

Your Bupa membership guide

Bupa Fundamental Health Insurance

Essential information explaining your Bupa cover
Please retain



About this guide

Welcome to your Bupa membership guide

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

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

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

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

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

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

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

Demands and needs statement

This policy is generally suitable for someone who is looking to cover the cost of a range of health expenses. **We** have not provided you with any advice regarding this policy. If you have purchased through a non-**Bupa** financial adviser then please refer to the demands and needs statement that they have provided you with.

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

How do I know what I'm covered for?

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

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

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

Bupa Anytime HealthLine[^]

If you have any questions or worries about your health call **our** confidential Bupa Anytime HealthLine on **0345 601 3216**[†]. **Our** qualified nursing team is on hand 24 hours a day, so whatever your health question or concern, they have the skills and practical, professional experience to help.

Family Mental HealthLine[^]

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

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

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

[#]Telephone support between 8am to 6pm Monday to Friday.

[†]Calls may be recorded and to maintain the quality of our service a nursing manager may monitor some calls always respecting the confidentiality of the call.

Contents

Your rules and benefits	5
Effective from date: 1 January 2021	5
Eligibility	6
How your membership works	7
The agreement between you and us	7
Payment of benefits	7
When your membership starts, renews and ends	8
Making changes	12
General information	13
Private Healthcare Information Network	14
Making a complaint	14
Understanding your cover	16
Claiming	18
Step-by-step guide to making a claim	18
A Information on claiming	20
B How we will deal with your claim	22
C If you want to withdraw a claim	24
D Treatment costs outside the terms of your cover	24
E If you have an excess	24
Benefits	26
Notes on benefits	26
What you are covered for	29
Cash benefits	38
What is not covered	40
Glossary	52
Privacy notice – in brief	60
Financial crime and sanctions	63

Your rules and benefits

Effective from date: 1 January 2021

These are the rules and benefits that apply to Bupa Fundamental Health Insurance.

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

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

Important note

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

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

This membership guide is a generic guide. It contains the general membership terms that apply to Bupa members. It also sets out all the elements of cover that are available for Bupa members under all their *schemes*. This means that you may not have all the cover set out in this membership guide. It is your *membership certificate* that shows the cover that is specific to your *benefits* and *scheme*. Any elements of cover in this membership guide that are either:

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

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

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

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

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

Eligibility

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

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

How your membership works

The agreement between you and us

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

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

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

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

Payment of benefits

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

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

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

In many cases **we** have arrangements with providers about how much they charge **our** members for **treatment** and how **we** pay them. For **treatment** costs covered under your **benefits we** will, in most cases, pay the provider of your **treatment** direct – such as the **recognised facility** or **consultant** – or whichever other person or facility is entitled to receive the payment. Otherwise **we** will pay the **main member**. **We** will write to tell the **main member** or **dependant** having **treatment** (when aged 16 and over) when there is an amount for them to pay in relation to any claim (for example if they have an **excess** amount to pay) and who payment should be made to.

Please also see the section 'Claiming'.

When your membership starts, renews and ends

Starting membership

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

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

Your right to cancel

You may cancel **your** membership for any reason by calling **us** on 0800 010 383* or writing to **us** within the later of 21 days of:

- receipt of **your** policy documents (including **your membership certificate**) **we** send **you** each **year** confirming **your** cover, or
- the **cover start date** of **your** policy.

During this period, if **you** have not made any claims **we** will refund all of **your** subscriptions for that **year**. After this period of time **you** can cancel **your** cover at any time, **we** will refund any subscriptions **you** have paid relating to the period after **your** cover ends.

You may cancel any of **your dependants'** membership for any reason by calling **us** on 0800 010 383* or writing to **us** within the later of 21 days of:

- receipt of **your** policy documents (including **your membership certificate**) **we** send **you** each **year** confirming cover for that **dependant**, or
- the **cover start date** of that **dependant**.

During this period, as long as no claims have been made in respect of their cover **we** will refund all of **your** subscriptions paid in respect of that **dependant's** cover for that **year**. After this period of time **you** can cancel their cover at any time, **we** will refund any subscriptions **you** have paid relating to the period after their cover ends.

*We may record or monitor our calls.

Renewing your membership

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

Your membership will renew automatically as long as *you* continue to pay *your* subscriptions and any other charges unless:

- *you* decide to end *your* membership
- *we* decide to end the *scheme*, or
- *we* do not agree to *your* membership or the membership of any of *your dependants* renewing.

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

How membership can end

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

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

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

A *dependant's* membership will automatically end if:

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

*We may record or monitor our calls.

When we may cancel cover

If there is reasonable evidence that **you** or a **dependant** did not take reasonable care in answering **our** questions (by this **we** mean giving false information or keeping necessary information from **us**) then if this was:

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

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

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

Joining another Bupa scheme

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

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

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

Paying subscriptions and other charges

You must pay subscriptions including Insurance Premium Tax (IPT) in advance throughout **your** membership. Bupa Insurance Services Limited acts as **our** agent for arranging and administering **your** policy. Subscriptions are collected by Bupa Insurance Services Limited as **our** agent for the purpose of receiving, holding and refunding subscriptions and claims monies. The amount and method of payment is shown on **your membership certificate**.

No claims discount (NCD)

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

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

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

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

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

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

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

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

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

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

Please note:

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

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

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

Making changes

Changes we can make

We can change the terms and conditions of the membership at **your renewal date**.

These changes could affect:

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

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

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

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

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

- 28 days of the date on which the change takes effect, or
- 28 days of **Bupa** telling **you** about the change.

Changes you can make

At **your renewal date** **you** can apply to:

- add, remove or change an **excess**
- change any of the product options **you** have chosen

if such options are available under your **scheme**. **We** will consider **your** application at **our** sole discretion. If **you** apply to increase cover under the **scheme**, **we** may ask **you** to agree to **special conditions** before **we** accept **your** application.

