

Your Bupa membership guide

Bupa Select membership guide

Essential information explaining your Bupa cover

Please retain



About this guide

Welcome to your Bupa Select membership guide.

At **Bupa**, **we** know that insurance can be hard to follow. That's why **we** have made this guide as simple as possible. You will find individual chapters that deal with each aspect of your **Bupa** cover, including a step-by-step guide to making a claim.

Please make sure that you keep this guide somewhere safe. You will need it when you come to claim.

If any of the terms or language used leave you confused – don't worry, **we** have also included a glossary featuring clear definitions of words that are in ***bold italics*** in the text.

If you require correspondence and marketing literature in an alternative format, we offer a choice of Braille, large print or audio. Please get in touch to let us know which you would prefer.

How do I know what I'm covered for?

The precise details of the cover **you** have chosen are listed on your **membership certificate**. Please read this membership guide together with your **membership certificate**, as together they set out full details of how your health insurance works.

How does the membership guide work with my membership certificate?

Your membership certificate explains the **benefits** available to you and also provides the benefit note numbers that correspond to the benefit notes in the Benefits section of the membership guide (where you will find a more detailed explanation of the **benefits** in your individual policy).

How do I contact Bupa?

We are always on hand to help.

For queries about your cover **we** have provided a dedicated number which you will find on your **membership certificate**.

You can also write to **us** at **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

Bupa Anytime HealthLine[^]

If you have any questions or worries about your health call **our** confidential Bupa Anytime HealthLine on **0345 604 0537***. **Our** qualified nursing team is on hand 24 hours a day, so whatever your health question or concern, they have the skills and practical, professional experience to help.

[^]Bupa Anytime HealthLine is not regulated by the Financial Conduct Authority.

*Calls may be recorded and to maintain the quality of our Bupa Anytime HealthLine service a nursing manager may monitor some calls always respecting the confidentiality of the call.

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Your rules and benefits

Effective from 1 January 2019

These are the rules and benefits of Bupa Select

They apply to members of the *scheme* whose 'Group contract start date', as stated in the Group details section of their *membership certificate*, is on or after the 'Effective from' date.

Words and phrases in *bold italics* in this membership guide are defined terms which have a specific meaning. You should check their meaning in the glossary.

Important note

Please read this note before you read the rest of this membership guide as it explains how this membership guide and your membership certificate work together.

This Bupa Select membership guide and your *membership certificate* together set out full details of your *benefits*. They should not be read as separate documents.

This membership guide is a generic guide. It contains the general membership terms that apply to all Bupa Select members. It also contains all the elements of cover that can be provided under Bupa Select. **You may not have all the cover set out in this membership guide.** It is your *membership certificate* that shows the cover that is specific to your *benefits*. Any elements of cover in this membership guide that are either:

- shown on your *membership certificate* as 'not covered', or
- do not appear on your *membership certificate*

you are not covered for, and you should therefore ignore them when reading this membership guide.

The 'Further details' section of your membership certificate: Your *membership certificate* could also show some changes to the terms of cover set out in this membership guide particularly in the 'Further details' section.

When reading this membership guide and your *membership certificate*, it is your *membership certificate* which is personal to you. This means that if your *membership certificate* contradicts this membership guide it is your *membership certificate* that will take priority.

Always call the helpline if you are unsure of your cover.

How your membership works

The agreement between the sponsor and us

Your cover is provided under a group insurance policy governed by the **agreement** and the terms and conditions of your membership have been agreed between your **sponsor** and **Bupa**. There is no legal contract between you and **us** for your cover under the **agreement**. Only the **sponsor** and **Bupa** have legal rights under the **agreement**. However:

- if **you** are a **contributing member you** will have legal rights as set out in this membership guide. Please see the section 'Contributing members'
- if **you** are not a **contributing member we** allow you access to the claims and complaints processes as set out in this membership guide.

The documents that set out your cover

The following documents set out the details of the cover **we** will provide for you under the **agreement**. These documents must be read together as a whole, they should not be read as separate documents.

- **The Bupa Select membership guide:** this sets out the general terms and conditions of membership (including exclusions) and all the elements of cover that can be provided under Bupa Select.
- **Your membership certificate:** this shows the cover that is specific to your **benefits**, including the underwriting method applied, the limits that apply, any variations to the benefits, terms or conditions explained in this membership guide and whether an **excess** or **co-insurance** applies to your cover and if it does, the amount and how it applies.

Payment of benefits

We only pay **benefits** for **treatment** you receive while you are covered under the **agreement** and **we** only pay **benefits** in accordance with the cover that applies to you on the date the **treatment** takes place. **We** do not pay for any **treatment**, including any **treatment we** have pre-authorized, that takes place on or after the date your cover ends.

When you receive private medical treatment you have a contract with the providers of your **treatment**. You are responsible for the costs you incur in having private **treatment**. However, if your **treatment** is **eligible treatment we** pay the costs that are covered under your **benefits**. Any costs, including **eligible treatment** costs, that are not covered under your **benefits** are your sole responsibility. The provider might, for example, be a **consultant**, a **recognised facility** or both. Sometimes one provider may have arrangements with other providers involved in your care and, therefore, be entitled to receive all the costs associated with your **treatment**. For example a **recognised facility** may charge for **recognised facility** charges, **consultants'** fees and **diagnostic tests** all together.

In many cases **we** have arrangements with providers about how much they charge **our** members for **treatment** and how **we** pay them. For **treatment** costs covered under your **benefits we** will, in most cases, pay the provider of your **treatment** direct – such as the **recognised facility** or **consultant** – or whichever other person or facility is entitled to receive the payment. Otherwise **we** will pay the **main member**. **We** will write to tell the **main member** when there is an amount for you to pay in relation to any claim (for example if you have an **excess** amount to pay) and who payment should be made to. *Please also see the section 'Claiming'.*

When your membership starts, renews and ends

Starting membership

Your membership under the **agreement** must be confirmed by the **sponsor**.

Your cover starts on **your cover start date**.

Your dependants' cover starts on their **cover start date**. **Your cover start date** and **your dependants' cover start date(s)** may not be the same.

Cover for a newborn baby

If the **sponsor** agrees, **you** may apply to include **your** newborn baby under **your** membership as one of **your dependants**. If your baby's membership would be as:

- an **underwritten member**, **we** will not apply any **special conditions** to the baby's cover
- a **moratorium member**, **we** will not apply the exclusion for **moratorium conditions** to the baby's cover – see *Exclusion 33 in the section 'What is not covered'*

but only if both the following apply:

- **you** and/or **your partner** have been covered under the **scheme** (and if applicable a **previous scheme**) for at least 12 continuous months before the baby's birth and
- **you** include **your** baby under **your** membership within three months of the baby's birth.

In which case if **we** agree to cover **your** baby it will be from their date of birth or **your cover start date** if their date of birth is before **your cover start date**.

Renewal of your membership

The renewal of your membership is subject to the **sponsor** renewing your membership under the **agreement**.

If you are a contributing member please see the section 'Contributing members'.

How membership can end

You or the **sponsor** can end **your** membership or the membership of any of **your dependants** at any time.

If **you** want to end **your** membership or that of any of **your dependants** **you** must write to **us**. If **your** membership ends the membership of all **your dependants** will also end.

If you are a contributing member please see the section 'Contributing members'

Your membership and that of **your dependants** will automatically end if:

- the **agreement** is terminated
- the terms of the **agreement** say that it must end
- the **sponsor** does not pay subscriptions or any other payment due under the **agreement** for you or any other person. *If you are a contributing member please see the section 'Contributing members'.*
- **you** stop living in the **UK** (**you** must inform **us** if **you** stop living in the **UK**), or
- **you** die.

Your dependants' membership will automatically end if:

- **your** membership ends
- the terms of the **agreement** say that it must end
- the **sponsor** does not renew the membership of that **dependant**
- that **dependant** stops living in the **UK** (**you** must inform **us** if that **dependant** stops living in the **UK**), or
- that **dependant** dies.

We can end a person's membership if there is reasonable evidence that **you** or a **dependant** did not take reasonable care in answering **our** questions.

By this **we** mean giving false information or keeping necessary information from **us** if:

- intentional, **we** may end the cover or not pay a claim in full or part
- careless, we may:
 - withdraw cover, refuse all claims and refund all of your subscriptions
 - change the cover
 - need to increase **your** subscription or **we** could reduce any claim payment by the same proportion.

When **your** membership or **your dependants'** membership ends, **we** may be able to offer **you** or them continuation of membership on a **Bupa** personal policy as an ex-group scheme member depending upon how long **you** or they have been a **Bupa** group scheme member.

- If **you** or they are an **underwritten member** this would allow you or them to transfer without any additional **special conditions**
- If **you** or they are a **moratorium member** this would allow **you** or them to transfer without a change to the **moratorium start date** that applies to **you** or them under the **Bupa** group scheme

but only if, in each case, **you** or they transfer within three months of the date **your** or their cover under the **Bupa** group scheme ends without any break in **your** or their cover. If **you** would like to consider this option please call **0800 600 500** to discuss it with **us**.

Paying subscriptions and other charges

The **sponsor** must pay to **us** subscriptions and any other payment due for **your** membership and that of every other person covered under the **agreement**. Bupa Insurance Services Limited acts as **our** agent for arranging and administering **your** policy. Subscriptions are collected by Bupa Insurance Services Limited as **our** agent for the purpose of receiving, holding and refunding premiums and claims monies.

*If you are a **contributing member** please see the section 'Contributing members'.*

Making changes

Changes to your membership

The terms and conditions of your membership, including your **benefits**, may be changed from time to time by agreement between the **sponsor** and **us**.

No other person is allowed to make or confirm any changes to your membership or your **benefits** on **our** behalf or decide not to enforce any of **our** rights. Equally, no change to your membership or your **benefits** will be valid unless it is specifically agreed between the **sponsor** and **us** and confirmed in writing.

*If you are a **contributing member** please see the section 'Contributing members'.*

General information

Change of address

You should call or write to tell **us** if **you** change **your** address.

Correspondence and documents

All correspondence and membership documents are sent to the **main member**.

When you send documents to **us**, **we** cannot return original documents to you. However, **we** will send **you** copies if you ask **us** to do so at the time you give **us** the documents.

Letters between us must be sent with the postage costs paid before posting. We can each assume that the letter will be received three days after posting.

Applicable law

The **agreement** is governed by English law.

Private Healthcare Information Network

You can find independent information about the quality and cost of private treatment available from doctors and hospitals from the Private Healthcare Information Network: www.phin.org.uk

Making a complaint

We are committed to providing you with a first class service at all times and will make every effort to meet the high standards **we** have set. If you feel that **we** have not achieved the standard of service you would expect or if you are unhappy in any other way, then please get in touch.

If **Bupa**, or any representative of **Bupa**, did not sell you this policy and your complaint is about the sale of your policy, please contact the party who sold the policy. Their details can be found on the status disclosure document or the terms of business document they provided to you.

If you need help or support or have any comments or complaints, please call your dedicated **Bupa** helpline number shown on your **membership certificate**. Alternatively you can contact **us**:

In writing: **Customer Relations, Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

By email: customerrelations@bupa.com

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress Switch.

For more information and to sign up for a free Egress Switch account, go to <https://switch.egress.com/ui/learn>. You will not be charged for sending secure emails to a Bupa email address using the Switch service.

Via our website: bupa.co.uk/members/member-feedback

How will we deal with your complaint and how long is this likely to take?

If **we** can resolve your complaint within three working days after the day you made your complaint, **we** will write to you to confirm this. Where **we** are unable to resolve your complaint within this time, **we** will promptly write to you to acknowledge receipt. **We** will then continue to investigate your complaint and aim to send you **our** final written decision within four weeks from the day of receipt. If **we** are unable to resolve your complaint within four weeks following receipt, **we** will write to you to confirm that **we** are still investigating it.

Within eight weeks of receiving your complaint **we** will either send you a final written decision explaining the results of **our** investigation or **we** will send you a letter advising that **we** have been unable to reach a decision at this time.

If you remain unhappy with **our** response, or after eight weeks you do not wish to wait for **us** to complete **our** review, you may refer your complaint to the Financial Ombudsman Service. You can write to them at: **Exchange Tower, London E14 9SR** or contact them via email at **complaint.info@financial-ombudsman.org.uk** or call them on **0800 023 4567** (calls to this number are now free on mobile phones and landlines) or **0300 123 9123** (free for mobile phone users who pay a monthly charge for calls to numbers starting 01 or 02).

For more information you can visit **www.financial-ombudsman.org.uk**

Your complaint will be dealt with confidentially and will not affect how **we** treat you in the future.

Whilst **we** are bound by the decision of the Financial Ombudsman Service, you are not. The European Commission also provides an online dispute resolution (ODR) platform which allows consumers who purchase online to submit complaints through a central site which forwards the complaint to the relevant Alternative Dispute Resolution (ADR) scheme. For **Bupa**, complaints will be forwarded to the Financial Ombudsman Service and you can refer complaints directly to them using the details above. For more information about ODR please visit <http://ec.europa.eu/consumers/odr/>

The Financial Services Compensation Scheme (FSCS)

In the unlikely event that **we** cannot meet **our** financial obligations, you may be entitled to compensation from the Financial Services Compensation Scheme. This will depend on the type of business and the circumstances of your claim.

The FSCS may arrange to transfer your policy to another insurer, provide a new policy or, where appropriate, provide compensation. Further information about compensation scheme arrangements is available from the FSCS on **0800 678 1100** or **020 7741 4100** or on its website at: **www.fscs.org.uk**

Contributing members

This section only applies to *contributing members*.

The *sponsor* must pay to *us* subscriptions and any other payment due for *your* membership, and that of *your dependants* and every other person covered under the *agreement*. *You* contributing to the cost of subscriptions for *you* and/or any of *your dependants* does not in any way affect the contractual position set out in the section 'The agreement between the sponsor and us'.

Contributions paid by *you* to the subscriptions the *sponsor* has paid for *you* (eg by payroll deduction) will be deemed to have been received by *Bupa* once they are received by *your sponsor*.

As soon as reasonably practicable *you* will be provided with the terms and conditions that will apply to *your* cover, and the *sponsor* will notify *you* of the contribution you will need to make to the cost of subscriptions from the *cover start date* for the next membership *year*.

If you do not want *your* cover (and therefore the cover for *your dependants*) or the individual cover for any of *your dependants* to renew at the *renewal date* you can notify *your sponsor* at any time in advance of the *renewal date*.

If *you* wish to end *your membership* (and therefore that of *your dependants*) the following terms apply:

- *You* may end *your* membership (and therefore the membership of *your dependants*) by informing the *sponsor* within 21 days of either:
 - the date you receive *your* terms and conditions (including *your membership certificate*) confirming your cover or
 - your *cover start date*

whichever is the later. During this 21 day period if you have not made any claims *we* will refund to the *sponsor* all of the subscriptions the *sponsor* has paid for *you* for that *year*.

After this 21 day period *you* can end *your* membership (and therefore the membership of all *your dependants*) by informing the *sponsor* at any time during the *year*. In which case *we* will refund to the *sponsor* any subscriptions the *sponsor* has paid for *you* that relate to the period after *your* membership ends.

- *You* may end the membership of any *dependant* by informing the *sponsor* within 21 days of either:
 - the date you receive *your* terms and conditions (including *your membership certificate*) confirming the cover for that *dependant* or
 - the *cover start date* for that *dependant*

whichever is the later. During this 21 day period if no claims have been made in respect of that *dependant* *we* will refund to the *sponsor* all of the subscriptions the *sponsor* has paid for you that relate to that *dependant* for that *year*.

