Bupa policy guide

Bupa Select

This guide, together with your membership certificate and confirmation of special conditions (if any), shows the full terms of your health insurance cover.

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, and
- **confirmation of special conditions**, if any **special conditions** apply, for you or your **dependants** (if any).

Although they're separate documents, you should read them together. Each **year**, we'll send you updated documents which will 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 **group** 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 changes to the cover set out in this policy guide that apply to you. Please see the 'Further details' section on your **membership certificate**.

Some words in this guide are in bold type. This is because they have a specific meaning which we explain on pages 56 to 63.

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.

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HealthLine and digital wellbeing services

Our HealthLine services are available to all our customers and are free to use. Digital wellbeing services are available to customers aged 16 and over. We may record or monitor phone calls.

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 at 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 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 not sure that 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.

Digital wellbeing services

If you are in the **UK**, our digital wellbeing services on the My Bupa app can help you keep your body and mind healthy. These services provide ways to support your mental and physical health.

Download the My Bupa app to get started.

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** to create your account or download the My Bupa app.

Call

For answers to questions about your cover and to ask us to pre-authorise consultations, tests and **treatment**, please call us on the number on your **membership certificate**. We may record or monitor phone calls.

Webchat

For answers to general questions and to ask us to pre-authorise consultations, tests and **treatment**, you can chat with us using your online account, or by visiting **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 your documents in any of these formats.

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, or
- mental health

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

You can call us about your symptoms without needing a referral from a **GP**. We'll provide support and 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 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.

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

Need to know

If your **benefits** include any of the 'Well-Health outpatient benefits' (see pages 31 to 33), you don't need a referral to access these.

If you're claiming for cash benefits or health expenses benefits (see pages 33 to 36), please contact us and we'll let you know how to claim.

How to get in touch with us

Call

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

We may record or monitor phone calls.

Webchat

bupa.co.uk/contact-us

Bupa digital account

Visit **bupa.co.uk** or use the My Bupa 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**
- shown as covered by a tick in this policy guide
- **eligible treatment**, and
- not shown as excluded by a cross in this policy guide.

It's also really important that you follow the process and requirements set out in this policy guide. If you don't, we may not be able to pay your claim.

Here are the general conditions which always apply to your cover and any claims. They're part of your **group'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. You'll be responsible for paying for this. Also, **treatment** that takes place after the renewal of your policy, if that **treatment** is no longer covered by your policy, won't be covered.

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 and 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. This will allow you to explore all of 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 we won't take the cost from your **outpatient** benefit **allowance** (if either of these apply to your policy). However, if you have a **total annual allowance** the cost will count towards your **total annual allowance**. If our Direct Access service refers you for a consultation, tests 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** will recommend the type of specialist you need to see instead of naming a specific specialist. When you contact us, we'll use your **GP's** recommendation to help you choose a **fee-assured consultant or healthcare professional** covered by your policy.

Need to know
Your **membership certificate** will show if the open referral cover option applies to you. (Look in the group details section, under cover option.)

If you have the open referral cover option the following conditions apply.

- You must ask for an open referral from a **GP** or our Direct Access service (if this is available for your condition).
- You must contact us before arranging any consultations, tests or **treatment** for pre-authorisation.
- 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 when you contact us, we'll help you find one.

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
- confirm the **consultants**, healthcare professionals, hospitals or clinics covered by your policy
- let you know how to claim for cash benefits or health expenses benefits, if these are covered (see pages 33 to 36 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** that is covered by your policy. We will write to the **main member**, or to their **dependant** who is having **treatment** (if they are aged 16 or over), if there is an amount for them to pay in relation to any claim (for example, if they have to pay an excess or co-insurance) to explain how much and who to pay.

Need to know
You don't need a pre-authorisation to use 'Digital GP services' (benefit 1.8) if it is covered by your policy. For anything else, if you don't get pre-authorisation from us, you'll be responsible for paying for all **treatment** that we wouldn't have pre-authorised if you'd contacted us before arranging it.

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, so **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 facility, **consultant** or 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 **inpatient treatment** or **day-patient treatment** (or both), the **recognised facility** must be part of the **facility access** list which applies to your cover and is shown on your **membership certificate**.
- The person who has overall responsibility for your **treatment** must be a **consultant**, unless the treatment is provided by 'Digital GP services' (benefit 1.8), 'Well-Health outpatient benefits' (WH1 to WH6) or where a **GP** or our Direct Access service refers you for **outpatient treatment** by a **therapist**, **complementary medicine practitioner** or **mental health and wellbeing therapist**.

Need to know

If you have the open referral cover option, any **consultant** you see needs to be in our open-referral network.

What we pay consultants for treatment in hospital

We pay **consultant** fees for **treatment** in hospital up to the amounts shown in our **schedule of procedures**. You can find the schedule at **bupa.co.uk/codes**.

If you see a **consultant** who charges more than we will pay, you may need to pay the difference.

Reasonable and usual charges

We only pay reasonable and usual 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** available in the **UK** that costs more than the **treatment** that the majority of our customers have for the same condition. If the other proven treatment doesn't provide a better clinical outcome, your policy will cover up to the amount the majority of our customers are charged for similar **treatment** or services.

Excess or co-insurance

If your **group** has decided an excess or co-insurance will apply to your policy, the details will be shown on your **membership certificate**, including:

- the amount
- who has to pay it, 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 shown on your **membership certificate**.

If your excess or co-insurance applies each **year**, it renews at the beginning of each policy **year**, even if you're part way through **treatment**. So, you could have to pay the excess or co-insurance twice during 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 the **main member** 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. You don't have to pay the excess or co-insurance if you're claiming for cash benefits or health expenses benefits (see pages 33 to 36) or for claims for 'Digital GP services' (benefit 1.8). 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.

Need to know

If you are claiming for **treatment** costs where an **allowance** applies, your excess or co-insurance payment will count towards the **allowance** for that benefit. If you have a **total annual allowance** your excess or co-insurance will count towards your **total annual allowance**. Your **membership certificate** will show any specific benefit **allowances** and if a **total annual allowance** applies to you.

Here's an example of how an excess which applies each year works

Helen's policy has a £100 excess which applies each **year**. Helen has some physiotherapy which costs £250. We pay Helen's physiotherapist £150 and we'll let Helen know that she needs to pay them £100 (the policy excess). If Helen needs other **treatment** (whether it's for the same condition or not) 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 an excess which applies on a 12 month rolling basis works

Helen's policy has a £100 rolling excess which applies in any 12 month period. Helen has some physiotherapy in February 2025 which costs £250. We pay Helen's physiotherapist £150 and we'll let Helen know that she needs to pay them £100 (the policy excess). If Helen needs other **treatment** (whether it's for the same condition or not) before February 2026, 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 2025.

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 them £50 (the 20% co-insurance). If Helen needs other **treatment** (whether it's for the same condition or not) 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.

With the six-week scheme, if the **NHS** cannot offer the eligible **day-patient treatment** or **inpatient treatment** (including diagnostic procedures such as 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

- You must confirm to us each time you need **day-patient** or **inpatient treatment** which isn't available on the **NHS** within six weeks.
- If the eligible **day-patient** or **inpatient treatment** (including any diagnostic procedures such as an endoscopy) you need is available on 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 **outpatient treatment**, so any eligible private **outpatient 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**. The **operation** isn't available on the **NHS** until 30 October at the earliest. As this is more than six weeks after his **consultant** says he needs the **operation**, and it's for **eligible treatment**, Jack can have the **operation** privately and the costs will be covered by his policy. If Jack could have had his **operation** on the **NHS** between 1 July and 12 August, his six-week scheme wouldn't have covered the cost of him having it privately.

Need to know
If you have cover for NHS cash benefits CB1, CB6.1, CB6.2 and CB7, we don't pay cash benefit for **NHS day-patient treatment** or **NHS inpatient treatment** if the **treatment** you need is available on 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. This might include for example:

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

We may not be able 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 you can ask your doctor to show you the medical report before they send it to us, but you must do this within 21 days from the date we ask them for it.
- If you don't contact your doctor within 21 days to ask to see your medical report, we'll ask them to send it 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 the report before the doctor sends 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, but if you do this we won't be able to tell you whether your consultation, test or **treatment** is covered, and we may not be able to pay your claim.
- You can ask your doctor to let you see a copy of your medical report within six months of it being sent to us.
- Your doctor can withhold some or all the information in the report if 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 a fee for a medical report. We'll let you know if we'll cover some of this cost.

There are more details about your rights in **The Access to Medical Reports Act 1988** and **The Access to Personal Files and Medical Reports (NI) Order 1991**, which you can find at **legislation.gov.uk**.

If you'd like to withdraw a claim

Please call us on the number on your **membership certificate** and let us know as soon as possible if you'd like to withdraw a claim you have made. (We may record or monitor phone calls.) You'll need to pay for your **treatment** if you do this. You cannot 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 us and the other policy. We will ask you for full details of any other relevant policy when you make a 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 **group** has chosen to apply to your policy.

Need to know

If your underwriting type is underwritten or moratorium, the following conditions apply.

- Your policy covers you for health risks that might arise in the future.
- Any conditions, **special conditions**, **pre-existing conditions**, **moratorium conditions**, symptoms, diseases, illnesses or injuries you had before your policy started aren't usually covered.
- If a **special condition** applies, we'll send a **confirmation of special conditions** to the **main member** or to the relevant **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**.
- At the **cover start date** you and your **dependants** must have been registered continuously with a **GP** for at least six months or must have access to, and be able to provide, your full medical records in English.

Types of underwriting and how they work

Underwritten

To help you understand what's covered by your policy, when you apply, we'll look at your medical history (and the medical history of any of your **dependants** if they'll be included on your policy), and let you know about **pre-existing conditions** that won't be covered. It's really important that you fill in your application form carefully and send it to us 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 make a claim, we may need to check that your symptoms or condition started after your cover started. We may also ask your doctor for more information, and they may charge for this. We'll let you know if your policy covers some of the cost. If not, you'll need to pay for it yourself.

When you join us, if you had a **previous policy** with another insurer that was an underwritten policy, we may agree to continue with your underwriting terms from your **previous policy**. We'll need to review your medical history and we'll let you know if there are any conditions that aren't covered. We and your **group** need to agree to this, and there must be no break in your cover.

Moratorium

When you apply for a policy, we don't look at your medical history (or the medical history of any of your **dependants** if they'll be included on your policy). Instead, if you claim we may ask you for more information about the history of your symptoms, so we can confirm if the condition is 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.

There are two types of moratorium underwriting.

Fixed moratorium underwriting

When you claim for a condition you had in the **moratorium qualifying period** before your **moratorium start date**, it will only be covered after you have had your cover for two consecutive years from your **moratorium start date**. Your **moratorium qualifying period** is shown in the 'Further details' section on your **membership certificate**.

Need to know

After you've had your cover for two consecutive years from your **moratorium start date**, **treatment** of a **moratorium condition** is covered subject to your policy terms.

Rolling moratorium underwriting

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 have had your cover for two consecutive years at any time after your **moratorium start date** without having any symptoms, **treatment**, medication, or advice for the condition. Your **moratorium qualifying period** is shown in the 'Further details' section on your **membership certificate**.

Non-underwritten

When you apply for a policy, we won't look at your medical history. So you, and anyone else covered by the policy, don't need to worry about there being any time periods during which you can't claim for certain conditions.

When you need treatment because of something that was 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 claim from the third party.

