Your Bupa membership guide

Bupa Fundamental Health Insurance

Essential information explaining your Bupa cover
Please retain
About this guide

Welcome to your Bupa 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 make a 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 italic 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.

For those with hearing or speech difficulties we use Relay UK which offers support for individuals who are deaf, hard-of-hearing, or speech-impaired. Relay UK allows for both smartphone and textphone communication:

- if you are using a smartphone, please download the Relay UK app and follow the steps outlined by the app. Then when you wish to make an outbound call just use the prefix 18001 followed by your Bupa helpline number and you’ll be connected, or
- if you are contacting us on a textphone please use the prefix 18001 followed by your Bupa helpline number.

To update your preferred contact method to Relay UK, please let one of our advisers know.

Demands and needs statement

This policy 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 regarding this policy. If you have purchased through a non-Bupa financial adviser then please refer to the demands and needs statement that they have provided you with.

Please read your membership certificate and this membership guide to ensure that this policy meets your needs.

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.

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 601 3216†**. *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.

**Family Mental HealthLine**
If you are a parent or care for a young person, and have concerns about their mental wellbeing, *our* Family Mental HealthLine is available to provide advice, guidance and support. A trained adviser and/or mental health nurse will listen to what your family is experiencing and give you advice about what to do next.

Call *our* Family Mental HealthLine on **0345 266 7938‡**. The young person does not have to be covered under your policy for you to be able to use this service.

*Bupa Anytime HealthLine and Family Mental HealthLine are not regulated by the Financial Conduct Authority or the Prudential Regulation Authority.*

*Telephone support between 8am to 6pm Monday to Friday.*

*Calls may be recorded and to maintain the quality of our service a nursing manager may monitor some calls always respecting the confidentiality of the call.*
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Effective from date: 1 January 2021
These are the rules and benefits that apply to Bupa Fundamental Health Insurance.

They apply to any main member whose cover start date is on or after the ‘Effective from date’ and to any dependants included in their policy from that dependant’s cover start date.

Words and phrases in bold italic 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 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 Bupa members. It also sets out all the elements of cover that are available for Bupa members under all their schemes. This means that 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 and scheme. 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 differences 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.
Eligibility
To be eligible for this cover the main member and dependants must:
- be resident in the UK
- at their cover start date 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.
How your membership works

The agreement between you and us

In return for you, the main member, paying us subscriptions, we agree to provide you and your dependants (if any) with cover under the terms of our agreement.

Only you and Bupa have legal rights under our agreement, although we will allow anyone who is covered under your membership complete access to our complaints process (please also see sub section ‘Making a complaint’ in this section).

The following documents make up our agreement. These documents must be read together as a whole, they should not be read as separate documents.

- **This Bupa 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 Fundamental Health Insurance.
- **Your membership certificate:** this shows your current membership details including:
  - who is covered by your Bupa membership, the dates when your cover starts and ends
  - the cover that is specific to your benefits, including the limits that apply, any variations to the benefits, terms or conditions explained in this membership guide
  - the subscriptions you will be paying
  - whether an excess applies to your cover and if it does the amount and how it applies
  - any special conditions which apply to you or anyone covered under your membership
  - the type of underwriting that applies to your membership.

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-authorised, 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.
Other than in relation to the reimbursement of eligible treatment costs, there is no contract between you and us in respect of any private medical treatment or any other clinical services that you receive under your policy. We are not the provider of these things and this means that we are not responsible for the delivery of your private medical treatment or other clinical services.

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 or dependant having treatment (when aged 16 and over) when there is an amount for them to pay in relation to any claim (for example if they 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 cover starts on your cover start date.

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

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.

During this period, if you have not made any claims we will refund all of your subscriptions for that year. After this period of time you can cancel your cover at any time, 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 for that dependant, or
- the cover start date of that dependant.

During this period, 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 any time, we will refund any subscriptions you have paid relating to the period after their cover ends.

*We may record or monitor our calls.
Renewing your membership

Our agreement is an annual one and your membership may be renewed each year on your renewal date, subject to the rule ‘Making changes’ in this section.

Your membership will renew automatically as long as you continue to pay your subscriptions and any other charges unless:
- you decide to end your membership
- we decide to end the scheme, or
- we do not agree to your membership or the membership of any of your dependants renewing.

If we decide to end the scheme or we do not agree to your membership or the membership of any of your dependants renewing we will write to let you know at least 28 days before your renewal date.

How membership can end

You can end your membership or the membership of any of your dependants at any time by calling us on 0800 010 383* or writing to us. We will refund any subscriptions you have paid which relate to a period after your or your dependant’s cover ends. If your membership ends the membership of all your dependants will also end.

Your membership and that of all your dependants will automatically end if:
- you do not renew your membership
- you do not pay your subscriptions, or any other payment you have to make in respect of the cover, on or before the date they are due. In the event of your membership terminating as a result of your failing to pay subscriptions in respect of your membership, on the due date, Bupa may at its sole discretion permit your membership and that of your dependants to continue, on condition that the overdue subscriptions payable in respect of your membership are received by Bupa within 30 days of the due date
- you stop being resident in the UK (you must inform us if you stop being resident in the UK)
- we do not have the correct address for you, and we are unable to confirm your correct address after using reasonable efforts to do so, then we will cancel your policy at renewal as we will not be able to confirm that you still require cover
- you die, or
- we decide to end your scheme.

A dependant’s membership will automatically end if:
- your membership ends
- you do not renew the membership of that dependant
- that dependant stops being resident in the UK (you must inform us if a dependant stops being resident in the UK)
- that dependant dies, or
- we decide to end their scheme.

*We may record or monitor our calls.
**When we may cancel cover**

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**) then if this was:

- intentional, **we** may treat *your* or (if applicable) *your dependant’s* cover as if it never existed and refuse to pay all claims
- careless, then depending on what **we** would have done if *you* or they had answered **our** questions correctly, **we** may treat *your* or (if applicable) *your dependant’s* cover as if it never existed and refuse to pay all claims (in which case **you** may need to repay any claims **we** have paid and **we** will return any subscriptions *you* have paid in respect of *your* or (if applicable) *your dependant’s* cover), change *your* or their cover, or **we** could reduce any claim payment.

**We** can cancel or refuse to renew a *main member’s* or a *dependant’s* cover if, in **our** reasonable opinion, **our** relationship with that *main member* or *dependant* has broken down. Such circumstances include but are not limited to:

- being abusive to **our** staff or providers
- issuing court proceedings entirely without merit
- any action which leads **us** to believe the member will not act in good faith in their dealings with **us**.

