefit limits of the cover you have selected. This includes Primary Care/ treatment given by a GP or local equivalent. The Emergency Abroad Cover is available for trips up to 70 days per trip starting on the day of your outward journey, subject to the maximum of 180 days and £500,000 per person per policy year. Unless we explicitly tell you otherwise, the general rules in the Guide will apply.

Important rules:

- **No treatment will be funded unless you have contacted the Worldwide Co-ordination Centre on (+44) 20 8680 3800 and cover has been agreed;**
- **No cover of any kind applies for the USA and its dependency Puerto Rico. This is because of uncontrollable and excessive treatment costs;**
- **Your cover abroad does not cover medical conditions (or related conditions) for which in the 6 months prior to travel, you have either undergone treatment, or that have required you to visit a medical practitioner for a condition that may require treatment;**
- We strongly recommend you have appropriate cover for travel overseas and you must let us have the details of any travel or any other relevant insurance cover you have so that we can pay our proper share of your claim;
- Overseas/abroad in this context means outside the UK, Channel Islands and the Isle of Man;
- If you are travelling in the EU (for the purpose of this cover EU will include Switzerland and Norway) it is essential to obtain and use a European Health Insurance Card (EHIC) to which all EU citizens are normally entitled;
- You are also advised to contact the Department of Health or visit their website at doh.gov.uk to understand the reciprocal health agreements in place between the UK and other countries before travelling;
- Where you receive treatment in a European state funded facility we will only pay for eligible treatment costs that are over and above those included by the EHIC or reciprocal health agreements in place with the country where treatment occurs;
- If you undergo private treatment where the EHIC is not valid or a reciprocal health agreement is not in place, the cost will be reimbursed under the terms of your policy;
- Treatment must be given by locally recognised providers or in locally recognised hospitals;
- If you are taken ill during your trip before 70 days have elapsed, cover for eligible treatment will continue, up to applicable benefit limits, until such time as medical advice indicates you are well enough to travel home, but no longer.

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

Medical Evacuation/Repatriation

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

practical and reasonable medical facility as we will not agree a transfer on your personal preference;
- We may, in extreme circumstances, repatriate you to the UK for treatment where this is medically necessary and the treatment cannot be obtained locally;
- In the event of the death of an insured person, our Worldwide Co-ordination Centre will make arrangements (including the completion of any documentation) for the return of the deceased to the UK. Cover does not include funeral expenses.

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

You are not covered under the emergency abroad option for treatment:
- Not authorised by our Worldwide Co-ordination Centre;
- For a medical condition (or related condition) that you are receiving treatment for, or have undergone treatment for in the 6 months prior to travel;
- In the USA and its dependency Puerto Rico;
- If you have a medical condition that is terminal;
- That you can have using your (EHIC) or if there is a reciprocal health agreement between the UK and the country where treatment takes place;
- Either overseas or on your return to the UK for a medical condition contracted or injury sustained whilst in a location to which you travelled (during the period of the advice) against advice issued by the Foreign and Commonwealth Office (FCO) either as all travel or all but essential travel;
- Either overseas or on your return to the UK for a medical condition contracted or injury sustained if you travelled against medical advice;
- You needed because you did not take the necessary precautions e.g. vaccinations as advised on the NHS website: fitfortravel.nhs.uk
- Not covered by the rules of your policy and the option you have chosen or treatment that is outside the benefit limits;
- That you can also claim for under the terms of a travel insurance or other insurance policy. We will only pay our share of the claim;
- Once discharged from medical care, an accompanying adult or medical escort even if recommended.

You are also not covered for:
- Trips outside the UK falling outside the limits set out on the Emergency Abroad Cover Benefit Table;
- Out-patient drugs.

How You Make a Claim

Your treatment will only be funded if authorised by the Worldwide Co-ordination Centre who will be able to give you valuable help and advice.
- In exceptional situations, such as an emergency admission to hospital, you must still contact the Worldwide Co-ordination Centre straight away or as soon as you are able to do so.

We will cover you, under this option only, against Acts of Terrorism. Cover is subject to you not being in a country or part of a country for which there is any warning against travel by the Foreign and Commonwealth Office (FCO). Please check their website gov.uk/foreign-travel-advice before you travel.

