Your Bupa membership guide

Bupa ClientChoice

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 in your benefit table. 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 or call your helpline number 0345 609 0111*.

*We may record or monitor our calls.
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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</tbody>
</table>
Effective from date: 1 January 2021
These are the rules and benefits that apply to Bupa members. By this we mean a member covered under one of the following Bupa private medical insurance products as shown on their membership certificate: ClientChoice Plus, ClientChoice, ClientChoice Essential.

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 is a generic guide and contains all the general membership terms that apply to Bupa members and 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.

This membership guide is divided into two parts: the section ‘Your benefit table’ which contains the benefit table that applies to your scheme and the general membership terms. Your benefit table sets out the cover that is specific to your scheme and provides benefit notes numbers that correspond to the benefits in the ‘Benefits’ section of this guide (where you will find more detailed explanations of your benefits).

Any elements of cover in the general membership terms that are either:
- shown in your benefit table as ‘not covered’ or
- do not appear in your benefit table
you are not covered for and you should therefore ignore them when reading this membership guide.

Your membership certificate could also show some limitations or exclusions to the terms of cover set out in this membership guide including your benefit table. When reading this membership guide and your membership certificate, it is your membership certificate which is personal to you and the benefit table that details your cover under your scheme. This means that if there is any contradiction between:
- your membership certificate, the benefit table and the general membership terms, your membership certificate will take priority
- the benefit table and the general membership terms, the benefit table 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 6 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.
Your benefit table

This is the benefit table. It is a generic table and shows all the benefits and benefit limits that apply to Bupa members under their schemes. This means you may not have all the cover shown in this table. Your membership certificate shows which scheme and therefore which benefit table applies to your cover. You should ignore any benefits and benefit limits in this table that do not apply to your scheme or benefit table.

The scheme that applies to your cover is shown against ‘Product name’ in the Membership details section of your membership certificate. Call the helpline if you are unsure of which scheme or benefit table applies to your cover.