**Joining another Bupa scheme**

If **we** decide to close the **scheme**, **we** may offer *you* the opportunity to join another **Bupa** private medical scheme on the basis of the terms and conditions of the new scheme that **we** offer *you*.

- If *you* and any of *your dependants* are *underwritten members* or *moratorium transfer members* and transfer within one month **we** will not add any *special conditions* to *your* (and their) membership under the new scheme other than those that apply under this **scheme**.
- If *you* and any of *your dependants* are *moratorium members* and transfer within one month **we** will keep the *moratorium start date* that applies to *your* (and their) cover under this **scheme** and not restart it upon transfer to the new scheme.

If your membership ends for any other reason you may apply to join another **Bupa** private medical scheme. You may only do this as long as your membership didn’t end because of any of the circumstances set out in the section ‘When we may cancel cover’. **We** will consider your application at **our** sole discretion.

**Paying subscriptions and other charges**

*You* must pay subscriptions including Insurance Premium Tax (IPT) in advance throughout **your** membership. **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 subscriptions and claims monies. The amount and method of payment is shown on **your membership certificate**.
**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 the month 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: 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.

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

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%.

<table>
<thead>
<tr>
<th>Discount level you are on</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount you will receive</td>
<td>0%</td>
<td>10%</td>
<td>20%</td>
<td>27.5%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
<td>55%</td>
<td>59%</td>
<td>62%</td>
<td>65%</td>
<td>68%</td>
<td>70%</td>
</tr>
</tbody>
</table>
Please note:

- *we* may change the no claims discount or withdraw it at any time in accordance with the ‘Making changes’ section of this 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 service.

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.

**Making changes**

**Changes we can make**

*We* can change the terms and conditions of the membership at your renewal date. These changes could affect:

- how *we* calculate subscriptions, the amount *you* have to pay, how often *you* pay them and the method of payment, the no claims discount, (the cost of subscriptions has typically risen higher than the retail price index (RPI) over the same period, but this does not mean that they will increase by the same rate in the future), and
- the amount and type of cover provided under the *scheme*.

*We* can, at any time, change the amount *you* have to pay *us* in respect of Insurance Premium Tax (IPT) or any other taxes, levies or charges that may be introduced and which are payable in respect of your cover if there is a change in the rate of IPT or if any such taxes, levies or charges are introduced.

For underwritten members who are not underwritten transfer members: *we* will not add any special conditions to someone’s cover for medical conditions that started after their effective underwriting date provided they gave *us* all the information *we* asked for before their effective underwriting date.

For moratorium transfer members and underwritten transfer members: *we* will not add any special conditions to someone’s cover for medical conditions that started after the date they joined the scheme provided they gave *us* all the information *we* asked for at the time of their transfer.

If *we* do make any changes to the terms and conditions of *your* membership *we* will write to tell *you* at least 28 days before the change takes effect. If *you* do not accept any of the changes *you* can cancel *your* Bupa policy within the later of:

- 28 days of the date on which the change takes effect, or
- 28 days of *Bupa* telling *you* about the change.
Changes you can make
At your renewal date you can apply to:
- add, remove or change an excess
- change any of the product options you have chosen
if such options are available under your scheme. We will consider your application at our sole discretion. If you apply to increase cover under the scheme, we may ask you to agree to special conditions before we accept your application.

These changes may also affect the subscriptions you have to pay.

Changes your authorised signatory can make
If you have agreed with us that your partner has the authority to make changes to your cover, your partner can make changes to the cover of anyone included under your membership as if your partner were the main member. However, your partner may not end the cover.

Other parties
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 main member and us and confirmed in writing.

General information

Change of address
You must call or write to tell us if you change your address or you stop (or any of your dependants stop) being resident in the UK. Please note that if we do not have the correct address for you, and we are unable to confirm your correct address after using reasonable efforts to do so, then we will cancel your policy at renewal as we will not be able to confirm that you still require cover.

Correspondence and documents
All membership documents are sent to the main member.

All claims correspondence is sent to the main member, or to the dependant having the treatment when they are aged 16 and over.

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.

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.

*We may record or monitor our calls.
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.

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
Understanding your cover

This section aims to help you understand how your cover works. As your out-patient cover is limited, it is important that you understand what is covered and what is not covered. Your out-patient cover for cancer treatment is different and is set out in Benefit 4 in the ‘Benefits’ section of this guide and your membership certificate.

Below is only an example of how your cover works in practice. You should always refer to your membership certificate and this membership guide to understand the full details of your cover. You can also call us on the dedicated number you will find on your membership certificate if you are unsure of your cover.

1 You consult a GP and they recommend seeing a consultant or therapist

Excluded treatment

- Consultations and therapies before hospital treatment are not included in your Bupa cover except for cancer treatment – see Benefit 4 in the section ‘Benefits’ and your membership certificate for details of your cover for cancer treatment.
- For certain medical conditions you may be able to use our Direct Access service for referral to a consultant or therapist usually without consulting a GP. For details about cover for Direct Access and how it works see the Benefits section of this guide under the heading ‘Direct Access service’.
- You may choose to self-pay for a private consultation or therapy or use the NHS.
- Use Consultant Finder or call Bupa to support your choice of consultant as selecting a fee-assured consultant recognised for the condition under investigation, will help ensure future eligible claims for consultants’ fees for hospital treatment, should you need it, are within your benefit limits.

2 You visit your consultant and they advise diagnostic scans or tests

Included treatment

Eligible facility charges for diagnostic scans and tests covered when requested by a GP or consultant and undertaken in a recognised facility.

If the tests will be done privately, contact Bupa member services at this stage on 0345 609 0111* and we will talk you through your options.

Excluded treatment

Any subsequent consultations before hospital treatment are not covered.

*We may record or monitor our calls.
3 Your scans or tests are completed and a diagnosis given. You are advised you need treatment in hospital

**Included treatment**
Eligible hospital *treatment* costs are paid in full when you use a *fee-assured consultant* and a *recognised facility*.

Contact *us* before arranging any *treatment* to check your *benefits* and pre-authorise your *treatment*.

4 Following your procedure, when you come out of hospital you may need a further consultation and follow-up physiotherapy

**Included treatment**
Eligible therapy and consultation costs are covered within six months of discharge date (the six months limit does not apply for *cancer treatment* – please see your *membership certificate* and the detail in this membership guide to understand specific cover, limits and exceptions).

Contact *us* again so *we* can pre-authorise the next steps of your *treatment*.
Being referred for treatment
Your consultation or treatment must follow an initial referral by:
- our Direct Access service, if you have cover for it as explained in Step 1
- a GP (including via a digital GP service), or
- another healthcare practitioner. The situations in which we will accept such a referral are set out on bupa.co.uk/referrals

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 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 in this guide under the heading ‘Direct Access service’.