After this 21 day period *you* can cancel a *dependant's* membership by informing the *sponsor* at any time during the *year*. In which case *we* will refund to the *sponsor* any subscriptions the *sponsor* has paid for *you* in respect of that *dependant* for the period after their membership ends.

Your membership and that of **your dependants** will automatically end if the **sponsor** does not pay subscriptions or any other payment due under the **agreement** for **you** or any other person, however, **we** will continue to pay eligible claims for **you** and/or **your dependant** for the period for which you can provide evidence (eg on payslips) that **you** paid contributions to subscriptions to the **sponsor**.

Where **we** have refunded to the **sponsor** subscriptions paid for **you** or **your dependants**, you should contact the **sponsor** in order to obtain a refund of the contributions **you** made to those refunded subscriptions.

Changes to your membership

If:

- any changes to the terms and conditions of your membership, including your **benefits**, are agreed between the **sponsor** and **us**, or
- **we** change the procedure for making a claim

you will be informed before the change takes effect. If **you** do not accept any of the changes **you** can end your membership by informing the **sponsor** either:

- within 28 days of the date on which the change takes effect or
- within 28 days of **you** being told about the change

whichever is later.

Demands and needs statement

The cover provided under membership of the **scheme** is generally suitable for someone who is looking to cover the cost of a range of health expenses. **We** have not provided you with any advice about your cover and how it meets your individual needs. Please read your **membership certificate** and this membership guide to make sure that the cover meets your needs.

Claiming

Step-by-step guide to making a claim

Step 1 Find out if the Direct Access service is available to you

For certain medical conditions you can call **us** directly for a referral to a **consultant** or **therapist** usually without seeing your **GP** and **we** call this **our** Direct Access service. For details about cover for Direct Access and how it works please see the Benefits section in this guide under the heading 'Direct Access service' and the 'Further details' section of your **membership certificate**.

Step 2 If Direct Access is not available (or if you prefer) – visit your GP for an open referral

Visit your GP. Your **GP** will assess if you need to see a **consultant**. If they decide that you do, ask them for an 'open referral' (unless a paediatric referral is required – see 'Information about cover for children' opposite). This allows **us** to offer you a choice of nearby **recognised practitioners** including **consultants** covered under your policy.

Check within the Group Details section of your membership certificate to see if the Open Referral service applies to your **benefits**.

If the Open Referral service does not apply to your benefits: Some **GPs** may prefer to give a 'named referral' to a certain **consultant**, however you should call **us** before you make an appointment to confirm that **we** recognise them under your **benefits**, to avoid your being liable to pay.

When you call **us we** will:

- help you find a **fee-assured consultant** or **recognised practitioner** within your local area covered under your **benefits** and
- confirm the **benefits** available to you under your cover

If the Open Referral service does apply to your benefits: you must:

- obtain an open referral from your **GP** to ensure that your **treatment** is covered, and to avoid having to return to your **GP** to get an open referral; then
- call **us** to pre-authorise any claim before arranging or receiving any **treatment**. When you call **we** will:
 - help you find a **fee-assured consultant** in **our** list of Open Referral Network **consultants** that applies to your **benefits**
 - help you find a **recognised practitioner** within your local area
 - confirm the **benefits** available to you under your cover.

Important note

Failure to obtain pre-authorisation from **us** means that you will be responsible for paying for all such **treatment** if **we** would not have pre-authorised that **treatment**.

Information about cover for children

It is not always possible for **us** to find you a paediatric **consultant** so when a paediatric referral is required **we** ask that you obtain a named referral from your **GP**.

Some private hospitals do not provide services for children or have restricted services available for children, so **treatment** may be offered at an **NHS** hospital. You can ask **us** about **recognised facilities** where paediatric services are available or you can find them on **finder.bupa.co.uk**

Where **in-patient** or **day-patient eligible treatment** is required, children are likely to be treated in a general children's ward. This is in line with good paediatric practice.

Step 3 Call us

Simply call the number on your **membership certificate** and **we** will talk you through your options. **We** will explain which nearby **consultants**, facilities and healthcare professionals are covered under your **Bupa** membership and provide you with a pre-authorisation number so your healthcare provider can send the bill directly to **us**.

If your **consultant** recommends further tests or **treatment**, it is important you check back with **us** to obtain further pre-authorisation.

Claims checklist

What you will need to make a claim – to help **us** to make the claims process as simple and swift as possible, please have the following information close to hand when you call to make a claim:

- your **Bupa** membership number
- the condition you are suffering from
- details of when your symptoms first began
- details of when you first consulted your **GP** about your condition
- details of the **treatment** that has been recommended

A Information on claiming

A1 Claims other than Cash benefits

If you are a moratorium member

As a **moratorium member** you are not covered for **treatment** of any **moratorium conditions**. Each time you make a claim you must provide **us** with information so **we** can confirm whether your proposed **treatment** is covered under your **benefits**.

Before you arrange any consultation or **treatment** call **us** and **we** will send you a form to complete. You will need to provide details of the history of the medical condition you are claiming for, including information that you will need to ask your **GP** or **consultant** for.

Your **GP** or **consultant** may charge you a fee for providing a report which **we** do not pay. Each claim you make while you are a **moratorium member** will be assessed on this information and any further information **we** ask you to provide to **us** at the time you claim.

Once **we** receive all the information **we** ask you for **we** will:

- confirm whether your proposed **treatment** will be eligible under your **benefits** and, if so, the medical providers or treatment facilities available to you
- confirm the level of **benefits** available to you, and
- tell you whether you will need to complete a claim form.

If you do not need to complete a claim form **we** will treat your submission of your form to **us** as your claim once **we** are notified that you have received your consultation or **treatment**. In most cases **we** will be notified that you have received your consultation or **treatment** by your **consultant** or the provider of your **treatment**.

If you do need to complete a claim form you will need to return the fully completed claim form to **us** as soon as possible and in any event within six months of receiving the **treatment** for which you are claiming unless this was not reasonably possible.

If you are not a moratorium member

When you call **us** **we** will:

- confirm whether your proposed **treatment** will be eligible under your **benefits** and, if so, the medical providers or treatment facilities available to you
- confirm the level of **benefits** available to you, and
- tell you whether you will need to complete a claim form.

If you do not need to complete a claim form, **we** will treat your call to **us** as your claim once **we** are notified that you have received your consultation or **treatment**. In most cases **we** will be notified that you have received your consultation or **treatment** by your **consultant** or the provider of your **treatment**.

If you do need to complete a claim form you will need to return the fully completed claim form to **us** as soon as possible and in any event within six months of receiving the **treatment** for which you are claiming unless this was not reasonably possible.

Case management

If **we** believe you are having **eligible treatment** that could benefit from **our** case management support **we** will provide a case manager to help you navigate through your healthcare experience. Your case manager will contact you by phone and will work with you to understand your individual needs and the best way to help you. This can include discussing options available to you, liaising with healthcare professionals and helping you get the most from your policy.

A2 Claims for Cash benefits

For benefits CB1 NHS cash benefit for NHS hospital in-patient treatment and CB6 NHS cash benefit for treatment for cancer

If you are a moratorium member

Call the helpline and **we** will send you a form to complete. You will need to provide details of the history of the medical condition you are claiming for, including information that you will need to ask your **GP** or **consultant** for. Your **GP** or **consultant** may charge you a fee for providing a report which **we** do not pay. Each claim you make while you are a **moratorium member** will be assessed on this information and any further information **we** ask you to provide to **us** at the time you claim.

Once **we** receive all the information **we** ask you for **we** will:

- confirm whether your **treatment** will be **eligible** for NHS cash benefit
- confirm the level of **benefits** available to you, and
- send you a claim form which you will need to take with you to the hospital and ask them to complete the hospital sections. You will need to return your fully completed form to **us** as soon as possible and in any event within six months of receiving your **treatment** unless this was not reasonably possible

If you are not a moratorium member

Call the helpline to check whether your **treatment** will be eligible for NHS cash benefit. **We** will confirm your **benefits** and send you a claim form which you will need to take with you to the hospital and ask them to complete the hospital sections. You will need to return your fully completed form to **us** as soon as possible and in any event within six months of receiving your **treatment** unless this was not reasonably possible.

For benefits CB2 to CB5

Call the helpline to check your **benefits**. **We** will confirm your **benefits** and tell you whether you need to complete a claim form. You must send **us** either:

- your completed claim form if you need to complete one - in which case you will need to return your fully completed form to **us** as soon as possible and in any event within six months of receiving your **treatment** unless this was not reasonably possible

or

- if you do not need a claim form, a covering letter giving your name, address and membership number together with:
 - for family cash benefit: a copy of **your** child's birth or adoption certificate
 - for other cash benefits: your original invoices and receipts.

A3 Claims for repatriation and evacuation assistance

You **must** contact **us** before any arrangements are made for your repatriation or evacuation. When you contact **us** **we** will check your cover and explain the process for arranging repatriation or evacuation and making a claim. From outside the **UK** - or inside the **UK** when your helpline is closed - call **us** on: **+44 (0)131 588 0542**. Lines open 24 hours 365 days a year. **We** may record or monitor **our** calls.

A4 Treatment needed because of someone else's fault

When you claim for **treatment** you need because of an injury or medical condition that was caused by or was the fault of someone else (a 'third party'), for example, an injury suffered in a road accident in which you are a victim, all of the following conditions apply when you make such a claim:

- you agree you are responsible for the payment of any costs which may ultimately be recovered from the third party
- you must notify **us** as soon as possible that your **treatment** was needed as a result of a third party. You can notify **us** either by writing to **us** or completing the appropriate section on your claim form. You must provide **us** with any further details that **we** reasonably ask you for
- you must take any reasonable steps **we** ask of you to recover from the third party the cost of the **treatment** paid for by **us** and claim interest if you are entitled to do so
- you (or your solicitor) must keep **us** fully informed in writing of the progress and outcome of your claim
- if you recover the cost of any **treatment** paid for by **us**, you must repay the amount and any interest to **us**.

A5 Other insurance cover

You can only claim for eligible private medical costs once. This means that if you have two policies that provide private medical cover, the costs of your **treatment** may be split between **Bupa** and the other insurance company. You will be asked to provide **us** with full details of any other relevant insurance policy at the time of claim.

B How we will deal with your claim

B1 General information

When **we** have determined that your **treatment** is **eligible treatment**, **we** will discuss your claim with you and issue you with a 'pre-authorisation number' confirming the **treatment** is eligible under your current cover.

You can then contact your **consultant** or healthcare professional to arrange an appointment. **We** recommend that you give them your 'pre-authorisation number' so the invoice for your **treatment** costs can be sent to **us** direct.

Please note: If your cover ends for any reason **we** will not pay for any **treatment** that takes place on or after the date your cover ends – even if **we** have pre-authorised the **treatment**.

Except for NHS cash benefit and Family cash benefit, **we** only pay eligible costs and expenses actually incurred by you for **treatment** you receive.

We do not have to pay a claim if you break any of the terms and conditions of your membership, which is related to the claim. **We** may not pay a claim in full or part if there is reasonable evidence that **you** or a **dependant** did not take reasonable care in answering **our** questions. By this we mean giving false information or keeping necessary information from us if:

- intentional, **we** may end the cover or not pay a claim in full or part
- careless, **we** may:
 - if you are not a **contributing member**, withdraw cover, refuse all claims, change your cover or **we** could reduce any claim payment by the same proportion (if applicable)

- if you are a **contributing member**, withdraw cover, refuse all claims and refund all of **your** subscriptions for the **year**, change the cover, need to increase your subscription or we could reduce any claim payment by the same proportion.

Unless **we** tell you otherwise, your claim form and proof to support your claim must be sent to **us**.

We reserve the right to change the procedure for making a claim. If so, **we** will write and tell the **sponsor** about any changes. If **you** are a **contributing member** please see the section 'Contributing members'.

B2 Providing us with information

You will need to provide **us** with information to help **us** assess your claim if **we** make a reasonable request for you to do so. For example, **we** may ask you for one or more of the following:

- medical reports and other information about the **treatment** for which you are claiming
- the results of any independent medical examination which **we** may ask you to undergo at **our** expense
- original accounts and invoices in connection with your claim (including any related to **treatment** costs covered by your **excess** or **co-insurance** – if any). **We** cannot accept photocopies of accounts or invoices or originals that have had alterations made to them.

If you do not provide **us** with any information **we** reasonably ask you for, **we** will be unable to assess your claim.

Obtaining medical reports from your doctor

When you need to request a medical report from your doctor, **we** can do this on your behalf with your consent.

We will always ask for your consent before requesting a report from your doctor on your behalf and we will ask for your consent on the telephone when we explain to you the need for the report. You can choose from three courses of action:

1. You can give your consent without asking to see the report before it is sent to **us**. Your doctor will send the report directly to **us**:

If you give your consent to **us** obtaining a report without indicating that you wish to see it, you can change your mind by contacting your doctor before the report is sent to **us**. In which case you will have the opportunity to see the report and ask your doctor to change the report or add your comments before it is sent to **us**, or withhold your consent for its release.

2. You can give your consent, but ask to see the report before it is sent to **us**, in which case you will have 21 days, after **we** notify you that **we** have requested a report from your doctor, to contact them to make arrangements to see the report.

If you fail to contact your doctor within 21 days, **we** will request they send the report direct to **us**. If however you contact your doctor with a view to seeing the report, you must give them written consent before they can release it to **us**.

You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comment to the report before it is sent to **us**.

3. You can withhold your consent, but if you do, please bear in mind that **we** may be unable to progress with your claim.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask them within six months of the report having been supplied to **us**.

Your doctor is entitled to withhold some or all of the information contained in the report if, in their opinion, this information (a) might cause serious harm to your physical or mental health or that of another person, or (b) would reveal the identity of another person without their consent (other than a healthcare professional in their professional capacity in relation to your care).

We may make a contribution to the costs of any report that **we** have requested on your behalf, this will be confirmed at point of telephone consent. If **we** do make a contribution, you will be responsible for any amount above this.

B3 How we pay your claim

Claims other than Cash benefits: for **treatment** costs covered under your **benefits we** will, in most cases, pay the provider of your **treatment** direct – such as the **recognised facility** or **consultant** – or whichever other person or facility is entitled to receive the payment. Otherwise **we** will pay the **main member**. **We** will write to tell the **main member** when there is an amount for you to pay in relation to any claim (for example if you have an **excess** amount to pay) and who payment should be made to.

Claims for cash benefits: **we** pay eligible claims to the **main member**.

Claims for overseas emergency treatment under benefit 9: **we** only pay eligible claims in £sterling. When **we** have to make a conversion from a foreign currency to £sterling **we** will use the exchange rate published in the **UK's** Financial Times on the Monday of the week in which the first day of your **treatment** takes place.

C If you want to withdraw a claim

If, for any reason, you wish to withdraw your claim for the costs of **treatment** you have received, you should call the helpline to tell **us** as soon as possible. You will be unable to withdraw your claim if **we** have already paid your claim.

If you do withdraw your claim you will be responsible for paying the costs of that **treatment**.

