

BUPA SELECT FOUNDATIONS

YOUR MEMBERSHIP GUIDE

Essential information explaining your
Bupa cover.

Please retain.

bupa.co.uk

ABOUT THIS GUIDE

Welcome to your Bupa Select Foundations membership guide.

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

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

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

HOW DO I KNOW WHAT I'M COVERED FOR?

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

HOW DOES THE MEMBERSHIP GUIDE WORK WITH MY MEMBERSHIP CERTIFICATE?

Your certificate explains the benefits available to you and also provides a series of notes that correspond to the relevant section of the membership guide (where you will find a more detailed explanation of the benefit in your individual policy).

HOW DO I CONTACT BUPA?

We're always on hand to help.

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

You can also write to us at Bupa, Salford Quays, Manchester, M50 3XL.

BUPA HEALTHLINE

If you have any questions or worries about your health call our confidential Bupa HealthLine on 0845 604 0537* or 0161 868 6415*. Our qualified nursing team is on hand 24 hours a day, so whatever your health question or concern, they have the skills and practical, professional experience to help.

*Calls may be recorded and to maintain the quality of our Bupa HealthLine service a nursing manager may monitor some calls always respecting the confidentiality of the call.

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YOUR RULES AND BENEFITS

Effective from 1 April 2014

These are the rules and benefits of Bupa Select Foundations

- For anyone joining Bupa Select Foundations they apply from their **start date**.
- For anyone whose membership of Bupa Select Foundations is renewed by the **sponsor** they apply for the period from the first **renewal date** on or after the 'effective from' date.

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

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

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

This membership guide is a generic guide. It contains the general membership terms that apply to all Bupa Select Foundations members. It also contains all the elements of cover that can be provided under Bupa Select Foundations. **You may not have all the cover set out in this membership guide.** It is your **membership certificate** that shows the cover that is specific to your **benefits**. Any elements of cover in this membership guide that are either:

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

you are not covered for and you should therefore ignore them when reading this membership guide. Your **membership certificate** could also show some changes to the terms of cover set out in this membership guide particularly in the 'Further Details' section of your **membership certificate**.

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

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

HOW YOUR MEMBERSHIP WORKS

The agreement between the sponsor and us

Your cover is provided under an **agreement** between the **sponsor** and **Bupa**. There is no legal contract between you and **us** for your cover under the **agreement**. Only the **sponsor** and **Bupa** have legal rights under the **agreement** and are the only ones who can enforce the **agreement**, although **we** will allow anyone who is covered under the **agreement** complete access to **our** complaints process (please also see 'Making a complaint' in this section).

The documents that set out your cover

The following documents set out the details of the cover **we** will provide for you under the **agreement**. These documents must be read together as a whole, they should not be read as separate documents.

- **The Bupa Select Foundations membership guide:** this sets out the general terms and conditions of membership (including exclusions) and all the elements of cover that can be provided under Bupa Select Foundations.
- **Your membership certificate:** this shows the cover that is specific to your **benefits**, including the underwriting method applied, the limits that apply, any variations to the benefits, terms or conditions explained in this membership guide and whether an **excess** applies to your cover and if it does, the amount and how it applies.

And for **underwritten members**

- **Your application for cover:** this includes any applications for cover for **underwritten members** and the declarations that **you** made during the application process.

Payment of benefits

We only pay for **treatment** that you receive, or the **benefits** that you are entitled to, while you are covered under the **agreement** and **we** only pay in accordance with the **agreement**. **We** also only pay the **benefits** that applied to you on the date you received your **treatment** or the date that you became entitled to those **benefits**.

When you receive private medical treatment you have a contract with the providers of your **treatment**. You are responsible for the costs you incur in having private **treatment**. However, if your **treatment** is **eligible treatment we** pay the costs that are covered under your **benefits**. Any costs, including **eligible treatment** costs, not covered under your **benefits** are your sole responsibility.

The provider might, for example, be a **consultant**, a **recognised facility** or both. Sometimes one provider may have arrangements with other providers involved in your care and, therefore, be entitled to receive all the costs associated with your **treatment**. For example a **recognised facility** may charge for **recognised facility** charges, **consultants' fees** and **diagnostic tests** all together.

In many cases **we** have arrangements with providers about how much they charge **our** members for **treatment** and how **we** pay them. For **treatment** costs covered under your **benefits we** will, in most cases, pay the provider of your **treatment** direct – such as the **recognised facility** or **consultant** – or whichever other person or facility is entitled to receive the payment. Otherwise **we** will pay the **main member**. **We** will write to tell the **main member** how **we** have dealt with any claim. *Please also see the section 'Claiming'.*

When your membership starts, renews and ends

Starting membership

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

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

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

Covering a newborn baby

If the **sponsor** agrees, **you** may apply to include **your** newborn baby under **your** membership as one of **your dependants**.

If **your** baby's membership would be as:

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

but only if the following apply:

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

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

Renewal of your membership

The renewal of your membership is subject to the **sponsor** renewing your membership under the **agreement**.

How membership can end

You or the **sponsor** can end **your** membership or the membership of any of **your dependants** at any time. If **you** want to end **your** membership or that of **your dependants** **you** must write to **us**. If **your** membership ends the membership of all **your dependants** will also end.

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

- the **agreement** is terminated
- the terms of the **agreement** say that it must end
- the **sponsor** does not pay subscriptions or any other payment due under the **agreement** for **you** or any other person
- **you** stop living in the **UK**, or
- **you** die.

Your dependants' membership will automatically end if:

- **your** membership ends
- the terms of the **agreement** say that it must end
- the **sponsor** does not renew the membership of that **dependant**
- that **dependant** stops living in the **UK**, or
- that **dependant** dies.

We can end a person's membership if there is reasonable evidence that **you** or they misled **us** or attempted to do so. By this **we** mean, giving false information or keeping necessary information from **us**, either intentionally or carelessly, which may influence **us** when deciding:

- whether or not **we** will provide cover for them
- whether **we** have to pay any claim.

Paying subscriptions and other charges

The **sponsor** must pay to **us** subscriptions and any other payment due for your membership and that of every other person covered under the **agreement**.

If **you** contribute to the cost of subscriptions for **you** and/or **your dependants** (for example by payroll deduction or by Direct Debit collected by **Bupa** on behalf of the **sponsor**) this arrangement does not in any way affect the contractual position set out in the rule 'The agreement between the sponsor and us' in this section.

Making changes

Changes to your membership

The terms and conditions of your membership, including your **benefits**, may be changed from time to time by agreement between the **sponsor** and **us**.

Other parties

No other person is allowed to make or confirm any changes to your membership or your **benefits** on **our** behalf or decide not to enforce any of **our** rights.

Equally, no change to your membership or your **benefits** will be valid unless it is specifically agreed between the **sponsor** and **us** and confirmed in writing.

General information

Change of address

You should call or write to tell **us** if **you** change **your** address.

Correspondence and documents

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

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

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

Applicable law

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

Making a complaint

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

If you are a member of a company or corporate scheme please call your dedicated Bupa helpline, this will be detailed on your **membership certificate**.

For any other complaint **our** member services department is always the first number to call if **you** need help or support or if you have any comments or complaints. You can contact **us** in several ways:

By phone: 0845 606 6739*

In writing: Customer Relations, Bupa, Salford Quays, Manchester, M50 3XL

By email: customerrelations@bupa.com

Or via our website: bupa.co.uk/members/member-feedback

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

If **we** cannot resolve your complaint immediately **we** will write to **you**, within five working days, to acknowledge receipt of your complaint. **We** will then continue to investigate your complaint and aim to send you **our** full written final decision within 15 working days. If **we** are unable to resolve your complaint within 15 working days **we** will write to you to confirm that **we** are still investigating your complaint.

Within eight weeks of receiving your complaint **we** will either send you a full written final decision detailing the results of **our** investigation or send you a letter advising that **we** have been unable to complete the review of your complaint.

*Calls may be recorded and may be monitored

If you remain dissatisfied after receiving **our** final decision, or after eight weeks you do not wish to wait for **us** to complete **our** review, you may refer your complaint to the Financial Ombudsman Service. You can write to them at: South Quay Plaza, 183 Marsh Wall, London, E14 9SR or call them on **0800 023 4567** (free for fixed line users) or **0300 123 9123** (free for mobile phone users who pay a monthly charge for calls to numbers starting 01 or 02).

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

Your complaint will be dealt with confidentially and will not affect how **we** treat **you** in the future.

Whilst **we** are bound by the decision of the Financial Ombudsman Service, you are not.

For members with special needs **we** can offer a choice of Braille, large print or audio for correspondence and marketing literature. Please get in touch to let **us** know which **you** would prefer.

The Financial Services Compensation Scheme (FSCS)

In the unlikely event that **we** cannot meet **our** financial obligations, you may be entitled to compensation from the Financial Services Compensation Scheme. This will depend on the type of business and the circumstances of **your** claim. The FSCS may arrange to transfer **your** policy to another insurer, provide a new policy or, where appropriate, provide compensation.

Further information about compensation scheme arrangements is available from the FSCS on **0800 678 1100** or **0207 741 4100** or on its website **www.fscs.org.uk**

HOW TO CLAIM FOR TREATMENT MEMBERS

Step-by-step guide to making a claim under the Open Referral pre-authorisation process

IMPORTANT: Please ensure that you follow the Open Referral process. You will be responsible for paying the treatment costs you incur for treatment that has not been pre-authorised by us.

If you are admitted to an **NHS hospital** for **treatment** and then wish to transfer from **NHS** to private **treatment** you must still call **us** to pre-authorise your private treatment before you arrange or receive any such **treatment**. This applies regardless of whether your being an **NHS** patient starts by you going to an **NHS** accident and emergency department or through an **NHS** emergency admission or being admitted for pre-planned **NHS treatment**. Please remember, any fees or charges you incur for **treatment** that has not been pre-authorised by **us** are your responsibility.

STEP
1

VISIT YOUR GP

The process generally starts with a visit to your **GP**. Your **GP** will either:

- refer you to a consultant for diagnosis of your condition, this could be under the **NHS** or paid for by you as a private patient
- refer you to a therapist for **treatment**.

There are some conditions where a **GP** referral is not required and details of these are available from **us** on request. For information on these conditions please call member services or go to [bupa.co.uk/policyinformation](https://www.bupa.co.uk/policyinformation). The list of conditions for which a **GP** referral is not required may be updated from time to time.

STEP
2

BEFORE YOU CALL US

- **If your GP refers you to a consultant for diagnosis of your condition:**

When your consultant recommends **treatment** after diagnosing your condition ask your consultant for the procedure code for the **treatment** they would like you to have. The procedure code is the clinical code that gives **us** the information **we** need about what **treatment** your consultant is recommending for you. You must obtain your procedure code from your consultant before you call **us** to go through the Open Referral pre-authorisation process in order to avoid having to contact your consultant again.

- **If your GP refers you to a therapist for treatment:**

Your **GP** will provide you with a referral letter. You must ask for an 'Open Referral letter'. This will detail the care your **GP** would like you to have but will not be addressed to a specific therapist. The Open Referral letter needs to include your **GP's** diagnosis and the body area

affected and treatment required. You'll find an Open Referral form for your **GP** to complete on: [bupa.co.uk/referral](https://www.bupa.co.uk/referral). You must obtain an 'Open Referral letter' from your **GP** in order to avoid having to return to your **GP** to obtain an Open Referral.

STEP 3

CALL US

Before you arrange any **treatment** you must call **us** to go through the Open Referral pre-authorisation process and get a pre-authorisation number.

We will also let you know what you need to do next and, if you are a **moratorium member**, send you any necessary pre-treatment forms you may need to complete.

