

Your policy summary

Bupa Fundamental Health Insurance

Effective from 1 January 2021



This policy summary contains key information about Bupa Fundamental Health Insurance. Please note that it does not contain the full terms and conditions or the exclusions of cover. These can be found in your membership guide and will be shown on your membership certificate. You should read this carefully and keep it in a safe place.

About your cover

The provider

Bupa Fundamental Health Insurance is provided by Bupa Insurance Limited (Bupa, we, us, our), a subsidiary of The British United Provident Association Limited. Other services are provided by or via other subsidiary companies.

The insurance and the cover that it provides

Bupa Fundamental Health Insurance offers you private medical health insurance which aims to fund medical treatment. It will cover the costs of your eligible treatment in the UK up to the limits of your chosen cover by Bupa recognised consultants, therapists and practitioners and in a recognised facility from within your facility access.

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.

This policy may be fully medically underwritten. This means that any symptoms or conditions you have prior to the start of your policy (before the 'effective underwriting date' shown on your membership certificate) may not be covered, and we may require further medical information to assess your claim, particularly where claims are made early in your policy.

Following medical underwriting you may not have all the cover set out in your membership guide. It is your membership certificate that shows the cover that is specific to you.

Alternatively, moratorium is an underwriting method where the member does not need to declare their medical history to us at the start of their cover under the policy. However, in the event of a claim we will ask the member questions about their (or any relevant dependants') health and medical history and may ask their GP for a medical report (which we do not pay for).

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

Choice of facility

There are three recognised facility networks that can apply to your cover:

- Essential Access facility
- Extended Choice facility, or
- Extended Choice with Central London facility.

The list of hospitals within each recognised facility will change from time to time, so please call us before you receive any treatment.

Where you receive treatment from a Bupa recognised facility that is not in your facility access, we will only pay a percentage of your facility charges.

For details visit our consultants and facilities website at finder.bupa.co.uk

The recognised facility network you choose will affect the price of your cover and the number of facilities you can access. Extended Choice with Central London facility offers the largest selection of recognised facilities, while Essential Access facility provides the smallest.

A recognised facility is a hospital or a treatment facility, centre or unit in accordance with the facility access that applies to your benefits.

Facility access is the network of recognised facilities for which you are covered under your benefits which will be shown on your membership certificate.

Eligibility

To be eligible for this cover the main member and dependants must:

- be resident in the UK
- at the cover start date shown on your membership certificate have been registered continuously with a GP for a period of at least six months, or have access to and be able to provide their full medical records in English, and
- not receive payment for taking part in sports.

Summary of cover

The summary of cover below contains key information about Bupa Fundamental Health Insurance. The full list of benefits, conditions, exclusions, limitations and definitions which apply to Bupa Fundamental Health Insurance can be found in your membership guide. The specific terms of cover that apply to you will be shown on your membership certificate.

Type of cover	Membership guide section	Available benefit
Being treated as an out-patient		
Out-patient consultations	1.1	Paid in full, only when directly following and related to private day-patient or in-patient treatment. Consultations must follow within six months of the discharge date of that treatment and are limited to a maximum of two per year
Out-patient therapies and related charges	1.2	<ul style="list-style-type: none">With a Bupa recognised therapist only when following and directly related to eligible private day-patient or in-patient treatment, within six months of the date of discharge from hospitalUp to £350 a year. This is the total amount we will pay towards therapiesPlease note the therapies benefit limit restriction does not apply when the out-patient treatments are for eligible treatment of cancer
Diagnostic tests and out-patient MRI, CT and PET scans	1.4 and 1.5	Paid in full in a recognised facility
Consultants' fees for surgical and medical hospital treatment	2	<ul style="list-style-type: none">Paid in full only for fee-assured consultants in a recognised facility. Paid to benefit limits for consultants who are not fee-assured consultants in a recognised facilityFor details visit our consultants and facilities website at finder.bupa.co.uk
Recognised facility charges: <ul style="list-style-type: none">out-patient for eligible surgical operations	3.1	Paid in full in a recognised facility

