

Flexible Health

Flexible Health Freelance

A Guide to Your Shared Responsibility Policy

Effective for registration or renewal on or after 1st April 2009

Large print guides are
available upon request



wpa.org.uk

Introduction

These are the Rules of WPA's Flexible Health and Flexible Health Freelance policies. They tell you what is and what is not covered. It is most important that you read these and e-mail pcd@wpa.org.uk or telephone 01823 625230 if there is anything about which you are uncertain. We also invite you to use the information in this booklet to assist you when deciding if our products are right for you.

The purpose of your policy is to cover elective, short term, specialist care which is provided with curative intent, in the reasonable expectation that it will restore you to the same or possibly even better health than you enjoyed before treatment. It is not to cover long term management or maintenance of incurable conditions.

Certain words in this Guide have special meaning, and are marked in bold. An explanation of these words can be found under Definitions on page 38.

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

Your policy

Flexible Health and Flexible Health Freelance are intended to cover treatment of **acute conditions and treatment**:

- 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**.

This may be:

- Consultations and diagnostic tests needed to establish a diagnosis;
- Surgery or medical treatment following the diagnosis to cure or stabilise the condition;
- Treatment for exacerbations or complications to return the condition to a stable state.

It does not include treatment for **chronic conditions**.

Your level of cover

Your chosen cover options are shown on your registration certificate.

You have the choice of **Essential Cover** which covers in-patient and day-patient treatment, as well as cancer care, out-patient procedures and MRI/CT scans.

Alternatively, you can choose **Essential Plus** which will increase your out-patient benefits and provide you with cover up to defined benefit limits for optical treatment, dental treatment and health screening.

You can also add other options to your cover such as **out-patient** treatment, treatment by **therapists**, emergency **worldwide** cover, **dental** cover or a **hospital assist** cash benefit. You can also choose different options for each member of your family. These are described on the Benefit Tables - see pages 6-9.

Please advise us prior to 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 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 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 pay 75% of eligible treatment costs up to your maximum annual limit directly to the provider of treatment. We will then 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.

Self-employed status (Flexible Health Freelance)

Please ensure you or a person on your plan continues to meet at least one of the following criteria to subscribe to the Flexible Health Freelance Plan.

- A director of a private limited company which employs no more than 5 additional salaried members of staff
- A partner within a partnership of not more than 2 partners that employs no more than 5 salaried staff
- Currently self-employed - i.e. as recognised by the Inland Revenue
- A holder of a recognised franchise agreement

Where these criteria are not met please let us know immediately as failure to do so may render your policy void. Please note that once you advise us of a change in status, alternative cover can then be arranged.

WPA reserve the right to request evidence of your status as above.

Flexible Health benefits

Benefits apply per person per policy year unless otherwise stated.

This Benefit Table provides a summary of the cover available per person per year under the Essential and Essential Plus cover. For more detail, please read the specific rules for each benefit on the following pages:

In-patient & Day-patient Treatment <i>see page 11</i>	Essential	Essential Plus
Hospital Treatment	✓	✓
Specialists' Fees ¹	✓	✓
Single Post-Hospital Consultation & Tests	✓	✓
Diagnostic Tests	✓	✓
Diagnostic Scans	✓	✓
NHS Hospital Cash Benefit	✓	✓
Psychiatric Treatment	X	X
Out-patient Treatment <i>see page 12</i>		
Consultations with a Specialist and Diagnostic Tests	✓ Up to £100	✓ Up to £400
Diagnostic Scans	✓	✓
Physiotherapy (and other therapies) ²	X	✓ Up to £400
Psychiatric Treatment	X	X
Out-patient Procedures ¹	✓	✓
Pre-admission Tests	✓	✓
Cancer Care ³ <i>see page 14</i>		
Consultations with a Specialist	✓	✓
Radiotherapy/Chemotherapy	✓	✓
Advanced Therapeutics ⁴	✓	✓
NHS Cancer Cash Benefit	✓	✓
Other Benefits <i>see page 17</i>		
Nursing at Home	✓	✓
Private Ambulance Transport	✓	✓
Parent and Child	✓	✓
Prostheses	✓	✓
Out of Pocket Expenses	✓	✓
Hospice Donation	✓	✓
Optical Treatment ⁵	X	✓ Up to £200
General Dental Treatment ⁵	X	✓ Up to £200
Health Screening ⁶	X	✓ Up to £200

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

¹ For a guideline of customary & reasonable fees contact WPA or visit wpa.org.uk/guideline

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 (i.e. new policyholders of WPA).

Notes
You can choose from over 600 hospitals nationwide
In line with customary & reasonable fees whilst in hospital
One follow-up consultation within the 90 days following a surgical procedure and associated tests carried out on the day of that consultation
Such as blood tests, ultrasound & x-rays
MRI, CT & PET scans only
£100 for each day, maximum of £3,000 (day-patient and in-patient treatment)
Consultations with a specialist and tests such as x-rays, pathology and ultrasound when referred by either your specialist or GP
MRI, CT and PET scans at the request of a specialist and/or one MRI or CT scan requested by a GP
In line with customary & reasonable fees for diagnostic or endoscopic procedures
In the 2 weeks prior to your operation
In line with customary & reasonable fees.
Advanced anti-cancer (targeted) treatment
£200 for each day, maximum of £6,000 for day-patient and in-patient treatment only
Up to 4 weeks
Hospital accommodation charges
In-patient and day-patient only
Up to £10 per day
£70 per day/night up to £700
One health screen every 2 years

⁴ WPA will fund the use of advanced anti-cancer (targeted) treatments which are not readily available on the NHS with our prior approval and when given with curative intent.

⁵ There is a 3 month qualifying period for optical and dental treatment.

⁶ There is a 12 month qualifying period for health screening.

Flexible Health options

Benefits apply per person per policy year unless otherwise stated.

These benefits are available as optional add-ons to the Essential & Essential Plus benefits listed on page 6. For more detail, please read the specific rules for each benefit on the following pages.

Out-patient

See page 19

Out-patient Treatment	Cover	Notes
Consultations with a Specialist	✓	No annual limit provided fees are customary & reasonable. Includes benefit for a second opinion if necessary
Diagnostic Tests	✓	Such as x-rays, pathology and ultrasound, when referred by your specialist or GP. A maximum benefit of £400 is available on your policy when referred by a GP

✓ = Cover available subject to your chosen Shared Responsibility limit.

Therapy

See page 19

Benefits	Cover	Notes
Acupuncture Chiropody/Podiatry Chiropractic Care Dietary Services Homeopathy Osteopathy Physiotherapy Speech and Language Therapy	✓	Up to a total of £1,000 (for any therapies listed) when referred by a GP or specialist to an approved therapist meeting our criteria (see pages 13 & 14 and page 20)

✓ = Cover available subject to your chosen Shared Responsibility limit.

Emergency Worldwide (not USA)

See page 19

Emergency Worldwide	Cover	Notes
Emergency Overseas Treatment Evacuation/Repatriation ¹ Family Assistance	✓	Up to 35 days per trip. Maximum of 90 days and £250,000 per year
Emergency Worldwide Plus	Cover	Notes
Emergency Overseas Treatment Evacuation/Repatriation ¹ Family Assistance	✓	Up to 70 days per trip. Maximum of 180 days and £500,000 per year

✓ = Cover available subject to your chosen Shared Responsibility limit.

¹ Repatriation to the nearest country for treatment where it is medically necessary and the treatment cannot be obtained locally (see page 20).

Hospital Assist

See page 22

Benefits	Cover	Notes
Hospital Cash Benefit	✓	£200 per day-patient/in-patient up to a maximum of £1,400

✓ = Cover available.

Dental

See page 22

Benefits	First Steps	Level 2	Notes
General Dental Treatment ^{1 2}	✓	✓	Covers 75% of the cost of treatment up to £250 per year when performed by a registered dental surgeon or dental hygienist in general dental surgery. There is a 3 month qualifying period before you can claim this benefit
Dental Emergencies ^{1 2}	x	✓	Covers treatment for incidents of acute pain, swelling or a dental haemorrhage requiring an emergency dental appointment up to £250 per course of treatment up to £1,000 per year. There is a 14 day qualifying period before you can claim this benefit
Dental Injuries ^{1 3 4}	x	✓	Covers in- and out-patient treatment up to £20,000 per year where injury has been caused by an external blow to the face, teeth or jaw and treatment is by a recognised Consultant Oral/Maxillo-Facial Surgeon
Defined Oral Problems ^{1 3 4}	x	✓	Covers in- and out-patient treatment under the care of a recognised Consultant Oral/Maxillo-Facial Surgeon/ recognised Specialist for any of the 6 defined problems (see page 24)

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

¹ To be paid in line with The WPA Dental Schedule. The WPA Dental Schedule is available on pages 26 & 27 or by visiting wpa.org.uk/dentalschedule. Where a claim is paid under General Dental Treatment, the WPA Dental Schedule only applies to claims exceeding £120.