STEP 4

GET A PRE-AUTHORISATION NUMBER

When **we** have confirmed whether your **treatment** is covered under your **benefits**, **we** will discuss your claim with you and if:

- your **GP** has referred you for **treatment** with a therapist: we will provide you with a choice of **therapists** who are covered under your **benefits** and are in your local area
- your consultant has recommended **treatment** **we** will provide you with a choice of **consultants** who are covered under your **benefits** and are in your local area. If your existing consultant is not on the list **we** provide you with there are certain options available to you. You can choose:
 - a new **consultant** from the choice **we** give you - in which case, if it is clinically necessary, you will also be covered for one initial consultation with your new **consultant** in order for them to assess your diagnostic results
 - to remain with your existing consultant if they are **Bupa** recognised but this may mean that not all your **treatment** costs will be covered under your **benefits** and you will be responsible for any costs that are not covered.

We will also:

- issue you with a pre-authorisation number
- explain the pre-authorisation process for any further **treatment** you may need following your Open Referral pre-authorisation.

You can then contact your chosen **consultant, therapist** or **recognised facility** from the choice **we** provided you with to arrange an appointment.

We recommend you give your pre-authorisation number to your chosen **consultant, therapist** or **recognised facility** so that the invoice for any treatment costs can be sent to **us** directly.

If for any reason you are sent an invoice, simply send it on to: Claims Department, Bupa, Salford Quays, M50 3XL.

Once **we** have paid the **eligible treatment** costs, **we** will send you a summary of your claim and **treatment** details. Please note that payment may take a number of weeks depending on how quickly invoices are submitted to **us**.

HOW TO CLAIM FOR DIAGNOSIS AND COMBINED CARE MEMBERS

Step-by-step guide to making a claim under the Open Referral pre-authorisation process

IMPORTANT: Please ensure that you follow the Open Referral process. You will be responsible for paying the treatment costs you incur for treatment that has not been pre-authorised by us.

If you are admitted to an **NHS** hospital for **treatment** and then wish to transfer from **NHS** to private **treatment** you must still call **us** to pre-authorise your private treatment before you arrange or receive any such **treatment**. This applies regardless of whether your being an **NHS** patient starts by you going to an **NHS** accident and emergency department or through an **NHS** emergency admission or being admitted for pre-planned **NHS treatment**. Please remember, any fees or charges you incur for **treatment** that has not been pre-authorised by **us** are your responsibility.

STEP 1

VISIT YOUR GP

The process generally starts with a visit to your **GP**. Your **GP** will advise you if you:

- need to see a consultant or therapist (as applicable)
- need a simple **diagnostic test**.

There are some conditions where a **GP** referral is not required and details of these are available from **us** on request. For information on these conditions please call member services or go to [bupa.co.uk/policyinformation](https://www.bupa.co.uk/policyinformation). The list of conditions for which a **GP** referral is not required may be updated from time to time.

STEP 2

ASK FOR AN OPEN REFERRAL LETTER

You must obtain an Open Referral letter from your **GP** or ask them to complete an Open Referral form.

You'll find a simple Open Referral form which your **GP** can complete on: [bupa.co.uk/referral](https://www.bupa.co.uk/referral)

The letter or form will need to detail the care your **GP** would like you to have, but will not be addressed to a specific consultant, **therapist** or **recognised facility**.

The letter or form needs to include your **GP's** assessment of your symptoms, the body area affected and medical speciality required.

You must obtain an Open Referral from your **GP** in order to avoid having to return to your **GP**.

STEP
3

CALL US

Before you arrange any consultations, **diagnostic tests** or **treatment** you must call us to get your Open Referral pre-authorisation for your consultations, **diagnostic tests** or **treatment** (as applicable) and get a pre-authorisation number.

We will also let you know what you need to do next and, if you are a **moratorium member**, send you any necessary pre-treatment forms you may need to complete.

STEP
4

GET A PRE-AUTHORISATION NUMBER

When **we** have confirmed whether your consultation, **diagnostic tests** or **treatment** is covered under your **benefits**, **we** will:

- discuss your claim with you
- provide you with a choice of **consultants, therapists** or **recognised facilities** (as applicable) that are in your local area and covered under your **benefits**
- issue you with a pre-authorisation number
- explain the pre-authorisation process for any further **treatment** you may need following your Open Referral pre-authorisation.

You can then contact your chosen **consultant, therapist** or **recognised facility** from the choice **we** provided you with to arrange an appointment.

We recommend you give your pre-authorisation number to your chosen **consultant, therapist** or **recognised facility** so that the invoice for any treatment costs can be sent to **us** directly.

If for any reason you are sent an invoice, simply send it on to: Claims Department, Bupa, Salford Quays, M50 3XL.

Once **we** have paid the **eligible treatment** costs, **we** will send you a summary of your claim and **treatment** details. Please note that payment may take a number of weeks depending on how quickly invoices are submitted to **us**.

CLAIMS CHECKLIST FOR ALL FOUNDATIONS MEMBERS

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

- **for Diagnosis and Combined Care members your Open Referral letter**
- **for Treatment members your procedure code**
- **your Bupa membership number**
- **the condition you are suffering from**
- **details of when your symptoms first began**
- **details of when you first consulted your GP about your condition.**

A Making a claim

A1 Claims other than Cash benefits

FOR TREATMENT MEMBERS

The Open Referral pre-authorisation process applies to your cover. This means that:

- if your **GP** refers you to a **therapist** or **mental health and wellbeing therapist** for **treatment** you must obtain an Open Referral from your **GP**
- if your consultant recommends **treatment** for your **acute condition** after it has been **diagnosed** you must call **us** to obtain pre-authorisation before you arrange or receive any **treatment** for that **acute condition**.

Please note there are some conditions where a **GP** referral is not required and details of these are available from **us** on request. For information on these conditions please call member services or go to bupa.co.uk/policyinformation. The list of conditions for which a **GP** referral is not required may be updated from time to time.

Please see 'How to claim for Treatment members' in this section for details of how the Open Referral process works.

FOR DIAGNOSIS AND COMBINED CARE MEMBERS

The Open Referral pre-authorisation process applies to your cover. This means that you must:

- obtain an 'Open Referral' from your **GP** and then
- call **us** to obtain pre-authorisation before you arrange or receive any **treatment**, including **out-patient** consultations or **diagnostic tests**.

Please note there are some conditions where a **GP** referral is not required and details of these are available from **us** on request. For information on these conditions please call member services or go to bupa.co.uk/policyinformation. The list of conditions for which a **GP** referral is not required may be updated from time to time.

Please see 'How to claim for Diagnosis and Combined Care members' in this section for details of how the Open Referral process works.

FOR ALL MEMBERS

At your Open Referral pre-authorisation **we** will:

- confirm the **consultants**, **therapists** and **recognised facilities** (as applicable) that you must use
- explain the pre-authorisation process for any further **treatment** you may need following your Open Referral pre-authorisation.

Important:

- if you do not call **us** to obtain pre-authorisation for your **treatment** you will be responsible for paying for all such **treatment**

- if you do not use a **consultant, therapist, or recognised facility** (as applicable) that **we** confirm you must use at your Open Referral pre-authorisation you will be responsible for paying for all such **treatment**.

If you are admitted to an **NHS** hospital for **treatment** and then wish to transfer from **NHS** to private **treatment** you must call **us** to pre-authorise your private **treatment** before you arrange or receive any such **treatment**. This applies regardless of whether your being an **NHS** patient starts by you going to an **NHS** accident and emergency department or through an **NHS** emergency admission or being admitted for pre-planned **NHS** treatment. Any fees or charges you incur for **treatment** that has not been pre-authorised by **us** are your responsibility.

For moratorium members

As a **moratorium member** you are not covered for **treatment** of any **moratorium conditions**. Each time you make a claim you must provide **us** with information so **we** can confirm whether your proposed **treatment** is covered under your **benefits**.

When you call **us** to pre-authorise your consultations or **treatment** under the Open Referral process **we** will send you a pre-treatment form to complete. You will need to provide details of the history of the medical condition you are claiming for, including information that you will need to ask your **GP** or consultant for. Your **GP** or consultant may charge you a fee for providing a report which **we** do not pay. Each claim you make while you are a **moratorium member** will be assessed on this information and any further information **we** ask you to provide to **us** at the time you claim.

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

- confirm whether your proposed **treatment** will be eligible under your **benefits** and, if so, give you a pre-authorisation number and details of the **consultants, therapists, or recognised facilities** you must use
- confirm the level of **benefits** available to you
- tell you whether you will need to complete a claim form.

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

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

For non-moratorium members

When you call **us** to pre-authorise your consultations or **treatment** under the Open Referral process **we** will:

- confirm whether your proposed **treatment** will be eligible under your **benefits** and, if so, give you a pre-authorisation number and details of the **consultants, therapists, or recognised facilities** you must use

- confirm the level of **benefits** available to you
- tell you whether you will need to complete a claim form, if you claim.

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

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

A2 Claims for Cash benefits

For moratorium members

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

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

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

For non-moratorium members

Call the helpline to check your **benefits**. **We** will confirm your **benefits** and send you a claim form which you will need to take with you to the hospital and ask them to complete the hospital sections. You will need to return your fully completed form to **us** as soon as possible and in any event within six months of receiving your **NHS treatment** unless this was not reasonably possible.

A3 Treatment needed because of someone else's fault

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

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

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

A4 Other insurance cover

If you have other insurance cover for the cost of the **treatment** or services that you are claiming from **us** you must provide **us** with full details of that other insurance policy as soon as possible. You must do this either by writing to **us** or by completing the appropriate section on your claim form. In which case **we** will only pay **our** share of the cost of the **eligible treatment** for which you are claiming.

B How we will deal with your claim

B1 General information

We only pay for **treatment** that you receive, or the **benefits** that you are entitled to, while you are covered under the **agreement** and **we** only pay in accordance with the **agreement**. **We** also only pay the **benefits** that applied to you on the date you received your **treatment** or the date that you became entitled to those **benefits**.

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

We do not have to pay a claim if you break any of the terms and conditions of your membership.

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

We reserve the right to change the procedure for making a claim. If so, **we** will write and tell the **sponsor** about any changes.

B2 Providing us with information

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

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

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

Obtaining medical reports from your GP: When you need to request a medical report from your **GP**, **we** can do this on your behalf with your consent.

We will always ask for your consent before requesting a report from your GP on your behalf and we will ask for your consent on the telephone when we explain to you the need for the report. You can choose from three courses of action:

1. You can give your consent without asking to see the **GP's** report before it is sent to **us**. The **GP** will send the report directly to **us**.

If you give your consent to **us** obtaining a report without indicating that you wish to see it, you can change your mind by contacting your **GP** before the report is sent to **us**. In which case you will have the opportunity to see the report and ask the **GP** to change the report or add your comments before it is sent to **us**, or withhold your consent for its release.

2. You can give your consent, but ask to see any report before it is sent to **us**, in which case you will have 21 days, after **we** notify you that **we** have requested a report from the **GP**, to contact your **GP** to make arrangements to see the report.

If you fail to contact the **GP** within 21 days, **we** will request they send the report direct to **us**. If, however, you contact your **GP** with a view to seeing the report, you must give the **GP** written consent before they can release it to **us**.

You may ask your **GP** to change the report if you think it is misleading. If your **GP** refuses, you can insist on adding your own comment to the report before it is sent to **us**.

3. You can withhold your consent, but if you do, please bear in mind that **we** may be unable to progress with your claim.

Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your **GP** to let you see a copy, provided that you ask them within six months of the report having been supplied to **us**.

Your **GP** is entitled to withhold some or all of the information contained in the report if (a) they feel it may be harmful to you (b) it would indicate their intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that of a health professional in relation to your care).

We may make a contribution to the costs of any report that **we** have requested on your behalf, this will be confirmed at point of telephone consent. If **we** do make a contribution, you will be responsible for any amount above this.

