YOUR GUIDE TO THE ILLNESSES COVERED BY THE PROTECT CRITICAL ILLNESS POLICY 

SERIES 10
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We regularly update our literature.
You can confirm that this July 2018 version is the latest by checking the literature library on our website at [www.oldmutualwealth.co.uk](http://www.oldmutualwealth.co.uk).
A Protect critical illness policy covers you for 78 different illnesses and conditions, plus a further 8 conditions for any children covered by the policy.

Each of these conditions will have its own specific definition often containing medical terminology which may be unfamiliar to you. This isn’t to baffle you with jargon or hide unfair clauses; it’s needed to set a precise definition of what we cover and to ensure we treat each claim we receive consistently.

The aim of this guide is to make it easy for you to understand what’s covered.

**BEYOND INDUSTRY STANDARDS**

To bring clarity and a consistency to the standard of cover provide by insurers the Association of British Insurers (ABI) publishes a set of standard definitions for 20 conditions. Insurers who cover any of these conditions must comply with, or surpass, the ABI definition. These definitions apply to the critical illnesses most commonly covered by insurance policies. For 16 of the conditions we cover, we offer a definition which gives you more cover than the standard ABI definition.

**These conditions are:**

- Alzheimer’s disease
- Aorta graft surgery
- Benign brain tumour
- Blindness
- Cancer
- Coma
- Coronary artery bypass grafts
- Deafness
- Heart attack
- Heart valve replacement or repair
- Major organ transplant
- Motor neurone disease
- Multiple sclerosis
- Parkinson’s disease
- Stroke
- Third degree burns

You can find details of how we are better than the ABI standard in the explanation for the relevant condition.

**MEDICAL SPECIALIST**

You will see that, in some definitions, we say we need information from a medical specialist. In these cases, the specialist will be a person who holds an appropriate appointment as a consultant or equivalent at a hospital in the UK, the Channel Islands or the Isle of Man and who has qualifications and experience that are acceptable to our Chief Medical Officer.
**CONDITIONS COVERED**

Please see relevant section for definitions, explanations and payment advice.

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Aplastic anaemia with permanent bone marrow failure
1.0 APLASTIC ANAEMIA WITH PERMANENT BONE MARROW FAILURE

**Definition**
A definite diagnosis of aplastic anaemia by a consultant haematologist. There must be permanent bone marrow failure with anaemia, neutropenia and thrombocytopenia.

**Explanation**
Aplastic anaemia is a failure of the bone marrow to produce sufficient blood cells for the circulation. It causes a lack of red blood cells (anemia), white blood cells (neutropenia) and platelets (thrombocytopenia) which are needed to prevent bleeding and bruising. It can happen at any age, but is more common in people aged between 10 and 20, and in people aged 40 or older. Successful treatment can take a long time.
1.1 **BRAIN, SPINE AND NERVES**

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1.1 BACTERIAL MENINGITIS

Resulting in permanent symptoms

Definition
A definite diagnosis of bacterial meningitis by a consultant neurologist with inflammation of either the membranes of the brain or spinal cord and resulting in permanent neurological deficit with persisting clinical symptoms. The following are not covered:

- All other forms of meningitis, including viral meningitis.

Explanation
Bacterial meningitis is an inflammation of the membranes that surround the brain and spinal cord. In many cases, it is possible to recover fully from bacterial meningitis with no lasting ill-effects. However, if there were lasting effects, we would pay a claim. Viral meningitis is much less severe and people often require no treatment.

1.2 BENIGN BRAIN TUMOUR

Resulting in permanent symptoms or specified treatment.

Definition
A non-malignant tumour or cyst in the brain, cranial nerves or meninges within the skull, including tumours arising from bone tissue in the skull base or paranasal cavities, resulting in either of the following:

- Permanent neurological deficit with persisting clinical symptoms; or
- Undergoing invasive surgery to remove part or all of the tumour; or
- Undergoing either stereotactic radiosurgery or chemotherapy treatment to destroy tumour cells.

The following are not covered:

- Tumours in the pituitary gland
- Angioma and cholesteatoma.

Explanation
A benign (or non-malignant) tumour is not cancerous. However, because of its location, it may put pressure on areas of the brain which could make the tumour life-threatening. It could also lead to neurological deficit which includes problems such as decreased sensation, weakness in the muscles, and changes in vision.

To claim, these problems must be permanent, or you must undergo surgery to remove the tumour, or radiotherapy or chemotherapy treatment to destroy it. The tumour can occur in the brain, the area of the skull that separates the brain from the rest of the skull (the skull base) and the air-filled bones that form the nose (nasal cavities).

The pituitary gland is a small gland at the base of the brain. We cover this separately as an additional illness – see page 19. Angiomas and cholesteatomas are benign growths but much less severe.

If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.

ABI+
We also cover surgery, radiosurgery and chemotherapy and tumours that start in certain parts of the skull.
**1.3 BENIGN SPINAL CORD TUMOUR**

Resulting in permanent symptoms or specified treatment.

**Definition**

A non-malignant tumour or cyst originating from the spinal cord, spinal nerves or meninges, resulting in any of the following:

- Permanent neurological deficit with persisting clinical symptoms; or
- Undergoing invasive surgery to remove the tumour; or
- Undergoing stereotactic radiotherapy to the tumour.

The following are not covered:

- Granulomas, haematomas, abscesses, disc protrusions and osteophytes.

**Explanation**

Benign (non-malignant) tumours are not cancerous. They can occur in the spinal cord, the nerves of the spinal cord and the membranes covering the spinal cord (meninges). Pressure on the nerves caused by the tumour can result in neurological deficit which includes problems such as numbness, weakness in the arms or legs and sometimes loss of bladder control. To claim, these problems must be permanent, or you must undergo surgery to remove the tumour, or radiotherapy or chemotherapy treatments to destroy it.

We do not cover less severe conditions such as benign growths (angiomas), inflammations (granulomas), bruising (haematomas) and bone spurs (osteophytes).

If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.

**1.4 BRAIN ABSCESS DRAINED VIA CRANIOTOMY**

**Definition**

Surgical drainage of an intracerebral abscess within the brain tissue through a craniotomy by a consultant neurosurgeon.

**Explanation**

A brain abscess results from an infection in the brain. Swelling and inflammation develop in response to the infection. Infected brain cells, white blood cells and organisms collect in an area of the brain, a membrane forms and creates the abscess. While this immune response can protect the brain from the infection, an abscess may put pressure on delicate brain tissue.

A craniotomy is a surgical operation in which part of the skull is removed in order to access the brain. You can claim if you are diagnosed with an intracerebral abscess (an abscess in the brain) which is treated by surgical drainage by craniotomy by a consultant neurosurgeon.
1.5 BRAIN INJURY DUE TO TRAUMA, ANOXIA OR HYPOXIA

Resulting in permanent symptoms.

**Definition**

Death of brain tissue due to trauma or reduced oxygen supply (anoxia or hypoxia) resulting in permanent neurological deficit with persisting clinical symptoms.

**Explanation**

A serious injury to the brain or a lack of oxygen can cause permanent physical damage which results in symptoms similar to those following a stroke, for example facial paralysis or the loss of use of an arm.

1.6 CAROTID ARTERY STENOSIS

Treated by endarterectomy or angioplasty

**Definition**

The undergoing of endarterectomy or angioplasty with or without stent on the advice of a consultant physician to treat severe symptomatic stenosis in a carotid artery. This operation must be to treat:

- At least 50% diameter narrowing; and
- Angiographic evidence will be required.

**Explanation**

The carotid artery is the large artery that supplies blood to the head. It splits into two with one branch running up either side of the neck. One side supplies blood to the brain, the other to the face, scalp and meninges. Stenosis is the narrowing of the artery. This is caused by plaque building up on the inner wall of the artery. Not only can this reduce blood flow to the head, but small pieces of the plaque can break off and block the smaller arteries in the brain leading to a stroke.

The two main treatments for this are endarterectomy and angioplasty. Endarterectomy is a procedure to cut open the artery and remove the plaque. Angioplasty is when a catheter is threaded through an artery in the groin. A small balloon is inflated to open up the carotid artery and sometimes a stent, a metal coil, is fitted to keep the artery open.

1.7 CAUDA EQUINA SYNDROME

With permanent symptoms.

**Definition**

Compression of the lumbosacral nerve roots (cauda equina) resulting in all of the following:

- Permanent bladder dysfunction; and
- Permanent weakness and loss of sensation in the legs

The diagnosis must be supported by appropriate neurological evidence.

**Explanation**

With cauda equina syndrome, nerves at the base of the spinal cord become compressed. This affects nerves important for messages to the legs, feet and pelvic organs. This is a serious condition which can cause lower back pain, numbness, paralysis and bowel or urine problems.
**1.8 CEREBRAL OR SPINAL ANEURYSM**

With surgery or radiotherapy.

**Definition**
The undergoing of craniotomy, endovascular repair or stereotactic radiotherapy to treat a cerebral or spinal aneurysm.

**Explanation**
A cerebral or spinal aneurysm is a weakness in the wall of a cerebral or spinal artery or vein resulting in a swelling of the blood vessel. A cerebral or spinal aneurysm can rupture, bleeding into surrounding tissue. Some cerebral aneurysms, particularly those that are very small, do not bleed or cause any problems.

You can claim if you have surgery, stereotactic radiosurgery, or endovascular treatment using coils under the care of a consultant neurologist or radiologist, as appropriate, to treat a cerebral or spinal aneurysm.

Stereotactic radiosurgery is a form of radiation therapy that focuses on a small area of the body. Endovascular treatment uses the natural access to the brain through the bloodstream via the arteries using catheters, balloons and stents.

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**1.9 CEREBRAL OR SPINAL ARTERIOVENOUS MALFORMATION**

With surgery or radiotherapy.