Step 2  If Direct Access is not available or if you prefer – consult a GP
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.

The GP will assess if you need to see a consultant. If you do, the GP will directly refer you or provide you with a referral letter which will detail the type of specialist the GP would like you to see.

As out-patient consultations are only covered when directly following and related to private out-patient surgical operations, day-patient treatment and in-patient treatment and takes place within the six months following the discharge date of that treatment, this means your cover does not include diagnostic consultations. Your out-patient cover for cancer treatment is different and you should refer to Benefit 4 in the ‘Benefits’ section of this guide and your membership certificate for details of your cover.

However, we strongly recommend that you ensure your selected consultant is a fee-assured consultant.
Step 3  Your consultant determines that treatment is needed – call us

As soon as your consultant determines that you require treatment, please call us so that we can discuss your options. We will let you know what you need to do next and send you any necessary forms you, or your consultant may need to complete.

Step 4  Get a pre-authorisation number

When we have determined that your treatment is covered, we will talk you through your options. We will help you find nearby consultants, facilities and recognised practitioners who are covered under your benefits (for paediatric referrals see ‘Information about cover for children below) and provide you with a ‘pre-authorisation’ number. You can then contact your consultant or healthcare provider to arrange an appointment. We recommend you give your pre-authorisation number to the consultant or healthcare professional you see so that the invoice for any treatment costs can be sent to us directly.

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

We strongly advise you to call us before arranging or receiving any treatment to pre-authorise it, as you will be responsible for paying any fees or charges that are not covered under your benefits.

Information about cover for children aged 17 or under

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 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

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.

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
- details of the condition you are suffering from
- details of when your symptoms first began
- details of when you first consulted a GP about your condition
- details of the treatment that has been recommended.

Claims Line 0345 609 0111*

*We may record or monitor our calls.
A Information on claiming

A1 Claims other than Cash benefits

If you are a moratorium member

When you joined the scheme as a moratorium member you agreed you would not be 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 pre-treatment 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 during your membership 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
- if you wish to make a claim, 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 pre-treatment 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 an underwritten 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
- if you wish to make a claim, 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
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 and if so the level of benefits available to you, and
  - if required, 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 an underwritten member
Call the helpline and we will:
- confirm whether your treatment will be eligible for NHS cash benefit and if so the level of benefits available to you, and
- if required, 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.

A3 Treatment needed because of someone else’s fault
When you claim for treatment 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.

A4 Other insurance cover
You can only claim for eligible private medical costs once. This means if you have two policies that provide private medical cover, the cost 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, 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 or a dependant break any of the terms and conditions of your or their membership, which are related to the claim. 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) then if this was:
- intentional, we may treat your or (if applicable) your dependant’s cover as if it never existed and refuse to pay all claims
- careless, then depending on what we would have done if you or they had answered our questions correctly, we may treat your or (if applicable) your dependant’s cover as if it never existed and refuse to pay all claims (in which case you may need to repay any claims we have paid and we will return any subscriptions you have paid in respect of your or (if applicable) your dependant’s cover), change your or their cover, or we could reduce any claim payment.

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

Medical reports – when we need more information from your doctor
When we need to ask your doctor for more information, in writing about your consultation, tests or treatment for insurance purposes, we will need your permission. The Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (NI) Order 1991 give you certain rights, which are:

1. You can give permission for your doctor to send us a medical report without asking to see it before they send it to us.
2. You can give permission for your doctor to send us a medical report and ask to see it before they send it to us.
   - You will have 21 days from the date we ask your doctor for your medical report to contact them and arrange to see it.
   - If you do not contact your doctor within 21 days we will ask them to send the report straight to us.
   - You can ask your doctor to change the report if you think it is inaccurate or misleading. If they refuse, you can insist on adding your own comments to the report before they send it to us.
   - Once you have seen the report, it will not be sent to us unless you give your doctor permission to do so.
3. You can withhold your permission for your doctor to send us a medical report. If you do, we will be unable to see whether the consultation, test or treatment is covered by your policy, and we will not be able to give you a pre-authorisation number or confirm whether we can contribute to the costs.

In any event you also have the right to ask your doctor to let you see a copy of your medical report within six months of it being sent to us.

Your doctor can withhold some or all the information in the report if, in their view, the information:
- might cause physical or mental harm to you or someone else, or
- it would reveal someone else’s identity without their permission (unless the person is a healthcare professional and the information is about your care provided by that person).

We may be able to pay towards the cost of a medical report. We will let you know when we ask for your permission to request the report from your doctor. If we can pay towards it, you will need to pay any remaining amount.
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 or dependant having treatment (when aged 16 and over) when there is an amount for them to pay in relation to any claim (for example if they have an excess amount to pay) and who payment should be made to (for example their consultant or treatment facility).

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

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. Any costs that are not covered under your benefits you are responsible for paying.

E If you have an excess
You may have agreed with us that an excess shall apply to your benefits. Your 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 will apply.

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

If you are unsure whether an excess does apply to you please refer to your membership certificate or contact the helpline.

E1 How an excess works
Having an excess 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. By eligible treatment costs we mean costs that would have been payable under your benefits if you had not had an excess. Costs you incur for treatment that are not payable under your benefits do not count towards your excess.
If your excess applies each year it starts at the beginning of each year even if your treatment is ongoing. So, your excess 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 or dependant having treatment (when aged 16 and over) to tell them who to pay their excess to, for example, their consultant, therapist or recognised facility. The excess must be paid direct to them - not to Bupa.

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

**E2 How the excess applies to your benefits**
Unless we say otherwise in your membership certificate:

- we apply the excess to your claims in the order in which we process those claims
- except for Benefit 1.2, when you claim for eligible treatment costs under a benefit that has a benefit limit, your excess amount will count towards your total benefit limit for that benefit
- the excess does not apply to: Benefit 1.2 out-patient therapies and charges related to out-patient treatment or cash benefits.
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 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.
- **Benefits 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**: this is explained in rule E in the section ‘Claiming’. Your membership certificate shows if an excess applies to your benefits. If one does apply, your benefit limits shown in your membership certificate will be subject to your excess.
- **Exclusions 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. For details about cover for Direct Access and how it works see the section ‘Direct Access service’
- a GP (including via a digital GP service), or
- another healthcare practitioner. The situations in which we will accept such a referral are set out on bupa.co.uk/referrals

Direct Access service

Our Direct Access service 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.
Except for *cancer treatment* as set out in Benefit 4, your *benefits* do not cover *out-patient* consultations and therapies before hospital *treatment*, however, you can still use the Direct Access service but any *out-patient* consultations or therapies the Direct Access service may refer you for would not be covered under your *benefits*. You would, therefore, need to choose whether to pay yourself for a private *out-patient* consultation or therapy or use the *NHS*. If you decide to pay yourself call *us* and *we* can talk through your options and help you find a *fee-assured consultant* or *recognised practitioner* covered under your *benefits* in case you should go on to need hospital *treatment* that is eligible under your *benefits*.