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

Changes your authorised signatory can make

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

Other parties

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

General information

Change of address

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

Correspondence and documents

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

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

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

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

Applicable law

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

Private Healthcare Information Network

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

Making a complaint

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

By phone: **0345 609 0111***

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

By email: **customerrelations@bupa.com**

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

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

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

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

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

If you remain unhappy with **our** response, or after eight weeks you do not wish to wait for **us** to complete **our** review, you may refer your complaint to the Financial Ombudsman Service. You can write to them at: **Exchange Tower, London E14 9SR** or contact them via email at **complaint.info@financial-ombudsman.org.uk** or call them on **0800 023 4567** (calls to this number are free on mobile phones and landlines) or **0300 123 9123** (calls to this number cost no more than calls to 01 and 02 numbers).

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

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

*We may record or monitor our calls.

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

The European Commission also provides an online dispute resolution (ODR) platform which allows consumers who purchase online to submit complaints through a central site which forwards the complaint to the relevant Alternative Dispute Resolution (ADR) scheme. For **Bupa**, complaints will be forwarded to the Financial Ombudsman Service and you can refer complaints directly to them using the details above. For more information about ODR please visit <http://ec.europa.eu/consumers/odr>

The Financial Services Compensation Scheme (FSCS)

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

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

Understanding your cover

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

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

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

Excluded treatment

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

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

Included treatment

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

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

Excluded treatment

Any subsequent consultations before hospital **treatment** are not covered.

*We may record or monitor our calls.

3 Your scans or tests are completed and a diagnosis given. You are advised you need treatment in hospital

Included treatment

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

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

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

Included treatment

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

Contact **us** again so **we** can pre-authorise the next steps of your **treatment**.

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](https://www.bupa.co.uk/referrals)

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

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

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

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

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

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

However, **we** strongly recommend that you ensure your selected consultant is a **fee-assured consultant**.

Step 3 Your consultant determines that treatment is needed – call us

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

Step 4 Get a pre-authorisation number

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

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

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

Information about cover for children aged 17 or under

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

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

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

Claims checklist

What you will need to make a claim

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

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

Claims Line 0345 609 0111*

*We may record or monitor our calls.

A Information on claiming

A1 Claims other than Cash benefits

If you are a moratorium member

When you joined the *scheme* as a *moratorium member* you agreed you would not be covered for *treatment* of any *moratorium conditions*. Each time you make a claim you must provide *us* with information so *we* can confirm whether your proposed *treatment* is covered under your *benefits*.

Before you arrange any consultation or *treatment* call *us* and *we* will send you a pre-treatment form to complete. You will need to provide details of the history of the medical condition you are claiming for, including information that you will need to ask your *GP* or *consultant* for. Your *GP* or *consultant* may charge you a fee for providing a report, which *we* do not pay. Each claim you make during your membership will be assessed on this information and any further information *we* ask you to provide to *us* at the time you claim.

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

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

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

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

If you are an underwritten member

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

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

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

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

Case management

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

A2 Claims for Cash benefits

If you are a *moratorium member*

- Call the helpline and **we** will send you a form to complete. You will need to provide details of the history of the medical condition you are claiming for, including information that you will need to ask your **GP** or **consultant** for. Your **GP** or **consultant** may charge you a fee for providing a report which **we** do not pay. Each claim you make while you are a **moratorium member** will be assessed on this information and any further information **we** ask you to provide to **us** at the time you claim.
- Once **we** receive all the information **we** ask you for **we** will:
 - confirm whether your **treatment** will be **eligible** for NHS cash benefit and if so the level of **benefits** available to you, and
 - if required, send you a claim form which you will need to take with you to the hospital and ask them to complete the hospital sections. You will need to return your fully completed form to **us** as soon as possible and in any event within six months of receiving your **treatment** unless this was not reasonably possible.

If you are an *underwritten member*

Call the helpline and **we** will:

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

A3 Treatment needed because of someone else's fault

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

- you agree you are responsible for the payment of any costs which may ultimately be recovered from the third party
- you must notify **us** as soon as possible that your **treatment** was needed as a result of a third party. You can notify **us** either by writing to **us** or completing the appropriate section on your claim form. You must provide **us** with any further details that **we** reasonably ask you for

- you must take any reasonable steps **we** ask of you to recover from the third party the cost of the **treatment** paid for by **us** and claim interest if you are entitled to do so
- you (or your solicitor) must keep **us** fully informed in writing of the progress and outcome of your claim
- if you recover the cost of any **treatment** paid for by **us**, you must repay the amount and any interest to **us**.

A4 Other insurance cover

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

B How we will deal with your claim

B1 General information

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

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

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

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

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

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

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

B2 Providing us with information

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

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

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

Medical reports – when we need more information from your doctor

When **we** need to ask your doctor for more information, in writing about your consultation, tests or treatment for insurance purposes, **we** will need your permission.

The Access to Medical Reports Act 1988 or the **Access to Personal Files and Medical Reports (NI) Order 1991** give you certain rights, which are:

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

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

Your doctor can withhold some or all the information in the report if, in their view, the information:

- might cause physical or mental harm to you or someone else, or
- it would reveal someone else's identity without their permission (unless the person is a healthcare professional and the information is about your care provided by that person).

We may be able to pay towards the cost of a medical report. **We** will let you know when **we** ask for your permission to request the report from your doctor. If **we** can pay towards it, you will need to pay any remaining amount.

B3 How we pay your claim

Claims other than cash benefits: for *treatment* costs covered under your *benefits* we will, in most cases, pay the provider of your *treatment* direct – such as the *recognised facility* or *consultant* – or whichever other person or facility is entitled to receive the payment. Otherwise *we* will pay the *main member*. *We* will write to tell the *main member* or *dependant* having *treatment* (when aged 16 and over) when there is an amount for them to pay in relation to any claim (for example if they have an *excess* amount to pay) and who payment should be made to (for example their *consultant* or *treatment* facility).