**Definition**
The undergoing of craniotomy, endovascular repair or stereotactic radiotherapy to treat a cerebral or spinal arteriovenous fistula or malformation.

**Explanation**
A cerebral arteriovenous malformation (AVM) is an abnormal connection between arteries and veins in the brain or spine that interrupts normal blood flow between them. An AVM is characterised by tangles of abnormal and enlarged blood vessels. In serious cases, the blood vessels rupture.

An arteriovenous fistula is an abnormal passageway between an artery and a vein. Normally blood flows from arteries into capillaries and back to your heart in veins. When an arteriovenous fistula is present, blood flows directly from an artery into a vein, bypassing the capillaries. If the volume of blood flow diverted is large, tissues downstream receive less blood supply. Also, there is a risk of heart failure due to the increased volume of blood returned to the heart.

You can claim if you have surgery, stereotactic radiosurgery, or endovascular treatment using coils under the care of a consultant neurologist or radiologist, as appropriate, to treat a cerebral AVM or AV fistula.

Stereotactic radiosurgery is a form of radiation therapy that focuses on a small area of the body. Endovascular treatment uses the natural access to the brain through the bloodstream via the arteries using catheters, balloons and stents.
2.0 COMA

With associated permanent symptoms.

Definition
A state of unconsciousness with no reaction to external stimuli or internal needs with associated permanent neurological deficit with persisting clinical symptoms.

The following are not covered:
- Coma secondary to alcohol or drug abuse.

Explanation
It is not unusual to fall into a coma but regain consciousness after a short time, for example after an accident. If consciousness returns within three or four days, there is usually no permanent damage to the nervous system.

If you fall into a coma where you do not react to stimuli (pain, light, sound etc) or internal needs, breathing for example, we would pay if you suffered permanent neurological problems such as weakness in the muscles, problems with walking and changes in vision.

We do not cover a coma that was the result of drug or alcohol abuse.

ABI+
We don’t require you to have been in a coma for a specific amount of time or to have been on life support. We also cover medically induced comas.

2.1 CREUTZFELDT – JAKOB DISEASE

With associated permanent symptoms.

Definition
Confirmation by a consultant neurologist of a definite diagnosis of Creutzfeldt-Jakob disease resulting in permanent neurological deficit with persisting clinical symptoms.

Explanation
Creutzfeldt-Jakob disease (CJD) is a disease of the nervous system that damages the brain. It is fatal, and there is no known cure.

We would pay the claim if you were diagnosed with CJD and suffered permanent neurological deficit which includes problems such as decreased sensation, weakness in the muscles, problems with walking and changes in vision.
2.2 DEMENTIA INCLUDING ALZHEIMER’S DISEASE

Resulting in permanent symptoms.

Definition
A definite diagnosis of dementia including Alzheimer’s disease by a consultant neurologist, psychiatrist or geriatrician. There must be permanent clinical loss of the ability to do all of the following:

- Remember
- Reason
- Perceive, understand, express and give effect to ideas

Explanation
Dementia can be caused by a variety of illnesses, such as Alzheimer’s disease (probably the most widely-known cause), Pick’s disease and Creutzfeldt-Jakob disease (CJD). It is a progressive condition, first affecting the memory and the ability to think clearly. This can result in confusion and the inability to recall recent events. At present the cause is unknown and there is no known cure.

We cover Creutzfeldt-Jakob disease as a separate illness.

2.3 DRUG RESISTANT EPILEPSY

With specified surgery.

Definition
The undergoing of invasive surgery to brain tissue in order to control epilepsy that cannot be controlled by oral medication. The following is not covered:

- Deep brain stimulation

Explanation
Epilepsy can usually be controlled with treatment, however in some cases surgery may be required to remove the part of your brain causing the epilepsy. We will not pay a claim where electrodes are implanted into specific areas of the brain (deep brain stimulation).
2.4 ENCEPHALITIS

Resulting in permanent symptoms.

Definition
A definite diagnosis of encephalitis by a consultant neurologist. There must be permanent neurological deficit with persisting clinical symptoms.

Explanation
Encephalitis is a serious condition which causes inflammation of the brain. It is most commonly a result of a viral infection or the immune system attacking either an infection or non-infectious cause, such as a tumour. In many cases it can lead to permanent neurological damage resulting in memory loss, seizures and personality and behavioural changes.

2.5 HAEMATOMA OF THE BRAIN

With surgery.

Definition
Haematoma within the skull due to haemorrhage resulting in surgery to relieve pressure to brain tissues.

Explanation
A haematoma is a collection of blood within the tissues.
2.6 MOTOR NEURONE DISEASE AND SPECIFIED DISEASES OF THE MOTOR NEURONES

Resulting in permanent symptoms.

**Definition**
A definite diagnosis by a consultant neurologist of one of the following motor neurone diseases or diseases of motor neurones:

- Amyotrophic lateral sclerosis (ALS)
- Primary lateral sclerosis (PLS)
- Progressive bulbar palsy (PBP)
- Progressive muscular atrophy (PMA)
- Kennedy’s disease, also known as spinal and bulbar muscular atrophy (SBMA)
- Spinal muscular atrophy (SMA)

There must also be permanent clinical impairment of motor function.

**Explanation**
This group of diseases damage the nerve cells, leading to a rapid muscle weakness (impairment of motor function) which continues to worsen over time. There is currently no known cure and the cause of the disease is also unknown. For us to pay the claim the effects must be permanent.

**ABI+**
We do not ask that the symptoms have lasted for a minimum amount of time and we include other diseases of the motor neurones.
2.7 MULTIPLE SCLEROSIS

where there have been symptoms.

**Definition**
A definite diagnosis by a UK consultant neurologist of multiple sclerosis. There must have been clinical impairment of motor or sensory function caused by multiple sclerosis.

**Explanation**
Multiple sclerosis is a disease of the brain and spinal cord. Its onset is often slow, but in time it may have symptoms such as paralysis and tremors. The disease usually happens in episodes that leave the patient more disabled than before. While some improvement can be made after an episode, a complete recovery is rare. Multiple sclerosis can be difficult to diagnose.

The specialist will typically look for double vision, numbness (sensory function) or weakness in the limbs (motor function) which may result in the person having to use a wheelchair.

**ABI+**
We do not ask that the symptoms have lasted for a minimum amount of time.
2.8 PARKINSON PLUS SYNDROMES

Resulting in permanent symptoms.

Definition
A definite diagnosis by a consultant neurologist or geriatrician of one of the following Parkinson plus syndromes:

- Multiple system atrophy
- Progressive supranuclear palsy
- Parkinsonism-dementia-amyotrophic lateral sclerosis complex
- Corticobasal ganglionic degeneration
- Diffuse Lewy body disease

There must also be permanent clinical impairment of at least one of the following:

- Motor function; or
- Eye movement disorder; or
- Postural instability; or
- Dementia

Explanation
Parkinson’s plus syndromes is a group of disorders that affect the nervous system and progressively worsen. Typical symptoms include stiffness of the muscles, shaking of the head and limbs (motor function), loss of eye movement, loss of balance (postural instability) and dementia.

2.9 PARKINSON'S DISEASE

Resulting in permanent symptoms

Definition
A definite diagnosis of Parkinson’s disease by a consultant neurologist.

There must be permanent clinical impairment of motor function with associated tremor or muscle rigidity.

The following are not covered:

- Parkinsonian syndromes/Parkinsonism

Explanation
Parkinson’s disease is a progressive degenerative disease of the nervous system, which characteristically includes rigidity of the muscles and shaking of the head or limbs. The condition gradually deteriorates and, currently, there is no cure.

Although we do not cover other conditions with similar symptoms under Parkinson’s disease we do cover these in Parkinson plus syndromes – see above.

ABI+
We only ask for one of the symptoms to be present, not both.
3.0  PITUITARY TUMOUR

With specified treatment.

Definition
A non-malignant tumour in the pituitary gland resulting in either of the following:
• Surgical removal of the tumour; or
• Use of radiotherapy to destroy tumour cells.

The following are not covered:
• Tumours treated with other forms of treatment than that stated.

Explanation
The pituitary gland is a small gland at the base of the brain which secretes hormones to regulate stress, growth, reproduction and other bodily functions. A non-malignant tumour is not cancerous, but when on the pituitary gland it can cause changes in hormone levels or pressure on the optic nerve (the nerve to the eye) causing headaches and eye problems.

It can be treated by surgical removal of the tumour and by radiotherapy: high energy rays that destroy abnormal cells.

Other treatments are not covered.

3.1  SPINAL STROKE

Resulting in permanent symptoms.

Definition
Death of spinal cord tissue due to inadequate blood supply or haemorrhage within the spinal column resulting in either:
• Permanent neurological deficit with persisting clinical symptoms or;
• Definite evidence of death of spinal cord tissue or haemorrhage within the spinal column on a relevant scan and neurological deficit with persistent clinical symptoms lasting at least 24 hours.

Explanation
All types of stroke are caused by a lack of blood to a specific part of the body. A spinal stroke is a lack of blood to the spinal cord. This can be caused by a blockage, such as a blood clot caused by cholesterol, or bleeding (haemorrhage) caused by a burst blood vessel. When this happens the tissue can die, preventing nerve impulses from travelling along the spinal cord (neurological deficit), causing symptoms such as muscle weakness in the legs, unusual sensations or pain in the lower body and bladder, and bowel problems.

We will pay a claim if your symptoms are permanent, or if a scan shows evidence of dead tissue or a haemorrhage and symptoms have lasted for at least 24 hours.
3.2 STROKE
Of specified severity.

**Definition**
Death of brain tissue due to inadequate blood supply or haemorrhage within the skull that has resulted in all of the following evidence of stroke:

- Neurological deficit with persistent clinical symptoms lasting at least 24 hours; and
- Definite evidence of death of tissue or haemorrhage on a brain scan.