² Benefit is only available for the removal of wisdom teeth if undertaken in a general practice (not hospital).

³ Also provides cover for NHS Cash Benefit of £200 per day-patient/inpatient up to £2,000 per policy year as well as Parent & Child hospital accommodation charges.

⁴ To be paid in line with customary and reasonable fees whilst in hospital. A guideline of customary and reasonable fees is available by contacting WPA or by visiting wpa.org.uk/guideline

How to make a claim

All claims must be pre-authorised.

To make a claim for treatment you start by visiting your GP. This is known as **Primary Care**. If your GP cannot treat you they will refer you to a **specialist** or therapist for **Secondary Care**.

You must contact us in advance to tell us about any proposed treatment, either by phoning us on 0845 122 3100 or by visiting wpa.org.uk/claim.

Based on the information provided we will let you know in writing whether the treatment is covered. Where cover is available we will send you a form (declaration) to be signed by your GP, **specialist** or therapist.

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

- Your **specialist** needs to sign the declaration confirming the details of your claim for **specialist** or hospital treatment;
- Your therapist can sign the declaration for physiotherapy or other therapy treatment. After you have had a maximum of 8 sessions, we require confirmation from your GP that the treatment is medically necessary.

If you have been covered by WPA for **less than two years**:

- Your GP needs to sign a declaration for all claims.

Please note:

If you have paid for any part of your authorised treatment and wish us to reimburse you, you must provide the original invoice and proof of payment such as a valid credit card receipt. Hand written receipts will not be accepted.

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

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

Are you making a personal injury claim?

WPA has a right in law to recover any medical expenses within the rules of your policy membership if you make a claim for treatment for an accident or illness that was the fault of someone else (a third party).

You will not be entitled to claim for these expenses unless you comply with the requirements of the Claims Co-operation procedure. Please contact us on 01823 625230 and we will be pleased to send you a leaflet.

Emergency Treatment

In the event of a medical emergency, we advise you to consult your GP, call the NHS emergency services or attend your local A & E department as they are usually best equipped to provide the required emergency care.

Once the medical condition has been stabilised you may wish to arrange transfer to private facilities. At this stage you must get authorisation from us as the transfer must be agreed in advance between the **specialist** and us.

Emergency Worldwide 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 19).

Dental Claims

Before you visit your dentist visit our website at wpa.org.uk to obtain a claim form online or call us on 01823 625230.

For further details regarding dental claims please see page 22.

For all overseas claims

We will pay benefit in pounds sterling and will convert overseas accounts into pounds sterling at the middle rate of exchange ruling on the day we settle your claim. Claim payments will always be made directly to the provider of your treatment.

What is covered

When reading the benefits available please refer to the Benefit Table at the start of this Guide. The following symbols are used to highlight the benefit available under the different base levels of cover. If not stated, the benefit applies to both Essential and Essential Plus.

E = Essential
EP = Essential Plus

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

- This is covered
- This is not covered
- Very important information

In-patient & day-patient

- An in-patient is a patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons;
- A day-patient is 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.

Hospital Treatment

Includes accommodation charges, operating theatre fees, drugs, dressings and medicines used while you are in a hospital that is included on our list of recognised hospitals. Critical care cover is detailed below.

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 patients requiring support for multi-organ failure.

Level 2 – High Dependency

Patients requiring more detailed observation (than in an ordinary bed) or intervention including support for a single failing organ system or postoperative care, and those stepping down from higher levels of care.

We will pay up to 28 days treatment each policy year (each 12 month period) 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.
- You are not covered for:**
 - Treatment in a unit or facility which is not a dedicated Critical Care Unit;
 - Admission as a private patient to an NHS Critical Care Unit following an unplanned/emergency admission to an NHS Hospital although we will pay the NHS Cash Benefit for such an admission;
 - Admission to a private hospital Critical Care Unit following an emergency (unplanned/non elective) admission;
 - Treatment as a private patient in the Critical Care Unit of an NHS hospital following transfer from a private hospital.

Specialists' Fees

Such as surgeons', physicians' and anaesthetists' fees whilst you are in hospital receiving in-patient or day-patient treatment, provided we recognise the **specialist** (or overseas is **locally recognised**) and the charges are **customary and reasonable**.

Operations are given codes and if your **specialist** says you need an operation please ask which code will be used and what the fee will be. We can then confirm whether it will be met in full before you have your treatment. We will always try to ensure that we do not shortfall **specialists'** accounts needlessly but if there is a shortfall you will need to pay this to your **specialist** yourself.

However, if the procedure is more complicated than normal the **specialist** can contact WPA in writing to give reasons for a higher fee and these will be considered.

Post Hospital Consultation & Tests

We will pay for one follow-up consultation with your **specialist** AND associated tests carried out on the day of that consultation, provided it takes place within 90 days following a surgical procedure (an operation described using an Office of Population Censuses and Surveys (OPCS) code or Clinical Classification and Schedule Development (CCSD) code) which you had as an in-patient or day-patient.

✓ 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 find or to help find the cause for your symptoms.

✓ 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 of £100 (maximum of £3,000 per person per policy year) for each day-patient admission OR for each night spent as an NHS patient in an NHS hospital during an in-patient admission, without charge, instead of being admitted to hospital as a private patient. The hospital or your **specialist** will need to confirm the dates that you were in hospital.

✗ You are not covered for:

- 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 overseas;
- Treatment that is excluded by these rules or any medical exclusions.

Out-patient

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

✓ Consultations with a Specialist and Diagnostic Tests [E]

Consultations with a **specialist** and tests such as x-rays, pathology and ultrasound when referred by either your **specialist** or GP, up to £100 per policy year.

✓ Consultations with a Specialist and Diagnostic Tests [EP]

Consultations with a **specialist** and tests such as x-rays, pathology and ultrasound when referred by either your **specialist** or GP, up to £400 per policy year.

✓ 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 [EP]

We will pay for the following therapies up to £400 per policy year.

You must be referred by your GP or specialist and you are not covered for fees charged for cancelled or missed appointments.

✓ Acupuncture

We will pay for treatment by an acupuncturist who is a member of the British Medical Acupuncture Society.

✓ Chiropody/Podiatry Benefit

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

✗ You are not covered for:

- Any surgery carried out by a chiropodist/podiatrist, (although we will cover treatment for ingrowing toenails; we will cover surgery to the forefoot by a WPA recognised NHS Consultant Podiatric Surgeon – this must be pre-authorised);
- Medical appliances such as insoles or orthoses.

✓ 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 Health Professions Council.

✓ Homeopathy

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

✗ You are not covered for:

Drugs or remedies prescribed by your homeopath or other therapist.

✓ 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 Health Professions Council.

✓ Speech and Language Therapy

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

✓ 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. We will pay for interventional surgical procedures and diagnostic endoscopic procedures that your **specialist** carries out while you are an out-patient. Please contact us in advance to make sure that the procedure is covered.

✓ Pre-admission Tests

We will pay for tests carried out in hospital that you need 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).

Cancer Care

What do you need to do if cancer is diagnosed?

You should read both these rules and our Cancer Care Leaflet right through so you know what is and what is not covered. You can view/download from wpa.org.uk/cancer or call us on 01823 625230.

You must contact us to **pre-authorise** your treatment. We will then contact your **oncologist** so that we can work together to smooth your claim process.

✓ What is covered:

- **Active, established** investigations and treatments in the UK for **cancer**, as set out here, whether a new **cancer** or a recurrence of the original;
- Treatment in hospital as an in-patient or day-patient, as an out-patient or at home;
- Surgery, radiotherapy and chemotherapy which is intended to remove, suppress or kill off cancerous cells;

! In addition you are covered for **Advanced Therapeutics** not readily available to you on the NHS.