- Tell us as soon as you know you need (or may need) **treatment** for something that was caused by a third party or was their fault. You can call us on **0800 028 6850** (we may record or monitor phone calls) or email us at **infothirdparty@bupa.com**. If you need to send us sensitive information, you can email us using Egress, which is a free secure email service (visit **switch.egress.com** for more information).
- Tell your solicitor, insurer or representative (if you're using one) that you have Bupa health insurance that may cover some of the costs.
- Give us your solicitor's, insurer's and representative's details and your permission to contact them.
- Help us to recover the cost of the **treatment** we paid for from the third party. 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 keeps us updated on their 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**, plus 8% interest for each year.
- If you agree a settlement with the third party, make sure it includes the full cost of the **treatment** we've paid for, and that you pay this amount (and any interest) to us as soon as possible.

What is covered

Need to know

This section explains the types of **treatment**, services and charges which Bupa Select can cover. Your **membership certificate** shows your specific cover and **allowances**. Please also see the 'How to get treatment and claim' on page 6 for details of who can refer you into **treatment** and 'Important information about your cover and any claims' on page 7. Your policy has some restrictions. It's important that you read the sections that tell you what is and isn't covered. Anything in the 'What isn't covered' section applies to your cover unless it says otherwise.

1. Outpatient consultations and treatment

Benefit	Description	Cover
1.1 Outpatient consultations	**Consultants**' fees for **outpatient** consultations for **acute conditions**.	✓
	Consultants' fees for phone or video consultations for **acute conditions**.	✓
1.2 Outpatient therapies and other outpatient charges	**Therapists**' fees for **outpatient treatment**.	✓
	Therapists' fees for phone or video consultations.	✓
	Therapists' fees for **treatment** at **home** if this is recommended by your healthcare professional or offered by us (as long as it's provided by a **therapist** recognised by us for **treatment** at **home**).	✓
	Recognised facility charges for **prostheses** and **appliances** that are needed as part of **outpatient treatment**.	✓
	Recognised healthcare professionals' fees and **recognised facility** charges for **outpatient treatment** that aren't described in any other benefit.	✓
1.3 Outpatient complementary medicine	**Complementary medicine practitioners**' fees for **outpatient treatment**.	✓
	Complementary or alternative products, preparations or remedies aren't covered.	✗
1.4 Outpatient diagnostic tests	**Recognised facility** charges or **consultants**' fees for **diagnostic tests** if these are requested by your **consultant** or another healthcare professional (as explained in 'How to get treatment and claim' on page 6) as part of **outpatient treatment**. The cost of reporting the results is included in the charge for the **diagnostic test**. Continued on the next page.	✓

Benefit	Description	Cover
1.4 Outpatient diagnostic tests (continued)	**Recognised facility** charges for **diagnostic tests** sent to your **home** if these are recommended by your healthcare professional or offered by us. **Need to know** Charges for **diagnostic tests** that aren't from a **recognised facility** or a **consultant** who is recognised by us to carry out **diagnostic tests** aren't covered.	✓
1.5 Outpatient MRI, CT and PET scans	**Recognised facility** charges for MRI, CT and PET scans if these are requested by a **consultant** or another healthcare professional (as explained in 'How to get treatment and claim' on page 6). The cost of reporting the results is included in the charge for the scan.	✓
1.6 Outpatient monitoring and management of chronic conditions	Your **membership certificate** shows if you are covered for this benefit and your **allowance**.	
	This benefit provides cover for: ▪ **outpatient treatment** for monitoring and management of a **chronic condition**, and ▪ **therapists**' fees for **outpatient 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. **Need to know** We pay for the same types of **treatment** that are described in outpatient benefits 1.1, 1.2, 1.3 and 1.4. We pay up to the **allowance** that applies for this benefit 1.6 as shown on your **membership certificate**.	✓
	This benefit does not provide cover for: ▪ any **treatment** that is excluded by your policy (including the section 'What isn't covered' in this policy guide, for example, Allergies, allergic disorders or food intolerances (exclusion 3), Outpatient drugs, dressings, complementary and alternative products (exclusion 14), and Sleep problems (exclusion 26)) ▪ **operations** ▪ MRI, CT and PET scans ▪ **treatment** of **mental health conditions**, please see 'Mental health treatment' (benefit 5) ▪ **eligible treatment** of unexpected acute symptoms of a **chronic condition** that flare up, this would be covered as explained in 'Chronic conditions' (exclusion 6, exception 1).	✗
1.7 Diagnosis of gender dysphoria	Your **membership certificate** shows if you are covered for this benefit and your **allowances**. Continued on the next page.	

Benefit	Description	Cover
1.7 Diagnosis of gender dysphoria (continued)	If you are aged 18 or over, we pay for up to three consultations for the diagnosis of **gender dysphoria**. Each consultation can be with a **consultant** psychiatrist or a chartered clinical psychologist who is recognised by us. **Need to know** This benefit is paid under 'Outpatient consultations' (benefit 1.1) and is subject to any **allowance** that applies to that **benefit**. Exclusion 22 'Pre-existing conditions and special conditions' and exclusion 23 'Moratorium conditions' do not apply to this benefit.	✓
1.8 Digital GP services	Your **membership certificate** shows if you are covered for this benefit and your **allowance**.	
	Consultations with a **digital primary care provider** (this may include digital consultations with a **GP**, or another healthcare professional such as a physiotherapist, **nurse** or pharmacist). **Need to know** We'll let you know the **digital primary care provider** you can use to access this benefit. If you use the Digital GP services benefit you won't need to pay an excess or co-insurance and we won't take the cost from your **outpatient** benefit **allowance** (if either of these apply to your policy). If you have a **total annual allowance**, the cost for each appointment will count towards your **total annual allowance**. If the **digital primary care provider** refers you for a consultation, tests or **treatment**, you may be able to claim for that consultation, test or **treatment**. You must contact us to pre-authorise your **treatment** and to check you're covered.	✓
	Any drugs or medicines prescribed to you by a **digital primary care provider** are not covered (these may be covered separately by another **benefit** in your policy).	✗

2. Consultants' fees for hospital treatment

Benefit	Description	Cover
2.1 Consultants' fees for hospital treatment	**Consultant** surgeons' and **consultant** anaesthetists' fees for **operations** covered by your policy.	✓
	Consultants' fees for **day-patient treatment** or **inpatient treatment**.	✓
	Consultants' fees for planning and supervising **chemotherapy** and radiotherapy if these are part of **eligible treatment**.	✓

3. Hospital or clinic charges

Need to know

Your **facility access** and the **allowances** we pay are shown on your **membership certificate**. The 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.

Benefit	Description	Cover
3.1 Outpatient operations	**Recognised facility** charges for **outpatient operations** covered by your policy. This includes the cost of using operating theatres, and equipment, **common drugs**, **advanced therapies**, **specialist drugs** and surgical dressings used during the **operation**.	✓
3.2a Staying in hospital	**Recognised facility** accommodation charges, including your meals and refreshments while you're having **day-patient treatment** or **inpatient treatment** that is covered by your policy.	✓
	Personal items (such as newspapers or personal laundry), meals and refreshments for your visitors, and phone calls aren't covered.	✗
	Recognised facility charges for accommodation aren't covered if: ▪ they're for an overnight stay for **treatment** that would normally be carried out as **outpatient treatment** or **day-patient treatment** ▪ they're for a bed for **treatment** that would normally be carried out as **outpatient treatment**, or ▪ the accommodation is mainly used for: – convalescence, rehabilitation, supervision or anything other than **eligible treatment** – general nursing care or any other services which could have been provided in a nursing home or anywhere else which is not a **recognised facility**, or – services provided by a **therapist** or **complementary medicine practitioner** or **mental health and wellbeing therapist**.	✗

Benefit	Description	Cover
3.2b Staying in hospital with a child	Accommodation for one parent each night they need to stay in a **recognised facility** with their child. The child must be covered by the policy, aged 17 or under and having **inpatient treatment**. The claim will be paid from the child's policy **benefits**.	✓
3.2c Theatre charges, nursing care, drugs and surgical dressings	Operating theatre and nursing care charges, **common drugs**, **advanced therapies**, **specialist drugs** and surgical dressings that are an essential part of your **day-patient treatment** or **inpatient treatment**.	✓
	Any drugs or surgical dressings provided or prescribed for **outpatient treatment** or for you to take home with you when leaving hospital or a clinic aren't covered (these may be covered separately by another **benefit** in your policy).	✗
	Any extra nursing services in addition to those which would usually be provided by a **recognised facility** as part of normal patient care without making any extra charge aren't covered.	✗
3.2d Day-patient or inpatient diagnostic tests, MRI, CT and PET scans	**Recognised facility** charges for **diagnostic tests**, MRI, CT and PET scans if these are recommended by your **consultant** as part of **day-patient treatment** or **inpatient treatment**.	✓
3.2e Therapies	**Recognised facility** charges for **eligible treatment** provided by **therapists**, if this is needed as part of your **day-patient treatment** or **inpatient treatment**.	✓
3.2f Prostheses and appliances	**Recognised facility** charges for **prostheses** or **appliances** that are needed as part of **day-patient treatment** or **inpatient treatment**.	✓
	The costs of maintaining, refitting or replacing a **prosthesis** or **appliance** if you have acute symptoms that directly relate to the **prosthesis** or **appliance** and it was fitted as part of **eligible treatment**.	✓
	The costs of maintaining, refitting or replacing a **prosthesis** or **appliance** if you don't have acute symptoms that are directly related to the **prosthesis** or **appliance** aren't covered.	✗

Benefit	Description	Cover
3.2g Intensive care	**Intensive care** which is essential, follows planned **inpatient treatment** in a **recognised facility**, takes place in a **critical care unit**, and is routinely needed by people having the same type of **treatment** as you. If your **inpatient treatment** or **day-patient treatment** in a **recognised facility** doesn't routinely need **intensive care**, and something unexpected happens which means you do need it, your **intensive care** will be covered if either: ■ it is provided in the **recognised facility's critical care unit**, or ■ the **recognised facility** doesn't have a **critical care unit**, but has an agreement with us to follow an emergency protocol to transfer patients to a specific **recognised facility critical care unit**, which is next to the original **recognised facility**, or part of the same hospital group. Your **consultant** or **recognised facility** will contact us if you're admitted into a **critical care unit**. There are situations when intensive care isn't covered, and these are explained in the 'Accident and emergency treatment' (exclusion 2) and 'Intensive care' (exclusion 18) in the 'What isn't covered' section of this guide. Need to know **Transferring into private inpatient 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, as long as: ■ you've been discharged from a **critical care unit** to a general ward for more than 24 hours before the transfer ■ the **consultants** in the hospital you are moving from and the **consultants** in the **recognised facility** you are transferring to 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 the transfer.	✓

4. Cancer treatment

4.1 Cancer cover

Your **membership certificate** will show if you have **cancer** cover. Once **cancer** has been diagnosed, benefits 4.1a to 4.1e apply to your **outpatient treatment** for **cancer**. Sections 1.5, 2, 3, 6, 7 and 8 apply to all other **eligible treatment** for **cancer** that's covered by your policy. **Eligible treatment** for side effects of **cancer**, or side effects of **treatment** for **cancer**, is covered on the same basis as **eligible treatment** for **cancer**. **Treatment** for **mental health conditions** relating to **cancer** is covered as set out in 'Mental health treatment' (benefit 5).