The following are not covered:

- Transient ischaemic attack.
- Death of tissue of the optic nerve or retina.

**Explanation**
A stroke happens when the blood supply to the brain is cut off and a portion of the brain dies as a result. This can happen when a blood clot enters or forms in the brain, causing a blockage, or when a blood vessel bleeds (haemorrhages) putting pressure on the brain where the leak settles. Symptoms of a stroke may take the form of muscle paralysis on one side of the face, slurred speech or the loss of use of one arm (neurological deficit). To be able to claim, these symptoms must have lasted at least 24 hours, but they do not have to be permanent. A brain scan must also confirm that tissue has died or that a haemorrhage has happened.

Transient Ischaemic Attacks (TIAs) are also known as mini-strokes. They have the same immediate effects as a stroke but no lasting impact, as all the symptoms disappear within 24 hours. We cover damage to the optic nerve and retina as an additional condition on page 57.

**ABI+**
We don’t require the symptoms of the stroke to be permanent.

3.3 SYRINGOMYELIA OR SYRINGOBULBIA REQUIRING SURGERY

**Definition**
The undergoing of surgery to treat a syrinx in the spinal cord or brain stem.

**Explanation**
A syrinx is a fluid-filled cavity within the spinal cord (syringomyelia) or brain stem (syringobulbia). These can increase over time, destroying the centre of the spinal cord or brain stem. If not treated surgically, they can lead to progressive weakness, pain and loss of sensation in the arms and legs.
## 3.4 Cancer

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3.4 CANCER

Excluding less advanced cancers.

**Definition**

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.

The term malignant tumour includes:

- Leukaemia
- Sarcoma
- Lymphoma (except cutaneous lymphoma - lymphoma confined to the skin)
- Pseudomyxoma peritonei
- Merkel cell cancer

The following are not covered:

- All cancers which are histologically classified as any of the following:
  - Premalignant
  - Noninvasive
  - Cancer in situ
  - Having either borderline malignancy, or low malignant potential.
- All tumours of the prostate unless histologically classified as having a Gleason score of 7 or above, or having progressed to at least TNM classification T2bNOM0.
- Malignant melanoma skin cancer that is confined to the epidermis (outer layer of skin).
- Any non-melanoma skin cancer or cutaneous lymphoma unless it has spread to lymph nodes or distant organs

**Explanation**

A malignant tumour is a growth that increases in size in an uncontrolled way, often spreading through the blood vessels or lymph glands to other parts of the body and eventually affecting the function of one or more organs. This spreading is also known as metastasis. Many cancers are now curable by removing or destroying the tumour and sufferers have a good chance of survival. However, cancer is still one of the biggest causes of death in the United Kingdom today.

Other cancers can affect the blood. For example, leukaemia is a cancer in which the patient becomes anaemic and grows progressively weaker because there are not enough red blood cells and/or haemoglobin in the blood.

Cancers described as premalignant, non-invasive or in situ are generally not life-threatening, as these are cancers at a very early stage which have not spread. A TNM classification describes the size, spread and location of lymph nodes and some cancers are not included until they reach a certain classification. Although these less severe cancers are excluded from this definition many are covered under our additional payment conditions.

Any tumour that is not spreading to other parts of the body is a benign tumour and not covered under this definition. However, benign brain or spinal tumours are covered as separate conditions.

**ABI+**

We cover a wider range of cancers, such as skin cancers, than the standard ABI definition.
3.5 CANCER IN SITU WITH SURGERY

**Definition**
Cancer in situ diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells that are confined to the epithelial linings of organs and that has been treated by surgery to remove the tumour.

The following are not covered:

- Any skin cancer (including melanoma); and
- Tumours treated with radiotherapy, laser therapy, cryotherapy, cone biopsy, LLETZ* or other diathermy treatment

* large loop excision of the transformation zone

**Explanation**
Carcinoma in situ are early forms of cancer which are not covered by the full cancer definition, as they have not yet spread or become life-threatening. These must be confirmed following microscopic examination of the cells or tissue (histologically) and the required surgery has been performed to remove the tumour.

We may pay out more than once for carcinoma in situ - with surgery. However, we will not accept a claim for carcinoma in situ if we have previously paid for a carcinoma in situ of the same type of organ or same type of tissue under your policy.

3.6 CANCER IN SITU OF THE URINARY BLADDER – of specified severity

**Definition**
A positive diagnosis with histological confirmation of cancer in situ of the urinary bladder.

The following are not covered:

- Non-invasive papillary carcinoma.
- Stage Ta bladder carcinoma.
- All other forms of non-invasive carcinoma.

**Explanation**
Carcinoma in situ of the urinary bladder is an early form of bladder cancer which is not covered by the full cancer definition, as it has not yet spread or become life threatening. It must be confirmed following microscopic examination of the cells or tissue of the bladder (histologically).

Non-invasive papillary carcinoma and stage TA carcinoma tend to grow away from the wall of the bladder and are less invasive.
3.7  CANCER IN SITU OF THE LARYNX – with specified treatment

**Definition**
Cancer in situ of the larynx treated with surgery, laser or radiotherapy.

**Explanation**
Carcinoma in situ of the larynx is an early form of cancer which is not covered by the full cancer definition, as it has not yet spread or become lifethreatening. This must be confirmed following microscopic examination of the cells or tissue (histologically) and treated with either surgery, laser or radiotherapy.

3.8  GASTROINTESTINAL STROMAL TUMOUR (GIST) OR NEUROENDOCRINE TUMOUR (NET) OF LOW MALIGNANT POTENTIAL

**With Surgery.**

**Definition**
Gastrointestinal stromal tumour (GIST) or neuroendocrine tumour (NET) of low malignant potential diagnosed by histological confirmation and that has been treated by surgery to remove the tumour.

The following is not covered:
- Tumours treated with radiotherapy, laser therapy, cryotherapy or diathermy treatment.

**Explanation**
Gastrointestinal stromal tumour (GIST) or neuroendocrine tumour (NET) are early forms of cancer which are not covered by the full cancer definition, as they have not yet spread or become life-threatening. These must be confirmed following microscopic examination of the cells or tissue (histologically) and the required treatment has been performed.

3.9  OVARIAN TUMOUR OF BORDERLINE MALIGNANCY/LOW MALIGNANT POTENTIAL

**With surgical removal of an ovary.**

**Definition**
An ovarian tumour of borderline malignancy/low malignant potential that has been positively diagnosed with histological confirmation and has resulted in surgical removal of an ovary.

The following is not covered:
- Removal of an ovary due to a cyst

**Explanation**
Tumours of borderline malignancy, or low malignant potential, are slower growing and are less likely to become cancerous than more aggressive tumours. Tumours that affect the ovaries are often detected early, before they have spread, and are treated by removing the affected ovary.
4.0 PROSTATE CANCER

Low grade.

Definition
Diagnosis of a tumour of the prostate histologically classified as having a Gleason score between 2 and 6 inclusive provided:

- The tumour has progressed to at least clinical TNM classification T1N0M0; and
- Treated with the complete removal of the prostate or external beam or interstitial implant radiotherapy.

The following are not covered: cases treated with cryotherapy, other less radical treatment (e.g., transurethral resection of the prostate), experimental treatments and hormone therapy.

Explanation
Prostate cancer with a low Gleason score (a grading system used specifically to measure prostate cancer) is less likely to grow and spread than a more highly scored cancer. If the tumour is also small and has not spread (as measured by a TNM classification) and is fully removed or treated by external or internal radiotherapy we will pay a claim.

Treatments such as freezing or removing part of the prostate and hormone therapy are not covered.

4.1 SKIN CANCER

Advanced stage as specified.

Definition
Skin cancer diagnosed with histological confirmation that the tumour is larger than 2 centimetres across and has at least one of the following features:

- Is thicker than 4 millimeters (mm); or
- Has invaded into subcutaneous tissue (Clark level V); or
- Has grown into nerves in the skin (perineural invasion); or
- Has been categorised as being poorly differentiated or undifferentiated (cells are very abnormal as demonstrated when seen under a microscope); or
- Has recurred despite previous treatment

Explanation
These skin cancers are early forms of cancer which are not covered by the full cancer definition, as it has not yet spread or become life-threatening.

4.2 TESTICULAR CANCER

Of low grade requiring removal of a testicle.

Definition
Diagnosis of intratubular germ cell neoplasia, unclassified, with histological confirmation by biopsy, together with the undergoing of surgery to remove a testicle.

Explanation
Intratubular germ cell neoplasia is when cells in the tests grow abnormally, and in a high percentage of cases these abnormal cells develop into cancerous tumours. The only way to diagnose it is to take a small sample of tissue (a biopsy) to analyse. One of the most common treatments is to remove the affected testicle.
4.3 **CHILD**

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4.3 CEREBRAL PALSY

Definition
A definite diagnosis of cerebral palsy made by an attending consultant.

Explanation
Cerebral palsy is the general term for a number of conditions caused by problems in the brain and nervous system that affect movement and coordination. Cerebral palsy is caused by a problem in the parts of the brain responsible for controlling muscles. The condition can occur if the brain develops abnormally or is damaged before, during or shortly after birth.

4.4 CRANIOSYNOSTOSIS

Requiring surgery.

Definition
A definite diagnosis of craniosynostosis by a consultant neurosurgeon which has been treated surgically.

Explanation
Craniosynostosis is a condition where a child’s skull fuses prematurely. As well a mis-shapen head and features it can limit the space for the brain to grow. The resulting pressure can lead to visual and mental impairment. We’ll pay a claim where surgery is required.

4.5 CYSTIC FIBROSIS

Definition
A definite diagnosis of cystic fibrosis made by an attending consultant.

