

Bupa policy guide

Bupa Select

Essential information explaining your Bupa cover

Please keep



Introduction

Your Bupa Select health insurance

There are three documents which set out full details of how your health insurance works:

- this **policy guide** which contains the general terms and all the possible cover for Bupa Select policies
- **your membership certificate** which shows your specific cover and **allowances**, and is personal to you
- any **confirmation of special conditions** if any **special conditions** apply, for **you** or **your dependants** (if any).

Although they're separate documents, they should be read together. Each **year**, we'll send you updated documents which apply from your latest **cover start date**.

Need to know

This policy guide contains all the possible cover under Bupa Select. Your **membership certificate** shows the cover that your **sponsor** has selected and that is available to you. This means you may not have all the cover set out in this policy guide. Your **membership certificate** could also show some changes to the cover set out in this policy guide, particularly in the 'Further details' section.

Some words in this guide are in **bold italics**. This is because they have a specific meaning which we explain on pages 56 to 62.

References to 'we', 'our' and 'us' mean Bupa Insurance Limited, registered in England and Wales with registration number 3956433 and registered office at 1 Angel Court, London, EC2R 7HJ.

Always get in touch with us before you have any consultations, tests or **treatment** to check that they're covered by your policy.

Contents

- 2-4 Introduction
- 5 How to get in touch with us
- 6-14 How to get treatment and claim
- 15-48 What is and isn't covered
- 49-54 How your health insurance policy works
- 55 How to complain
- 56-62 What some of the words and phrases in this guide mean
- 63-66 How we use and protect your information

HealthLine services

Our HealthLine services are available to all our customers and are free to use.

Bupa Anytime HealthLine[^]

If you have any health questions or concerns you can call our confidential Bupa Anytime HealthLine on **0345 607 7777***

You can speak to our qualified nurses anytime of the day or night. They have practical, professional experience and skills to help.



Family Mental HealthLine[^]

If you're a parent or care for a young person and are concerned about their mental wellbeing, our confidential Family Mental HealthLine can provide advice, guidance and support. A trained adviser and/or mental health nurse will give you advice about what to do next. You can call our Family Mental HealthLine on **0345 266 7938*** between 8am and 6pm, Monday to Friday. You can use this service even if the young person isn't covered under your policy.

Menopause HealthLine[^]

You, or anyone covered on the policy, can talk to one of our menopause trained nurses. They'll offer advice, guidance, and support, even if you're unsure if you're menopausal. This includes support that you can give to a partner who may be going through the menopause. You can call our Menopause HealthLine on **0345 608 9984*** between 8am and 8pm, every day.

*We may record or monitor our calls.

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

How to get in touch with us

We're always here for our customers and happy to help.

Bupa digital account

Your own secure online account so you can see your **Bupa** policy documents and a personalised view of your cover in one place wherever you are.

Visit [bupa.co.uk](https://www.bupa.co.uk) to create your account or download the **Bupa Touch** app.



Call

For answers to questions about your cover and to authorise consultations, tests and **treatment**, please call us on the number on your **membership certificate**.



Webchat

For answers to general questions and to authorise consultations, tests and **treatment**, you can chat with us using your online account, or by visiting [bupa.co.uk](https://www.bupa.co.uk)



If you have hearing or speech difficulties

You can use the Relay UK service, visit www.relayuk.bt.com for more information.

If you have sight difficulties

We have documents in Braille, large print or audio.

Please let us know if you'd like us to send you some.



Write

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

How to get treatment and claim

We're here to help.

If it's about:

- **cancer**
- muscles, bones and joints
- mental health

use our Direct Access service if your **membership certificate** shows it is available to you.

This means you can call us about your symptoms without needing a referral from a **GP**. We'll provide support, advice, and a referral for consultations, tests or **treatment** if you need them.

You can find more information on the next page.

If Direct Access is not available to you or if you prefer, see a **GP**. This can be your own or a digital **GP**.

If it's about anything else:

You'll first need to see a **GP**. This can be your own or a digital **GP**.

If you need a consultation, tests or **treatment**, ask the **GP** for an open referral and contact us. We can then help you find a **consultant** or healthcare professional covered by your policy.

Need to know

We may also accept referrals from other healthcare professionals, find out more at bupa.co.uk/referrals

How to get in touch with us

Call

The helpline number on your **membership certificate**.

Webchat

bupa.co.uk/contact-us

Bupa digital account

Visit bupa.co.uk or use the Bupa Touch app.

Important information about your cover and any claims

For **treatment** to be covered it needs to be:

- shown as covered on your **membership certificate**, and
- shown as covered in this policy guide, and
- **eligible treatment**, and
- not shown as excluded in this policy guide.

It's also really important that you follow the process and requirements in this policy guide otherwise we may be unable to pay your claim.

Here are the general conditions which always apply to your cover and any claims. They're part of your **sponsor's agreement** with us.

Need to know

Any **treatment** that takes place after the date your policy ends isn't covered, even if it's been pre-authorised. This includes **treatment** that takes place after the renewal of your policy if that **treatment** is no longer covered by your **benefits**. You'll be responsible for paying for this.

Direct Access to treatment and care

You don't always need to see a **GP** before contacting us. If you have cover for our Direct Access service you can call us if you're worried about **cancer**, mental health or muscle bone and joint problems. We'll provide support, advice and a referral for consultations, tests or **treatment** if you need them.

If you have a **GP** referral, we may also offer you a phone or video assessment with a healthcare professional who specialises in your condition to explore all your **treatment** options.

If you have a Direct Access phone or video assessment you won't need to pay an excess or co-insurance for it and the cost won't be subtracted from your **out-patient benefit allowance** (if any of these apply to your policy). If our Direct Access service refers you for a consultation, test or **treatment** you may be able to claim for that consultation, test or **treatment** and we'll explain how to do this after your assessment.

You can find more information about our Direct Access service at bupa.co.uk/direct-access

Getting a GP referral

If you see a **GP** and you need a consultation, tests or **treatment**, ask for an open referral. This means your **GP** recommends the type of specialist you need to see instead of naming a specific specialist. When you contact us, we'll use your **GP's** speciality recommendation to help you choose a **fee-assured consultant** or healthcare professional covered by your policy.

Need to know

For customers with the Open Referral cover option:

- you need an open referral from a **GP** or our Direct Access service, and
- if you need to see a **consultant**, they need to be in our Open Referral Network. You can check that a **consultant** is in our Open Referral Network on finder.bupa.co.uk or contact us and we'll help you find one.

It's important that you contact us before arranging any consultations, tests or **treatment** to make sure you're covered.

Your **membership certificate** will show if the Open Referral cover option applies to you in the Group details section under Cover option. For anyone aged 17 or under, please ask the **GP** for a named referral.

Before you arrange consultations, tests or treatment

Pre-authorisation

It's important that you contact us before arranging any consultations, tests or **treatment** so we can:

- confirm whether the consultation, test or **treatment** is **eligible treatment** and if it's covered by your policy, and
- confirm the **consultants**, healthcare professionals, hospitals or clinics covered by your policy, and
- let you know how to claim for cash benefits, if these are covered (see page 32 for more information about these benefits), and
- give you a pre-authorisation number.

We may ask you for information about the history of your symptoms, including details from your **GP** or **consultant**. You can then contact the **consultant**, healthcare professional, hospital or clinic to arrange an appointment. You'll need to give them your pre-authorisation number so we can pay them for your **treatment** covered by your policy. We will write to the **main member** or **dependant** having **treatment** (when aged 16 or 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.

Need to know

You don't need a pre-authorisation to use the digital GP services benefit if it is available to you. For anything else, if you don't get pre-authorisation from us, you'll be responsible for paying all **treatment** that we wouldn't have pre-authorised.

Cover for people aged 17 or under

We always need a named referral for a paediatric **consultant**. If someone aged 17 or under who is covered on your policy needs to see a **consultant**, please ask their **GP** for a named referral, and not an open referral. Some private hospitals don't provide services for children or have restricted services available, and **treatment** may be at an **NHS** hospital. Please visit finder.bupa.co.uk to see paediatric services available in your area and contact us before any consultations, tests or **treatment** so we can confirm that these are covered.

The consultants, healthcare professionals, hospitals and facilities that your policy covers

Your policy covers certain *Bupa* recognised **consultants**, healthcare professionals and **recognised facilities**:

- the **recognised facility, consultant** or the healthcare professional must be recognised by us for treating the medical condition you have, and for providing the type of **treatment** you need on the date you receive that **treatment**
- if you need **in-patient treatment** and/or **day-patient treatment** the **recognised facility** must be part of the **facility access** list which applies to your cover and this is shown on your **membership certificate**
- the person who has overall responsibility for your **treatment** must be a **consultant** - the only exception to this is where the treatment is under your digital GP services benefit or where a **GP** or our Direct Access service refers you for **out-patient treatment** by a **therapist, complementary medicine practitioner** or **mental health and wellbeing therapist**.

Need to know

For customers with the Open Referral cover option - the **consultant** you see needs to be in our Open Referral Network.

What we pay consultants

We pay **consultant** fees up to the amounts shown in our **schedule of procedures**. The schedule can be found at [bupa.co.uk/codes](https://www.bupa.co.uk/codes)

If you see a **consultant** who doesn't charge within our rates, you may need to pay the difference.

Reasonable and customary charges

We only pay reasonable and customary charges for **eligible treatment**. This means that the amount we will pay **consultants**, healthcare professionals, hospitals and facilities will be in line with what the majority of our customers are charged for similar **treatment** or services.

There may be another proven **treatment** which is available in the **UK** for a condition, that costs more than the **treatment** that the majority of our customers have. Where this doesn't provide a better clinical outcome, we will only pay what the majority of our customers are charged for similar **treatment** or services.

Excess or co-insurance

You can find details of any excess or co-insurance the **sponsor** has decided may apply to your policy on your **membership certificate**, including:

- the amount, and
- who it applies to, and
- when it will apply.

How an excess or co-insurance works

Having an excess or co-insurance means that you must pay part of any **treatment** costs covered by your policy up to the excess or co-insurance amounts.

If your excess or co-insurance applies each **year** it renews at the beginning of each policy **year** even if you're mid way through **treatment**. So, your excess or co-insurance could apply twice to a single course of **treatment** if your **treatment** begins in one policy **year** and continues into the next policy **year**.