<table>
<thead>
<tr>
<th>Type of cover</th>
<th>Benefit note</th>
<th>Cover</th>
<th>Limits for each member (subject to benefit note(s))</th>
</tr>
</thead>
</table>
| **out-patient** consultations and therapies | 1.1, 1.2     | yes   | - for Bupa ClientChoice Plus: up to £1,000 combined limit each year  
- for Bupa ClientChoice: up to £500 combined limit each year  
- for Bupa ClientChoice Essential: up to £500 combined limit each year when directly related to private day-patient treatment or in-patient treatment and follows within six-months of the discharge date of that treatment with a maximum of two consultations with a consultant during that six-month period |
| **out-patient** complementary medicine | 1.3          | yes   | - not covered for Bupa ClientChoice Essential  
- for Bupa ClientChoice and Bupa ClientChoice Plus: up to £250 each year from within your available out-patient consultations and therapies limit above  
- facility that is not a recognised facility: up to £100 towards the total facility charges and not each service or charge individually |
| **out-patient diagnostic tests**    | 1.4          | yes   | recognised facility: paid in full                                                                                                                                                                                                                                                                                 |
| **out-patient** MRI, CT and PET scans | 1.5          | yes   | recognised facility: paid in full  
- facility that is not a recognised facility: up to £100 towards the total facility charges and not each service or charge individually |
<table>
<thead>
<tr>
<th>Type of cover</th>
<th>Benefit note</th>
<th>Cover</th>
<th>Limits for each member (subject to benefit note(s))</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Being treated in hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>consultants’ fees</strong></td>
<td>2</td>
<td>yes</td>
<td>- fee-assured consultants in a recognised facility: paid in full</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- consultants who are not fee-assured consultants in a recognised facility: up to the limits of the consultant fees schedule</td>
</tr>
<tr>
<td><strong>facility access</strong></td>
<td>3</td>
<td>partnership facility</td>
<td></td>
</tr>
<tr>
<td>facility charges for surgical operations carried out as out-patient treatment</td>
<td>3, 3.1</td>
<td>yes</td>
<td>- recognised facility: paid in full</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- facility that is not a recognised facility: up to £100 towards the total facility charges and not each service or charge individually</td>
</tr>
<tr>
<td>facility charges for day-patient treatment and in-patient treatment</td>
<td>3, 3.2</td>
<td>yes</td>
<td>recognised facility: paid in full</td>
</tr>
<tr>
<td>parent accommodation</td>
<td>3.2.2</td>
<td>yes</td>
<td>aged 17 or under</td>
</tr>
<tr>
<td><strong>Cancer treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cancer treatment</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>out-patient consultations and therapies</td>
<td>4.1.1, 4.1.2</td>
<td>yes</td>
<td>paid in full</td>
</tr>
<tr>
<td>out-patient complementary medicine</td>
<td>4.1.3</td>
<td></td>
<td>- yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- not covered for Bupa ClientChoice Essential</td>
</tr>
<tr>
<td>out-patient diagnostic tests</td>
<td>4.1.4</td>
<td>yes</td>
<td>recognised facility: paid in full</td>
</tr>
<tr>
<td>out-patient cancer drugs</td>
<td>4.1.5</td>
<td>yes</td>
<td>recognised facility charges: paid in full</td>
</tr>
<tr>
<td><strong>Mental health treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mental health treatment</td>
<td>5</td>
<td>Bupa ClientChoice and Bupa ClientChoice Essential: not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>not covered</td>
</tr>
<tr>
<td>mental health treatment</td>
<td>5</td>
<td>Bupa ClientChoice Plus: covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>up to a maximum of 28 days each year for mental health day-patient treatment and mental health in-patient treatment combined and not individually</td>
</tr>
<tr>
<td>Type of cover</td>
<td>Benefit note</td>
<td>Cover</td>
<td>Limits for each member (subject to benefit note(s))</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Mental health treatment (continued)</strong></td>
<td></td>
<td></td>
<td>paid in full to and from within your available out-patient benefit limit(s) for benefit notes 1.1 and 1.2</td>
</tr>
<tr>
<td>consultant psychiatrists’ fees and mental health and wellbeing therapists’ fees for out-patient mental health treatment</td>
<td>5.1, 5.1.1, 5.1.2</td>
<td>yes</td>
<td><strong>Consultant psychiatrists’ fees for</strong> out-patient mental health treatment</td>
</tr>
<tr>
<td>out-patient diagnostic tests for out-patient mental health treatment</td>
<td>5.1, 5.1.3</td>
<td>yes</td>
<td><strong>Consultant psychiatrists’ fees for</strong> out-patient mental health treatment</td>
</tr>
<tr>
<td>consultant psychiatrists’ fees for day-patient treatment and in-patient treatment</td>
<td>5.2</td>
<td>yes</td>
<td><strong>Consultant psychiatrists’ fees for</strong> day-patient treatment and in-patient treatment</td>
</tr>
<tr>
<td>facility charges for mental health day-patient treatment and mental health in-patient treatment</td>
<td>5.2</td>
<td>yes</td>
<td><strong>Consultant psychiatrists’ fees for</strong> day-patient treatment and in-patient treatment</td>
</tr>
<tr>
<td>Additional benefits</td>
<td></td>
<td></td>
<td><strong>Consultant psychiatrists’ fees for</strong> day-patient treatment and in-patient treatment</td>
</tr>
<tr>
<td>treatment at home</td>
<td>6</td>
<td>discretionary benefit</td>
<td>if we agree, we pay in full for the charges that we agree to pay on your behalf</td>
</tr>
<tr>
<td>home nursing</td>
<td>7</td>
<td>yes</td>
<td>up to £600 each year</td>
</tr>
<tr>
<td>private ambulance charges</td>
<td>8</td>
<td>yes</td>
<td>up to £60 for each single trip up to an overall maximum amount of £120 each year</td>
</tr>
<tr>
<td>Cash benefits</td>
<td></td>
<td></td>
<td><strong>Consultant psychiatrists’ fees for</strong> day-patient treatment and in-patient treatment</td>
</tr>
<tr>
<td>NHS cash benefit for NHS in-patient treatment for cancer</td>
<td>CB6.1</td>
<td>yes</td>
<td>£100 each night as set out in benefit note CB6.1</td>
</tr>
<tr>
<td>NHS cash benefit for NHS out-patient or day-patient treatment or NHS home treatment for cancer</td>
<td>CB6.2</td>
<td>yes</td>
<td>£100 each day as set out in benefit note CB6.2</td>
</tr>
<tr>
<td>Procedure Specific NHS cash benefit</td>
<td>CB8</td>
<td>yes</td>
<td>the amount we pay depends on the type of treatment you receive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>for more information call us or go to bupa.co.uk/pscb. The cash benefits available will change from time to time</td>
</tr>
</tbody>
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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 ‘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 includes:
  - your benefit table which explains the benefits which are specific to your scheme, including the limits that apply, any variations to the benefits, terms or conditions in this membership guide
  - the general membership terms which detail the elements of cover (including exclusions)

- **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 applies to your benefits
  - the subscriptions you will be paying
  - whether an excess applies to your cover
  - 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.

Cover for a newborn baby

You may apply to include your newborn baby under your membership as one of your dependants, free of charge, until your first renewal date after their birth.

If you and/or your partner have been a Bupa member for at least 12 continuous months before the baby’s birth and you include your baby under your membership within three months of the baby’s birth and your baby’s membership under the scheme would be as:

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

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

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.

*We may record or monitor our calls.
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.

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.

*We may record or monitor our calls.
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.

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 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 moratoria 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

We calculate and apply the NCD for you and your dependants (if any) collectively.

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 whether we have paid any claims excluding any claims that are entirely within the excess amounts that you are responsible for paying. As we calculate your subscriptions prior to your renewal date, we will assess if any eligible claims have been paid by us:

- in the first 10 months of your first year of cover, and
- for subsequent years, in months 11 and 12 of the previous year plus months one to 10 of the current year.

If during the assessment period:

- we do not pay any claims for you we will increase your no claims discount by one level.
- we do pay a claim for you we will reduce your no claims discount by two levels.