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

Extra

Premium Hospitals

You can choose to include or exclude the Premium Hospitals as listed below (which are primarily based in Central London):

- BUPA Cromwell Hospital;
- 30 Devonshire Street;
- Harley Street at Queen's (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.

If you choose to exclude Premium Hospitals

- You will not be covered for any treatment in these hospitals;
- You will still have a wide choice of over 600 hospitals nationwide, including BMI, Spire, Nuffield Health, Circle, Ramsay and the private wings of NHS hospitals.

! You will only be able to include Premium Hospitals at a future renewal date. You will then not be able to claim for treatment in one of these centres until a qualifying period of 90 days has passed.

What is not covered

Some conditions and types of treatment are not covered by your policy, whether or not you have any personal medical exclusions. The following exclusions apply to all the benefits in this Guide and on your 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.

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 is only covered within the terms of your General Dental, Dental Emergency, Dental Injury and Oral Cancer benefits

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.

We will however pay for an initial consultation with a consultant, specialist or with a psychologist we recognise to diagnose the cause of the symptoms.

- Full psychological or educational assessments are not covered, even when carried out on the day of the initial consultation.

Dialysis except for short term haemofiltration because of sudden kidney injury (failure) due to an eligible acute condition.

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 unless we have authorised this and you have first had a consultation with a specialist and he/she has decided to admit you.

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
Unless used in the diagnosis of cancer.

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 unless you have included these in your cover;
- Treatment in convalescent, nursing or residential homes, health-hydros, nature cure clinics or similar establishments;
- Private in-patient treatment following an accident and emergency admission to a hospital unless the transfer to a private bed is arranged by the specialist at the patient's own request and of his own free will. The patient needs to complete and sign the hospital's appropriate authorisation form. Private treatment will only be covered with effect from the date the form was signed;
- 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.

You are of course entitled to NHS Cash Benefit as set out in these rules.

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;
- In the unfortunate event that your treatment becomes recurrent, continuing or long term, the costs of treatment for this long term condition – including monitoring, consultations and check-ups – and associated conditions will not be covered. We will write to let you know if this is the case;
- There are certain conditions that are likely to require on-going treatment such as Crohn's disease, Multiple Sclerosis and long term depressive illnesses – which require management of recurrent episodes where the condition's symptoms deteriorate. Because of the ongoing nature of these conditions we will write to tell you when benefit for that condition will no longer be available;
- We may provide cover for initial investigations needed to diagnose a new long term (chronic) condition and the initial short term treatment up to the point of stabilisation - a period not exceeding 3 months. You should contact us in these circumstances for pre-approval;

We will also cover the in-patient treatment of new severe or life-threatening complications which have not been previously experienced in order to quickly return the chronic condition to its controlled state. You should contact us in these circumstances for pre-approval.

- This would not include investigations such as endoscopies that are primarily diagnostic or treatment for relief of symptoms relating to a long term illness e.g. pain relief injections;

- We do not consider cancer as a long term (chronic) condition. For advice on cover for cancer please see the Cancer Care section on page 12.

Targeted/Biological Therapies (Advanced Therapeutics) for long term (chronic) conditions

- Targeted/Biological Therapies are now being used for some long term (chronic) conditions. If your specialist considers that you may respond to a short term course of Targeted/ Biological Therapies you must contact us and your specialist must confirm that the treatment is not readily available to you as an NHS patient.

We may then cover the authorised treatment to allow your specialist to find out if it will be effective and can stabilise your condition for a period not exceeding 3 months. We have produced an advisory leaflet about cover for long term (chronic) conditions. If you would like a copy of this, please visit our website wpa.org.uk/chronic or call us on 01823 625230.

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.

Nursing at home
- Not provided by a qualified nurse;
- Simply for help with mobility or personal care.

Obesity
- Investigations and/or treatment either medical or surgical arising from or related to obesity including bariatric surgery;
- Care and/or treatment arising from or related to the removal of fat or surplus healthy tissue from any part of the body even if this is for medical or psychological reasons.