D Treatment costs outside the terms of your cover

When you receive private medical treatment you have a contract with the providers of your **treatment**. You are responsible for paying any costs that are not covered under your **benefits**. In exceptional circumstances, **we** may agree to pay for the costs of **treatment** to which you are not entitled under your cover. If **we** do, this payment will count towards the maximum amount **we** will pay under your related cover. Making these payments does not oblige **us** to make them in the future.

E If you have an excess or co-insurance

The **sponsor** may have agreed with **us** that either an **excess** or **co-insurance** shall apply to your **benefits**. The **membership certificate** shows if one does apply and if so,

- the amount
- who it applies to
- what type of **treatment** it is applied to, and
- the period for which the **excess** or **co-insurance** will apply.

Some further details of how an **excess** or **co-insurance** works are set out below and should be read together with your **membership certificate**.

If you are unsure:

- whether an **excess** or **co-insurance** does apply to you or
- how your **excess** or **co-insurance** works

please refer to your **membership certificate** or contact the helpline.

E1 How an excess or co-insurance works

Having an **excess** or **co-insurance** means that you have to pay part of any **eligible treatment** costs that would otherwise be paid by us up to the amount of your **excess** or **co-insurance**. By **eligible treatment** costs **we** mean costs that would have been payable under your **benefits** if you had not had an **excess** or **co-insurance**.

If your **excess** or **co-insurance** applies each **year** it starts at the beginning of each **year** even if your **treatment** is ongoing. So, your **excess** or **co-insurance** could apply twice to a single course of **treatment** if your **treatment** begins in one **year** and continues into the next **year**.

We will write to the **main member** to tell them who you should pay the **excess** or **co-insurance** to, for example, your **consultant**, **therapist** or **recognised facility**.

The **excess** or **co-insurance** must be paid direct to them – not to **Bupa**. **We** will also write to tell the **main member** the amount of the **excess** or **co-insurance** that remains (if any).

You should always make a claim for **eligible treatment** costs even if **we** will not pay the claim because of your **excess** or **co-insurance**. Otherwise the amount will not be counted towards your **excess** or **co-insurance** and you may lose out should you need to claim again.

E2 How the excess or co-insurance applies to your benefits

Unless **we** say otherwise on your **membership certificate**:

- **we** apply the **excess** or **co-insurance** to your claims in the order in which **we** process those claims
- when you claim for eligible **treatment** costs under a **benefit** that has a benefit limit your **excess** or **co-insurance** amount will count towards your total benefit limit for that **benefit**
- the **excess** or **co-insurance** does not apply to Cash benefits.

Excess and Co-insurance examples

The following are examples only. You should check your **membership certificate** to see how your **excess** or **co-insurance** applies to you and your **benefits**.

Example of how an annual fixed excess works: this is an example only and assumes that all costs are *eligible treatment* costs and:

- an *excess* of £50 a *year*
- an *out-patient* benefit limit of £500 a *year*.

<i>Out-patient</i> benefit limit for the <i>year</i>	£500
You incur costs for <i>out-patient</i> physiotherapy	£250
<i>We</i> pay your <i>therapist</i>	£200
<i>We</i> notify <i>you</i> of <i>excess</i> amount you pay direct to your <i>therapist</i>	£50
Your remaining <i>out-patient</i> benefit limit for the rest of the <i>year</i>	£250
Your remaining <i>excess</i> for the rest of the <i>year</i>	£0

Example of how a rolling excess works: this is an example only and assumes that all costs are *eligible treatment* costs and:

- a rolling *excess* of £100 in any 12 month period
- an *out-patient* benefit limit of £500 a *year*
- that you join the *scheme* on 1 January 2018.

<i>Out-patient</i> benefit limit for the <i>year</i>	£500
On 1 March 2018 you incur costs for <i>out-patient</i> physiotherapy	£150
<i>We</i> pay your <i>therapist</i>	£50
<i>We</i> notify <i>you</i> of <i>excess</i> amount you pay direct to your <i>therapist</i>	£100
Your remaining <i>out-patient</i> benefit limit for the rest of the <i>year</i>	£350
Your remaining <i>excess</i> until 1 March 2019. As you have paid your <i>excess in</i> full you will not have to pay an <i>excess</i> towards any further claims you make until 1 March 2019 when your <i>excess</i> will then return to the full amount of £100	£0

Example of how a co-insurance works: this is an example only and assumes that all costs are *eligible treatment* costs and:

- a *co-insurance* of 20% up to a maximum of £500 each *year*
- an *out-patient* benefit limit of £500 a *year*.

<i>Out-patient</i> benefit limit for the <i>year</i>	£500
You incur costs for <i>out-patient</i> physiotherapy	£250
<i>We</i> pay your <i>therapist</i> 80%	£200
<i>We</i> notify <i>you</i> of the 20% <i>co-insurance</i> payment you pay direct to your <i>therapist</i>	£50
Your remaining <i>out-patient</i> benefit limit for the rest of the <i>year</i>	£250
Your remaining maximum <i>co-insurance</i> for the rest of the <i>year</i>	£450

Benefits

This section explains the type of charges **we** pay for **eligible treatment** subject to your medical condition, the type of **treatment** you need and your chosen medical practitioners and/or treatment facility all being eligible under your **benefits**.

Notes on benefits

The following notes apply equally to all the benefits and should be read together with those benefits.

Restrictions and/or limitations to benefits

Your cover may be limited or restricted through one or more of the following:

- If you are a **moratorium member**
- If you are an **underwritten member**: please note, if **you** and/or **your dependants** are an **underwritten member**, it is important that **you** complete and send **us** the **application form** for **you** and/or for **your dependants** if the **special conditions** section of **your membership certificate** states that **we** require **you** to do so. Until **you** have completed this **we** won't be able to confirm exactly what **your** policy covers **you** and/or **your dependants** for, meaning your claims might take longer for **us** to process or you might not be eligible to claim for **treatment** you need
- Benefit limits: these are limits on the amounts **we** will pay and/or restrictions on the cover you have under your **benefits**. Your **membership certificate** shows the benefit limits and/or restrictions that apply to your **benefits**
- **Excess** or **co-insurance**: these are explained in rule E in the section 'Claiming'. Your **membership certificate** shows if an **excess** or **co-insurance** applies to your **benefits**. If one does apply, your benefit limits shown on your **membership certificate** will be subject to your **excess** or **co-insurance**
- **Overall annual maximum benefit**: this is a limit on the overall amount **we** will pay under your **benefits** each **year**. Your **membership certificate** shows if an **overall annual maximum benefit** applies to your **benefits**. If one does apply, your benefit limits shown on your **membership certificate** will be subject to your **overall annual maximum benefit**. Your **excess**, **co-insurance** and any amounts **we** pay to you that are outside the terms of your cover will count towards your **overall annual maximum benefit**
- If the Open Referral service applies to your **benefits**: check within the 'Group Details' section of your **membership certificate** to see if the Open Referral service applies to your **benefits**. If it does, you must be referred for **treatment** either:
 - by **our** Direct Access service (if you have cover for it) or,
 - by obtaining an open referral from your **GP**. You should then call **us** to pre-authorise your **treatment** and **we** will help you find:
 - a **fee-assured** consultant in **our** list of Open Referral Network **consultants** that applies to your **benefits** or
 - a **recognised practitioner** in your local area

Failure to call **us** to obtain pre-authorization for your **treatment** means that you will be responsible for paying for all such **treatment** if **we** would not have pre-authorized it. The Open Referral service does not apply to referral for a child. For full details of the Open Referral service please see 'A step-by-step guide to making a claim' in the Claiming section of this membership guide.

- Exclusions that apply to your cover: the general exclusions are set out in the section 'What is not covered'. Some exclusions also apply in this section and there may also be exclusions on your **membership certificate**.

Being referred for treatment

Your consultation or **treatment** must follow an initial referral by:

- **our** Direct Access service, if you have cover for it, or
- a **GP** or **therapist**.

Direct Access service

Important: You are only covered for Direct Access when the 'Further Details' section on your **membership certificate** says it is covered and if it is it will also say which medical conditions Direct Access is available for. If you do not have cover for any Direct Access you should ignore all references to Direct Access in this membership guide.

If you do have cover for **our** Direct Access service, it can help provide a fast and convenient way for you to access **eligible treatment** for certain medical conditions without the need for a **GP** referral. Age limits apply to who can use the service. Further details about the Direct Access service, including the age limits that apply, can be found on bupa.co.uk/direct-access or you can call **us**.

Please note:

- **if you are an underwritten member**, before a referral for **treatment** can be made through **our** Direct Access service you may need to provide **us** with certain information to establish that your condition is not a **pre-existing condition** (please see 'B2 Providing us with information' in the 'Claiming' section of this guide for full details)
- **if you are a moratorium member**, before using the Direct Access service you will need to follow the standard process for claiming to establish that your condition is not a **moratorium condition** (please see 'If you are moratorium member' under A1 in the Claiming section of this guide for full details).
- **if monetary limits apply to your benefits for out-patient consultations and therapies** and you have used all the out-patient **benefits** available to you for the **year** you can still use the Direct Access service but any out-patient consultations or therapies you are referred for would not be covered under your **benefits**.

The charge for any telephone assessments required as part of **our** Direct Access process will not:

- erode your **out-patient** benefit limit if you have one, nor
- be subject to your **excess** or **co-insurance** if they apply to your cover

However, if you have an **overall annual maximum benefit**, the charge will count towards your **overall annual maximum benefit**.

If you go on to receive and claim for **eligible treatment** following referral by **our** Direct Access service, that **treatment** will be treated as a normal claim under your cover.

Bupa recognised medical practitioners and recognised facilities

Your cover for **eligible treatment** costs depends on you using certain **Bupa** recognised medical and other health practitioners and **recognised facilities**.

Please note:

- the medical practitioners, other healthcare professionals and *recognised facilities* you use can affect the level of *benefits we* pay you
- certain medical practitioners, other healthcare professionals and *recognised facilities* that *we* recognise may only be recognised by *us* for certain types of *treatment* or treating certain medical conditions or certain levels of benefits
- the medical practitioners, other healthcare professionals and *recognised facilities* that *we* recognise and the type of medical condition and/or type of *treatment* and/or level of benefit that *we* recognise them for will change from time to time.

Your *treatment* costs are only covered when:

- if the Open Referral service does not apply to your *benefits*: the person who has overall responsibility for your *treatment* is a *consultant*. If the person who has overall responsibility for your *treatment* is not a *consultant* then none of your *treatment* costs are covered – the only exception to this is where a *GP* or *our* Direct Access service refers you for *out-patient treatment* by a *therapist, complementary medicine practitioner or mental health and wellbeing therapist*
- if the Open Referral service does apply to your *benefits*: the person who has overall responsibility for your *treatment* is a *consultant* in *our* list of Open Referral Network *consultants* that applies to your *benefits*. If the person who has overall responsibility for your *treatment* is not in *our* list of Open Referral Network *consultants* that applies to your *benefits* then none of your *treatment* costs are covered – the only exception to this is where a *GP* or *our* Direct Access service refers you for *out-patient treatment* by a *therapist, complementary medicine practitioner or mental health and wellbeing therapist*
- the medical practitioner or other healthcare professional and the *recognised facility* are recognised by *us* for treating the medical condition you have and for providing the type of *treatment* you need.

Changes to lists

Where *we* refer to a list that *we* can change, it will be for one or more of the following reasons:

- where *we* are required to by any industry code, law or regulation
- where a contract ends or is amended by a third party for any reason
- where *we* elect to terminate or amend a contract, for example because of quality concerns or changes in the provision of facilities and/or specialist services
- where the geographic balance of the service *we* provide is to be maintained
- where effectiveness and/or costs are no longer in line with similar treatments or services, or accepted standards of medical practice, or
- where a new service, treatment or facility is available.

The lists that these criteria are applied to include the following:

- *advanced therapies*
- *appliances*
- *consultant fees schedule*
- *critical care units*
- *fee-assured consultants*
- *medical treatment providers*
- *prostheses*

- *recognised facilities*
- *recognised practitioners*
- *schedule of procedures*
- *specialist drugs*
- Open Referral Network *consultants*

Reasonable and customary charges

We only pay reasonable and customary charges for *eligible treatment* performed by *recognised practitioners* in the *recognised facility* available under your cover. This means that the amount *we* will pay medical practitioners, other healthcare professionals and/or *treatment* facilities for *eligible treatment* will be in line with what the majority of *our* members are charged for similar *treatment* or services. If you see a *consultant* who does not charge within *our* benefit limits without prior approval from *us*, *we* will fund up to the limits in *our consultant fees schedule*. The schedule will change from time to time.

Details of the schedule can be found at bupa.co.uk/codes

If there is another proven *treatment* for your condition which is available in the *UK*, that is more costly than the *treatment* that the majority of *our* members receive and does not provide a better clinical outcome, *we* will fund what the majority of *our* members are charged for similar *treatment* or services.

What you are covered for

Finding out what is wrong and being treated as an out-patient

Benefit 1 Out-patient consultations and treatment

This benefit 1 explains the type of charges *we* pay for *out-patient treatment*. The benefits you are covered for and the amounts *we* pay are shown on your *membership certificate*. You are not covered for any benefits that are either shown on your *membership certificate* as 'not covered' or do not appear on your *membership certificate*.

benefit 1.1 out-patient consultations

We pay *consultants'* fees for consultations that are to assess your *acute condition* when carried out as *out-patient treatment* and you are referred for the *out-patient* consultation by your *GP, consultant* or our Direct Access service.

We pay for remote consultations by telephone or via any other remote medium with a *consultant* if the *consultant* is, at the time of your *treatment*, recognised by *us* to carry out remote consultations. You can contact *us* to find out if a *consultant* is recognised by *us* for remote consultations or you can access the details at finder.bupa.co.uk

benefit 1.2 out-patient therapies and charges related to out-patient treatment

Out-patient therapies

We pay *therapists'* fees for *out-patient treatment* when you are referred for the *out-patient treatment* by your *GP, consultant* or by *our* Direct Access service.

We pay for remote consultations by telephone or via any other remote medium with a *therapist* if they are, at the time of your *treatment*, recognised by *us* to carry out remote consultations. You can contact *us* to find out if a *therapist* is recognised by *us* for remote consultations or you can access the details at finder.bupa.co.uk

Charges related to out-patient treatment

We pay provider charges for *out-patient treatment* which is related to and is an integral part of your *out-patient treatment*. *We* treat these charges as falling under this benefit 1.2 and subject to its benefit limit.

benefit 1.3 out-patient complementary medicine treatment

We pay **complementary medicine practitioners'** fees for **out-patient treatment** when you are referred for the **treatment** by your **GP** or **consultant**.

We do not pay for any complementary or alternative products, preparations or remedies.

Please see Exclusion 14, 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What is not covered'.

benefit 1.4 diagnostic tests

When requested by your **consultant** to help determine or assess your condition as part of **out-patient treatment** we pay **recognised facility** charges (including the charge for interpretation of the results) for **diagnostic tests**.

We do not pay charges for **diagnostic tests** that are not from the **recognised facility**. (MRI, CT and PET scans are not paid under this benefit – see benefit 1.5.)

benefit 1.5 out-patient MRI, CT and PET scans

When requested by your **consultant** to help determine or assess your condition as part of **out-patient treatment** we pay **recognised facility** charges (including the charge for interpretation of the results), for:

- MRI scans (magnetic resonance imaging)
- CT scans (computed tomography), and
- PET scans (positron emission tomography).

We do not pay charges for MRI, CT and PET scans that are not from the **recognised facility**.