B3 How we pay your claim

Claims other than cash benefits: for **treatment** costs covered under your **benefits we** will, in most cases, pay the provider of your **treatment** direct – such as the **recognised facility** or **consultant** – or whichever other person or facility is entitled to receive the payment. Otherwise **we** will pay the **main member**. **We** will write to tell the **main member** how **we** have dealt with any claim.

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

C If you want to withdraw a claim

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

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

D Ex-gratia payments

If **we** agree to pay for the costs of **treatment** to which you are not entitled under your **benefits**, ie an 'ex-gratia payment', this payment will still count towards the maximum amount **we** will pay under your **benefits**. Making these payments does not oblige **us** to make them in the future.

E If you have an excess

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

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

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

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

E1 How an excess works

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

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

We will write to the **main member** to tell them who you should pay the **excess** to, for example, your **consultant, therapist** or **recognised facility**.

The **excess** must be paid direct to them – not to **Bupa**. **We** will also write to tell the **main member** the amount of the **excess** that remains (if any).

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

E2 How the excess applies to your benefits

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

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

BENEFITS

What you are covered for

There are three tiers of cover set out in this 'Benefits' section – Diagnosis, Treatment and Combined Care. Your **membership certificate** shows which tier applies to your **benefits**. Please look at your **membership certificate** for the list of the specific benefits that you are covered for and the limits that apply to those benefits. Any elements of cover that you see described in this guide that are either shown as 'not covered' or are not listed on your **membership certificate** are not included in your cover.

This section explains the charges **we** pay for **eligible treatment**. It also explains:

- how Open Referral and the requirement for all your consultations and **treatment** to be pre-authorised affect your **benefits**
- how the type of **treatment** you need and the medical practitioners and/or treatment facility you use can impact your **benefits**.

Notes on benefits

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

Restrictions and/or limitations to benefits.

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

- **benefit limits** – there may be limits on:
 - the amounts **we** will pay and/or restrictions on the cover you have under your **benefits**. Your **membership certificate** shows the benefit limits and/or restrictions that apply to your **benefits**
 - the maximum amounts **we** will pay towards the costs of your **treatment**
- **an excess** – this is explained in rule E in the section 'Claiming'. Your **membership certificate** shows if an **excess** applies to your **benefits**. If one does apply, your benefit limits shown in your **membership certificate** will be subject to your **excess**
- **exclusions** apply to your cover – the general exclusions are set out in the section 'What is not covered'. Some exclusions also apply in this section and there may also be exclusions in your **membership certificate**.

Being referred for treatment

The Open Referral pre-authorization process applies to your cover as shown on your **membership certificate** under 'Access option'. This means that before you arrange any **treatment**, including **out-patient** consultations and **diagnostic tests** (where applicable) you must call **us** to pre-authorise it.

Please see the section, 'Claiming', for full details of how the Open Referral pre-authorization process works and what you need to do.

You are only covered for **eligible treatment**. Please see the glossary section for

what **we** mean by **eligible treatment**. Your cover for **eligible treatment** costs depends on you using certain **Bupa** recognised medical and other healthcare professionals and **recognised facilities**. Please note:

- o the medical practitioners, other healthcare professionals and **recognised facilities** that **we** recognise and
- o the type of medical condition and/or type of **treatment** and/or level of benefit that **we** recognise them for can change from time to time.

Reasonable and customary charges

We only pay **eligible treatment** charges that are reasonable and customary. This means that the amount you are charged by medical practitioners, other healthcare professionals and/or treatment facilities and what you are charged for have to be in line with what the majority of **our** other members are charged for similar **treatment** or services.

DIAGNOSIS

Getting diagnosed

You are only covered for Diagnosis benefits if your **membership certificate** shows they are covered. If you are covered for these benefits your **membership certificate** shows the benefit limits that apply.

Benefit D1 Consultations and diagnosis

Under this benefit D1 **we** do not pay benefits for any fees or charges, including **consultants'** fees and **facility charges** that are for or related to a disease, illness or injury which has been **diagnosed**.

We do not pay any **consultants'** fees or **facility charges** for or in relation to the diagnosis of any **mental health condition**.

We do not pay any **therapists'** fees or **mental health and wellbeing therapists'** fees for or in relation to the diagnosis of any disease, illness or injury including the diagnosis of any **mental health condition**.

Your **treatment** costs for diagnosing your **acute condition** are only covered when:

- o you have gone through the Open Referral pre-authorisation process for that **treatment**
- o **we** have pre-authorised the **treatment** and you use the **consultants** and/or the **recognised facilities we** confirm at pre-authorisation that you must use
- o the person who has overall responsibility for your **treatment** is an **open referral consultant**. If the person who has overall responsibility for your **treatment** is not an **open referral consultant** then none of your **treatment** costs are covered.

benefit D1.1 out-patient consultations

We pay **consultants'** fees for **out-patient** consultations to enable the diagnosis of your disease, illness or injury when carried out as **out-patient treatment** and you are referred for the **out-patient** consultation by your **consultant**.

benefit D1.2 out-patient diagnostic tests

When requested by your **consultant** for the diagnosis of your disease, illness or injury **we** pay **facility charges** (including the charge for interpretation of the results)

for **diagnostic tests** for the diagnosis of your disease, illness or injury received as **out-patient treatment**.

benefit D1.3 diagnostic surgical operations

Consultants' fees

We pay **consultants'** fees for **eligible surgical operations** undertaken for the diagnosis of your disease, illness or injury.

Facility charges

We pay **facility charges** for **eligible surgical operations** undertaken for the diagnosis of your disease, illness or injury. Benefit note: D1.3.1 explains the type of **facility charges we** pay for **eligible surgical operations** carried out as **out-patient treatment**. Benefit notes D1.3.2 to D 1.3.4 explain the type of **facility charges we** pay for **eligible surgical operations** carried out as **day-patient treatment** or **in-patient treatment**.

Please also see exclusion 35, 'Non-diagnostic treatment' in the section 'What is not covered'.

benefit D1.3.1 out-patient surgical operations

We pay for theatre use, including equipment, **common drugs, advanced therapies, specialist drugs** and surgical dressings used during your **eligible surgical operation** for the diagnosis of your disease, illness or injury as **out-patient treatment**.

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

benefit D1.3.2 accommodation

We pay for your accommodation costs including your own meals and refreshments while you are receiving an **eligible surgical operation** for the diagnosis of your disease, illness or injury as **day-patient treatment** or **in-patient treatment**.

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

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

- the charge is for an overnight stay for a **surgical operation** that would normally be carried out as **out-patient treatment** or **day-patient treatment**
- the charge is for use of a bed for a **surgical operation** that would normally be carried out as **out-patient treatment**
- the accommodation is primarily used for any purpose other than receiving an **eligible surgical operation** for the diagnosis of your disease, illness or injury.

benefit D1.3.3 parent accommodation

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

- a member under the **agreement**
- under 16 years of age, and
- receiving **in-patient treatment**.

benefit D1.3.4 theatre charges, nursing care, drugs and surgical dressings

We pay for use of the operating theatre and for nursing care, **common drugs, advanced therapies, specialist drugs** and surgical dressings when needed as an essential part of **eligible surgical operations** undertaken for the diagnosis of your disease, illness or injury, which you receive as **day-patient treatment** or **in-patient treatment**.

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

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

(MRI, CT and PET scans are not paid under this benefit – see benefit D1.4)

benefit D1.4 out-patient MRI, CT and PET scans

When requested by your **consultant** to enable the diagnosis of your condition **we** pay **facility charges** (including the charge for interpretation of the results), for:

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

received as **out-patient treatment**.

TREATMENT

You are only covered for these Treatment benefits if your **membership certificate** shows they are covered. If you are covered for these benefits your **membership certificate** shows the benefit limits that apply.

Benefit T1 Getting treated

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

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

- you have gone through the Open Referral pre-authorisation process for that **treatment**
- **we** have pre-authorised the **treatment** and confirmed the **consultants, therapists** and **recognised facilities** you must use
- the person who has overall responsibility for your **treatment** is an **open referral consultant** or, if specifically agreed by **us**, an **agreed consultant**. If the person who has overall responsibility for your **treatment** is not an **open referral consultant** or an **agreed consultant** (as applicable) then none of your **treatment** costs are covered – the only exception to this is where your **GP** refers you to a **therapist** or **mental health and wellbeing therapist** for **treatment** (or where **we** refer you when **we** have told you that a **GP** referral is not required for your condition).

Important: How your benefits are affected by your choice of consultant at your Open Referral pre-authorisation

We do not pay any benefits under this benefit T1 before your **acute condition** has been **diagnosed**. Once your **acute condition** has been **diagnosed** (whether this was as an **NHS** patient or as a private patient) and your consultant recommends **treatment** you must call **us** to go through the Open Referral pre-authorisation process. When you call **we** will provide you with a choice of **consultants** who are **open referral consultants**. If your existing consultant isn't an **open referral consultant** there are certain options available to you as follows. Please note your **benefits** may be affected as explained below depending on the type of **consultant** that **we** agree, as part of your Open Referral pre-authorisation process, that you must use for your **treatment**.

Choosing an open referral consultant

You can choose a **consultant** who is an **open referral consultant** from the choice **we** provide to you as part of your Open Referral pre-authorisation process. In which case:

- your **benefits** for **consultants'** fees for **eligible treatment** will be paid up to the limits shown on your **membership certificate** and
- if you have changed consultant and if it is clinically necessary, you will be covered for one **out-patient** consultation with your chosen **open referral consultant** before your **treatment** takes place in order for them to assess your diagnostic results. Benefits for this **out-patient** consultation will be paid as follows:
 - for **eligible treatment** for **cancer** – paid in full on the basis set out in benefit CC5

- for **eligible treatment** other than **treatment for cancer** – paid in full on the basis set out in benefits CC2.1 and CC6.1.1 (as applicable) and subject to your available combined annual benefit limit for those benefits as shown in your **membership certificate**.

Choosing a consultant who is not an open referral consultant

We may agree to you using a **consultant** who is not an **open referral consultant** if:

- o your diagnosing consultant is a **Bupa** recognised **consultant** but is not an **open referral consultant** or
- o your diagnosing consultant refers you to a **Bupa** recognised **consultant** who is not an **open referral consultant**.

If, as part of your Open Referral pre-authorisation process, **we** agree that you can use a **consultant** who is an **agreed consultant** for your **treatment** then your **benefits** for:

- o **consultants' fees for eligible treatment** carried out by an **agreed consultant** and
- o **consultants' fees for all eligible treatment** that is under the overall responsibility of an **agreed consultant**

will be paid as set out in your **membership certificate** up to the limits of the **consultants' fees schedule** subject to any overall annual benefits limits that apply to your **benefits** for that type of **eligible treatment** as shown in your **membership certificate**.

benefit T1.1 treatment of your acute condition

We do not pay any **benefits** under this benefit T1 before your **acute condition** has been **diagnosed**.

If **benefits** are payable under this benefit T1 **we** pay for **eligible treatment** on the basis set out in benefits CC2, CC3, CC4, CC7 and CC8 in the Combined Care section of this membership guide.

Once your **acute condition** has been **diagnosed we** pay **benefits** as follows:

- o **we** pay **benefits for treatment** you need but only when the **treatment**:
 - is for or related to that **acute condition** and
 - it is to treat that **acute condition** and is not for or related to the diagnosis of your condition or any other disease, illness or injury
- o **we** pay for **out-patient** consultations, **out-patient diagnostic tests** and **out-patient** MRI, CT and PET scans but only when:
 - they are directly related to private **out-patient treatment, day-patient treatment, in-patient treatment** or an **out-patient surgical operation** carried out to treat that **acute condition** and
 - they follow within six months of the discharge date of that **treatment**
- o **we** pay for an **eligible surgical operation**, including an **out-patient surgical operation**, that is to treat your **acute condition** or to assess your **acute condition** following **eligible treatment**, but not when it is for or related to the diagnosis of your condition or any other disease, illness or injury.