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 *our* 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*).

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

- erode your *out-patient* benefit limit if you have one, nor
- be subject to your *excess* if one applies to your cover
- count as claims in the assessment of your no claims discount.

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**

You are only covered for *eligible treatment*. *Please see the glossary section for what we mean by *eligible treatment*.*

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:

- 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 eligible out-patient treatment by a 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.

Please note that we cannot guarantee the availability of any facility, practitioner or treatment.

**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 out-patient consultations that are to assess your acute condition when carried out as out-patient treatment and you are referred for the consultation by:
- our Direct Access service
- a GP (including via a digital GP service) or consultant, or
- another healthcare practitioner as explained in ‘Being referred for treatment’, in the ‘Notes on benefits’ section.

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

Note: We only pay for out-patient consultations when the consultation, including a remote consultation, follows and is directly related to an eligible out-patient surgical operation, day-patient treatment or in-patient treatment and takes place within six months of the discharge date of that treatment. Consultations that do not meet these criteria are not covered.

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 treatment by:
- our Direct Access service
- a GP (including via a digital GP service) or consultant, or
- another healthcare practitioner as explained in ‘Being referred for treatment’, in the ‘Notes on benefits’ section.

We pay for remote consultations by telephone or via any other remote medium with a therapist or recognised practitioner 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 or recognised practitioner is recognised by us for remote consultations or you can access the details at finder.bupa.co.uk
Note: We only pay for out-patient therapies when the therapy, including a remote consultation, follows and is directly related to eligible day-patient treatment or in-patient treatment and takes place within six months of the discharge date of that treatment. Therapies, including consultations that do not meet these criteria are not covered.

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, including recognised facility charges for a prosthesis or appliance needed as part of that 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
This benefit 1.3 is not covered under your policy.

benefit 1.4 diagnostic tests
When requested by a GP or 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)
- 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 cancer treatment we only pay consultant physicians’ fees if the attendance of a consultant physician is medically necessary because of your eligible cancer treatment, 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 amount 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, 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. 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*.

**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.

*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 pay for *intensive care* 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 *eligible treatment*.

If you are receiving private *eligible treatment* which does not routinely require *intensive care* as part of that *eligible treatment* and unforeseen circumstances arise that require *intensive care* we will only pay for the *intensive care* if you are receiving your private *eligible treatment* in a *recognised facility* and either:
- the *recognised facility* is equipped with a *critical care unit*, and your *intensive care* is carried out in that *critical care unit*, or
- the **recognised facility** is not equipped with a **critical care unit** but has a prior agreement with **us** to follow an emergency protocol agreed with another **recognised facility** that is equipped with a **critical care unit**, which is either adjacent or is part of the same group of companies, and you are transferred under that prior emergency protocol and your **intensive care** is carried out in that **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 (other than routinely needed after private day-patient treatment or in-patient treatment)’ and ‘Exclusion 2 Accident & emergency treatment’ 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 further **treatment** which is associated with or related to a **prosthesis** or **appliance** such as its maintenance, refitting or replacement when you do not have acute symptoms that are directly related to that **prosthesis** or **appliance**.
Benefits for specific medical conditions

Benefit 4 Cancer treatment
Your membership certificate shows whether you have cover for treatment for cancer and if so whether you are covered for:
- benefit 4.1 Cancer Cover, or
- benefit 4.2 NHS Cancer Cover Plus.

Benefit 4.1 Cancer cover
You are only covered for this benefit if your membership certificate shows it is covered and only after a diagnosis of cancer has been confirmed.

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:
- our Direct Access service
- a GP (including via a digital GP service) or consultant, or
- another healthcare practitioner as explained in ‘Being referred for treatment’, in the ‘Notes on benefits’ section.

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:
- our Direct Access service
- a GP (including via a digital GP service) or consultant, or
- another healthcare practitioner as explained in ‘Being referred for treatment’, in the ‘Notes on benefits’ section.

We pay for remote consultations by telephone or via any other remote medium with a therapist or recognised practitioner 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 or recognised practitioner 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
This benefit is not covered under your policy.

benefit 4.1.4 out-patient diagnostic tests for cancer
When requested by a GP or 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 either:

- when they can only be dispensed by a hospital and are not available from a GP, or
- when they are available from a GP and you are prescribed an initial small supply on discharge from the recognised facility to enable you to start your treatment straight away.

We do not pay for any common drugs, advanced therapies and specialist drugs that are otherwise available from a GP or are available to purchase without a prescription. We do not pay for any complementary, homeopathic or alternative products, preparations or remedies for treatment of cancer.

Please also see Exclusion 14, ‘Drugs and dressings for out-patient and 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 and only after a diagnosis of cancer has been confirmed.

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

- the radiotherapy, chemotherapy, drug therapy or surgical operation you need to treat your cancer is not available to you from the NHS, and
- what is not available to you from the NHS does not consist solely of supportive medicines for cancer or diagnostic tests, 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 the *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.

**Benefit 5 Mental health treatment**
This benefit is not covered under your policy.

**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 *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.
Cash benefits

Benefit CB1 NHS cash benefit for NHS hospital in-patient treatment
If this benefit does not appear on your membership certificate then you do not have cover for this benefit.

We pay NHS cash benefit for each night you receive in-patient treatment provided to you free under the NHS. We only pay NHS cash benefit if your treatment would otherwise have been covered for private in-patient treatment under your benefits. We do not pay this NHS cash benefit when your admission and discharge occur on the same date.

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.

Except for NHS cash benefit for cancer treatment taken by mouth 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.

Benefits CB2 to CB5 do not apply to your cover

Benefit CB6 NHS cash benefit for treatment for cancer

Benefit CB6.1 NHS cash benefit for NHS in-patient treatment for cancer
You are only covered for this benefit if your membership certificate shows it is covered. If you are covered, your membership certificate shows the benefit limits that apply.

Except for NHS cash benefit for cancer treatment taken by mouth 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 the 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 the NHS.

Benefit CB6.2 NHS cash benefit for NHS out-patient, day-patient and home treatment for cancer
You are only covered for this benefit if your membership certificate shows it is covered. If you are covered, your membership certificate shows the benefit limit that applies.
Except for NHS cash benefit for cancer treatment taken by mouth, 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 cancer treatment taken by mouth 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 this NHS cash benefit as follows:

- for each day you receive radiotherapy and/or proton beam therapy in a hospital setting
- for each day you receive IV-chemotherapy treatment
- 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
- for the day on which you undergo a surgical operation when such treatment is eligible treatment for cancer carried out as out-patient treatment, day-patient treatment or treatment in your home, and is provided to you free under the NHS.