We apply your no claims discount to your net subscription rate, excluding IPT.

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.

No claims discount scale: this scale shows the amount of discount that applies for each no claims discount level. Discount level 7 is the maximum discount level available.

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Discount you will receive</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
<td>30%</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
- 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 CB6.1 and CB6.2)
  - Anytime HealthLine
  - The charge for any telephone assessments required as part of our Direct Access service.

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 we will not add any special conditions to someone’s cover for medical conditions that started after their effective underwriting date provided that they gave us all the information we asked for:

- before their effective underwriting date, or
- if they transferred to the scheme from a previous scheme, they gave us all the information we asked for at the time of that 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 or change your cover 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.

*We may record or monitor our calls.
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’s necessary to investigate your complaint and this may include medical information. If you are concerned about this, please contact us.

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

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
Claiming

Step-by-step guide to making a claim

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, therapist or mental health and wellbeing 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 for an open referral

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.

A GP will assess if you need to go to see a consultant. If they decide that you do and:
- your benefits include cover for out-patient consultations and therapies before hospital treatment, ask the GP for an ‘open referral’ (unless a paediatric referral is required – see below). This allows us to offer you a choice of nearby recognised practitioners covered under your policy. Some GPs may prefer to give a ‘named referral’ to a certain consultant, however, you should call us before you make an appointment to confirm that we recognise them under your cover, to avoid your being liable to pay.
- your benefits do not cover out-patient consultations or therapies before hospital treatment, you will 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 recognised practitioner covered under your benefits in case you should go on to need hospital treatment.
Step 3  Call us

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

If your consultant recommends further tests or treatment, it’s 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*

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.

*We may record or monitor our calls.
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 - if any). We cannot accept photocopies of accounts or invoices or originals that have had alterations made to them.
If you do not provide *us* with any information *we* reasonably ask you for *we* will be unable to assess your claim.

**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 don’t 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’s 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’ve seen the report, it won’t 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* won’t 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
   - 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 on your *membership certificate*:

- *we* apply the *excess* to your claims in the order in which *we* process those claims
when you claim for eligible treatment costs under a benefit that has a benefit limit, your excess amount will count towards your total benefit limit for that benefit – see the example below
- the excess does not apply to cash benefits.

**Excess example**
The following is an example only. You should check your membership certificate to see how your excess applies to you and your benefits.

**Example of how an annual excess works:** this is an example only and assumes that all costs are eligible treatment costs and:
- an excess of £500 a year
- an out-patient benefit limit of £500 a year.

<table>
<thead>
<tr>
<th>Example</th>
<th>Excess</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-patient</strong> benefit limit for the year</td>
<td>£500</td>
</tr>
<tr>
<td>You incur costs for out-patient physiotherapy</td>
<td>£500</td>
</tr>
<tr>
<td>We pay your therapist</td>
<td>£0</td>
</tr>
<tr>
<td>We notify you of excess amount you pay direct to your therapist</td>
<td>£500</td>
</tr>
<tr>
<td>Your remaining out-patient benefit limit for the rest of the year</td>
<td>£0</td>
</tr>
<tr>
<td>Your remaining excess for the rest of the year</td>
<td>£0</td>
</tr>
</tbody>
</table>
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 and/or your dependants are a moratorium member
- If you and/or your dependants are an underwritten member: it is important that you complete and send us the application form for you and/or for your dependants if the special conditions section of your membership certificate states that we require you to do so. Until you have completed this we won’t be able to confirm exactly what your policy covers you and/or your dependants for, meaning your claims might take longer for us to process or you might not be eligible to claim for treatment you need

- Benefit limits: these are limits on the amounts we will pay and/or restrictions on the cover you have under your benefits. Your benefit table shows the benefit limits and/or restrictions that apply to your benefits
- Excess: these are 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 benefit table 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.
Please note:

- if you are an **underwritten member**, before a referral for **treatment** can be made through our Direct Access service you may need to provide us with certain information to establish that your condition is not a **pre-existing condition** (please see ‘B2 Providing us with information’ in the ‘Claiming’ section of this guide for full details)

- if you are a **moratorium member**, before using the Direct Access service you will need to follow the standard process for claiming to establish that your condition is not a **moratorium condition** (please see ‘If you are moratorium member’ under A1 in the Claiming section of this guide for full details)

- if your **benefits** do not cover **out-patient** consultations and therapies before **hospital treatment**, 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**

- if monetary limits apply to your **benefits** for **out-patient** consultations and therapies and you have used all the **out-patient benefits** available to you for the **year** you can still use the Direct Access service but any **out-patient** consultations or therapies you are referred for would not be covered under your **benefits**.

The charge for any telephone assessments required as part of our Direct Access 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.

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 out-patient treatment by a therapist, complementary medicine practitioner or mental health and wellbeing therapist.

- the medical practitioner or other healthcare professional and the recognised facility are recognised by us for treating the medical condition you have and for providing the type of treatment you need.