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

C If you want to withdraw a claim

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

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

D Treatment costs outside the terms of your cover

When you receive private medical treatment you have a contract with the providers of your *treatment*. Any costs that are not covered under your *benefits* you are responsible for paying.

E If you have an excess

You may have agreed with *us* that an *excess* shall apply to your *benefits*. *Your membership certificate* shows if one does apply and if so:

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

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

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

E1 How an excess works

Having an *excess* means that you have to pay part of any *eligible treatment* costs that would otherwise be paid by *us* up to the amount of your *excess*. By *eligible treatment* costs *we* mean costs that would have been payable under your *benefits* if you had not had an *excess*. Costs you incur for *treatment* that are not payable under your *benefits* do not count towards your *excess*.

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

We will write to the **main member** or **dependant** having **treatment** (when aged 16 and over) to tell them who to pay their **excess** to, for example, their **consultant, therapist** or **recognised facility**. The **excess** must be paid direct to them – not to **Bupa**.

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

E2 How the excess applies to your benefits

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

- **we** apply the **excess** to your claims in the order in which **we** process those claims
- except for Benefit 1.2, when you claim for **eligible treatment** costs under a **benefit** that has a benefit limit, your **excess** amount will count towards your total benefit limit for that **benefit**
- the **excess** does not apply to: Benefit 1.2 **out-patient** therapies and charges related to **out-patient treatment** or cash benefits.

Benefits

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

Notes on benefits

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

Restrictions and/or limitations to benefits

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

- **If you are a moratorium member**
- **If you are an underwritten member:** please note, if **you** and/or **your dependants** are an **underwritten member**, it is important that **you** complete and send **us** the **application form** for **you** and/or 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
- **Benefits limits:** these are limits on the amounts **we** will pay and/or restrictions on the cover you have under your **benefits**. Your **membership certificate** shows the benefit limits and/or restrictions that apply to your **benefits**
- **Excess:** this is explained in rule E in the section 'Claiming'. Your **membership certificate** shows if an **excess** applies to your **benefits**. If one does apply, your benefit limits shown in your **membership certificate** will be subject to your **excess**
- **Exclusions apply to your cover:** the general exclusions are set out in the section 'What is not covered'. Some exclusions also apply in this section and there may also be exclusions on your **membership certificate**.

Being referred for treatment

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

- **our** Direct Access service, if you have cover for it. For details about cover for Direct Access and how it works see the section 'Direct Access service'
- a **GP** (including via a digital **GP** service), or
- another healthcare practitioner. The situations in which **we** will accept such a referral are set out on [bupa.co.uk/referrals](https://www.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](https://www.bupa.co.uk/direct-access) or you can call **us**.

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

Please note:

- **if you are an underwritten member**, before a referral for **treatment** can be made through **our** Direct Access service you may need to provide **us** with certain information to establish that your condition is not a **pre-existing condition** (please see 'B2 Providing us with information' in the 'Claiming' section of this guide for full details)
- **if you are a moratorium member**, before using **our** Direct Access service you will need to follow the standard process for claiming to establish that your condition is not a **moratorium condition** (please see 'If you are moratorium member' under A1 in the Claiming section of this guide for full details).

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

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

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

Bupa recognised medical practitioners and recognised facilities

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

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

Please note:

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

Your **treatment** costs are only covered when:

- the person who has overall responsibility for your **treatment** is a **consultant**. If the person who has overall responsibility for your **treatment** is not a **consultant** then none of your **treatment** costs are covered – the only exception to this is where a **GP** or **our** Direct Access service refers you for eligible **out-patient treatment** by a **therapist**
- the medical practitioner or other healthcare professional and the **recognised facility** are recognised by **us** for treating the medical condition you have and for providing the type of **treatment** you need.

Changes to lists

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

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

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

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

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

Reasonable and customary charges

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

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

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

What you are covered for

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

Benefit 1 out-patient consultations and treatment

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

benefit 1.1 out-patient consultations

We pay **consultants'** fees for **out-patient** consultations that are to assess your **acute condition** when carried out as **out-patient treatment** and you are referred for the consultation by:

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

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

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

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

Out-patient therapies

We pay **therapists'** fees for **out-patient treatment** when you are referred for the **treatment** by:

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

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

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

Charges related to out-patient treatment

We pay provider charges for **out-patient treatment** which is related to and is an integral part of your **out-patient treatment**, including **recognised facility** charges for a **prosthesis** or **appliance** needed as part of that **out-patient treatment**. *We* treat these charges as falling under this benefit 1.2 and subject to its benefit limit.

benefit 1.3 out-patient complementary medicine treatment

This benefit 1.3 is not covered under your policy.

benefit 1.4 diagnostic tests

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

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

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

benefit 1.5 out-patient MRI, CT and PET scans

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

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

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

Being treated in hospital

Benefit 2 Consultants' fees for surgical and medical hospital treatment

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

benefit 2.1 surgeons and anaesthetists

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

benefit 2.2 physicians

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

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

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

Benefit 3 Recognised facility charges

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

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

benefit 3.1 out-patient surgical operations

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

benefit 3.2 day-patient and in-patient treatment

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

Using a non-recognised facility

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

benefit 3.2.1 accommodation

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

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

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

- the charge is for an overnight stay for **treatment** that would normally be carried out as **out-patient treatment** or **day-patient treatment**
- the charge is for use of a bed for **treatment** that would normally be carried out as **out-patient treatment**

- the accommodation is primarily used for any of the following purposes:
 - convalescence, rehabilitation, supervision or any purpose other than receiving **eligible treatment**
 - receiving general nursing care or any other services which could have been provided in a nursing home or in any other establishment which is not a **recognised facility**
 - receiving services from a **therapist**.

benefit 3.2.2 parent accommodation

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

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

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

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

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

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

benefit 3.2.4 intensive care

We pay for **intensive care** when needed as an essential part of your **eligible treatment** if all the following conditions are met:

- the **intensive care** is required routinely by patients undergoing the same type of **treatment** as yours, and
- you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**, and
- the **intensive care** is carried out in the **critical care unit**, and
- it follows your planned admission to the **recognised facility** for private **eligible treatment**.