Explanation
Cystic fibrosis is an inherited condition in which the lungs and digestive system can become clogged with thick, sticky mucus. It can cause problems with breathing and digestion from a young age. Over many years, the lungs become increasingly damaged and may eventually stop working properly.
4.6 DIABETES MELLITUS TYPE 1

Definition
A definite diagnosis of Type 1 insulin dependent diabetes mellitus by a consultant. There must be abrupt onset, accompanied by ketonuria or other biochemical evidence of ketosis. Permanent insulin injections must be the only effective treatment to prevent life-threatening diabetic ketoacidosis and these must have continued for a period of at least 12 months.

The following are not covered:

- Gestational diabetes unless the child has been on continuous insulin injections to prevent diabetic ketoacidosis for 12 months after delivery of a baby; and
- Type 2 diabetes mellitus including if treated with oral medications or treated with insulin to improve diabetic control.

We will only consider a claim for a child with diabetes under this definition in this section. It is not possible to make a claim for a child with diabetes under the adult version of the condition as well.

Explanation
Diabetes is caused when the body’s immune system attacks the cells in the pancreas that create insulin. Insulin is essential to the body and a lack of insulin results in ketonuria, an increase in the level of sugar in the blood and urine. This can lead to ketoacidosis where the sugar turns to acid causing damage to the organs and eyes and stroke.

Without regular injections of insulin, complications can occur potentially resulting in coma and even death.

Type 2 diabetes also results in high blood sugar levels but is as a result of low levels of insulin rather than a complete absence. While it can be treated with insulin, a controlled diet and exercise are often enough. Like type 2 diabetes, gestational diabetes (diabetes during pregnancy) can also potentially be treated with a controlled diet or oral insulin. We therefore do not cover these types of diabetes.

4.7 DOWN’S SYNDROME

Definition
A definite diagnosis of Down’s syndrome by a paediatrician.

Explanation
Down’s syndrome is a genetic condition that typically causes some level of learning disability and characteristic physical features. It can lead to an increased risk of health problems late in life.
4.8 HYDROCEPHALUS

Treated with the insertion of a shunt.

**Definition**
A definite diagnosis of hydrocephalus which is treated with an insertion of shunt.

**Explanation**
Hydrocephalus is a build-up of fluid on the brain. The excess fluid puts pressure on the brain, which can damage it. Hydrocephalus can usually be treated using a shunt, a thin tube that’s surgically implanted in the brain and drains away the excess fluid.

4.9 MUSCULAR DYSTROPHY

**Definition**
A definite diagnosis of muscular dystrophy made by a consultant neurologist.

**Explanation**
Muscular Dystrophy is a genetic condition where slow progressive muscle wasting leads to increasing weakness and disability.

5.0 SPINA BIFIDA

**Definition**
A definite diagnosis of spina bifida myelomeningocele or rachischisis by a paediatrician.

The following are not covered:
- Spina bifida occulta
- Spina bifida with meningocele.

**Explanation**
Spina bifida is a condition where the spine does not develop properly, leaving a gap in the spine. Myelomeningocele and rachischisis are the most serious types of spina bifida. The opening in the spinal arches allows the spinal cord and the protective membranes surrounding it (the meninges) to push out and create a sac in the baby’s back.

It can be associated with significant damage to the spinal cord and can leave the nervous system vulnerable to life-threatening infections.

We will not pay a claim for spina bifida occulta (the opening is very small and covered with skin) or spina bifida with meningocele (only the meninges push out of the opening in the spine). Neither of these are severe forms.
5.1 DIGESTIVE SYSTEM

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5.1 CROHN’S DISEASE

With specified surgery.

Definition
A definite diagnosis by a consultant gastroenterologist of Crohn’s disease. There must have been two or more bowel segment resections on separate occasions. There must also be evidence of continued inflammation with ongoing symptoms.

Explanation
Crohn’s disease is an inflammatory bowel disease that causes the body’s immune system to attack the intestines, resulting in a wide variety of symptoms including abdominal pain, diarrhea and weight loss. In severe cases abnormal connections between the intestines can form, called fistulas, or the intestine can become constricted causing obstruction. There is no known cure for Crohn’s disease, but changes to diet, medications and surgery to remove the worst affected sections of the bowel (surgical resection) are used to control the symptoms. We also cover less severe Crohn’s disease as an additional payment - see below.

5.2 CROHN’S DISEASE

Treated with surgical resection.

Definition
A definite diagnosis of Crohn’s disease confirmed by a consultant gastroenterologist treated with surgical intestinal resection.

Explanation
Crohn’s disease is an inflammatory bowel disease, that causes the body’s immune system to attack the intestines, resulting in a wide variety of symptoms including abdominal pain, diarrhea and weight loss. There is no known cure for Crohn’s disease, but changes to diet, medications and surgery to remove the worse affected sections of the bowel (surgical resection) are used to control the symptoms.

5.3 ULCERATIVE COLITIS

Treated with total colectomy (removal of the entire bowel).

Definition
A definite diagnosis by a consultant gastroenterologist of ulcerative colitis, treated with total colectomy (removal of the entire large bowel).

Explanation
Ulcerative colitis is a disease which causes ulcers to form on the large bowel, the colon. It is not known what causes the disease, and symptoms can sometimes come and go. Medication can be used to induce and maintain remission, but in severe cases surgery to remove the large bowel (a colectomy) is required. If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.
5.4 HEART AND ARTERIES

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5.4 AORTA GRAFT SURGERY

Definition
The undergoing of surgery to the aorta with excision and surgical replacement of a portion of the affected aorta with a graft. The term aorta includes the thoracic and abdominal aorta but not its branches.

The following is not covered:
• Any other surgical procedure, for example the insertion of stents or endovascular repair.

Explanation
The aorta is the main artery that carries blood from the heart around the body. It may become blocked or weakened by an enlargement and thinning of its walls (an aneurysm). Either condition may require a graft using another blood vessel to replace the damaged portion. Only the thoracic and abdominal parts of the aorta are covered because these are closest to the heart, where any blockage or weakening is more serious. The branches of the aorta are less critical and damage to these is not usually life-threatening. We don’t cover any other surgery such as those that are used to widen the artery such as angioplasty or endovascular repair. If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.

ABI+
As well as disease we also cover surgery following an injury to the aorta.

5.5 AORTIC ANEURYSM

With endovascular repair.

Definition
The undergoing of endovascular repair of an aneurysm of the thoracic or abdominal aorta with a graft.

The following is not covered:
• Procedures to any branches of the thoracic and abdominal aorta.

Explanation
An aortic aneurysm is an enlargement of the aorta (the main artery in the body originating from the heart and extending down to the abdomen). You can claim if you undergo endovascular repair (key hole surgery) to repair the aneurysm. Aneurysms in any of the branches of the thoracic and abdominal aorta are not covered.
5.6 CARDIAC ARREST

With insertion of a defibrillator.

Definition
Sudden loss of heart function with interruption of blood circulation around the body resulting in unconsciousness and resulting in either of the following devices being surgically implanted:

- Implantable cardioverter-Defibrillator (ICD); or
- Cardiac resynchronization therapy with Defibrillator (CRT-D).

The following are not covered:

- Insertion of a pacemaker
- Insertion of a defibrillator without cardiac arrest

Explanation
Cardiac arrest is when the heart stops, meaning blood containing oxygen is no longer pumped to the rest of the body, causing unconsciousness.

A cardiac arrest can be caused by several conditions and is sometimes treated by implanting a defibrillator into the chest. Defibrillators deliver an electric shock to the heart to prevent it from beating too quickly or contracting irregularly, both of which can lead to cardiac arrest.

A cardiac arrest differs from a heart attack which is when oxygen does not reach the heart causing a portion of the heart muscle to die. Insertion of a defibrillator that it is not as a result of a cardiac arrest is not covered. We cover insertion of a pacemaker, due to heartbeat abnormalities, under our additional payments. If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.

5.7 CARDIOMYOPATHY

Of specified severity.

Definition
A definite diagnosis of cardiomyopathy by a consultant cardiologist. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least class 3 of the New York Heart Association classification of functional capacity*. The diagnosis must be supported by echocardiogram.

The following are not covered:

- All other forms of heart disease, heart enlargement and myocarditis

*NYHA class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

Explanation
Cardiomyopathy is a disorder affecting the muscle of the heart, the cause of which is unknown.

It may result in enlargement of the heart, heart failure, abnormal rhythms of the heart or a blockage. An echocardiogram measures the shape and volume of the chambers of the heart and is used to determine whether the symptoms are caused by cardiomyopathy.

The NYHA Function classification is a measure used to classify the extent of heart failure. Other forms of heart disease are excluded, but various heart related conditions are covered by the policy.
5.8 CORONARY ANGIOPLASTY

With specified treatment.

**Definition**
The undergoing of balloon angioplasty, including atherectomy, laser treatment or stent insertion on the advice of a consultant cardiologist to either two or more main coronary arteries, or to left main stem, to correct narrowing or blockages. The main coronary arteries for this purpose are defined as right coronary artery, left anterior descending and left circumflex.

Angiographic evidence will be required. Two coronary angioplasty procedures performed in different arteries at different times is covered.

The following is not covered:
- Two angioplasty procedures to a single main artery, other than if it is left main stem, or branches of the same artery.

**Explanation**
Angioplasty is a treatment to unblock coronary arteries, and is normally carried out by ‘keyhole’ surgery. This can include widening the artery with a balloon or stent (metal coil) or removing the blockage (atherectomy and laser treatment). We will pay a claim if you have this treatment to two or more main coronary arteries, even if the procedures were carried out at different times or if you have this treatment to the Left Main Stem Artery.

**ABI+**
We cover all types of surgery, not just open heart surgery.

5.9 CORONARY ARTERY BY-PASS GRAFTS

With specified treatment.