Any fees or charges you incur for any **out-patient** consultations, **diagnostic tests** or scans that take place either before you receive **out-patient treatment**, **day-patient treatment**, **in-patient treatment** or an **out-patient surgical operation** to treat your **acute condition** or more than six months after the discharge date of your **treatment** for that **acute condition** are your responsibility.

benefit T1.2 treatment for cancer under NHS Cancer Cover Plus

We do not pay any **benefits** under this benefit T1.2 before your **acute condition of cancer** has been **diagnosed**.

If **benefits** are payable under this benefit T1.2 **we** pay for **eligible treatment of cancer** on the basis set out in benefits CC5 and CC7 in the Combined Care section of the membership guide and benefits T2 and T3.

Once your **acute condition of cancer** has been **diagnosed**:

- **we** pay **benefits** for your **cancer treatment** but only when the **treatment** is for or related to your **cancer**
- **we** pay for **diagnostic tests**, including **out-patient** consultations, diagnostic procedures or scans, but only when:
 - it is required as a medically essential part of the planning or carrying out of your **treatment** for **cancer** and
 - **we** confirm at pre-authorisation that **we** will pay for such **treatment**.

Any fees or charges that you incur for **out-patient** consultations, **diagnostic tests** including diagnostic **surgical operations** or scans before your **cancer** has been **diagnosed** are your responsibility.

benefit T1.3 mental health treatment

We do not pay any **benefits** under this benefit T1.3 before your **mental health condition** has been **diagnosed**.

Once your **mental health condition** has been **diagnosed we** pay **benefits** as follows:

- **we** pay **benefits** for **eligible treatment** you need, including **out-patient treatment**, but only when the **treatment**:
 - is for or related to that **mental health condition** and
 - it is to treat that **mental health condition** and is not for or related to the diagnosis of your condition or any other disease, illness or injury
- **we** pay for **out-patient** consultations that are to assess your condition, **out-patient diagnostic tests** and **out-patient** MRI, CT and PET scans but only when:
 - they are directly related to **out-patient treatment**, **day-patient treatment**, **in-patient treatment** or an **out-patient surgical operation** carried out to treat that **mental health condition** and
 - they follow within six months of the discharge date of that **treatment**

- o **we** only pay for a **surgical operation**, including an **out-patient surgical operation**, that is to treat your **mental health condition** and not when it is for or related to the diagnosis of your condition or any other disease, illness or injury.

If **benefits** are payable under this benefit T1.3 **we** pay for **eligible treatment** on the basis set out in benefit CC6 in the Combined Care section of this membership guide and benefits T2 and T3.

Any fees or charges you incur for any **out-patient** consultations, **diagnostic tests** or scans that take place either before you receive **out-patient treatment, day-patient treatment, in-patient treatment** or an **out-patient surgical operation** for your **mental health condition** or more than six months after the discharge date of **treatment** for that **mental health condition** are your responsibility.

Benefit T2 Home nursing after private eligible in-patient treatment

We pay for home nursing immediately following private **in-patient treatment** if the home nursing:

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

You must have **our** written agreement before the **treatment** starts and **we** need full clinical details from your **consultant** before **we** can make our decision.

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

Benefit T3 Private ambulance charges

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

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

COMBINED CARE

You are only covered for these Combined Care benefits if your **membership certificate** shows they are covered. If you are covered for these benefits your **membership certificate** shows the benefit limits that apply.

Important: How your benefits for cancer treatment under NHS Cancer Cover Plus are affected by your choice of consultant at your Open Referral pre-authorisation

When you call **us** to go through the Open Referral pre-authorisation for **treatment for cancer we** will provide you with a choice of **consultants** who are **open referral consultants**. If you are already under the care of an NHS consultant who is not an **open referral consultant** there are certain options available to you as set out below.

Please note your **benefits** may be affected as explained below depending on the type of **consultant** that **we** agree, as part of your Open Referral pre-authorisation process, that you must use for your **treatment**.

Choosing an open referral consultant

You can choose a **consultant** who is an **open referral consultant** from the choice **we** provide to you as part of your Open Referral pre-authorisation process. In which case:

- your **benefits** for **consultants'** fees for **eligible treatment** of **cancer** will be paid up to the limits shown on your **membership certificate** and
- if for **treatment** of **cancer** you change your consultant and it is clinically necessary, you will be covered for one **out-patient** consultation with your chosen **open referral consultant** before your **treatment** for cancer takes place in order for them to assess your diagnostic results. This **out-patient** consultation will be paid in full.

Choosing a consultant who is not an open referral consultant

We may agree to you using an **agreed consultant** if:

- your **NHS** consultant is a **Bupa** recognised consultant but is not an **open referral consultant** or
- your **NHS** consultant refers you to a **Bupa** recognised **consultant** who is not an **open referral consultant**.

If, as part of your Open Referral pre-authorisation process, **we** do agree that you can use an agreed **consultant** for your **treatment** then your **benefits** for:

- **consultants'** fees for **eligible treatment** carried out by the **agreed consultant** and
- **consultants'** fees for all **eligible treatment** that is under the overall responsibility of the **agreed consultant**

will be paid as set out in your **membership certificate** up to the limits of the **consultants' fees schedule** and subject to any overall annual benefit limits that apply to your **benefits** for that type of **eligible treatment** as shown on your **membership certificate**.

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

- o you have gone through the Open Referral pre-authorisation process for that **treatment**
- o **we** have pre-authorised the **treatment** and you use the **consultants, therapists,** and/or the **recognised facilities we** confirm at pre-authorisation that you must use
- o the person who has overall responsibility for your **treatment** is an **open referral consultant** or, if specifically agreed by **us** for **treatment of cancer**, an **agreed consultant**. If the person who has overall responsibility for your **treatment** is not an **open referral consultant** or an **agreed consultant** then none of your **treatment** costs are covered – the only exceptions to this is where your **GP** refers you to a **therapist** or **mental health and wellbeing therapist** for **treatment** (or where **we** refer you when **we** have told you that a **GP** referral is not required for your condition).

Getting diagnosed

Benefit CC1 Consultations and diagnosis

benefit CC1.1 out-patient consultations

We pay **consultants'** fees for **out-patient** consultations to enable the diagnosis of your disease, illness or injury when carried out as **out-patient treatment** and you are referred for the **out-patient** consultation by your **GP** or **consultant**.

benefit CC1.2 out-patient diagnostic tests

When requested by your **GP** or **consultant** for the diagnosis of your disease, illness or injury **we** pay **facility charges** (including the charge for interpretation of the results) for **diagnostic tests** received as **out-patient treatment**.

benefit CC1.3 diagnostic surgical operations

Consultants' fees

When requested by your **consultant we** pay **consultants'** fees for **eligible surgical operations** undertaken for the diagnosis of your disease, illness or injury.

Facility charges

When requested by your **consultant we** pay **facility charges** for **eligible surgical operations** undertaken for the diagnosis of your disease, illness or injury. Benefit note CC1.3.1 explains the type of **facility charges we** pay for **eligible surgical operations** carried out as **out-patient treatment**. Benefit notes CC1.3.2 to CC1.3.4 explain the type of **facility charges we** pay for **eligible surgical operations** carried out as **day-patient treatment** or **in-patient treatment**.

benefit CC1.3.1 out-patient surgical operations

We pay for theatre use, including equipment, **common drugs, advanced therapies, specialist drugs** and surgical dressings used during your **eligible surgical operation**.

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

benefit CC1.3.2 accommodation

We pay for your accommodation costs including your own meals and refreshments while you are receiving an **eligible surgical operation** as **day-patient treatment** or **in-patient treatment**.

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

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

- the charge is for an overnight stay for a **surgical operation** that would normally be carried out as **out-patient treatment** or **day-patient treatment**
- the charge is for use of a bed for a **surgical operation** that would normally be carried out as **out-patient treatment**
- the accommodation is primarily used for any purpose other than receiving an **eligible surgical operation**.

benefit CC1.3.3 parent accommodation

We pay for each night a parent needs to stay in the **facility** with their child.

We only pay for one parent each night. This benefit applies to the child's cover and any charges are payable from the child's **benefits**. The child must be:

- a member under the **agreement**
- under 16 years of age, and
- receiving **in-patient treatment**.

benefit CC1.3.4 theatre charges, nursing care, drugs and surgical dressings

We pay for use of the operating theatre and for nursing care, **common drugs**, **advanced therapies**, **specialist drugs** and surgical dressings when needed as an essential part of your **eligible surgical operation**.

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

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

(MRI, CT and PET scans are not paid under this benefit – see benefit CC1.4)

benefit CC1.4 out-patient MRI, CT and PET scans

When requested by your **consultant** to enable the diagnosis of your condition **we** pay **facility charges** (including the charge for interpretation of the results), for:

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

received as **out-patient treatment**.

Getting treated

Benefit CC2 Consultations and diagnosis

Important: Benefit CC2 also applies to *Treatment members* on the basis set out in benefit T1.

Benefit CC2.1 out-patient consultations

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

Benefit CC2.2 out-patient therapies and charges related to out-patient treatment

Out-patient therapies

We pay **therapists'** fees for **out-patient treatment** of your **acute condition** when you are referred for the **treatment** by your **GP** or **consultant** or, where **we** have told you that a **GP** referral is not required for your condition, by **us**.

If your **consultant** refers you to a medical or health practitioner who is not a **therapist we** may pay the charges as if the practitioner were a **therapist** if all of the following apply:

- your **consultant** refers you to the practitioner before the **out-patient treatment** takes place and remains in overall charge of your care; and
- the practitioner has applied for **Bupa** recognition and **we** have not written to say he/she is not recognised by **Bupa**.

Charges related to out-patient treatment

We pay **facility charges** for **out-patient treatment** which is related to and is an integral part of your **out-patient treatment**. **We** treat these charges as falling under this benefit CC2.2 and subject to its benefit limit.

Benefit CC2.3 out-patient diagnostic tests

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

Benefit CC2.4 out-patient MRI, CT and PET scans

When requested by your **consultant** to help determine or assess your **acute condition we** pay **facility charges** (including the charge for interpretation of the results), for:

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

received as **out-patient treatment**.

Being treated in hospital

Benefit CC3 Consultants' fees for surgical and medical hospital treatment

Important: Benefit CC3 also applies to *Treatment members* on the basis set out in benefit T1.

benefit CC3.1 surgeons and anaesthetists

We pay **consultant** surgeons' fees and **consultant** anaesthetists' fees for **eligible surgical operations** carried out as **out-patient treatment**, **day-patient treatment** and **in-patient treatment** of your **acute condition**.

benefit CC3.2 physicians

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

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

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

Benefit CC4 Facility charges

Important: Benefit CC4 also applies to *Treatment members* on the basis set out in benefit T1.

We pay **facility charges** for **out-patient surgical operations**, **day-patient treatment** and **in-patient treatment**, including **eligible surgical operations**, of your **acute condition**.

Benefit note CC4.1 explains the type of **facility charges** we pay for **eligible surgical operations** carried out as **out-patient treatment**. Benefit note CC4.2 explains the type of **facility charges** we pay for **day-patient treatment** or **in-patient treatment**.

benefit CC4.1 out-patient surgical operations

We pay for theatre use, including equipment, **common drugs**, **advanced therapies**, **specialist drugs** and surgical dressings used during your **eligible surgical operation**.

We do not pay for drugs and surgical dressings for you to use after you leave the facility.

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

benefit CC4.2 day-patient and in-patient treatment

benefit CC4.2.1 accommodation

We pay for your accommodation costs including your own meals and refreshments while you are receiving an **eligible surgical operation** as **day-patient treatment** or **in-patient treatment**.