Type of cover	Membership guide section	Available benefit
Being treated in hospital		
Recognised facility charges: <ul style="list-style-type: none"> day-patient and in-patient treatment including eligible surgical operations 	3.2	Paid in full in a recognised facility
Diagnostic tests and MRI, CT and PET scans	3.2.5	Paid in full in a recognised facility
Cancer treatment after a diagnosis of cancer has been confirmed		
Cancer cover	4.1	<ul style="list-style-type: none"> Paid in full Except for MRI, CT and PET scans are not paid under this benefit – see benefit 1.5
NHS cancer cover plus	4.2	Cancer treatment is only covered when the radiotherapy, chemotherapy, drug therapy or surgical operation you need to treat your cancer is not available to you under the NHS
Mental health treatment		
Out-patient, day-patient and in-patient mental health treatment	5	This cover is not included in your policy
Cash benefits		
NHS cash benefit for NHS in-patient treatment	CB1	<ul style="list-style-type: none"> We pay an NHS cash benefit for each night you receive in-patient treatment provided to you free under the NHS. We only pay an NHS cash benefit if your treatment would otherwise have been covered for private in-patient treatment under your benefits <ul style="list-style-type: none"> £50 per night (up to a maximum of 35 nights a year for eligible in-patient treatment) 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 the NHS

Type of cover	Membership guide section	Available benefit
Cash benefits (continued)		
NHS cash benefit for NHS in-patient stays that you receive radiotherapy, chemotherapy or a surgical operation that is for cancer treatment	CB6.1	<ul style="list-style-type: none"> ■ We pay an NHS cash benefit for each night of in-patient stay that you receive radiotherapy, chemotherapy or a surgical operation that is for cancer treatment 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 the NHS and we only pay if your treatment would otherwise have been covered for private in-patient treatment under your benefits <ul style="list-style-type: none"> - £100 each night for NHS in-patient treatment that would otherwise have been covered for private in-patient treatment under your scheme ■ 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 the NHS
NHS cash benefit for NHS out-patient or day-patient treatment or NHS home treatment for cancer	CB6.2	<ul style="list-style-type: none"> ■ We pay an NHS cash benefit as follows: <ul style="list-style-type: none"> - radiotherapy - for each day radiotherapy and/or proton beam therapy is received in a hospital setting - chemotherapy - for each day you receive treatment for IV-chemotherapy - cancer treatment taken by mouth - for each day on which you have a consultation with your consultant and they provide you with a prescription for cancer treatment taken by mouth - 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 the NHS - £100 per day ■ Except for eligible treatment for cancer treatment taken by mouth, this benefit is not payable at the same time as any other NHS cash benefit and 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 ■ We only pay this benefit once even if you have more than one eligible treatment on the same day ■ For eligible treatment for cancer treatment taken by mouth we pay this benefit at the same time as another NHS cash benefit you may be eligible for on the same day
Procedure Specific NHS cash benefit	CB7	<ul style="list-style-type: none"> ■ Available for certain eligible treatments. Call us or go to bupa.co.uk/pscb for more information ■ Except for eligible treatment for cancer treatment taken by mouth, this benefit is not payable at the same time as any other NHS cash benefit ■ We only pay this benefit if your treatment would otherwise have been eligible under your benefits

No claims discount (NCD)

We calculate and apply the NCD for you and each of your dependants individually.

In calculating the subscriptions payable next year we will apply a no claims discount to the subscriptions you would otherwise pay next year based upon the value of the claims paid excluding any excess amounts that you are responsible for paying. As we calculate your subscriptions prior to your renewal date, we will assess all eligible claims paid by us for you:

- in the first 10 months of your first year of cover (or, if you are a dependant and first join the scheme mid-year, the period from your cover start date for that year to the end of month 10 preceding our calculation), and
- for subsequent years, in months 11 and 12 of the previous year plus months one to 10 of the current year.

We apply your no claims discount to your net subscription rate excluding Insurance Premium Tax.