If there's an excess or co-insurance to pay, we'll write to **you** or the **dependant** having **treatment** (if they're aged 16 or over). We apply your excess or co-insurance in the order in which we receive your claims. When you claim for **treatment** costs where an **allowance** applies, your excess or co-insurance payment will count towards the total **allowance** for that benefit. You don't have to pay the excess or co-insurance if you're claiming for cash benefits (see pages 32-35) or for claims for benefit 1.11 digital GP services. Your **membership certificate** will show if there are any other benefits that your excess or co-insurance does not apply to. We'll let you know which **consultant**, healthcare professional, hospital or clinic you need to pay your excess or co-insurance to.

Here's an example of how an annual fixed excess works

Helen's policy has a £50 excess. Helen has some physiotherapy which costs £250. We pay Helen's physiotherapist £200 and we'll let Helen know that she needs to pay the physiotherapist £50 (which is the policy excess). If Helen needs other **treatment** during the policy **year**, she doesn't need to pay another excess. When Helen's policy renews, the excess will also renew.

Here's an example of how a rolling excess works

Helen's policy has a £50 rolling excess which applies in any 12 month period. Helen has some physiotherapy in February 2024 which costs £250. We pay Helen's physiotherapist £200 and we'll let Helen know that she needs to pay the physiotherapist £50 (which is the policy excess). If Helen needs other **treatment** before February 2025, she doesn't need to pay another excess. Helen's excess will only apply again if she needs treatment more than 12 months after her physiotherapy in February 2024.

Here's an example of how a co-insurance works

Helen's policy has a co-insurance of 20% of any **treatment** costs up to a maximum of £500 each **year**. Helen has some physiotherapy which costs £250. We pay Helen's physiotherapist £200 and we'll let Helen know that she needs to pay the physiotherapist £50 (which is the 20% co-insurance). If Helen needs other **treatment** during the policy **year**, she needs to pay 20% of the **treatment** costs up to the remaining £450 co-insurance.

Need to know

You should always claim for **eligible treatment** even if it costs less than your excess or co-insurance. Otherwise, if you need to claim again, your remaining excess or co-insurance may be higher than it would have been.

The 'Six-week scheme'

Your *membership certificate* will show if you have a Six-week scheme.

The Six-week scheme means that, if the **NHS** cannot offer the eligible **day-patient** or **in-patient treatment** including diagnostic procedures (for example an endoscopy) you need within six weeks of a **consultant** saying that you need it, your policy will cover the cost of you having your **treatment** privately.

Need to know

- your **consultant** must confirm to us each time you need **day-patient** or **in-patient treatment** which isn't available via the **NHS** within six weeks
- if the eligible **day-patient** or **in-patient treatment** including diagnostic procedures (for example an endoscopy) you need is available via the **NHS** within six weeks, your policy won't cover the cost of you having your **treatment** privately
- the Six-week scheme doesn't apply to **out-patient treatment** - this means any eligible private **out-patient treatment** you need will be covered in line with your policy terms.

For example:

Jack's consultant tells him on 1 July that he needs to have an **operation**. He finds that the **operation** isn't available on the **NHS** until 30 October at the earliest. As this is more than six weeks after the **consultant** says he needs the **operation** and it's for **eligible treatment**, Jack can have it privately and the costs will be covered by his policy.

If Jack could have had his **operation** in the **NHS** between 1 July and 12 August, his Six-week scheme wouldn't have covered the cost of him having it privately.

If you have cover for Benefit CB1, CB6.1, CB6.2 and CB7, we don't pay cash benefit for **NHS day-patient treatment** or **NHS in-patient treatment** if the **treatment** you need is available via the **NHS** within six weeks of the **consultant** saying that you need it.

Providing us with information

We may need some information from you to help us with your claim.

For example:

- medical reports and other information about the **treatment** you're claiming for
- the results of any independent medical examination which we may ask you to have (which we'll pay for)
- original unaltered invoices for your claim (including any **treatment** costs covered by your excess or co-insurance).

We may be unable to review or pay your claim without this information.

Medical reports

We may need to ask your doctor for information about your consultation, tests, or **treatment** to see if your policy covers these. We'll need your permission to do this, and you have certain rights when it comes to your personal and medical information:

- you can give your doctor permission to send us a medical report without you seeing it first or ask to see it before they send it to us
- you can ask your doctor to show you the medical report before they send it to us so long as you do this within 21 days from the date we ask them for it
- if you don't contact your doctor within 21 days, we'll ask them to send the report straight to us
- you can ask your doctor to change the report if you think it's inaccurate or misleading - if they refuse, you can add your own comments to it before they send it to us
- once you've seen the report, your doctor can't send it to us unless you give them permission to do so
- you can ask your doctor not to send us the medical report - if this happens, we may be unable to tell you whether your consultation, test or **treatment** is covered, and we may be unable to pay your claim
- you can ask your doctor to let you see a copy of your medical report within 6 months of it being sent to us
- your doctor can withhold some or all the information in the report if they believe the information:
 - might cause you or someone else physical or mental harm, or
 - would reveal someone else's identity without their permission (unless the person is a healthcare professional, and the information they provide is about your care)
- your doctor may charge you for a medical report - we'll let you know if we'll cover some of this cost - if not, you'll need to pay for it yourself.

There's more detail about your rights in **The Access to Medical Reports Act 1988** and **The Access to Personal Files and Medical Reports (NI) Order 1991**.

If you'd like to withdraw a claim

Please call your Bupa helpline and let us know as soon as possible. If you withdraw a claim you'll need to pay for all your **treatment**. It's not possible to withdraw a claim we've already paid.

Treatment or costs not covered by your policy

You're responsible for paying for any consultations, tests, **treatment** or costs that aren't covered by your policy.

Other insurance cover

You cannot claim more than once for the same private medical expenses. This means that if you have two policies that provide private medical cover, the costs of your **treatment** may be split between **Bupa** and the other insurance company. You will be asked to provide us with full details of any other relevant insurance policy at the time of claim.

Underwriting

Insurance companies look at the risk of insuring someone before a policy starts. This is known as underwriting. Your **membership certificate** shows the type of underwriting your **sponsor** has chosen to apply to your policy.

Need to know:

If your underwriting type is underwritten or moratorium:

- your policy covers you for future health risks
- any **special conditions, pre-existing conditions, moratorium conditions**, conditions, symptoms, diseases, illnesses or injuries you had before your policy started aren't usually covered
- where a **special condition** applies, we'll send a **confirmation of special conditions** to the **main member** or to the **dependant** if they're aged 16 or over
- if you need to claim, we may ask you for some information about your symptoms and when they started before we can pre-authorise any **treatment**.

Types of underwriting and how they work

Underwritten

When **you** apply for a policy, we look at **your** and **your dependants** (if any) medical history, and let you know which specific symptoms or conditions you had before aren't covered. It's important that you send us your completed application form so we can confirm what is and isn't covered by your policy.

Depending on your symptoms and how long you've been covered, when you contact us to claim we may need to check that your symptoms or condition started after you joined the policy. We may also ask your doctor for more information, and they may charge for this. If your **treatment** is covered by your policy, you can claim £15 towards the cost of the medical report.

If you had a **previous policy** with another insurer that was underwritten, we may base your underwriting on your **previous policy** start date when **you** join us. We and your **sponsor** need to agree to this, and there must be no break in **your** cover. We may need to review your medical history and let you know if there are any conditions that are not covered.

Moratorium

When **you** apply for a policy, we don't look at **your** or any of **your dependants** (if any) medical history. Instead, when you claim for a condition you had in the **moratorium qualifying period** before your **moratorium start date**, it will only be covered if you've not had any symptoms, treatment, medication or advice for the condition as explained in the further details section of your **membership certificate**. If you claim, we may ask you for more information about the history of your symptoms, so we can confirm it's covered by your policy. We may also need details from your doctor and they may charge for this. If so, you'll need to pay for this yourself.

Non-underwritten

When you apply for a policy, we won't look at your medical history so **you** or **your dependants** don't need to worry about any time periods during which you're unable to claim for certain conditions.

Treatment needed because of someone else's fault

You may need to claim for **treatment** you need because of an injury or medical condition that was caused by someone else (a 'third party') or was their fault. This could be due to a road accident, an injury or potential clinical negligence.

If this happens you should let us know as soon as possible as we'll need to recover costs we've paid for your **treatment** from the third party. This won't reduce the amount you can recover from the third party.

If this applies to you:

- tell us as soon as you know you need (or may need) **treatment** that was caused by a third party or was their fault - you can call us on **0800 028 6850*** or email us at **infothirdparty@bupa.com[^]**
- inform your solicitor, insurer or representative (if using one) that you have Bupa health insurance that may have covered some of the costs
- provide us with your solicitor's, insurer's and/or representative's details and give us your permission to contact them
- help us to recover the cost of the treatment we paid for from the third party by doing as we ask - this includes making sure we can communicate with you and your legal representative (if you appoint one) about this and that you or your legal representative regularly keep us updated on progress with any recovery action
- ask your solicitor, insurer or representative to include in your claim all the costs we've paid for your **treatment**, including 8% interest for each year
- make sure that if you agree settlement with a third party, it includes the full cost of your treatment that we've paid for, and that you pay this amount (and any interest) to us as soon as possible.

*We may record or monitor our calls.

[^]If you need to send us sensitive information you can email us securely using Egress. For more information and to sign up for a free Egress account, go to **switch.egress.com**. You won't have to pay for sending secure emails to a Bupa email address using Egress.

What is covered

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**.

Need to know

This section explains the types of **treatment**, services and charges which Bupa Select can cover. Please also see 'Important information about your cover and any claims' on page 7.

Your policy has some restrictions. It's important that you read the sections about what is and isn't covered. Anything in the 'What isn't covered' section applies to your cover unless it says otherwise.

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

Benefit 1 Out-patient consultations and treatment

This benefit explains what we pay for **out-patient treatment**.

We will pay for **out-patient treatment** at **home** when recommended by your healthcare professional or offered by us. We only pay if your treatment provider is recognised by us for **treatment** at **home**.

benefit 1.1 out-patient consultations

We pay **consultants'** fees for consultations that are to assess your **acute condition** when carried out as **out-patient treatment** when you are referred by our Direct Access service, a **GP, consultant**, or another healthcare professional (as explained in 'How to get treatment and claim'). We pay for remote consultations by phone or video with a **consultant**.

benefit 1.2 out-patient therapies and other out-patient charges

Out-patient therapies

We pay **therapists'** fees for **out-patient treatment** when you are referred by our Direct Access service, a **GP, consultant**, or another healthcare professional (as explained in 'How to get treatment and claim'). This includes fees for phone or video consultations with a **therapist**.