WPA will pay for a course of treatment with **Advanced Therapeutics** for your **cancer** lasting up to a total of 12 consecutive calendar months starting from the date on which the first treatment with them is given. This may be extended if your oncologist can provide us with convincing clinical evidence that it continues to be given with **curative intent**. Funding will continue, provided clinical evidence continues to justify its use at review at 3 monthly intervals. This is payable only in line with the policy benefits and when the policy is in force.

Further funding for **Advanced Therapeutics** would be available to you if you were to develop a different (**histologically distinct**) **cancer**.

WPA will provide benefit for **Advanced Therapeutics** provided that:

! Your oncologist states that they would not be readily available to you as an NHS patient under any circumstances.

- They have been granted an European Medicines Agency (EMA) product licence 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 formally pre-authorise their use.

Follow up consultations - Visits to your **specialist** to monitor your condition once your treatment has finished may be important to you. These will normally be covered for up to 5 years from the completion of **active treatment** for your **cancer**. The frequency of consultations we fund will be agreed within the NHS protocols for the particular **cancer**.

Clinical trials - cover may be available for certain expenses if you volunteer to be included in a NHS based research trial that has local research and ethical approval and is registered by a non-commercial organisation such as the Medical Research Council or UKCCCR. Any side effects or complications that result directly or indirectly from the trial would not be covered as they are funded by the NHS.

WPA will not cover any cost incurred by policyholders when included in clinical trials in the private sector. Further we will not fund any treatment for side effects or complications arising directly or indirectly from inclusion in such trials.

You should seek clarification before volunteering to be included in any research trial.

Treatment overseas – although you are not automatically covered for investigations or treatment outside the UK, approval may be given up to the level of benefit of the nearest equivalent procedure or treatment regime in the UK. You need to seek **pre-authorisation** for this before any treatment will be funded.

Bone marrow or stem-cell transplants may occasionally be recommended as part of your **cancer** treatment. We will pay for one complete procedure for the lifetime of the plan if it is not readily available to you on the NHS.

To obtain funding from WPA you need **pre-authorisation** before your **bone marrow** or **stem-cell treatment** starts. Please note that the costs to the donor will not be covered.

✗ What is not covered:

- New policyholders are not covered for **cancers** occurring before or within the first 90 days of the policy starting whether the **cancer** has been formally diagnosed or not;
- Treatment for **cancer** with **Advanced Therapeutics** to maintain or prolong **remission**, to maintain good health in the absence of symptoms of **active cancer**, or for preventative use;
- Advanced Therapeutics that are readily available to you on the NHS. We will need your oncologist to confirm whether this applies to you or not;
- Treatment with Advanced Therapeutics beyond twelve months unless clinically justified by your Consultant Oncologist, or for treatment that is not clinically effective;
- Treatment or care for **cancer** described by your oncologist as **terminal**, (sometimes described as palliative care) whether carried out in a hospital, at home or in a hospice. If you are admitted to a hospice we will make a contribution to the hospice if you ask us to do so;
- Treatment that has not been **pre-authorised** where this is required or treatment that is prescribed by a General Practitioner and not your **specialist**.

✓ NHS Hospital Cash Benefit (Cancer)

We will pay a cash benefit of £200 for each day-patient admission OR for each night spent as a NHS patient when receiving treatment related to **cancer** in a NHS hospital during a day-patient/ in-patient admission, without charge, instead of being admitted to a hospital as a private patient (up to a maximum of £6,000 per person per policy year). Your hospital or **specialist** will need to confirm the dates that you were in hospital.

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

All treatment for cancer requires pre-authorisation

Summary of cancer cover

Please read the rules on pages 14 & 15 of this guide for more detailed information.

Place of treatment	✓	Established investigations and active treatments for cancer in the UK in hospital as an in-patient or day-patient, as an out-patient or at home. We will also make a donation on your behalf if you are admitted to a hospice.
Diagnosis	✓	Consultations with your specialist including second opinions and diagnostic tests, scans and biopsies.
Surgery	✓	We will provide benefit for fees up to a level that is customary and reasonable.
Prevention	✗	You are not covered for screening or tests to determine the existence of a condition for which you do not have any symptoms, including genetic tests, the removal of tissue or preventative treatment (e.g. vaccines) for it even if you have a family history of that condition (e.g. prophylactic mastectomy, vaccines etc).
Drug therapy	✓	<ul style="list-style-type: none"> Chemotherapy Advanced Therapeutics that are not readily available to you as an NHS patient (see definitions) for a maximum of 12 consecutive months from the start of treatment with any form of Advanced Therapeutics. This benefit can only be extended if the treating oncologist provides us with convincing clinical evidence that it continues to be given with curative intent, when we will continue to fund it, with a further review after 3 months. Biological therapy e.g. hormone tablets when these are supplied by your specialist, not your GP
	✗	You are not covered for Advanced Therapeutic drugs given to maintain remission or that are prescribed by your GP
Radiotherapy	✓	This includes radiotherapy given for pain relief.
Terminal care (sometimes referred to as palliative care)	✗	You are not covered for terminal care. We will however make a donation to a hospice on your behalf.
Monitoring	✓	Follow up consultations and reviews will be covered for 5 years within NHS protocols from the time when your active treatment for cancer has finished.
Established (not experimental) treatment	✓	You are covered for established treatment as defined in these rules.
	✗	You are not covered for new or experimental treatment outside these conditions.
Clinical trials	✓	Pre authorise - We may pay for treatment given in recognised research trials approved by a local NHS Ethics and Research Committee.
NHS treatment	✓	If you choose to be treated as an NHS patient you will be entitled to a daily cash benefit whether you are being treated as a day-patient or in-patient provided your claim is covered by the rules of your policy. A financial contribution to the cancer unit caring for you to improve the service for others using the unit will be made if you ask us to do so.
Bone marrow or stem cell treatment	✓	Pre authorise - Such treatment must be pre-authorized before your bone marrow or stem-cell treatment starts. Please note that we will not contribute to the costs to the donor.
Treatment outside the UK	✓	Pre authorise - Benefit may be available based on the costs that would be incurred and regarded as customary and reasonable for the nearest equivalent investigation or treatment in the UK. Specific agreement is required from WPA before any treatment takes place. We will need to communicate with your oncologist in your chosen location as part of the pre-authorization process.

✓ = Covered.
✗ = Not covered.

Other benefits

✓ Nursing at Home

You must contact WPA for **pre-authorization** before nursing at home is arranged.

We will pay for:

- Nursing carried out by a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number;
- Nursing (but not simply help with mobility or personal care) by a qualified nurse at your main address for up to 4 weeks if your **specialist** agrees that you can leave hospital early provided that you are able to have the same level of nursing care at home. The nursing should be arranged by your **specialist** and can be covered provided your **specialist** remains in charge of your treatment.

✓ 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 (up to the maximum shown on the Benefit Table).

✓ Parent and Child

We will pay for the accommodation charge made by the hospital for one parent to stay in hospital with a child or for a child to accompany their parent 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** – by which we mean inert passive replacements of joints, blood vessels or other organs. Examples include a hip replacement or an aortic graft, but not an artificial limb;

or

- **Active** – these are usually electronic devices implanted permanently within the body to correct or modify an abnormal bodily function caused by disease, illness or injury. Examples include spinal nerve stimulators and pacemakers.

Passive prostheses

✓ We will pay for:

- The reasonable cost of the prosthesis provided that it is in established common clinical practice and has been approved by NICE. Payment for other prostheses will only be made following **pre-authorization** by WPA's Medical Advisory and Clinical Governance Committee (MACGC). The full costs of insertion will also be covered provided they are customary and reasonable.

✗ You are not covered for:

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

Active electronic implantable medical devices

WPA cover those that are used to prevent the risk of potentially fatal organ failure e.g. cardiac pacemakers or defibrillators.

Implantable spinal nerve stimulators, cochlear implants or intracranial devices for a variety of neurological conditions are not covered as these conditions are usually not acute and are therefore outside the terms of the policy.

Several new devices are currently in development for a variety of functional disorders but will not be covered unless passed by NICE as safe and effective and used in the treatment of potentially fatal organ failure.

Pre-authorization is required before benefit will be paid for treatment with an active prosthesis.