Benefit	Description	Cover
4.1a Outpatient consultations for cancer	**Consultants**' fees for **outpatient** consultations for **cancer**.	✓
	Consultants' fees for phone or video consultations for **cancer**.	✓
4.1b Outpatient therapies and other outpatient charges for cancer treatment	**Therapists**' fees for **outpatient treatment** for **cancer**.	✓
	Therapists' fees for phone or video consultations.	✓
	Recognised healthcare professionals' fees and **recognised facility** charges for your **outpatient treatment** or consultation for **cancer**.	✓
	Charges for clinical reviews we request to confirm that your **treatment** is eligible.	✓
4.1c Outpatient complementary medicine treatment for cancer	**Complementary medicine practitioners**' fees for **outpatient treatment** for **cancer**.	✓
	Complementary or alternative products, preparations or remedies aren't covered.	✗
4.1d Outpatient diagnostic tests for cancer	**Recognised facility** charges or **consultants**' fees for **diagnostic tests** if these are requested by your **consultant** as part of **outpatient treatment** for **cancer**. The cost of reporting the results is included in the charge for the **diagnostic test**. Need to know ▪ Charges for **diagnostic tests** that aren't from a **recognised facility** or a **consultant** who is recognised by us to carry out **diagnostic tests** aren't covered. ▪ **Outpatient** MRI, CT and PET scans for **cancer** are covered under benefit 1.5.	✓
4.1e Outpatient cancer drugs	**Recognised facility** charges for **common drugs**, **advanced therapies** and **specialist drugs** specifically for planning and providing **outpatient treatment** for **cancer**. Continued on the next page.	✓

Benefit	Description	Cover
4.1e Outpatient cancer drugs (continued)	Your policy doesn't cover: ■ **common drugs**, **advanced therapies** and **specialist drugs** that are available from a **GP**, unless you're prescribed an initial small supply when you're discharged from the **recognised facility** (so you can start your **treatment** straight away) ■ **common drugs**, **advanced therapies** and **specialist drugs** that are available to buy without a prescription, or ■ complementary, homeopathic or alternative products, preparations or remedies for **cancer**.	✗
	If a **total annual allowance** applies to your policy, drug **treatment** for **cancer** (such as **chemotherapy** drugs, hormone therapies and biological therapies) where the drug hasn't got a **UK** license or is not used within its **UK** license isn't covered.	✗
4.2 NHS Cancer Cover Plus	Your **membership certificate** shows if you are covered for NHS Cancer Cover Plus.	
	Eligible treatment for **cancer** is covered only if the following criteria applies: ■ the radiotherapy, **chemotherapy**, drug therapy or **operation** you need to treat your **cancer** isn't available to you on the **NHS**, and ■ the **NHS** care that isn't available to you isn't solely supportive medicines for **cancer** or **diagnostic tests**, and ■ you receive your **treatment** for **cancer** in a **recognised facility**. Where the above criteria applies: ■ your policy covers **eligible treatment** for **cancer** as explained in 'Cancer cover' (benefit 4.1) and 'Cash benefit for wigs or hairpieces' (CB6.4) and 'Cash benefit for mastectomy bras' (CB6.5) ■ if you have cover for 'NHS cash benefit for treatment for cancer' (benefits CB6.1, CB6.2 and CB6.3) and you are covered for **eligible treatment** for **cancer** as explained in 'Cancer cover' (benefit 4.1), and you have part of your **cancer treatment** on the **NHS**, that otherwise would have been covered privately by your policy, you can claim these cash benefits as explained in: – 'NHS cash benefit for NHS inpatient treatment for cancer' (CB6.1) – 'NHS cash benefit for NHS outpatient, day-patient and home treatment for cancer' (CB6.2), and – 'NHS cash benefit for oral drug treatment for cancer' (CB6.3).	✓
	Where the above criteria doesn't apply, we don't cover your **treatment** for **cancer**.	✗

5. Mental health treatment

Your **membership certificate** shows if you have mental health cover and your **allowances**.

Need to know

Mental health treatment for, or relating to, any **special conditions**, **pre-existing conditions** or **moratorium conditions** isn't covered. **Mental health treatment** which relates to anything else listed in the 'What isn't covered' section is covered as explained in this benefit.

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

Benefit	Description	Cover
5.1a Outpatient consultant psychiatrists' fees for mental health conditions	**Consultant** psychiatrists' fees for **outpatient treatment** for a **mental health condition**.	✓
	Consultant psychiatrists' fees for phone or video consultations for a **mental health condition**.	✓
5.1b Outpatient mental health therapy	**Mental health and wellbeing therapists**' fees or **recognised facility** charges for **outpatient mental health treatment**.	✓
	Mental health and wellbeing therapists' fees for phone or video consultations.	✓
	Online therapy programme (as long as you use the online programme or service we guide you to).	✓
5.1c Outpatient mental health diagnostic tests	**Recognised facility** charges for **diagnostic tests** if these are requested by your **consultant** psychiatrist as part of your **outpatient mental health treatment**. The cost of reporting the results is included in the charge for the **diagnostic test**. Need to know **Outpatient** MRI, CT and PET scans for **mental health treatment** are covered under benefit 1.5.	✓
5.1d Assessments for neurodiverse conditions	Your **membership certificate** shows if you are covered for this benefit and your **allowances**. Continued on the next page.	

Benefit	Description	Cover
5.1d Assessments for neurodiverse conditions (continued)	**Consultant** fees, **mental health and wellbeing therapist** fees and **recognised facility** charges for one **outpatient** assessment (which may include a combination of assessments) for any of the following suspected conditions: ▪ attention deficit hyperactivity disorder (ADHD) ▪ autism spectrum disorder (ASD) ▪ dyslexia ▪ dyscalculia, or ▪ dysgraphia. This benefit is available to customers aged 6 years or over. Only one **outpatient** assessment (which may include a combination of assessments) is covered in each person's lifetime. This applies to all **Bupa** policies and health trusts we manage, which you've been covered by previously, are covered by now or become covered for in the future. You must use the **consultant**, **mental health and wellbeing therapist** and **recognised facility** we guide you to. **Need to know** For customers aged 16 or over, you need to be referred for an assessment by a **consultant** or **GP**. For customers aged 6 to 15, **GP** referrals are not accepted. You need to be referred by a **consultant**, or your school Special Educational Needs Coordinator (SENCo) or equivalent. To pre-authorise please contact us.	✓
	Any assessments for screening purposes when there are no signs or symptoms of a neurodiverse condition aren't covered.	✗
5.2 Day-patient and inpatient mental health treatment	**Need to know** Your **membership certificate** shows the maximum number of days that your policy covers for **day-patient treatment** or **inpatient treatment** for a **mental health condition**.	
	Consultant psychiatrists' fees for mental health **day-patient treatment** or mental health **inpatient treatment**.	✓
	Recognised facility charges for **day-patient** or **inpatient mental health treatment**. **Need to know** Your policy covers the type of **recognised facility** charges listed as covered in benefit 3.	✓
	Your policy covers one addiction **treatment** programme in each person's lifetime. This applies to all **Bupa** policies and health trusts we manage, which you've been covered by previously, are covered by now or become covered for in the future. Addiction **treatment** programme means **treatment** of substance related addictions or substance misuse, including detoxifications carried out as **inpatient treatment** or **day-patient treatment**.	✓

6. Treatment at home

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

Benefit	Description	Cover
6 Treatment at home	**Eligible treatment** provided at **home** instead of **inpatient treatment**, **day-patient treatment** or **chemotherapy** as an **outpatient** as long as: ▪ your **consultant** recommends that you receive the **treatment** at **home** and continues to be in charge of your **treatment** ▪ you'd need to have the **treatment** in a **recognised facility** for medical reasons if you didn't have it at **home**, and ▪ a **medical treatment provider** needs to provide the **treatment**. We need full details of your **treatment** at **home** from your **consultant** before it starts so that we can confirm whether it's covered. Your policy covers: ▪ **consultants**' fees for **treatment** at **home** as described in benefit 2, and ▪ **medical treatment providers**' fees for **treatment** at **home** as described in benefit 3. **Need to know** **Outpatient** therapies and **diagnostic tests** at **home** are covered under benefit 1 and not under this benefit.	✓

7. Home nursing after private eligible inpatient treatment

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

Benefit	Description	Cover
7 Home nursing after private eligible inpatient treatment	**Home** nursing immediately after private **inpatient treatment** as long as it: ▪ is for **eligible treatment** ▪ is needed for medical reasons and not domestic or social reasons ▪ starts immediately after you leave a **recognised facility** ▪ is necessary and without it you would have to stay in the **recognised facility** ▪ is provided by a **nurse** in your own **home**, and ▪ is supervised by your **consultant**. Before your **home** nursing starts, we need full details about your care from your **consultant** so we can confirm that it's covered.	✓
	Home nursing provided by a community psychiatric nurse isn't covered.	✗

8. Private ambulance charges

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

Benefit	Description	Cover
8 Private ambulance charges	Private road ambulance charges if you need private **day-patient treatment** or **inpatient treatment** and an ambulance is medically necessary for travel: ■ to a **recognised facility** from your **home**, place of work, or an airport or seaport ■ between **recognised facilities** if you need to move for **inpatient treatment**, or ■ from a **recognised facility** to your **home**.	✓

9. Overseas emergency treatment

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

Benefit	Description	Cover
9 Overseas emergency treatment	Emergency **treatment** of an **acute condition** that you need because of a sudden illness or injury when you are temporarily travelling outside the **UK**. The **treatment** must be provided by a consultant, therapist, or complementary medicine practitioner. 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**. You are covered for the same types of **treatment** as set out in benefits 1.1 to 1.5, 2, and 3. We cover up to the **allowances** that apply for this benefit 9, as shown on your **membership certificate**. Need to know The emergency **treatment** must be consistent with generally accepted standards of emergency medical practice in the country in which you are receiving **treatment**. The **treatment** must be provided by a consultant, therapist or complementary medicine practitioner who is fully trained and legally qualified to practice by the relevant authorities in the country in which your **treatment** takes place for the **treatment** you need. We only pay facility charges when the facility is registered under the laws of the territory in which it stands as existing primarily for carrying out major surgical operations and providing **treatment** only a consultant can provide. If we agree to pay towards your overseas emergency **treatment**, you'll need to pay for it yourself and send us your itemised dated receipts and invoices. We will 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**.	✓
	Overseas emergency **treatment** isn't covered if any of the following apply: ■ you were 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 charges are excluded from your cover ■ the **treatment** is provided by a GP, or ■ the **treatment** you need is **outpatient** drugs and dressings. Please also see 'Overseas Treatment' (exclusion 20) in the 'What isn't covered' section.	✗

10. Repatriation and evacuation assistance

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

Benefit	Description	Cover
10 Repatriation and evacuation assistance	Need to know This benefit provides cover towards repatriation and evacuation transport costs if you're ill or injured whilst abroad and you need to be admitted to hospital for **day-patient treatment** or **inpatient treatment** with a consultant that cannot be provided in the country or location you are in and it would have been covered in the **UK** by your policy. We only cover for repatriation or evacuation transport costs if you don't have any other repatriation or evacuation insurance cover to help you receive the **treatment** you need. You or somebody on your behalf must call us before any arrangements are made. Please call us on the helpline on your **membership certificate**. When the helpline is closed, you can call us on **+44 (0)1925 361 337**. Lines are open 24 hours, 365 days a year. We may record or monitor phone calls. You must provide us or the **medical assistance company**, with any information we may reasonably ask for, to support your request. All arrangements for your repatriation or evacuation must be made by the **medical assistance company** and only in advance of your repatriation or evacuation. We only pay transport costs for your repatriation or evacuation. We don't pay any other costs related to the repatriation or evacuation such as hotel accommodation or taxis. Costs of any **treatment** you receive aren't covered under this benefit. We only pay for costs we consider to be reasonable. This means the amount we'll pay will be in line with what the majority of our customers are charged for similar services. Continued on the next page.	