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

Where we refer to ‘cancer treatment taken by mouth’ we mean:

- chemotherapy, or
- one of the following biological therapies:
  - monoclonal antibodies (MABs)
  - blood cell growth factors
  - cancer growth blockers
  - drugs that block cancer blood vessel growth (anti-angiogenics)
  - Immunotherapy (including Interferon and Interleukin-2)
  - gene therapy, or
  - hormonal therapy

that can only be prescribed under a consultant’s supervision and is not available from a GP and which you take by mouth.

Please also see benefit 4.1.5 out-patient cancer drugs.

Benefit CB7 Procedure Specific NHS cash benefit

Except for NHS cash benefit for cancer treatment taken by mouth as set out in benefit CB6.2 Procedure Specific NHS cash benefit is not payable at the same time as any other cash benefit.

We pay Procedure Specific NHS cash benefit in relation to certain specific treatment provided to you free of charge under the NHS. We only pay Procedure Specific NHS cash benefit if your treatment would otherwise have been covered for private treatment under your benefits. We pay your Procedure Specific NHS cash benefit directly to the main member. For information on Procedure Specific NHS cash benefits please call us or go to bupa.co.uk/pscb. These cash benefits may change from time to time.
What is not covered

This section explains the treatment, services and charges that are not covered. 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.

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. For example, we do not pay for the treatment of acne arising from natural hormonal changes.

Exclusion 2 Accident and emergency treatment
We do not pay for any treatment, including immediate care, received during a visit to an NHS or private accident and emergency (A&E) department, urgent care centre or walk in clinic.

We also do not pay for any treatment received following an admission via an NHS or private A&E department, urgent care centre or walk-in clinic until after you are referred by a consultant for eligible treatment in a recognised facility. In these circumstances, before you receive any treatment, you should contact us as soon as reasonably possible to confirm whether your treatment is covered under your benefits as you are responsible for any costs you incur that are not covered under your benefits.

Please also see ‘benefit 3.2.4 intensive care’ in the section ‘Benefits’ and ‘Exclusion 19 Intensive care (other than routinely needed after private day-patient or in-patient treatment)’ in this section.

Exclusion 3 Allergies, allergic disorders or food intolerances
We do not pay for treatment:
- to de-sensitise or neutralise any allergic condition or disorder, or
- of any food intolerance.

Once a diagnosis of an allergic condition or disorder or food intolerance has been confirmed we do not pay for any further treatment, including diagnostic tests, to identify the precise allergen(s) or foodstuff(s) involved – this means, for example, if you are diagnosed with a tree nut allergy we will not pay for further investigations into which specific nut(s) you are allergic to.
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. These include, for example, personal travel and/or accommodation costs which are not expressly set out in 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 dysphoria or 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 dysphoria or gender reassignment
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 your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

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. When you are receiving in-patient treatment, in making our decision on whether your condition is, or has become, a chronic condition, we will consider the period of days during which there has been no change in your clinical condition or change in your 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.
We do not consider a mental health condition as a chronic condition. We explain what we pay for eligible treatment of mental health conditions in Benefit 5 Mental health 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.

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, and immediately follows, 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 therapists, each from a different specialism not including occupational therapy, and
- is led or supported by a consultant trained and accredited in Rehabilitation Medicine, and
- takes place at 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 one of the above criteria has been met before **we** can determine this.

### Exception 2: **We** pay for eligible surgical operations to restore the appearance of the specific part of your body that has been affected:
- by an accident, or
- if your **benefits** include cover for **cancer treatment**, as a direct result of surgery for **cancer**.

**Eligible surgical operations** to restore appearance include those for the purposes of symmetry (eg surgery to a healthy breast to make it match a breast reconstructed following cancer surgery). Once the initial **eligible treatment** to restore your appearance is complete (including delayed surgery, such as delayed breast reconstructions) **we** do not pay for repeat surgeries or reconstructions, or further **treatment** to restore or amend your appearance.
We only pay if all the following apply:

- the accident or the cancer surgery takes place during your current continuous period of cover under this scheme, 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: We pay for an eligible surgical operation carried out by a consultant to:

- 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
- 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).

Licensed gene therapy, somatic-cell therapy or tissue engineered medicines for conditions other than cancer that have not been tested in phase III clinical trials will be considered experimental.

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), and
For the proposed treatment we are provided with an MDT report, which includes 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, with supporting phase III clinical trial evidence, for your exact condition (ie the specific indication including tumour type, staging and phase of treatment if relevant), or
- evidence that the drug treatment has published phase III clinical trial results showing that it is safe and effective for your condition.

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 or epidemic disease**

*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 the occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events materially in excess of normal expectancy, or as otherwise defined by the World Health Organisation (WHO).

**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:

- you have been directly admitted into a critical care unit at the point of admission, such as following:
  - an NHS transfer to a recognised facility
  - an out-patient consultation
  - a GP referral
  - repatriation
  - private facility to private facility transfer
- 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, or
- it is carried out in a unit or facility which is not a critical care unit.

Please also see ‘benefit 3.2.4 Intensive care’ 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.

Exclusion 21 Overseas treatment or repatriation

We do not pay for treatment that you receive outside the UK or for repatriation to the UK or any other country.

Exception: 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 ‘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 benefits 1 and 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
- stillbirth
- 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 dysphoria or 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 (including vaccinations)
- 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 and moratorium transfer 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.

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 pay for treatment to manage the symptoms of a terminal illness or disease from the date on which your consultant tells you that your ongoing treatment will be to support your end of life care only and you will not receive treatment that is intended to halt or improve the terminal illness or disease itself. We then pay all charges and fees for the treatment you need in accordance with, and on the same basis as, your other benefits (including Benefit 6 Treatment at home), for a maximum period of 21 consecutive days. We only pay for this once in your lifetime.

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:

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

- 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, 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.

For **moratorium members** who are **moratorium transfer members** we also do not pay for moratorium pending treatment conditions or a disease, illness or injury that results from or is related to a moratorium pending treatment condition.

**Exception 1:** For **moratorium members**, we pay for treatment of a moratorium condition if at any time after your **moratorium start date** you do not:

- receive any medication for
- ask for or receive any medical advice or treatment for, or
- experience symptoms of

that moratorium condition for a continuous period of two years cover.

We may take your cover under a previous scheme into account when assessing your claim for a moratorium condition but only if we specifically agreed that we would do this when you joined the scheme.

