

Your Bupa membership guide

Bupa Select

Essential information explaining your Bupa cover

Please retain



About this guide

Welcome to your Bupa Select membership guide

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

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

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

How do I know what I'm covered for?

The precise details of the cover **you** have chosen are listed on your **membership certificate**. Please read this membership guide together with your **membership certificate** and any **confirmation of special conditions**, as together they set out full details of how your health insurance works. **We** will send a **confirmation of special conditions** for anyone to whom a **special condition** applies.

How does the membership guide work with my membership certificate?

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

Bupa Anytime HealthLine[^]

If you have any questions or worries about your health call **our** confidential Bupa Anytime HealthLine on **0345 604 0777***. **Our** qualified nursing team is on hand 24 hours a day, so whatever your health question or concern, they have the skills and practical, professional experience to help.

Family Mental HealthLine[^]

If you are a parent or care for a young person, and have concerns about their mental wellbeing, **our** Family Mental HealthLine is available to provide advice, guidance and support. A trained adviser and/or mental health nurse will listen to what your family is experiencing and give you advice about what to do next. Call **our** Family Mental HealthLine on **0345 266 7938*†**. The young person does not have to be covered under your policy for you to be able to use this service.

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

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

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

How do I contact Bupa?

We are always on hand to help.

Bupa digital account

Creating an account provides on the go access to your **Bupa** policy. Giving you a comprehensive, personalised view of your cover in one place, visit **bupa.co.uk** to create an account or download the Bupa Touch App. From here you can call or use webchat to get in touch, which is the quickest way of reaching **us**.



Call

For any queries about your cover please call **us** on the dedicated number found on your **membership certificate**. **We** may record or monitor **our** calls.



Webchat

You can now chat with **us** either using your Bupa digital account, or by visiting **bupa.co.uk**. You can use this service to ask general queries and authorise **treatment**. **We** may ask you to call **us** based on your needs.



If you have difficulties

For those with hearing or speech difficulties you can use the Relay UK service on your smartphone or textphone. For further information visit **www.relayuk.bt.com**. **We** also offer documents in Braille, large print or audio.



Write

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

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Your rules and benefits

Effective from 1 January 2023

These are the rules and benefits of Bupa Select

They apply to members of the *scheme* whose 'Group contract start date', as stated in the Group details section of their *membership certificate*, is on or after the 'Effective from' date.

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

Important note

Please read this note before you read the rest of this membership guide as it explains how this membership guide, your *membership certificate* and any *confirmation of special conditions* work together. We will send a *confirmation of special conditions* for anyone to whom a *special condition* applies.

Together, these are your membership documents and 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 members. It also contains all the elements of cover that can be provided under Bupa Select. **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 on your *membership certificate* as 'not covered', or
- do not appear on your *membership certificate*

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

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

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

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

How your membership works

The agreement between the sponsor and us

Your cover is provided under a group insurance policy governed by the **agreement** and the terms and conditions of your membership have been agreed between your **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**. However:

- if **you** are a **contributing member you** will have legal rights as set out in this membership guide. Please see the section 'Contributing members'
- if **you** are not a **contributing member we** allow you access to the claims and complaints processes as set out in this membership guide.

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 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.
- **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** or **co-insurance** applies to your cover and if it does, the amount and how it applies.
- **Confirmation of special conditions:** **we** will send a **confirmation of special conditions** for anyone to whom a **special condition** applies.

Payment of benefits

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

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

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

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

Please also see the section 'Claiming'.

When your membership starts, renews and ends

Starting membership

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

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

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

Cover for a newborn baby

If the **sponsor** agrees, **you** may apply to include **your** newborn baby under **your** membership as one of **your dependants**. If your baby's 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 exclusion for **moratorium conditions** to the baby's cover – see Exclusion 33 in the section 'What is not covered'

but only if both the following apply:

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

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

Renewal of your membership

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

If you are a **contributing member** please see the section 'Contributing members'.

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 any of **your dependants** you must write to **us**. If **your** membership ends the membership of all **your dependants** will also end.

If you are a **contributing member** please see the section 'Contributing members'.

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. If you are a **contributing member** please see the section 'Contributing members'.
- **you** stop living in the **UK** (**you** must inform **us** if **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** (**you** must inform **us** if that **dependant** stops living in the **UK**), or
- that **dependant** dies.