Organ transplant(s)

A transplant is where a patient receives an organ or tissue from another person (surgically implanted or infused).
- Operations including investigations done before the operation or treatment needed as a result of the operation.

We will however cover:
- Cornea transplants, skin grafts and blood transfusions;
- Bone marrow or stem cell transplants will also be considered where this forms part of treatment for cancer (see the Cancer Cover section for full details).

  For other conditions we will pay for one complete procedure (of bone marrow or stem cell transplant) per lifetime for each individual person covered by the policy if it is not readily available to you on the NHS. Funding will only be available if we agree to cover this before your bone marrow or stem cell treatment starts. We reserve the right to ask for a second clinical opinion as to the evidence of efficacy of the proposed treatment for each particular case. Costs to the donor will not be covered.

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).

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.

You are not covered for rehabilitation unless:

- It immediately follows an in-patient admission that has been covered by your policy.
- And we specifically agree the extent of the cover before rehabilitation starts.

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

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 (except within limited health screening benefit) 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.

Please note that there is limited benefit available for out-patient diagnostic tests and scans on your GP's referral (see the Out-patient treatment section 'Consultations with a specialist and Diagnostic Tests').

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 can join this policy as the primary policyholder between the ages of 18 and 65. 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 2 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.

For any children covered by your policy we will pay 75% towards the cost of admissible claims and the remaining 25% will be paid by you and deducted from the maximum annual Shared Responsibility limit of the eldest person. Once the eldest person's Shared Responsibility limit is reached, WPA will pay 100% of eligible claims for the remainder of the policy year for any children covered, as well as the eldest person.

If a new family member joins the policy during a policy year and becomes the eldest member, a child's claim will continue to be deducted from the original eldest member until the next annual renewal date.

Once a child reaches 18 and provided they continue to reside at the main residence, the minimum Shared Responsibility level of £500 will automatically be applied to them from the next annual renewal date. Any claims made after this date will then be deducted from their own maximum annual limit. Should you wish to amend the level of Shared Responsibility please contact us.

Underwriting explained

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

- Full Medical Underwriting (FMU) – Detailed Medical History; or
- Moratorium Underwriting; or
- WPA Continued Personal Medical Exclusions (CPME) – Switch.

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 ever be covered by your policy. This is because you/the patient will not have a two year period clear of medical advice/symptoms.

Other examples of long-term (chronic) conditions are: Atypical haemolytic uraemic syndrome; Chronic fatigue syndrome; Crohn's disease; Diabetes type 1 and 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.

WPA Continued Personal Medical Exclusions (CPME) – Switch
If you are transferring from a previous insurer where you completed an application form giving your detailed medical history (not moratorium) you will be considered for cover based on Switch terms. This means that, if accepted, you will join WPA with the same medical underwriting as that on your old policy and any exclusions which were present on your previous registration certificate will be transferred to your WPA certificate. You will not be covered for illness or injury which was excluded by your previous insurer, or which existed before the period of continuous insurance cover started, even if the reasons for symptoms had not been diagnosed at that time. Please check the availability of Switch with WPA or your advisor.

WPA's individual health insurance policies have a 90 day deferment period relating to any cancer claims and a 14 day deferment period for any other conditions. If your current health insurance policy has an equivalent level of cover and/or comprehensive cancer cover, we may be able to waive the 14 and 90 day deferment periods, providing there is no break in cover.

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;
- Shared Responsibility level you have chosen;
- 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.

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;
- You can downgrade from a higher Shared Responsibility limit to a lower Shared Responsibility limit by one step at a time and at renewal only;
- If you have chosen to exclude Premium Hospitals you will only be able to add this at a future renewal date and you will not be able to claim for treatment in one of these centres until a qualifying period of 90 days has passed.

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.

If you cancel your policy no further premiums will be due.

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 detailed medical history 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 appropriate 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 to 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 or your GP 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 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.

Dental Treatment
Treatment of a condition which involves teeth, their roots and surrounding tissue attachments where this forms part of the dental procedure.

Dentist
A dentist who is registered with the General Dental Council.

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.

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.