Your **specialist** will need to provide full details of your proposed treatment for assessment prior to approval by WPA's MACGC.

It is important that you discuss these particular conditions with your consultant/specialist.

With pre-authorisation we will pay for:

- The initial supply and fitting of an active electronic implantable medical device, provided that the device has been approved by NICE, and is accepted and recognised treatment within the NHS.

You are not covered for:

- Any subsequent maintenance, including battery replacement;
- A further procedure/device unless the device fails because of a fault in its manufacture.
- We do not cover revision surgery or faults in clinical benefit caused by mis-placement or misuse;
- Treatment with active electronic implantable devices that have not been specifically authorised.

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.

Optical Treatment [EP]

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

You are not covered for:

- Replacement glasses needed because of damage or wear and tear;
- Refractive eye surgery for the correction of imperfect sight;
- Replacement or disposable contact lenses (by disposable we mean monthly or daily);
- Treatment undertaken during the first 3 months of cover with Essential Plus (i.e. a 3 month qualifying period applies).

General Dental Treatment [EP]

We will pay for:

- Up to a maximum of £200 each plan year for all receipted accounts for general dental treatment or £450 combined benefit if you have selected the Dental Option (see page 22).
- Treatment must be performed by a **registered dental surgeon or registered hygienist** in general practice. (This means that it must be carried out in a dentist's or hygienist's chair in a general dental surgery only).
- This benefit covers treatment not classed as an emergency, dental injury or defined oral problem (see page 22).
- Claims over £120 will be paid in line with the WPA Dental Schedule (see pages 26 & 27) and the dentist must give details of the treatment provided.

You are not covered for:

- Treatment outside the UK;
- Treatment received within the first three (3) months of cover with Essential Plus;
- Treatment that requires hospitalisation;
- Implants, dentures, veneers and orthodontics;
- Removal of wisdom teeth (unless carried out in the dentist's chair in a dental surgery).

Health Screening [EP]

We will pay the cost of one health screen every 2 policy years which is carried out by a medically qualified practitioner we approve up to £200.

You are not covered for:

- Health screens needed for legal, insurance or employment reasons.
- A screen undertaken during the first year of cover with Essential Plus.
- More than one screen in a 24 month period.

Additional Options

WPA Flexible Health and Flexible Health Freelance provides each person the choice of two base levels of cover (Essential or Essential Plus) and you can also choose from a number of Options to enhance this cover as detailed below. Please check your Certificate of Registration to remind yourself which Options (if any) you have chosen.

Out-patient

Out-patient treatment is treatment given at a hospital, consulting room or out-patient clinic where you do not go in for day-patient or in-patient treatment.

Consultations with a Specialist and Diagnostic Tests

We will provide benefit with no overall limit for consultations and diagnostic tests, such as x-rays, ultrasound scans and investigations or blood tests arranged by your **specialist**. There is a maximum of £400 towards diagnostic tests arranged by your GP each policy year.

Therapy

We will pay for the following therapies each policy year up to:

- £400 on Essential Plus
- £1,000 on Essential Cover with Therapy Option
- £1,400 on Essential Plus with Therapy Option per policy year.

Please see the Physiotherapy (and other therapies) section on pages 12 & 13 for full details.

You must be referred by your GP or specialist and you are not covered for fees charged for cancelled or missed appointments.

Emergency Worldwide (not USA)

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

Your Certificate of Registration confirms whether you have chosen one of these two Emergency Worldwide Options.

- **Emergency Worldwide** – cover is for trips abroad for up to 35 days per trip starting on the day of your outward journey, up to an overall maximum of 90 days and £250,000 per person per policy year.
- **Emergency Worldwide Plus** – cover is for trips abroad for up to 70 days per trip starting on the day of your outward journey, up to an overall maximum of 180 days and £500,000 per person per policy year.

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.

Emergency treatment means unforeseen treatment that is due to a sudden, acute illness or injury that, for medical reasons, cannot be delayed until your return to the UK. Overseas in this context means outside the UK, Channel Islands and the Isle of Man.

If you are travelling in the EU and you are entitled to a European Health Insurance Card (EHIC) you must get one before you travel. Also contact the Department of Health on their website which is <http://www.dh.gov.uk> and search for 'reciprocal health agreements' to understand the reciprocal health agreements in place between the UK and other countries before travelling.

Where you receive treatment in a state funded facility we will only pay for eligible treatment costs that are over and above those covered by the EHIC or reciprocal health agreements in the country where treatment occurs. If you undergo private treatment where the EHIC is not valid or a reciprocal health agreement is not in place, we will pay the claim under the terms of your policy.

No treatment will be funded unless you have contacted the Worldwide Co-ordination Centre and your treatment has been approved.

Should you be taken ill during your trip before 35 (or 70) days have elapsed, cover for eligible treatment will continue until such time as medical advice indicates you are well enough to travel home.

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

Evacuation/Repatriation

- If you are outside the UK and need eligible medical treatment that in our opinion is not available in the country you are in, we will, through the Worldwide Co-ordination Centre, evacuate you to the nearest suitable medical facility where the treatment you need is available;
- We may, in extreme circumstances, repatriate you to the UK for treatment where this is medically necessary and the treatment cannot be obtained locally;
- In the event of the death of an insured person, our Worldwide Co-ordination Centre will make arrangements (including the completion of any documentation) for the return of the deceased to the UK. Cover does not include funeral expenses.


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.

What is not covered:

- Treatment that you have not advised to and has not been authorised with the Worldwide Co-ordination Centre;
- Treatment that is available to you using your European Health Insurance Card (EHIC) or where a reciprocal health agreement exists between the UK and the country where the treatment takes place – see first section of the Emergency Worldwide rule;
- Trips outside the UK falling outside the limits set out in the Benefit Table;
- Any treatment in the USA;
- Elective overseas treatment – see page 21;
- Any costs which you can also claim under the terms of a Travel Insurance or other insurance policy. We will only pay our share of the claim;
- Treatment relating to general or personal exclusions that is not covered by your policy in the UK, for example winter or professional sports;
- Benefits under the Hospital Assist Option;
- Treatment either overseas or on your return to the UK for a medical condition contracted or injury sustained whilst in a location to which you travelled (during the period of the advice) against advice issued by the Foreign and Commonwealth Office (FCO) either as all travel or all but essential travel. Please check their website www.fco.gov.uk before you travel, alternatively call their advice line on 0845 850 2829;
- Treatment either overseas or on your return to the UK for a medical condition contracted or injury sustained if you travelled against medical advice;
- Any costs incurred where the necessary precautions were not taken, for example vaccinations;
- Repatriation to the UK when the treatment you require is available in the country you have been hospitalised in.

How you make a claim:

 **No treatment will be funded unless you have contacted the Worldwide Co-ordination Centre and your treatment has been approved** so you must call the Worldwide Co-ordination Centre on **(+44) 020 8680 3800** who will be able to give you valuable help and advice; In exceptional situations, such as an emergency admission to hospital, you must still contact the Worldwide Co-ordination Centre straight away or as soon as you are able to do so;

We will cover you, under the Worldwide Cover but not under the general policy benefits, against Acts of Terrorism as long as you are not in a country or part of a country explicitly warned against travel by the Foreign and Commonwealth Office (FCO) either as all travel or all but essential travel. Please check their website www.fco.gov.uk before you travel, alternatively call their advice line on 0845 850 2829.

Payment for your treatment:

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

Elective overseas treatment

Elective overseas treatment is treatment overseas (outside the UK) where part or the whole reason for travelling or being abroad is to get that treatment.

It applies only to treatment that is otherwise covered by your policy.

What may be covered:

- We will contribute to the cost of elective overseas treatment to no greater extent than if you had your treatment in the UK, but only if:
 - The proposed treatment overseas has been recommended or is supported in writing by the specialist who is treating you in the UK and the specialist or your GP writes to us to confirm this at your expense and
 - You send us a written quotation of the full cost before you arrange the treatment. We will refer this and the letter from your specialist/GP to our Medical Adviser for pre-authorisation and approval. We will then consider the extent to which we can contribute to the cost of your elective treatment overseas and
 - We confirm the extent to which we will assist you in writing before you undertake the treatment.

→ **We will make an administration charge for authorising your elective overseas treatment which will be 5% of the cost of treatment with a minimum fee of £250;**

→ Please note that we will be in direct contact with the hospital and consultant who will be providing your treatment before the treatment takes place.