**Exception 2:** For **moratorium transfer members** we pay for treatment of a moratorium pending treatment condition if at any time after the date you join the scheme you do not:

- receive any medication for
- ask for or receive any medical advice or treatment for, or
- experience symptoms of

that moratorium pending treatment condition for a continuous period of two years cover.

**Exclusion 34 Mental health conditions**

We do not pay for treatment for any mental health condition or for any disease or illness arising from or related to a mental health condition.

**Exclusion 35 Advanced therapies and specialist drugs**

We do not pay for:

- any gene therapy, somatic-cell therapy or tissue engineered medicines that are not on the list of advanced therapies that applies to your benefits
- any drugs or medicines that are neither common drugs nor specialist drugs for which a separate charge is made by your recognised facility.
Glossary

All words and phrases printed in **bold italic** in the earlier pages of this membership guide have the meanings set out below.

Not all the words and phrases set out below are used within this membership guide. This Glossary is a general Glossary, which is also used for other Bupa health insurance schemes.

<table>
<thead>
<tr>
<th>Word/phrase</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities of daily living</strong></td>
<td>functional mobility, bathing/showering, self-feeding, personal hygiene/grooming, toilet hygiene, fulfilment of work or educational responsibilities.</td>
</tr>
<tr>
<td><strong>Acute condition</strong></td>
<td>a disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.</td>
</tr>
<tr>
<td><strong>Advanced therapies</strong></td>
<td>gene therapy, somatic-cell therapy or tissue engineered medicines classified as Advanced Therapy Medical Products (ATMPs) by the European Medicines Agency to be used as part of your eligible treatment and which are, at the time of your eligible treatment, included (with the medical condition(s) for which we pay for them) on our list of advanced therapies that applies to your benefits. The list is available at bupa.co.uk/policyinformation or you can call us. The advanced therapies on the list will change from time to time.</td>
</tr>
<tr>
<td><strong>Agreement</strong></td>
<td>the agreement between the main member and us to provide cover for you and your dependants (if any) under the terms and conditions set out in the documents referred to under the heading ‘The agreement between you and us’ in the section ‘How your membership works’.</td>
</tr>
<tr>
<td><strong>Appliance</strong></td>
<td>any appliance which is in our list of appliances for your benefits at the time you receive your treatment. The list of appliances will change from time to time. Details of the appliances are available on request or at bupa.co.uk/prostheses-and-appliances</td>
</tr>
<tr>
<td><strong>Application form</strong></td>
<td>the questionnaire we provide to you when you and/or your dependants first take out or are added as a dependent to a policy with us which requires you and/or your dependants to disclose details of your and their health, medical history and lifestyle. If you no longer have the application form, you may call us to request a replacement.</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>the benefits specified on your membership certificate for which you are entitled as an individual under the scheme subject to the terms and conditions that apply to your membership in this membership guide including all exclusions.</td>
</tr>
<tr>
<td><strong>Bupa</strong></td>
<td>Bupa Insurance Limited. Registered in England and Wales No. 3956433. Registered office: 1 Angel Court, London EC2R 7HJ</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>a malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.</td>
</tr>
<tr>
<td><strong>Word/phrase</strong></td>
<td><strong>Meaning</strong></td>
</tr>
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</tr>
<tr>
<td><strong>Chronic condition</strong></td>
<td>a disease, illness or injury which has one or more of the following characteristics:</td>
</tr>
<tr>
<td></td>
<td>▪ it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests</td>
</tr>
<tr>
<td></td>
<td>▪ it needs ongoing or long-term control or relief of symptoms</td>
</tr>
<tr>
<td></td>
<td>▪ it requires rehabilitation or for you to be specially trained to cope with it</td>
</tr>
<tr>
<td></td>
<td>▪ it continues indefinitely</td>
</tr>
<tr>
<td></td>
<td>▪ it has no known cure</td>
</tr>
<tr>
<td></td>
<td>▪ it comes back or is likely to come back.</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Common drugs</strong></td>
<td>commonly used medicines, such as antibiotics and painkillers that in our reasonable opinion based on established clinical and medical practice should be included as an integral part of your eligible treatment.</td>
</tr>
<tr>
<td><strong>Complementary medicine practitioner</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Consultant</strong></td>
<td>a registered medical or dental practitioner who, at the time you receive your treatment:</td>
</tr>
<tr>
<td></td>
<td>▪ 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</td>
</tr>
<tr>
<td></td>
<td>▪ is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and</td>
</tr>
<tr>
<td></td>
<td>▪ is in our list of consultants that applies to your benefits.</td>
</tr>
<tr>
<td></td>
<td>You can ask us if a medical or dental practitioner is recognised by us as a consultant and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</td>
</tr>
<tr>
<td><strong>Consultant fees schedule</strong></td>
<td>the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants’ fees based on:</td>
</tr>
<tr>
<td></td>
<td>▪ the type of treatment carried out</td>
</tr>
<tr>
<td></td>
<td>▪ the surgical operations, the type and complexity of the surgical operation according to the schedule of procedures</td>
</tr>
<tr>
<td></td>
<td>▪ the Bupa recognition status of the consultant, and</td>
</tr>
<tr>
<td></td>
<td>▪ where the treatment is carried out both in terms of the treatment facility and the location.</td>
</tr>
<tr>
<td></td>
<td>The schedule will change from time to time. Details of the schedule can be found at bupa.co.uk/codes</td>
</tr>
<tr>
<td><strong>Cover end date</strong></td>
<td>the date on which your current period of cover under the scheme ends shown as ‘Cover end date’ on your membership certificate.</td>
</tr>
<tr>
<td><strong>Cover start date</strong></td>
<td>the date on which your current period of cover under the scheme starts shown as ‘Cover start date’ on your membership certificate.</td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
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<tr>
<td><strong>Critical care unit</strong></td>
<td>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 <strong>intensive care</strong> that you require at the time you receive your <strong>treatment</strong>. The units on the list and the type of <strong>intensive care</strong> 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</td>
</tr>
<tr>
<td><strong>Day-patient</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Day-patient treatment</strong></td>
<td><strong>eligible treatment</strong> that for medical reasons is received as a <strong>day-patient</strong>.</td>
</tr>
<tr>
<td><strong>Dependant</strong></td>
<td>your partner and any child for whom you or your partner hold responsibility and who is a member of the <strong>scheme</strong> and named on your <strong>membership certificate</strong>.</td>
</tr>
<tr>
<td><strong>Diagnostic tests</strong></td>
<td>investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.</td>
</tr>
<tr>
<td><strong>Effective underwriting date</strong></td>
<td>the date you started your continuous period of cover under the <strong>scheme</strong> shown as ‘Effective underwriting date’ on your <strong>membership certificate</strong>. This may be the date you originally joined <strong>Bupa</strong> or if you transferred your cover to <strong>Bupa</strong> from a <strong>previous scheme</strong> the date of underwriting by your previous insurer or administrator for your <strong>previous scheme</strong>.</td>
</tr>
<tr>
<td><strong>Eligible surgical operation</strong></td>
<td><strong>eligible treatment</strong> carried out as a <strong>surgical operation</strong>.</td>
</tr>
</tbody>
</table>
| **Eligible treatment** | **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 **UK**  
- 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  
- 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**. |
<p>| <strong>Excess</strong> | the amount that you have to pay towards the cost of <strong>treatment</strong> that you receive that would otherwise have been payable under your <strong>benefits</strong>. For details please see rule E in the ‘Claiming’ section of this guide and your <strong>membership certificate</strong>. |
| <strong>Facility access</strong> | the list of <strong>Bupa</strong> recognised hospitals and treatment facilities, centres or units for which you are covered under your <strong>benefits</strong> as shown on your <strong>membership certificate</strong> against ‘facility access’. The hospitals and treatment facilities, centres or units in the list and the medical conditions and types of <strong>treatment</strong> we recognise them for will change from time to time. Details are available on request or at finder.bupa.co.uk |</p>
<table>
<thead>
<tr>
<th>Word/phrase</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fee-assured consultant</strong></td>
<td>a consultant who, at the time you receive <em>treatment</em>, is:</td>
</tr>
<tr>
<td></td>
<td>▪ recognised by us as a fee-assured consultant, and</td>
</tr>
<tr>
<td></td>
<td>▪ in the list of fee-assured consultants that applies to your benefits.</td>
</tr>
<tr>
<td>You can ask us if a consultant is a fee-assured consultant and if they are in the list of consultants that apply to your benefits or you can access these details at finder.bupa.co.uk</td>
<td></td>
</tr>
<tr>
<td><strong>Gender dysphoria</strong></td>