If you are receiving private **eligible treatment** which does not routinely require **intensive care** as part of that **eligible treatment** and unforeseen circumstances arise that require **intensive care** we will only pay for the **intensive care** if you are receiving your private **eligible treatment** in a **recognised facility** and either:

- the **recognised facility** is equipped with a **critical care unit**, and your **intensive care** is carried out in that **critical care unit**, or

- the **recognised facility** is not equipped with a **critical care unit** but has a prior agreement with **us** to follow an emergency protocol agreed with another **recognised facility** that is equipped with a **critical care unit**, which is either adjacent or is part of the same group of companies, and you are transferred under that prior emergency protocol and your **intensive care** is carried out in that **critical care unit**,

in which case your **consultant** or **recognised facility** should contact **us** at the earliest opportunity.

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

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

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

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

Please also see 'Exclusion 19 Intensive care (other than routinely needed after private day-patient treatment or in-patient treatment)' and 'Exclusion 2 Accident & emergency treatment' in the section 'What is not covered'.

benefit 3.2.5 diagnostic tests and MRI, CT and PET scans

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

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

benefit 3.2.6 therapies

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

benefit 3.2.7 prostheses and appliances

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

We do not pay for any further **treatment** which is associated with or related to a **prosthesis** or **appliance** such as its maintenance, refitting or replacement when you do not have acute symptoms that are directly related to that **prosthesis** or **appliance**.

Benefits for specific medical conditions

Benefit 4 Cancer treatment

Your **membership certificate** shows whether you have cover for **treatment** for **cancer** and if so whether you are covered for:

- benefit 4.1 Cancer Cover, or
- benefit 4.2 NHS Cancer Cover Plus.

Benefit 4.1 Cancer cover

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

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

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

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

benefit 4.1.1 out-patient consultations for cancer

We pay **consultants'** fees for consultations that are to assess your **acute condition** of **cancer** when carried out as **out-patient treatment** and you are referred for the **out-patient** consultation by:

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

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

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

Out-patient therapies

We pay **therapists'** fees for **out-patient treatment** for **cancer** when you are referred for the **treatment** by:

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

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

if a **therapist** or **recognised practitioner** is recognised by **us** for remote consultations or you can access the details at **finder.bupa.co.uk**

Charges related to out-patient treatment

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

benefit 4.1.3 out-patient complementary medicine treatment for cancer

This benefit is not covered under your policy.

benefit 4.1.4 out-patient diagnostic tests for cancer

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

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

benefit 4.1.5 out-patient cancer drugs

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

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

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

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

Benefit 4.2 NHS Cancer Cover Plus

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

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

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

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

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

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

Benefit 5 Mental health treatment

This benefit is not covered under your policy.

Additional benefits

Benefit 6 Treatment at home

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

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

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

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

Benefit 7 Home nursing after private eligible in-patient treatment

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

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

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

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

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

Benefit 8 Private ambulance charges

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

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

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

Cash benefits

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

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

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

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

Except for NHS cash benefit for *cancer treatment* taken by mouth as set out in benefit CB6.2, this benefit CB1 is not payable at the same time as any other NHS cash benefit for *NHS in-patient treatment*.

Benefits CB2 to CB5 do not apply to your cover

Benefit CB6 NHS cash benefit for treatment for cancer

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

You are only covered for this benefit if your *membership certificate* shows it is covered. If you are covered, your *membership certificate* shows the benefit limits that apply.

Except for NHS cash benefit for *cancer treatment* taken by mouth as set out in benefit CB6.2, this benefit CB6.1 is not payable at the same time as any other NHS cash benefit for *NHS in-patient treatment*.

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

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

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

You are only covered for this benefit if your *membership certificate* shows it is covered. If you are covered, your *membership certificate* shows the benefit limit that applies.

Except for NHS cash benefit for **cancer treatment** taken by mouth, this benefit CB6.2 is:

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

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

We pay this NHS cash benefit as follows:

- for each day you receive radiotherapy and/or proton beam therapy in a hospital setting
- for each day you receive IV-chemotherapy **treatment**
- for each day on which you have a consultation with your consultant and they provide you with a prescription for **cancer treatment** taken by mouth
- for the day on which you undergo a **surgical operation**

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

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

Where **we** refer to '**cancer treatment** taken by mouth' **we** mean:

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

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

Please also see benefit 4.1.5 out-patient cancer drugs.

Benefit CB7 Procedure Specific NHS cash benefit

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

We pay Procedure Specific NHS cash benefit in relation to certain specific **treatment** provided to you free of charge under the **NHS**. **We** only pay Procedure Specific NHS cash benefit if your **treatment** would otherwise have been covered for private **treatment** under your **benefits**. **We** pay your Procedure Specific NHS cash benefit directly to the **main member**. For information on Procedure Specific NHS cash benefits please call **us** or go to **bupa.co.uk/pscb**. These cash benefits may change from time to time.

What is not covered

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

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

Exclusion 1 Ageing, menopause and puberty

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

Exclusion 2 Accident and emergency treatment

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

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

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

Exclusion 3 Allergies, allergic disorders or food intolerances

We do not pay for **treatment**:

- to de-sensitise or neutralise any allergic condition or disorder, or
- of any food intolerance.