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 **prostheses** or **appliances** needed as part of that **out-patient treatment**. We treat these charges as falling under this benefit 1.2 and subject to its **allowance**.

benefit 1.3 out-patient complementary medicine treatment

We pay **complementary medicine practitioners'** fees for **out-patient treatment** when you are referred by our Direct Access service, a **GP, consultant**, or another healthcare professional (as explained in 'How to get treatment and claim').

We don't pay for any complementary or alternative products, preparations or remedies.

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

benefit 1.4 out-patient diagnostic tests

When requested by your **consultant** or another healthcare professional (as explained in 'How to get treatment and claim') to help determine or assess your condition as part of **out-patient treatment**, we pay **recognised facility** charges or **consultant** fees for **diagnostic tests**. The cost for reporting is included within the charge for the **diagnostic test**.

We don't pay charges for **diagnostic tests** that are not from a **recognised facility** or from a **consultant** who is not recognised by us to carry out **diagnostic tests**.

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** or another healthcare professional (as explained in 'How to get treatment and claim') to help determine or assess your condition as part of **out-patient treatment** we pay **recognised facility** charges for:

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

The cost for reporting is included within the charge for the scan.

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

benefit 1.6 out-patient monitoring and management of chronic conditions

Your **membership certificate** shows if you are covered for this benefit.

Call us to check that your proposed **treatment** is covered. Please remember that any costs you incur for **treatment** that isn't covered are your responsibility.

We pay for

- eligible monitoring and management received as an **out-patient** for a **chronic condition**, other than an acute flare up of that condition
- **therapists'** fees for **out-patient treatment** that, although not likely to quickly cure you or return you to your previous state of health, is clinically appropriate and likely to improve your condition.

We pay on the same basis as we pay for treatment as an **out-patient** as set out in benefits 1.1, 1.2, 1.3 and 1.4. We only pay as set out in those benefits and we only pay up to the **allowance** that applies to benefit 1.6 as shown in your **membership certificate**.

You're covered for **eligible treatment** arising out of a **chronic condition**, or acute symptoms of a **chronic condition** that flare up, as explained in Exclusion 6 Chronic Conditions under Exception 1 in the section 'What isn't covered'. Such **eligible treatment** is not paid under this benefit 1.6 so will not affect your benefit **allowance** for this benefit 1.6.

Please note: we don't pay for any **treatment** for a **mental health condition** under this benefit 1.6 – please see Benefit 5 in this section for **mental health treatment**.

Under this benefit 1.6 we also do not pay for any:

- **treatment** that is excluded by the terms of this policy (including the section 'What isn't covered' in this policy guide) such as, but not limited to, Exclusion 3 Allergies, allergic disorders or food intolerances, Exclusion 14 Drugs and dressings for out-patient or take-home use and complementary and alternative products, and Exclusion 26 Sleep problems and disorders
- **operations**
- MRI, CT and PET scans.

For the purposes of this benefit 1.6 only, eligible monitoring and management means medical services (including investigations and tests such as X-rays or blood tests), together with the products and equipment used as part of those services, that are needed to monitor or manage an ongoing disease, illness or injury and which:

- are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the **UK**
- are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided, for example as specified by NICE (or equivalent bodies in Scotland) in its guidance on specific conditions or **treatment** where such guidance is available
- are demonstrated through scientific evidence to be effective in improving health outcomes, and
- are not provided or used primarily for the expediency of you or your consultant or other healthcare professional

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

benefit 1.7 Well Health - cancer screening

Your **membership certificate** shows if you are covered for this benefit.

We pay for you to have a Bupa cancer screening at a Bupa health centre once each **year**. You must be aged 18 years or over to use this benefit.

These screenings are targeted on early detection of breast, cervical, prostate and testicular cancer and are not suitable for anyone showing symptoms.

The Bupa cancer screening comprises:

- a consultation with a **GP** including medical history review
- if clinically indicated:
 - physical examination of the breast
 - physical examination of the pelvis
 - test for Human Papilloma Virus (HPV) for those aged 25 and over, cervical screening will be carried out if HPV virus is present

- physical examination of the prostate
 - physical examination of the testicles
 - Prostate Specific Antigen (PSA) blood test (age 50+)[#]
- where relevant: onward referral either during the appointment or upon receipt of any test results.

[#]PSA blood tests are not generally recommended for those under 50. If you are under 50 and have concerns, you can discuss this with the **GP** who will advise what to do next.

Bupa cancer screening is payable under benefit 1.1 out-patient consultations and subject to any **allowance** that applies to that **benefit**.

To pre-authorise or for more information please contact us.

benefit 1.8 diagnosis of gender dysphoria

Your **membership certificate** shows if you are covered for this benefit.

If you are aged 18 or over, we pay for the diagnosis of **gender dysphoria** as follows:

- one **out-patient** consultation with a **consultant** psychiatrist
- one **out-patient** consultation with a chartered clinical psychologist who is recognised by us
- one **out-patient** consultation with a **consultant** endocrinologist.

These consultations are payable under benefit 1.1 out-patient consultations and subject to any **allowance** that applies to that **benefit**.

benefit 1.9 Well Health - menopause plan

Your **membership certificate** shows if you are covered for this benefit.

We pay for you to have a Bupa menopause plan at a Bupa health centre once each **year**. You must be aged 18 years or over to use this benefit.

The Bupa menopause plan is intended for those looking for advice and support with menopause.

The plan comprises:

- a pre-appointment questionnaire and symptom-checker
- appointment with a **GP** specially trained in menopause
- personalised care plan, and
- follow up appointment with a **GP**.

The Bupa menopause plan is payable under benefit 1.1 out-patient consultations and subject to any **allowance** that applies to that **benefit**.

Please note, any **treatment** associated with menopause will be subject to your benefit terms and exclusions. Please see the 'What is and isn't covered' sections for further information.

To pre-authorise or for more information please contact us.

benefit 1.10 - Well Health - out-patient fertility check

Your **membership certificate** shows if you are covered for this benefit.

You should always contact us before receiving a fertility check to confirm that it is covered under your **benefits**.

If you are aged 18 or over, we pay for one fertility check per **year** at a **fertility check facility**. We don't pay for any **treatment** and/or further investigations arising from the fertility check.

A fertility check consists of individual tests delivered in an **out-patient** setting to investigate fertility. After the tests have been done, as part of the check a follow up consultation will take place at the **fertility check facility** to discuss the results.

The out-patient fertility check is payable under benefit 1.1 out-patient consultations and subject to any **allowance** that applies to that **benefit**.

To pre-authorise or for more information please contact us.

benefit 1.11 digital GP services

Your **membership certificate** shows if you are covered for this benefit.

This digital GP services benefit provides consultations with a **GP** or with another healthcare professional such as a physiotherapist, **nurse** or pharmacist available through the **digital primary care provider**. We pay for consultations with a **digital primary care provider** recognised by us under this benefit.

We'll let you know which **digital primary care provider** you can use to access this benefit. If you are unsure, please contact us.

Please note: Claims under this benefit will not erode any **out-patient** benefit **allowance** nor be subject to any excess or co-insurance that you have on your policy.

You will need to pay for the cost of any medicines prescribed by the **digital primary care provider**, unless your policy includes cover for these medicines.

If the **digital primary care provider** refers you for any further **treatment**, this **treatment** will be treated as a different claim under your policy and pre-authorisation for the **treatment** will be needed. You should always contact us to check you are covered for any **treatment**.

benefit 1.12 Well Health – face to face GP

Your **membership certificate** shows if you are covered for this benefit.

We pay for you to have planned face-to-face consultations with a **GP** at a Bupa health centre. You must be aged 18 years or over to use this benefit.

We don't pay face to face GP benefit for:

- virtual consultations
- any **out-patient** consultation or **treatment** relating to, antibody testing, medical reports, **out-patient** drugs and dressings or vaccinations.

To pre-authorise or for more information please contact us.

benefit 1.13 Well Health - nutrition health

Your **membership certificate** shows if you are covered for this benefit.

We pay for you to have three Bupa nutrition health appointments each **year** with a Lifestyle Coach or Health Advisor provided virtually by a Bupa health centre. You must be aged 18 years or over to use this benefit.

The nutrition health benefit is intended for those looking for support or guidance with their nutrition health.

The Bupa nutrition health benefit is payable under benefit 1.1 out-patient consultations and subject to any **allowance** that applies to that **benefit**.

To pre-authorise or for more information please contact us.

benefit 1.14 Well Health - men's sexual function plan

Your **membership certificate** shows if you are covered for this benefit.

We pay for you to have a Bupa men's sexual function plan at a Bupa health centre once each **year**. You must be aged 18 years or over to use this benefit.

The men's sexual function plan is intended for those looking for advice, assessment, and support with their sexual function for example erectile dysfunction or reduced sex drive.

The plan comprises:

- a pre-appointment questionnaire and symptom-checker
- time with a **GP**
- specific blood tests to support diagnosis of symptoms
- follow up appointment.

The Bupa men's sexual function plan is payable under benefit 1.1 out-patient consultations and subject to any **allowance** that applies to that benefit.

To pre-authorise or for more information please contact us.

Being treated in hospital

Benefit 2 Consultants' fees for surgical and medical hospital treatment

This benefit explains the type of **consultants'** fees we pay for **eligible treatment**.

benefit 2.1 surgeons and anaesthetists

We pay **consultant** surgeons' fees and **consultant** anaesthetists' fees for **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 an **operation** or **cancer treatment**.

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

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

Benefit 3 Recognised facility charges

This benefit explains the type of facility charges we pay for **eligible treatment**.

The **benefits** you are covered for, including your **facility access** and the amounts we pay are shown on your **membership certificate**.

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 operations

We pay **recognised facility** charges for **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 **operation**.

benefit 3.2 day-patient and in-patient treatment

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

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 don't pay for personal items such as telephone calls, newspapers, guest meals and refreshments or personal laundry.

We don't 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** or **complementary medicine practitioner** or **mental health and wellbeing therapist**.

benefit 3.2.2 parent accommodation

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

- a member under the **agreement**, and
- 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 don't pay for extra nursing services in addition to those that the **recognised facility** would usually provide as part of normal patient care without making any extra charge.