Being treated in hospital

Benefit 2 Consultants' fees for surgical and medical hospital treatment

This benefit 2 explains the type of **consultants'** fees we pay for **eligible treatment**. The **benefits** you are covered for and the amounts we pay are shown on your **membership certificate**. You are not covered for any benefits that are either shown on your **membership certificate** as 'not covered' or do not appear on your **membership certificate**.

benefit 2.1 surgeons and anaesthetists

We pay **consultant** surgeons' fees and **consultant** anaesthetists' fees for **eligible surgical operations** carried out in a **recognised facility**.

benefit 2.2 physicians

We pay **consultant** physicians' fees for **day-patient treatment** or **in-patient treatment** carried out in a **recognised facility** if your **treatment** does not include a **surgical operation** or **cancer treatment**.

If your **treatment** does include an **eligible surgical operation** we only pay **consultant** physicians' fees if the attendance of a physician is medically necessary because of your **eligible surgical operation**.

If your **benefits** include cover for **cancer treatment** and your **treatment** does include **eligible treatment** for **cancer** we only pay **consultant** physicians' fees if the attendance of a **consultant** physician is medically necessary because of your **eligible treatment** for **cancer**, for example, if you develop an infection that requires **in-patient treatment**.

Benefit 3 Recognised facility charges

This benefit 3 explains the type of facility charges *we* pay for *eligible treatment*. The *benefits* you are covered for, including your *facility access* and the amounts *we* pay are shown on your *membership certificate*. You are not covered for any benefits that are either shown on your *membership certificate* as 'not covered' or do not appear on your *membership certificate*.

Important: the *recognised facility* that you use for your *eligible treatment* must be recognised by *us* for treating both the medical condition you have and the type of *treatment* you need otherwise benefits may be restricted or not payable.

benefit 3.1 out-patient surgical operations

We pay *recognised facility* charges for *eligible surgical operations* carried out as out-patient *treatment*. *We* pay for theatre use, including equipment, *common drugs, advanced therapies, specialist drugs* and surgical dressings used during the *surgical operation*.

benefit 3.2 day-patient and in-patient treatment

We pay *recognised facility* charges for *day-patient treatment* and *in-patient treatment*, including *eligible surgical operations*, and the charges *we* pay for are set out in 3.2.1 to 3.2.7.

Using a non-recognised facility

If, for medical reasons, your proposed *day-patient treatment* or *in-patient treatment* cannot take place in a *recognised facility* *we* may agree to your *treatment* being carried out in a treatment facility that is not a *recognised facility*. *We* need full clinical details from your *consultant* before *we* can give *our* decision. If *we* do agree, *we* pay benefits for the *treatment* as if the treatment facility had been a *recognised facility* and when you contact *us* *we* will check your cover and help you to find a suitable alternative treatment facility that is recognised by *Bupa*.

benefit 3.2.1 accommodation

We pay for your *recognised facility* accommodation including your own meals and refreshments while you are receiving your *treatment*.

We do not pay for personal items such as telephone calls, newspapers, guest meals and refreshments or personal laundry.

We do not pay *recognised facility* charges for accommodation if:

- the charge is for an overnight stay for *treatment* that would normally be carried out as *out-patient treatment* or *day-patient treatment*
- the charge is for use of a bed for *treatment* that would normally be carried out as *out-patient treatment*
- the accommodation is primarily used for any of the following purposes:
 - convalescence, rehabilitation, supervision or any purpose other than receiving *eligible treatment*
 - receiving general nursing care or any other services which could have been provided in a nursing home or in any other establishment which is not a *recognised facility*
 - receiving services from a *therapist, complementary medicine practitioner* or *mental health and wellbeing therapist*.

benefit 3.2.2 parent accommodation

We pay for each night a parent needs to stay in the **recognised facility** with their child. **We** only pay for one parent each night. This benefit applies to the child's cover and any charges are payable from the child's **benefits**. The child must be:

- a member under the **agreement**
- under the age limit shown against parent accommodation on the **membership certificate** that applies to the child's **benefits**, and
- receiving **in-patient treatment**.

benefit 3.2.3 theatre charges, nursing care, drugs and surgical dressings

We pay for use of the operating theatre and for nursing care, **common drugs, advanced therapies, specialist drugs** and surgical dressings when needed as an essential part of your **day-patient treatment** or **in-patient treatment**.

We do not pay for extra nursing services in addition to those that the **recognised facility** would usually provide as part of normal patient care without making any extra charge.

For information on drugs and dressings for out-patient or take-home use, please also see Exclusion 14, 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What is not covered'.

benefit 3.2.4 intensive care

We only pay for **intensive care** either:

- when needed as an essential part of your **eligible treatment** if all the following conditions are met:
 - the **intensive care** is required routinely by patients undergoing the same type of **treatment** as yours, and
 - you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**, and
 - the **intensive care** is carried out in the **critical care unit**, and
 - it follows your planned admission to the **recognised facility** for private **treatment**

or

- if unforeseen circumstances arise from a medical or surgical procedure which does not routinely require **intensive care** as part of the **treatment** and:
 - you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**, and
 - the **intensive care** is carried out in the **critical care unit**in which case your **consultant** or **recognised facility** should contact **us** at the earliest opportunity.

If you want to transfer your care from an **NHS** hospital to a private **recognised facility** for **eligible treatment**, **we** only pay if all the following conditions are met:

- you have been discharged from an **NHS critical care unit** to an **NHS** general ward for more than 24 hours, and
- it is agreed by both your referring and receiving consultants that it is clinically safe and appropriate to transfer your care, and
- **we** have confirmed that your **treatment** is eligible under your **benefits**.

However, **we** need full clinical details from your **consultant** before **we** can make **our** decision.

Please remember that any **treatment** costs you incur that are not eligible under your **benefits** are your responsibility.

Please also see Exclusion 19, 'Intensive care' in the section 'What is not covered'.

benefit 3.2.5 diagnostic tests and MRI, CT and PET scans

When recommended by your **consultant** to help determine or assess your condition as part of **day-patient treatment** or **in-patient treatment** we pay **recognised facility** charges for:

- **diagnostic tests** (such as ECGs, X-rays and checking blood and urine samples)
- MRI scans (magnetic resonance imaging)
- CT scans (computed tomography), and
- PET scans (positron emission tomography).

benefit 3.2.6 therapies

We pay **recognised facility** charges for **eligible treatment** provided by **therapists** when needed as part of your **day-patient treatment** or **in-patient treatment**.

benefit 3.2.7 prostheses and appliances

We pay **recognised facility** charges for a **prosthesis** or **appliance** needed as part of your **day-patient treatment** or **in-patient treatment**.

We do not pay for any **treatment** which is for or associated with or related to a prosthesis or appliance that you are not covered for under your **benefits**.

Benefits for specific medical conditions

Benefit 4 Cancer treatment

benefit 4.1 cancer cover

You are only covered for this benefit if your **membership certificate** shows it is covered.

This benefit 4.1 explains what **we** pay for:

- **out-patient treatment** for **cancer**
- **out-patient common drugs, advanced therapies** and **specialist drugs** for **eligible treatment** for **cancer**.

For all other **eligible treatment** for **cancer**, including **out-patient** MRI, CT and PET scans, you are covered on the same basis and up to the same limits as your **benefits** for other **eligible treatment** as set out in benefits 1.5, 2, 3, 6, 7 and 8 in this section.

benefit 4.1.1 out-patient consultations for cancer

We pay **consultants'** fees for consultations that are to assess your **acute condition** of **cancer** when carried out as **out-patient treatment** and you are referred for the **out-patient** consultation by your **GP, consultant** or by **our** Direct Access service.

We pay for remote consultations by telephone or via any other remote medium with a **consultant** if the **consultant** is, at the time of your **treatment**, recognised by **us** to carry out remote consultations. You can contact **us** to find out if a **consultant** is recognised by **us** for remote consultations or you can access the details at finder.bupa.co.uk

benefit 4.1.2 out-patient therapies and charges related to out-patient treatment for cancer

Out-patient therapies

We pay **therapists'** fees for **out-patient treatment** for **cancer** when you are referred for the **treatment** by your **GP, consultant** or by **our** Direct Access service.

We pay for remote consultations by telephone or via any other remote medium with a **therapist** if they are, at the time of your **treatment**, recognised by **us** to carry out remote consultations. You can contact **us** to find out if a **therapist** is recognised by **us** for remote consultations or you can access the details at finder.bupa.co.uk

Charges related to out-patient treatment

We pay provider charges for **out-patient treatment** when the **treatment** is related to and is an integral part of your **out-patient treatment** or **out-patient** consultation for **cancer**.

benefit 4.1.3 out-patient complementary medicine treatment for cancer

We pay **complementary medicine practitioners'** fees for **out-patient treatment** for **cancer** when you are referred for the **treatment** by your **GP, consultant** or by our Direct Access service.

We do not pay for any complementary or alternative products, preparations or remedies.

Please see Exclusion 14 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What is not covered'.

benefit 4.1.4 out-patient diagnostic tests for cancer

When requested by your **consultant** to help determine or assess your condition as part of **out-patient treatment** for **cancer** we pay **recognised facility** charges (including the charge for interpretation of the results) for **diagnostic tests**. We do not pay charges for **diagnostic tests** that are not from the **recognised facility**.

(MRI, CT and PET scans are not paid under this benefit – see benefit 1.5.)

benefit 4.1.5 out-patient cancer drugs

We pay **recognised facility** charges for **common drugs, advanced therapies** and **specialist drugs** that are related specifically to planning and carrying out **out-patient treatment** for **cancer**.

We do not pay for any complementary, homeopathic or alternative products, preparations or remedies for **treatment** of **cancer**.

Please see Exclusion 14, 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What is not covered'.

benefit 4.2 NHS Cancer Cover Plus

You are only covered for this benefit if your **membership certificate** shows it is covered.

We only pay for **eligible treatment** for **cancer** if the following conditions apply:

- the radiotherapy, chemotherapy or **surgical operation** you need to treat your **cancer** is not available to you from your **NHS**, and
- you receive your **treatment** for **cancer** in a **recognised facility**.

Where the criteria set out above do apply, **we** pay for your **eligible treatment** for **cancer** as set out in benefit 4.1.

If you have cover for benefit CB6: if the above criteria apply and you have **eligible treatment** for **cancer** as set out in benefit 4.1 but have part of your **cancer treatment** provided under your **NHS** we pay NHS cash benefit as set out in benefit CB6 for that part of your **cancer treatment** received in the **NHS** if it would otherwise have been covered under your **benefits** for private **treatment**.

Where the criteria set out above do NOT apply, **we** do not cover your **treatment** for **cancer**.

When you are receiving **NHS treatment** for **cancer** we may, at **our** discretion, pay for certain tests, procedures or **treatment** that are for or directly related to your core **NHS treatment** for **cancer** (details of the tests, procedures or **treatment** that may be covered are available upon request). You must have **our** written agreement before you have such tests, procedures or **treatment** and **we** need full clinical details from your **NHS** consultant before **we** can make our decision. **We** will pay for such **treatments** and related **consultants'** fees for **out-patient** consultations relevant to such tests, procedures or **treatment** if all of the following apply to the test, procedure or **treatment**:

- it is a medically essential part of your **NHS treatment** for **cancer**, and
- the test, procedure or **treatment** is carried out in a **recognised facility**, and
- it is requested by your **NHS** consultant oncologist to help determine, assess or refine your **treatment** plan, and
- it is not available to you from your **NHS**.

Where **we** pay for such tests, procedures and **treatment** that is not radiotherapy, chemotherapy or a **surgical operation**, this does not constitute a transfer of your **treatment** from the **NHS** to private **treatment** under your **Bupa** cover.

Benefit 5 Mental health treatment

You are only covered for this benefit if your **membership certificate** shows it is covered. Cover is subject to the limits shown on your **membership certificate**.

We pay for **eligible treatment** of **mental health conditions** as set out in this Benefit 5.

Your **eligible treatment** must be provided by a **consultant** psychiatrist or a **mental health and wellbeing therapist**.

We do not pay for **treatment** of dementia, behavioural or developmental problems.

What we pay for mental health treatment

We pay **consultant** psychiatrists' and **mental health and wellbeing therapists'** fees and **recognised facility** charges for **mental health treatment** as follows:

benefit 5.1 out-patient mental health treatment

We pay fees and charges for **out-patient mental health treatment** as set out in benefits 5.1.1 to 5.1.3.

benefit 5.1.1 consultants' fees

We pay **consultant** psychiatrists' fees for **out-patient** consultations to assess your **mental health condition** and for **out-patient mental health treatment** and you are referred for the consultation or **treatment** by your **GP, consultant** or by **our** Direct Access service.

Remote consultations by telephone or via any other remote medium with a **consultant** psychiatrist are only covered if the **consultant** is, at the time of your **treatment**, recognised by **us** to carry out remote consultations. You can contact **us** to find out if a **consultant** psychiatrist is recognised by **us** for remote consultations or you can access the details at finder.bupa.co.uk

benefit 5.1.2 mental health and wellbeing therapists' fees

We pay **mental health and wellbeing therapists'** fees for **out-patient mental health treatment** when the **treatment** is recommended by your **GP, consultant** or by **our** Direct Access service.

Remote consultations by telephone or via any other remote medium with a **mental health and wellbeing therapist** are only covered if they are, at the time of your **treatment**, recognised by **us** to carry out remote consultations. You can contact **us** to find out if a **mental health and wellbeing therapist** is recognised by **us** for remote consultations or you can access the details at finder.bupa.co.uk

benefit 5.1.3 diagnostic tests

When requested by your **consultant** psychiatrist to help determine or assess your condition as part of **out-patient mental health treatment** we pay **recognised facility** charges (including the charge for interpretation of the results) for **diagnostic tests**.

We do not pay charges for **diagnostic tests** that are not from the **recognised facility**.
(MRI, CT and PET scans are not paid under this benefit – see benefit 1.5.)

benefit 5.2 day-patient and in-patient mental health treatment

Your **membership certificate** shows the maximum number of days that **we** will pay up to for **mental health day-patient treatment** and **mental health in-patient treatment** under your **benefits**.

We only pay for one addiction **treatment** programme in each member's lifetime. This applies to all **Bupa** schemes and/or **Bupa** administered trusts you have been a member and/or beneficiary of in the past or may be a member and/or beneficiary of in the future, whether your being a member and/or beneficiary is continuous or not. By addiction **treatment** programme **we** mean a period of **eligible treatment** carried out as **mental health in-patient treatment** and/or **mental health day-patient treatment** for the **treatment** of substance related addictions or substance misuse, including detoxification programmes.

We pay **consultant** psychiatrists' fees and **recognised facility** charges for **mental health day-patient treatment** and **mental health in-patient treatment** as set out below.

Consultants' fees

We pay **consultant** psychiatrists' fees for **mental health treatment** carried out in a **recognised facility**.