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

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

- o the charge is for an overnight stay for a **surgical operation** that would normally be carried out as **out-patient treatment** or **day-patient treatment**
- o the charge is for use of a bed for a **surgical operation** that would normally be carried out as **out-patient treatment**
- o the accommodation is primarily used for any purpose other than receiving an **eligible surgical operation**.

benefit CC4.2.2 parent accommodation

We pay for each night a parent needs to stay in the **facility** with their child.

We only pay for one parent each night. This benefit applies to the child's cover and any charges are payable from the child's **benefits**. The child must be:

- o a member under the **agreement**
- o under 16 years of age, and
- o receiving **in-patient treatment**.

benefit CC4.2.3 theatre charges, nursing care, drugs and surgical dressings

We pay for use of the operating theatre and for nursing care, **common drugs, advanced therapies, specialist drugs** and surgical dressings when needed as an essential part of your **eligible surgical operation**.

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

*For information on drugs and dressings for **out-patient** or take-home use, please see exclusion 14, 'Drugs and dressings for out-patient or take-home use and complementary and alternative products' in the section 'What is not covered'.*

benefit CC4.2.4 intensive care

We only pay for **intensive care** either:

- o when needed as an essential part of your **eligible treatment** if all the following conditions are met:
 - the **intensive care** is required routinely by patients undergoing the same type of **treatment** as yours, and
 - you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**, and
 - the **intensive care** is carried out in the **critical care unit**, and
 - it follows your planned admission to the **recognised facility** for private **treatment**

or

- o if unforeseen circumstances arise from a medical or surgical procedure which does not routinely require **intensive care** as part of the **treatment** and:
 - you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**, and
 - the **intensive care** is carried out in the **critical care unit** in which case your **consultant** or **recognised facility** should contact **us** at the earliest opportunity.

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

- o you have been discharged from an **NHS critical care unit** to an **NHS** general ward for more than 24 hours, and
- o it is agreed by both your referring and receiving **consultants** that it is clinically safe and appropriate to transfer your care, and
- o **we** have confirmed that your **treatment** is eligible under your **benefits**. However, **we** need full clinical details from your **consultant** before **we** can give **our** decision.

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

Please also see exclusion 19, 'Intensive care' in the section 'What is not covered.'

benefit CC4.2.5 diagnostic tests and MRI, CT and PET scans

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

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

benefit CC4.2.6 therapies

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

benefit CC4.2.7 prostheses and appliances

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

We do not pay for any **treatment** which is for or associated with or related to a **prosthesis** or **appliance** that you are not covered for under your **benefits**.

Benefits for specific medical conditions

Benefit CC5 NHS Cancer Cover Plus

Important: Benefit CC5 also applies to *Treatment members* on the basis set out in benefit T1 and T1.2.

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

- the radiotherapy, chemotherapy or **surgical operation** you need to treat your **cancer** is not available to you from your **NHS**, and
- you have gone through the Open Referral pre-authorisation process and **we** have confirmed to you:
 - the **recognised facility** for your **treatment** for **cancer**, and
 - the **open referral consultant** or **agreed consultant** for your **treatment** for **cancer**.

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

Where the conditions set out above do apply, **we** pay for your **eligible treatment** for **cancer** as follows:

- this benefit note CC5 explains what **we** pay for
 - **out-patient treatment** for **cancer**,
 - **outpatient common drugs, advanced therapies** and **specialist drugs** for **eligible treatment** for **cancer**
 - NHS cash benefit for **treatment** for **cancer**
- for all other **eligible treatment** for **cancer**, including **out-patient** MRI, CT and PET scans **we** pay on the same basis as your **benefits** for other **eligible treatment** as set out in benefits CC2.4, CC3, CC4 and CC7.

When you are receiving **NHS treatment** for **cancer** **we** may, at **our** discretion, pay for certain tests, procedures or **treatment** that are for or directly related to your core **NHS treatment** for **cancer** (details of the tests, procedures or **treatment** that may be covered are available upon request). You must have **our** written agreement before you have such tests, procedures or **treatment** and **we** need full clinical details from your **NHS** consultant before **we** can make **our** decision. **We** will pay for such **treatments** and related **consultant's** fees for **out-patient** consultations relevant to such tests, procedures or **treatment** if all of the following apply to the test, procedure or **treatment**:

- it is a medically essential part of your **NHS treatment** for **cancer**, and
- the test, procedure or **treatment** is carried out in a **recognised facility**, and
- it is requested by your **NHS** consultant oncologist to help determine, assess or refine your **treatment** plan, and
- it is not available to you from your **NHS**.

Where **we** pay for such tests, procedures and **treatment** that is not radiotherapy, chemotherapy or a **surgical operation**, this does not constitute a transfer of your **treatment** from the **NHS** to **Bupa**.

benefit CC5.1 out-patient consultations for cancer

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

We may agree to pay **facility charges** for the use of a consulting room used during your **out-patient** consultation, where we do agree we pay the charge under this benefit CC5.1.

benefit CC5.2 out-patient therapies and charges related to out-patient treatment for cancer

Out-patient therapies

We pay **therapists'** fees for eligible **out-patient treatment** for **cancer** when you are referred for the **treatment** by your **GP** or **consultant**.

If your **consultant** refers you to a medical or health practitioner who is not a **therapist** we may pay the charges as if the practitioner were a **therapist** if all of the following apply:

- o your **consultant** refers you to the practitioner before the **out-patient treatment** takes place and remains in overall charge of your care, and
- o the practitioner has applied for **Bupa** recognition and we have not written to say he/she is not recognised by **Bupa**.

Charges related to out-patient treatment

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

benefit CC5.3 out-patient diagnostic tests for cancer

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

(Out-patient MRI, CT and PET scans are not paid under this benefit – see benefit C2.4.)

benefit CC5.4 out-patient cancer drugs

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

We do not pay for any complementary, homeopathic or alternative products, preparations or remedies for **treatment of cancer**.

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

benefit CC5.5 NHS cash benefit for NHS treatment for cancer

This benefit is not payable at the same time as any other NHS cash benefit for **NHS** treatment.

benefit CC5.5.1 NHS cash benefit: in-patient treatment for cancer

We pay NHS cash benefit for each night of **in-patient** stay that you receive radiotherapy, chemotherapy or a **surgical operation** that is for **cancer treatment**, including **in-patient treatment** related to blood and marrow transplants, when those are carried out in the **NHS**. The **in-patient treatment** must be provided to you free under your **NHS** and **we** only pay if your **treatment** for **cancer** would otherwise have been covered for private **in-patient treatment** under your **benefits** and only as set out in benefit CC5.

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

benefit CC5.5.2 NHS cash benefit: out-patient, day-patient and home treatment for cancer

We pay NHS cash benefit as follows:

- o radiotherapy: for each day radiotherapy is received in a hospital setting
- o chemotherapy: for each day you receive **treatment** for IV-chemotherapy and for each three-weekly interval of oral chemotherapy, or part thereof
- o a **surgical operation**: on the day of your operation,

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

We only pay NHS cash benefit if your **treatment** for **cancer** would otherwise have been covered for private **out-patient** or **day-patient treatment** under your **benefits**. **We** only pay this benefit once even if you have more than one **eligible treatment** on the same day.

Benefit CC6 Mental health treatment

Important: Benefit CC6 also applies to Treatment members on the basis set out in benefits T1 and T1.3.

Your cover is designed to provide help for short- or medium-term medical **treatment** that restores you back to health. Some **mental health conditions** are long-term in nature and may change in nature over time.

We do not pay for any **mental health treatment** for any member who has suffered from or is suffering from a **chronic mental health condition** (see exclusion 34, 'Mental health conditions' in the section 'What is not covered'). If this exclusion applies you will not be covered for this benefit even if your **membership certificate** shows it is covered.

What we pay for mental health treatment

We pay **consultants'** and **mental health and wellbeing therapists'** fees and **facility charges** for **mental health treatment** as follows:

benefit CC6.1 out-patient mental health treatment

We pay fees and charges for **out-patient mental health treatment** as set out in benefits CC6.1.1 to CC6.1.3.

benefit CC6.1.1 consultants' fees

We pay **consultants'** fees for **out-patient mental health treatment** and **out-patient** consultations to assess your **mental health condition**.

benefit CC6.1.2 mental health and wellbeing therapists' fees

We pay **mental health and wellbeing therapists'** fees for **out-patient mental health treatment** when the **treatment** is recommended by your **GP** or **consultant**.

If your **GP** or **consultant** refers you to a medical or health practitioner who is not a **mental health and wellbeing therapist** we may pay the charges as if the practitioner were a **mental health and wellbeing therapist** if all of the following apply:

- your **GP** or **consultant** refers you to the practitioner before the **out-patient treatment** takes place and remains in overall charge of your care, and
- the practitioner has applied for **Bupa** recognition and **we** have not written to say he/she is not recognised by **Bupa**.

benefit CC6.1.3 diagnostic tests

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

(Out-patient MRI, CT and PET scans are not paid under this benefit - see benefit C2.4.)

benefit CC6.2 day-patient and in-patient mental health treatment

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

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

Consultants' fees

We pay **consultants'** fees for **mental health treatment**.

Facility charges

We pay the type of **facility charges** we say **we** pay for in benefit CC4.

Please also see exclusion 6, 'Chronic conditions' and exclusion 29, 'Remote consultations' and exclusion 34, 'Mental health conditions' in the section 'What is not covered'.

Additional benefits

Benefit CC7 Treatment at home

Important: Benefit CC7 also applies to *Treatment members* on the basis set out in benefit T1.

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

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

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

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

Benefit CC8 NHS cash benefit for NHS hospital in-patient treatment

Important: Benefit CC8 also applies to *Treatment members* on the basis set out in benefit T1.

You are only covered for this benefit if your **membership certificate** shows it is covered. If you are covered, your **membership certificate** shows the benefit limits that apply. This benefit does not apply to **treatment for cancer** – NHS cash benefits for **treatment for cancer** are explained in benefit CC5.5.

We pay NHS cash benefit for each night you receive **in-patient treatment** provided to you free under your **NHS**. **We** only pay NHS cash benefit if your **treatment** would otherwise have been covered for private **in-patient treatment** under your **benefits**.

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

WHAT IS NOT COVERED

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

This section does not contain all the limits and exclusions to cover. For example the benefits, set out in the section 'Benefits', also describe some limitations and restrictions for particular types of treatment, services and charges. Also, your **membership certificate** could show changes to the terms of cover including exclusions set out in this membership guide.

Exclusion 1 Ageing, menopause and puberty

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

Exclusion 2 AIDS/HIV

We do not pay for **treatment** for, related to or arising from, AIDS or HIV, including any condition which is related to, or results from, AIDS or HIV.

Exception: **We** pay for **eligible treatment** for or arising from AIDS or HIV if the person with AIDS or HIV:

- o became infected five years or more after their current continuous membership began, or
- o has been covered for this type of **treatment** under a **Bupa** private medical insurance scheme (including under the **agreement**) since at least July 1987 without a break in their cover.

Exclusion 3 Allergies or allergic disorders

We do not pay for **treatment** to de-sensitise or neutralise any allergic condition or disorder.

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

We do not pay for any **treatment**, services or charges that are not covered under your **benefits**. **We** also do not pay for any **treatment** costs in excess of the amounts for which you are covered under your **benefits**.

Exclusion 5 Birth control, conception, sexual problems and sex changes

We do not pay for **treatment**:

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

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

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

Exclusion 6 Chronic conditions

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

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

Exception: **We** pay for **eligible treatment** arising out of a **chronic condition**, or for **treatment** of acute symptoms of a **chronic condition** that flare up. However, **we** only pay if the **treatment** is likely to lead quickly to a complete recovery or to you being restored fully to your previous state of health, without you having to receive prolonged **treatment**. For example, **we** pay for **treatment** following a heart attack arising out of chronic heart disease. This exception does not apply to **treatment** of a **mental health condition**.