Payment for your treatment:

- Once we have authorised your treatment we will be happy to fund it in advance to the agreed level - however we will only make payment direct to the provider of your treatment by international fund transfer;
- Do not make any payment for your treatment in cash as we will not be able to refund it to you;
- We will need all the original accounts and medical reports before we can make any payment.

You are not covered for:

- Treatment that we have not pre-authorised;
- Treatment that costs more than the contribution we have agreed;
- Treatment not normally covered in the UK by your policy, for example treatment that is not established;
- Treatment either overseas or on your return to the UK for a medical condition contracted or injury sustained whilst in a location to which you travelled (during the period of the advice) against advice issued by the Foreign and Commonwealth Office (FCO);
- Any travel costs relating to your treatment abroad;
- Any cost relating to companion(s) travelling with you;
- The cost of accommodation except for the charges made for your hospital admission;
- Any cost relating to evacuation or repatriation in the event of complications or death;
- Any additional charges made by the hospital in the event of complications. **We therefore strongly advise you** to seek a package deal with the hospital abroad that includes treatment of unforeseen complications.

Hospital Assist

Hospital Cash Benefit

- ✓ We will pay a cash benefit of £200 per night for a stay in hospital (NHS or private) up to a maximum of £1,400 per policy year.

✗ You are not covered for:

- Hospitalisation relating to a condition which is not covered under this policy;
- Treatment overseas;
- Treatment received within the first three months of cover.

This benefit is in addition to any NHS Cash Benefits that may apply.

Dental

The Benefit Table (on page 9) provides a summary of the cover available per person under the Dental Option. For more detail please read the special rules for each benefit on the following pages.

All benefits will be paid in line with the WPA Dental Schedule (shown on pages 26 & 27).

Here are more details about each of the benefits the Dental Option covers along with any rules that relate to them. Please note that with the exception of General Dental Treatment you are not covered for dental problems that started on or before the date your cover started on the Dental Option.

The Dental Option offers 2 levels of cover:

First Steps is designed for children aged 0 to 3 years and covers General Dental Treatment only (please note that children will automatically transfer to Level 2 at renewal after their 4th birthday);

Level 2 is available to all customers from the age of 4 and covers General Dental Treatment, Dental Emergencies, Dental Injuries and Defined Oral Problems.

The following symbols are used to highlight the benefit available under the different levels of cover:

[FS] = First Steps

[L2] = Level 2

General Dental Treatment [FS & L2]

✓ We will pay:

- 75% up to £250 for General Dental Treatment under Essential Cover;
- or
- 75% up to £450 for General Dental Treatment under Essential Plus Cover.
- Treatment must be performed by a **registered dental surgeon, registered hygienist or dental therapist** in general dental practice.
- This benefit covers treatment not classed as an Emergency, Dental Injury or Defined Oral Problem.
- Original invoices and proof of payment such as a valid credit card receipt must be attached to all dental claims.
- Claims over £120 will be paid in line with the WPA Dental Schedule (see pages 26 & 27) and the dentist must give details of the treatment provided.

! If wisdom teeth are extracted this must be carried out in the dentist's chair in a dental surgery (or as a dental emergency).

✗ You are not covered for:

- Treatment outside the UK;
- Treatment received within the first 3 months from your Dental cover start date;
- Treatment that requires hospitalisation;
- Implants, dentures, veneers and orthodontics;
- Adhesive bridges of the Maryland or Rochette type, unless we have given prior written approval;
- Orthodontic treatment;
- Treatment by any dentist we have given written notice to, withdrawing our acceptance for the payment of benefit;
- Treatment provided by any dentist who is related to you or your family members;
- Fees which are recoverable from other forms of insurance.

Dental Emergencies [L2]

✓ We will pay:

- Up to £250 for each new episode/course of treatment required for a dental emergency. Cover available for up to 4 emergencies (i.e. £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 dental surgeon or A&E department only. (This means that it must be carried out in a dentist's chair (general dental surgery) 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 defined oral problem.
- Benefit will be paid in line with the WPA Dental Schedule on pages 26 & 27.

! Wisdom teeth are covered only when carried out as a dental emergency (or under the General Dental Treatment benefit if carried out in the dentist's chair in a dental surgery).

✗ You are not covered for:

- Treatment received within the first 14 days from your Dental Option cover start date;
- Treatment that requires hospitalisation;
- Treatment relating to periodontal emergencies;
- Implants, dentures, veneers and orthodontics;
- Adhesive bridges of the Maryland or Rochette type, unless we have given prior written approval;
- Orthodontic treatment, except the repair of orthodontic appliances as a result of a dental injury;
- Treatment by any dentist/hospital we have given written notice to, withdrawing our acceptance for the payment of benefit;
- Treatment provided by any dentist or Consultant Oral/Maxillo-Facial Surgeon/recognised specialist who is related to you or your family members;
- Fees which are recoverable from other forms of insurance.

Dental Injuries [L2]

✓ 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 dentition and support structures caused by an extra oral impact, (an external blow to the face, teeth or jaws).
- You must inform WPA and have the emergency appointment by a dentist or at a hospital Accident & Emergency (A&E) department within **72 hours of the injury**. You can only claim this benefit if you have had an emergency appointment first. This emergency appointment is a pre-requisite for claiming under the Dental Injury benefit.
- 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.
- **WPA must grant prior approval for any treatment plan following a dental injury.**
- All subsequent treatment related to this injury will be subject to the normal limits:
- **Your dentist must provide:**
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 commence and the date treatment will be completed,
 - the name of the Consultant Oral/Maxillo-Facial Surgeon/recognised Specialist who will undertake the treatment,
 - detailed treatment costs;
- A full report on the incident and all injuries sustained;
- Evidence of an injury and x-rays to show the injuries sustained;
- Evidence that the injury is not related to chronic periodontal disease.
- On the basis of this information, WPA will give prior written approval (**pre-authorisation**) for your treatment. Cover will not commence until this pre-authorisation has been sought 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 on pages 26 & 27.

X You are not covered for:

- Treatment outside the UK except as detailed above;
- Treatment given without our prior written approval (pre-authorisation);
- Treatment given following an accident if you did not inform us within 72 hours and where you did not have an emergency appointment with a dentist or at a hospital Accident & Emergency (A&E) department;
- 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.
- Treatment given more than 12 months after the date of the extra oral impact to which the treatment relates unless we have agreed in writing to cover it;
- Treatment relating to periodontal disease;
- Veneers. We will only provide benefit for the cost of a replacement veneer if the original is damaged as a result of a dental injury;
- Adhesive bridges of the Maryland or Rochette type, unless we have given prior written approval;
- Orthodontic treatment, except the repair of orthodontic appliances as a result of a dental injury;
- Treatment resulting from accidents to dentures or implants;
- Treatment given by a Consultant Oral/Maxillo-Facial Surgeon/recognised specialist who we do not recognise;
- Treatment by any dentist/hospital/Consultant Oral/Maxillo-Facial Surgeon/recognised specialist we have given written notice to, withdrawing our acceptance for the payment of benefit;
- Treatment provided by any dentist or Consultant Oral/Maxillo-Facial Surgeon/recognised specialist who is related to you or your family members;
- Treatment arising as a result of a road traffic accident/collision where you were not wearing a seat belt or a suitable child restraint (as appropriate) as required by law;
- Treatment you receive arising as a result of a road traffic accident/collision in relation to which you are convicted of a criminal offence;
- Fees which are recoverable from other forms of insurance.

Defined Oral Problems [L2]

✓ We will pay:

- Up to £10,000 each policy year for the following defined oral problems, these are:
 - Treatment of oral cancer including reconstructive plastic surgery;
 - Treatment of bone cyst of the jaw (i.e. not tooth or gum cysts);
 - Treatment of tumour of the mouth or jaw;
 - Treatment of conditions of the salivary glands;
 - Surgical removal of retained buried roots under general anaesthetic (**extraction of roots which can be done in a dentist's chair are not included in this benefit**);
 - Surgery to the temporomandibular joint.
- You must be under the care of a **Consultant Oral / Maxillo-Facial Surgeon / recognised Specialist (i.e. not your general dentist)**.
- Treatment must be carried out by a Consultant Oral/Maxillo-Facial Surgeon/recognised specialist in hospital and will not qualify for benefit when carried out by a dentist unless part of follow-up treatment agreed by us.
- Before your treatment starts we require a **detailed treatment plan** including costs and x-rays from your Consultant Oral/Maxillo-Facial Surgeon/recognised Specialist to show the diagnosis of the defined oral problem and that the treatment is not needed because of chronic periodontal (gum) disease.
- If you need to claim you must contact us **within 72 hours** of the diagnosis of a defined oral problem so that we can confirm the extent of your cover.
- Benefit will be paid in line with the WPA Dental Schedule on pages 26 & 27 or the WPA Schedule for customary and reasonable fees as appropriate.