Once a diagnosis of an allergic condition or disorder or food intolerance has been confirmed **we** do not pay for any further **treatment**, including **diagnostic tests**, to identify the precise allergen(s) or foodstuff(s) involved – this means, for example, if you are diagnosed with a tree nut allergy **we** will not pay for further investigations into which specific nut(s) you are allergic to.

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

We do not pay for any **treatment**, services or charges that are not covered under your **benefits**. These include, for example, personal travel and/or accommodation costs which are not expressly set out in your **benefits**. **We** also do not pay for any **treatment** costs in excess of the amounts for which you are covered under your **benefits**.

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

We do not pay for **treatment**:

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

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

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

Exclusion 6 Chronic conditions

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

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

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

Please note: in some cases it might not be clear, at the time of **treatment**, that the disease, illness or injury being treated is a **chronic condition**. **We** are not obliged to pay the ongoing costs of continuing, or similar, **treatment**. This is the case even where **we** have previously paid for this type of or similar **treatment**. When you are receiving **in-patient treatment**, in making **our** decision on whether your condition is, or has become, a **chronic condition**, **we** will consider the period of days during which there has been no change in your clinical condition or change in your **treatment**.

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

We do not consider a **mental health condition** as a **chronic condition**. We explain what we pay for **eligible treatment of mental health conditions** in Benefit 5 Mental health treatment in the 'Benefits' section of this guide.

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

Exclusion 7 Complications from excluded conditions/treatment and experimental treatment

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

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

Exclusion 8 Contamination, wars, riots and terrorist acts

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

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

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

Exclusion 9 Convalescence, rehabilitation and general nursing care

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

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

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

- is an integral part of, and immediately follows, **in-patient treatment**, and
- starts within 42 days from and including the date you first receive that **in-patient treatment**, and
- is part of a personalised programme involving at least two **therapists**, each from a different specialism not including occupational therapy, and
- is led or supported by a **consultant** trained and accredited in Rehabilitation Medicine, and

- takes place at a **recognised facility**, and
- your **consultant** confirms to **us** that you are physically and mentally able to start the rehabilitation programme within the defined timescales.

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

Exclusion 10 Cosmetic, reconstructive or weight loss treatment

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

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

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

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

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

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

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

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

Before any **treatment** starts you must have **our** confirmation that one of the above criteria has been met before **we** can determine this.

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

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

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

We only pay if all the following apply:

- the accident or the **cancer** surgery takes place during your current continuous period of cover under this **scheme**, and
- this is part of the original **eligible treatment** resulting from the accident or **cancer** surgery.

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

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

Exclusion 11 Deafness

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

Exclusion 12 Dental/oral treatment

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

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

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

- treat a jaw bone cyst, but not if it is related to a cyst or abscess on the tooth root or any other tooth or gum disease or damage
- surgically remove a complicated, buried or impacted tooth root, such as an impacted wisdom tooth, but not if the purpose is to facilitate dentures or the **acute condition** relates to a **pre-existing condition** or a **moratorium condition**.

Exclusion 13 Dialysis

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

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

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

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

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

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

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

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

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

Exclusion 15 Excluded treatment or medical conditions

We do not pay for:

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

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

Exclusion 16 Experimental drugs and treatment

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

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

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

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

- for the proposed **treatment we** are provided with an MDT report, which includes one of the following:
 - evidence that the drug **treatment** has been found to have likely benefit on your condition through a predictive genetic test where appropriate/available, or
 - evidence there is a European Medicines Agency (EMA) licence for the drug used to treat **your** condition and the drug is used within its licensed protocol, or
 - evidence that at least one **NHS**/National Comprehensive Cancer Network (NCCN)/European Society for Medical Oncology (ESMO) protocol exists, with supporting phase III clinical trial evidence, for your exact condition (ie the specific indication including tumour type, staging and phase of **treatment** if relevant), or
 - evidence that the drug treatment has published phase III clinical trial results showing that it is safe and effective for your condition.

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

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

Exclusion 17 Eyesight

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

We do not pay for laser-assisted cataract surgery.

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

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

Exclusion 18 Pandemic or epidemic disease

We do not pay for **treatment** for or arising from any pandemic disease and/or epidemic disease. By pandemic **we** mean the worldwide spread of a disease with epidemics occurring in many countries and most regions of the world. By epidemic **we** mean the occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events materially in excess of normal expectancy, or as otherwise defined by the World Health Organisation (WHO).

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

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

- you have been directly admitted into a **critical care unit** at the point of admission, such as following:
 - an **NHS** transfer to a **recognised facility**
 - an **out-patient** consultation
 - a **GP** referral
 - repatriation
 - private facility to private facility transfer

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

Please also see 'benefit 3.2.4 Intensive care' in the section 'Benefits'.

Exclusion 20 Learning difficulties, behavioural and developmental problems

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

Exclusion 21 Overseas treatment or repatriation

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

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

Before the **treatment** starts you must have **our** written confirmation that the above criteria have been met and **we** need full clinical details from your **consultant**, including confirmation that the **treatment** is not available in the **UK**, before **we** can determine this.

You will need to settle the claim direct to the medical provider or treatment facility yourself and submit your receipts to **us** before **we** reimburse you up to the level of the alternative **treatment** available in the **UK**.

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

Exclusion 22 Physical aids and devices

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

Exception: **We** pay for **prostheses** and **appliances** as set out in benefits 1 and 3, in the section 'Benefits'.

Exclusion 23 Pre-existing conditions

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

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

- **you** have been sent your **membership certificate** which lists the person with the **pre-existing condition** (whether this is **you** or one of **your dependants**)
- **you** gave **us** all the information **we** asked **you** for, before **we** sent **you your** first membership certificate listing the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**

- neither **you** nor the person with the **pre-existing condition** knew about it before **we** sent **you your** first membership certificate which lists the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**, and
- **we** did not exclude cover (for example under a **special condition**) for the costs of the **treatment**, when **we** sent **you your membership certificate**.