Benefit	Description	Cover
10 Repatriation and evacuation assistance (continued)	If we agree to pay towards your repatriation or evacuation transport costs, we pay for the following. ■ Your repatriation transport costs back to the **UK** from abroad so you're able to be admitted immediately to a hospital for your **day-patient treatment** or **inpatient treatment**. ■ When medically essential, your evacuation transport costs to the nearest medical facility where your **day-patient treatment** or **inpatient 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 your **treatment**, you're covered for immediate onward repatriation to a hospital in the **UK** but only if its medically essential for you to be repatriated to the **UK** and your **day-patient treatment** and **inpatient treatment** needs to continue immediately when you arrive in the **UK**. ■ A **partner** or relative to accompany you during your repatriation or evacuation. ■ If you die abroad, we'll pay reasonable transport costs to bring your body back to a port or airport in the **UK**.	✓
	Repatriation or evacuation isn't covered 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 or evacuation would be against medical advice. ■ The arrangements for your repatriation or evacuation haven't been made by the **medical assistance company**. ■ You have separate travel insurance which provides cover for repatriation or evacuation to help you receive the **treatment** you need. **Need to know** We or the **medical assistance company** cannot be held responsible if we are not able to arrange your evacuation or repatriation where the local situation makes it impossible or dangerous to enter the area, for example, a warzone. We also cannot be held responsible for any delays or restrictions associated with arranging transportation that are beyond our control such as weather conditions, remote locations, mechanical problems, or restrictions imposed by local or national authorities.	✗

Well-Health outpatient benefits

Your **membership certificate** will show which (if any) of these Well-Health benefits you are covered for and your **allowances**. These **outpatient benefits** are designed to support your personal wellbeing and provide quick access to screening, diagnosis and aftercare for a range of wellbeing worries. If your policy provides cover for any of these **benefits** you don't need a referral to access them. You must call us to pre-authorise any Well-Health benefits on the number on your **membership certificate**.

Need to know

The general exclusions in the 'What isn't covered' section don't apply to any of these Well-Health benefits. Any further **treatment** you need following use of a Well-Health benefit will be subject to your policy terms.

Benefit	Description	Cover
WH1 Targeted cancer screening	Targeted **cancer** screening once each **year** at a Bupa health centre. These screenings are targeted on early detection of breast, cervical, prostate, testicular and bowel **cancer**. They include: ▪ a consultation with a **GP** including medical history review ▪ if clinically indicated a: – physical examination of the breast – physical examination of the pelvis – test for human papilloma virus (HPV), 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, and – bowel screening stool test (qFIT). **Need to know** You must be aged 18 years or over to use this benefit. These screenings are not suitable for anyone showing symptoms. Some of the tests may not be recommended due to your age. This benefit is paid under 'Outpatient consultations' (benefit 1.1) and is subject to any **allowance** that applies to that **benefit**.	✓

Benefit	Description	Cover
WH2 Menopause plan	A Bupa menopause plan once each **year** at a Bupa health centre. The Bupa menopause plan is intended for those looking for advice and support with menopause. The plan includes: ■ a pre-appointment questionnaire and symptom-checker ■ an appointment with a **GP** specially trained in menopause ■ a personalised care plan, and ■ a follow up appointment with a **GP**. **Need to know** You must be aged 18 years or over to use this benefit. This benefit is paid under 'Outpatient consultations' (benefit 1.1) and is subject to any **allowance** that applies to that **benefit**. Following your Menopause plan, any **treatment** you require that's associated with menopause will be subject to your policy terms.	✓
WH3 Outpatient fertility check	A fertility check once each **year** at a **fertility check facility**. A fertility check includes a consultation with a fertility specialist, **outpatient** tests, and a consultation afterwards to discuss your results. **Need to know** You must be aged 18 years or over to use this benefit. Any additional fertility service or fertility **treatment** isn't covered once a fertility check has been completed. Please see 'Birth control, conception and sexual problems' (exclusion 5). This benefit is paid under 'Outpatient consultations' (benefit 1.1) and is subject to any **allowance** that applies to that **benefit**.	✓
WH4 Face to face GP	Planned face-to-face consultations with a **GP** at a Bupa health centre. We cover up to the **allowance** as shown on your **membership certificate**. **Need to know** You must be aged 18 years or over to use this benefit. If the **GP** refers you for a consultation, tests or **treatment** you may be able to claim for that consultation, test or **treatment**. You must contact us to pre-authorise your **treatment** and to check you're covered.	✓
	Face-to-face GP benefit does not provide cover for: ■ phone or video consultations with a **GP** ■ any **treatment** costs other than the consultation cost ■ any preventive **treatment** or medical services that arise from the consultation, for example, health screening, vaccinations or medical reports, and ■ any drugs or medicines prescribed to you by the **GP** (these may be covered separately by another **benefit** in your policy).	✗

Benefit	Description	Cover
WH5 Nutrition health	Up to three virtual Bupa nutrition health appointments each **year** with a lifestyle coach or health adviser provided by a Bupa health centre. The nutrition health benefit is a virtual only benefit. It is intended for those looking for support or guidance with their nutrition and health. **Need to know** You must be aged 18 years or over to use this benefit. This benefit is paid under 'Outpatient consultations' (benefit 1.1) and is subject to any **allowance** that applies to that **benefit**.	✓
WH6 Men's sexual function plan	A Bupa men's sexual function plan once each **year** at a Bupa health centre. 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 includes: ▪ a pre-appointment questionnaire and symptom-checker ▪ time with a **GP** ▪ blood tests to support diagnosis of symptoms, and ▪ a follow up appointment. **Need to know** You must be aged 18 years or over to use this benefit. This benefit is paid under 'Outpatient consultations' (benefit 1.1) and is subject to any **allowance** that applies to that **benefit**. Following your Men's sexual function plan, any **treatment** you require for sexual problems is not covered. Please see 'Birth control, conception and sexual problems' (exclusion 5).	✓

Cash benefits and health expenses benefits

You may be able to claim a payment for some types of **treatment**, or health expenses or CB2 Family cash benefit. 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.

Benefit	Description	Cover
CB1 NHS cash benefit for NHS hospital inpatient treatment	If you have free **NHS inpatient treatment** which would have been covered by your policy if you'd had it privately, you can claim NHS cash benefit for each night you stay in an **NHS** hospital. **Need to know** We don't pay this benefit (CB1) in addition to any other NHS cash benefit for **treatment** that takes place on the same date, apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3). Continued on the next page.	✓

Benefit	Description	Cover
CB1 NHS cash benefit for NHS hospital inpatient treatment (continued)	Any additional **NHS** hospital charges, such as the cost of an amenity room (a private room you pay for and which you receive **NHS treatment** in) aren't covered.	✗
	NHS cash benefit isn't paid when you are admitted to and discharged from hospital on the same date.	✗
CB2 Family cash benefit	Family cash benefit is available for the **main member** when they have or adopt a child during the **year**. Please see your **membership certificate** for full details.	✓
CB3 Optical cash benefit	The following goods and services are covered during your optical cash benefit period for you or a **dependant** who is aged 16 or over at your or their **cover start date**. ▪ Routine eye tests provided by an **optician**. ▪ Glasses or contact lenses prescribed by an **optician**. ▪ Laser eye surgery to correct your sight as long as you're treated by a **consultant** or other qualified practitioner. **Need to know** The optical cash benefit period is two consecutive **years** (the whole time in which optical cash benefit must be covered by your policy). It begins on the **cover start date** when optical cash benefit is included on your policy. Each two **year** optical cash benefit period will start once your last one ends.	✓
	Any other optical goods or services aren't covered (for example, sunglasses whether they are prescribed or not).	✗
CB4 Accidental dental injury cash benefit	Dental **treatment** by a **dentist** which you or a **dependant** who is aged 16 or over at your or their **cover start date**, need because of an **accidental dental injury**. **Need to know** We only pay this benefit if the **accidental dental injury** and the dental **treatment** needed as a result takes place while this benefit is included on your policy. The dental **treatment** must take place within six months of the **accidental dental injury**.	✓
CB5 Prescription cash benefit	Charges for prescribed medicines or devices used to treat a medical condition or symptoms for you or a **dependant** who is aged 16 or over at your or their **cover start date**. This includes charges for: ▪ **NHS** or private prescriptions issued by a **GP**, hospital or consultant ▪ drugs or dressings for you to use at **home** after hospital **treatment**, if these are prescribed by your consultant or the hospital, and ▪ prescription prepayment certificates.	✓
	Prescription charges for medicines or devices to prevent illness (such as anti-malaria medication) aren't covered.	✗

Benefit CB6 NHS cash benefit for treatment for cancer

Benefit	Description	Cover
CB6.1 NHS cash benefit for NHS inpatient treatment for cancer	Cash benefit for each night you have free **NHS inpatient treatment** for **cancer**, which would have been covered by your policy if you'd had it as a private **inpatient** and which includes: ▪ radiotherapy ▪ **chemotherapy** ▪ an **operation** for **cancer** ▪ a blood transfusion, or ▪ a bone-marrow or stem-cell transplant. **Need to know** We don't pay this benefit (CB6.1) in addition to any other NHS cash benefit for **treatment** that takes place on the same date, apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3).	✓
	Any additional **NHS** hospital charges, such as the cost of an amenity room (a private room you pay for and which you receive **NHS treatment** in), aren't covered.	✗
CB6.2 NHS cash benefit for NHS outpatient, day-patient and home treatment for cancer	When you have any of the following **outpatient**, **day-patient** or **home treatments** free on the **NHS**, if they would have been covered by your policy if you'd had them privately, you can claim for: ▪ each day you have radiotherapy ▪ each day you have **chemotherapy**, apart from **oral chemotherapy**, and ▪ the day you have an **operation** for **cancer** that is **eligible treatment** for **cancer**. **Need to know** ▪ We don't pay this benefit (CB6.2) in addition to any other NHS cash benefit for **treatment** that takes place on the same date, apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3). ▪ This benefit is only paid once, even if you have more than one **eligible treatment** on the same day.	✓
CB6.3 NHS cash benefit for oral drug treatment for cancer	Cash benefit for each three-weekly period of **treatment** which is provided to you free by the **NHS** but which would have been covered by your policy if you'd had it as private **treatment**, during which you take: ▪ **oral chemotherapy**, or ▪ oral anti-hormone therapy that isn't available from a **GP**. **Need to know** This benefit is paid at the same time as other NHS cash benefits you may be eligible for.	✓

Benefit	Description	Cover
CB6.4 Cash benefit for wigs or hairpieces	Cash benefit for a wig or hairpiece if you lose your hair during eligible **cancer treatment**. This cash benefit is paid each time: ■ a new **cancer** is diagnosed, or ■ a previous **cancer** comes back. If 'NHS Cancer Cover Plus' (benefit 4.2) applies to your **benefits**, we pay this cash benefit as set out in benefit 4.2.	✓
CB6.5 Cash benefit for mastectomy bras	Cash benefit for mastectomy bras and prostheses after an eligible mastectomy where a reconstruction isn't done at the same time. This cash benefit is paid once for each mastectomy **operation**. If 'NHS Cancer Cover Plus' (benefit 4.2) applies to your **benefits**, we pay this cash benefit as set out in benefit 4.2.	✓

Benefit CB7 Procedure specific NHS cash benefit

Benefit	Description	Cover
CB7 Procedure specific NHS cash benefit	Cash benefit for some treatments provided to you free on the **NHS** that would otherwise have been covered by your policy if you'd had them privately. For information about the **treatments** this cash benefit is available for, please contact us or go to **bupa.co.uk/pscb**. These **treatments** may change from time to time. **Need to know** We don't pay this benefit (CB7) in addition to any other NHS cash benefit for **treatment** that takes place on the same date, apart from 'NHS cash benefit for oral drug treatment for cancer' (benefit CB6.3).	✓

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 outpatient benefits' WH1 to WH6
- 'Digital GP services' benefit 1.8, and
- Cash benefits CB2 to CB5.