<td>a condition where a person experiences discomfort or distress because there is a mismatch between their biological sex and gender identity, sometimes known as gender identity disorder, gender incongruence or transgenderism.</td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>a doctor who, at the time they refer you for your consultation or <em>treatment</em>, is on the UK General Medical Council’s General Practitioner Register.</td>
</tr>
<tr>
<td><strong>Home</strong></td>
<td>either:</td>
</tr>
<tr>
<td></td>
<td>▪ the place where you normally live, or</td>
</tr>
<tr>
<td></td>
<td>▪ another non-healthcare setting where you want to have your <em>treatment</em>.</td>
</tr>
<tr>
<td><strong>In-patient</strong></td>
<td>a patient who is admitted to a hospital or treatment facility and who occupies a bed overnight or longer for medical reasons.</td>
</tr>
<tr>
<td><strong>In-patient treatment</strong></td>
<td>eligible treatment that for medical reasons is received as an in-patient.</td>
</tr>
<tr>
<td><strong>Intensive care</strong></td>
<td>eligible treatment for intensive care, intensive therapy, high dependency care, coronary care or progressive care.</td>
</tr>
<tr>
<td><strong>Main member</strong></td>
<td>the person named as the main member on the membership certificate.</td>
</tr>
<tr>
<td><strong>Medical treatment provider</strong></td>
<td>a person or company who is recognised by us as a medical treatment provider for the type of <em>treatment at home</em> that you need at the time you receive your <em>treatment</em>. The list of medical treatment providers and the type of <em>treatment we</em> recognise them for will change from time to time. Details of these medical treatment providers and the type of <em>treatment we</em> recognise them for are available on request or you can access these details at finder.bupa.co.uk</td>
</tr>
<tr>
<td><strong>Membership certificate</strong></td>
<td>the most recent membership certificate that we issue to you for your current continuous period of membership of the scheme.</td>
</tr>
</tbody>
</table>
| **Mental health and wellbeing therapist** |▪ 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  
who is a recognised practitioner. You can ask us 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 |
<table>
<thead>
<tr>
<th>Word/phrase</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health condition</td>
<td>a condition which is a mental health condition according to a reasonable body of medical opinion, and/or which is diagnosed, treated and managed as a mental health condition including alcoholism, drug addiction, anorexia nervosa and bulimia nervosa.</td>
</tr>
<tr>
<td>Mental health eligible treatment</td>
<td>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.</td>
</tr>
<tr>
<td>Mental health in-patient treatment</td>
<td>eligible treatment of a mental health condition that, for medical reasons, is received as an in-patient.</td>
</tr>
<tr>
<td>Mental health treatment</td>
<td>eligible treatment as set out in Benefit 5 Mental health treatment in the ‘Benefits’ section of this guide.</td>
</tr>
<tr>
<td>Moratorium condition</td>
<td>any disease, illness or injury or related condition, whether diagnosed or not, which you:</td>
</tr>
<tr>
<td></td>
<td>▪ received medication for</td>
</tr>
<tr>
<td></td>
<td>▪ asked for or received, medical advice or treatment for</td>
</tr>
<tr>
<td></td>
<td>▪ experienced symptoms of, or</td>
</tr>
<tr>
<td></td>
<td>▪ were to the best of your knowledge aware existed</td>
</tr>
<tr>
<td></td>
<td>in the five years 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.</td>
</tr>
<tr>
<td>Moratorium member</td>
<td>a member whose membership certificate shows the underwriting method applied to them is moratorium.</td>
</tr>
<tr>
<td>Moratorium pending treatment</td>
<td>any disease, illness or injury or related condition, whether diagnosed or not, for which you are due to receive medical advice, or planned or pending treatment (whether private or under the NHS) at the date you join the scheme.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Moratorium start date</td>
<td>the date you started your continuous period of cover under the scheme shown as ‘Moratorium start date’ on your membership certificate. This may be the date you originally joined Bupa or, if you transferred your cover to Bupa from a previous scheme, the date identified by your previous insurer or administrator for determining moratorium conditions under your previous scheme.</td>
</tr>
<tr>
<td>Moratorium transfer member</td>
<td>a moratorium member who:</td>
</tr>
<tr>
<td></td>
<td>▪ applied to join the scheme from a previous scheme provided or administered by another insurer, and</td>
</tr>
<tr>
<td></td>
<td>▪ as part of their application to join the scheme was required by us to disclose details of their medical history for the purpose of underwriting.</td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
</tr>
<tr>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **NHS**                     | - the National Health Service operated in Great Britain and Northern Ireland, or  
- the healthcare scheme 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.                                                                 |
| **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**.                                                                                                                     |
| **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.                                      |
| **Pre-existing condition**  | any disease, illness or injury for which in the seven years before your **effective underwriting date**:  
  - you have received medication, advice or **treatment**, or  
  - you have experienced symptoms whether the condition was diagnosed or not.                                                                 |
| **Previous scheme**         | - another **Bupa** private medical insurance scheme, or  
- a private medical insurance scheme or medical healthcare trust provided or administered by another insurer that **we** specifically agree will be treated as a previous scheme for the purpose of assessing your **moratorium start date**, **effective underwriting date** or continuous periods of cover as applicable provided that:  
  - you have provided **us** with evidence of your continuous cover under the previous scheme, and  
  - there is no break in your cover between the previous scheme and your **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 will change from time to time. Details of the prostheses covered under your **benefits** for your type of **treatment** are available on request or at bupa.co.uk/prostheses-and-appliances |
| **Recognised facility**     | a hospital or a treatment facility, centre or unit within your **facility access**, which at the time you receive your **eligible treatment** is recognised by **us** for both:  
  - treating the medical condition you have, and  
  - carrying out the type of treatment you need.                                                                                           |
<table>
<thead>
<tr>
<th>Word/phrase</th>
<th>Meaning</th>
</tr>
</thead>
</table>
| **Recognised practitioner** | a healthcare practitioner who at the time of your treatment:
  - 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.
You can ask us 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 |
| **Renewal date** | each anniversary of your cover start date. |
| **Resident** | where your current, permanent address is. |
| **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 may change from time to time. Not all procedures listed in the schedule are covered under Bupa schemes. Details of the schedule can be found at bupa.co.uk/codes |
| **Scheme** | the cover and benefits we provide as shown on your membership certificate together with this membership guide subject to the terms and conditions of the agreement. |
| **Special condition** | 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 individual’s cover these are shown as applying to that member in the ‘Special conditions’ section 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 that applies to your benefits. The list is available at bupa.co.uk/policyinformation or you can call us. The specialist drugs on the list will change from time to time. |
| **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** | - 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 Chiropodists and Podiatrists registered podiatrist, or
- a British Dietetic Association registered dietitian
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 |
<table>
<thead>
<tr>
<th>Word/phrase</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.</td>
</tr>
<tr>
<td>Underwritten member</td>
<td>a member whose membership certificate shows the underwriting method applied to them is underwritten.</td>
</tr>
<tr>
<td>Underwritten transfer member</td>
<td>an underwritten member who:</td>
</tr>
<tr>
<td></td>
<td>▪ applied to join the scheme from a previous scheme provided or administered by another insurer, and</td>
</tr>
<tr>
<td></td>
<td>▪ as part of their application to join the scheme was required by us to disclose details of their medical history for the purpose of underwriting.</td>
</tr>
<tr>
<td>United Kingdom/ UK</td>
<td>Great Britain, Northern Ireland, the Channel Islands and the Isle of Man.</td>
</tr>
<tr>
<td>Waiting period</td>
<td>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.</td>
</tr>
<tr>
<td>We/our/us</td>
<td>Bupa.</td>
</tr>
<tr>
<td>Year</td>
<td>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.</td>
</tr>
<tr>
<td>You/your</td>
<td>this means the main member only.</td>
</tr>
</tbody>
</table>
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, how we use it and how we protect it. It also provides information about your rights. The information we process about you, and our reasons for processing it, depends on the products and services you use. You can find more details 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, please 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