Recognised facility charges

We pay the type of **recognised facility** charges **we** say **we** pay for in benefit 3.

benefit 5.3 treatment otherwise excluded by the 'What is not covered' section

We pay for **eligible treatment** of mental health symptoms related to or arising from **treatment** otherwise excluded by the following exclusions in the 'What is not covered' section of this membership guide:

- Exclusion 1: Ageing, menopause and puberty
- Exclusion 2: AIDS/HIV
- Exclusion 3: Allergies or allergic disorders
- Exclusion 5: Birth control, conception, sexual problems and gender reassignment
- Exclusion 6: Chronic conditions
- Exclusion 10: Cosmetic, reconstructive or weight loss treatment
- Exclusion 11: Deafness
- Exclusion 13: Dialysis
- Exclusion 17: Eyesight
- Exclusion 24: Pregnancy and childbirth

- Exclusion 25: Screening, monitoring and preventative treatment
- Exclusion 26: Sleep problems and disorders
- Exclusion 28: Speech disorders

Additional benefits

Benefit 6 Treatment at home

You are only covered for this benefit if your *membership certificate* shows it is covered.

We may, at **our** discretion, pay for you to receive *eligible treatment at home*. You must have **our** written agreement before the *treatment* starts and **we** need full clinical details from your *consultant* before **we** can make **our** decision. **We** will only consider *treatment at home* if all the following apply:

- your *consultant* has recommended that you receive the *treatment at home* and remains in overall charge of your *treatment*
- if you did not have the *treatment at home* then, for medical reasons, you would need to receive the *treatment* in a *recognised facility*, and
- the *treatment* is provided to you by a *medical treatment provider*.

We do not pay for any fees or charges for *treatment at home* that has not been provided to you by the *medical treatment provider*.

Benefit 7 Home nursing after private eligible in-patient treatment

If this benefit does not appear on your *membership certificate* then you do not have cover for this benefit.

We pay for *home* nursing immediately following private *in-patient treatment* if all the following criteria apply:

the *home* nursing:

- is for *eligible treatment*
- is needed for medical reasons ie not domestic or social reasons
- is necessary ie without it you would have to remain in the *recognised facility*
- starts immediately after you leave the *recognised facility*
- is provided by a *nurse* in your own *home*, and
- is carried out under the supervision of your *consultant*.

You must have **our** written confirmation before the *treatment* starts that the above criteria have been met and **we** need full clinical details from your *consultant* before **we** can determine this.

We do not pay for *home* nursing provided by a community psychiatric nurse.

Benefit 8 Private ambulance charges

If this benefit does not appear on your *membership certificate* then you do not have cover for this benefit.

We pay for travel by private road ambulance if you need private *day-patient treatment* or *in-patient treatment*, and it is medically necessary for you to travel by ambulance:

- from your *home* or place of work to a *recognised facility*
- between *recognised facilities* when you are discharged from one *recognised facility* and admitted to another *recognised facility* for *in-patient treatment*
- from a *recognised facility* to *home*, or
- between an airport or seaport and a *recognised facility*.

Benefit 9 Overseas emergency treatment

If this benefit does not appear on your *membership certificate* then you do not have cover for this benefit.

We pay for emergency *treatment* that you need because of a sudden illness or injury when you are temporarily travelling outside the *United Kingdom*. By temporarily travelling **we** mean a trip of up to a maximum of 28 consecutive days starting from the date you leave the *UK* and ending on the date you return to the *UK*. There is no limit to the number of temporary trips outside the *UK* that you take each *year*.

We do not pay for overseas emergency *treatment* if any of the following apply:

- you travelled abroad despite being given medical advice not to travel abroad
- you were told before travelling that you were suffering from a terminal illness
- you travelled abroad to receive *treatment*
- you knew you would need the *treatment* or thought you might
- the *treatment* is the type of *treatment* that is normally provided by *GPs* in the *UK*
- the *treatment*, services and/or charges are excluded under your *benefits*.

You are not covered for:

- *treatment* provided by a general practitioner
- *out-patient* or take home drugs and dressings.

What we pay for

Subject to the *treatment* being Eligible Treatment **we** pay for the same type of fees and charges and on the same basis as **we** pay for *treatment* in the *UK* as set out in benefits 1, 2 and 3.

Please note: you will need to settle all accounts direct with the medical providers in the country of *treatment* and, on return to the *UK*, submit the itemised and dated receipted invoices to **us** for assessment.

Important: for the purpose of this benefit 9:

- **we** only pay for Eligible Treatment carried out by a consultant, therapist or complementary medicine practitioner who is:
 - fully trained and legally qualified and permitted to practice by the relevant authorities in the country in which your *treatment* takes place, and
 - is recognised by the relevant authorities in that country as having specialised knowledge of, or expertise in, the *treatment* of the disease, illness or injury being treated
- **we** only pay facility charges for Eligible Treatment when the facility is specifically recognised or registered under the laws of the territory in which it stands as existing primarily for:
 - carrying out major surgical operations, and
 - providing treatment that only a consultant can provide
- where **we** refer to Eligible Treatment **we** mean, *treatment* of an *acute condition* together with the products and equipment used as part of the *treatment* that:
 - are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the country in which the overseas emergency treatment is carried out
 - are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided

- are demonstrated through scientific evidence to be effective in improving health outcomes, and
- are not provided or used primarily for the expediency of you or your consultant or other healthcare professional

and the **treatment**, services or charges are not excluded under your **benefits**.

Please also see Exclusion 21, 'Overseas treatment' in the section 'What is not covered'.

Benefit 10 Repatriation and evacuation assistance

If this benefit does not appear on your **membership certificate** then you do not have cover for this benefit.

We only pay repatriation and evacuation assistance benefit at **our** discretion.

We will only consider repatriation or evacuation if all the following apply:

- you do not have any other repatriation or evacuation insurance cover to help you receive the **treatment** you need
- the **treatment** you need is either **day-patient treatment** or **in-patient treatment** that is covered under your **benefits**
- you need to get **eligible treatment** from a **consultant** which, for medical reasons, cannot be provided in the country or location you are visiting.

We will not consider repatriation or evacuation if any of the following apply:

- you travelled abroad despite being given medical advice that you should not travel abroad
- you were told before travelling abroad that you were suffering from a terminal illness
- you travelled abroad to receive **treatment**
- you knew that you would need **treatment** before travelling abroad or thought you might
- repatriation and/or evacuation would be against medical advice.

What we pay for

Important notes: these notes apply equally to benefits 10.1 to 10.3.

- You must provide **us**, and where applicable the **medical assistance company**, with any information or proof that **we** may reasonably ask you for to support your request for repatriation/evacuation.
- **We** only pay costs that are reasonable. **We** only pay costs incurred for you by the **medical assistance company** and only when the arrangements have been made in advance of your repatriation/evacuation by the **medical assistance company**. **We** do not pay any costs that have not been arranged by the **medical assistance company**.
- **We** only pay for transport costs incurred during your repatriation and/or evacuation. **We** do not pay any other costs related to the repatriation and/or evacuation such as hotel accommodation or taxis. Costs of any **treatment** you receive are not covered under this benefit.
- **We** may not be able to arrange evacuation or repatriation in cases where the local situation makes it impossible, unreasonably dangerous or impractical to enter the area; for example from an oil rig or within a war zone. **We** also cannot be held responsible for any delays or restrictions associated with the transportation that are beyond **our** control such as weather conditions, mechanical problems, restrictions imposed by local or national authorities or the pilot.

If **we** agree to your request for repatriation or evacuation **we** pay the following travel costs subject to **us** agreeing with your consultant whether you should be repatriated or evacuated.

benefit 10.1 your repatriation/evacuation

We pay for either:

- your repatriation back to a hospital in the **UK** from abroad for your **day-patient treatment** or **in-patient treatment**, or
- when medically essential, for evacuation to the nearest medical facility where your **day-patient treatment** or **in-patient treatment** is available if it is not available locally. This could be another part of the country you are in or another country, whichever is medically appropriate. Following such **treatment**, **we** pay for your immediate onward repatriation to a hospital in the **UK** but only if it is medically essential that:
 - you are repatriated to the **UK**, and
 - your **day-patient** or **in-patient treatment** is continued immediately after you arrive in the **UK**.

benefit 10.2 accompanying partner/relative

We pay for your **partner** or a relative to accompany you during your repatriation and/or evacuation but only if **we** have authorised this in advance of the repatriation and/or evacuation.

benefit 10.3 in the event of death

If you die abroad **we** will pay reasonable transport costs to bring your body back to a port or airport in the **UK**, including reasonable statutory costs associated with transporting the body, but only when all the arrangements are made by the **medical assistance company**.

To make a claim for repatriation and evacuation assistance

We must be contacted before any arrangements are made for your repatriation or evacuation. **We** will check your cover and explain the process for arranging repatriation or evacuation.

From outside the **UK** - or inside the **UK** when your helpline is closed - call **us** on: **+44 (0)131 588 0542**. Lines open 24 hours 365 days a year. **We** may record or monitor **our** calls.

Cash benefits

Your **membership certificate** shows which Cash benefits (if any) apply to your **benefits** and the benefit limits that apply. If any Cash benefit does not appear on your **membership certificate** then you are not covered for that benefit.

Important note for Cash benefits CB3 to CB5

We do not pay Cash benefits CB3 to CB5 for **you**, if **you** are under 16 years old, or for any **dependant** under 16 years old. If these Cash benefits are included in the cover under the **agreement** they will only apply to **you** or such a **dependant** at **your** or their **cover start date** following **your** or their 16th birthday and then only if the **sponsor** includes that Cash benefit in **your** or their cover from that **cover start date**.

Benefit CB1 NHS cash benefit for NHS hospital in-patient treatment

We pay NHS cash benefit for each night you receive **in-patient treatment** provided to you free under your **NHS**. **We** only pay NHS cash benefit if your **treatment** would otherwise have been covered for private **in-patient treatment** under your **benefits**.

Any costs you incur for choosing to occupy an amenity bed while receiving your **in-patient treatment** are not covered under your **benefits**. By an amenity bed **we** mean a bed for which the hospital makes a charge but where your **treatment** is still provided free under your **NHS**.

Except for NHS cash benefit for oral chemotherapy **treatment** as set out in benefit CB6.2 this benefit CB1 is not payable at the same time as any other NHS cash benefit for **NHS in-patient treatment**.

Benefit CB2 Family cash benefit

We pay Family cash benefit for a **main member** only.

Waiting period. This benefit is only payable if **your benefits** have included cover for Family cash benefit for at least 10 continuous months before the date of **your** child's birth or adoption. If **you** had cover for Family cash benefit under a **previous scheme** **we** take this into account when assessing **your** 10 continuous months cover provided there has been no break in **your** cover between the **previous scheme** and this **scheme**.

What we pay

We pay benefits on the birth or adoption of **your** child during the **year**.

Benefit CB3 Optical cash benefit

We only pay benefits during your **optical benefit period** and only if, at the time you incur the cost of the goods or services for which you are claiming:

- you are covered under the **agreement**, and
- Optical cash benefit is covered under your **benefits**.

What is covered

We pay benefits for the following goods and services when provided to or prescribed for you by an **optician**:

- routine sight tests
- the purchase of prescribed glasses
- the purchase of non-disposable contact lenses.

We also pay benefits when you receive laser eye surgery to correct your sight when provided to you by a **consultant** or other qualified practitioner.

What is not covered

We do not pay for any optical goods or services that are not specified as being covered under this benefit including but not limited to:

- cosmetic contact lenses
- sunglasses whether they have been prescribed for you or not
- prescription diving masks.

Benefit CB4 Accidental dental injury cash benefit

What is covered

We pay benefits for **dental treatment** provided to you by a **dentist** and which you need as a result of an **accidental dental injury**.

Both the **accidental dental injury** and the **dental treatment** needed as a result of it must take place while:

- you are covered under the **agreement**, and
- this benefit CB4 is covered under your **benefits**.

Also, the **dental treatment** must take place within six months of the date you suffered the **accidental dental injury** for which your **dental treatment** is needed.

Benefit CB5 Prescription cash benefit

What is covered

We pay benefits for prescription charges you incur for prescribed medicines and/or devices used to treat a medical condition and/or alleviate symptoms. Eligible prescription charges include those for:

- **NHS** or private prescriptions issued by your **GP**, hospital or consultant
- drugs and/or dressings for take-home use after hospital treatment when prescribed by your consultant or the hospital
- prescription pre-payment certificates.

What is not covered

We do not pay benefit for any prescription charges you incur for medicines used solely to prevent contracting an illness and/or prevent the onset of an illness. For example, we do not pay when a prescription is for prophylactic medication for malaria.

Benefit CB6 NHS cash benefit for treatment for cancer

benefit CB6.1 NHS cash benefit for NHS in-patient treatment for cancer

Except for NHS cash benefit for oral chemotherapy **treatment** as set out in benefit CB6.2 this benefit CB6.1 is not payable at the same time as any other NHS cash benefit for **NHS in-patient treatment**.

We pay NHS cash benefit for each night of **in-patient** stay that you receive radiotherapy, chemotherapy or a **surgical operation** that is for **cancer treatment** when it follows a diagnosis of **cancer**, including **in-patient treatment** related to blood transfusions and marrow transplants, when those are carried out in the **NHS**. The **in-patient treatment** must be provided to you free under your **NHS** and we only pay if your **treatment** would otherwise have been covered for private **in-patient treatment** under your **benefits**.

Any costs you incur for choosing to occupy an amenity bed while receiving your **in-patient treatment** are not covered under your **benefits**. By an amenity bed **we** mean a bed which the hospital makes a charge for but where your **treatment** is still provided free under your **NHS**.

benefit CB6.2 NHS cash benefit for NHS out-patient, day-patient and home treatment for cancer

Except for NHS cash benefit for **eligible treatment** for oral chemotherapy this benefit CB6.2 is:

- not payable at the same time as any other NHS cash benefit for **NHS treatment** and
- only payable once even if you have more than one **eligible treatment** on the same day.

For **eligible treatment** for oral chemotherapy **we** pay this benefit CB6.2 at the same time as another NHS cash benefit you may be eligible for under your **benefits** on the same day.

We pay NHS cash benefit as follows:

- radiotherapy: for each day radiotherapy is received in a hospital setting
- chemotherapy: for each day you receive **treatment** for IV-chemotherapy and for each three-weekly interval of oral chemotherapy, or part thereof
- a **surgical operation**: on the day of your operation

which is **treatment** for **cancer** carried out as **out-patient treatment, day-patient treatment** or in your **home**, when it is provided to you free under your **NHS**.

We only pay NHS cash benefit if your **treatment** would otherwise have been covered for private **out-patient** or **day-patient treatment** under your **benefits**.

What is not covered

This section explains the **treatment**, services and charges that are not covered under Bupa Select. The exclusions are grouped under headings. The headings are just signposts, they are not part of the exclusion. If there is an exception to an exclusion this is shown. In the exceptions where, as an example, **we** refer to specific treatments or medical conditions these are examples only and not evidence that it is covered under your **benefits**.

This section does not contain all the limits and exclusions to cover. For example the benefits set out in the section 'Benefits' also describe some limitations and restrictions for particular types of **treatment**, services and charges. There may also be some exclusions on your **membership certificate**.

This section does not apply to Cash benefits CB2 to CB5 as set out in the section 'Cash benefits'.

Exclusion 1 Ageing, menopause and puberty

We do not pay for **treatment** to relieve symptoms commonly associated with any bodily change arising from any physiological or natural cause such as ageing, menopause or puberty and which is not due to any underlying disease, illness or injury.

Exclusion 2 AIDS/HIV

We do not pay for **treatment** for, related to, or arising from, AIDS or HIV, including any condition which is related to, or results from, AIDS or HIV.

Exception: We pay for **eligible treatment** for or arising from AIDS or HIV if the person with AIDS or HIV:

- became infected five years or more after their current continuous membership began, or
- has been covered for this type of **treatment** under a **Bupa** private medical insurance scheme (including under the **agreement**) since at least July 1987 without a break in their cover.