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

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

When **your** membership or **your dependants'** membership ends, **we** may be able to offer **you** or them continuation of membership on a **Bupa** personal policy as an ex-group scheme member depending upon how long **you** or they have been a **Bupa** group scheme member.

- If **you** or they are an **underwritten member** this would allow you or them to transfer without any additional **special conditions**
- If **you** or they are a **moratorium member** this would allow **you** or them to transfer without a change to the **moratorium start date** that applies to **you** or them under the **Bupa** group scheme

but only if, in each case, **you** or they transfer within three months of the date **your** or their cover under the **Bupa** group scheme ends without any break in **your** or their cover. If **you** would like to consider this option please call **0800 600 500** to discuss it with **us**. **We** may record or monitor **our** calls.

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**. Bupa Insurance Services Limited acts as **our** agent for arranging and administering **your** policy. Subscriptions are collected by Bupa Insurance Services Limited as **our** agent for the purpose of receiving, holding and refunding premiums and claims monies.

If you are a **contributing member** please see the section 'Contributing members'.

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**.

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.

If you are a **contributing member** please see the section 'Contributing members'.

General information

Change of address

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

Correspondence and documents

Membership documents are sent to the **main member**. However, a **confirmation of special conditions** will be sent, for anyone to whom a **special condition** applies, to the **main member** or to the **dependant** when they are aged 16 or over.

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

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

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

Bupa digital account

When **you** or any **dependant** over 16 provides **us** with an email address, **we** will invite **you** or **your dependant** by email to create a Bupa digital account.

Applicable law

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

Private Healthcare Information Network

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

Making a complaint

We are sorry if you need to complain. **We** will do **our** best to understand what has happened and put things right.

Ways to get in touch

- Call us: using your **Bupa** helpline phone number, which can be found on your **membership certificate**. If you can't find your **Bupa** helpline phone number, you can contact Customer Relations on **0345 606 6739**[†]
- Chat to us online: **bupa.co.uk/complaints**
- Email us: **customerrelations@bupa.com**
If you need to send **us** sensitive information you can email **us** securely using Egress. For more information and to sign up for a free Egress account, go to **https://switch.egress.com**. You will not be charged for sending secure emails to a **Bupa** email address using the Egress service.
- Write to us: **Customer Relations, Bupa, Bupa Place, 102 The Quays, Salford M50 3SP**

What happens with my complaint?

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

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

If **we** have not resolved your complaint within eight weeks, or if you are unhappy with **our** decision, you may be able to refer your complaint to the Financial Ombudsman Service for an independent review. The service they provide is free and impartial. You can visit their website, **financial-ombudsman.org.uk**, or:

- call them on **0800 023 4567**
- submit a complaint online at **financial-ombudsman.org.uk/contact-us/complain-online**
- email them at **complaint.info@financial-ombudsman.org.uk**
- write to them at the **Financial Ombudsman Service, Exchange Tower, London E14 9SR**

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

The Financial Services Compensation Scheme (FSCS)

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

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

[†]We may record or monitor our calls.

Contributing members

This section only applies to *contributing members*.

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

Contributions paid by *you* to the subscriptions the *sponsor* has paid for *you* (eg by payroll deduction) will be deemed to have been received by *Bupa* once they are received by *your sponsor*.

As soon as reasonably practicable *you* will be provided with the terms and conditions that will apply to *your* cover, and the *sponsor* will notify *you* of the contribution you will need to make to the cost of subscriptions from the *cover start date* for the next membership *year*.

If you do not want *your* cover (and therefore the cover for *your dependants*) or the individual cover for any of *your dependants* to renew at the *renewal date* you can notify *your sponsor* at any time in advance of the *renewal date*.

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

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

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

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

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

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

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

You membership and that of **your dependants** will automatically end if the **sponsor** does not pay subscriptions or any other payment due under the **agreement** for **you** or any other person, however, **we** will continue to pay eligible claims for **you** and/or **your dependant** for the period for which you can provide evidence (eg on payslips) that **you** paid contributions to subscriptions to the **sponsor**.

Where **we** have refunded to the **sponsor** subscriptions paid for **you** or **your dependants**, you should contact the **sponsor** in order to obtain a refund of the contributions **you** made to those refunded subscriptions.