Please note: in some cases it might not be clear, at the time of **treatment**, that the disease, illness or injury being treated is a **chronic condition**. **We** are not obliged to pay the ongoing costs of continuing, or similar, **treatment**. This is the case even where **we** have previously paid for this type of or similar **treatment**.

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

Exclusion 7 Complications from excluded conditions/treatment and experimental treatment

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

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

Exclusion 8 Contamination, wars, riots and terrorist acts

We do not pay for **treatment** for any disease, illness or injury arising directly or indirectly from:

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

Exclusion 9 Convalescence, rehabilitation and general nursing care

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

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

Exception 1: For **Combined Care members** and **Treatment members:** **we** may, at **our** discretion, pay for **eligible treatment** for rehabilitation. By rehabilitation **we** mean **treatment** which is aimed at restoring health or mobility or to allow you to live an independent life, such as after a stroke. **We** will only consider cases where the rehabilitation:

- is an integral part of eligible **in-patient treatment**
- takes place in a **recognised facility** that was in the choice of **recognised facilities we** provided to you at pre-authorisation
- starts within 42 days from and including the date you first receive that **in-patient treatment**, and for **Treatment members** is carried out within six months of the discharge date of the **treatment** the rehabilitation is related to.

You must have **our** pre-authorisation before the rehabilitation starts and **we** need full clinical details from your **consultant** before **we** can give **our** decision. If **we** agree **we** pay for up to a maximum of 21 consecutive days' rehabilitation.

Exclusion 10 Cosmetic, reconstructive or weight loss treatment

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

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

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

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

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

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

Exception: For **Combined Care members** and **Treatment members** we pay for an **eligible surgical operation** to restore your appearance when it is needed as a direct result of surgery for **cancer**. **We** only pay if the **eligible surgical operation** for **cancer** takes place during your current continuous period of cover under this **scheme** and any other **Bupa** scheme provided there has been no break in your cover between this **scheme** and the other **Bupa** scheme. **We** will only pay if this is part of the original **eligible treatment** resulting from **cancer** surgery and you have obtained **our** written agreement before receiving the **treatment**.

We pay for **eligible treatment** on the basis set out in benefit CC5 for **Combined Care members** and benefits T1 and CC5 for **Treatment members**.

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

Exclusion 11 Deafness

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

Exclusion 12 Dental/oral treatment

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

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

For **Combined Care members, we** also do not pay for consultations with or **treatment** carried out by a maxillofacial surgeon or dental surgeon.

Exception 1: For **Treatment members we** pay for **treatment** for oral **cancer** but only after **cancer** has been **diagnosed** and only as set out in benefits T1 and CC5 in the section 'Benefits'.

For **Treatment members we** pay for an **eligible surgical operation** carried out by a **consultant** to:

- put a natural tooth back into a jaw bone after it is knocked out or dislodged in an unexpected accidental injury
- treat a jaw bone cyst, but not if it is related to a cyst or abscess on the tooth root or any other tooth or gum disease or damage
- surgically remove a complicated, buried or impacted tooth root, such as an impacted wisdom tooth, but not if the purpose is to facilitate dentures or the **acute condition** relates to a **pre-existing condition** or a **moratorium condition**

but only as set out in benefit T1 in the section 'Benefits'.

Exception 2: For **Combined Care members we** pay for:

- **treatment** for oral **cancer**
- consultations with and **treatment** carried out by a **consultant** maxillofacial surgeon or **consultant** dental surgeon when the consultation or **treatment** is for **eligible treatment for cancer**

but only after **cancer** has been **diagnosed** and only as set out in benefit CC5 in the section 'Benefits'.

Exclusion 13 Dialysis

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

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

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

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

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

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

We do not pay for any complementary or alternative therapy products or preparations, including but not limited to homeopathic remedies or substances,

regardless of who they are prescribed or provided by or the type of **treatment** or medical condition they are used or prescribed for.

Exception: For **Combined Care members, we** pay for **out-patient common drugs, advanced therapies** and **specialist drugs** for **eligible treatment** of **cancer** but only as set out in benefits CC5 in the section 'Benefits'.

For **Treatment members, we** pay for **out-patient common drugs, advanced therapies** and **specialist drugs** for **eligible treatment** of **cancer** but only as set out in benefits T1 and CC5 in the section 'Benefits'.

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

Exclusion 15 Excluded treatment or medical conditions

We do not pay for:

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

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

Exclusion 16 Experimental drugs and treatment

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

Exception: For **Combined Care members** and **Treatment members we** may pay for this type of **treatment** of an **acute condition**. However, you will need **our** pre-authorisation before the **treatment** is received and **we** need full clinical details from your **consultant** before **we** can give **our** decision.

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

Exclusion 17 Eyesight and eye conditions

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

For **Combined Care members: we** also do not pay for:

- any **treatment** for, related to or arising from any eye condition including but not limited to cataracts, detached retina or glaucoma
- any consultations with or **treatment** carried out by an ophthalmologist.

Exception 1: For **Treatment members: we** pay for **eligible treatment** for your eyesight if it is needed as a result of an injury or an **acute condition** but only as set out in benefit T1 in the section 'Benefits'.

Exception 2: For **Combined Care members: we** pay for:

- o **treatment** for **cancer** of the eye and
- o consultations with and **treatment** carried out by a **consultant** ophthalmologist when the **treatment** and consultation is for **eligible treatment** for **cancer**

but only after **cancer** has been **diagnosed** and only as set out in benefit CC5 in the section 'Benefits'.

Exclusion 18 Pandemic

We do not pay for **treatment** for or arising from any pandemic disease and/or epidemic disease. By pandemic **we** mean the worldwide spread of a disease with epidemics occurring in many countries and most regions of the world. By epidemic **we** mean more cases of a disease than would be expected for that disease in that area at that time.

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

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

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

We do not pay for any **intensive care**, or any other **treatment** in a **critical care unit**, if it is not routinely required as a medically essential part of the **eligible treatment** being carried out.

Exception: For **Combined Care members: we** pay for **eligible treatment** for **intensive care** but only as set out in benefit CC4.2.4 in the section 'Benefits'.

For **Treatment members: we** pay for **eligible treatment** for **intensive care** but only as set out in benefits T1 in the section 'Benefits'.

Please also see 'Treatment, healthcare practitioners and facilities that have not been pre-authorized' in this section.

Exclusion 20 Learning difficulties, behavioural and developmental problems

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

Exclusion 21 Overseas treatment

We do not pay for **treatment** that you receive outside the **United Kingdom**.

Exclusion 22 Physical aids and devices

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

Exception: For **Combined Care members we** pay for **prostheses** and **appliances** as set out in benefit CC4.2.7 in the section 'Benefits'.

For **Treatment members we** pay for **prostheses** and **appliances** as set out in benefit T1 in the section 'Benefits'.

Exclusion 23 Pre-existing conditions

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

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

- o **you** have been sent your **membership certificate** which lists the person with the **pre-existing condition** (whether this is **you** or one of **your dependants**)
- o **you** gave us all the information **we** asked **you** for, before **we** sent **you your** first membership certificate listing the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**
- o neither **you** nor the person with the **pre-existing condition** knew about it before **we** sent **you your** first membership certificate which lists the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**, and
- o **we** did not exclude cover (for example under a **special condition**) for the costs of the **treatment**, when **we** sent **you your membership certificate**.

Exclusion 24 Pregnancy and childbirth

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

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

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

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

Exception 2: **We** may pay for the delivery of a baby by caesarean section when the life of the member (mother) is in immediate danger or would be put at direct risk by vaginal delivery. However, **we** need full clinical details from your **consultant** before **we** can give **our** decision.

Exception 3: **We** pay for **eligible treatment** of an **acute condition** of the member (mother) that relates to pregnancy or childbirth but only if all the following apply:

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

Please also see 'Birth control, conception, sexual problems and sex changes', 'Screening, monitoring and preventive treatment' and 'Chronic conditions' in this section.

Exclusion 25 Screening, monitoring and preventive treatment

We do not pay for:

- health checks or health screening, by health screening **we** mean where you may not be aware you are at risk of, or are affected by a disease or its complications but are asked questions or have tests to find out if you are and which may lead to you needing further tests or **treatment**
- routine tests, or monitoring of medical conditions, including:
 - routine antenatal care or screening for and monitoring of medical conditions of the mother or foetus during pregnancy
 - routine checks or monitoring of **chronic conditions** such as diabetes mellitus or hypertension
- tests or procedures which, in **our** reasonable opinion based on established clinical and medical practice, are carried out for screening or monitoring purposes, such as endoscopies when no symptoms are present
- preventive **treatment**, procedures or medical services.

Exception: If you are being treated for **cancer**, have strong direct family history of **cancer** and your **consultant** has advised that you receive a genetically-based test to evaluate future risk of developing further cancers, **we** may at **our** discretion cover this test as well as the recommended prophylactic surgery when it is recommended by your **consultant**. You must have **our** written agreement before you have tests, procedures or **treatment** and **we** will need full clinical details from your **consultant** before **we** can give **our** decision.

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

Exclusion 26 Sleep problems and disorders

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

Exclusion 27 Special conditions

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

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

Please also see the 'Covering a newborn baby' rule in the section 'How your membership works'.

Exclusion 28 Speech disorders

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

Exception: **We** may, at **our** discretion, pay for short-term speech therapy when it is part of **eligible treatment**. The speech therapy must be provided by a **therapist** who is a member of the Royal College of Speech and Language Therapists.

Exclusion 29 Remote consultations

We do not pay for any remote consultations by telephone or any other remote medium with a **consultant, therapist, mental health and wellbeing therapist** or any other healthcare professional, unless such healthcare professional is at the time of your **treatment** recognised by **us** to carry out remote consultations and is on **our** list of **recognised practitioners**, which is available on request or you can access these details at finder.bupa.co.uk

Exclusion 30 Temporary relief of symptoms

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

Exception 1: For **Combined Care members**

- o **we** may pay for this type of **treatment** if you need it to relieve the symptoms of a terminal disease or illness
- o **we** pay for this type of **treatment** for **eligible treatment of cancer** but only as set out in the 'Combined Care' section in the section 'Benefits'.

Exception 2: For **Treatment members**

- o **we** may pay for this type of **treatment** if you need it to relieve the symptoms of a terminal disease or illness
- o **we** pay for this type of **treatment** for **eligible treatment of cancer**

but only as set out in the 'Treatment' section in the section 'Benefits'.

Exclusion 31 Treatment, healthcare practitioners and facilities that have not been pre-authorised

We do not pay any fees or charges for **treatment** that has not been pre-authorised by **us**.

We do not pay any fees or charges for **treatment** carried out by a **consultant, therapist, mental health and wellbeing therapist** or other healthcare provider who was not included in the choice of such providers that **we** provided to you when you pre-authorised the **treatment** with **us**.

We do not pay any fees or charges for **treatment** carried out in a **treatment** facility that was not included in the choice of **recognised facilities** that **we** provided to you when you pre-authorised the **treatment** with **us**.

Important: If you are admitted to an **NHS** hospital for **treatment** and then wish to transfer from **NHS** to private **treatment** you must still call **us** to pre-authorise your private **treatment** before you arrange or receive any such **treatment**. This applies regardless of whether your being an **NHS** patient starts by you going to an **NHS** accident and emergency department or through an **NHS** emergency admission or being admitted for pre-planned **NHS** treatment. Any fees or charges you incur for **treatment** that has not been pre-authorised by **us** are your responsibility.

Exclusion 32 Unrecognised medical practitioners, providers and facilities

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

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

- the consultant, medical practitioner, therapist, complementary medicine practitioner, mental health and wellbeing therapist or other healthcare professional is:
 - not recognised by **Bupa** for treating the medical condition you have and/or for providing the type of **treatment** you need, and/or
 - is not included in the choice of **recognised practitioners** that **we** provide you with when you call to pre-authorise
- the hospital or treatment facility is:
 - not recognised by **Bupa** for treating the medical condition you have and/or for providing the type of **treatment** you need, and/or
 - is not included in the choice of **recognised facilities** **we** provide you with when you call to pre-authorise
- the hospital or treatment facility or any other provider of services is not recognised by **us** and/or **we** have sent a written notice saying that **we** no longer recognise them for the purpose of **our** private medical insurance schemes.