**Definition**
The undergoing of surgery on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

**Explanation**
If one or more of the major blood vessels leading into the heart (the coronary arteries) becomes blocked or narrowed due to a build up of material (atheroma), the blood supply to the heart is reduced. This puts extra strain on the heart and can cause problems such as pain and breathlessness during exercise (angina). In more serious cases, without treatment, it is likely that the artery would continue to narrow and this may result in a heart attack if the blood supply cannot get through.

However, the symptoms can be lessened by creating a bypass so the blood does not flow through the blocked or narrow artery. This bypass surgery uses an artery or vein from elsewhere in the body, often from the leg. If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.

**ABI+**
We cover all types of surgery, not just open heart surgery.
6.0 HEART ATTACK

Of specified severity.

Definition
Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

• The characteristic rise of cardiac enzymes or troponins.
• New characteristic electrocardiographic changes or other positive findings on diagnostic imaging tests.

The evidence must show a definite acute myocardial infarction.

The following are not covered:
• Other acute coronary syndromes.
• Angina without myocardial infarction.

Explanation
When someone has a heart attack (myocardial infarction), part of the heart muscle dies because the blood supply has been restricted to that part of the heart. This is often accompanied by chest pain which is acute (severe and short-term) or continues, on and off, for some time. To confirm the diagnosis, a doctor will usually test the patient’s heart using a machine called an electrocardiograph (ECG) or other diagnostic tests. This tells the doctor whether there have been any changes in the heart’s function and whether it is likely that the patient has suffered a heart attack.

While the ECG can show changes in the heart, it cannot identify when they happened. To do this, the doctor may take a blood sample. This can show that markers are present in the blood (in the form of enzymes or troponins) at a much higher level than is normally expected. This indicates that the heart muscle has been damaged and that a heart attack has recently taken place.

Angina can be confused with a heart attack. Although there may be considerable chest pain, this normally comes with physical exertion and will ease on rest. With angina, no part of the heart muscle dies, so we would not pay a claim.

ABI+
We have no set level of severity. All heart attacks are covered.
6.1 HEART FAILURE

Of specified severity.

Definition
A definite diagnosis by a consultant cardiologist of failure of the heart to function as a pump which is evidenced by all of the following:

- Permanent and irreversible limitation of function to at least class 3 on the New York Heart Association (NYHA) functional classification.*
- Permanent and irreversible ejection fraction of 39% or less.

* NYHA class 3. Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

Explanation
Heart failure means that the heart is unable to pump blood around the body properly. It usually occurs because the heart has become too weak or stiff. Heart failure doesn’t mean your heart has stopped working – it just needs some support to help it work better.

Doctors usually classify patients’ heart failure according to the severity of their symptoms. The most commonly used classification system is the New York Heart Association (NYHA) functional classification. It places patients in one of four categories based on how much they are limited during physical activity. Alternatively, the ejection fraction (EF) refers to a measure how effective the heart is at pumping blood around the body and helps doctors to establish the severity of heart conditions and how they should be treated.

The NYHA functional classification is a measure used to classify the extent of heart failure. Other forms of heart disease are excluded, but various heart related conditions are covered by the policy.

6.2 HEART VALVE REPLACEMENT OR REPAIR

Definition
The actual undergoing of a surgical procedure (including balloon valvuloplasty) to replace or repair one or more heart valves on the advice of a consultant cardiologist.

Explanation
Heart valves regulate and control the flow of blood to and from the heart. If the valves may become narrowed they can sometimes be widened by inflating a tiny balloon in the valve to stretch it (balloon valvuloplasty). If they leak or are damaged, they may need to be repaired or replaced. This is quite a common operation and without it, the patient’s lifestyle is impaired by tiredness and breathlessness on exertion.

If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.

ABI+
We cover all types of surgery, not just open heart surgery.
6.3 HEARTBEAT ABNORMALITIES WITH PERMANENT PACEMAKER INSERTION

**Definition**
The definite diagnosis of an abnormal rhythm of heartbeat by a consultant cardiologist resulting in the insertion of an artificial pacemaker on a permanent basis.

**Explanation**
A pacemaker may be inserted to correct an abnormal heart rhythm. We will pay a claim if this is inserted permanently, we will not pay a claim if this is only required on a temporary basis.

6.4 PERIPHERAL VASCULAR DISEASE

With bypass surgery.

**Definition**
A definite diagnosis of peripheral vascular disease with objective evidence from an ultrasound of obstruction in the arteries which results in bypass graft surgery to the arteries of the legs.

The following is not covered:
- Angioplasty

**Explanation**
Peripheral vascular disease is a condition that occurs when fatty deposits, such as cholesterol, collect in the arteries. These deposits prevent adequate blood flow and can cause a number of symptoms such as:
- Pain, weakness or cramping of the muscles
- Sores, wounds or ulcers
- Blue and cold limbs.

In some cases the treatment is a bypass graft where a section of a healthy artery is taken from elsewhere in the body to bypass the blocked area.

We don’t cover treatments that aim to widen the blocked area (angioplasty) rather than bypass it.
6.5 PRIMARY PULMONARY ARTERIAL HYPERTENSION

Of specified severity.

Definition
A definite diagnosis of pulmonary arterial hypertension by a consultant cardiologist, with unknown cause. There must be clinical impairment of heart function resulting in the permanent loss of ability to perform physical activities to at least class 3 of the New York Heart Association classifications of functional capacity*.

The following are not covered:
- Pulmonary hypertension secondary to any other known cause i.e. not Primary.
- Other types of hypertension.

* NYHA class 3: Heart disease resulting in marked limitation of physical activities where less than ordinary activity causes fatigue, palpitation, breathlessness or chest pain.

Explanation
If the small arteries in the lungs narrow it increases resistance to the blood flowing through them. This in turn, raises the blood pressure (hypertension) in the artery that carries the blood from the heart to the lungs, the pulmonary artery, as well as in the heart itself. Symptoms include shortness of breath during activity, fainting spells, chest pain and a racing pulse.

The NYHA Function classification is a measure used to classify the extent of heart failure.

Hypertension as a result of a known cause is called secondary hypertension. It can be caused by a disease, tumour or a side effect of medication. We don’t cover this.

6.6 PULMONARY ARTERY GRAFT SURGERY

Definition
The undergoing of surgery for disease to the pulmonary artery with excision and surgical replacement of a portion of the diseased pulmonary artery with a graft.

The following are not covered:
- Any other surgical procedure for example the insertion of stents or endovascular repairs.

Explanation
The pulmonary artery carries deoxygenated blood from the heart to the lungs so that it can become oxygenated again and passed back into the rest of the body. In some cases the artery is not connected correctly or becomes stiff, or blocked by blood clots, preventing blood flow and potentially causing damage to the heart. Either condition may require a graft using another blood vessel to replace the damaged portion.

The insertion of stents (metal coils designed to keep the artery open) and surgery via an artery (endovascular) is much less invasive and is therefore not covered.

If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.
6.7 STRUCTURAL HEART SURGERY

**Definition**
The undergoing of heart surgery requiring thoracotomy on the advice of a consultant cardiologist to correct any structural abnormality of the heart.
The following are not covered: any percutaneous, transluminal or investigative procedure.

**Explanation**
A structural abnormality is a defect in the structure of the heart such as the muscles or the valves. It can be present from birth (congenital) or acquired in adulthood as a result of a heart attack or prolonged high blood pressure. In some cases it can restrict, or change the pattern of, the blood flow through the heart, or affect the rhythm of the heart. This can often cause unusual sounds in the heart referred to as ‘heart murmurs’. Symptoms can include trouble breathing, light headedness and chest pain. Severe abnormalities are treated by corrective surgery requiring an incision in the chest wall (thoracotomy).

Surgery through an artery (percutaneous transluminal) or surgery to investigate, but not correct, the problem are not covered.

If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61. We don’t cover treatments that aim to widen the blocked area (angioplasty) rather than by-pass it.
6.8 HOSPITALISATION

6.8 Intensive care for 7 days continuous duration 42
6.8 INTENSIVE CARE FOR 7 DAYS CONTINUOUS DURATION

Definition
Any sickness or injury resulting in the life assured requiring continuous mechanical ventilation by means of tracheal intubation for 7 consecutive days (24 hours per day) or more in an intensive care unit in a UK hospital.

The following are not covered:
• Sickness or injury as a result of drug or alcohol intake or other self-inflicted means
• Children born prematurely (before 37 weeks of pregnancy).

Explanation
If an illness or injury means a person cannot breathe for themselves a machine (a ventilator) is used to pump air in and out of their lungs. This is known as mechanical ventilation.

Tracheal intubation is the placement of the tube from the ventilator down the windpipe in order to keep the airway open and pass the air to the lungs. You are covered if you need this assistance constantly for at least seven days.
6.9 IMMUNE SYSTEM

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6.9 DIABETES MELLITUS TYPE 1

Requiring permanent insulin injections.

**Definition**

A definite diagnosis of diabetes mellitus type 1 with abrupt onset requiring the permanent use of insulin injections.

The following are not covered:

- Gestational diabetes unless the person covered has been on continuous insulin injections to prevent diabetic ketoacidosis for 12 months after delivery of a baby
- Type 2 diabetes (including type 2 diabetes treated with insulin)

**Explanation**

Diabetes is caused when the body’s immune system attacks the cells in the pancreas that create insulin. Insulin is essential to the body and a lack of insulin results in ketonuria, an increase in the level of sugar in the blood and urine. This can lead to heart disease, stroke, kidney failure and damage to the eyes.

Without regular injections of insulin complications can occur potentially resulting in coma and even death.