Changes to your membership

If:

- any changes to the terms and conditions of your membership, including your **benefits**, are agreed between the **sponsor** and **us**, or
- **we** change the procedure for making a claim

you will be informed before the change takes effect. If **you** do not accept any of the changes **you** can end your membership by informing the **sponsor** either:

- within 28 days of the date on which the change takes effect, or
- within 28 days of **you** being told about the change

whichever is later.

Demands and needs statement

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

Claiming

Step-by-step guide to making a claim

Being referred for treatment

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

- **our** Direct Access service, if you have cover for it as explained in 'Step 1 Find out if the Direct Access service is available to you'
- a **GP** (including via a digital **GP** service), or
- another healthcare practitioner. The situations in which **we** will accept such a referral are set out on [bupa.co.uk/referrals](https://www.bupa.co.uk/referrals)

Digital primary care services

If you have cover for benefit 1.11 digital primary care services under your policy, no referral or pre-authorisation is needed to book a digital primary care appointment under this benefit. If further **treatment** is recommended by the **digital primary care provider**, you will need to follow the claims process set out in this section for that recommended **treatment**.

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

If it is available to you, it applies only to certain medical conditions and has two parts to it:

- first you can contact **us** directly without consulting a **GP** for a remote assessment with a trained advisor, **therapist, mental health and wellbeing therapist** or other clinician who specialises in your condition. This may lead to a referral for a consultation or **treatment**
- second, if you already have a **GP** referral, you may also be offered the option to speak to a **therapist**, practitioner or other clinician who specialises in your condition to explore all of your **treatment** options.

For details about cover for the Direct Access service and how it works please see the Benefits section in this guide under the heading 'Direct Access service' and the benefit table on your **membership certificate**.

Step 2 If Direct Access is not available (or if you prefer) – consult a GP for an open referral

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

Consult a GP, they will assess if you need to see a **consultant**. If they decide that you do, ask them for an 'open referral' (unless a paediatric referral is required – see 'Information about cover for children' in this Step 2). This allows **us** to offer you a choice of nearby **recognised practitioners** including **consultants** covered under your policy.

Check within the Group Details section of your membership certificate to see if the Open Referral service applies to your **benefits**.

If the Open Referral service does not apply to your benefits: Some **GPs** may prefer to give a 'named referral' to a certain **consultant**, however you should call **us** before you make an appointment to confirm that **we** recognise them under your **benefits**, to avoid your being liable to pay.

When you call **us we** will:

- help you find a **fee-assured consultant** or **recognised practitioner** within your local area covered under your **benefits**, and
- confirm the **benefits** available to you under your cover.

If the Open Referral service does apply to your benefits

You must:

- obtain an open referral from a **GP** to ensure that your **treatment** is covered, and to avoid having to return to a **GP** to get an open referral; then
- call **us** to pre-authorise any claim before arranging or receiving any **treatment**. When you call **we** will:
 - help you find a **fee-assured consultant** in **our** list of Open Referral Network **consultants** that applies to your **benefits**
 - help you find a **recognised practitioner** within your local area
 - confirm the **benefits** available to you under your cover.

Important note

Failure to obtain pre-authorisation from **us** means that you will be responsible for paying for all such **treatment** if **we** would not have pre-authorised that **treatment**.

Information about cover for children aged 17 or under

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

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

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

Step 3 Contact us

You can call the number on your *membership certificate* and **we** will talk you through your options. Alternatively, you can contact **us** via **our** webchat service or complete the online request for treatment form. **We** will explain which nearby *consultants*, facilities and healthcare professionals are covered under your *Bupa* membership and provide you with a pre-authorisation number so your healthcare provider can send the bill directly to **us**.

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

The 'Six-week scheme'

The benefit table on your *membership certificate* shows whether this 'Six-week scheme' applies to you. If it applies to you, **we** do not pay for any *treatment* (including diagnostic procedures) that is to be carried out as a *day-patient* or *in-patient* if it is available under the *NHS* within six weeks of the date on which your *consultant* tells you that you need that *treatment*.

How it works

- If the *NHS* can offer you the *treatment* you need (including diagnostic procedures) as a *day-patient* or *in-patient* within six weeks of the date on which your *consultant* tells you that you need that *treatment*, **we** will not pay for your *treatment* privately.
- If the *NHS* cannot offer the *treatment* you need within those six weeks, **we** will pay for your *eligible treatment* privately.
- Each time you need *eligible treatment* as a *day-patient* or *in-patient* your *consultant* must confirm to **us** whether there is a wait of more than six weeks for you to have that *treatment* through the *NHS*.