Mental health treatment for, or relating to, **special conditions**, **pre-existing conditions** and **moratorium conditions** isn't covered. **Mental health treatment** which relates to anything else in this section is covered as explained in 'Mental health treatment' (benefit 5).

Exclusion	Description	Cover
1 Ageing, menopause and puberty	**Treatment** to relieve symptoms linked to the body's natural changes, such as ageing, menopause or puberty, and not due to any disease, illness or injury, isn't covered (for example, acne which is caused by natural hormonal changes).	✗
	Exception: **eligible treatment** of an **acute condition** that develops during menopause, such as heavy bleeding (menorrhagia) or urinary incontinence, is covered in line with the other policy terms. **Need to know** If your policy includes cover for the 'Menopause plan' (benefit WH2), you are covered for advice and support associated to menopause symptoms as set out in 'Menopause plan' (benefit WH2).	✓
2 Accident and emergency treatment	Any accident and emergency **treatment**, including immediate care, provided by an **NHS** or private accident and emergency (A&E) department, urgent care or walk-in clinic isn't covered.	✗
	Any urgent **treatment** or **treatment** you need immediately when you are admitted to hospital, including accommodation costs, isn't covered if you are admitted directly after and in connection with: ▪ attending an **NHS** or private A&E department, an urgent care centre or a walk-in clinic, or ▪ a consultation with a **GP** or **consultant**. **Need to know** After any urgent or immediate **treatment** has been completed, your policy may cover any further **treatment** you need. Please contact us and we can let you know how we can support you. Continued on the next page.	✗

Exclusion	Description	Cover
2 Accident and emergency treatment (continued)	**Exception: day-patient** or **inpatient treatment**, including immediate **treatment**, which directly follows a consultation with a **consultant** is covered if: ▪ you have been having **eligible treatment** with that **consultant** before the date of your **day-patient treatment** or **inpatient treatment**, and the **day-patient treatment** or **inpatient treatment** is related to the condition or **treatment** you have seen that **consultant** for, or ▪ it is for **mental health treatment**. We need full details of your **treatment** from your **consultant** before it starts so that we can confirm whether it's covered. **Need to know** Your policy doesn't cover any of your **treatment** costs if you're admitted straight into a **critical care unit**. Please see 'Intensive care' (exclusion 18).	✓
3 Allergies, allergic disorders or food intolerances	**Treatment** isn't covered once an allergic condition, disorder or food intolerance has been diagnosed. This includes tests to identify the exact allergen or food involved, or to desensitise or neutralise any allergic condition.	✗
	Exception: **treatment** to diagnose a suspected allergy or food intolerance is covered.	✓
4 Benefits that are not covered or are above your allowances	**Treatment**, services or charges that aren't listed as covered by your policy aren't covered.	✗
	Any costs above your **allowances** aren't covered.	✗
5 Birth control, conception and sexual problems	**Treatment** isn't covered for: ▪ contraception, sterilisation or termination of pregnancy ▪ sexual problems (including impotence, whatever the cause), or ▪ fertility **treatment** such as assisted reproduction, fertility investigations, IVF, surrogacy, harvesting of (collecting) donor eggs or donor sperm. **Need to know** If your policy includes cover for 'Outpatient fertility check' (benefit WH3) or a 'Men's sexual function plan' (benefit WH6), you are covered for these as set out in these **benefits**.	✗

Exclusion	Description	Cover
6 Chronic conditions	**Treatment** of **chronic conditions** isn't covered. 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 or tests. ■ It needs ongoing or long-term control or relief of symptoms. ■ It needs rehabilitation or for you to be specially trained to cope with it. ■ It continues indefinitely. ■ It doesn't have a known cure. ■ It comes back or is likely to come back. Your policy doesn't cover **treatment** for expected flare-ups of a **chronic condition**. This is because the **treatment** is part of the ongoing management of the condition. For example, conditions where symptoms come and go, such as inflammatory bowel disease. There may be times when symptoms are severe (a flare-up), followed by long periods when there are few or no symptoms (remission). These are called 'relapsing and remitting conditions' and aren't covered because the flare-ups are an expected part of the condition. **Need to know** Sometimes, it may not be immediately clear that the disease, illness or injury being treated is a **chronic condition**. Once a condition is confirmed as being chronic, your policy won't cover any further consultations, tests or **treatment**. If this happens during a hospital stay, we'll help you transfer to the **NHS** or you can arrange to pay for the **treatment** yourself.	✗
	Exception 1: your policy covers **eligible treatment** of unexpected acute symptoms of a **chronic condition** that flare up and don't need prolonged **treatment**, as long as the **treatment** is likely to quickly: ■ lead to a complete recovery, or ■ get you back to how you were before the flare-up. For example, **treatment** following a heart attack as a result of chronic heart disease is covered.	✓
	Exception 2: **eligible treatment** of **cancer** and **mental health conditions** is covered if your **membership certificate** shows you have cover for these. You can find details of the cover available in 'Cancer treatment' (benefit 4) and 'Mental health treatment' (benefit 5) in the 'What is covered' section of this guide. Please also see 'Temporary relief of symptoms' (exclusion 29) in this section.	✓
	Exception 3: if your policy includes cover for 'Outpatient monitoring and management of chronic conditions' (benefit 1.6), you are covered for **outpatient** monitoring and management of **chronic conditions** as set out in benefit 1.6.	✓

Exclusion	Description	Cover
7 Treatment or medical conditions that are not covered, and their complications	Your policy doesn't cover: ■ **treatment** or medical conditions that are excluded from your cover ■ **treatment** for complications of medical conditions that are excluded from your cover, or ■ **treatment** for complications from treatment that is excluded from your cover.	✗
8 Contamination, wars, riots and terrorist acts	**Treatment** isn't covered for any condition directly or indirectly arising from: ■ wars, riots, terrorist acts, civil disturbances or acts against any foreign hostility, whether or not war has been declared, or ■ chemical, biological, radioactive or nuclear contamination, including the effects of burning chemicals or nuclear fuel.	✗
	Exception: **eligible treatment** needed following a terrorist act is covered as long as the act doesn't cause chemical, biological, radioactive or nuclear contamination.	✓
9 Convalescence, rehabilitation and general nursing care	Accommodation isn't covered if it's mainly for: ■ convalescence, rehabilitation, supervision or anything other than providing **eligible treatment** ■ general nursing care or other services which could be provided in a nursing home or anywhere else which isn't a **recognised facility**, or ■ services from a **therapist**, **complementary medicine practitioner** or **mental health and wellbeing therapist**. Need to know This does not apply to addiction treatment programmes if they are covered by your policy under 'Mental health treatment' (benefit 5).	✗
10 Cosmetic, reconstructive or weight-loss treatment	**Treatment** isn't covered even if it's needed for medical or psychological reasons, if: ■ it's to change your appearance, such as surgery to reshape your nose, a facelift or a breast enlargement ■ an intended result of the **treatment** is weight loss, whether this is a direct or indirect result and even if the **treatment** may cure or relieve other conditions or symptoms (for example, bariatric surgery) ■ it involves removing healthy (not diseased) or surplus tissue or fat (liposuction), such as breast reduction as **treatment** for backache or men's breast swelling (gynaecomastia), or ■ it's to reduce scarring, including keloid scars.	✗
	Exception 1: **eligible treatment** to remove a lesion is covered if: ■ a biopsy shows, or a **consultant** believes, that the lesion is diseased ■ the lesion stops you from being able to see, smell or hear ■ the lesion causes pressure on your organs, or ■ the lesion stops you from being able to carry out **activities of daily living**. Continued on the next page.	✓

Exclusion	Description	Cover
10 Cosmetic, reconstructive or weight-loss treatment (continued)	**Exception 2**: eligible **operations** following an accident, eligible **cancer** surgery or eligible preventive surgery (prophylactic surgery) to restore the appearance of the affected part of your body are covered. This includes **operations** on a healthy breast to make its appearance match the other breast which has been reconstructed following **cancer** surgery. Once you've had initial **eligible treatment** to restore your appearance (including delayed **operations**), any repeat **operations**, reconstructions and further **treatment** to restore or amend your appearance aren't covered.	✓
11 Deafness	**Treatment** for or arising from deafness that is present from birth, or that develops due to maturing or ageing isn't covered.	✗
	Exception: **treatment** for deafness caused by an infection, injury or tumour is covered.	✓
12 Dental or oral treatment	Dental and oral **treatment** isn't covered. This includes: ▪ fitting dental implants or dentures, or repairing or replacing damaged teeth, including crowns, bridges, dentures, or any other dental prosthesis ▪ management of, or **treatment** for, jaw shrinkage or loss as a result of having teeth removed or gum disease, and ▪ bone disease **treatment** for gum or tooth disease or damage.	✗
	Exception 1: if your policy includes cover for **cancer treatment**, we cover **eligible treatment** for oral **cancer treatment** as set out in 'Cancer treatment' (benefit 4).	✓
	Exception 2: an eligible **operation** is covered if it is carried out by a **consultant** to: ▪ treat a jawbone cyst, as long as it's not for a cyst or abscess on the tooth root, or any other tooth or gum disease or damage, or ▪ surgically remove a complicated, buried or impacted tooth or root, which is causing infection or pain (such as an impacted wisdom tooth), as long as it's not to make space for dentures.	✓
13 Dialysis	**Treatment** for or linked to kidney dialysis (haemodialysis and peritoneal dialysis) isn't covered.	✗
	Exception: **eligible treatment** for short-term kidney dialysis or peritoneal dialysis is covered if it's needed: ▪ temporarily for sudden kidney failure caused by a disease, illness or injury affecting another part of your body, or ▪ immediately before or after a kidney transplant.	✓
14 Outpatient drugs, dressings, complementary and alternative products	Drugs or surgical dressings provided or prescribed for **outpatient treatment** or for you to take home when you leave hospital or a treatment facility aren't covered. Continued on the next page.	✗

Exclusion	Description	Cover
14 Outpatient drugs, dressings, complementary and alternative products (continued)	Complementary or alternative therapy products aren't covered. This includes homeopathic remedies.	✗
	Exception: if your policy includes cover for **cancer treatment**, **outpatient common drugs**, **advanced therapies** and **specialist drugs** for **eligible treatment** of **cancer** are covered only as set out in 'Cancer treatment' (benefit 4).	✓
15 Unproven drugs and treatment	**Treatment** or procedures which are, in our reasonable opinion, unproven based on established medical practice in the **UK** aren't covered. This includes: ▪ drugs used outside their licence or procedures which haven't been satisfactorily reviewed by NICE (National Institute for Health and Care Excellence), and ▪ licensed **advanced therapies** for conditions other than **cancer** that haven't been tested in phase-3 clinical trials.	✗
	Exception: if a **total annual allowance** doesn't apply to your policy, unproven drug **treatment** for **cancer** is covered as long as: ▪ it follows an unsuccessful initial licensed **treatment** ▪ you speak regularly to our nurses, so we can support you and monitor your **treatment**, and ▪ it has been agreed by a multidisciplinary team (MDT) which meets the NHS Cancer Action Team standards. Before we can confirm the **treatment** is covered we'll need a detailed MDT report, including evidence that there are published phase-3 clinical trial results for the drug showing that it's safe and effective for your condition. Please contact us for more information or ask your **consultant** to contact us. Need to know If a **total annual allowance** applies to your policy, unproven drug **treatment** for **cancer** isn't covered.	✓
16 Eyesight	**Treatment** to correct your eyesight (for example, long or short sight) or **treatment** for poor sight due to ageing isn't covered. Glasses or contact lenses aren't covered.	✗
	Laser-assisted cataract surgery isn't covered.	✗
	Exception 1: **eligible treatment** for your sight is covered if it's needed as a result of an injury or an **acute condition**, such as a detached retina.	✓
	Exception 2: **eligible treatment** for cataract surgery performed using ultrasonic emulsification is covered.	✓