Type 2 diabetes also results in high blood sugar levels but is as a result of low levels of insulin rather than a complete absence. While it can be treated with insulin, a controlled diet and exercise are often enough. Like type 2 diabetes, latent autoimmune diabetes of adulthood (a slowly developing diabetes in older ages) and gestational diabetes (diabetes during pregnancy) can also potentially be treated with a controlled diet or oral insulin. We therefore do not cover these types of diabetes.

Children are covered separately by a child specific definition – see page 28.

7.0 HIV INFECTION

Caught from a blood transfusion, a physical assault or at work.

**Definition**

Infection by human immunodeficiency virus resulting from:

- A blood transfusion given as part of medical treatment
- A physical assault; or
- Accident occurring during the course of performing normal duties of employment after the start of the policy and satisfying all of the following:
  - The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.
  - Where HIV infection is caught through a physical assault or as a result of an incident occurring during the course of performing normal duties of employment, the incident must be supported by a negative HIV antibody test taken within 5 days of the incident.
  - There must be a further HIV test within 12 months confirming the presence of HIV or antibodies to the virus.

The following is not covered:

- HIV infection resulting from any other means, including sexual activity or drug abuse.

**Explanation**

When someone is affected with HIV, the body’s immune system breaks down. This means that they are more prone to illnesses and less able to fight infection when they do fall ill. There is no cure for the condition at present, although treatment can now slow the onset. AIDS is the final stage of the disease, which starts when the person is infected with HIV (often referred to as being HIV positive).

The virus is acquired through the exchange of body fluids. We cover this if it was the result of a blood transfusion, physical assault or because you came into contact with blood or other body fluids infected by HIV in the course of your work.

We don’t cover HIV as a result of sexual contact or the sharing of needles for drugs.
7.1 SYSTEMIC LUPUS ERYTHEMATOSUS

Of specified severity.

Definition
A definite diagnosis of systemic lupus erythematosus by a consultant rheumatologist resulting in either of the following:

- Permanent neurological deficit with persisting clinical symptoms, or
- Permanent impairment of kidney function tests as follows:
  - Glomerular filtration rate (GFR) below 30 ml/min

Explanation
The immune system is the body’s way of fighting illness and disease, however sometimes it can attack healthy cells. In the case of systemic lupus erythematosus, often just called lupus, the immune system targets tissues and organs for no known reason. Symptoms are wide ranging but can include chronic fatigue and muscle pain (neurological deficit) as well as inflammation of the brain, causing personality changes and seizures. The kidneys can also be affected, reducing their ability to filter fluids (as measured by the glomerular filtration rate). We would pay a claim if there was permanent damage and symptoms.
7.2 MENTAL ILLNESS
7.2 MENTAL ILLNESS

Of specified severity.

Definition
Any mental illness that has resulted in all of the following:

• An admission to a psychiatric ward where treatment was provided for at least 14 consecutive nights; and
• Chronic unremitting symptoms; and
• No response to comprehensive management and treatment for which the person has completed based on best clinical practice for more than 1 year; and
• The inability to perform any type of work for payment or reward for a period of at least 1 year

For this definition, the following is not covered:

• Conditions related to or exacerbated by alcohol or drug abuse

Explanation
Rather than specify a specific illness we cover a wide range of conditions that are considered to be mental illness provided the criteria is met. The criteria are for a severe mental illness and require you to have been constantly ill and unable to work for at least a year, have not responded to treatment during this time and admitted to a psychiatric ward for treatment for at least 14 nights.
7.3 **MULTIPLE CAUSES**

### MULTIPLE CAUSES 48 - 49

- 7.3 Loss of independence 49
- 7.4 Terminal illness 49
7.3 LOSS OF INDEPENDENCE

Of specified severity.

**Definition**

Confirmation by a consultant physician of the permanent loss of the ability to live independently which meets the following criteria:

either

- Mental failure: the diagnosis by a consultant neurologist or psychiatrist, of an irreversible and permanent mental impairment due to an organic brain disease or brain injury supported by evidence of the loss of ability to:
  - Remember
  - Reason, and
  - Perceive, understand and give effect to ideas which causes a significant reduction in mental and social functioning, requiring continuous supervision.

or

- the life assured is unable to perform two out of the following five activities without the help of another person, even with the use of appropriate assistive aids:
  - Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower).
  - Dressing: the ability to put on and take off, secure and unfasten all garments.
  - Getting between rooms: the ability to get from room to room on a level floor.
  - Feeding yourself: the ability to feed yourself when food and drink has been prepared.
  - Maintaining personal hygiene: the ability to maintain a satisfactory level by using the toilet or otherwise managing bowel and bladder functions.

**Explanation**

When someone’s mental or physical health deteriorates so much that they need help with simple daily activities, they can be said to have lost their independence. We’ll pay a claim if you are unable to do at least two of the activities, and this is expected to be permanent. If you are able to do an activity using aids or equipment, then we consider that you are able to do that activity. For example, someone may be able to walk from one room to another using a walking stick (but not without it). In this case, we would not consider that the person had failed that activity.

Alternatively if you suffer from an organic (physical not psychiatric) brain disease, or injury to the brain that means you are unable to remember, understand and interact with people and you therefore need supervision, we will pay the claim.

7.4 TERMINAL ILLNESS

Where death is expected within 12 months.

**Definition**

A definite diagnosis by the attending consultant of an illness that satisfies both of the following:

- The illness either has no known cure or has progressed to the point where it cannot be cured; and
- In the opinion of the attending consultant, the illness is expected to lead to death within 12 months.

**Explanation**

There may be occasions where an illness or condition is not named as one of the specific critical illnesses, but where life expectancy is severely limited. Terminal illness covers any condition that, in the opinion of a specialist and our chief medical officer, is likely to lead to death within 12 months of the date that we are notified of the claim.
7.5 **MUSCLES, LIMBS AND JOINTS**

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7.5 GUILLAIN-BARRÉ SYNDROME

With persisting clinical symptoms.

**Definition**
A definite diagnosis of Guillain-Barré syndrome by a consultant neurologist. There must be clinical impairment of motor or sensory function which must have persisted for a continuous period of at least six months.

**Explanation**
Guillain-Barré syndrome is a very rare and serious condition that affects the nerves. It mainly affects the feet, hands and limbs, causing problems such as numbness, weakness and pain.

It can be treated and most people will eventually make a full recovery, although it can occasionally be life-threatening and some people are left with long-term problems.

7.6 MYASTHENIA GRAVIS

With persisting clinical symptoms.

**Definition**
A definite diagnosis of myasthenia gravis by a consultant neurologist. There must be clinical impairment of muscle weakness that must have persisted for a continuous period of at least six months or treated with removal of the thymus gland.

**Explanation**
Myasthenia gravis is a rare long-term condition that causes muscle weakness that comes and goes. It most commonly affects the muscles that control the eyes and eyelids, facial expressions, chewing, swallowing and speaking. But it can affect most parts of the body. We will pay a claim if the clinical impairment has lasted at least 6 months or the thymus gland has been removed.

7.7 PARALYSIS OF LIMBS

Total and irreversible.

**Definition**
Total and irreversible loss of muscle function to the whole of any one limb.

**Explanation**
An arm or a leg must be completely paralysed as a result of an accident or disease. The paralysis might be temporary, with a full recovery later. Therefore, a neurosurgeon must carry out the necessary tests to confirm that the paralysis is permanent.
7.8 RHEUMATOID ARTHRITIS

Resulting in a loss of the ability to do specified physical activities.

**Definition**

A definite diagnosis by a consultant rheumatologist of rheumatoid arthritis, resulting in the permanent inability of the claimant to perform three of the six activities listed below.

- **Mobility** – the ability to walk more than 200 metres on a level surface, with or without the aid of simple assistive devices, for example a walking stick or a crutch.
- **Climbing** – the ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
- **Lifting** – the ability to pick up an everyday object weighing 2kg at table height, hold for 60 seconds, transfer to the other hand and to replace the object on the table. Everyday objects can include a kettle of water, a bag of shopping, an overnight bag or briefcase.
- **Bending** – the ability to bend or kneel to touch the floor and straighten up again.
- **Getting in and out of a car** – the ability to enter and get out again of a standard saloon car, including being able to unlock and operate the door handles.
- **Manual dexterity** – the ability to write legibly using a pen or pencil or type using a desktop personal computer keyboard.

**Explanation**

Chronic inflammation of the joints, and sometimes the organs and bodily tissues, is known as rheumatoid arthritis. It can be a very painful and severely reduce mobility. To claim you must be unable to perform three of the six everyday activities.
7.9 ORGANS

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7.9 INTERSTITIAL LUNG DISEASE

**Definition**
A definite diagnosis of interstitial lung disease by a consultant respiratory physician resulting in all of the following:
- Radiological evidence of pulmonary fibrosis
- Permanent and irreversible DLCO (diffusing capacity of the lung for carbon monoxide) below 40% of predicted

**Explanation**
The term interstitial lung disease covers a wide range of conditions affecting the lung tissue. These conditions can sometimes result in scarring of the lungs (pulmonary fibrosis).

Diffusing capacity of the lungs for carbon monoxide (DLCO) is a medical test that determines how much oxygen travels from the lungs to the bloodstream. Generally, a healthy person has a DLCO value of between 75% and 125% of the average result. The lower the percentage, the worse the condition is.

8.0 KIDNEY FAILURE

Requiring dialysis.

**Definition**
Chronic and end stage failure of both kidneys to function, as a result of which regular dialysis is permanently required.

**Explanation**
The kidneys remove waste products from the blood, for example by producing urine. While many people can lead a normal life with only one kidney, if both stop working (chronic and end stage failure), a substitute is needed. This may be in the form of a dialysis machine or a transplant.

In some circumstances, both kidneys may stop working temporarily. In these circumstances, dialysis may be needed for a short time until the kidneys recover. We only cover dialysis if it becomes permanent.