Exclusion 24 Pregnancy and childbirth

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

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

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

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

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

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

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

Exclusion 25 Screening, monitoring and preventive treatment

We do not pay for:

- health checks or health screening, by health screening **we** mean where you may or may not be aware you are at risk of, or are affected by, a disease or its complications but are asked questions or have tests to find out if you are and which may lead to you needing further tests or **treatment**
- routine tests, or monitoring of medical conditions, including:
 - routine antenatal care or screening for and monitoring of medical conditions of the mother or foetus during pregnancy
 - routine checks or monitoring of **chronic conditions** such as diabetes mellitus or hypertension

- tests or procedures which, in **our** reasonable opinion based on established clinical and medical practice, are carried out for screening or monitoring purposes, such as endoscopies when no symptoms are present
- preventive **treatment**, procedures or medical services (including vaccinations)
- medication reviews or appointments where you have had no change in your usual symptoms.

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

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

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

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

Exclusion 26 Sleep problems and disorders

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

Exclusion 27 Special conditions

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

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

Exclusion 28 Speech disorders

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

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

Exclusion 29 This exclusion does not apply to your cover

Exclusion 30 Temporary relief of symptoms

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

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

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

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

If your **facility access** is:

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

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

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

Please also see the section 'Benefits'.

Exclusion 32 Unrecognised medical practitioners, providers and facilities

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

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

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

Bupa does not recognise consultants, therapists, or other healthcare professionals in the following circumstances:

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

Exclusion 33 Moratorium conditions

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

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

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

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

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

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

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

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

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

Exclusion 34 Mental health conditions

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

Exclusion 35 Advanced therapies and specialist drugs

We do not pay for:

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

Glossary

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

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

Word/phrase	Meaning
Activities of daily living	functional mobility, bathing/showering, self-feeding, personal hygiene/grooming, toilet hygiene, fulfilment of work or educational responsibilities.
Acute condition	a disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
Advanced therapies	gene therapy, somatic-cell therapy or tissue engineered medicines classified as Advanced Therapy Medical Products (ATMPs) by the European Medicines Agency to be used as part of your eligible treatment and which are, at the time of your eligible treatment , included (with the medical condition(s) for which we pay for them) on our list of advanced therapies that applies to your benefits. The list is available at bupa.co.uk/policyinformation or you can call us . The advanced therapies on the list will change from time to time.
Agreement	the agreement between the main member and us to provide cover for you and your dependants (if any) under the terms and conditions set out in the documents referred to under the heading 'The agreement between you and us' in the section 'How your membership works'.
Appliance	any appliance which is in our list of appliances for your benefits at the time you receive your treatment . The list of appliances will change from time to time. Details of the appliances are available on request or at bupa.co.uk/prostheses-and-appliances
Application form	the questionnaire we provide to you when you and/or your dependants first take out or are added as a dependant to a policy with us which requires you and/or your dependants to disclose details of your and their health, medical history and lifestyle. If you no longer have the application form, you may call us to request a replacement.
Benefits	the benefits specified on your membership certificate for which you are entitled as an individual under the scheme subject to the terms and conditions that apply to your membership in this membership guide including all exclusions.
Bupa	Bupa Insurance Limited. Registered in England and Wales No. 3956433. Registered office: 1 Angel Court, London EC2R 7HJ
Cancer	a malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Word/phrase	Meaning
Chronic condition	<p>a disease, illness or injury which has one or more of the following characteristics:</p> <ul style="list-style-type: none"> ■ it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests ■ it needs ongoing or long-term control or relief of symptoms ■ it requires rehabilitation or for you to be specially trained to cope with it ■ it continues indefinitely ■ it has no known cure ■ it comes back or is likely to come back.
Co-insurance	<p>the percentage of the cost of eligible treatment that you have to pay that would otherwise have been payable under your benefits. The amount you have to pay is subject to a set maximum amount. For details please see rule E in the 'Claiming' section of this guide and your membership certificate.</p>
Common drugs	<p>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.</p>
Complementary medicine practitioner	<p>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.</p>
Consultant	<p>a registered medical or dental practitioner who, at the time you receive your treatment:</p> <ul style="list-style-type: none"> ■ is recognised by us as a consultant and has received written confirmation from us of this, unless we recognised him or her as being a consultant before 30 June 1996 ■ is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and ■ is in our list of consultants that applies to your benefits. <p>You can 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</p>
Consultant fees schedule	<p>the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants' fees based on:</p> <ul style="list-style-type: none"> ■ the type of treatment carried out ■ 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. <p>The schedule will change from time to time. Details of the schedule can be found at bupa.co.uk/codes</p>
Cover end date	<p>the date on which your current period of cover under the scheme ends shown as 'Cover end date' on your membership certificate.</p>
Cover start date	<p>the date on which your current period of cover under the scheme starts shown as 'Cover start date' on your membership certificate.</p>

Word/phrase	Meaning
Critical care unit	any intensive care unit, intensive therapy unit, high dependency unit, coronary care unit or progressive care unit which is in our list of critical care units and recognised by us for the type of intensive care that you require at the time you receive your treatment . The units on the list and the type of intensive care that we recognise each unit for will change from time to time. For details of a hospital or a treatment facility, centre or unit in your recognised facility network visit our consultants and facilities website at finder.bupa.co.uk
Day-patient	a patient who is admitted to a hospital, treatment facility or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
Day-patient treatment	eligible treatment that for medical reasons is received as a day-patient .
Dependant	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 .
Diagnostic tests	investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.
Effective underwriting date	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 .
Eligible surgical operation	eligible treatment carried out as a surgical operation .
Eligible treatment	treatment of an acute condition together with the products and equipment used as part of the treatment that: <ul style="list-style-type: none"> ■ are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the UK ■ are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided ■ are demonstrated through scientific evidence to be effective in improving health outcomes ■ are not provided or used primarily for the expediency of you or your consultant or other healthcare professional and the treatment , services or charges are not excluded under your benefits .
Excess	the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits . For details please see rule E in the 'Claiming' section of this guide and your membership certificate .
Facility access	the list of Bupa recognised hospitals and treatment facilities, centres or units for which you are covered under your benefits as shown on your membership certificate 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