Exclusion	Description	Cover
17 Epidemic or pandemic disease	**Treatment** for or arising from an epidemic or pandemic isn't covered. Need to know Epidemic means significantly more cases of an illness, specific health-related behaviour or other health-related events in a community or region than would normally be expected (unless the World Health Organization provides another definition). Pandemic means the worldwide spread of a disease with epidemics in many countries and most regions of the world.	✗
18 Intensive care	Intensive care isn't covered if: ▪ it follows a transfer from a private **recognised facility** to an **NHS** hospital ▪ it follows a transfer from an **NHS** critical care unit to a private one ▪ it's not carried out in a **critical care unit**, or ▪ you go straight into a **critical care unit** when you're admitted to hospital, for example, following: – an **NHS** transfer to a **recognised facility** – an **outpatient** consultation – a **GP** referral – return to the **UK** (repatriation), or – transferring from one private facility to another.	✗
19 Learning difficulties, behavioural and development conditions	**Treatment** for learning difficulties, such as dyslexia isn't covered.	✗
	Treatment for behavioural conditions, such as attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD) isn't covered.	✗
	Treatment for development conditions such as shortness of stature isn't covered.	✗
	Exception: if your policy includes cover for 'Assessments for neurodiverse conditions' (benefit 5.1d), you are covered for an **outpatient** assessment for neurodiverse conditions as set out in benefit 5.1d.	✓
20 Overseas treatment	**Treatment** you have outside of the **UK** isn't covered.	✗
	Exception 1: if your policy includes cover for 'Overseas emergency treatment' (benefit 9), we cover **treatment** needed as a result of a sudden illness or injury when you're travelling outside the **UK**, but only as set out in benefit 9. Continued on the next page.	✓

Exclusion	Description	Cover
20 Overseas treatment (continued)	**Exception 2**: if **treatment** for your condition isn't available in the **UK** but would have been **eligible treatment** if it were available in the **UK**, your policy will cover up to the cost of the standard alternative **treatment** which is routinely available in the **UK**. You'll need to pay the difference between the cost of **treatment** abroad and the cost of the standard alternative **treatment** which is routinely available in the **UK**. We need full details of the **treatment** from your **consultant** before it starts, including confirmation that the **treatment** is not available in the **UK**, so that we can confirm whether we'll pay towards it. **Need to know** If we agree to pay towards your **treatment** abroad, 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 'Unproven drugs and treatment' (exclusion 15) in this section.	✓
21 Physical aids and devices	**Treatment** for supplying or fitting physical aids and devices isn't covered. This includes hearing aids, glasses, contact lenses, crutches and walking sticks.	✗
	Exception 1: **recognised facility** charges for **prostheses** or **appliances** that are needed as part of **outpatient treatment**, **day-patient treatment** or **inpatient treatment** are covered as set out in 'Outpatient therapies and other outpatient charges' (benefit 1.2) and 'Prostheses and appliances' (benefit 3.2f).	✓
	Exception 2: the costs of maintaining, refitting or replacing a **prosthesis** or **appliance** which was fitted as part of **eligible treatment** are covered if you have acute symptoms that directly relate to the **prosthesis** or **appliance**, as set out in 'Prostheses and appliances' (benefit 3.2f).	✓
22 Pre-existing conditions and special conditions	Your **membership certificate** shows the type of underwriting your **group** has chosen to apply to your policy. If your underwriting type is underwritten: ▪ **treatment** of **pre-existing conditions** isn't covered (this includes any **special conditions** listed on any **confirmation of special conditions** we send you), and ▪ **treatment** of any condition, symptom, disease, illness or injury resulting from **pre-existing conditions** or **special conditions** isn't covered. **Need to know** If you have a **special condition** on your policy and you're unlikely to need **treatment** for it in the future, you can ask us to review it when your policy is due to renew. We'll let you know if we can and whether it can be covered in the future. We'll need a medical report from your doctor. If there is a charge for the medical report, you'll need to pay this as it isn't covered by your policy.	✗

Exclusion	Description	Cover
23 Moratorium conditions	Your **membership certificate** shows the type of underwriting your **group** has chosen to apply to your policy. If your underwriting type is moratorium: ■ **treatment** of **moratorium conditions** isn't covered ■ **treatment** of any condition, symptom, disease, illness or injury resulting from **moratorium conditions** isn't covered.	✗
24 Pregnancy and childbirth	**Treatment** isn't covered for: ■ pregnancy, including **treatment** of an embryo or foetus ■ childbirth (including delivery of a baby by caesarean section), or ■ termination of pregnancy, or any condition resulting from this.	✗
	Exception 1: **eligible treatment** of the conditions below, including complications following them, is covered. ■ Miscarriage ■ Stillbirth ■ Abnormal cell growth in the womb (hydatidiform mole) ■ Foetus growing outside the womb (ectopic pregnancy) ■ Heavy bleeding immediately after childbirth (post-partum haemorrhage) ■ Part of the afterbirth being left in the womb after having a baby (retained placental membrane).	✓
	Exception 2: **eligible treatment** of an **acute condition** of the mother that relates to pregnancy or childbirth is covered as long as: ■ it's needed to treat a flare-up, and ■ it's likely to lead to a quick and complete recovery of the mother or restore her to how she was before the condition flared up, without needing prolonged **treatment**.	✓
25 Screening, monitoring and preventive treatment	Health checks and screening aren't covered. Health screening is where you may or may not know that you're at risk of, or affected by, a disease or its complications, and answer questions or have tests to find out if you are.	✗
	Routine tests or monitoring of medical conditions isn't covered. This includes: ■ antenatal care or screening of the mother or foetus during pregnancy ■ checks or monitoring of **chronic conditions** such as diabetes mellitus or high blood pressure (hypertension), and ■ tests or procedures which, in our reasonable opinion based on established clinical and medical practice, are for screening or monitoring (for example, an endoscopy, when you don't have any symptoms). Continued on the next page.	✗

Exclusion	Description	Cover
25 Screening, monitoring and preventive treatment (continued)	Preventive **treatment**, procedures or medical services aren't covered. This includes: ▪ vaccinations, and ▪ medication reviews and appointments where there's no change in your usual symptoms.	✗
	Exception 1: genetic tests to measure your future risk of **cancer** are covered if: ▪ you have cover for **cancer** ▪ you're being treated for **cancer** ▪ you have a strong direct family history of **cancer**, and ▪ your **consultant** recommends the test. We'll need full details of your **treatment** from your **consultant** before it starts so that we can confirm whether it's covered.	✓
	Exception 2: if an eligible genetic test shows your risk of developing more cancers is high, preventive surgery (prophylactic surgery) recommended by your **consultant** is covered. Reconstructive surgery following eligible preventive surgery is also covered, as described in 'Cosmetic, reconstructive or weight-loss treatment' (exclusion 10 under exception 2 in the 'What isn't covered' section).	✓
	Exception 3: if you have **cancer** cover, **eligible treatment** to monitor **cancer**, is covered as described in 'Outpatient consultations for cancer' (benefit 4.1a in the 'What is covered' section) and 'Outpatient diagnostic tests for cancer' (benefit 4.1d in the 'What is covered' section).	✓
	Exception 4: if your policy includes cover for 'Outpatient monitoring and management of chronic conditions' (benefit 1.6), you are covered for **outpatient** monitoring and management of **chronic conditions** as set out in benefit 1.6.	✓
	Need to know If your policy includes cover for 'Targeted cancer screening' (benefit WH1), you are covered for targeted cancer screening as set out in benefit WH1.	
26 Sleep problems	**Treatment** for or needed as a result of sleep problems such as insomnia, snoring or sleep apnoea (temporarily stopping breathing during sleep) isn't covered.	✗
27 Speech and language disorders	**Treatment** for, or relating to, developmental speech, language and communication difficulties, including stammering, isn't covered.	✗
	Exception 1: short-term speech therapy provided by a **therapist** is covered when it's part of **eligible treatment** and takes place during or immediately after it.	✓
	Exception 2: up to 12 sessions of speech therapy is covered for acute symptoms of glue ear which affect speech development.	✓

Exclusion	Description	Cover
28 Gender dysphoria or gender affirmation	**Treatment** for **gender dysphoria** or gender affirmation isn't covered.	✗
	Exception: if your policy includes cover for 'Diagnosis of gender dysphoria' (benefit 1.7) and you are aged 18 of over, you are covered for **outpatient** consultations for the diagnosis of **gender dysphoria** as set out in benefit 1.7.	✓
29 Temporary relief of symptoms	**Treatment** which is mainly to temporarily relieve symptoms or is for the ongoing management of a condition isn't covered.	✗
	Exception 1: up to 21 days of **treatment** to support your end-of-life care for a terminal illness is covered if: ▪ it's needed as part of your care plan ▪ your **consultant** tells you that the ongoing **treatment** will be to support your end-of-life care, and ▪ you're no longer receiving **treatment** to stop or improve the illness. **Treatment** can take place in a **recognised facility** or in another location of your choice, such as your **home**. The **treatment** must be provided by services registered with the CQC (Care Quality Commission). This **treatment** is covered on the same basis as 'Consultants' fees for hospital treatment' (benefit 2.1) and 'Staying in hospital' (benefit 3.2a). This benefit can only be claimed once.	✓
	Exception 2: if your policy includes cover for 'Outpatient monitoring and management of chronic conditions' (benefit 1.6), you are covered for **outpatient** monitoring and management of **chronic conditions** as set out in benefit 1.6.	✓
30 Unrecognised healthcare professionals, hospitals and clinics	We don't cover any of your **treatment** costs, from any **consultants**, healthcare professionals, hospitals, clinics or any treatment facility if your **treatment** is provided under the care or supervision of a **consultant** who isn't recognised by us for: ▪ treating the medical condition you have, or ▪ providing the **treatment** you need. This includes **treatment** provided under the care or supervision of **consultants** who are not in our open-referral network, if your cover option is open referral.	✗
	We don't cover any part of your **treatment** costs for **day-patient** or **inpatient treatment** that takes place in a hospital, clinic or treatment facility that isn't included in the **facility access** list that applies to your policy or isn't recognised for the type of **treatment** you need or treating the medical condition you have.	✗
	We don't cover any **treatment** costs from **consultants**, healthcare professionals, hospitals, clinics or treatment facilities that aren't recognised by us for the type of **treatment** you need or medical condition you have. Continued on the next page.	✗

Exclusion	Description	Cover
30 Unrecognised healthcare professionals, hospitals and clinics (continued)	**Exception**: if, for medical reasons, your **day-patient** or **inpatient treatment** can't take place in a **recognised facility**, we may cover your **treatment** somewhere else. We need full details of your **treatment** from your **consultant** before it starts so that we can confirm whether it's covered.	✓
31 Advanced therapies and specialist drugs	Any gene therapy, somatic-cell therapy and tissue engineered medicines that aren't on the list of **advanced therapies** that applies to your cover aren't covered. You can find the list of advanced therapies at **bupa.co.uk/policyinformation**.	✗
	Any drugs or medicines which the **recognised facility** charges separately for that aren't **common drugs** or **specialist drugs** aren't covered.	✗
32 Leg varicose veins	Only one **operation** on each leg for varicose veins is covered in each person's lifetime (both legs treated on the same day counts as one **operation** on each leg). Any further **operations** for varicose veins aren't covered. Need to know This applies to each person's lifetime, and includes **operations** provided under all **Bupa** policies and health trusts we manage, which you've been covered by previously, are covered by now or become covered by in the future.	✗
	Exception: the following **treatment** for leg varicose veins is covered. ■ If you still have symptoms following an **operation** for varicose veins, we cover a single sclerotherapy **treatment** within six months of your **operation**. ■ Any eligible consultations and **diagnostic tests** needed for your **operation**.	✓

How your health insurance policy works

The agreement between your group and us

Your cover is provided by a **group** policy. This is governed by the **agreement** and the terms and conditions of your cover, which we and your **group** have agreed. Only we and your **group** have any legal rights under the **agreement**. There's no legal contract between you and us for your cover. However, if you're a **contributing member** you will have some 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 anyone else on your policy.
- Your **membership certificate** which shows your specific cover and **allowances** and is personal to you.
- A **confirmation of special conditions** (if any apply), which we will send to the **main member** or to the **dependant** covered by the policy (if they are aged 16 or over).