8.1 LIVER FAILURE

End stage liver failure resulting in all of the following:
- Permanent jaundice
- Ascites
- Encephalopathy

**Explanation**
The liver is an organ that performs a wide range of vital functions. These include breaking down toxins, storing vitamins and minerals, and producing bile to aid digestion. Liver failure can be caused by hepatitis B or C, disease caused by diabetes or obesity, or excessive alcohol.

Jaundice, a yellowing of the skin, occurs when too many red blood cells are broken down by the liver. Ascites is the accumulation of an excessive amount of fluid in the body around the stomach, intestines and organs in that area of the body. Encephalopathy is a disease of the brain which can be caused by liver failure. All of these must be present for us to pay the claim.
8.2 MAJOR ORGAN TRANSPLANT FROM ANOTHER DONOR

**Definition**
The undergoing as a recipient of a transplant from either a human donor, animal or insertion of an artificial device, or inclusion on an official UK waiting list for any of the following:

- Transplant of a bone marrow;
- Haematopoietic stem cells preceded by total bone marrow ablation
- Transplant of a complete heart, kidney, liver, lung or pancreas;
- Transplant of a lobe of liver, or
- Transplant of a lobe of lung.

The following is not covered:

- Transplant of any other organs, parts of organs, tissues or cells.

**Explanation**
If a major organ, such as the heart or lungs, is badly diseased or damaged and beyond treatment, a doctor may consider that a transplant is essential. We cover you if you have a transplant from a person or animal, a replacement artificial organ, or if you are on a UK waiting list.

As well as the major organs we cover transplants of:

- A part of the liver or lung, known as lobes.
- Bone marrow
- Haematopoietic stem cells (cells that develop into different types of blood cells) after the bone marrow has been removed (ablation).

**ABI+**
In addition to the standard definition we also cover: partial transplants and the use of animal or artificial organs.

8.3 PNEUMONECTOMY

**Definition**
The undergoing of surgery on the advice of a consultant medical specialist to remove an entire lung for any physical injury or disease.

**Explanation**
Pneumonectomy is the surgical removal of a lung. This is most commonly used to remove cancerous tumours or when the lung is severely injured in an accident.

If you are on a waiting list for this surgery you can use our Surgery Benefit to receive the payout more quickly – see page 61.

8.4 REMOVAL OF ONE OR MORE LOBE(S) OF THE LUNG

For disease and trauma.

**Definition**
The undergoing of surgery for the removal of one or more lobes of the lung due to underlying disease or trauma. The surgery must be carried out on the advice of a consultant physician.

**Explanation**
Surgical removal of a lobe of lung: this is most commonly used to remove cancerous tumours, or other serious respiratory disorders, or when the lung is severely injured in an accident.
8.5 RESPIRATORY FAILURE – of specified severity

Definition
Confirmation by a UK Consultant Physician of severe lung disease which is evidenced by the need for continuous daily oxygen therapy on a permanent basis.

Explanation
There are several diseases of the lung that could cause respiratory failure including chronic bronchitis and emphysema, both of which restrict airflow from the lungs. Chronic bronchitis is when the tubes carrying the air in and out of the lungs become inflamed, which in turn can cause them to thicken, scar and produce mucus. In emphysema the walls of the lungs become damaged and the lung tissue weakens, reducing the amount of oxygen in the bloodstream. Oxygen therapy is having to breathe oxygen from a cannister through a mask or tube in your nose.
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8.5  BLINDNESS

Permanent and irreversible.

**Definition**

Permanent and irreversible loss of sight to the extent that even when tested with the use of visual aid, it is measured by a certified ophthalmologist as having a best corrected (with glasses or lenses) visual acuity in the better eye of:

- 6/60 or worse using a Snellen eye chart, or
- A loss of peripheral visual field and a central visual field of no more than 20 degrees in total.

**Explanation**

This means a permanent loss of sight in both eyes, or almost lost with any remaining sight confined to a narrow point straight ahead of you (a loss of peripheral visual field).

A Snellen chart is the test an optician uses, where you are asked to read rows of letters. 6/60 is the measure when you can only see at six feet away what someone with perfect sight could see at 60 feet away. We also include cover for significant visual impairment.

**ABI+**

As well as covering a less severe loss of sight we also cover a narrowing of the field of vision.

8.6  CENTRAL RETINAL ARTERY OR VEIN OCCLUSION

Resulting in permanent visual loss.

**Definition**

Death of optic nerve or retinal tissue due to inadequate blood supply or haemorrhage within the central retinal artery or vein, resulting in permanent visual impairment of the affected eye.

The following are not covered:

- Branch retinal artery or vein occlusion or haemorrhage

**Explanation**

This is also known as an ‘eye stroke’ and happens when a blockage (occlusion) in the veins and arteries, or a loss of blood (haemorrhage) prevents an adequate blood flow to the eye. The blood carries vital nutrients and oxygen and without these the tissues in the nerves can become damaged, causing distorted or decreased vision, or blindness. We wouldn’t pay this benefit if the blockage or haemorrhage was not in the central artery or vein.

8.7  DEAFNESS

Permanent and irreversible.

**Definition**

Permanent and irreversible loss of hearing to the extent that the loss is greater than 70 decibels across all frequencies in the better ear using a pure tone audiogram.

**Explanation**

It is possible to lose your hearing temporarily. An example of this would be damage to the eardrum this could result from a pressure difference caused by diving or flying, or as a result of an infection. However, if a doctor is sure that the loss of hearing is permanent and in both ears, we would pay a claim. A pure tone audiogram is a hearing test where a series of bleeps, which gradually become quieter, are played through headphones. A decibel is a measurement of sound.
8.8 LOSS OF SPEECH

Permanent and irreversible.

Definition
Total permanent and irreversible loss of the ability to speak as a result of physical injury or disease.

Explanation
Sometimes a temporary loss of speech can be caused by an injury to the vocal cords, or even a severe sore throat. A doctor would need to be certain that the loss of speech was permanent and had no likelihood of ever improving for us to pay a claim.

8.9 NEUROMYELITIS OPTICA (DEVIC’S DISEASE)

With persisting symptoms.

Definition
A definite diagnosis of neuromyelitis optica by a consultant neurologist. There must have been clinical impairment of motor or sensory function caused by neuromyelitis optica.

Explanation
Neuromyelitis optica (also called Devic’s disease) affects both the optic nerve (the main nerve to the eye) and the spinal cord. These become both inflamed and damaged, disrupting the signals from the brain to the muscles. This results in loss of motor function such as muscle weakness, paralysis of the limbs and blindness, and loss of sensation (sensory function).

9.0 SIGNIFICANT VISUAL IMPAIRMENT

Permanent and irreversible.

Definition
Permanent and irreversible loss of sight in the better eye to the extent that even when tested with the use of visual aids is measured by a certified ophthalmologist as follows:

- Acuity of up to 6/24 (Snellen) with moderate contraction of the field, or aphakia (lens removal) or opacities blocking vision in the eye itself
- Acuity of 6/18 or better, if in addition suffering from a gross defect of visual fields (of both eyes, such as hemianopia) or marked contraction of the visual field (i.e. in retinitis pigmentosa, or glaucoma).

Explanation
This covers a lower level of loss of sight than in the critical illness definition for blindness, as well as conditions that reduce the field of vision. Hemianopia reduces the field of vision by half and is often the result of stroke or trauma. Glaucoma is a disease affecting the optic nerves and retinitis pigmentosa is a disease that affects the tissue at the back of the eye, the retina. Both reduce the field of vision, often known as tunnel vision. The impairment must be permanent and irreversible.
# 9.1 Trauma

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9.1 LOSS OF HAND OR FOOT

Permanent physical severance.

Definition
Permanent physical severance of any combination of one or more hands or feet at or above the wrist or ankle joints.

Explanation
To qualify for this cover, the person insured must lose one, or more, of their hands or feet, cut off above the wrist or ankle. If the hand or foot is surgically re-attached, we will not pay a claim.

9.2 SERIOUS ACCIDENT BENEFIT

Definition
An accident resulting in a severe physical injury where the life assured is immediately admitted to hospital for at least 28 consecutive days to receive medical treatment. (Where severe physical injury means injury resulting solely and directly from unforeseen, external, violent and visible means and independent of any other cause.)

Explanation
If you are involved in an accident which causes severe injury, you are admitted to hospital straightaway, and you have to stay there for 28 days or more, we will pay the claim.

9.3 THIRD DEGREE BURNS

Definition
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 20 percent of the body’s surface area or 20 percent loss of surface area of the face which for the purposes of this definition includes the forehead and ears.

Explanation
Burns are categorised by severity, and third degree burns are the most severe. These burn through the full thickness of the skin. An example of 20% of the body surface area would be the whole of the back. We also cover less extensive third degree burns which cover less of the body’s and face’s surface under our additional payments.

ABI+
We also cover burns to the face.

9.4 THIRD DEGREE BURNS – LESS EXTENSIVE (5%)

Definition
Burns that involve damage or destruction of the skin to its full depth through to the underlying tissue and covering at least 5% of the body’s surface area.

Explanation
This benefit covers serious burns which cover less of the body than the main definition of third degree burns. It covers burns to between 5% and 19% of the body’s surface.
Surgery Benefit

A number of the critical illnesses covered by the policy require surgery to take place. If you claim for one of these and you are included on an NHS waiting list, we will pay the full amount of cover before you undergo surgery.

This means you could choose to pay for the cost of private treatment rather than waiting for the operation under the NHS.