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

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

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

- advanced therapies
- appliances
- consultant fees schedule
- critical care units
- fee-assured consultants
- medical treatment providers
- prostheses
- recognised facilities
- recognised practitioners
- schedule of procedures
- specialist drugs.

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 in your benefit table.

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

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

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

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

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

benefit 1.4 diagnostic tests

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

We do not pay charges for diagnostic tests that are not from the recognised facility.

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

benefit 1.5 out-patient MRI, CT and PET scans

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

- MRI scans (magnetic resonance imaging)
- CT scans (computed tomography)
- 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 in your benefit table. You are not covered for any benefits that are either shown in your benefit table as ‘not covered’ or do not appear in your benefit table.

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 in your benefit table. You are not covered for any benefits that are either shown in your benefit table as ‘not covered’ or do not appear in your benefit table.

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

benefit 3.1 out-patient surgical operations
We pay recognised facility charges for eligible surgical operations carried out as out-patient treatment. We pay for theatre use, including equipment, common drugs, advanced therapies, specialist drugs and surgical dressings used during the surgical operation.

benefit 3.2 day-patient and in-patient treatment
We pay recognised facility charges for day-patient treatment and in-patient treatment, including eligible surgical operations, and the charges we pay for are set out in 3.2.1 to 3.2.7.

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

benefit 3.2.1 accommodation
We pay for your recognised facility accommodation including your own meals and refreshments while you are receiving your treatment.

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

We do not pay recognised facility charges for accommodation if:

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

benefit 3.2.2 parent accommodation
We pay for each night a parent needs to stay in the recognised facility with their child. We only pay for one parent each night. This benefit applies to the child’s cover and any charges are payable from the child’s benefits. The child must be:
• a member under the agreement
• under the age limit shown against parent accommodation in the benefit table 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

Benefit 4.1 Cancer cover
You are only covered for this benefit if your benefit table 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 **eligible 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**

*We* pay **complementary medicine practitioners’** fees for **out-patient treatment** for **cancer** when you are referred for the **treatment** by a **GP** (including via a digital **GP** service) or **consultant**.

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

*Please see ‘Exclusion 14 Drugs and dressings for out-patient or take-home use and complementary and alternative products’ in the section ‘What is not covered’.*
benefit 4.1.4 out-patient diagnostic tests for cancer
When requested by your consultant to help determine or assess your condition as part of out-patient treatment for cancer we pay recognised facility charges (including the charge for interpretation of the results) for diagnostic tests. We do not pay charges for diagnostic tests that are not from the recognised facility.

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

benefit 4.1.5 out-patient cancer drugs
We pay recognised facility charges for common drugs, advanced therapies and specialist drugs that are related specifically to planning and carrying out out-patient treatment for cancer 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 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 5 Mental health treatment
You are only covered for this benefit if your benefit table shows it is covered.

Cover is subject to the limits shown in your benefit table.

We pay for eligible treatment of mental health conditions as set out in this Benefit 5. Your eligible treatment must be provided by a consultant psychiatrist or a mental health and wellbeing therapist.

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

What we pay for mental health treatment
We pay consultant psychiatrists’ and mental health and wellbeing therapists’ fees and recognised facility charges for mental health treatment as follows:

benefit 5.1 out-patient mental health treatment
We pay fees and charges for out-patient mental health treatment as set out in benefits 5.1.1 to 5.1.3.

benefit 5.1.1 consultants’ fees
We pay consultant psychiatrists’ fees for out-patient consultations to assess your mental health condition and for out-patient mental health treatment when you are referred for the consultation or 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.
Remote consultations by telephone or via any other remote medium with a consultant psychiatrist are covered if the consultant is, at the time of your treatment, recognised by us to carry out remote consultations. You can contact us to find out if a consultant psychiatrist is recognised by us for remote consultations or you can access the details at finder.bupa.co.uk

benefit 5.1.2 mental health and wellbeing therapists’ fees
We pay:
- mental health and wellbeing therapists’ fees for out-patient mental health treatment
- for you to have access to an online supported therapy programme/service. The online therapy is based on guided self help and you must use the online programme/service we direct you to,

when the treatment or therapy is recommended 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.

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

benefit 5.1.3 diagnostic tests
When requested by your consultant psychiatrist to help determine or assess your condition as part of out-patient mental health treatment we pay recognised facility charges (including the charge for interpretation of the results) for diagnostic tests.

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

benefit 5.2 day-patient and in-patient mental health treatment
Your benefit table shows the maximum number of days that we pay up to for mental health day-patient treatment and mental health in-patient treatment under your benefits.

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

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

Consultants’ fees
We pay consultant psychiatrists’ fees for mental health treatment carried out in a recognised facility.
Recognised facility charges
We pay the type of recognised facility charges we say we pay for in benefit 3.