1. Scope of our privacy notice
This privacy notice applies to anyone who interacts with us about our products and services (‘you’, ‘your’), in any way (for example, email, website, phone, app and so on).

2. How we collect personal information
We collect personal information from you and from certain other organisations (those acting on your behalf, for example, brokers, health-care providers and so on). If you give us information about other people, you must make sure that they have seen a copy of this privacy notice and are comfortable with you giving us their information.

3. Categories of personal information
We process the following categories of personal information about you and, if it applies, your dependants. This is standard personal information (for example, information we use to contact you, identify you or manage our relationship with you), special categories of information (for example, health information, information about race, ethnic origin and religion that allows us to tailor your care), and information about any criminal convictions and offences (we may get this information when carrying out anti-fraud or anti-money-laundering checks, or other background screening activity).

4. Purposes and legal grounds for processing personal information
We process your personal information for the purposes set out in our full privacy notice, including to deal with our relationship with you (including for claims and handling complaints), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and to protect our rights, property, or safety, or that of our customers, or others. The legal reason we process personal information depends on what category of personal information we process. We normally process standard personal information on the basis that it is necessary so we can
perform a contract, for our or others’ legitimate interests or it is needed or allowed by law. We process special categories of information because it is necessary for an insurance purpose, because we have your permission or as described in our full privacy notice. We may process information about your criminal convictions and offences (if any) if this is necessary to prevent or detect a crime.

5. Marketing and preferences
We may use your personal information to send you marketing by post, phone, social media, email and text. We only use your personal information to send you marketing if we have either your permission or a legitimate interest. If you don’t want to receive personalised marketing about similar 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

6. 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 interest you (including discounts on our products and services). This may involve evaluating information about you and, in 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.

7. Sharing your information
We share your information within the Bupa group of companies, with relevant policyholders (including your employer if you are covered under a group scheme), with funders who arrange services on your behalf, those acting on your behalf (for example, brokers and other intermediaries) and with others who help us provide services to you (for example, health-care providers) or who we need information from to handle or check claims or entitlements (for example, professional associations). We also share your information in line with the law. You can read more about what information may be shared in what circumstances in our full privacy notice.

8. Transfers outside of the European Economic Area (EEA)
We deal with many international organisations and use global information systems. As a result, we transfer your personal information to countries outside of the European Economic Area (the EU member states plus Norway, Liechtenstein and Iceland) for the purposes set out in this privacy policy.

9. How long we keep your personal information
We keep your personal information in line with periods we work out using the criteria shown in the full privacy notice available on our website.
10. Your rights
You have rights to have access to your information and to ask us to correct, erase and restrict use of your information. You also have rights to object to your information being used; to ask us to transfer information you have made available to us; to withdraw your permission for us to use your information; and to ask us not to make automated decisions which produce legal effects concerning you or significantly affect you. Please contact us if you would like to exercise any of your rights.

11. Data-protection contacts
If you have any questions, comments, complaints or suggestions about this notice, or any other concerns about the way in which we process information about you, please contact us at dataprotection@bupa.com. You can also use this address to contact our Data Protection Officer.

You also have a right to make a complaint to your local privacy supervisory authority. Our main office 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. Phone: 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.
Bupa Anytime HealthLine is provided by:
Registered office: 1 Angel Court, London EC2R 7HJ

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:
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Registered office: 1 Angel Court, London EC2R 7HJ
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