Exclusion 3 Allergies or allergic disorders

We do not pay for **treatment** to de-sensitise or neutralise any allergic condition or disorder.

Exclusion 4 Benefits that are not covered and/or are above your benefit limits

We do not pay for any **treatment**, services or charges that are not covered under your **benefits**. **We** also do not pay for any **treatment** costs in excess of the amounts for which you are covered under your **benefits**.

Exclusion 5 Birth control, conception, sexual problems and gender reassignment

We do not pay for **treatment**:

- for any type of contraception, sterilisation, termination of pregnancy
- for any type of sexual problems (including impotence, whatever the cause)
- for any type of assisted reproduction (eg IVF investigations or **treatment**), surrogacy, the harvesting of donor eggs or donor insemination
- where it relates solely to the **treatment** of infertility
- for gender reassignments

or **treatment** for or arising from any of these.

Please also see 'Pregnancy and childbirth' in this section.

Exclusion 6 Chronic conditions

We do not pay for **treatment** of **chronic conditions**. By this, **we** mean a disease, illness or injury which has at least one of the following characteristics:

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

Exception: **We** pay for **eligible treatment** arising out of a **chronic condition**, or for **treatment** of acute symptoms of a **chronic condition** that flare up. However, **we** only pay if the **treatment** is likely to lead quickly to a complete recovery or to you being restored fully to your previous state of health, without you having to receive prolonged **treatment**. For example, **we** pay for **treatment** following a heart attack arising out of chronic heart disease.

Please note: in some cases it might not be clear, at the time of **treatment**, that the disease, illness or injury being treated is a **chronic condition**. **We** are not obliged to pay the ongoing costs of continuing, or similar, **treatment**. This is the case even where **we** have previously paid for this type of or similar **treatment**.

We do not consider **cancer** as a **chronic condition**. **We** explain what **we** pay for **eligible treatment** of **cancer** in Benefit 4 Cancer treatment in the 'Benefits' section of this guide.

Please also see 'Temporary relief of symptoms' in this section.

Exclusion 7 Complications from excluded conditions, treatment and experimental treatment

We do not pay any **treatment** costs, including any increased **treatment** costs, you incur because of complications caused by a disease, illness, injury or **treatment** for which cover has been excluded or restricted from your membership. For example, if cover for diabetes is excluded by a **special condition**, and you have to spend any extra days in hospital or a treatment facility after an operation because you have diabetes, **we** would not pay for these extra days.

We do not pay any **treatment** costs you incur because of any complications arising or resulting from experimental **treatment** that you receive or for any subsequent **treatment** you may need as a result of you undergoing any experimental **treatment**.

Exclusion 8 Contamination, wars, riots and terrorist acts

We do not pay for **treatment** for any condition arising directly or indirectly from:

- war, riots, terrorist acts, civil disturbances, acts against any foreign hostility, whether war has been declared or not, or any similar cause
- chemical, biological, radioactive or nuclear contamination, including the combustion of chemicals or nuclear fuel, or any similar event.

Exception: We pay for **eligible treatment** that is required as a result of a terrorist act providing that the act does not cause chemical, biological, radioactive or nuclear contamination.

Exclusion 9 Convalescence, rehabilitation and general nursing care

We do not pay for **recognised facility** accommodation if it is primarily used for any of the following purposes:

- convalescence, rehabilitation, supervision or any purpose other than receiving **eligible treatment**
- receiving general nursing care or any other services which could have been provided in a nursing home or in any other establishment which is not a **recognised facility**
- receiving services from a **therapist, complementary medicine practitioner or mental health and wellbeing therapist**.

Exception: We, pay for **eligible treatment** for rehabilitation in the following circumstances. By rehabilitation **we** mean **treatment** which is aimed at restoring health or mobility or to allow you to live an independent life, such as after a stroke or an accident. **We** will only pay in cases where the rehabilitation:

- is an integral part of **in-patient treatment**, and
- starts within 42 days from and including the date you first receive that **in-patient treatment**, and
- is part of a personalised programme involving at least two different medical therapies, and
- takes place in a **recognised facility**, and
- your **consultant** confirms to **us** that you are physically and mentally able to start the rehabilitation programme within the defined timescales.

Before the rehabilitation starts you must have **our** confirmation that the above criteria have been met and **we** need full details from your **consultant** before **we** can determine this. When all the above criteria have been met **we** pay up to a maximum of 21 consecutive days' rehabilitation.

Exclusion 10 Cosmetic, reconstructive or weight loss treatment

We do not pay for **treatment** to change your appearance, such as a remodelled nose or facelift whether or not it is needed for medical or psychological reasons.

We do not pay for breast enlargement or reduction or any other **treatment** or procedure to change the shape or appearance of your breast(s) whether or not it is needed for medical or psychological reasons, for example, for backache or gynaecomastia (which is the enlargement of breasts in males).

We do not pay for any **treatment**, including surgery:

- which is for or involves the removal of healthy tissue (ie tissue which is not diseased), or the removal of surplus or fat tissue, or
- where the intention of the **treatment**, whether directly or indirectly, is the reduction or removal of surplus or fat tissue including weight loss (for example, surgery related to obesity including morbid obesity)

whether or not the **treatment** is needed for medical or psychological reasons.

We do not pay for **treatment** of keloid scars. **We** also do not pay for scar revision.

Exception 1: **We** pay for **eligible treatment** for an excision of a lesion if any of the following criteria are met:

- a biopsy or clinical appearance indicates that disease is present
- the lesion obstructs one of your special senses (vision/smell/hearing) or causes pressure on other organs
- the lesion stops you from performing the **activities of daily living**.

Before any **treatment** starts you must have **our** confirmation that the above criteria have been met and **we** need full clinical details from your **consultant** before **we** can determine this.

Exception 2: **We** pay for one course/one set of **eligible surgical operations** to restore the appearance of the specific part of your body that has been directly affected:

- by an accident, or
- if your **benefits** include cover for **cancer treatment**, as a direct result of surgery for **cancer**.

We only pay if all the following apply:

- the accident or the **cancer** surgery takes place during your current continuous period of being a member under this **scheme** and/or a member of another **Bupa** scheme and/or a beneficiary of a trust administered by **Bupa** eligible to receive benefits for this type of **treatment** provided there has been no break in your being a member of this **scheme** and/or member and/or beneficiary as applicable and
- this is part of the original **eligible treatment** resulting from the accident or **cancer** surgery.

Before any **treatment** starts you must have **our** confirmation that the above criteria have been met and **we** need full clinical details from your **consultant** before **we** can determine this. **We** do not pay for more than the one course/ one set of **surgical operations** or for repeat cosmetic procedures.

Please also see 'Screening, monitoring and preventive treatment' in this section.

Exclusion 11 Deafness

We do not pay for **treatment** for or arising from deafness caused by a congenital abnormality, maturing or ageing.

Exclusion 12 Dental/oral treatment

We do not pay for any dental or oral **treatment** including:

- the provision of dental implants or dentures, the repair or replacement of damaged teeth (including crowns, bridges, dentures, or any dental prosthesis made by a laboratory technician)

- the management of, or any **treatment** related to, jaw shrinkage or loss as a result of dental extractions or gum disease
- the **treatment** of bone disease when related to gum disease or tooth disease or damage.

Exception 1: *We* pay for an **eligible surgical operation** carried out by a **consultant** to:

- put a natural tooth back into a jaw bone after it is knocked out or dislodged in an unexpected accidental injury
- treat a jaw bone cyst, but not if it is related to a cyst or abscess on the tooth root or any other tooth or gum disease or damage.

Exception 2: *We* pay for an **eligible surgical operation** carried out by a **consultant** to surgically remove a complicated, buried or impacted tooth root, such as an impacted wisdom tooth, but not if the purpose is to facilitate dentures or the **acute condition** relates to a **pre-existing condition** or a **moratorium condition**.

Exclusion 13 Dialysis

We do not pay for **treatment** for or associated with kidney dialysis (haemodialysis), meaning the removal of waste matter from your blood by passing it through a kidney machine or dialyser.

We do not pay for **treatment** for or associated with peritoneal dialysis, meaning the removal of waste matter from your blood by introducing fluid into your abdomen which acts as a filter.

Exception 1: *We* pay for **eligible treatment** for short-term kidney dialysis or peritoneal dialysis if the dialysis is needed temporarily for sudden kidney failure resulting from a disease, illness or injury affecting another part of your body.

Exception 2: *We* pay for **eligible treatment** for short-term kidney dialysis or peritoneal dialysis if you need this immediately before or after a kidney transplant.

Exclusion 14 Drugs and dressings for out-patient or take-home use and complementary and alternative products

We do not pay for any drugs or surgical dressings provided or prescribed for **out-patient** treatment or for you to take home with you on leaving hospital or a treatment facility.

We do not pay for any complementary or alternative therapy products or preparations, including but not limited to homeopathic remedies or substances, regardless of who they are prescribed or provided by or the type of **treatment** or medical condition they are used or prescribed for.

Exception: If your **benefits** include cover for **cancer treatment** *we* pay for **out-patient common drugs, advanced therapies** and **specialist drugs** for **eligible treatment** of **cancer** but only as set out in benefit 4 in the section 'Benefits'.

Please also see 'Experimental drugs and treatment' in this section.

Exclusion 15 Excluded treatment or medical conditions

We do not pay for:

- **treatment** of any medical condition, or
- any type of **treatment**

that is specifically excluded from your **benefits**.

Exclusion 16 Experimental drugs and treatment

We do not pay for **treatment** or procedures which, in **our** reasonable opinion, are experimental or unproved based on established medical practice in the **United Kingdom**, such as drugs outside the terms of their licence or procedures which have not been satisfactorily reviewed by NICE (National Institute for Health and Care Excellence).

Exception: We pay for experimental drug **treatment** for **cancer** subject to the following criteria:

- the use of this drug **treatment** follows an unsuccessful initial licensed **treatment** where available, and
- you speak regularly to **our** nurse, as **we** may reasonably require in order to allow **us** to effectively monitor your **treatment** and provide support, and
- the drug **treatment** has been agreed by a multidisciplinary team that meets the NHS Cancer Action Team standards defined in The Characteristics of an Effective Multidisciplinary Team (MDT),

or

- when your **consultant** provides **us** with one of the following:
 - evidence that the drug **treatment** has been found to have likely benefit on your condition through a predictive genetic test where appropriate/available, or
 - evidence there is a European Medicines Agency (EMA) licence for the drug used to treat **your** condition and the drug is used within its licensed protocol, or
 - evidence that at least one NHS/National Comprehensive Cancer Network (NCCN)/European Society for Medical Oncology (ESMO) protocol exists, other than as part of research/clinical trials protocol, for your exact condition (ie the specific indication including tumour type, staging and phase of **treatment** if relevant), or
 - a published positive opinion on the Orphan Drug EMA Register for your exact condition (ie the specific indication including tumour type, staging and phase of **treatment** if relevant), or
 - Phase III clinical trial results showing clinical efficacy and safety for the drug **treatment** published in a peer-reviewed journal.

Before starting this type of **treatment** you must have **our** confirmation that the above criteria have been met and **we** need full clinical details from your **consultant** before **we** can determine this.

Please also see 'Complications from excluded conditions/treatment and experimental treatment' and 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in this section.

Exclusion 17 Eyesight

We do not pay for **treatment** to correct your eyesight, for example for long or short sight or failing eyesight due to ageing, including spectacles or contact lenses.

We do not pay for laser-assisted cataract surgery.

Exception 1: We pay for **eligible treatment** for your eyesight if it is needed as a result of an injury or an **acute condition**, such as a detached retina.

Exception 2: We pay for **eligible treatment** for cataract surgery using ultrasonic emulsification.

Exclusion 18 Pandemic

We do not pay for **treatment** for or arising from any pandemic disease and/or epidemic disease. By pandemic **we** mean the worldwide spread of a disease with epidemics occurring in many countries and most regions of the world. By epidemic **we** mean more cases of a disease than would be expected for that disease in that area at that time.

Exclusion 19 Intensive care (other than routinely needed after private day-patient treatment or in-patient treatment)

We do not pay for any **intensive care** if:

- it follows an unplanned or an emergency admission to an **NHS** hospital or facility
- it follows a transfer (whether on an emergency basis or not) to an **NHS** hospital or facility from a private **recognised facility**
- it follows a transfer from an **NHS critical care unit** to a private **critical care unit**
- it is carried out in a unit or facility which is not a **critical care unit**.

We do not pay for any **intensive care**, or any other **treatment** in a **critical care unit**, if it is not routinely required as a medically essential part of the **eligible treatment** being carried out.

Exception: **We** pay for **eligible treatment** for **intensive care** but only as set out in benefit 3 in the section 'Benefits'.

Exclusion 20 Learning difficulties, behavioural and developmental problems

We do not pay for **treatment** related to learning difficulties, such as dyslexia, or behavioural problems, such as attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD), or developmental problems, such as shortness of stature.

Exception: If your **benefits** include Benefit 5 Mental health treatment **we** pay for eligible **diagnostic tests** to rule out ADHD and ASD when a **mental health condition** is suspected. You must have **our** confirmation before any **diagnostic tests** are carried out that the above criterion has been met and **we** need full clinical details from your **consultant** before **we** can determine this.

Exclusion 21 Overseas treatment

We do not pay for **treatment** that you receive outside the **United Kingdom**.

Exception 1: If your **benefits** include 'Overseas emergency treatment' **we** pay for Eligible Treatment needed as a result of a sudden illness or injury when you are travelling outside the **UK** but only as set out in benefit 9, in the section 'Benefits'.

Exception 2: If the **treatment** you need is not available in the **UK** and would have been **eligible treatment** except for it not being available in the **UK**, **we** will pay you a contribution up to the cost that **we** would have paid to you to have the standard alternative **treatment** available in the **UK**.

Before the **treatment** starts you must have **our** written confirmation that the above criteria have been met and **we** need full clinical details from your **consultant**, including confirmation that the **treatment** is not available in the **UK**, before **we** can determine this. You will need to settle the claim direct to the medical provider or treatment facility yourself and submit your receipts to **us** before **we** reimburse you up to the level of the alternative **treatment** available in the **UK**.

Please also see 'Exclusion 16 Experimental drugs and treatment' in this section.

Exclusion 22 Physical aids and devices

We do not pay for supplying or fitting physical aids and devices (eg hearing aids, spectacles, contact lenses, crutches, walking sticks, etc).

Exception: **We** pay for **prostheses** and **appliances** as set out in benefit 3, in the section 'Benefits'.

Exclusion 23 Pre-existing conditions

For **underwritten members we** do not pay for **treatment** of a **pre-existing condition**, or a disease, illness or injury that results from or is related to a **pre-existing condition**.

Exception: For **underwritten members we** pay for **eligible treatment** of a **pre-existing condition**, or a disease, illness or injury which results from or is related to a **pre-existing condition**, if all the following requirements have been met:

- **you** have been sent **your membership certificate** which lists the person with the **pre-existing condition** (whether this is **you** or one of **your dependants**)
- **you** gave **us** all the information **we** asked **you** for, before **we** sent **you your** first membership certificate listing the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**
- neither **you** nor the person with the **pre-existing condition** knew about it before **we** sent **you your** first membership certificate which lists the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**, and
- **we** did not exclude cover (for example under a **special condition**) for the costs of the **treatment**, when **we** sent **you your membership certificate**.