Benefit 5.3 Treatment otherwise excluded by the ‘What is not covered’ section
We pay for eligible treatment of mental health symptoms related to or arising from treatment otherwise excluded by the following exclusions in the ‘What is not covered’ section of this membership guide:
- Exclusion 1: Ageing, menopause and puberty
- Exclusion 2: Accident and emergency treatment
- Exclusion 3: Allergies, allergic disorders or food intolerances
- Exclusion 5: Birth control, conception, sexual problems and gender dysphoria or reassignment
- Exclusion 6: Chronic conditions
- Exclusion 10: Cosmetic, reconstructive or weight loss treatment
- Exclusion 11: Deafness
- Exclusion 13: Dialysis
- Exclusion 17: Eyesight
- Exclusion 20: Learning difficulties, behavioural and developmental problems
- Exclusion 24: Pregnancy and childbirth
- Exclusion 25: Screening, monitoring and preventive treatment
- Exclusion 26: Sleep problems and disorders
- Exclusion 28: Speech disorders
- Exclusion 36: Sexually transmitted diseases
- Exclusion 37: Organ transplants
- Exclusion 38: Bone marrow and stem cell transplants

Additional benefits

Benefit 6 Treatment at home
You are only covered for this benefit if your benefit table 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
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**

**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**.

Benefits numbered 9 and 10 do not apply to your cover
Cash benefits

Benefits CB1 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
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
Your benefit table shows the benefit limits that apply.

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:
- or 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 see benefit 4.1.5 out-patient cancer drugs.

Benefit CB7 does not apply to your cover

Benefit CB8 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 in your benefit table and/or 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, complementary medicine practitioner or mental health and wellbeing therapist.

Exception: We pay for eligible treatment for rehabilitation in the following circumstances. By rehabilitation we mean treatment which is aimed at restoring health or mobility or to allow you to live an independent life, such as after a stroke or an accident. We will only pay in cases where the rehabilitation:
- is an integral part of, 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 to change your appearance, such as a remodelled nose or facelift whether or not it is needed for medical or psychological reasons.

**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 and we need full clinical details from your consultant 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 directly affected:
- by an accident, or
- if your benefits include cover for cancer treatment, as a 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 being a member under this scheme and/or a member of another Bupa scheme and/or beneficiary under a trust administered by Bupa eligible to receive benefits for this type of treatment provided there has been no break in your being a member of this scheme and/or member and/or beneficiary as applicable, and
- this is part of the original eligible treatment resulting from the accident or cancer surgery.

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

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

Exclusion 11 Deafness
We do not pay for treatment for or arising from deafness caused by a congenital abnormality, maturing or ageing.

Exclusion 12 Dental/oral treatment
We do not pay for any dental or oral treatment including:

- the provision of dental implants or dentures, the repair or replacement of damaged teeth (including crowns, bridges, dentures, or any dental prosthesis made by a laboratory technician)
- the management of, or any treatment related to, jaw shrinkage or loss as a result of dental extractions or gum disease
- the treatment of bone disease when related to gum disease or tooth disease or damage.

Exception: 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 diseases**

*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.

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

Exclusion 21 Overseas treatment 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 we do not pay for treatment directly or indirectly relating to special conditions.

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

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

Exclusion 28 Speech disorders

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

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

Exclusion 29 This exclusion does not apply to your cover

Exclusion 30 Temporary relief of symptoms

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

We also do not pay for facility charges for treatment that you receive in a hospital or any other type of treatment facility that is not a recognised facility.

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

Please also see the section ‘Benefits’.

Exclusion 32 Unrecognised medical practitioners, providers and facilities
We do not pay for any of your treatment if the consultant who is in overall charge of your treatment is not recognised by Bupa.

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

- the consultant, medical practitioner, therapist, complementary medicine practitioner, mental health and wellbeing therapist or other healthcare professional is:
  - not recognised by Bupa for treating the medical condition you have and/or for providing the type of treatment you need, and/or
  - is not in the list of recognised practitioners that applies to your benefits

- the hospital or treatment facility is:
  - not recognised by Bupa for treating the medical condition you have and/or for providing the type of treatment you need, and/or
  - is not in the facility access list that applies to your benefits

- the hospital or treatment facility or any other provider of services is not recognised by us and/or we have sent a written notice saying that we no longer recognise them for the purpose of our private medical insurance schemes.

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

- where we do not recognise them as having specialised knowledge of, or expertise in, the treatment of the disease, illness or injury being treated
- where we do not recognise them as having specialised expertise and ongoing experience in carrying out the type of treatment or procedure needed
- where we have sent a written notice to them saying that we no longer recognise them for the purposes of our schemes.
Exclusion 33 Moratorium conditions
For *moratorium members* we do not pay for *treatment* of a *moratorium condition*, or a disease, illness or injury that results from or is related to a *moratorium condition*.

**Exception 1:** For *moratorium members*, we pay for *treatment* of a *moratorium condition* if at any time after your *moratoria 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:** If you apply to add your newborn baby as a *dependant* under your membership and the baby’s membership would be as a *moratorium member* we will not apply this exclusion to the baby’s cover if you or your partner have been a member under your *scheme* for at least 12 continuous months before the baby’s birth and you include the baby as a *dependant* within three months of their birth.