For information on drugs and dressings for out-patient or take-home use, please also see 'Exclusion 14 Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What isn't 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 as soon as they can.

Need to know

Transferring into private in-patient care from an NHS hospital

If you want to transfer your care from an **NHS** hospital, or a hospital stay that you're paying for yourself, to a private **recognised facility**, your policy will cover your **eligible treatment** costs following the transfer, if:

- you've been discharged from a **critical care unit** to a general ward for more than 24 hours, and
- your referring and receiving **consultants** agree that it's clinically safe and appropriate to transfer your care, and
- we've had full clinical details from your **consultant** and confirmed that you're having **eligible treatment** before you transfer.

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 isn't 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 **prostheses** or **appliances** needed as part of your **day-patient treatment** or **in-patient treatment**.

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

Benefits for specific medical conditions

Benefit 4 Cancer treatment

benefit 4.1 Cancer cover

Your **membership certificate** shows if you are covered for this benefit. Cover is only available after a diagnosis of **cancer** has been confirmed.

Eligible treatment for side effects of **cancer**, or side effects of **treatment** for **cancer**, is covered on the same basis and up to the same **allowances** as set out in this section.

This benefit 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 **allowances** 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** when you are referred by our Direct Access service, a **GP, consultant** or another healthcare professional (as explained in 'How to get treatment and claim'). We pay for remote consultations by phone or video with a **consultant**.

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 by our Direct Access service, a **GP, consultant** or another healthcare professional (as explained in 'How to get treatment and claim'). This includes fees for phone or video consultations with a **therapist**.

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**. We also pay charges for clinical reviews we may request to establish the eligibility of **treatment**.

benefit 4.1.3 out-patient complementary medicine treatment for cancer

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

We don't pay for any complementary or alternative products, preparations or remedies.

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

benefit 4.1.4 out-patient diagnostic tests for cancer

When requested by your **consultant** to help determine or assess your condition as part of **out-patient treatment** for **cancer** we pay **recognised facility** charges or **consultant** fees for **diagnostic tests**. The cost for reporting is included within the charge for the **diagnostic test**.

We don't pay charges for **diagnostic tests** that are not from a **recognised facility** or from a **consultant** who is not recognised by us to carry out **diagnostic tests**.

(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 don't 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 don't pay for any complementary, homeopathic or alternative products, preparations or remedies for **treatment** of **cancer**.

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

benefit 4.2 NHS Cancer Cover Plus

Your **membership certificate** shows if you are covered for this benefit.

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

- the radiotherapy, chemotherapy, drug therapy or an **operation** you need to treat your **cancer** isn't available to you from the **NHS**, and
- what isn't available to you from the **NHS** isn't solely 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 and cash benefits CB6.4 and CB6.5.

If you have cover for benefit CB6.1, CB6.2 and CB6.3: 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 CB6.1, CB6.2 and CB6.3 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 don't cover your **treatment** for **cancer**.

Benefit 5 Mental health treatment

Your **membership certificate** shows if you are covered for this benefit. Cover is subject to the **allowances** shown on your **membership certificate**.

Need to know

Mental health treatment for or related to **special conditions, pre-existing conditions** and **moratorium conditions** isn't covered. **Mental health treatment** related to anything else in the 'What isn't covered' section is covered as set out in this benefit.

We do not pay for **treatment** of dementia.

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

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

benefit 5.1 out-patient mental health treatment

benefit 5.1.1 out-patient mental health consultants' fees

We pay **consultant** psychiatrists' fees for **out-patient** consultations to assess your **mental health condition** and for **out-patient mental health treatment** when you are referred by our Direct Access service, a **GP, consultant** or another healthcare professional (as explained in 'How to get treatment and claim'). We pay for remote consultations by phone or video with a **consultant** psychiatrist.

benefit 5.1.2 out-patient mental health and wellbeing therapists' fees

When you are referred by our Direct Access service, a **GP, consultant** or another healthcare professional (as explained in 'How to get treatment and claim') we pay:

- **mental health and wellbeing therapists'** fees for **out-patient mental health treatment** including fees for phone or video consultations
- for you to have access to an online supported therapy programme/service - the online therapy is based on guided self help and you must use the online programme/service we direct you to.

benefit 5.1.3 out-patient mental health diagnostic tests

When requested by your **consultant** psychiatrist to help determine or assess your condition as part of **out-patient mental health treatment** we pay **recognised facility** charges for **diagnostic tests**. The cost for reporting is included within the charge for the **diagnostic test**.

We don't pay charges for **diagnostic tests** that aren't from the **recognised facility**.

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

benefit 5.1.4 - assessments for neurodiverse conditions

Your **membership certificate** shows if you are covered for this benefit.

We pay **consultants** fees, **mental health and wellbeing therapists** fees and **recognised facility** charges for **out-patient** assessments for the neurodiverse conditions named below when they are suspected. We pay for **out-patient** assessments when you are referred by a Special Educational Needs Coordinator (SENCo), a **consultant** or another healthcare professional (as explained in 'How to get treatment and claim') if you are aged 6 to 15 or by a **GP, a consultant** or another healthcare professional if you are aged 16 or over.

We pay for the assessment of attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), dyslexia, dysgraphia and dyscalculia when one of these neurodiverse conditions is suspected. We pay for one assessment or a combination of assessments once in your lifetime of being covered under a Bupa health insurance policy and/or a beneficiary of a Bupa administered trust. You must be aged 6 years or over to use this benefit.

We don't pay for any assessments when the only purpose is for screening and there are no signs or symptoms of a neurodiverse condition. We don't accept a referral for an assessment from a **GP** if you are aged 6 to 15.

To pre-authorise or for more information please contact us.

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

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

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

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

Consultants' fees

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

Recognised facility charges

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

Additional benefits

Benefit 6 Treatment at home

Your *membership certificate* shows if you are covered for this benefit.

This benefit applies when you receive *eligible treatment at home* where this would otherwise require *in-patient treatment* or *day-patient treatment* or *chemotherapy* as an *out-patient*. 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*, and
- if you did not have the *treatment at home* then, for medical reasons, you would need to receive *in-patient treatment* or *day-patient treatment* or *chemotherapy* as an *out-patient*, and
- the *treatment* is provided to you by a *medical treatment provider*.

We need full details of your *treatment at home* from your *consultant* before it starts so that we can confirm whether it's covered.

We don't pay for any fees or charges for *treatment at home* that has not been provided to you by the *medical treatment provider*. You are covered on the same basis as set out in benefits 2 and 3. This benefit does not apply to *out-patient treatment* which takes place at *home* as explained in benefit 1.

Benefit 7 Home nursing after private eligible in-patient treatment

Your *membership certificate* shows if you are covered 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*, and
 - is needed for medical reasons i.e. not domestic or social reasons, and
 - is necessary i.e. without it you would have to remain in the *recognised facility*, and
 - starts immediately after you leave the *recognised facility*, and
 - is provided by a *nurse* in your own *home*, and
 - is carried out under the supervision of your *consultant*.

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

We don't pay for *home* nursing provided by a community psychiatric nurse.

Benefit 8 Private ambulance charges

Your *membership certificate* shows if you are covered 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*, or
- between *recognised facilities* when you are discharged from one *recognised facility* and admitted to another *recognised facility* for *in-patient treatment*, or
- from a *recognised facility* to *home*, or
- between an airport or seaport and a *recognised facility*.

Benefit 9 Overseas emergency treatment

Your *membership certificate* shows if you are covered for this benefit.

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

We don't pay for overseas emergency *treatment* if any of the following apply:

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

You aren't covered for:

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

What we pay for

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

Need to know

You'll need to settle all accounts direct with the medical providers in the country of **treatment** and, on return to the **UK**, submit the itemised and dated receipted invoices to us for assessment. We only pay eligible claims in pound sterling. When we have to make a conversion from a foreign currency to pound sterling we will use the exchange rate published on **Oanda.com** on the date you paid for your treatment.

Important: for the purpose of this benefit 9:

- we only pay for Eligible Treatment carried out by a consultant, therapist or complementary medicine practitioner who is:
 - fully trained and legally qualified and permitted to practice by the relevant authorities in the country in which your **treatment** takes place, and
 - is recognised by the relevant authorities in that country as having specialised knowledge of, or expertise in, the **treatment** of the disease, illness or injury being treated
- we only pay facility charges for Eligible Treatment when the facility is specifically recognised or registered under the laws of the territory in which it stands as existing primarily for:
 - carrying out major surgical operations, and
 - providing treatment that only a consultant can provide
- where we refer to Eligible Treatment we mean, **treatment** of an **acute condition** together with the products and equipment used as part of the **treatment** that:
 - are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the country in which the overseas emergency treatment is carried out
 - are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided
 - are demonstrated through scientific evidence to be effective in improving health outcomes, and
 - aren't provided or used primarily for the expediency of you or your consultant or other healthcare professional

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

Please also see 'Exclusion 21 Overseas treatment' in the section 'What isn't covered'.

Benefit 10 Repatriation and evacuation assistance

Your *membership certificate* shows if you are covered for this benefit.

Need to know

You must contact us before any arrangements are made for your repatriation or evacuation. We'll check your cover and explain the process for arranging repatriation or evacuation and making a claim. From inside or outside the **UK** please contact us using the helpline on your *membership certificate*. When your helpline is closed call us on: **+44 (0)1925 361 337**. Lines are open 24 hours 365 days a year. We may record or monitor our calls.

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

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

We won't consider repatriation or evacuation if any of the following apply:

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

What we pay for

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

- You must provide us, and where applicable the *medical assistance company*, with any information or proof that we may reasonably ask you for to support your request for repatriation/evacuation.
- We only pay costs that we consider to be reasonable. This means that the amount we'll pay will be in line with what the majority of our members are charged for similar *treatment* or services. We only pay costs incurred for you by the *medical assistance company* and only when the arrangements have been made in advance of your repatriation/evacuation by the *medical assistance company*. We don't pay any costs that haven't been arranged by the *medical assistance company*.
- We only pay for transport costs incurred during your repatriation and/or evacuation. We don't pay any other costs related to the repatriation and/or evacuation such as hotel accommodation or taxis. Costs of any *treatment* you receive aren't covered under this benefit.

- We may not be able to arrange evacuation or repatriation in cases where the local situation makes it impossible, unreasonably dangerous or impractical to enter the area; for example from an oil rig or within a war zone. We also cannot be held responsible for any delays or restrictions associated with the transportation that are beyond our control such as weather conditions, mechanical problems, restrictions imposed by local or national authorities or the pilot.