Histologically distinct
Every cancer has a unique "footprint" that can be identified by examining tumour cells in the laboratory. One method is histology which is the microscopic study of tissues and cells.

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;
- Or overseas is locally recognised.

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

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.

Locally recognised
Locally recognised means recognised by the appropriate authority of the country outside the UK in which the hospital is situated or the specialist or therapist practices.

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.

NHS Consultant Podiatric Surgeon
A Fellow of the Surgical Faculty of the College of Podiatrists whose qualification is registered under the HCPC and who is employed as a consultant by the NHS.

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. WPA provides benefit for Consultant Oncologists. Best Clinical Practice expects that your Consultant Oncologist will form part of a Multi-disciplinary Team overseeing your cancer care.

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.

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

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

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 declared 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.

Session
A maximum of one per day in a series of short daily treatments (for example therapy, radiotherapy or chemotherapy).

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.

Targeted/Biological Therapies (Advanced Therapeutics)
Drugs that stop cells from multiplying and spreading or developing a blood supply to sustain themselves. Targeted/Biological therapies also include immunotherapies which use your own immunological system to treat the underlying condition. Further information on Targeted/Biological Therapies 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 on this policy. Please read the rules in the 'What is covered' section under 'Cancer Care' for more detailed information.

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.

Depending on the type of treatment prescribed by your specialist, you will have a choice of where you receive the treatment – as a private patient as an in-patient or day-patient in hospital, as an out-patient or at home. Customers may also choose to have their treatment as an NHS patient and can then claim the NHS hospital cash benefit of up to £6,000 per person per policy year.

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?

WPA would cover her surgery, radiotherapy and chemotherapy provided that these are active established treatments given with curative intent. The breast reconstruction would be paid for provided that it took place within a reasonable period, usually 5 years. We would need a treatment plan for this, setting out the procedures and the timescale. Follow up treatment by her specialist would be covered for up to 5 years. Hormone treatment prescribed by her GP would not be covered.

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?

Yes, as long as it is medically necessary as part of active cancer treatment. Emergency admissions to either a private hospital or critical care unit are not covered.

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?

Yes, her admission would be covered. Generally she does have a choice where she receives treatment, based on what her specialist recommends – in hospital as an in-patient, day-patient and out-patient or

at home. Emergency admission to either a private hospital or critical care unit are not covered. If she chooses to have treatment in an NHS hospital she could claim NHS hospital cash benefit.

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 licensed chemotherapy is covered in full. Treatment with drugs classed as Targeted/Biological Therapies which are:

- EMEA approved;
- NOT readily available to her on the NHS;
- Given by the oncologist with curative intent under the terms of the EMEA product licence.

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.

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?

Yes. This treatment MUST be pre-authorised. We will pay for one complete bone-marrow transplant per lifetime for each individual person covered by the policy if it is not readily available to them on the NHS.

We must agree to cover this before the bone marrow or stem cell treatment starts. We reserve the right to ask for a second clinical opinion as to the evidence of efficacy of the proposed treatment for each particular case. Costs to the donor will not be covered.

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?

Follow up check-ups would be covered for up to five years.

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.

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?

This policy does not have monetary benefit limits on cancer care as a private patient. If a single aspect of her treatment falls outside the benefit provided by the policy and she needs to split her cancer care i.e. have some treatment on the NHS while continuing to have other treatment privately, we will work with Customer C and her Oncologist to arrange a timely and smooth transition into NHS care, ensuring no detriment to her or her ongoing treatment. Whilst it may sometimes be feasible for the NHS to provide a single aspect of treatment, but for all other cancer care to continue to be given on a private basis, in our experience the NHS may request the patient be transferred to the NHS for the totality of their cancer treatment.

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. Where a patient is admitted to a hospice we will make a contribution to the hospice.

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 plan literature.

WPA

wpa.org.uk

bsi. ISO 9001 Quality Management FS 28452

bsi. ISO 22301 Business Continuity Management BCMS 538164

bsi. ISO 14001 Environmental Management EMS 505226

bsi. ISO/IEC 27001 Information Security Management IS 553152

Western Provident Association Limited
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Registered in England No. 475557

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