*Please also see ‘Cover for a newborn baby’ in the section ‘How your membership works’.*

Exclusion 34 This exclusion does not apply to your cover

Exclusion 35 Neonatal treatment
*We* do not pay for any *treatment* that takes place within the first 28 days of birth including but not limited to *diagnostic tests*, investigations and scans.

*Please also see ‘Pregnancy and childbirth’ in this section.*

Exclusion 36 Sexually transmitted diseases
*We* do not pay for *treatment* for, related to or arising from any sexually transmitted disease or infection.

Exclusion 37 Organ Transplants
*We* do not pay for *treatment* for, related to or arising from organ transplants of the heart, liver or kidney.

Exclusion 38 Bone marrow and stem cell transplants
*We* do not pay for *treatment* for, related to or arising from bone marrow transplants or stem cell transplants.

**Exception:** *We* pay for *eligible cancer treatment* for a bone marrow transplant or stem cell transplant.

Exclusion 39 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*.
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 <strong>treatment</strong> 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 <strong>eligible treatment</strong>, and which are, at the time of your <strong>eligible treatment</strong> included (with the medical condition(s) for which <strong>we</strong> pay for them) on our list of advanced therapies which applies to your <strong>benefits</strong>. The list is available at <a href="http://bupa.co.uk/policyinformation">bupa.co.uk/policyinformation</a> 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 <strong>main member</strong> and us to provide cover for <strong>you</strong> and <strong>your dependants</strong> (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 <strong>benefits</strong> at the time you receive your <strong>treatment</strong>. The list of appliances will change from time to time. Details of the appliances are available on request or at <a href="http://bupa.co.uk/prostheses-and-appliances">bupa.co.uk/prostheses-and-appliances</a></td>
</tr>
<tr>
<td><strong>Application form</strong></td>
<td>the questionnaire we provide to <strong>you</strong> when <strong>you</strong> and/or <strong>your dependants</strong> first take out or are added as a <strong>dependant</strong> to a policy with us which requires <strong>you</strong> and/or <strong>your dependants</strong> to disclose details of <strong>your</strong> and their health, medical history and lifestyle. If <strong>you</strong> no longer have the application form, <strong>you</strong> may call us to request a replacement.</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>the benefits specified on your <strong>benefit table</strong> for which you are entitled as an individual under the <strong>scheme</strong> subject to the terms and conditions that apply to your membership in this membership guide including all exclusions.</td>
</tr>
<tr>
<td><strong>Benefit table</strong></td>
<td>the benefit table included in this membership guide in the section ‘Your benefit table’ which sets out the elements of cover specific to the <strong>scheme</strong>.</td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
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</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>
</tbody>
</table>
| **Chronic condition**         | a disease, illness or injury which has one or more of the following characteristics:  
• it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests  
• it needs ongoing or long-term control or relief of symptoms  
• it requires 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.                                      |
| **Common drugs**              | 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. |
| **Complementary medicine practitioner** | an acupuncturist, chiropractor or osteopath who is a recognised practitioner.  
You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for. |
| **Consultant**                | a registered medical or dental practitioner who, at the time you receive your treatment:  
• is recognised by us as a consultant and has received written confirmation from us of this, unless we recognised him or her as being a consultant before 30 June 1996  
• is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and  
• is in our list of consultants that applies to your benefits.  
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 |
| **Consultant fees schedule**  | the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants’ fees based on:  
• the type of treatment carried out  
• the surgical operations, the type and complexity of the surgical operation according to the schedule of procedures  
• the Bupa recognition status of the consultant, and  
• where the treatment is carried out both in terms of the treatment facility and the location.  
The schedule will change from time to time. Details of the schedule can be found at bupa.co.uk/codes |
<p>| <strong>Cover end date</strong>            | the date on which your current period of cover under the scheme ends shown as ‘Cover end date’ on your membership certificate.            |
| <strong>Cover start date</strong>          | the date on which your current period of cover under the scheme starts shown as ‘Cover start date’ on your membership certificate.        |</p>
<table>
<thead>
<tr>
<th>Word/phrase</th>
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</tr>
</thead>
<tbody>
<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 intensive care that you require at the time you receive your treatment. The units on the list and the type of intensive care that we recognise each unit for will change from time to time. For details of a hospital or a treatment facility, centre or unit in your recognised facility network visit our consultants and facilities website at finder.bupa.co.uk</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>eligible treatment that for medical reasons is received as a day-patient.</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 scheme and named on your membership certificate.</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 scheme shown as ‘Effective underwriting 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 of underwriting by your previous insurer or administrator for your previous scheme.</td>
</tr>
<tr>
<td><strong>Eligible surgical operation</strong></td>
<td>eligible treatment carried out as a surgical operation.</td>