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

benefit 10.1 your repatriation/evacuation

We pay for either:

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

benefit 10.2 accompanying partner/relative

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

benefit 10.3 in the event of death

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

Cash benefits

You may be able to claim a payment for some types of **treatment**, health expenses or the birth/adoption of a child.

Your **membership certificate** shows which (if any) of these apply to your policy and your **allowances**.

Need to know

Please contact us before your **treatment** so we can let you know how to claim.

Important note for Cash benefits CB3 to CB5

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

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

We pay **NHS** cash benefit for each night you receive **in-patient treatment** provided to you free under 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 don't 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** aren't 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**.

Need to know

Apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3) this benefit (CB1) isn't payable at the same time as any other NHS cash benefit for **NHS treatment**.

Benefit CB2 Family cash benefit

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

What we pay

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

Please see your **membership certificate** for full details.

Benefit CB3 Optical cash benefit

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

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

What's covered

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

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

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

What isn't covered

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

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

Benefit CB4 Accidental dental injury cash benefit

What's covered

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

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

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

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

Benefit CB5 Prescription cash benefit

What's covered

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

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

What isn't covered

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

Benefit CB6 Cash benefit for treatment for cancer

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

We pay NHS cash benefit for each night you receive **NHS In-patient treatment** for **cancer** when it includes one of the following:

- radiotherapy
- **chemotherapy**
- an **operation**
- a blood transfusion
- a bone marrow or stem cell transplant.

We only pay if your **treatment** would otherwise have been covered for private **in-patient treatment** under your **benefits** and is provided to you free under the **NHS**.

Any costs you incur for choosing to occupy an amenity bed while receiving your **in-patient treatment** aren't 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**.

Need to know

Apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3) this benefit (CB6.1) isn't payable at the same time as any other NHS cash benefit for **NHS treatment**.

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

We pay this NHS cash benefit for:

- each day you receive radiotherapy, including proton beam therapy in a hospital setting
- each day you receive **chemotherapy**, other than **oral chemotherapy**
- the day on which you undergo an **operation** that is **eligible treatment** for **cancer**.

We only pay if your **treatment** would otherwise have been covered for private **out-patient treatment**, **day-patient treatment** or **treatment at home** under your **benefits** and is provided to you free under the **NHS**.

Need to know

- apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3) this benefit (CB6.2) isn't payable at the same time as any other NHS cash benefit for **NHS treatment**
- this benefit is only payable once, even if you have more than one **eligible treatment** on the same day.

benefit CB6.3 NHS cash benefit for oral drug treatment for cancer

We pay NHS cash benefit for each three-weekly interval, or part thereof, during which you take:

- **oral chemotherapy**, or
- oral anti-hormone therapy that is not available from a **GP**.

Need to know

We pay this benefit CB6.3 at the same time as another NHS cash benefit you may be eligible for under your **benefits** on the same day.

We only pay if your **treatment** would otherwise have been covered for private **treatment** under your **benefits** and is provided to you free under the **NHS**.

benefit CB6.4 Cash benefit for wigs or hairpieces

We pay cash benefit for a wig or hairpiece if you experience hair loss during eligible **cancer treatment**. This benefit is paid once per **cancer** occurrence.

If benefit 4.2 NHS Cancer Cover Plus applies to your **benefits**, we pay this cash benefit as set out in benefit 4.2.

benefit CB6.5 Cash benefit for mastectomy bras

We pay cash benefit for mastectomy bras and prostheses following an eligible mastectomy procedure where a reconstruction is not performed at the same time. This benefit is paid once per mastectomy surgery.

If benefit 4.2 NHS Cancer Cover Plus applies to your **benefits**, we pay this cash benefit as set out in benefit 4.2.

Benefit CB7 Procedure Specific NHS cash benefit

We pay Procedure Specific NHS cash benefit in relation to certain specific **treatment** provided to you free 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 contact us or go to bupa.co.uk/pscb. These cash benefits may change from time to time.

Need to know

Apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3) this benefit (CB7) isn't payable at the same time as any other NHS cash benefit for **NHS treatment**.

What isn't covered

This section explains the type of **treatment**, services and charges which aren't covered by your policy and the exceptions when cover is available.

The 'What is covered' section of this policy guide, your **membership certificate** and any **confirmation of special conditions** will also show any **treatment** or conditions that aren't covered. This section doesn't apply to:

- 'Well Health' benefits 1.7, 1.9, 1.10, 1.12, 1.13 and 1.14, or
- benefit 1.11 'digital GP services', or
- Cash benefits CB2 to CB5.

Mental health treatment for or related to **special conditions, pre-existing conditions** and **moratorium conditions** isn't covered. **Mental health treatment** related to anything else in this section is covered as set out in 'Mental health treatment' (Benefit 5).

Exclusion 1 Ageing, menopause and puberty

We don't 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 don't pay for the **treatment** of acne arising from natural hormonal changes.

Exception 1: We pay for **eligible treatment** of an **acute condition** that you develop during menopause, such as heavy bleeding (menorrhagia) or urinary incontinence subject to the other policy terms.

Exception 2: If your **benefits** include benefit 1.9 Well Health - menopause plan, we pay for advice and support associated to menopause symptoms as set out in benefit 1.9.

Exclusion 2 Accident and Emergency Treatment

We don't 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 don't 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 'What is covered' and the exclusion '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 don't 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 don't 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 won't pay for further investigations into which specific nut(s) you're allergic to.

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

We don't 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 don't pay for any **treatment** costs in excess of the amounts for which you're covered under your **benefits**.

Exclusion 5 Birth control, conception and sexual problems

We don't 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 (e.g. IVF investigations or **treatment**), surrogacy, the harvesting of donor eggs or donor insemination
- where it relates solely to the **treatment** of infertility

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

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

Exception: If your **benefits** include benefit 1.10 Well Health - out-patient fertility check, we pay for one fertility check per **year** as set out in benefit 1.10.

Exclusion 6 Chronic conditions

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

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

Exception 1: We pay for **eligible treatment** arising out of a **chronic condition**, or for **treatment** of unexpected 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. We don't pay for **treatment** required due to the expected deterioration or flare up of a **chronic condition**. This includes conditions which have a relapsing-remitting nature and require management of recurrent flare-ups, for example, inflammatory bowel disease. In such cases, the flare-ups are an expected part of the normal course of the illness and therefore we don't consider them as acute complications of the disease.

Exception 2: If your **benefits** include benefit 1.6 out-patient monitoring and management of chronic conditions, we pay for eligible monitoring and management of a **chronic condition** as set out in benefit 1.6.

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're not obliged to pay the ongoing costs of continuing, or similar **treatment**. This is the case even where we've previously paid for this type of or similar **treatment**. When you're receiving **in-patient treatment**, in making our decision on whether your condition is, or has become, a **chronic condition**, we'll consider the period of days during which there has been no change in your clinical condition or change in your **treatment**.

We don't consider **cancer** as a **chronic condition**. We explain what we pay for **eligible treatment** of **cancer** in Benefit 4 Cancer treatment in the 'What is covered' section of this guide.

We don't 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 'What is covered' 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 don't 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 policy.

We don't 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 don't 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 doesn't cause chemical, biological, radioactive or nuclear contamination.

Exclusion 9 Convalescence, rehabilitation and general nursing care

We don't 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 isn't a **recognised facility**
- receiving services from a **therapist, complementary medicine practitioner or mental health and wellbeing therapist**.

This does not apply to addiction treatment programmes if they are covered by your policy under Benefit 5 Mental health treatment.

Exclusion 10 Cosmetic, reconstructive or weight loss treatment

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

We don't 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's needed for medical or psychological reasons, for example, for backache or gynaecomastia (which is the enlargement of breasts in males).

We don't pay for any **treatment**, including surgery:

- which is for or involves the removal of healthy tissue (i.e. tissue which isn't 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)

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

We don't pay for **treatment** of keloid scars. We also don't pay for scar revision.

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

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

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

Exception 2: We pay for **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**, or eligible prophylactic surgery (as explained in Exclusion 25 Screening, monitoring and preventive treatment under Exception 1).

Operations to restore appearance include those for the purposes of symmetry (e.g. 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 don't pay for repeat surgeries or reconstructions, or further **treatment** to restore or amend your appearance.

We only pay if this is part of the original **eligible treatment** resulting from the accident, **cancer** surgery or prophylactic surgery.

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

Exclusion 11 Deafness

We don't pay for **treatment** for or arising from deafness caused by a congenital abnormality, maturing or ageing.

Exclusion 12 Dental/oral treatment

We don't 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:

- oral cancer, as described in benefit 4 Cancer treatment - if your benefits include cover for **cancer**
- an **operation** carried out by a **consultant** to:
 - treat a jaw bone cyst, but not if it's related to a cyst or abscess on the tooth or root or any other tooth or gum disease or damage
 - surgically remove a complicated, buried or impacted tooth or root, which is causing infection or pain such as an impacted wisdom tooth, but not if the purpose is to facilitate dentures.

Exclusion 13 Dialysis

We don't 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 don't 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 don't 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 don't 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 'What is covered'.

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

Exclusion 15 Excluded treatment or medical conditions

We don't 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 don't 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 haven't 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 that the drug has had a health technology assessment with a positive outcome and there is a European Medicines Agency (EMA) licence for the drug with the drug being 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 (i.e. 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's 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 don't 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 don't pay for laser-assisted cataract surgery.

Exception 1: We pay for **eligible treatment** for your eyesight if it's 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 don't 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 don't 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**
- it's carried out in a unit or facility which isn't a **critical care unit**.

Please see 'benefit 3.2.4 Intensive care' in the section 'What is covered'.

Exclusion 20 Learning difficulties, behavioural and developmental conditions

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

Exception: If your **benefits** include benefit 5.1.4 assessments for neurodiverse conditions, we pay for **out-patient** assessments for a neurodiverse condition as set out in benefit 5.1.4.

Exclusion 21 Overseas treatment

We don't pay for **treatment** that you receive outside the **United Kingdom**.

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

Exception 2: If the **treatment** you need isn't available at all 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** isn't available in the **UK**, before we can determine this.

Need to know

If your **treatment** abroad is covered, you'll need to pay for it yourself and send us your receipts so we can pay your claim up to the cost of the standard alternative **treatment** which is routinely available in the **UK**.