Although these are separate documents, you should read them 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 available under Bupa Select. Your **membership certificate** shows the cover that your **group** has selected for you. This means you may not have all the cover set out in this policy guide.

Paying for treatment

Your policy pays for **treatment** you have 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. We don'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 of having private **treatment**. However, we pay the costs that are covered under your policy. If your **treatment** isn't covered under 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 direct for your **treatment**. Otherwise, we'll pay the **main member**. We'll write to the **main member** or to their **dependant** who is having **treatment** (if they are aged 16 or over), if there is an amount for them to pay in relation to any claim (for example, if they have to pay an excess or co-insurance) to explain how much and who to pay.

Changes to lists

If we tell you that a list may change (for example, a list of recognised services, **treatments** or facilities), we will only change it for one or more of the following reasons.

- We are required to make a change under any industry code, law or regulation that applies.
- A contract (for example, with a treatment provider) ends or is amended by a third party for any reason.
- We decide to end or amend a contract (for example, because of quality concerns or changes to the facilities or specialist services provided).
- To make sure we are providing a balanced service – for example, we may need to add or remove treatment providers if we find that services in some areas of the **UK** are no longer in line with similar **treatments** or services (in terms of effectiveness or cost) or are not in line with accepted standards of medical practice.
- A new service, **treatment** or facility is available.

The lists we may change 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**
- Open-referral network **consultants**
- **Prostheses**
- **Recognised facilities**
- **Schedule of procedures**
- **Specialist drugs**
- **Therapists**.

Please note, we cannot guarantee that any facility, practitioner or **treatment** on one of our lists will be available.

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 your **group**.

Cover for a newborn baby

If your **group** agrees, your newborn baby can be added to your policy as one of your **dependants**. If your baby's cover would be:

- underwritten, they won't have any **special conditions** applied to their cover
- moratorium underwriting, the exclusion for **moratorium conditions** (exclusion 23) won't apply to their cover

but only if the following conditions are met:

- you or your partner (or both) has been covered by the policy (or a **previous policy**) for at least 12 continuous months before the baby's birth, and
- you include your baby on your policy within three months of their birth.

If you meet these conditions, your baby's cover will start from the date they're born or your **cover start date**, if this is later.

Renewing your cover

Your cover will renew as long as your **group's** policy is renewed and it includes you and your **dependants** (if any).

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

How your cover can end

The **main member** or your **group** 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 the **main member's** 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
- your **group** doesn't pay premiums 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 die.

Cover for a child **dependant** will automatically end as explained in the 'Further details' section on your **membership certificate**.

Cover for your **dependants** will automatically end if:

- your cover ends
- the terms of the **agreement** say that it must end
- your **group** 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 die.

If there is reasonable evidence that you or a **dependant** didn't take reasonable care answering our questions correctly (for example, you gave false information or kept important information from us), the following will apply.

- If this was intentional, we may treat your or your **dependant's** (or both of your) cover as if it never existed, not pay any claims and, if you're a **contributing member**, keep any premiums you have paid.
- If this was careless, depending on what we would have done if you or they had answered our questions correctly, we may treat your or your **dependant's** (or both of your) cover as if it had never existed and refuse to pay all claims, change your or their cover, or reduce any claim payment we make. (If we refuse to pay all claims, you may need to repay any claims we've already paid and, if you're a **contributing member**, we'll return to your **group** any premiums you've paid for your or your **dependant's** cover.)

Continuing your cover if you leave your group policy

If 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. If you want to transfer to a **Bupa** personal policy without any break in your cover, you must transfer within three months of the date your or your **dependants**' **Bupa** group scheme cover ends.

We can explain how to do this. Please call us on **0800 600 500** to discuss the options available. We may record or monitor phone calls.

Paying premiums and other charges

Your **group** must pay us premiums and any other payment that is due for your cover and the cover of anyone else included on your policy. Bupa Insurance Services Limited acts as our agent for arranging and administering your policy and collects premiums for the purpose of receiving, holding and refunding premiums and paying claims.

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 as long as we and your **group** agree to this.

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. No change to your policy or your **benefits** will apply unless it is specifically agreed between your **group** and us, and confirmed in writing.

If we and your **group** agree any changes to the terms and conditions of your policy, including your **benefits**, we'll let you know before the change takes effect. If you don't accept any of the changes, you can end your policy by letting your **group** know within 28 days of either the date when:

- the change happens, or
- we (or your **group**) tell you about the change

whichever is later.

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

General information

Change of address

The **main member** 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** (if they are aged 16 or over)
- all claims correspondence to the **main member** or to the **dependant** having **treatment** (if they are aged 16 or over)
- copies of any original documents you send us if you ask us for the documents back (because we can't return the originals), and
- an invitation to create a **Bupa** digital account if you or anyone covered who is aged 16 or over gives us their email address.

The law that applies to this agreement

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

Private Healthcare Information Network

You can get 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**.

Your **group** must pay premiums and any other payment due for your cover, and that of your **dependants** and every other person covered under the **agreement**, to us. If you contribute to the cost of premiums, this does not in any way affect the contract that exists between us and your **group**, as set out in the section 'The agreement between your group and us'.

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

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

If you do not want your cover (and therefore the cover of all of your **dependants**) to renew on your **renewal date**, you can let your **group** know at any time before the policy **renewal date**. The same applies if you want to remove a **dependant** from your policy, but you want your cover to continue.

If you want to end your cover (or the cover of any of your **dependants**) the following terms apply.

- You can end your cover (and therefore the cover of all your **dependants**) by letting your **group** know 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 later. During this 21-day period, if you have not made any claims we will refund to your **group** all of the premiums it has paid for you for that **year**.

After this 21-day period, you can end your cover (and therefore the cover of all of your **dependants**) by letting your **group** know at any time during the **year**. We will refund to your **group** any premiums it has paid for you that relate to the period after your cover ends.

- You can end the cover of any **dependant** by letting your **group** know 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 later. During this 21-day period, if no claims have been made relating to that **dependant** we will refund to your **group** all of the premiums it 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 letting your **group** know at any time during the **year**. We will refund to your **group** any premiums it has paid for you that relate to that **dependant** for the period after their cover ends.

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

If we refund premiums paid for you or your **dependants** to the **group**, you should ask the **group** administrator to refund your contributions.

How to complain

We work hard to provide a great service to our customers, but occasionally things can go wrong and when this happens we'll do our best to put things right quickly.

How to get in touch

Call us on your **Bupa** helpline number, which you can find on your **membership certificate**, or call our Customer Relations team on **0345 606 6739** between 9am and 5pm, Monday to Friday. We may record or monitor phone calls.

Chat to us online at **bupa.co.uk/complaints**.

Email us at **customerrelations@bupa.com** (please include your membership number).

If you need to send us sensitive information you can email us using Egress, which is a free secure email service. Visit **switch.egress.com**.

Write to us at **Customer Relations**, **Bupa**, **Bupa Place**, **102 The Quays**, **Salford, M50 3SP**.

If we can't resolve your complaint straight away, we'll email or write to you within five business days to explain the next steps.

You may be able to refer your complaint to the Financial Ombudsman Service for a free, independent and impartial review.

You can:

- visit **financial-ombudsman.org.uk**
- call them on **0800 023 4567**, or
- 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 will only give them information that is necessary to investigate your complaint, but this may include medical information. If you're 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, if appropriate, pay compensation. You can get more information at **www.fscs.org.uk** or by calling the FSCS on **0800 678 1100** or **020 7741 4100**.

What some of the words and phrases in this guide mean

Wherever the following words and phrases appear in this guide in bold type, they have the meanings shown below.

Word or phrase	Meaning
Accidental dental injury	Damage to your teeth or gums caused by accidentally being hit by or colliding with an object.
Activities of daily living	■ Being able to move from one place to another to carry out day-to-day activities. ■ Having a shower or bath. ■ Feeding yourself. ■ Maintaining personal hygiene (for example, brushing your teeth, washing your hands and washing your hair). ■ Going to the toilet. ■ Being able to work or take part in education.
Acute condition	A disease, illness or injury that is likely to respond quickly to **treatment** which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
Advanced therapies	Gene therapy, somatic-cell therapy or tissue-engineered medicines which: ■ the UK medicines regulator has classified as advanced therapy medicinal products (ATMPs) to be used as part of your **eligible treatment**, and ■ at the time of your **eligible treatment** are included (with the medical conditions we cover them for) on the list of advanced therapies that applies to your **benefits**, as shown on your **membership certificate** under the heading 'Advanced therapies list'. The list of advanced therapies that applies to your **benefits** is available at **bupa.co.uk/policyinformation**, or you can contact us. The advanced therapies on the list will change from time to time.
Agreement	The agreement between your **group** and us, which sets out the terms under which we provide your cover.
Allowances	The financial allowances of your **benefits**, as shown on your **membership certificate**.
Appliances	Any medical appliances which are on our appliance list for your cover when you have your **treatment**. You can find the list at **bupa.co.uk/prostheses-and-appliances**.
Benefits	The benefits you're covered for, as listed on your **membership certificate**.

Word or phrase	Meaning
Bupa	Bupa Insurance Limited. Registered in England and Wales with registration number 3956433. Registered office: 1 Angel Court, London EC2R 7HJ
Cancer	A malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
Chemotherapy	Systemic anti-cancer therapies (SACT), not including anti-hormone therapies. SACT are used to destroy cancer cells or stop them growing and spreading.
Chronic condition	A disease, illness or injury which has one or more of the following characteristics: ■ It needs ongoing or long-term monitoring through consultations, examinations, check-ups 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) which, 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 a complementary medicine practitioner at **finder.bupa.co.uk** or contact us.
Confirmation of special conditions	The most recent confirmation of special conditions we send to the **main member** or to anyone covered under the policy who the **special condition** applies to (if they are aged 16 or over). We only send confirmation of special conditions if a **special condition** applies.
Consultant	A registered medical healthcare professional who, when you have your **treatment** is: ■ recognised by us as a consultant ■ recognised by us for treating your condition and providing the type of **treatment** you need, and ■ on our list of recognised consultants, which applies to your policy. You can search for a consultant at **finder.bupa.co.uk** or contact us.
Contributing member	A **main member** who contributes to the costs of premiums for themself or any of their **dependants**.
Cover end date	The date when your current cover ends. This is either: ■ the 'Cover end date' on your **membership certificate**, or ■ if there is no cover end date shown, the day before your policy renews.
Cover start date	The date when your current cover starts – this is shown as the 'Cover start date' on your **membership certificate**.