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<tr>
<td><strong>Eligible treatment</strong></td>
<td>treatment of:</td>
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<td></td>
<td>■ an acute condition, or</td>
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<td></td>
<td>■ a mental health condition</td>
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<td>together with the products and equipment used as part of the treatment that:</td>
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<tr>
<td></td>
<td>■ are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the UK</td>
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<tr>
<td></td>
<td>■ are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided</td>
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<tr>
<td></td>
<td>■ are demonstrated through scientific evidence to be effective in improving health outcomes, and</td>
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<tr>
<td></td>
<td>■ are not provided or used primarily for the expediency of you or your consultant or other healthcare professional</td>
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<tr>
<td></td>
<td>and the treatment, services or charges are not excluded under your benefits.</td>
</tr>
<tr>
<td><strong>Excess</strong></td>
<td>the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits. For details please see rule E in the ‘Claiming’ section of this guide and your membership certificate.</td>
</tr>
<tr>
<td><strong>Facility access</strong></td>
<td>the list of Bupa recognised hospitals and treatment facilities, centres or units for which you are covered under your benefits as shown on your benefit table against ‘facility access’. The hospitals and treatment facilities, centres or units in the list and the medical conditions and types of treatment we recognise them for will change from time to time. Details are available on request or at finder.bupa.co.uk</td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
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<tr>
<td><strong>Fee-assured consultant</strong></td>
<td>a <strong>consultant</strong> who, at the time you receive <strong>treatment</strong>, is:&lt;br&gt;- recognised by <strong>us</strong> as a fee-assured consultant, and&lt;br&gt;- in the list of fee-assured consultants that applies to your <strong>benefits</strong>. You can ask <strong>us</strong> if a consultant is a fee-assured consultant and if they are in the list of consultants that applies to your <strong>benefits</strong> or you can access these details at <strong>finder.bupa.co.uk</strong></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 <strong>treatment</strong>, is on the UK General Medical Council’s General Practitioner Register.</td>
</tr>
<tr>
<td><strong>Home</strong></td>
<td>either:&lt;br&gt;- the place where you normally live, or&lt;br&gt;- another non-healthcare setting where you want to have your <strong>treatment</strong>.</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><strong>eligible treatment</strong> that for medical reasons is received as an <strong>in-patient</strong>.</td>
</tr>
<tr>
<td><strong>Intensive care</strong></td>
<td><strong>eligible treatment</strong> 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 <strong>membership certificate</strong>.</td>
</tr>
<tr>
<td><strong>Medical treatment provider</strong></td>
<td>a person or company who is recognised by <strong>us</strong> as a medical treatment provider for the type of <strong>treatment at home</strong> that you need at the time you receive your <strong>treatment</strong>. The list of medical treatment providers and the type of <strong>treatment we</strong> recognise them for will change from time to time. Details of these medical treatment providers and the type of <strong>treatment we</strong> recognise them for are available on request or you can access these details at <strong>finder.bupa.co.uk</strong></td>
</tr>
<tr>
<td><strong>Membership certificate</strong></td>
<td>the most recent membership certificate that <strong>we</strong> issue to <strong>you</strong> for your current continuous period of membership of the <strong>scheme</strong>.</td>
</tr>
<tr>
<td><strong>Mental health and wellbeing therapist</strong></td>
<td>- a psychologist registered with the Health Professions Council&lt;br&gt;- a psychotherapist accredited with UK Council for Psychotherapy, the British Association for Counselling and Psychotherapy or the British Psychoanalytic Council&lt;br&gt;- a counsellor accredited with the British Association for Counselling and Psychotherapy, or&lt;br&gt;- a cognitive behavioural therapist accredited with the British Association for Behavioural and Cognitive Psychotherapies&lt;br&gt;who is a <strong>recognised practitioner</strong>. You can ask <strong>us</strong> if a practitioner is a <strong>recognised practitioner</strong> and the type of <strong>treatment we</strong> recognise them for or you can access these details at <strong>finder.bupa.co.uk</strong></td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
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</tr>
<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 and treated and managed as a mental health condition by a <strong>consultant psychiatrist</strong> or a <strong>mental health and wellbeing therapist</strong>. <strong>We</strong> do not pay for <strong>treatment</strong> of dementia, behavioural or developmental problems once diagnosed.</td>
</tr>
<tr>
<td>Mental health day-patient treatment</td>
<td><em>eligible treatment</em> of a <strong>mental health condition</strong> which for medical reasons means you have to be admitted to a <strong>recognised facility</strong> because you need a period of clinically-supervised <em>eligible treatment</em> of a <strong>mental health condition</strong> as a day case but do not have to occupy a bed overnight and the <strong>mental health treatment</strong> is provided on either an individual or group basis.</td>
</tr>
<tr>
<td>Mental health in-patient treatment</td>
<td><em>eligible treatment</em> of a <strong>mental health condition</strong> that, for medical reasons, is received as an <strong>in-patient</strong>.</td>
</tr>
<tr>
<td>Mental health treatment</td>
<td><em>eligible treatment</em> as set out in Benefit 5 Mental health treatment in the ‘Benefits’ section of this guide.</td>
</tr>
<tr>
<td>Moratoria start date</td>