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

Exclusion 22 Physical aids and devices

We don't pay for supplying or fitting physical aids and devices (e.g. 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 'What is covered'.

Exclusion 23 Pre-existing conditions

Your **membership certificate** shows the type of underwriting that applies to your policy.

For underwritten policies we don't pay for **treatment** of a **pre-existing condition**, or a symptom, condition, disease, illness or injury that results from or is related to a **pre-existing condition**.

Exception: We pay for **eligible treatment** of a **pre-existing condition**, or a symptom, condition, 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**), and
- **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 policy, and

- 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 policy, 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** and any **confirmation of special conditions** we send for anyone to whom a **special condition** applies.

Exclusion 24 Pregnancy and childbirth

We don't 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 and sexual problems', 'Screening, monitoring and preventive treatment' and 'Chronic conditions' in this section.

Exclusion 25 Screening, monitoring and preventive treatment

We don't 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 1: If your **benefits** include cover for **cancer**, you are being treated for **cancer** and have strong direct family history of **cancer**, we pay for a genetically-based test to evaluate future risk of developing further cancers, if recommended by your **consultant**. If the test shows you are at high risk of developing further cancers we pay for prophylactic surgery, if recommended by your **consultant**. We'll pay for reconstructive surgery following eligible prophylactic surgery as set out in Exclusion 10 Cosmetic, reconstructive or weight loss treatment under Exception 2.

Before you have any tests, procedures or **treatment** you must have our written confirmation that the above criteria have been met and we'll need full clinical details from your **consultant** before we can determine this.

Exception 2: If your **benefits** include **cancer** cover we pay for **eligible treatment** for the monitoring of **cancer** as set out in benefit 4.1.1 out-patient consultations for cancer and benefit 4.1.4 out-patient diagnostic tests for cancer.

Exception 3: If your **benefits** include benefit 1.6 out-patient monitoring and management of chronic conditions, we pay for eligible monitoring and management of a **chronic condition** as set out in benefit 1.6.

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

Exclusion 26 Sleep problems and disorders

We don't 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

Your **membership certificate** shows the type of underwriting that applies to your policy.

For underwritten policies we don't pay for **treatment** directly or indirectly relating to **special conditions**.

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

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

Exclusion 28 Speech disorders

We don't pay for **treatment** for or relating to any speech disorder, for example stammering.

Exception: We pay for short-term speech therapy when it's 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 Gender dysphoria or gender affirmation

We don't pay for **treatment** for **gender dysphoria** or gender affirmation.

Exception: If your **benefits** include benefit 1.8 diagnosis of gender dysphoria and you are aged 18 or over, we pay for **out-patient** consultations for the diagnosis of **gender dysphoria** as set out in benefit 1.8.

Exclusion 30 Temporary relief of symptoms

We don't 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 1: We pay for **treatment** for a maximum of 21 consecutive days to manage the symptoms of a terminal illness or disease, if needed as part of your care plan. We only pay if your **consultant** tells you that your ongoing **treatment** will be to support your end of life care and you will not receive **treatment** that is intended to halt or improve the terminal illness or disease itself.

Treatment can take place:

- within a **Bupa** recognised hospital, or
- in another location of your choosing, such as your **home**.

Treatment must be provided by services registered with the CQC (Care Quality Commission).

We then pay all charges and fees for the **treatment** you need on the same basis as otherwise eligible hospital treatment, under benefit 3.2. We only pay for this once in your lifetime.

Exception 2: If your **benefits** include benefit 1.6 out-patient monitoring and management of chronic conditions, we pay for eligible monitoring and management of a **chronic condition** as set out in benefit 1.6.

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

We don't pay **consultants'** fees for **treatment** that you receive in a hospital or any other type of treatment facility that isn't a **recognised facility**.

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

Exception: We may pay **consultants'** fees and facility charges for **eligible treatment** in a treatment facility that isn't 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 'What is covered'.

Exclusion 32 Unrecognised medical practitioners, providers and facilities

We don't pay for any of your **treatment** if the consultant who is in overall charge of your **treatment** isn't recognised by **Bupa**.

We also don't pay for **treatment** if any of the following apply:

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

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

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

Exclusion 33 Moratorium conditions

Your **membership certificate** shows the type of underwriting that applies to your policy.

For moratorium policies we don't pay for **treatment** of a **moratorium condition**, or a symptom, condition, disease, illness or injury that results from or is related to a **moratorium condition**.

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

Exclusion 34 Advanced therapies and specialist drugs

We don't pay for:

- any gene therapy, somatic-cell therapy or tissue engineered medicines that aren't 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**.

Exclusion 35 Varicose veins of the legs

We don't pay for the **treatment** of varicose veins of the legs.

Exception: We pay for one **operation** for varicose veins per leg in your lifetime of being covered under a **Bupa** health insurance policy and/or a beneficiary of a **Bupa** administered trust. This applies to all **Bupa** insurance schemes and/or **Bupa** administered trusts you may be a member and/or beneficiary of in the future, whether your being a member and/or beneficiary is continuous or not.

Both legs being treated on the same day is considered one surgical operation on each leg.

We also pay:

- any eligible consultations and **diagnostic tests** needed for your **operation**
- a single sclerotherapy **treatment** within six months of an original **operation** if there are remaining symptoms.

How your health insurance policy works

The agreement between your sponsor and us

Your cover is provided by a group policy. This is governed by the **agreement** and terms and conditions of your cover which your **sponsor** and **Bupa** have agreed.

Only the **sponsor** and **Bupa** have legal rights under the **agreement**. There's no legal contract between you and **Bupa** for your cover. However, if you're a **contributing member** you will have legal rights as set out under 'Contributing members' in this section.

The documents that set out your cover

There are three documents which set out full details of how your health insurance works under the **agreement**:

- this policy guide which contains details about the general cover for you and **dependants** covered on your policy, and
- your **membership certificate** which shows your specific cover and **allowances**, when your cover starts and ends and is personal to you, and
- a **confirmation of special conditions** (if any apply) for the **main member** or any **dependant's** when they are aged 16 or over.

Although they're separate documents, they should be read together as a whole. Each year, we'll send you a **membership certificate** and a policy guide, both of which apply from your latest **cover start date**.

Need to know

This policy guide contains all the possible cover under Bupa Select. Your **membership certificate** shows the cover that **your sponsor** has selected and that is available to you. This means you may not have all the cover set out in this policy guide.

Demands and needs statement

The cover provided under this policy is generally suitable for someone who is looking to cover the cost of a range of health expenses. We haven't provided you with any advice about your cover and how it meets your individual needs. Please read your **membership certificate**, this policy guide and any **confirmation of special conditions** we send for anyone to whom a **special condition** applies to make sure that the cover meets your needs (including the needs of any **dependants** covered).

Payment for treatment

Your policy pays for **treatment** you have on the date the **treatment** takes place while you're covered under the **agreement**. We only pay **benefits** in line with the cover that applies to you on the date the **treatment** takes place. It doesn't cover any **treatment** that takes place after the date your cover ends even if we've pre-authorised it.

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, we pay the costs that are covered under your policy. If your **treatment** isn't covered by your policy, you'll be responsible for paying the costs of that **treatment** to your treatment provider.

We don't provide private **treatment** or any other clinical services that are covered by your policy. In many cases we have agreements with **consultants**, healthcare professionals, hospitals and clinics for how much they charge our customers for **treatment** and how we pay them. We'll usually pay the **consultant**, healthcare professional, hospital or clinic directly for your **treatment**. Otherwise we'll pay the **main member**. We'll write to the **main member** or **dependant** having **treatment** (when aged 16 or over), when there is an amount for them to pay in relation to any claim (for example if they have an excess or co-insurance amount to pay) and who the payment should be made to.

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**
- **complementary medicine practitioners**
- **consultants**
- **critical care units**
- **fee-assured consultants**
- **fertility check facility**
- **medical treatment providers**
- **mental health and wellbeing therapists**
- **prostheses**
- **recognised facilities**
- **schedule of procedures**
- **specialist drugs**
- **therapists**
- Open Referral Network **consultants**.

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

When your cover starts, renews and ends

Starting your cover

You can find your **cover start date** on your **membership certificate**. This applies to you and your **dependants**. **Your cover start date** and your **dependants cover start date** may be different.

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

Cover for a newborn baby

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

- underwritten we won't apply any **special conditions** to the baby's cover
- moratorium we won't apply the exclusion for **moratorium conditions** to the baby's cover – see Exclusion 33 in the section 'What isn't covered'

but only if both the following apply:

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

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

Renewing your cover

The renewal of your cover depends on **your sponsor** renewing its group policy.

If you're a **contributing member** please see the 'Contributing members' in this section.

How your cover can end

You or your **sponsor** can end **your** cover (and the cover of anyone else included on your policy) at any time.

If you'd like to do this **you** must write to us. If **your** cover ends, so does the cover of everyone else on your policy. If you're a **contributing member** please see 'Contributing members' in this section.

Your cover and the cover for **your dependants** (if any) will automatically end if:

- the **agreement** is ended
- the terms of the **agreement** say that it must end
- the **sponsor** doesn't pay subscriptions or any other payment due under the **agreement** for you or anyone else
- **you** stop living in the **UK** (**you** must let us know if **you** stop living in the **UK**), or
- **you** pass away.

Cover for **your dependants** on the policy will automatically end if:

- **your** cover ends
- the terms of the **agreement** say that it must end
- the **sponsor** doesn't renew the policy for them
- they stop living in the **UK** (**you** must let us know if they stop living in the **UK**), or
- they pass away.

If there's reasonable evidence that **you** or a **dependant** didn't take reasonable care 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** and/or **your dependant's** cover as if it never existed and not 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** and/or **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've paid and if you're a **contributing member** we'll return to the **sponsor** any premiums you've paid in for **your** and/or **your dependant's** cover), change your or their cover, or reduce any claim payment.

Continuing your cover if you leave your group policy

When **your** cover, or cover for **your dependants** (if any) ends, we may be able to offer a **Bupa** personal policy with no break in cover. This will depend on how long you or they have been a **Bupa** group scheme member. If you wish to transfer to a **Bupa** personal policy without any break in your cover, you must transfer within three months of the date **your** or their **Bupa** group scheme cover ends.

We can explain how to do this. Please call us on **0800 600 500*** to discuss the options available.