Word/phrase	Meaning
<i>Fee-assured consultant</i>	<p>a consultant who, at the time you receive treatment, is:</p> <ul style="list-style-type: none"> ■ recognised by us as a fee-assured consultant, and ■ in the list of fee-assured consultants that applies to your benefits. <p>You can ask us if a consultant is a fee-assured consultant and if they are in the list of consultants that apply to your benefits or you can access these details at finder.bupa.co.uk</p>
<i>Gender dysphoria</i>	<p>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.</p>
<i>GP</i>	<p>a doctor who, at the time they refer you for your consultation or treatment, is on the UK General Medical Council's General Practitioner Register.</p>
<i>Home</i>	<p>either:</p> <ul style="list-style-type: none"> ■ the place where you normally live, or ■ another non-healthcare setting where you want to have your treatment.
<i>In-patient</i>	<p>a patient who is admitted to a hospital or treatment facility and who occupies a bed overnight or longer for medical reasons.</p>
<i>In-patient treatment</i>	<p>eligible treatment that for medical reasons is received as an in-patient.</p>
<i>Intensive care</i>	<p>eligible treatment for intensive care, intensive therapy, high dependency care, coronary care or progressive care.</p>
<i>Main member</i>	<p>the person named as the main member on the membership certificate.</p>
<i>Medical treatment provider</i>	<p>a person or company who is recognised by us as a medical treatment provider for the type of treatment at home that you need at the time you receive your treatment. The list of medical treatment providers and the type of treatment we recognise them for will change from time to time. Details of these medical treatment providers and the type of treatment we recognise them for are available on request or you can access these details at finder.bupa.co.uk</p>
<i>Membership certificate</i>	<p>the most recent membership certificate that we issue to you for your current continuous period of membership of the scheme.</p>
<i>Mental health and wellbeing therapist</i>	<ul style="list-style-type: none"> ■ a psychologist registered with the Health Professions Council ■ a psychotherapist accredited with UK Council for Psychotherapy, the British Association for Counselling and Psychotherapy or the British Psychoanalytic Council ■ a counsellor accredited with the British Association for Counselling and Psychotherapy, or ■ a cognitive behavioural therapist accredited with the British Association for Behavioural and Cognitive Psychotherapies <p>who is a recognised practitioner. You can ask us if a practitioner is a recognised practitioner and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</p>

Word/phrase	Meaning
Mental health condition	a condition which is a mental health condition according to a reasonable body of medical opinion, and/or which is diagnosed, treated and managed as a mental health condition including alcoholism, drug addiction, anorexia nervosa and bulimia nervosa.
Mental health day-patient treatment	eligible treatment of a mental health condition which for medical reasons means you have to be admitted to a recognised facility because you need a period of clinically-supervised eligible treatment of a mental health condition as a day case but do not have to occupy a bed overnight and the mental health treatment is provided on either an individual or group basis.
Mental health in-patient treatment	eligible treatment of a mental health condition that, for medical reasons, is received as an in-patient .
Mental health treatment	eligible treatment as set out in Benefit 5 Mental health treatment in the 'Benefits' section of this guide.
Moratorium condition	any disease, illness or injury or related condition, whether diagnosed or not, which you: <ul style="list-style-type: none"> ▪ received medication for ▪ asked for or received, medical advice or treatment for ▪ experienced symptoms of, or ▪ were to the best of your knowledge aware existed in the five years before your moratoria start date . By a related condition we mean any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury.
Moratorium member	a member whose membership certificate shows the underwriting method applied to them is moratorium.
Moratorium pending treatment condition	any disease, illness or injury or related condition, whether diagnosed or not, for which you are due to receive medical advice, or planned or pending treatment (whether private or under the NHS) at the date you join the scheme . By a related condition we mean any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury.
Moratorium start date	the date you started your continuous period of cover under the scheme shown as 'Moratorium start date' on your membership certificate . This may be the date you originally joined Bupa or, if you transferred your cover to Bupa from a previous scheme , the date identified by your previous insurer or administrator for determining moratorium conditions under your previous scheme .
Moratorium transfer member	a moratorium member who: <ul style="list-style-type: none"> ▪ applied to join the scheme from a previous scheme provided or administered by another insurer, and ▪ as part of their application to join the scheme was required by us to disclose details of their medical history for the purpose of underwriting.

Word/phrase	Meaning
NHS	<ul style="list-style-type: none"> the National Health Service operated in Great Britain and Northern Ireland, or the healthcare scheme that is operated by the relevant authorities of the Channel Islands, or the healthcare scheme that is operated by the relevant authorities of the Isle of Man.
Nurse	a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.
Out-patient	a patient who attends a hospital, consulting room, out-patient clinic or treatment facility and is not admitted as a day-patient or an in-patient .
Out-patient surgical operation	an eligible surgical operation received as an out-patient .
Out-patient treatment	eligible treatment that for medical reasons is received as an out-patient .
Partner	your husband or wife or civil partner or the person you live with in a relationship similar to that of a husband and wife whether of the opposite sex or not.
Pre-existing condition	<p>any disease, illness or injury for which in the seven years before your effective underwriting date:</p> <ul style="list-style-type: none"> you have received medication, advice or treatment, or you have experienced symptoms <p>whether the condition was diagnosed or not.</p>
Previous scheme	<ul style="list-style-type: none"> another Bupa private medical insurance scheme, or a private medical insurance scheme or medical healthcare trust provided or administered by another insurer <p>that we specifically agree will be treated as a previous scheme for the purpose of assessing your moratorium start date, effective underwriting date or continuous periods of cover as applicable provided that:</p> <ul style="list-style-type: none"> you have provided us with evidence of your continuous cover under the previous scheme, and there is no break in your cover between the previous scheme and your scheme.
Prosthesis	any prosthesis which is in our list of prostheses for both your benefits and your type of treatment at the time you receive your treatment . The prostheses on the list will change from time to time. Details of the prostheses covered under your benefits for your type of treatment are available on request or at bupa.co.uk/prostheses-and-appliances
Recognised facility	<p>a hospital or a treatment facility, centre or unit within your facility access, which at the time you receive your eligible treatment is recognised by us for both:</p> <ul style="list-style-type: none"> treating the medical condition you have, and carrying out the type of treatment you need.