<td>the date you started your continuous period of cover under the scheme shown as ‘Moratoria start 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 identified by your previous insurer or administrator for determining moratorium conditions under your <strong>previous scheme</strong>.</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 <strong>treatment</strong> for</td>
</tr>
<tr>
<td></td>
<td>• experienced symptoms of, or</td>
</tr>
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<td></td>
<td>• were to the best of your knowledge aware existed</td>
</tr>
<tr>
<td></td>
<td>in the five years before your <strong>moratoria start date</strong>. By a related condition <strong>we</strong> 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 <strong>membership certificate</strong> shows the underwriting method applied to them is moratorium.</td>
</tr>
<tr>
<td>NHS</td>
<td>• the National Health Service operated in Great Britain and Northern Ireland, or</td>
</tr>
<tr>
<td></td>
<td>• the healthcare scheme that is operated by the relevant authorities of the Channel Islands, or</td>
</tr>
<tr>
<td></td>
<td>• the healthcare scheme that is operated by the relevant authorities of the Isle of Man.</td>
</tr>
<tr>
<td>Nurse</td>
<td>a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.</td>
</tr>
<tr>
<td>Out-patient</td>
<td>a patient who attends a hospital, consulting room, out-patient clinic or treatment facility and is not admitted as a <strong>day-patient</strong> or an <strong>in-patient</strong>.</td>
</tr>
<tr>
<td>Out-patient surgical operation</td>
<td>an <strong>eligible surgical operation</strong> received as an <strong>out-patient</strong>.</td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
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<tr>
<td>---------------------</td>
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</tr>
<tr>
<td>Out-patient treatment</td>
<td><em>eligible treatment</em> that for medical reasons is received as an <em>out-patient</em>.</td>
</tr>
<tr>
<td>Partner</td>
<td><em>your</em> husband or wife or civil partner or the person <em>you</em> live with in a relationship similar to that of a husband and wife whether of the opposite sex or not.</td>
</tr>
<tr>
<td>Pre-existing condition</td>
<td>any disease, illness or injury for which in the seven years before your <em>effective underwriting date</em>: • you have received medication, advice or <em>treatment</em>, or • you have experienced symptoms whether the condition was diagnosed or not.</td>
</tr>
<tr>
<td>Previous scheme</td>
<td>• another <em>Bupa</em> 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 <em>waiting periods</em>, <em>moratoria start date</em>, <em>effective underwriting date</em> or continuous periods of cover as applicable provided that: • you have provided <em>us</em> with evidence of your continuous cover under the previous scheme, and • there is no break in your cover between the previous scheme and your <em>scheme</em>.</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>any prosthesis which is in <em>our</em> list of prostheses for both your <em>benefits</em> and your type of <em>treatment</em> at the time you receive your <em>treatment</em>. The prostheses on the list will change from time to time. Details of the prostheses covered under your <em>benefits</em> for your type of <em>treatment</em> are available on request or at bupa.co.uk/prostheses-and-appliances</td>
</tr>
<tr>
<td>Recognised facility</td>
<td>a hospital or a treatment facility, centre or unit within your <em>facility access</em>, which at the time you receive your <em>eligible treatment</em> is recognised by <em>us</em> for both: • treating the medical condition you have, and • carrying out the type of treatment you need.</td>
</tr>
<tr>
<td>Recognised practitioner</td>
<td>a healthcare practitioner who at the time of your <em>treatment</em>: • is recognised by <em>us</em> for the purpose of our private medical insurance schemes for treating the medical condition you have and for providing the type of <em>treatment</em> you need, and • is in <em>our</em> list of recognised practitioners that applies to your <em>benefits</em>. You can ask <em>us</em> if a practitioner is a recognised practitioner and the type of <em>treatment</em> <em>we</em> recognise them for or you can access these details at finder.bupa.co.uk</td>
</tr>
<tr>
<td>Renewal date</td>
<td>• each anniversary of your <em>cover start date</em>, or • a common renewal date. Cover is generally renewed annually. Depending on the month in which you first join the <em>scheme</em> your initial period of cover may not be a full 12 months. Your cover and your <em>subscriptions</em> may change at the common renewal date. To identify which applies to <em>you</em> please see your <em>membership certificate</em> or eligibility information leaflet.</td>
</tr>
<tr>
<td>Resident</td>
<td>where your current, permanent address is.</td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
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</tr>
<tr>
<td><strong>Schedule of</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>procedures</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Scheme</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Special condition</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Specialist drugs</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Surgical operation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Therapist</strong></td>
<td>a chartered physiotherapist</td>
</tr>
<tr>
<td>Word/phrase</td>
<td>Meaning</td>
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<td>--------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>We/our/us</td>
<td>Bupa.</td>
</tr>
<tr>
<td><strong>Year</strong></td>
<td>for each period of your cover, the period beginning on your <em>cover start date</em> and ending on your <em>cover end date</em> for that period of cover.&lt;br&gt;If your <em>renewal date</em> is a common renewal date or if you are a <em>dependant</em> joining an existing policy then depending on the month in which you first join the <em>scheme</em>, your initial period of cover may not be a full 12 months. Your cover and your subscriptions may change at the <em>renewal date</em>.</td>
</tr>
<tr>
<td><strong>You/your</strong></td>
<td>this means the <em>main member</em> 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

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

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.