Paying subscriptions and other charges

The **sponsor** must pay to us subscriptions and any other payment due for **your** cover and **your dependants** covered on your policy. Bupa Insurance Services Limited acts as our agent for arranging and administering **your** policy and collects subscriptions for the purpose of receiving, holding and refunding subscriptions and making claims payments.

If you're a **contributing member** please see 'Contributing members' in this section.

Making changes to your policy

The terms and conditions of your policy, including your **benefits**, may be changed from time to time so long as we and the **sponsor** agree.

No-one else is allowed to make or confirm any changes to your policy or your **benefits** on our behalf or decide not to enforce any of our rights. Equally, no change to your policy or your **benefits** will apply unless it is specifically agreed between the **sponsor** and us and confirmed in writing.

*We may record or monitor our calls.

If any changes to the terms and conditions of your policy, including your **benefits**, are agreed between the **sponsor** and us, we'll let you know before the change happens. If **you** don't accept any of the changes **you** can end your policy by letting the **sponsor** know within 28 days of either:

- the date when the change happens, or
- **you** being told about the change

whichever is later.

If you're a **contributing member** please see 'Contributing members' in this section.

General information

Change of address

You should let us know if **you** change **your** address.

Documents and communications

We'll send:

- policy documents to the **main member**
- a **confirmation of special conditions** (if any apply) to the **main member** or to the **dependant** when they are aged 16 or over
- all claims correspondence to the **main member**, or to the **dependant** having **treatment** when they're aged 16 or over
- copies of any original documents you send us if you ask us to, because we're unable to return the originals
- an invitation to create a **Bupa** digital account when you or any **dependant** who is aged 16 or over gives us their email address.

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

Contributing members

This section only applies to **contributing members**.

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

If you pay for your cover, we will take it that we have received your contributions to the subscriptions the **sponsor** has paid for **you** (e.g. by payroll deduction) once these are received by **your sponsor**.

We'll send **you** the terms and conditions that will apply to **your** cover as soon as we can, and the **sponsor** will let **you** know the amount you will need to contribute from the **cover start date**.

If you don't want **your** cover (and therefore cover for **your dependants**) to renew at your **renewal date you** can let **your sponsor** know at any time before the policy **renewal date**. The same applies if **you** want to remove a **dependant** from your policy.

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

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

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

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

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

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

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

Your cover, and **your dependants** cover, will automatically end if the **sponsor** doesn't pay the subscriptions or any other payments due under the **agreement**. However, we'll continue to pay claims covered by your policy if you can confirm (e.g. by providing a copy of your payslips) that **you** paid **your** contributions to **your sponsor**.

Where we refund subscriptions to the **sponsor you** should ask the **sponsors** administrator for a refund of **your** contributions.

How to complain

We work hard to give our customers great service. Occasionally things go wrong and when this happens we'll do our best to put things right quickly.

How to get in touch

- call us: using your **Bupa** helpline number, which you can find on your **membership certificate** or call our Customer Relations team on **0345 606 6739***
- chat to us online: **bupa.co.uk/complaints**
- email us: **customerrelations@bupa.com**

If you need to send us sensitive information you can email us securely using Egress. For more information and to sign up for a free Egress account, go to **switch.egress.com**. You won't have to pay for sending secure emails to a **Bupa** email address using Egress.

- write to us: **Customer Relations, Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

What happens with my complaint?

We'll carefully consider your complaint and do our best to resolve it quickly. If we can't resolve it straight away, we'll email or write to you within five business days to explain the next steps.

We'll keep you updated on our progress and once we have fully investigated your complaint, we'll email or write to you to explain our decision. If we have not resolved it within eight weeks we'll email or write to you and explain the reasons for the delay.

If we haven't resolved your complaint within eight weeks, or if you are unhappy with our decision, you may be able to refer your complaint to the Financial Ombudsman Service for an independent review. The service they provide is free and impartial. You can

- visit **financial-ombudsman.org.uk**
- call them on **0800 023 4567**
- submit a complaint online at **financial-ombudsman.org.uk/make-complaint**
- email them at **complaint.info@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'll only give them what's necessary to investigate your complaint and this may include medical information. If you are concerned about this, please contact us.

The Financial Services Compensation Scheme (FSCS)

In the unlikely event that we can't 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. More information is available at **www.fscs.org.uk** or by calling the FSCS on **0800 678 1100** or **020 7741 4100**

*We may record or monitor our calls.

What some of the words and phrases in this guide mean

Here's what the words and phrases in ***bold italic*** in this guide mean.

Word/phrase	Meaning
<i>Accidental dental injury</i>	Damage to your teeth or gums caused by accidental external impact.
<i>Activities of daily living</i>	<ul style="list-style-type: none">▪ functional mobility - being able to move from one place to another for daily activities▪ having a shower and/or bath▪ feeding yourself▪ personal hygiene and grooming▪ toilet hygiene▪ work or education - being able to carry these out.
<i>Acute condition</i>	A disease, illness or injury that is likely to respond quickly to <i>treatment</i> which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
<i>Advanced therapies</i>	Gene therapy, somatic-cell therapy or tissue engineered medicines classified as Advanced Therapy Medicinal Products (ATMPs) by the UK medicines regulator to be used as part of your <i>eligible treatment</i> and which are, at the time of your <i>eligible treatment</i> , included (with the medical condition(s) for which we pay for them) on the list of advanced therapies that applies to your <i>benefits</i> as shown on your <i>membership certificate</i> under the heading 'Advanced therapies list'. The list that applies to your <i>benefits</i> is available at bupa.co.uk/policyinformation or you can contact us. The advanced therapies on the list will change from time to time.
<i>Agreement</i>	The agreement between the <i>sponsor</i> and us under which you have cover.
<i>Allowance(s)</i>	The financial allowances of your <i>benefits</i> , these are shown on your <i>membership certificate</i> .
<i>Appliance(s)</i>	Any medical appliances which are on our list for your cover when you have your <i>treatment</i> - you can find the list at bupa.co.uk/prostheses-and-appliances
<i>Benefits</i>	The benefits listed on your <i>membership certificate</i> which you're covered for.
<i>Bupa</i>	Bupa Insurance Limited. Registered in England and Wales with registration number 3956433. Registered office: 1 Angel Court, London EC2R 7HJ.
<i>Cancer</i>	A malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
<i>Chemotherapy</i>	Systemic Anti-Cancer Therapies (SACT), excluding anti-hormone therapies. SACT are used to destroy or stop cancer cells growing and spreading.

Word/phrase	Meaning
Chronic condition	A disease, illness or injury which has one or more of the following characteristics: <ul style="list-style-type: none"> ▪ it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests ▪ it needs ongoing or long-term control or relief of symptoms ▪ it requires rehabilitation or for you to be specially trained to cope with it ▪ it continues indefinitely ▪ it has no known cure ▪ it comes back or is likely to come back.
Common drugs	Commonly used medicines, such as antibiotics and painkillers that in our reasonable opinion based on established clinical and medical practice, should be an essential part of your eligible treatment .
Complementary medicine practitioner	An acupuncturist, chiropractor or osteopath who is recognised by us. You can search for one at finder.bupa.co.uk or contact us.
Confirmation of special conditions	Where a special condition applies, the most recent confirmation of special conditions we send to the main member or dependant if they're aged 16 or over.
Consultant	A registered medical healthcare professional who, when you have your treatment : <ul style="list-style-type: none"> ▪ is recognised by us as a consultant ▪ is recognised by us both for treating your condition and providing the type of treatment you need, and ▪ is in our list of recognised consultants which applies to your policy. You can search for one at finder.bupa.co.uk or contact us.
Contributing member	Contributing members are main members who pay towards their cover.
Cover end date	The date when your current cover ends. This is either the 'Cover end date' on your membership certificate or, if this isn't listed, the day before your policy renews.
Cover start date	The date when your current cover starts. This is shown as 'Cover start date' on your membership certificate .
Critical care unit	Any intensive care unit, intensive therapy unit, high dependency unit, coronary care unit or progressive care unit which is recognised by us at the time of the treatment for the type of intensive care that you need. You can search for one at finder.bupa.co.uk or contact us.
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 you have as a day-patient .
Dentist	Any general dental practitioner who is registered with the General Dental Council when you have your dental treatment.
Dependant	Your partner and/or any child you or your partner are responsible for and who is covered 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.

Word/phrase	Meaning
Digital primary care provider	A digital primary care provider we recognise for providing a digital consultation in a primary care setting, this can include a GP and other healthcare practitioners registered with the digital primary care provider.
Effective underwriting date	<p>If you're 'Underwritten', the effective underwriting date is the date you started your continuous period of cover under the policy. This is the date shown as 'Effective underwriting date' on your membership certificate.</p> <p>If this is not displayed on your membership certificate, your effective underwriting date is your cover start date shown on the first membership certificate we provided which lists you as a member under the policy.</p> <p>If you joined from a previous policy and we have agreed with the sponsor that you continue with your original previous policy start date, your effective underwriting date is the date of underwriting by the insurer or administrator of your previous policy.</p> <p>If you're unsure of your effective underwriting date contact us and we can let you know.</p>
Eligible treatment	<p>Treatment of an acute condition or a mental health condition, together with the products and equipment used as part of the treatment that are:</p> <ul style="list-style-type: none"> ■ consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the UK, and ■ clinically appropriate in terms of the type, frequency, extent, duration and the facility or location where the services are provided for example as specified by NICE (National Institute for Health and Care Excellence), or equivalent bodies in Scotland, in guidance on specific conditions or treatment where available, and ■ demonstrated through scientific evidence to be effective in improving health outcomes and the treatment, services or charges are not listed in the 'What isn't covered' section in this guide, and ■ not provided or used primarily for the expediency of you or your consultant or other healthcare professional <p>and the treatment, services or charges are not excluded under your benefits.</p>
Facility access	The network of recognised facilities which you're covered for and listed on your membership certificate . This is participating facility , or partnership facility .
Fee-assured consultant	<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 search for one at finder.bupa.co.uk or contact us.</p>
Fertility check facility	A facility that, at the time you receive a fertility check, is recognised by us for fertility checks. You can search for details of these providers at finder.bupa.co.uk
Gender dysphoria	When someone has a sense of unease because of a mismatch between their biological sex and gender identity.
GP	A doctor who refers you for a consultation or treatment and is on the UK General Medical Council's General Practitioner Register.
Home	The place where you normally live or another non-healthcare setting where you have your treatment .