Under Benefit CB1 **we** do not pay cash benefit for *NHS in-patient treatment* if the *treatment* you need is available under the *NHS* within this six-week period.

For example:

Jack is told on 1 July by his *consultant* that he needs to have an operation and finds that the *NHS* cannot perform the operation until 30 October at the earliest. As this timescale is outside the six-week period, and it is for *eligible treatment*, Jack can have his operation privately.

If the *NHS* had been able to schedule Jack's operation before 12 August, under the Six-week scheme, he would have been treated by the *NHS*.

Claims checklist

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

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

A Information on claiming

A1 Claims other than Cash benefits

If you are a moratorium member

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**.

Before you arrange any consultation or **treatment** call **us** and **we** will send you a pre-treatment form to complete. You will need to provide details of the history of the medical condition you are claiming for, including information that you will need to ask your **GP** or **consultant** for.

Your **GP** or **consultant** may charge you a fee for providing a report which **we** do not pay. Each claim you make 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, the medical providers or treatment facilities available to you
- confirm the level of **benefits** available to you, and
- 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 pre-treatment form to **us** as soon as possible and in any event within six months of receiving the **treatment** for which you are claiming unless this was not reasonably possible.

If you are not a moratorium member

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

- confirm whether your proposed **treatment** will be eligible under your **benefits** and, if so, the medical providers or treatment facilities available to you

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

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

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

Case management

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

A2 Claims for Cash benefits

For benefits CB1 NHS cash benefit for NHS hospital in-patient treatment and CB6 Cash benefit for treatment for cancer

If you are a moratorium member

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

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

- confirm whether your **treatment** will be **eligible** for cash benefit
- confirm the level of **benefits** available to you, and
- if required, send you a claim form which you will need to take with you to the hospital and ask them to complete the hospital sections. You will need to return your fully completed form to **us** as soon as possible.

If you are not a moratorium member

Call the helpline to check whether your **treatment** will be eligible for cash benefit. **We** will confirm your **benefits** and, if required, send you a claim form which you will need to take with you to the hospital and ask them to complete the hospital sections. You will need to return your fully completed form to **us** as soon as possible.

For benefits CB2 to CB5

Call the helpline to check your **benefits**. **We** will confirm your **benefits** and tell you whether you need to complete a claim form. You must send **us** either:

- your completed claim form if you need to complete one – in which case you will need to return your fully completed form to **us** as soon as possible and in any event within six months of receiving your **treatment** unless this was not reasonably possible

or

- if you do not need a claim form, a covering letter giving your name, address and membership number together with:
 - for Family cash benefit: a copy of **your** child's birth or adoption certificate
 - for other cash benefits: your original invoices and receipts.

A3 Claims for repatriation and evacuation assistance

You **must** contact **us** before any arrangements are made for your repatriation or evacuation. When you contact **us** **we** will check your cover and explain the process for arranging repatriation or evacuation and making a claim. From inside or outside the **UK** please contact **us** using your dedicated helpline. When your helpline is closed call **us** on: **+44 (0)131 588 0542**. Lines open 24 hours 365 days a year. **We** may record or monitor **our** calls.

A4 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') it is your responsibility to notify **us** as soon as reasonably possible and ensure **our** interests are protected in any legal action required so that **we** are able to recover any costs that **we** have paid for your **treatment**. This includes:

- Notifying **us** as soon as you become aware that you require (or may require) **treatment** that was caused by or was otherwise the fault of a third party. You can contact **us** with this information on **0800 028 6850**[†] or email infotthirdparty@bupa.com[^]
- Taking steps **we** ask of you to recover from the third party the cost of the **treatment** paid for by **us**. This includes ensuring that **we** are able to liaise with you and your legal representative (if you appoint one) in relation to this and that you or your legal representative regularly keep **us** updated as to progress with any recovery action.
- Ensuring that where you agree settlement with a third party, the settlement includes the cost of **treatment** that **we** have paid for you in full, and that you pay such sum (and applicable interest) to **us** as soon as reasonably possible.