X You are not covered for:

- Treatment given following diagnosis if you did not inform us within 72 hours;
- Treatment given more than 12 months after the date of the defined oral problem to which the treatment relates unless we have agreed in writing to cover it;
- Treatment given without our prior written approval (pre-authorisation);
- Treatment relating to periodontal (gum) disease;
- Treatment of tooth-related cysts;

- Treatment carried out in a General Dental Surgery by your General Dental Practitioner;
- Treatment provided by any dentist or Consultant Oral/Maxillo-Facial Surgeon/recognised specialist who is related to you or your family members;
- Fees which are recoverable from other forms of insurance.

Hospital Charges

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

In-patient treatment is treatment which, for dental reasons, means you have to stay in hospital overnight or longer;

Day-patient treatment means treatment which, for dental reasons, means you have to go into hospital or a day-patient unit because you need a period of clinically supervised recovery but do not have to stay overnight;

✓ We will pay:

- The cost of your room, food, nursing, operating theatre fees, drugs and medical supplies while you are in hospital. The hospital will usually send the invoice straight to us. 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. We will reimburse the cost of this treatment directly to the hospital.
- This benefit will be payable within the maximum benefit allowed by either the Dental Injury benefit or the Defined Oral Problem benefit.

X You are not covered for:

- 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.

Specialists'/Consultant's fees while you are in hospital

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

✓ We will pay:

- The fees charged by your specialist and anaesthetist which are customary and reasonable.
- If your specialist tells you that you need an operation please ask him/her to let us know which operation he/she will be performing and what his/her fee will be before treatment starts, we can then confirm if the benefit available covers your treatment costs in full.

X You are not covered for:

- Treatment that is given by a specialist who we don't recognise; or who is related to you/the patient or is recommended by a General Dental Practitioner (GDP) who is a member of your/the patient's family;
- Specialists' fees when the patient receives treatment as a non-private (NHS) patient in a non-private (NHS) hospital.

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

This benefit will be payable within the maximum benefit allowed by either the Dental Injury Benefit or the Defined Oral Problem benefit.

✓ We will pay:

- A cash benefit of £200 for each night you spend as a non-private (NHS) patient in a NHS hospital, without charge, instead of being admitted to hospital as a private patient. This will be payable for up to a maximum of 10 nights for in-patient treatment as an NHS patient or overseas in a hospital where no charge is made by the hospital or Consultant Oral/Maxillo-Facial Surgeon/recognised Specialist. The Hospital will need to confirm the dates you were in hospital.

Parent and Child

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



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.

WPA Dental Schedule

The WPA Dental Schedule is shown below (and is also available by contacting WPA or by visiting wpa.org.uk/dentalschedule). This schedule shows the maximum amount we will reimburse you for treatment you are claiming for under the Dental Emergency, Dental Injury and Defined Oral Problems benefits. In addition, the Schedule will be applied where a General Dental Treatment claim exceeds £120.

Item	Reimbursement limit
Out of hours telephone consultation with patient	Up to £35
Out of hours attendance fee	
a) Registered dentist	Up to £175
b) Registered dental surgery assistant	Up to £75
Consultation, examination & report	Up to £45
Radiographs (a) small	Up to £20
Radiographs (b) panoral	Up to £45
Provision of prescription antibiotics/analgesics	Up to £25
Sedative dressings – 1st tooth	Up to £40
Sedative dressings – multiple	Up to £70
Sedation	Up to £120
Incising an abscess	Up to £30
Arrest of haemorrhage	Up to £60
Root canal treatment, opening and dressing	Up to £40 (single)
Root canal treatment, opening and dressing	Up to £65 (multiple)
Scale & polish/consultation with hygienist	Up to £40
Fillings	
Single surface	Up to £40
Two surface	Up to £55
Multi-surface	Up to £70
Pin retention	Up to £25

Item	Reimbursement limit
Root fillings	
Incisor/canine	Up to £110
Pre-molar	Up to £140
Molar	Up to £275
Apicectomy	Up to £150
Extractions	
One tooth	Up to £45
Multiple	Up to £60
Surgical extraction	Up to £120
Crown & Bridge	
Ceramic crown	Up to £300
Bonded crown – precious metal	Up to £340
Cast gold crown	Up to £300
Inlays	Up to £300
Bridgework – precious metal	Up to £300
Re-cement crown/bridge/inlay	Up to £40
Temporary crown	Up to £50
Temporary bridge	Up to £100
Dentures (Please note dentures & orthodontics will only be covered if related to a Defined Oral Problem or a Dental Injury)	
Complete set acrylic resin	Up to £575
Full upper or lower resin	Up to £325
Partial resin	Up to £220
Partial metal	Up to £525
Repairs	Up to £40
Repairs – emergency out of hours	Up to £70
Dental implants (Please note: Implants will only be covered if related to a Defined Oral Problem or a Dental Injury)	
This is the maximum benefit payable for the placement of titanium implants and associated restorative treatment.	£1,800 per implant Overall maximum £3,600 per policy year

Please note that the overall benefit limit for General Dental and Dental Emergency treatment still applies.

What is not covered

General Exclusions

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

We cannot pay your claim if:

- Your claim has not been pre-authorised in all circumstances;
- The specialist/therapist you have been referred to by your GP is not recognised;
- Your treatment is carried out by any provider of treatment who is related to you/the patient or is recommended by a GP who is a member of your/the patient's family;
- You have not sent us a fully completed declaration;
- Your treatment is not for an acute condition;
- You cease to live in the UK for at least 6 months a year;
- Your policy is not in force and/or the premiums are not up to date at the time of treatment;
- 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 policy (i.e. an insured may not make a profit from claims). Private Medical Insurance is an indemnity policy. If you or your family members hold more than one indemnity policy you must tell us (for example if you also have travel insurance or hold an individual policy but are also covered by your own or a partner's company medical insurance). If you make a claim we will contact the other insurer and share the claim between us;
- Your treatment took place outside the UK (unless it is authorised by WPA);
- You accept or have accepted any inducement (financial or otherwise) to have private treatment.

Your Policy Does Not Cover

- Allergic conditions.
Treatment related to or arising from neutralising/desensitising these.
 - Breast surgery
You are not covered for care and/or treatment arising from or related to breast modification whether for medical or psychological reasons for example gynaecomastia (breast enlargement in men) except as shown.
- We will pay for:

 - One procedure for breast reduction following cancer surgery in the opposite breast;
 - One procedure for breast reconstruction on one or both sides after removal of one or both breast(s) as part of the treatment for cancer.
- Cosmetic/aesthetic treatment.
This is treatment intended to improve the patient's appearance.
 - Cosmetic or aesthetic treatment 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 taking part in winter sports of any kind, scuba diving and motor sports of any kind;
If you are not sure whether an activity you plan to do falls within this rule you should check with us first. You are strongly advised to take out the appropriate specialist insurance if you are undertaking a particular sport or activity.
 - Care and/or treatment arising from or related to engaging in professional sport that is a sport where any fee, donation or benefit in kind is received either directly or indirectly for playing, training or coaching;

- Medical conditions arising out of war, invasion, riot, revolution, act of terrorism, act of piracy, nuclear, biological or chemical contamination or any similar event.
- Deliberately self-inflicted injuries or attempted suicide.
- Care and/or treatment arising from or related to deliberately self inflicted injuries or attempted suicide.
- Dental Treatment (unless covered by the Dental Option). This means treatment of a condition which involves any teeth, their roots and surrounding tissue attachments.
- Developmental, behavioural or educational problems (or speech problems arising from these).
 - We will however pay for an initial consultation with a consultant, specialist or with a psychologist we recognise to diagnose the cause of the symptoms. Full psychological or educational assessments are not covered.
- Dialysis for chronic kidney failure (unless we agree to cover as part of emergency treatment.)
- Drooping Eyelids (ptosis) - we only cover surgery for this if the visual field is obstructed by more than 50%.
- Drug/substance dependency or abuse of alcohol.
 - Care and/or treatment arising from or related to dependency on or abuse of alcohol, drugs or other addictive substances.
- HIV, aids.
 - Care and/or treatment arising from or related to HIV, AIDS or similar infections or illnesses and injuries or medical conditions arising from these;
- Hormone replacement therapy (HRT)
We do not pay for Hormone Replacement Therapy (HRT) or other treatments intended to relieve symptoms arising from or related to any natural cause such as the menopause which are not due to any underlying disease, illness or injury.