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

- where **we** do not recognise them as having specialised knowledge of, or expertise in, the **treatment** of the disease, illness or injury being treated

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

Exclusion 33 Moratorium conditions

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

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

Exclusion 34 Mental health conditions

For **Combined Care members** and **Treatment members, we** do not pay for any **mental health treatment** for any member who has suffered from or is suffering from a **chronic mental health condition**.

For **Diagnosis members we** do not pay for the diagnosis of any **mental health condition**.

Exclusion 35 Non-diagnostic treatment

For **Diagnosis members we** do not pay for:

- any **treatment** including any consultation or **surgical operation**, which is undertaken for any purpose other than to help diagnose your disease, illness or injury
- any **diagnostic tests** or **surgical operations** undertaken for the diagnosis of your disease, illness or injury when **treatment** that is intended to relieve or cure a disease, illness or injury is carried out at the same time as your **diagnostic test** or **surgical operation**.

Exception: We pay for **treatment** intended to relieve or cure a disease illness or injury when it is provided as part of a **diagnostic test** and carried out during the same theatre time as the **diagnostic test** but only if:

- the **diagnostic test** is commenced solely for the purpose of the diagnosis of your disease, illness or injury, and
- the **treatment** carried out was unplanned but medically necessary, and
- the **treatment** relates to an **arthroscopy procedure** of the knee or a **coronary angioplasty procedure**.

Exclusion 36 Complementary medicine

We do not pay for any complementary medicine including osteopathy, chiropractic or acupuncture.

Exclusion 37 Skin conditions

For **Combined Care members we** do not pay for **treatment** for, related to or arising from any skin conditions. **We** also do not pay for any consultations with or **treatment** carried out by a dermatologist.

Exception: **We** pay for **eligible treatment** for **cancer** for malignant melanoma but only after malignant melanoma has been **diagnosed** and only as set out in benefit CC5 in the section 'Benefits'.

Exclusion 38 Muscle, bone and joint conditions

For **Combined Care members we** do not pay for **treatment** for, related to or arising from any muscle, bone or joint condition anywhere in your body. **We** also do not pay for any consultations with or **treatment** carried out by a consultant, therapist or healthcare practitioner in any of the muscle, bone or joint medicine specialities.

Exception 1: **We** pay for **eligible treatment** for **cancer** of muscles, joints and bones but only after **cancer** has been **diagnosed** and only as set out in benefit CC5 in the section 'Benefits'.

Exception 2: **We** pay for physiotherapy carried out as **eligible treatment** by a **therapist** who is a physiotherapist but only as set out in benefit CC2.2 in the section 'Benefits'.

Exclusion 39 Consultations and diagnostic tests carried out before treatment

For **Treatment members we** do not pay for any **treatment**, including **out-patient** consultations and **diagnostic tests** or diagnostic procedures or scans, that are carried out before your **acute condition** has been **diagnosed** except when it is part of **eligible treatment** of cancer as set out in benefits T1 and CC5.

Except for **eligible treatment** for **cancer we** do not pay for any **out-patient** consultations or **out-patient diagnostic tests** or scans unless:

- they follow and are directly related to **out-patient treatment, day-patient treatment, in-patient treatment**, or an out-patient surgical operation carried out to treat your **acute condition**, and
- follow within six months of the discharge date of that **treatment**.

Exception 1: for **eligible treatment** for **cancer we** will pay for diagnostic **treatment**, including **out-patient** consultations and **diagnostic tests** or diagnostic procedures or scans, when:

- required as a medically essential part of the planning or carrying out of your **treatment** for **cancer**, and
- **we** confirm at pre-authorisation that we will pay for such **treatment**

in which case **we** will pay on the basis set out in benefits T1 and CC5.

Exception 2: **we** may pay for one initial **out-patient** consultation with a consultant before you receive **treatment** for your **acute condition** but only if:

- the consultant who **diagnosed** your **acute condition** is not an **open referral consultant**, and
- as a result of the Open Referral process for pre-authorising **treatment** for that **acute condition** you choose to use an **open referral consultant**, and
- **we** confirm at that Open Referral pre-authorisation that **we** will pay for such an out-patient consultation with the **open referral consultant** you choose

in which case we will pay on the basis set out in benefit T1.

GLOSSARY

Words and phrases printed in bold and italic in these rules and benefits have the meanings set out below.

Word / Phrase	Meaning
<i>Acute condition</i>	a disease, illness or injury that is likely to respond quickly to <i>treatment</i> which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
<i>Advanced therapies</i>	new and innovative targeted/bespoke therapies using advanced materials and methods to be used as part of your <i>eligible treatment</i> that are at the time of your <i>eligible treatment</i> included on <i>our</i> list of advanced therapies that applies to your <i>benefits</i> , which is available at <i>bupa.co.uk/policyinformation</i> and on request. The advanced therapies on the list may change from time to time.
<i>Agreed consultant</i>	for <i>Combined Care members</i> , a <i>consultant</i> who is not an <i>open referral consultant</i> but who Bupa agrees at Open Referral pre-authorisation that you may choose to stay with for continuity of care or because of a referral from your diagnosing consultant for <i>treatment of cancer</i> . for <i>Treatment members</i> a <i>consultant</i> who is not an <i>open referral consultant</i> but who <i>Bupa</i> agrees at Open Referral pre-authorisation that you may choose to stay with for continuity of care or because of a referral from your diagnosing consultant for <i>treatment</i> .
<i>Agreement</i>	the agreement between the <i>sponsor</i> and <i>us</i> under which you have cover for your <i>benefits</i> .
<i>Appliance</i>	any appliance which is in <i>our</i> list of appliances for your <i>benefits</i> at the time you receive your <i>treatment</i> . The list of appliances may change from time to time. Details of the appliances are available on request.
<i>Arthroscopy procedure</i>	an internal joint investigation which at the time your current period of cover began was included on the list of arthroscopy procedures used by <i>Bupa</i> for the purpose of providing benefits for <i>Diagnosis members</i> under this <i>scheme</i> . Details of the list are available on request.
<i>Benefits</i>	the benefits specified in your <i>membership certificate</i> for which you are entitled as an individual under the <i>scheme</i> subject to the terms and conditions that apply to your membership in this Bupa membership guide including all exclusions.
<i>Bupa</i>	Bupa Insurance Limited. Registered in England and Wales No. 3956433. Registered office: Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA. Bupa provides the cover.
<i>Cancer</i>	a malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Word / Phrase	Meaning
Chronic condition	<p>a disease, illness or injury which has one or more of the following characteristics:</p> <ul style="list-style-type: none"> ○ it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests ○ it needs ongoing or long-term control or relief of symptoms ○ it requires rehabilitation or for you to be specially trained to cope with it ○ it continues indefinitely ○ it has no known cure ○ it comes back or is likely to come back.
Chronic mental health condition	<p>a mental health condition which either:</p> <ul style="list-style-type: none"> ○ meets the definition of a chronic condition; or ○ is a mental health condition, or is related to any mental health condition, for which benefits for mental health treatment have been paid by Bupa in three different membership years, which need not be consecutive or relate to the same scheme. This applies to all Bupa administered plans you have been a member of in the past, or may be a member of in the future, whether your membership is continuous or not. <p>(A “membership year” in this definition means the period from:</p> <ul style="list-style-type: none"> ○ the date you started cover under any Bupa scheme to the day before the renewal date for that scheme or the date cover ended; or ○ the renewal date for any Bupa scheme to the day before the next renewal date for that scheme or the date cover ended. <p>For the avoidance of doubt, any reference to a Bupa scheme includes a Bupa administered plan.)</p>
Combined Care member	<p>a member whose membership certificate shows the product tier that applies to them is Foundations – Combined Care.</p>
Common drugs	<p>commonly used medicines, such as antibiotics and painkillers that in our reasonable opinion based on established clinical and medical practice should be used as part of your eligible treatment.</p>

Word / Phrase	Meaning
Consultant	<p>a registered medical or dental practitioner who, at the time you receive your treatment:</p> <ul style="list-style-type: none"> o is recognised by us as a consultant and has received written confirmation from us of this, unless we recognised him or her as being a consultant before 30 June 1996 o is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and o is in our list of consultants that applies to your benefits <p>You can contact us to find out if a medical or dental practitioner is recognised by us as a consultant and the type of treatment we recognise them for.</p>
Consultant fees schedule	<p>the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants' fees based on:</p> <ul style="list-style-type: none"> o the type of treatment carried out o for surgical operations, the type and complexity of the surgical operation according to the schedule of procedures - the benefits available for consultant surgeons and consultant anaesthetists may differ for the same surgical operation o the Bupa recognition status of the consultant, and o where the treatment is carried out both in terms of the treatment facility and the location. <p>The schedule may change from time to time. Details of the schedule are available on request.</p>
Coronary angioplasty procedure	<p>a procedure to unblock blood vessels that supply the heart muscle with blood and which at the time your current period of cover began was included on the list of coronary angioplasty procedures used by Bupa for the purpose of providing benefits for Diagnosis members under this scheme. Details of the list are available on request.</p>
Critical care unit	<p>any intensive care unit, intensive therapy unit, high dependency unit, coronary care unit or progressive care unit which is in our list of critical care units and recognised by us for the type of intensive care that you require at the time you receive your treatment. The units on the list and the type of intensive care that we recognise each unit for may change from time to time. Details of these critical care units are available on request.</p>
Day-patient	<p>a patient who is admitted to a hospital, treatment facility or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.</p>
Day-patient treatment	<p>eligible treatment, that, for medical reasons, is received as a day-patient.</p>
Dependant	<p>your partner and any child of yours who, with the sponsor's approval, is a member under the agreement.</p>
Diagnosed	<p>the confirmation of a disease, illness or injury by a consultant following diagnosis.</p>

Word / Phrase	Meaning
Diagnostic tests	investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.
Diagnosis member	a member whose membership certificate shows the product tier that applies to them is Foundations – Diagnosis.
Eligible surgical operation	eligible treatment carried out as a surgical operation .
Eligible treatment	<p>treatment of an acute condition together with the products and equipment used as part of the treatment that:</p> <ul style="list-style-type: none"> ○ are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the UK ○ are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided ○ are demonstrated through scientific evidence to be effective in improving health outcomes, and ○ are not provided or used primarily for the expediency of you or your consultant or other healthcare professional <p>and the treatment, services or charges are covered and not excluded under your benefits.</p>
Excess	the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits .
Facility charges	the charges we pay to recognised facilities for your eligible treatment . The amount we pay for facility charges depends on whether the recognised facility you use is included in the choice of recognised facilities we provide you with when you call to pre-authorise.
Fee assured partner	a consultant who, at the time of your treatment , is recognised by us as a fee assured partner. You can contact us to find out if a consultant is a fee assured partner .
GP	<p>a doctor who, at the time he/she refers you for your consultation or treatment, is on the UK General Medical Council's General Practitioner Register, and</p> <ul style="list-style-type: none"> ○ has seen you whilst practising in the NHS primary care setting as an NHS GP, or ○ is a private sector GP who is recognised by us as an independent general practitioner for the purposes of your scheme.
Home	<ul style="list-style-type: none"> ○ the place where you normally live or ○ any other establishment, including a non-healthcare setting, which we may decide to treat as a home for the purpose of your benefits.
In-patient	a patient who is admitted to a hospital or treatment facility and who occupies a bed overnight or longer for medical reasons.
In-patient treatment	eligible treatment that, for medical reasons, is received as an in-patient .