Any NCD increase or discount applied each year for you will form part of the subscriptions on which we will base our no claims discount calculation for you in successive years.

Please note: that payment of a claim may take a few weeks from the date of your treatment, depending on how quickly invoices are submitted to us.

The following table shows how the value of claims paid by us for you will affect your level of no claims discount.

Value of claims paid during the calculation period	Change in discount level applied at the next renewal date (subject to the minimum and maximum discount levels available)
£0.00	Move up the scale by 1 level
£0.01 to £250	Move down the scale by 1 level
£250.01 to £500	Move down the scale by 2 levels
£500.01 and above	Move down the scale by 3 levels

The following table shows the amount of no claims discount that applies for each no claims discount level. Discount level 14 is the maximum discount level available and your no claims discount will therefore never exceed 70%.

Discount level you are on	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Discount you will receive	0%	10%	20%	27.5%	35%	40%	45%	50%	55%	59%	62%	65%	68%	70%

Please note:

- we may change the no claims discount or withdraw it at any time in accordance with the ‘Making changes’ section of your membership guide
- that claims you may make in relation to any of the following benefits do not count as claims in the assessment of the no claims discount to be applied to your subscriptions:
 - NHS cash benefits (benefits CB1, CB6.1 and CB6.2)
 - Anytime HealthLine
 - The charge for any telephone assessments required as part of our Direct Access process.

In addition, any claims we pay for you during the calculation period that fall entirely within your excess will not be counted.

If you are unwell, you should not delay seeking treatment because of the impact it will have on your no claims discount.

What your policy does not cover

Exclusions

The following are significant general exclusions for certain conditions, treatments and services on this policy, full details of which can be found by referring to the relevant exclusion number in the section 'What is not covered' of your membership guide. The section 'What is not covered' also details the other general exclusions on the policy.

Exclusion 1

Ageing, menopause and puberty.

Exclusion 2

Accident and emergency treatment.

Exclusion 3

Allergies, allergic disorders or food intolerances and conditions.

Exclusion 5

Birth control, conception, sexual problems and gender dysphoria or reassignment.

Exclusion 6

Chronic conditions (except for acute symptoms of a chronic condition that flares up).

Note: we do not consider cancer as a chronic condition.

Exclusion 8

Contamination, wars, riots and some terrorist acts.

Exclusion 9

Convalescence, rehabilitation and general nursing home care (exceptions apply for rehabilitation).

Exclusion 10

Cosmetic, reconstructive or weight loss treatment (except for excision of some lesions or surgery to restore appearance after an accident or after surgery for cancer).

Exclusion 12

Dental/oral treatment (exceptions apply for accidents, jaw bone cysts and impacted teeth).

Exclusion 14

Drugs and dressings for out-patient or take-home use and complementary and alternative products (except for cancer treatment).

Exclusion 16

Experimental drugs and treatment (exceptions apply for certain drug treatment for cancer).

Exclusion 18

Pandemic or epidemic disease.

Exclusion 19

Intensive care (except following an eligible procedure in a recognised facility, as defined in benefit 3 of your membership guide).

Exclusion 20

Learning difficulties, behavioural and developmental problems.

Exclusion 21

Overseas treatment or repatriation.

Exclusion 23

Pre-existing conditions (except for a condition that neither you nor the person with the pre-existing condition knew about).

Exclusion 24

Pregnancy and childbirth (various exceptions apply).

Exclusion 25

Screening, monitoring and preventive treatment (except for specific circumstances where you are being treated for cancer).

Exclusion 33

Moratorium conditions.

Exclusion 35

Advanced therapies and specialist drugs (except those included on the list of advanced therapies or specialist drugs that applies to your benefits).

Policy excesses

(See 'Claiming' section of your membership guide for full details.) You can choose to pay a policy excess, where you pay up to the first £100, £150, £200, £250 or £500 of your eligible treatment costs in any policy year and your Bupa Fundamental Health Insurance policy will then pay the rest. The higher your policy excess, the lower your subscription costs will be. The excess is payable per person on the cover. Details of the excess option that you have chosen are shown on your membership certificate.