- Hospitals that are not on our list of recognised hospitals
- We reserve the right to withdraw or amend the list of recognised hospitals (without prior notice if necessary) in such a way as we feel is reasonable and commercially necessary.

→ Long term conditions - also called **chronic conditions**.

Your policy is intended to cover short-term, not long-term, treatment of **acute medical conditions** which start after you have taken out your policy. An acute medical condition is defined by most medical insurers as '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.'

Your policy is not intended to cover treatment for conditions that keep on coming back or need long term monitoring and management to suppress their effects. Examples include: diabetes, glaucoma, Alzheimer's disease, macular degeneration, ulcerative colitis, rheumatoid or juvenile arthritis and Crohn's disease.

We may provide cover for initial investigations needed to diagnose a new condition and the initial short term treatment up to the point of stabilisation - a period not exceeding 3 months.

You should contact us in these circumstances for pre-approval.

A **chronic medical condition** is commonly recognised as a disease, illness, or injury that has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests;
- It needs ongoing or long-term control or relief of symptoms;
- It requires your rehabilitation or for you to be specially trained to cope with it;
- It continues indefinitely;
- It has no known cure;
- It comes back or is likely to come back;
- It can only be contained by repetitive treatment or medication.

We will only decide that your condition is **chronic** once we have received a report from the doctor who is in charge of your treatment and taken that advice into account. We will give you time to make other arrangements for your future treatment, such as asking your doctor to transfer you to NHS care.

Advanced Therapeutics for chronic conditions

- Certain Advanced Therapeutics are now being used for long term chronic conditions ranging from macular degeneration, to Crohn's disease and Rheumatoid arthritis.
- If your specialist considers that you may respond to a short term course of an Advanced Therapeutic, such as Lucentis, Xolair or Remicade (Infliximab) you must obtain pre-authorisation from us.
- A short term course of an Advanced Therapeutic is to allow your specialist to ascertain whether the treatment will be effective and can stabilise your condition.

Cover for these **Advanced Therapeutics** for chronic conditions is only available if you obtain **pre-authorisation** and your **specialist** affirms that they are not readily available to you as an NHS patient and then for a period not exceeding 3 months.

WPA and cancer:

We do not consider **cancer** as a **chronic condition** although it does have some features in common. Similarly it does not fit our definition of an acute condition. With new treatments controlling cancer more effectively it is becoming – in some cases – a long term condition. Long term monitoring is not covered, nor is the maintenance of remission with Advanced Therapeutics. Cover is available under the plan terms for a relapse or acute exacerbation up to the point of further remission. We always take expert advice about specific treatment plans and the length of time for which it is clinically appropriate to follow them. We do however set a limit on the cover we offer for long term follow up consultations which is normally 5 years with the frequency of follow up consultations being

covered within non-private (NHS) protocols. We will keep in touch with your **specialist** so that we can make the most appropriate decisions for your case.

We have produced a leaflet about Cancer Care which explains our cover for cancer and contains further examples. If you would like a copy of this, please contact us on 01823 625230 – or it is available on our website wpa.org.uk/cancer.

- Medical/professional fees that are over and above those of customary and reasonable levels;
- Neonatal treatment for babies within 90 days of birth:
 - Any condition that is present at birth or detected in the first 90 days of life.
- Non Established Treatment. Established treatment is treatment:
 - Approved by NICE for routine use in the NHS;
 - For which there is substantial clinical evidence of benefit;
 - Accepted and practised by more than one group of specialists in the field in the UK;
 - Involving the use of drugs that are recognised and licensed in the UK for safe use and for the stage of the condition being treated;
 - Considered to be acceptable recognised clinical practice by WPA's Medical Advisors in the particular circumstances.
- Obesity
 - Investigations and/or treatment either medical or surgical for obesity including barometric 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).
 - Operations including investigations done before the operation or treatment needed as a result of the operation;
 - A transplant is where a patient receives an organ or tissue from another person (surgically implanted or infused). This does not include blood transfusion. We will however cover cornea transplants or skin grafts, and bone marrow or stem cell transplants where this forms part of treatment for cancer (see page 15 for full details).

- Out-patient drugs/dressings.
 - This includes drugs and dressings you are given to take home from hospital unless they are needed to complete a short course of treatment (i.e. antibiotics).
 - Pre-existing medical conditions. Any disease, illness or injury for which:
 - You have received medication, advice or treatment;
 - You have experienced symptoms whether the condition has been diagnosed or not before the start of your cover.
 - Preventative tests or operations
 - Tests to rule out the existence of a condition for which you do not have any symptoms, even if you have a family history of that condition
 - Removal of tissue for a condition for which you do not have any symptoms, even if you have a family history of that condition.
 - Psychiatric conditions.
 - Treatment of mental illness or disorder (including stress).
 - Rehabilitation.
 - Treatment helping towards improving physical and/or mental capacities, following illness or injury.
 - This treatment is often given at a special centre or unit, by specialists or other health professionals (such as physiotherapists, speech therapists or occupational therapists).
- You are not covered for rehabilitation unless:
- The rehabilitation immediately follows an in-patient admission that has been covered by your policy. and
 - We specifically agree the extent of the cover before the rehabilitation starts.
- We will then agree to cover only a short course of rehabilitation (not to exceed 2 weeks) which will not be extended.
- Refractive eye surgery for the correction of imperfect sight.

- Reproductive problems, pregnancy, fertility problems, assisted conception, contraception, miscarriage, sterilisation and child birth. You are not covered for any investigations, care or treatment arising from or related to these.
- Road traffic accident/collision.
 - Treatment arising as a result of road traffic accident/collision where you were not wearing a seat belt or suitable child restraint (as appropriate) as required by law;
 - Treatment you receive arising as a result of a road traffic accident/collision in relation to which you are convicted of a criminal offence
- Routine medical examinations, health screening or medical appliances, such as:
 - Hearing aids;
 - Wheelchairs;
 - Crutches;
 - Braces;
 - Surgical orthoses.
- Sexual problems
 - Care and/or treatment arising from or related to investigating and /or treating sexual dysfunction however caused;
 - Care and/or treatment for sexually transmitted diseases;
 - Care and/or treatment arising from or related to sex change/gender reassignment.
- Snoring or sleep disorders.
 - Sleep apnoea including sleep studies or corrective surgery.
- Terminal care.
 - (sometimes referred to as palliative care) - treatment that concentrates on controlling pain and other symptoms when the patient is near or approaching the end of life and active treatment for the causative disease is no longer considered effective or appropriate.

- Tests/investigations.
 - Tests or investigations arranged by your GP (unless covered by the limits shown under Essential or Essential Plus – see page 13) or therapist even if they are carried out and reported by a consultant radiologist who is not the specialist in overall charge of your treatment.

- Varicose veins.

Your policy covers

- Treatment after you have been a policyholder for 2 years;
- One admission per leg for an operative laser or foam injection procedure for varicose veins for the duration of your membership;
- One visit only for injections of residual veins after treatment to the main veins.

Your policy does not cover

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

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. You must reside in the UK for at least 6 months of the year. You and your family must all live at your permanent address in the UK. 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. When your cover is cancelled we will not be able to refund premiums.

We reserve the right to undertake credit checks on you when you apply for cover. By applying you are consenting to this.

We reserve the right to decline any application for cover in our absolute discretion without supplying reasons.

WPA Flexible Health Freelance policyholders may be asked to provide proof of their self-employed or franchise status at application, renewal or point of claim (see page 5).