Exclusion 24 Pregnancy and childbirth

We do not pay for **treatment** for:

- pregnancy, including **treatment** of an embryo or foetus
- childbirth and delivery of a baby
- termination of pregnancy, or any condition arising from termination of pregnancy.

Exception 1: **We** pay for **eligible treatment** of the following conditions:

- miscarriage or when the foetus has died and remains with the placenta in the womb
- still birth
- hydatidiform mole (abnormal cell growth in the womb)
- foetus growing outside the womb (ectopic pregnancy)
- heavy bleeding in the hours and days immediately after childbirth (post-partum haemorrhage)
- afterbirth left in the womb after delivery of the baby (retained placental membrane)
- complications following any of the above conditions.

Exception 2: **We** pay for **eligible treatment** of an **acute condition** of the member (mother) that relates to pregnancy or childbirth but only if all the following apply:

- the **treatment** is required due to a flare-up of the medical condition, and
- the **treatment** is likely to lead quickly to a complete recovery or to you being restored fully to your state of health prior to the flare-up of the condition without you needing to receive prolonged **treatment**.

Please also see 'Birth control, conception, sexual problems and gender reassignment', 'Screening, monitoring and preventive treatment' and 'Chronic conditions' in this section.

Exclusion 25 Screening, monitoring and preventive treatment

We do not pay for:

- health checks or health screening. By health screening **we** mean where you may or may not be aware you are at risk of, or are affected by a disease or its complications but are asked questions or have tests to find out if you are and which may lead to you needing further tests or **treatment**
- routine tests, or monitoring of medical conditions, including:
 - routine antenatal care or screening for and monitoring of medical conditions of the mother or foetus during pregnancy
 - routine checks or monitoring of **chronic conditions** such as diabetes mellitus or hypertension
- tests or procedures which, in **our** reasonable opinion based on established clinical and medical practice, are carried out for screening or monitoring purposes, such as endoscopies when no symptoms are present
- preventive **treatment**, procedures or medical services
- medication reviews or appointments where you have had no change in your usual symptoms.

Exception: If you are being treated for **cancer**, have strong direct family history of **cancer** and your **consultant** has:

- demonstrated that you are at high risk of recurring **cancer**, due to having triple negative breast **cancer**, strong family history and/or through the use of a validated risk scoring system in line with NICE guidelines and
- recommended that you receive a genetically-based test to evaluate future risk of developing further **cancers**

we pay for this test as well as the recommended prophylactic surgery when it is recommended by your **consultant**. Before you have any tests, procedures or **treatment** you must have **our** written confirmation that the above criteria have been met and **we** will need full clinical details from your **consultant** before **we** can determine this.

Please also see, 'Chronic conditions' and 'Pregnancy and childbirth' in this section.

Exclusion 26 Sleep problems and disorders

We do not pay for **treatment** for or arising from sleep problems or disorders such as insomnia, snoring or sleep apnoea (temporarily stopping breathing during sleep).

Exclusion 27 Special conditions

For **underwritten members we** do not pay for **treatment** directly or indirectly relating to **special conditions**.

We are willing, at your **renewal date**, to review certain **special conditions**. **We** will do this if, in **our** opinion, no **treatment** is likely to be needed in the future, directly or indirectly, relating to the disease, illness or injury referred to in the **special condition** or for a related disease, illness or injury. However, there are some **special conditions** which **we** do not review. If you would like **us** to consider a review of your **special conditions** please call the helpline prior to your **renewal date**. **We** will only determine whether a **special condition** can be removed or not, once **we** have received full current clinical details from your **GP** or **consultant**. If you incur costs for providing the clinical details to **us** you are responsible for those costs, they are not covered under your **benefits**.

Please also see the 'Cover for a newborn baby' rule in the section 'How your membership works'.

Exclusion 28 Speech disorders

We do not pay for **treatment** for or relating to any speech disorder, for example stammering.

Exception: **We** pay for short-term speech therapy when it is part of **eligible treatment** and takes place during or immediately following the **eligible treatment**. The speech therapy must be provided by a **therapist** who is a member of the Royal College of Speech and Language Therapists.

Exclusion 29 This exclusion does not apply to your cover

Exclusion 30 Temporary relief of symptoms

We do not pay for **treatment**, the main purpose or effect of which is to provide temporary relief of symptoms or which is for the ongoing management of a condition.

Exception: **We** may pay for this type of **treatment** if you need it to relieve the symptoms of a terminal disease or illness.

Exclusion 31 Treatment in a treatment facility that is not a recognised facility

We do not pay **consultants'** fees for **treatment** that you receive in a hospital or any other type of treatment facility that is not a **recognised facility**.

If your **facility access** is **partnership facility**, **we** also do not pay for facility charges for **treatment** that you receive in a hospital or any other type of treatment facility that is not a **recognised facility**.

Exception: **We** may pay **consultants'** fees and facility charges for **eligible treatment** in a treatment facility that is not a **recognised facility** when your proposed **treatment** cannot take place in a **recognised facility** for medical reasons. However, you will need **our** written agreement before the **treatment** is received and **we** need full clinical details from your **consultant** before **we** can give **our** decision.

Please also see the section 'Benefits'.

Exclusion 32 Unrecognised medical practitioners, providers and facilities

We do not pay for any of your **treatment** if the consultant who is in overall charge of your **treatment** is not recognised by **Bupa**.

We also do not pay for **treatment** if any of the following apply:

- the consultant, medical practitioner, therapist, complementary medicine practitioner, mental health and wellbeing therapist or other healthcare professional is:
 - not recognised by **Bupa** for treating the medical condition you have and/or for providing the type of **treatment** you need, and/or
 - is not in the list of **recognised practitioners** that applies to your **benefits**,
- if the Open Referral service applies to your **benefits**, the **consultant** is not in **our** list of Open Referral Network **consultants** that applies to your **benefits**
- the hospital or treatment facility is:
 - not recognised by **Bupa** for treating the medical condition you have and/or for providing the type of **treatment** you need, and/or
 - is not in the **facility access** list that applies to your **benefits**
- the hospital or treatment facility or any other provider of services is not recognised by **us** and/or **we** have sent a written notice saying that **we** no longer recognise them for the purpose of **our** private medical insurance schemes.

Bupa does not recognise consultants, therapists, complementary medicine practitioners, mental health and wellbeing therapists or other healthcare professionals in the following circumstances:

- where **we** do not recognise them as having specialised knowledge of, or expertise in, the **treatment** of the disease, illness or injury being treated
- where **we** do not recognise them as having specialised expertise and ongoing experience in carrying out the type of **treatment** or procedure needed
- where **we** have sent a written notice to them saying that **we** no longer recognise them for the purposes of **our** schemes.

Exclusion 33 Moratorium conditions

For **moratorium members we** do not pay for **treatment** of a **moratorium condition**, or a disease, illness or injury that results from or is related to a **moratorium condition**.

Exception: If you apply to add your newborn baby as a **dependant** under your membership and the baby's membership would be as a **moratorium member we** will not apply this exclusion to the baby's cover if **you** have been a member under your **scheme** (and if applicable your **previous scheme**) for at least 12 continuous months before the baby's birth and **you** include the baby as a **dependant** within three months of their birth.

Glossary

Words and phrases printed in ***bold italic*** in these rules and benefits have the meanings set out below.

Word/phrase	Meaning
<i>Accidental dental injury</i>	damage or deformity to teeth or gums arising from an unexpected accidental external impact, including one sustained during participation in a sporting activity.
<i>Activities of daily living</i>	functional mobility, bathing/showering, self-feeding, personal hygiene/grooming, toilet hygiene, fulfilment of work or educational responsibilities.
<i>Acute condition</i>	a disease, illness or injury that is likely to respond quickly to <i>treatment</i> which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
<i>Advanced therapies</i>	new and innovative targeted/bespoke therapies using advanced materials and methods to be used as part of your <i>eligible treatment</i> that are at the time of your <i>eligible treatment</i> included on <i>our</i> list of advanced therapies that applies to your <i>benefits</i> , which is available at <i>bupa.co.uk/policy</i> information and on request. The advanced therapies on the list will change from time to time.
<i>Agreement</i>	the agreement between the <i>sponsor</i> and <i>us</i> under which you have cover for your <i>benefits</i> .
<i>Appliance</i>	any appliance which is in <i>our</i> list of appliances for your <i>benefits</i> at the time you receive your <i>treatment</i> . The list of appliances will change from time to time. Details of the appliances are available on request.
<i>Application form</i>	the questionnaire <i>we</i> provide to <i>you</i> when <i>you</i> and/or <i>your dependants</i> first take out or are added as a <i>dependant</i> to a policy with <i>us</i> which requires <i>you</i> and/or <i>your dependants</i> to disclose details of <i>your</i> and their health, medical history and lifestyle. If <i>you</i> no longer have the application form, <i>you</i> may call <i>us</i> to request a replacement.
<i>Benefits</i>	the benefits specified on your <i>membership certificate</i> for which you are entitled as an individual under the <i>scheme</i> subject to the terms and conditions that apply to your membership in this Bupa Select membership guide including all exclusions.
<i>Bupa</i>	Bupa Insurance Limited. Registered in England and Wales No. 3956433. Registered office: 1 Angel Court, London EC2R 7HJ
<i>Cancer</i>	a malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
<i>Chronic condition</i>	a disease, illness or injury which has one or more of the following characteristics: <ul style="list-style-type: none">■ it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests■ it needs ongoing or long-term control or relief of symptoms■ it requires rehabilitation or for you to be specially trained to cope with it■ it continues indefinitely■ it has no known cure■ it comes back or is likely to come back.

Word/phrase	Meaning
Co-insurance	the percentage of the cost of eligible treatment that you have to pay that would otherwise have been payable under your benefits . The amount you have to pay is subject to a set maximum amount. For details please see rule E in the 'Claiming' section of this guide and your membership certificate .
Common drugs	commonly used medicines, such as antibiotics and painkillers that in our reasonable opinion based on established clinical and medical practice should be used as part of your eligible treatment .
Complementary medicine practitioner	an acupuncturist, chiropractor or osteopath who is a recognised practitioner . You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.
Consultant	<p>a registered medical or dental practitioner who, at the time you receive your treatment:</p> <ul style="list-style-type: none"> is recognised by us as a consultant and has received written confirmation from us of this, unless we recognised him or her as being a consultant before 30 June 1996 is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and is in our list of consultants that applies to your benefits. <p>You can contact us to find out if a medical or dental practitioner is recognised by us as a consultant and the type of treatment we recognise them for.</p>
Consultant fees schedule	<p>the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants' fees based on:</p> <ul style="list-style-type: none"> the type of treatment carried out for surgical operations, the type and complexity of the surgical operation according to the schedule of procedures the Bupa recognition status of the consultant, and where the treatment is carried out both in terms of the treatment facility and the location. <p>The schedule will change from time to time. Details of the schedule can be found at bupa.co.uk/codes</p>
Contributing member	a main member who contributes to the costs of subscriptions for themselves and/or any of their dependants .
Cover end date	<p>the date on which your current period of cover under the scheme ends. This is either the date:</p> <ul style="list-style-type: none"> shown as 'Cover end date' on your membership certificate <p>or if this is not displayed on your membership certificate,</p> <ul style="list-style-type: none"> the day before your renewal date.
Cover start date	the date on which your current period of cover under the scheme starts, shown as 'Cover start date' on your membership certificate .
Critical care unit	any intensive care unit, intensive therapy unit, high dependency unit, coronary care unit or progressive care unit which is in our list of critical care units and recognised by us for the type of intensive care that you require at the time you receive your treatment . The units on the list and the type of intensive care that we recognise each unit for will change from time to time. For details of a hospital or a treatment facility, centre or unit in your recognised facility network visit our consultants and facilities website at finder.bupa.co.uk

Word/phrase	Meaning
Day-patient	a patient who is admitted to a hospital, treatment facility or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
Day-patient treatment	eligible treatment that, for medical reasons, is received as a day-patient .
Dental treatment	dental or oral surgical or medical services (including diagnostic tests) which are needed to diagnose, relieve or cure an accidental dental injury .
Dentist	any general dental practitioner who is registered with the General Dental Council at the time you receive your dental treatment .
Dependant	your partner and any child of yours who, with the sponsor's approval, is a member under the agreement .
Diagnostic tests	investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.
Effective underwriting date	<p>if you are an underwritten member, the date you started your continuous period of cover under the scheme. This is:</p> <ul style="list-style-type: none"> ▪ the date shown as 'Effective underwriting date' on your membership certificate, or if this is not displayed on your membership certificate ▪ your cover start date shown on the first membership certificate we provided that lists you as a member under the scheme or ▪ if you joined the scheme from a previous scheme and we have agreed with the sponsor that no further underwriting would apply, the date of underwriting by the insurer or administrator of your previous scheme. <p>If you are unsure of your effective underwriting date call us and we can tell you.</p>
Eligible surgical operation	eligible treatment carried out as a surgical operation .
Eligible treatment	<p>treatment of:</p> <ul style="list-style-type: none"> ▪ an acute condition or ▪ a mental health condition <p>together with the products and equipment used as part of the treatment that:</p> <ul style="list-style-type: none"> ▪ are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the UK ▪ are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided, for example as specified by NICE (or equivalent bodies in Scotland) in its guidance on specific conditions or treatment where such guidance is available ▪ are demonstrated through scientific evidence to be effective in improving health outcomes, and ▪ are not provided or used primarily for the expediency of you or your consultant or other healthcare professional <p>and the treatment, services or charges are not excluded under your benefits.</p>
Excess	the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits . For details please see rule E in the 'Claiming' section of this guide and your membership certificate .

Word/phrase	Meaning
Facility access	the network of recognised facilities for which you are covered under your benefits as shown on your membership certificate and being either: <ul style="list-style-type: none"> ▪ participating facility, or ▪ partnership facility.
Fee-assured consultant	a consultant who, at the time you receive your treatment , is: <ul style="list-style-type: none"> ▪ recognised by us as a fee-assured consultant and ▪ in the list of fee-assured consultants that applies to your benefits. You can contact us to find out if a consultant is a fee-assured consultant and if they are in the list of consultants that applies to your benefits .
GP	a doctor who, at the time he/she refers you for your consultation or treatment , is on the UK General Medical Council's General Practitioner Register, and <ul style="list-style-type: none"> ▪ has seen you whilst practising in the NHS primary care setting as an NHS GP, or ▪ is a private sector GP who is recognised by us as an independent general practitioner for the purposes of your scheme.
Home	either: <ul style="list-style-type: none"> ▪ the place where you normally live, or ▪ another non-healthcare setting where you want to have your treatment.
In-patient	a patient who is admitted to a hospital or treatment facility and who occupies a bed overnight or longer for medical reasons.
In-patient treatment	eligible treatment that, for medical reasons, is received as an in-patient .
Intensive care	eligible treatment for intensive care, intensive therapy, high dependency care, coronary care or progressive care.
Main member	the person who is covered under the agreement by virtue of being eligible in his or her own right rather than as a dependant .
Medical assistance company	the company who is appointed by Bupa as a medical assistance company for the purpose of its medical insurance schemes for arranging repatriation and/or evacuation at the time that you need repatriation and/or evacuation. The medical assistance company may change from time to time and current details are available on request.
Medical treatment provider	a person or company who is recognised by us as a medical treatment provider for the type of treatment at home that you need at the time you receive your treatment . The list of medical treatment providers and the type of treatment we recognise them for will change from time to time. Details of these medical treatment providers and the type of treatment we recognise them for are available on request or you can access these details at finder.bupa.co.uk
Membership certificate	either: <ul style="list-style-type: none"> ▪ the most recent membership certificate that we issue to you for your current continuous period of membership under the agreement, or ▪ if we do not issue a membership certificate to you the most recent Group Certificate that we issue to your sponsor that provides the details of the cover that applies to you under the agreement.