Word or phrase	Meaning
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 your **treatment**, for the type of **intensive care** that you need. You can search for a critical care unit 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 who 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** or any child you or your **partner** is responsible for and who is covered under your policy 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.
Digital primary care provider	A digital primary care provider we recognise for providing a digital primary care consultation, this can include a **GP** and other healthcare professionals registered with the digital primary care provider. (Primary care services provide the first point of contact in the healthcare system.)
Effective underwriting date	If your underwriting type is 'underwritten', the effective underwriting date is the date you started your continuous period of cover under the policy. This is the date shown as the 'Effective underwriting date' on your **membership certificate**. If the effective underwriting date isn't shown on your **membership certificate**, it will be your **cover start date** shown on the first **membership certificate** we provided which lists you as a member under the policy. If you joined from a **previous policy** and we have agreed with your **group** to continue your cover with the original start date from your **previous policy**, your effective underwriting date is the date of underwriting provided by the insurer or administrator of your **previous policy**. If you're not sure of your effective underwriting date, contact us and we'll tell you it.

Word or phrase	Meaning
Eligible treatment	**Treatment** (including any products and equipment used as part of the **treatment**): ■ of an **acute condition**, **cancer**, a **mental health condition**, or ■ covered on your policy through benefits 1.6, 1.7 and any Well-Health benefits (WH1 to WH6). The **treatment** must be: ■ consistent with generally accepted standards of medical practice and best practice in the medical profession in the **UK** (for example, as specified by the National Institute for Health and Care Excellence (NICE), or equivalent bodies in Scotland) ■ clinically appropriate, in terms of the facility or location where the services are provided and the type, frequency, extent and duration of **treatment** ■ demonstrated through scientific evidence to be effective in improving health outcomes ■ not provided or used mainly for the convenience or financial (or other) advantage of you, your **consultant** or another healthcare professional, and ■ not excluded from your **benefits**.
Facility access	The network of recognised facilities which you're covered for, as shown on your **membership certificate**. This is **participating facility**, or **partnership facility**.
Fee-assured consultant or healthcare professional	A **consultant** or other healthcare professional recognised by us, who is on the fee-assured list. They won't send you any extra bills for **treatment** and care as long as it's covered by your policy and the costs are within your **allowances**. You can search for a fee-assured consultant or healthcare professional at **finder.bupa.co.uk** or contact us. The list may change from time to time.
Fertility check facility	A facility that, at the time you receive a fertility check, is recognised by us and on our list for fertility checks. You can search for details of these providers at **finder.bupa.co.uk**. The list may change from time to time.
Gender dysphoria	When someone has a sense of unease because of a mismatch between their biological sex (the sex they were assigned at birth) and the gender they identify with.
GP	A doctor who refers you for a consultation or **treatment** and who is on the UK General Medical Council's General Practitioner Register.
Group	The company, business or organisation we have entered into an **agreement** with to provide cover.
Home	The place where you normally live or another non-healthcare setting where you have your **treatment**.
Inpatient	A patient who is admitted to a hospital or treatment facility and who occupies a bed overnight (or for longer) for medical reasons.
Inpatient treatment	**Eligible treatment** you have as an **inpatient**.
Intensive care	**Eligible treatment** for intensive care, intensive therapy, high dependency care, coronary care or progressive care.

Word or phrase	Meaning
Main member	The person named as the main member on the **membership certificate**. The term main member doesn't include any **dependants**.
Medical assistance company	The company who works with us as a medical assistance company for arranging repatriation and evacuation. The medical assistance company may change from time to time and current details are available on request.
Medical treatment provider	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**.
Membership certificate	The most recent membership certificate we send you for your cover, or the most recent group certificate we send to your **group** that provides the details of your cover.
Mental health and wellbeing therapist	A healthcare professional recognised by us who is: ■ a psychologist registered with the Health and Care Professions Council ■ a psychotherapist accredited with UK Council for Psychotherapy, the British Association for Counselling and Psychotherapy, or the British Psychoanalytic Council ■ a counsellor accredited with the British Association for Counselling and Psychotherapy, or the National Counselling and Psychotherapy Society, or ■ a cognitive behavioural therapist accredited with the British Association for Behavioural and Cognitive Psychotherapies. You can search for a recognised mental health and wellbeing therapist at **finder.bupa.co.uk**.
Mental health condition	An illness or condition which a reasonable medical authority considers to be a mental health condition (for example, anxiety or depression).
Mental health treatment	**Eligible treatment** as set out in benefit 5 'Mental health treatment' in the 'What is covered' section of this guide.
Moratorium condition	Any condition, disease, illness or injury (including related conditions), whether diagnosed or not, which you: ■ asked for or received medical advice, **treatment** or medication for, or ■ had symptoms of or knew existed 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.
Moratorium qualifying period	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**.

Word or phrase	Meaning
Moratorium start date	If you're covered by a moratorium policy, the moratorium start date is the date you started your continuous period of cover under the policy. This is the date shown as the 'Moratorium start date' on your **membership certificate**. If the moratorium start date isn't shown on your **membership certificate**, it will be your **cover start date** shown on the first **membership certificate** we sent you. If you had a moratorium underwriting policy with us or another insurer before joining this policy, and we have agreed with your **group** to continue your cover from the start date of your **previous policy**, your moratorium start date will be your original moratorium start date from your **previous policy**. If you're not sure of your moratorium start date, contact us and we'll tell you it.
NHS	■ The National Health Service in Great Britain and Northern Ireland. ■ The healthcare system that is operated by the relevant authorities of the Channel Islands. ■ The healthcare scheme that is operated by the relevant authorities of the Isle of Man.
Nurse	A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.
Operation	**Eligible treatment** that is a medical procedure. This includes surgery and complex diagnostic procedures (such as an endoscopy) and all associated **treatment** that is medically necessary.
Optician	An ophthalmic optician or optometrist who is registered with the General Optical Council.
Oral chemotherapy	**Chemotherapy** taken by swallowing a pill, capsule or liquid.
Outpatient	A patient who attends a hospital, consulting room, outpatient clinic or treatment facility and is not admitted as a **day patient** or an **inpatient**.
Outpatient treatment	**Eligible treatment** that you have as an **outpatient**.
Participating facility	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: ■ treating your medical condition, and ■ carrying out the type of **treatment** you need. The hospitals, treatment facilities, centres or units on this 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**.

Word or phrase	Meaning
Partnership facility	A hospital or a treatment facility, centre or unit that is on our partnership facility list that applies to your policy, and is recognised by us for: ■ treating your medical condition, and ■ carrying out the type of **treatment** you need. The hospitals, treatment facilities, centres or units on this 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**.
Partner	Your husband, wife, civil partner or the person you live with in a relationship.
Pre-existing condition	Any condition, disease, illness or injury (including related conditions), whether diagnosed or not, which you: ■ received medication, advice or **treatment** for, or ■ had symptoms of or knew you had before your **effective underwriting 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.
Previous policy	Another health insurance policy or medical healthcare trust provided or administered by us or another insurer or healthcare trust that we agree with your **group** will be treated as a previous policy for **waiting periods** or underwriting purposes as long as: ■ the person covered has shown us proof of 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 of prostheses 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 on 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	The date agreed between your **group** and us on which your **group's** cover is due for renewal. Cover is usually renewed each year. Depending on the month in which you first join, your initial period of cover may not be a full 12 months. Your **benefits** and **allowances** and, if you are a **contributing member**, your premiums may change on the renewal date.
Schedule of procedures	The rates up to which we will pay **consultants** for treating our members. These rates are set out in our Schedule of Procedures and are based on the complexity of the procedure and the time and skill needed to perform it. You can find the Schedule of Procedures at **bupa.co.uk/codes**.

Word or phrase	Meaning
Special condition	Specific medical conditions that someone isn't covered for based on their medical history. If a special condition applies, we'll send a **confirmation of special conditions** to the **main member** or to anyone covered under the policy who the special condition applies to (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 which 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.
Therapist	A healthcare professional registered with the Health and Care Professions Council (HCPC), and on our list of recognised therapists, who is: ■ a chartered physiotherapist ■ an occupational therapist registered with the British Association of Occupational Therapists ■ an orthoptist registered with the British and Irish Orthoptic Society ■ a speech and language therapist registered with the Royal College of Speech and Language Therapists ■ a podiatrist registered with the Society of Chiropodists and Podiatrists, or ■ a dietitian registered with the British Dietetic Association. You can search for a recognised therapist at **finder.bupa.co.uk**. The therapists on the list will change from time to time.
Total annual allowance	This is the total **allowance** your policy will cover each **year** for all of your **eligible treatment** costs. If one applies to your cover, it applies to each person separately and will be shown on your **membership certificate**. Your **allowances** shown on your **membership certificate** will be subject to your total annual allowance. Any excess or co-insurance will count towards your total annual allowance.
Treatment	Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.
UK	Great Britain, Northern Ireland, the Channel Islands and the Isle of Man.
Waiting period	The 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 first year may not be a full 12 months. Your **benefits**, **allowances** and, if you are a **contributing member**, your premiums may change on the **renewal date**.

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, which is 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 Privacy Team, Bupa, 1 Angel Court, London EC2R 7HJ**. If you have any questions about how we handle your information, please contact us at **dataprotection@bupa.com**.

Information about us

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

1. Who this privacy notice applies to

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

2. How we collect personal information

We collect personal information from you and from certain other organisations 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 appropriate, your **dependants**.

- 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).
- 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 healthcare 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 it is. We normally process standard personal information if this is necessary to provide the services set out in a contract, it is in our or a third party's legitimate interests or it is needed or allowed by law. We process special categories of information (commonly referred to as sensitive 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 your permission or it is in our 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 Privacy Team, Bupa, 1 Angel Court, London EC2R 7HJ**.

6. Processing for profiling and automated decision-making

Like many businesses, we sometimes use automation to provide you with a fairer, quicker, better, and more consistent service, and provide 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 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 (automated processing of your information to help us evaluate certain things about you, for example, your personal preferences and your interests) 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 allow us 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, and in what circumstances, in our full privacy notice.

8. International transfers

Some companies that we work in partnership with or that provide services to us (such as healthcare providers, other Bupa companies and IT providers) are located in, or run their services from, countries across the world. As a result, we may transfer your personal information to different countries for the purposes set out in this privacy notice. This may include transferring information 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. When we transfer your personal information to another country, we take steps to make sure that 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 for periods we work out using the criteria shown in the full privacy notice available on our website.

10. Your rights

You have the right to access your information and to ask us to correct, delete and restrict the use of your information. You also have rights to:

- object to your information being used
- ask us to transfer your information to someone else
- withdraw your permission for us to use your information, and
- ask us not to make automated decisions which produce legal effects that concern 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 privacy 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 complain 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
Your **group** agree to keep to all **UK** laws relating to detecting and preventing financial crime (including, the Bribery Act 2010 and the Proceeds of Crime Act 2002).

Sanctions
We will not provide cover and we will not pay any claim or provide any benefit under this insurance, if doing so would:

- break any United Nations resolution, or any trade or economic sanctions, laws or regulations that apply to us (including those of the European Union, the **UK**, or the US)
- put us at risk of being sanctioned by any relevant authority competent body, or
- put us at risk of being involved (directly or indirectly) in something which any relevant authority, banks we use, or competent body would consider to be banned or restricted.

If any resolutions, sanctions, laws or regulations referred to in this clause apply (or start to apply), we will take any action we consider necessary to make sure we continue to work within them. If this happens, you acknowledge that this may restrict, delay or end our obligations under your policy, and we may not be able to pay any claim.

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

Well-Health - Targeted 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 - Targeted 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

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