The surgeries covered:

• Aorta graft surgery
• Removal of all or part of a benign brain tumour
• Removal of a benign spinal cord tumour
• Insertion of a defibrillator following a cardiac arrest
• Coronary artery bypass grafts
• Heart valve replacement or repair
• Major organ transplant
• Pneumonectomy
• Pulmonary artery surgery
• Structural heart surgery
• Colectomy for ulcerative colitis

Surgery cover is also included under the children’s cover. This covers the same surgeries as above, but the maximum total payment is £25,000 or 50% of the policy, whichever is lower.
ADDITIONAL CARE BENEFIT

Additional care benefit provides £50,000, or an amount equal to your cover if lower, in addition to the full amount of your cover when you claim for total permanent disability or a critical illness that leaves you with severe and permanent physical or mental symptoms.

To claim you must meet at least one of four scenarios:

SCENARIO ONE
When you make a claim

At the time you make a claim for the full amount of cover on your policy we’ll also pay the additional care benefit if you also have a total and permanent inability to perform at least three of the following everyday activities:

- Feeding yourself – the ability to feed yourself when food has been prepared and made available.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.

SCENARIO TWO
When you make a claim

We’ll pay your full cover plus the additional care benefit if you claim for one of the following conditions before you are 50:

- Dementia including Alzheimer’s disease
- Parkinson’s disease
- Parkinson plus syndromes
- Motor neurone disease

SCENARIO THREE
Within a year of being diagnosed with one of the critical illnesses

Within a year of being diagnosed with one of the critical illnesses covered, or a total permanent disability (if you have chosen this), you can claim the additional care benefit if you are also diagnosed with:

Locked-in syndrome
Permanent complete paralysis of voluntary muscles in all parts of the body, or all parts of the body except for the eyes.

This is a condition where the part of the brain that transfers messages to the rest of the body becomes damaged causing paralysis to the body and most of the face, but leaving some eye movement and full consciousness.

Permanent vegetative
A state of wakefulness without awareness, characterised by complete absence of evidence of self or environmental awareness, for a minimum period of six months.

A vegetative state is different to a coma in that the person may move parts of their body and their eyes may be open. They may even react to loud noises or pain. However they are still unconscious and not aware of themselves or their surroundings.

Minimally conscious state
Wakefulness, but with permanent minimal or inconsistent awareness for a minimum period of six months

This differs from a vegetative state in that there is some awareness, although it may be inconsistent. It can be difficult to distinguish between the two states. Minimal awareness could be following simple instructions or basic verbal responses to questions.
SCENARIO FOUR

At least one year after being diagnosed with a critical illness

You can claim additional care benefit if at least one year after being diagnosed with a critical illness covered by the policy, or total permanent disability (if you have chosen this) and solely as a result of that illness or total permanent disability you have:

Permanent severe heart failure

A definite diagnosis of heart failure by a consultant cardiologist. There must be permanent clinical impairment of heart function resulting in all of the following:

- Permanent loss of ability to perform physical activities to at least Class 4 of the New York Heart Association (NYHA) classification of functional capacity. (This means inability to carry out any physical activity without discomfort, symptoms of heart failure at rest and if any physical activity is undertaken, discomfort increases) and;
- Permanent and irreversible ejection fraction of 39% or less.

Heart failure means that the heart is unable to pump blood around the body properly. It usually occurs because the heart has become too weak or stiff. Heart failure doesn’t mean your heart has stopped working – it just needs some support to help it work better.

Doctors usually classify patients’ heart failure according to the severity of their symptoms. The most commonly used classification system is the New York Heart Association (NYHA) Functional Classification. It places patients in one of four categories based on how much they are limited during physical activity. Class 4 is the most severe category.

Alternatively, the ejection fraction (EF) refers to a measure of how effective the heart is at pumping blood around the body and helps doctors to establish the severity of heart conditions and how they should be treated.

Loss of independence

When someone’s mental or physical health deteriorates so much that they need help with simple daily activities, they can be said to have lost their independence. We’ll pay the additional care benefit if you are unable to do at least three of the following activities, and this is expected to be permanent.

- Feeding yourself – the ability to feed yourself when food has been prepared and made available.
- Getting between rooms – the ability to get from room to room on a level floor.
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances.
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function.
- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.

If you are able to do an activity using aids or equipment, then we consider that you are able to do that activity. For example, someone may be able to walk from one room to another using a walking stick (but not without it). In this case, we would not consider that the person had failed that activity.

FOR SCENARIOS 3 AND 4

The cause of the additional care benefit claim must be solely caused by the full payment of a claim for one of the critical illnesses, or a total permanent disability, covered by the policy.

A claim for additional care benefit must be made within 24 months from the diagnosis of the critical illness or total permanent disability (if applicable). Claims cannot be made after this period.
Our critical illness policies automatically cover your children, from birth or the date the cover starts, whichever is later, to their 22nd birthday.

By children we mean:
- Children by birth
- Legally adopted children, or
- Stepchildren from a legally recognised marriage or registered civil partnership as defined by the Civil Partnership Act 2004.

Unlike some cover, your children don’t have to be in full-time education after the age of 18 to qualify.

If you don’t have children, but are planning a family in the future, they’ll be covered automatically too.

A claim for children’s cover will not reduce your own critical illness cover, and your policy will not end.

WHEN WE WILL PAY

We will pay a children’s cover claim if your child:
- Is diagnosed with one of the 50 full payment or eight child specific illnesses covered by the policy (£25,000 or 50% of the policy, whichever is lower)
- Or
- Is diagnosed with one of 27 additional illnesses covered by the policy (£25,000 or 25% of your cover, whichever is lower)
- And
- Survives for at least 10 days after diagnosis of the illness

This includes if your child had the condition at birth before the cover started and:
- You were not aware of an increased risk of your child having the condition. For example, you did not receive any counselling or medical advice in relation to the condition before the policy started.

It also covers your child if they had symptoms before your cover started and:
- Treatment for the condition has been completed
- Your child had been discharged from follow-up for the condition
- Your child had not consulted any medical practitioner or received further treatment or advice for the condition within the last five years.

WHEN WE WON’T PAY

We won’t pay a children’s cover claim if:
- Your child dies within 10 days of meeting one of the critical illness definitions
- The condition was present at birth before the cover started and:
  - You were aware of an increased risk of your child suffering the critical illness before the start date of your policy (for example you had received medical advice or counselling in relation to the critical illness before your policy started)
- The symptoms started before your child was covered and:
  - Treatment for the condition has not been completed
  - Your child has not been discharged from follow-up for the condition
  - Your child has consulted a medical practitioner or received further treatment or advice for the condition within the last five years.

ADVANCED ILLNESS COVER

If you make a children’s cover claim and the illness you claim for meets our definition of an advanced illness we will pay an additional £10,000.

By advanced illness we mean: an advanced or rapidly progressing and incurable condition with a life expectancy of no greater than 12 months. This must be confirmed by the consultant treating your child.
DOUBLE PAYMENTS

If both parents are insured by the policy, or each parent has their own separate policy, we pay double the amount of children’s cover. Each parent could therefore claim up to £25,000, making a total of £50,000.

OVERSEAS TREATMENT

A children’s critical illness benefit will be doubled if, in the opinion of the treating consultant and our consultant medical officer:

- Your child is unable to receive treatment for their illness in the UK that is effective in curing or preventing further deterioration of the condition; and
- A treatment that is effective, curative or prevents further deterioration is available overseas.

That means if both parents are covered and treatment that could cure or prevent the condition getting worse is only available in another country, we could pay up to a total maximum of £100,000.

CHILDREN’S SURGERY BENEFIT

We also include children’s surgery benefit. If a child is included on an NHS waiting list for one of the surgeries listed on page 62 we will pay the full amount of children’s cover. This means the parents could choose to pay for the cost of private treatments rather than waiting for the operation under the NHS.
Having to make a claim usually comes at a very worrying or distressing time, so we try to take away as much of the worry and stress as we can by making your claim experience as smooth as possible.

Contact us on 0808 171 25 70 to discuss a claim or for a claims form.

We send the form and advise you of any documents and information that we may need.

We receive the form and assess the claim. For a death claim, if we have everything that we need we will pay the claim.

For an illness or disability claim we may need medical reports to help us assess the claim. If you have your own copies of medical reports, sending these in with the form can help speed up the claim.

We aim to pay the claim within 2 to 3 days of receiving all the information we need.

OTHER INFORMATION ABOUT OUR POLICY
You can find information on all of the features of your Protect policy in the terms and conditions that you receive when you first take out the policy. You can also find information in the Key Features Document and the Explaining Protect guide. All of these can be found on our website or you can contact us for copies.

MAKING A CLAIM

EXCLUSIONS

INDIVIDUAL EXCLUSIONS
If you have had, or have an increased risk of developing, a particular illness we may exclude that illness from the cover which means you won’t be able to claim for that illness. We’ll tell you before the cover starts if we exclude an illness.

If we exclude the following illnesses it will reduce the cost of the cover:
• Cancer
• Multiple sclerosis
• Conditions of the heart and arteries

GENERAL EXCLUSIONS
The only general exclusion (an exclusion that applies to everyone) we may apply is if your claim is made while you are outside of the UK and certain other countries.

It applies to critical illness cover, total permanent disability cover, premium protection benefit, serious accident benefit, children’s cover, surgery cover and children’s surgery cover.

The policy wording is:
In order to claim:
• You must provide medical evidence to support your claim and diagnosis.
• The claim must have occurred in one of these countries: Andorra, Australia, Austria, Belgium, Canada, Channel Islands, Cyprus, Denmark, Finland, France, Germany, Greece, Republic of Ireland, Isle of Man, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, Portugal, San Marino, South Africa, Spain, Sweden, Switzerland, UK, USA and Vatican City.

If the claim occurs outside these countries, we may still be able to consider it. You may need to provide supporting evidence from a medical practitioner or consultant registered in the UK, and we may ask you to have an examination by a specialist in the UK.

We don’t automatically decline a claim if you are in a country that is not listed above, but we may need to get additional medical evidence of your illness or we may ask you to have an examination in the UK. If so, we will help you to do this.