How long your cover will last

Cover under your policy will last for an initial period of 12 months from your cover start date, unless your policy is subject to a common renewal date.

To identify which applies to you please see your membership certificate or eligibility information leaflet. If you are subject to a common renewal, depending on the month in which you join the scheme, your initial period of cover may not be a full year and your subscription and benefits and those of your dependants may change at the common renewal date. This date may be different from the cover start date shown on your membership certificate.

Cover is automatically renewed each year and will continue until:

- you stop paying subscriptions
- you stop being resident in the UK
- you die
- your policy is cancelled or ends in accordance with the terms and conditions in the membership guide.

Cover for dependants will always end when the main member's cover ends.

You should review and update your cover periodically to ensure it remains adequate for you and your dependants' needs.

Changing your mind

Your right to cancel

You may cancel your membership for any reason by calling us on **0800 010 383*** or writing to us within the later of 21 days of receipt of your policy documents (including your membership certificate) we send you each year confirming your cover, or the cover start date of your policy. If you have not made any claims we will refund all of your subscriptions paid for that year. After this period of time you can cancel your cover at anytime, we will refund any subscriptions you have paid relating to the period after your cover ends.

You may cancel any of your dependants' membership for any reason by calling us on **0800 010 383*** or writing to us within the later of 21 days of receipt of your policy documents (including your membership certificate) we send you each year confirming cover, or the cover start date of your policy. As long as no claims have been made in respect of their cover we will refund all of your subscriptions paid in respect of that dependant's cover for that year. After this period of time you can cancel their cover at anytime, we will refund any subscriptions you have paid relating to the period after their cover ends. (See 'How your membership works' section of your membership guide for full details.)

Getting in touch

The Bupa helpline is always the first number to call if you need help or support. Please call us on **0345 609 0111***, alternatively you can write to us at: **Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

For those with hearing or speech difficulties who use the Relay UK smartphone app or textphone, use the prefix **18001** followed by your Bupa helpline number.

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 to make a claim

For certain medical conditions you can call us directly for a referral to a consultant or therapist usually without consulting a 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 of your membership guide under the heading 'Direct Access service' or visit **bupa.co.uk/direct-access**

Sometimes, when you have had a consultation with another healthcare practitioner before consulting a GP and they believe referral to a consultant is appropriate, a GP appointment may not be clinically necessary. The situations in which we will accept such a referral are set out on **bupa.co.uk/referrals** or you can call us.

If these routes are not available (or if you prefer) – consult a GP.

We accept referrals from a digital GP service.

*We may record or monitor our calls.

Once you have a referral simply call the number on your membership certificate and we will talk you through your options. You will also need to have your Bupa membership number handy when you call. (See 'Claiming' section of your membership guide for full details.)

If your membership lapses for any reason before the completion of your eligible treatment, your claim will not be paid by Bupa.

Important information about cover for children aged 17 or under

When a paediatric referral is required we ask that you obtain a named referral from a 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**

In-patient and day-patient eligible treatment for children is likely to be provided in a general children's ward in line with good paediatric practice.

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.

By phone: **0345 609 0111***

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.

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

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 free on mobile phones and landlines) or **0300 123 9123** (calls to this number cost no more than calls to 01 and 02 numbers).

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

If you refer your complaint to the Financial Ombudsman Service, they will ask for your permission to access information about you and your complaint. We will only give them what is necessary to investigate your complaint and this may include medical information. If you are concerned about this, please contact us.

Your complaint will be dealt with confidentially and will not affect how we treat you in the future. Following the complaints procedure does not affect your right to take legal action.

*We may record or monitor our calls.

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

Privacy notice

Our privacy notice explains how we take care of your personal information and how we use it to provide your cover. A brief version of the notice can be found in your membership guide or the full version is online at bupa.co.uk/privacy

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.

Arranged and administered by:

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

Registered office: 1 Angel Court,
London EC2R 7HJ

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