Word/phrase	Meaning
Mental health and wellbeing therapist	<ul style="list-style-type: none"> ▪ a psychologist registered with the Health Professions Council ▪ a psychotherapist accredited with UK Council for Psychotherapy, the British Association for Counselling and Psychotherapy or the British Psychoanalytic Council ▪ a counsellor accredited with the British Association for Counselling and Psychotherapy, or ▪ a cognitive behavioural therapist accredited with the British Association for Behavioural and Cognitive Psychotherapies <p>who is a recognised practitioner. You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.</p>
Mental health condition	a condition which is a mental health condition according to a reasonable body of medical opinion, and/or which is diagnosed and treated and managed as a mental health condition by a consultant psychiatrist or a mental health and wellbeing therapist . We do not pay for treatment of dementia, behavioural or developmental problems once diagnosed.
Mental health day-patient treatment	eligible treatment of a mental health condition which for medical reasons means you have to be admitted to a recognised facility because you need a period of clinically-supervised eligible treatment of a mental health condition as a day case but do not have to occupy a bed overnight and the mental health treatment is provided on either an individual or group basis.
Mental health in-patient treatment	eligible treatment of a mental health condition that, for medical reasons, is received as an in-patient .
Mental health treatment	eligible treatment as set out in Benefit 5 Mental health treatment in the 'Benefits' section of this guide.
Moratoria start date	<p>if you are a moratorium member, the date you started your continuous period of cover under the scheme. This is:</p> <ul style="list-style-type: none"> ▪ the date shown as 'Moratoria start date' on your membership certificate, or if this is not displayed on your membership certificate ▪ your cover start date shown on the first membership certificate we provided that lists you as a member under the scheme or ▪ if you joined the scheme from a previous scheme and we have agreed with the sponsor that no further underwriting would apply, the date identified by the insurer or administrator of your previous scheme for determining moratorium conditions under your previous scheme. <p>If you are unsure of your moratoria start date call us and we can tell you.</p>
Moratorium condition	<p>any disease, illness or injury or related condition, whether diagnosed or not, which you:</p> <ul style="list-style-type: none"> ▪ received medication for ▪ asked for or received, medical advice or treatment for ▪ experienced symptoms of, or ▪ were to the best of your knowledge aware existed <p>in your moratorium qualifying period immediately before your moratoria start date. By a related condition we mean any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury.</p>

Word/phrase	Meaning
Moratorium member	a member whose membership certificate shows the underwriting method applied to them is moratorium.
Moratorium qualifying period	the number of years stated in the 'Further details' section of your membership certificate as being your moratorium qualifying period.
NHS	<ul style="list-style-type: none"> ▪ the National Health Service operated in Great Britain and Northern Ireland, or ▪ the healthcare system that is operated by the relevant authorities of the Channel Islands, or ▪ the healthcare scheme that is operated by the relevant authorities of the Isle of Man.
Nurse	a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.
Optician	an ophthalmic optician or optometrist who is registered with the General Optical Council.
Optical benefit period	<p>a period of two consecutive years, the entire period of which Optical cash benefit must have been covered under your benefits. Each optical benefit period shall not start until your last optical benefit period expires, this means that:</p> <ul style="list-style-type: none"> ▪ your second optical benefit period will start on the second renewal date following either your original date of joining the scheme or the renewal date on which your first optical benefit period began (as applicable) ▪ your third and any subsequent optical benefit periods will start on the second renewal date following the renewal date on which your immediately preceding optical benefit period began.
Out-patient	a patient who attends a hospital, consulting room, out-patient clinic or treatment facility and is not admitted as a day-patient or an in-patient .
Out-patient surgical operation	an eligible surgical operation received as an out-patient .
Out-patient treatment	eligible treatment that, for medical reasons, is received as an out-patient .
Overall annual maximum benefit	the total amount we pay up to each year for eligible treatment covered under your benefits . This is the amount we pay up to collectively each year for all your eligible treatment and not for each type of treatment individually. Your excess, co-insurance and any treatment costs we pay to you that are outside the terms of your cover all count towards your overall annual maximum benefit.
Participating facility	<p>a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our participating facility list that applies to your benefits, and is recognised by us for both:</p> <ul style="list-style-type: none"> ▪ treating the medical condition you have, and ▪ carrying out the type of treatment you need. <p>The hospitals, treatment facilities, centres or units in the list and the medical conditions and types of treatment we recognise them for will change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>

Word/phrase	Meaning
Partner	your husband or wife or civil partner or the person you live with in a relationship similar to that of a husband and wife whether of the opposite sex or not.
Partnership facility	<p>a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our partnership facility list that applies to your benefits and is recognised by us for both:</p> <ul style="list-style-type: none"> ■ treating the medical condition you have, and ■ carrying out the type of treatment you need. <p>The hospitals, treatment facilities, centres and units in the list and the medical conditions and types of treatment we recognise them for will change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>
Pre-existing condition	<p>any disease, illness or injury for which in the seven years before your effective underwriting date:</p> <ul style="list-style-type: none"> ■ you have received medication, advice or treatment, or ■ you have experienced symptoms <p>whether the condition was diagnosed or not.</p>
Previous scheme	<ul style="list-style-type: none"> ■ another Bupa private medical insurance scheme or Bupa administered medical healthcare trust ■ a private medical insurance scheme or medical healthcare trust provided or administered by another insurer <p>that we specifically agree with the sponsor will be treated as a previous scheme for the purpose of assessing waiting periods, moratoria start date, effective underwriting date or continuous periods of cover as applicable provided that:</p> <ul style="list-style-type: none"> ■ the member has provided us with evidence of their continuous cover under the previous scheme and ■ there is no break in a member's cover between the previous scheme and their scheme.
Prosthesis	any prosthesis which is in our list of prostheses for both your benefits and your type of treatment at the time you receive your treatment . The prostheses on the list may change from time to time. Details of the prostheses covered under your benefits for your type of treatment are available on request.
Recognised facility	<p>either a:</p> <ul style="list-style-type: none"> ■ participating facility, or ■ partnership facility <p>according to the facility access that applies to your benefits.</p>
Recognised practitioner	<p>a healthcare practitioner who at the time of your treatment:</p> <ul style="list-style-type: none"> ■ is recognised by us for the purpose of our private medical insurance schemes for treating the medical condition you have and for providing the type of treatment you need, and ■ is in our list of recognised practitioners that applies to your benefits.
Renewal date	<p>for each period of your cover the date agreed between the sponsor and us on which the group cover is due for renewal.</p> <p>Cover is generally renewed annually. Depending on the month in which you first join the scheme, your initial period of cover may not be a full twelve months. Your benefits and, if you are a contributing member, your subscriptions may change at the renewal date.</p>

Word/phrase	Meaning
Schedule of procedures	the schedule used by Bupa for the purpose of providing benefits which classifies surgical operations according to their type and complexity. The schedule will change from time to time. Not all procedures listed in the schedule are covered under Bupa schemes. Further information on the schedule is available on request. Detail of the schedule can be found at bupa.co.uk/codes
Scheme	the cover we provide as shown on your membership certificate together with this Bupa Select membership guide subject to the terms and conditions of the agreement .
Session	periods of 24 hours during which the specified type of treatment is received for an acute condition .
Special condition	for underwritten members , any exclusions or restrictions to cover that are personal to an individual based on the medical history given to us for that individual. If special conditions apply to an underwritten member's cover these are shown in the 'Special conditions' section for that underwritten member on your membership certificate .
Specialist drugs	drugs and medicines to be used as part of your eligible treatment , which are not common drugs and are at the time of your eligible treatment included on our list of specialist drugs and medicines that applies to your benefits that is available at bupa.co.uk/policyinformation and on request. The specialist drugs on the list will change from time to time.
Sponsor	the company, firm or individual with whom we have entered into an agreement to provide cover.
Surgical operation	a surgical procedure or complex investigative/diagnostic procedure including all medically necessary treatment related to the procedure and all consultations carried out from the time you are admitted to a recognised facility until the time you are discharged, or if it is carried out as out-patient treatment , all medically necessary treatment related to the operation and any consultation on the same day which is integral to the operation.
Therapist	<ul style="list-style-type: none"> ▪ a chartered physiotherapist ▪ a British Association of Occupational Therapists registered occupational therapist ▪ a British and Irish Orthoptic Society registered orthoptist ▪ a Royal College of Speech and Language Therapists registered speech and language therapist ▪ a Society of Chiropractors and Podiatrists registered podiatrist, or ▪ a British Dietetic Association registered dietitian <p>who is Health and Care Professions Council Registered and is a recognised practitioner. You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</p>
Treatment	surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.
Underwritten member	a member who as part of his/her application for cover under the agreement was required to provide (or the main member provided on his/her behalf) details of his/her medical history to us for the purpose of underwriting.
United Kingdom/UK	Great Britain, Northern Ireland, the Channel Islands and the Isle of Man.

Word/phrase	Meaning
<i>Waiting period</i>	a period of continuous cover during which benefits are not payable. The length of any waiting periods that apply to your benefits are shown under the 'Waiting periods' section on your membership certificate .
<i>We/our/us</i>	Bupa .
<i>Year</i>	for each period of your cover, the period beginning on your cover start date and ending on your cover end date for that period of cover. Depending on the month in which you join the scheme your initial year may not be a full twelve months. Your benefits and, if you are a contributing member , your subscriptions may change at the renewal date .
<i>You/your</i>	this means the main member only.

Privacy notice

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you and how we use and protect it. It also provides information about your rights. Further details can be found in our Full Privacy Notice available at bupa.co.uk/privacy. If you do not have access to the internet and would like a paper copy of the Full Privacy Notice, please contact the Bupa Privacy team on **+44 (0) 1784 893706**. Alternatively you can email the team at dataprotection@bupa.com or write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-Upon-Thames, Middlesex TW18 3DZ**. If you have any questions about how we handle your information, please contact us at dataprotection@bupa.com

Information about Bupa

In this privacy notice, references to 'we' or 'us' or 'our' are to Bupa. Bupa is registered with the Information Commissioners Office, registration number Z6831692. Bupa is comprised of a number of trading companies, many of which also have their own data protection registrations. For company contact details, visit bupa.co.uk/legal-notice

Scope of our privacy notice

This privacy notice applies to anyone who interacts with us in relation to our products and services ('you', 'your'), via any channel (eg email, website, telephone, app etc).

Ways in which we obtain personal information

We obtain personal information from you and from certain third parties (eg those acting on your behalf, like brokers, healthcare providers etc). Where you provide us with information about other individuals, you must ensure that they have seen a copy of this privacy notice and are comfortable with you doing this.

Categories of personal information

We process two categories of personal information about you and/or, where applicable, your dependants, namely standard personal information (eg information we use to contact you, identify you or manage our relationship with you); and special categories of information (eg health information, information about race, ethnic origin and religion that allows us to tailor your care, and information about crime in connection with screening).

Purposes and lawful grounds of our processing personal information

We process your personal information for the purposes set out in our Full Privacy Notice, including to administer our relationship with you (including for claims and complaints handling), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and in order to protect the rights, property, or safety of Bupa, our customers, or others. The legal ground upon which we process personal information depends on what category of personal information we process. Standard personal information is normally processed by us on the basis that it is necessary for the performance of a contract, our or a third parties' legitimate interests or it is required or permitted by applicable law.

Marketing and preferences

We may use your personal information to send you marketing by post, telephone, social media platforms, email and text. We only use your personal information to send you marketing if we have either your consent or a legitimate interest. If you don't want to receive personalised marketing about similar Bupa products and services that we think are relevant to you, please contact us at optmeout@bupa.com or write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-Upon-Thames, Middlesex TW18 3DZ**

Processing for Profiling and Automated Decision Making

Like many businesses, we sometimes use automation to provide you with a quicker, better, more consistent and fair service, as well as with marketing information we think will be of interest (including discounts on our products and services). This may involve evaluating information about you and, in some limited cases, using technology to provide you with automatic responses or decisions. You can read more about this in our Full Privacy Notice. You have the right to object to direct marketing and profiling relating to direct marketing. You may also have rights to object to other types of profiling and automated decision-making. Further details are available in our Full Privacy Notice.

Sharing your information

We share your information within the Bupa Group, with relevant policyholders (including your employer if you are covered under a group scheme), with funders commissioning services on your behalf, those acting on your behalf (eg brokers and other intermediaries) and with others who help us provide services to you (eg healthcare providers) or from whom we need information to handle or verify claims or entitlements (eg professional associations). We also share your information in accordance with the law. You can read more about what information may be shared in what circumstances in our Full Privacy Notice.

Transfers outside of the European Economic Area (EEA)

Bupa deals with many international organisations and uses global information systems. As a result, Bupa transfers your personal information to countries outside of the European Economic Area ('EEA'), (the EU member states plus Norway, Liechtenstein and Iceland) for the purposes set out in this privacy policy.

How long we retain your personal information

Bupa retains your personal information in accordance with retention periods calculated in accordance with the criteria detailed in the Full Privacy Notice available on our website.

Your rights

You have rights to have access to your information and to ask us to rectify, erase and restrict use of your information. You also have rights to object to your information being used, to ask for the transfer of information you have made available to us, to withdraw consent to the use of your information and not to be subject to automated decision-making which produce legal effects concerning you or similarly significantly affects you.

Data Protection Contacts

If you have any questions, comments, complaints or suggestions in relation to this notice, or any other concerns about the way in which we process information about you, please contact us at **dataprotection@bupa.com**

You also have a right to make a complaint to your local privacy supervisory authority. Bupa's main establishment is in the UK, where the local supervisory authority is the Information Commissioner, who can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, United Kingdom. Tel: 0303 123 1113 (local rate) or 01625 545 745 (national rate).

Financial crime and sanctions

Financial crime

You agree to comply with all applicable UK legislation relating to the detection and prevention of financial crime (including, without limitation, the Bribery Act 2010 and the Proceeds of Crime Act 2002).

Sanctions

Bupa, through your policy, shall not provide cover or be liable to pay any claim where this would expose Bupa to any sanction, prohibition or restriction under United Nations resolutions, or trade or economic sanctions, laws or regulations of the European Union, United Kingdom, United States of America, and/or all other jurisdictions where Bupa transacts its business, including but not limited to providing medical coverage inside Sudan, Iran, North Korea, Syria, and Cuba.

Notes

Bupa health insurance is provided by:

Bupa Insurance Limited. Registered in England and Wales No. 3956433. Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services Register No. 203332.

Bupa insurance policies are administered by:

Bupa Insurance Services Limited. Registered in England and Wales No. 3829851. Bupa Insurance Services Limited is authorised and regulated by the Financial Conduct Authority. Financial Services Register No. 312526.

You can check the Financial Services Register by visiting <https://register.fca.org.uk> or by contacting the Financial Conduct Authority on 0800 111 6768.

Registered office: 1 Angel Court, London EC2R 7HJ

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