Word/phrase	Meaning
<i>In-patient</i>	A patient who is admitted to a hospital or treatment facility and who occupies a bed overnight or longer for medical reasons.
<i>In-patient treatment</i>	Eligible treatment you have as an <i>in-patient</i> .
<i>Intensive care</i>	Eligible treatment for intensive care, intensive therapy, high dependency care, coronary care or progressive care.
<i>Main member</i>	The person named as the main member not a dependant .
<i>Medical assistance company</i>	The company who is appointed by Bupa as a medical assistance company for arranging repatriation and/or evacuation. The medical assistance company may change from time to time and current details are available on request.
<i>Medical treatment provider</i>	A person or company recognised by us as a medical treatment provider for the type of treatment at home that you need. The list of medical treatment providers and the type of treatment we recognise them for will change from time to time. You can search for details of these providers at finder.bupa.co.uk
<i>Membership certificate</i>	The most recent membership certificate we send you for your cover, or the most recent Group Certificate that we send your sponsor that provides the details of your cover.
<i>Mental health and wellbeing therapist</i>	<p>A healthcare professional recognised by us who is:</p> <ul style="list-style-type: none"> ■ a psychologist registered with the Health Professions Council ■ a psychotherapist accredited with the 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>You can search for a recognised mental health and wellbeing therapist at finder.bupa.co.uk</p>
<i>Mental health condition</i>	A mental illness or condition which is a mental health condition according to a reasonable body of medical opinion.
<i>Mental health treatment</i>	Eligible treatment as set out in Benefit 5 Mental health treatment in the 'What is covered' section of this guide.
<i>Moratorium start date</i>	<p>If you're covered by a moratorium policy, the date you started your continuous period of cover is:</p> <ul style="list-style-type: none"> ■ the 'Moratorium start date' on your membership certificate, or ■ if this isn't shown on your membership certificate, your cover start date on the first membership certificate we sent you, or ■ your original moratorium start date from a previous policy if you had a moratorium underwriting policy with Bupa or another insurer and we have agreed with the sponsor that this would continue to apply when you joined this policy. <p>If you're unsure of your moratorium start date contact us and we can tell you.</p>

Word/phrase	Meaning
Moratorium condition	<p>Any condition, disease, illness or injury including related conditions, whether diagnosed or not, which you:</p> <ul style="list-style-type: none"> asked for or received, medical advice or treatment or medication for, or had symptoms or knew existed <p>in your moratorium qualifying period immediately before your moratorium start date. By a related condition we mean any symptom, condition, disease, illness or injury which in our reasonable medical opinion is associated with another symptom, condition, disease, illness or injury.</p>
Moratorium qualifying period	<p>The number of years prior to your moratorium start date in which a symptom, condition, disease, illness or injury including related condition is considered a moratorium condition. The moratorium qualifying period is stated in the 'Further details' section of your membership certificate.</p>
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	<p>A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.</p>
Operation	<p>Eligible treatment that is a medical procedure, including surgery and complex diagnostic procedures (such as an endoscopy) including all medically necessary treatment.</p>
Optician	<p>An ophthalmic optician or optometrist who is registered with the General Optical Council.</p>
Optical benefit period	<p>A period of two consecutive years, the entire period of which Optical cash benefit must have been covered under your benefits. Each optical benefit period shall not start until your last optical benefit period expires, this means that:</p> <ul style="list-style-type: none"> your second optical benefit period will start on the second renewal date following either your original date of joining the policy or the renewal date on which your first optical benefit period began (as applicable) your third and any subsequent optical benefit periods will start on the second renewal date following the renewal date on which your immediately preceding optical benefit period began.
Oral chemotherapy	<p>Chemotherapy taken by swallowing a pill, capsule or liquid.</p>
Out-patient	<p>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.</p>
Out-patient treatment	<p>Eligible treatment that you have as an out-patient for medical reasons.</p>

Word/phrase	Meaning
Participating facility	<p>A hospital or a treatment facility, centre or unit that is on our participating facility list that applies to your policy, and is recognised by us for:</p> <ul style="list-style-type: none"> ■ treating your medical condition, and ■ carrying out the type of treatment you need <p>The hospitals, treatment facilities, centres or units in the list and the medical conditions and types of treatment we recognise them for will change from time to time. You can search for a participating facility at finder.bupa.co.uk</p>
Partner	Your husband, wife, civil partner or the person you live with in a relationship.
Partnership facility	<p>A hospital or a treatment facility, centre or unit that is on our partnership list that applies to your policy, and is recognised by us for:</p> <ul style="list-style-type: none"> ■ treating your medical condition, and ■ carrying out the type of treatment you need. <p>The hospitals, treatment facilities, centres or units in the list and the medical conditions and types of treatment we recognise them for will change from time to time. You can search for a partnership facility at finder.bupa.co.uk</p>
Pre-existing condition	<p>Any condition, disease, illness or injury including related condition which you had before your effective underwriting date and:</p> <ul style="list-style-type: none"> ■ you received medication or advice or treatment for it, or ■ you've had symptoms of it, or ■ you knew you had it <p>whether the condition was diagnosed or not. By a related condition we mean any symptom, condition, disease, illness or injury which in our reasonable medical opinion is associated with another symptom, condition, disease, illness or injury.</p>
Previous policy	<p>Another health insurance policy or medical healthcare trust provided or administered by Bupa or another insurer that we agree with the sponsor will be treated as a previous policy for waiting periods or underwriting so long as:</p> <ul style="list-style-type: none"> ■ the person covered has shown us their continuous cover under the previous policy, and ■ there's no interruption between the previous policy and their current policy.
Prostheses	Any prostheses which are on our list for your cover when you have your treatment . The prostheses on the list may change from time to time. You can find the list at bupa.co.uk/prostheses-and-appliances
Recognised facility	A participating facility or partnership facility according to the facility access that applies to your policy. The hospitals, treatment facilities, centres or units in these lists and the medical conditions and types of treatment we recognise them for will change from time to time. You can search for a recognised facility at finder.bupa.co.uk
Renewal date	<p>For each period of your cover, the date agreed between the sponsor and us on which the group cover is due for renewal.</p> <p>Cover is generally renewed annually. Depending on the month in which you first join the policy, your initial period of cover may not be a full twelve months.</p> <p>Your benefits and allowances and, if you are a contributing member, your subscriptions may change at the renewal date.</p>

Word/phrase	Meaning
Schedule of procedures	The rates up to which we will pay consultants for treating Bupa customers. These are set out in our Schedule of procedures and are based on the complexity, time and skill required to perform a procedure. You can find the Schedule of procedures at bupa.co.uk/codes
Special condition	Specific medical conditions that someone isn't covered for based on their medical history. Where a special condition applies, we'll send a confirmation of special conditions to the main member or dependant if they're aged 16 or over.
Specialist drugs	Drugs and medicines to be used as part of your eligible treatment which are not common drugs and are included on our list of specialist drugs that applies to your policy. The list is available at bupa.co.uk/policyinformation . The specialist drugs on the list will change from time to time.
Sponsor	The company, firm or individual with whom we have entered into an agreement to provide cover.
Therapist	A healthcare professional registered with the Health and Care Professions Council and on our list of recognised therapists who is: <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. You can search for a recognised therapist at finder.bupa.co.uk The therapists on the list will change from time to time.
Treatment	Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.
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 on your membership certificate .
Year	The period beginning on your cover start date and ending on your cover end date . Depending on when you join the policy your initial year may not be a full twelve months. Your benefits, allowances and, if you are a contributing member , your subscriptions may change at the policy renewal date .
You/your	This means the main member only.

How we use and protect your information

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, healthcare 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, healthcare 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. International Transfers

We work with companies that we partner with, or that provide services to us (such as healthcare providers, other Bupa companies and IT providers) that are located in, or run their services from, countries across the world. As a result, we transfer your personal information to different countries including transfers from within the UK to outside the UK, and from within the EEA (the EU member states plus Norway, Liechtenstein and Iceland) to outside the EEA, for the purposes set out in this privacy notice. We take steps to make sure that when we transfer your personal information to another country, appropriate protection is in place, in line with global data-protection laws.

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).

Financial crime and sanctions



Financial crime

The *sponsor* agrees 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

We will not provide cover and we shall not be liable to pay any claim or provide any benefit to the extent that such cover, payment of a claim(s) or *benefits* would:

- be in contravention of any United Nations resolution or the trade or economic sanctions, laws or regulations of any jurisdiction to which we are subject (which may include without limitation those of the European Union, the *United Kingdom*, and/or the United States of America); and/or
- expose us to the risk of being sanctioned by any relevant authority or competent body; and/or
- expose us to the risk of being involved in conduct (either directly or indirectly) which any relevant authority, banks we transact through, or competent body would consider to be prohibited.

Where any resolutions, sanctions, laws or regulations referred to in this clause are, or become applicable we reserve all of our rights to take all and any such actions as may be deemed necessary in our absolute discretion, to ensure that we continue to be compliant. You acknowledge that this may restrict, delay or terminate our obligations and we may not be able to pay any claim(s) in the event of a sanctions-related concern.

Notes

Well Health - cancer screening, menopause plan, nutrition health, men's sexual function plan, face to face GP, Bupa Anytime HealthLine, Family Mental HealthLine, Menopause HealthLine and Digital GP services are not regulated by the Financial Conduct Authority or the Prudential Regulation Authority.

Well Health - cancer screening, menopause plan, nutrition health, men's sexual function plan, face to face GP, Menopause HealthLine and Bupa Anytime HealthLine are provided by:

Bupa Occupational Health Limited.
Registered in England and Wales with registration number 631336.

Registered office: 1 Angel Court,
London EC2R 7HJ

Digital GP services are provided by Babylon Healthcare Services Limited.
Registered in England and Wales with registration number: 09229684.
Registered office: 1 Knightsbridge Green,
London, England SW1X 7QA

Bupa health insurance is provided by:
Bupa Insurance Limited. Registered in England and Wales with registration number 3956433.
Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Financial Services registration number 203332.

Bupa insurance policies are arranged and administered by:

Bupa Insurance Services Limited. Registered in England and Wales with registration number 3829851. Bupa Insurance Services Limited is authorised and regulated by the Financial Conduct Authority. Financial Services registration number 312526.

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

Registered office: 1 Angel Court,
London EC2R 7HJ

© Bupa 2024

bupa.co.uk