Word/phrase	Meaning
Recognised practitioner	<p>a healthcare practitioner who at the time of your treatment:</p> <ul style="list-style-type: none"> is recognised by us for the purpose of our private medical insurance schemes for treating the medical condition you have and for providing the type of treatment you need, and is in our list of recognised practitioners that applies to your benefits. <p>You can ask us if a practitioner is a recognised practitioner and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</p>
Renewal date	each anniversary of your cover start date .
Resident	where your current, permanent address is.
Schedule of procedures	<p>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.</p> <p>Details of the schedule can be found at bupa.co.uk/codes</p>
Scheme	the cover and benefits we provide as shown on your membership certificate together with this membership guide subject to the terms and conditions of the agreement .
Special condition	any exclusions or restrictions to cover that are personal to an individual based on the medical history given to us for that individual. If special conditions apply to an individual's cover these are shown as applying to that member in the 'Special conditions' section on your membership certificate .
Specialist drugs	drugs and medicines to be used as part of your eligible treatment which are not common drugs and are at the time of your eligible treatment included on our list of specialist drugs that applies to your benefits . The list is available at bupa.co.uk/policyinformation or you can call us . The specialist drugs on the list will change from time to time.
Surgical operation	a surgical procedure or complex investigative/diagnostic procedure including all medically necessary treatment related to the procedure and all consultations carried out from the time you are admitted to a recognised facility until the time you are discharged, or if it is carried out as out-patient treatment , all medically necessary treatment related to the operation and any consultation on the same day which is integral to the operation.
Therapist	<ul style="list-style-type: none"> a chartered physiotherapist a British Association of Occupational Therapists registered occupational therapist a British and Irish Orthoptic Society registered orthoptist a Royal College of Speech and Language Therapists registered speech and language therapist a Society of Chiropractors and Podiatrists registered podiatrist, or a British Dietetic Association registered dietitian <p>who is Health and Care Professions Council registered and is a recognised practitioner. You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</p>

Word/phrase	Meaning
Treatment	surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.
Underwritten member	a member whose membership certificate shows the underwriting method applied to them is underwritten.
Underwritten transfer member	an underwritten member who: <ul style="list-style-type: none"> ▪ applied to join the scheme from a previous scheme provided or administered by another insurer, and ▪ as part of their application to join the scheme was required by us to disclose details of their medical history for the purpose of underwriting.
United Kingdom/ UK	Great Britain, Northern Ireland, the Channel Islands and the Isle of Man.
Waiting period	a period of continuous cover during which benefits are not payable. The length of any waiting periods that apply to your benefits are shown under the 'Waiting periods' section on your membership certificate .
We/our/us	Bupa .
Year	for each period of your cover, the period beginning on your cover start date and ending on your cover end date for that period of cover.
You/your	this means the main member only.

Privacy notice – in brief

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-notice

1. Scope of our privacy notice

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

2. How we collect personal information

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

3. Categories of personal information

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

4. Purposes and legal grounds for processing personal information

We process your personal information for the purposes set out in our full privacy notice, including to deal with our relationship with you (including for claims and handling complaints), for research and analysis, to monitor our expectations of performance (including of health providers relevant to you) and to protect our rights, property, or safety, or that of our customers, or others. The legal reason we process personal information depends on what category of personal information we process. We normally process standard personal information on the basis that it is necessary so we can

perform a contract, for our or others' legitimate interests or it is needed or allowed by law. We process special categories of information because it is necessary for an insurance purpose, because we have your permission or as described in our full privacy notice. We may process information about your criminal convictions and offences (if any) if this is necessary to prevent or detect a crime.

5. Marketing and preferences

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

6. Processing for profiling and automated decision-making

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

7. Sharing your information

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

8. Transfers outside of the European Economic Area (EEA)

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

9. How long we keep your personal information

We keep your personal information in line with periods we work out using the criteria shown in the full privacy notice available on our website.

10. Your rights

You have rights to have access to your information and to ask us to correct, erase and restrict use of your information. You also have rights to object to your information being used; to ask us to transfer information you have made available to us; to withdraw your permission for us to use your information; and to ask us not to make automated decisions which produce legal effects concerning you or significantly affect you. Please contact us if you would like to exercise any of your rights.

11. Data-protection contacts

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

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

Financial crime and sanctions

Financial crime

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

Sanctions

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

Bupa Anytime HealthLine is provided by:
Bupa Occupational Health Limited. Registered
in England and Wales No. 631336.

Registered office: 1 Angel Court,
London EC2R 7HJ

Bupa health insurance is provided by:
Bupa Insurance Limited. Registered in England
and Wales No. 3956433. Bupa Insurance
Limited is authorised by the Prudential
Regulation Authority and regulated by the
Financial Conduct Authority and the Prudential
Regulation Authority.

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

Registered office: 1 Angel Court,
London EC2R 7HJ

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