Children

A child may join your policy as a family member. He or she cannot remain on the policy once they marry or 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 and a charge will not apply. The baby's premiums will not be included on your invoice until the next renewal date following the date of birth. If you add them after they are 6 months old they will need to be fully medically underwritten and a charge will apply.

No claims will be paid for babies for the first 90 days of their life. They will also be excluded for any condition that is present at birth or detected in the first 90 days of their life.

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.

Policy documents

We will send you a Certificate of Registration when you join and when we offer you the chance to renew your cover. Your premium will include Insurance Premium Tax.

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. E-mail our Customer Service 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);
- How often you pay your premiums;
- Where you live;
- Shared Responsibility level you have chosen;
- 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.

You may pay the full annual premium by cheque, direct debit, with a Maestro 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 Maestro 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.

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

Cancellation of the policy cannot be backdated.

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

Making changes

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.

At the point of renewal you can make changes to your policy. Please visit wpa.org.uk which will enable you to access your policy membership 24 hours a day, 365 days a year. Take a look at all the things it can do for you. When registering you will be asked for a password of your choice. A 'user name' will be sent to you through the post or by e-mail if we hold a valid e-mail address for you to ensure your information is kept secure. After receiving this you will be ready to:

- Change address;
- Add/remove family members;
- View claims;
- Make a new claim online;
- View policy documentation;
- View correspondence;
- And much more.

Renewing the policy

Your policy runs for a period of 12 months from the inception date shown on your Certificate of Registration. At the end of this period you can renew your policy for a further 12 months at a time, subject to the benefits and premiums applicable but on the same medical underwriting terms.

WPA will automatically offer you the opportunity to renew your policy at least 21 days before your policy expires, unless you advise us otherwise.

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 fail to act honestly in relation to your policy and WPA, recklessly or negligently mislead us or give incorrect information and/or fail to pay premiums. In any of these circumstances you must return any benefit we have paid as a result of misleading information and we will not refund any part of your premiums.

We reserve the right to discontinue all or part of the policy. Any insurance policy may cease to comply with current legislation. In these events we will refund the premium on a pro rata basis. Your policy will automatically become void 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 fully underwrite your policy 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 and regulated by the Financial Services Authority. We are authorised to arrange and underwrite general insurance contracts. Our FSA registration number is 202608. Our authorisation can be checked at fsa.gov.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:

- 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 of receiving your policy documents. If you do not exercise this right within the 14 day (or 28 days if purchased on-line) period then you are committed to the cover and premium for the rest of the cover period. You must return your Certificate of registration with your notice to cancel.

How do I make a complaint?

If you have a complaint you can write, e-mail or telephone the member of staff/Appointed Representative you have been dealing with and ask them to refer the matter to the appropriate level of management. The manager will send you a decision letter. If you are not satisfied with this, the Independent Review Team will independently review your case. If at any stage you feel your complaint has not been satisfactorily resolved, please do not hesitate to contact the Director of Best Practice at WPA.

We have a free leaflet, which explains our complaints procedure and we will be pleased to send you a copy if you ask for one.

Financial Ombudsman Service (FOS)

WPA is a member of the FOS. This provides an independent and impartial method of resolving complaints. The Ombudsman will need to know that you have given us the chance to put things right. If we are unable to resolve a complaint we will send you a leaflet setting out details of the service the FOS provides.

The Ombudsman's address is:
The Financial Ombudsman Service
South Quay Plaza, 183 Marsh Wall, London
E14 9SR
(Telephone: 0845 080 1800)

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

Financial Services Compensation Scheme (FSCS)

WPA customers are covered by the FSCS which can provide entitlement to compensation to customers where an insurer cannot meet its obligations. Further information about compensation scheme arrangements is available from the FSCS (www.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 information about you

We will hold and process your personal information in accordance with the Data Protection Act 1998.

To detect and prevent fraud or improper claims we may check your details 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.



We may use and disclose your information to provide our services, to administer your policy including underwriting, claims processing, assessment and analysis, to improve our services and to protect our interests.

We may share customer information, including medical information, in strict confidence, with other persons who provide a service to us, or act as agents, including our FSA registered Appointed Representatives and companies located outside the EEA.

We may also share medical information with those involved in a patient's care or treatment eg their GP, specialist, therapist.

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 both yourself and your family members..

Giving you information

We may advise you by letter, telephone, electronic mail or otherwise of services or products which we believe you may be interested in. If you do not wish to receive such information please tell us at any time.

You have a right to know what information we hold about you. We may request a small administration fee for supplying a copy of any personal information.

Communication

We may monitor any communication we have with you, including recording telephone conversations, to assist with the administration of your policy.

You should notify us of any changes to your personal information such as a change to your name or address to ensure your personal information is correct and up to date.

E-mails are a useful way for you to contact us and for us to communicate with you – but please remember that the e-mail address you give us must be secure and not accessible by anyone else (e.g. a work e-mail address).

Definitions

Some words and phrases used in WPA policies have a particular meaning and this is explained below. These definitions may not all apply to your particular policy, depending on the cover it offers.

Active treatment

Treatment that is of **curative intent**.

Acute condition

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

Advanced Therapeutics

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

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

For more information about Advanced Therapeutics for **cancer** see page 15 or see page 33 for Advanced Therapeutics for **chronic** conditions.

Cancer

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

Chronic medical condition

Commonly recognised as a disease, illness, or injury that has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests;
- It needs ongoing or long-term control or relief of symptoms;
- It requires your rehabilitation or for you to be specially trained to cope with it;
- It continues indefinitely;
- It has no known cure;
- It comes back or is likely to come back;
- It can only be contained by repetitive treatment or medication.

Clinical trial

An NHS based research trial that has local research and ethical approval and is registered by a non-commercial organisation such as the Medical Research Council or UKCCCR. Any side effects or complications that result from the trial would not be covered as they are funded by the NHS.

Contract

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

Curative intent

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

Customary and Reasonable

In accordance with the Supply of Goods and Services Act (1982) we reserve the right to pay the agreed percentage contribution towards charges which are in line with charges made by other providers of treatment of the same services;

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.

Established treatment

Treatment that is:

- Approved by NICE (National Institute for Health and Clinical Excellence) for routine use in the NHS;
- For which there is substantial published clinical evidence of benefit;
- Accepted and practised by more than one group of specialists in the field in UK;
- Involving the use of drugs that are recognised and licensed in the UK for safe use for the condition being treated;
- Considered to be acceptable clinical practice by WPA's Medical Advisors in the particular circumstances.

Exclusion

A condition, circumstance or type of treatment that is not covered. This may be a general rule or based on individual medical underwriting.

Histologically Distinct

Every **cancer** has a unique 'footprint' that can be identified by histological pathology demonstrating if it is a spread of an existing **cancer** or a new disease. Histology is the microscopic study of tissues and cells.

Insurance Premium Tax (IPT)

This is a tax levied by the government on the value of insurance premiums;

Locally recognised

If you have Worldwide or overseas cover, 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;

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.

Pre-authorisation

You need to contact us to tell us about your treatment before it starts so that we can confirm whether it will be covered.

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.

Related condition

Any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury;

Remission

A clinical state where a disease is suppressed and under control, or the patient is symptom free and apparently cured.

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.

You are not covered for tests or investigations arranged by a GP or therapist;

Specialists

We will cover treatment provided or requested by a medical practitioner whose name appears on the current GMC Specialist Register;

Terminal care - (sometimes referred to as palliative care) Treatment that concentrates on controlling pain and other symptoms when the patient is near or approaching the end of life and active treatment for the causative disease is not longer considered effective or appropriate.

UK

England, Wales, Scotland, Northern Ireland, the Channel Islands and the Isle of Man;

Us, we, our

This association, the Western Provident Association Limited (WPA);

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.

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



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



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



WPA is one of the first UK companies to achieve the environmental quality standard.



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 customers are covered by the Financial Services Compensation Scheme (FSCS) which can entitle customers to compensation should an insurer become insolvent. Further information can be found at www.fscs.org.uk



wpa.org.uk

Western Provident Association Limited

Rivergate House, Blackbrook Park, Taunton, Somerset, TA1 2PE
E-mail: pcd@wpa.org.uk

Registered in England No. 475557

WPA is a registered service mark of Western Provident Association Limited.

The member state of the insurer is the United Kingdom.

To help protect your interests, and those of the Association, telephone conversations may be recorded for the purpose of ensuring an accurate record of discussions.

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