Word / Phrase	Meaning
Intensive care	eligible treatment for intensive care, intensive therapy, high dependency care, coronary care or progressive care.
Main member	the person who is covered under the agreement by virtue of being eligible in his or her own right rather than as a dependant .
Medical treatment provider	a person or company who is recognised by us as a medical treatment provider for the type of treatment at home that you need at the time you receive your treatment . These medical treatment providers and the type of treatment we recognise them for may change from time to time. Details of these medical treatment providers and the type of treatment we recognise them for are available on request.
Membership certificate	the most recent membership certificate that we issue to you for your current continuous period of membership under the agreement .
Mental health and wellbeing therapist	<ul style="list-style-type: none"> ○ a psychologist registered with the Health Professions Council ○ a psychotherapist accredited with the UK Council for Psychotherapy, the British Association for Counselling and Psychotherapy or the British Psychoanalytical Council ○ a counsellor accredited with the British Association for Counselling and Psychotherapy or ○ a cognitive behavioural therapist accredited with the British Association for Behavioural and Cognitive Psychotherapies <p>who is a recognised practitioner. You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.</p>
Mental health condition	a mental health condition, including alcoholism, drug addiction, anorexia nervosa and bulimia nervosa.
Mental health day-patient treatment	mental health treatment which for medical reasons means you have to be admitted to a facility because you need a period of clinically-supervised mental health treatment as a day case but do not have to occupy a bed overnight and the mental health treatment is provided on either an individual or group basis.
Mental health in-patient treatment	mental health treatment that, for medical reasons, is received as an in-patient .
Mental health treatment	eligible treatment of a mental health condition .

Word / Phrase	Meaning
Moratorium condition	<p>any disease, illness or injury or related condition, whether diagnosed or not, which you:</p> <ul style="list-style-type: none"> ○ received medication for ○ asked for or received, medical advice or treatment for ○ experienced symptoms of, or ○ were to the best of your knowledge aware existed <p>in your moratorium qualifying period immediately before your start date. By a related condition we mean any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury. We may take your cover under a previous scheme into account when assessing if a condition is a moratorium condition but we will only do this if we have specifically agreed with the sponsor that we will do this under the agreement and you have provided us with evidence of your continuous cover under the previous scheme.</p>
Moratorium member	a member whose membership certificate shows the underwriting method applied to them is moratorium.
Moratorium qualifying period	the moratorium qualifying period described in the further details section of your membership certificate .
Moratoria start date	the moratoria start date shown on your membership certificate .
NHS	the National Health Service operated in Great Britain and Northern Ireland.
Nurse	a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.
Open Referral consultant	a consultant who, when you phone us to go through your Open Referral pre-authorisation process for treatment of an acute condition , is in the choice of fee assured partners that we provide to you during your Open Referral pre-authorisation for that treatment .
Out-patient	a patient who attends a hospital, consulting room, out-patient clinic or treatment facility and is not admitted as a day-patient or an in-patient .
Out-patient surgical operation	an eligible surgical operation received as an out-patient .
Out-patient treatment	eligible treatment that, for medical reasons, is received as an out-patient .

Word / Phrase	Meaning
Partner	you husband or wife or civil partner or the person you live with in a relationship similar to that of a husband and wife whether of the opposite sex or not.
Pre-existing condition	any disease, illness or injury for which in the seven years before your start date : <ul style="list-style-type: none"> ○ you have received medication, advice or treatment; or ○ you have experienced symptoms whether the condition was diagnosed or not.
Previous scheme	<ul style="list-style-type: none"> ○ another Bupa private medical insurance scheme or Bupa administered medical healthcare trust ○ a private medical insurance scheme or medical healthcare trust provided or administered by another insurer that we specifically agree with the sponsor will be treated as a previous scheme for the purpose of assessing moratoria start date or continuous periods of cover provided that there is no break in a member's cover between the previous scheme and their current scheme .
Prosthesis	any prosthesis which is in our list of prostheses for both your benefits and your type of treatment at the time you receive your treatment . The prostheses on the list may change from time to time. Details of the prostheses covered under your benefits for your type of treatment are available on request.
Recognised facility	<ul style="list-style-type: none"> ○ a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our recognised facility list that applies to your benefits, and is recognised by us for both: <ul style="list-style-type: none"> - treating the medical condition you have and - carrying out the type of treatment you need ○ any other establishment which we may decide to treat as a recognised facility for the purpose of the scheme. The hospitals, treatment facilities, centres or units in the list and the medical conditions and types of treatment we recognise them for may change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.
Recognised practitioner	a healthcare practitioner who at the time of your treatment : <ul style="list-style-type: none"> ○ is recognised by us for the purpose of our private medical insurance schemes for treating the medical condition you have and for providing the type of treatment you need, and ○ is in our list of recognised practitioners that applies to your benefits.
Renewal date	the date each year agreed between the sponsor and us on which the group cover is due for renewal.

Word / Phrase	Meaning
Schedule of procedures	the schedule used by Bupa for the purpose of providing benefits which classifies surgical operations according to their type and complexity. The schedule may change from time to time. Not all procedures listed in the schedule are covered under Bupa schemes. Further information on the schedule is available on request.
Scheme	the cover we provide as shown on your membership certificate together with this Bupa membership guide subject to the terms and conditions of the agreement .
Special condition	any exclusions or restrictions to cover that are personal to an individual based on the medical history given to us for that individual. If special conditions apply to a member's cover these are shown in the 'Special conditions' section for that member in your membership certificate .
Specialist drugs	drugs and medicines to be used as part of your eligible treatment , which are not common drugs and are at the time of your eligible treatment included on our list of specialist drugs that applies to your benefits that is available at bupa.co.uk/policyinformation and on request. The specialist drugs on the list may change from time to time.
Sponsor	the company, firm or individual with whom we have entered into an agreement to provide cover.
Start date	the date you started your current continuous period of cover under the scheme .
Surgical operation	a surgical procedure or complex investigative/diagnostic procedure including all medically necessary treatment related to the procedure and all consultations carried out from the time you are admitted to a facility until the time you are discharged, or if it is carried out as out-patient treatment , all medically necessary treatment related to the operation and any consultation on the same day which is integral to the operation.
Therapist	<ul style="list-style-type: none"> ○ a chartered physiotherapist ○ a British Association of Occupational Therapists registered occupational therapist ○ a British and Irish Orthoptic Society registered orthoptist ○ a Royal College of Speech and Language Therapists registered speech and language therapist; or ○ a chiropodist or podiatrist <p>who is Health Professions Council Registered and is a recognised practitioner. You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.</p>
Treatment	surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.

Word / Phrase	Meaning
Treatment member	a member whose membership certificate shows the Product tier that applies to them is Foundations - Treatment.
Underwritten member	a member who as part of his/her application for cover under the agreement was required to provide (or the main member provided on his/her behalf) details of his/her medical history to us for the purpose of underwriting.
United Kingdom/UK	Great Britain and Northern Ireland only.
We/our/us	Bupa
Year	<ul style="list-style-type: none"> ○ when you first become a member under the scheme this is the period beginning on your start date and ending on the day before the renewal date ○ for continuing members this is the period beginning on the renewal date and ending on the day before the next renewal date.
You/your	this means the main member only.

BUPA PRIVACY NOTICE

Confidentiality: The confidentiality of patient and member information is of paramount concern to the companies in the Bupa Group. To this end, we comply with Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf. Such processing, which may be outside of the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security, in addition to the obligations imposed by the Data Protection Act.

Medical information: Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care.

Audit of medical and billing information: When we process claims or investigate complaints on your behalf, Bupa may request and obtain further details from your treatment provider. The information may be sought either at the time of processing or subsequently, for the purposes of ensuring the accuracy of information and the quality of treatment and care. Please note it is a term and condition of your policy that Bupa may obtain medical and billing information from your treatment provider relating to claims or complaints you may make.

Member details: All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main member. Your membership and contact details may be shared by the companies in the Bupa Group to enable us to manage our relationship with you as a Bupa customer and update and improve our records. Bupa does not share the names, addresses and other contact details of our members with other organisations.

Telephone calls: In the interest of continuously improving our services to members, calls may be recorded and may be monitored.

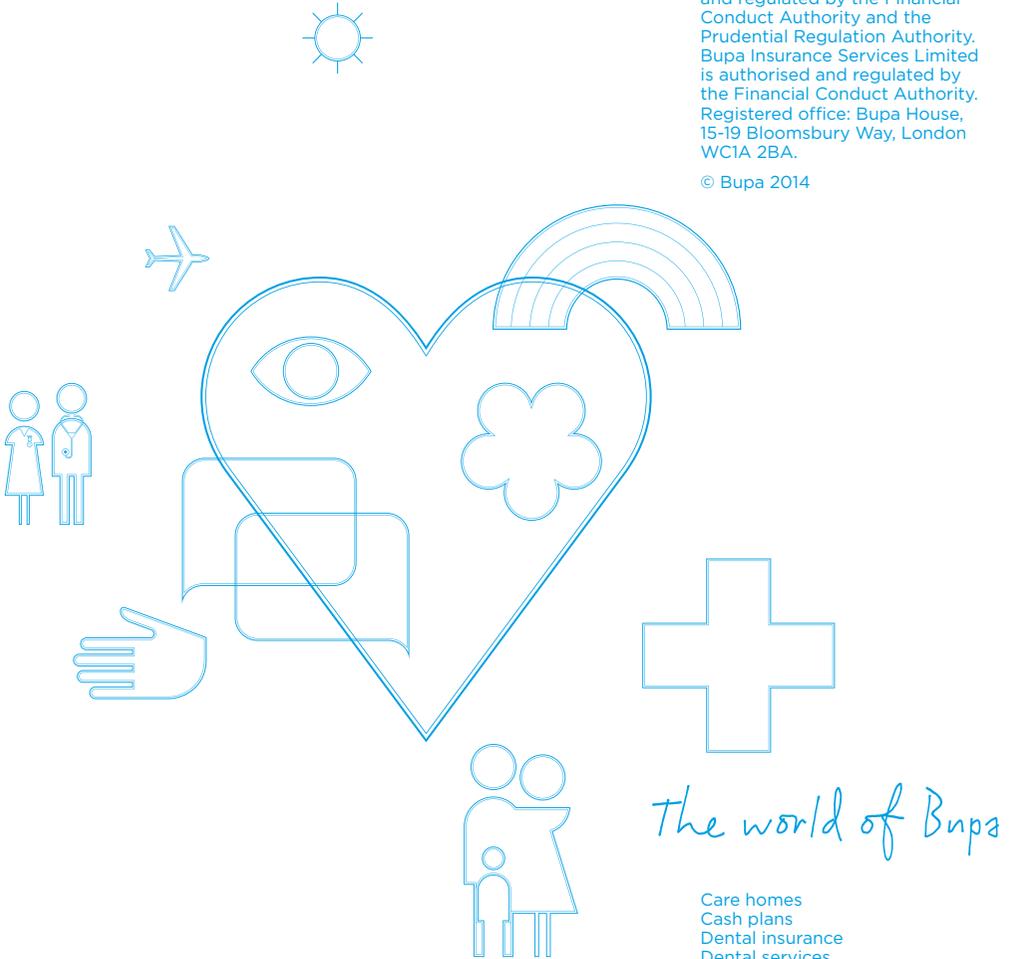
Research: Anonymised or aggregated data may be used by us, or disclosed to others, for research or statistical purposes.

Fraud: Information may be disclosed to others with a view to detecting and/or preventing fraudulent or improper claims.

Keeping you informed: The Bupa Group would, on occasion, like to keep you informed of the Bupa Group's products and services that we consider may be of interest to you. If you do not wish to receive information about our products and services, or have any other Data Protection queries, please write to: Bupa UK Information Governance Team, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3DZ or contact us via email at: DataProtection@bupa.com

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The world of Bupa

Care homes
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