A5 Other insurance cover

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

[^]If you need to send us sensitive information you can email us securely using Egress. For more information and to sign up for a free Egress account, go to <https://switch.egress.com>. You will not be charged for sending secure emails to a Bupa email address using the Egress service.

[†]We may record or monitor our calls.

B How we will deal with your claim

B1 General information

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

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

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

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

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

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

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

We reserve the right to change the procedure for making a claim. If so, **we** will write and tell the **sponsor** about any changes. If **you** are a **contributing member** please see the section 'Contributing members'.

B2 Providing us with information

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

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

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

Medical reports – when we need more information from your doctor

When **we** need to ask your doctor for more information, in writing about your consultation, tests or treatment for insurance purposes, **we** will need your permission. The **Access to Medical Reports Act 1988** or the **Access to Personal Files and Medical Reports (NI) Order 1991** give you certain rights, which are:

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

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

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

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

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

B3 How we pay your claim

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

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

Claims for overseas emergency treatment under benefit 9: *we* only pay eligible claims in £sterling. When *we* have to make a conversion from a foreign currency to £sterling *we* will use the exchange rate published on **Oanda.com** on the date you paid for your *treatment*.

C If you want to withdraw a claim

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

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

D Treatment costs outside the terms of your cover

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

E If you have an excess or co-insurance

The *sponsor* may have agreed with *us* that either an *excess* or *co-insurance* shall apply to your *benefits*. Your *membership certificate* shows if one does apply and if so,

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

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

If you are unsure:

- whether an *excess* or *co-insurance* does apply to you, or
- how your *excess* or *co-insurance* works

please refer to your *membership certificate* or contact the helpline.

E1 How an excess or co-insurance works

Having an *excess* or *co-insurance* 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* or *co-insurance*. By *eligible treatment* costs *we* mean costs that would have been payable under your *benefits* if you had not had an *excess* or *co-insurance*.

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

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

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

E2 How the excess or co-insurance applies to your benefits

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

- **we** apply the **excess** or **co-insurance** 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** or **co-insurance** amount will count towards your total benefit limit for that **benefit**
- the **excess** or **co-insurance** does not apply to benefit 1.11 digital primary care services and Cash benefits.

Excess and co-insurance examples

The following are examples only. You should check your **membership certificate** to see how your **excess** or **co-insurance** applies to you and your **benefits**.

Example of how an annual fixed excess works: this is an example only and assumes that all costs are **eligible treatment** costs and:

- an **excess** of £50 a **year**
- an **out-patient** benefit limit of £500 a **year**.

Example

Out-patient benefit limit for the year	£500
You incur costs for out-patient physiotherapy	£250
We pay your therapist	£200
We notify you of excess amount you pay direct to your therapist	£50
Your remaining out-patient benefit limit for the rest of the year	£250
Your remaining excess for the rest of the year	£0

Example of how a rolling excess works: this is an example only and assumes that all costs are *eligible treatment* costs and:

- a rolling **excess** of £100 in any 12 month period
- an **out-patient** benefit limit of £500 a **year**
- that you join the **scheme** on 1 January 2022.

Example

Out-patient benefit limit for the year	£500
On 1 March 2022 you incur costs for out-patient physiotherapy	£150
We pay your therapist	£50
We notify you of excess amount you pay direct to your therapist	£100
Your remaining out-patient benefit limit for the rest of the year	£350
Your remaining excess until 1 March 2023	£0
As you have paid your excess in full you will not have to pay an excess towards any further claims you make until 1 March 2023 when your excess will then return to the full amount of £100	

Example of how a co-insurance works: this is an example only and assumes that all costs are *eligible treatment* costs and:

- a **co-insurance** of 20% up to a maximum of £500 each **year**
- an **out-patient** benefit limit of £500 a **year**.

Example

Out-patient benefit limit for the year	£500
You incur costs for out-patient physiotherapy	£250
We pay your therapist 80%	£200
We notify you of the 20% co-insurance payment you pay direct to your therapist	£50
Your remaining out-patient benefit limit for the rest of the year	£250
Your remaining maximum co-insurance for the rest of the year	£450

Benefits

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

Notes on benefits

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

Restrictions and/or limitations to benefits

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

- If you are a **moratorium member**
- If you are an **underwritten member**: please note, if **you** and/or **your dependants** are an **underwritten member**, it is important that **you** complete and send **us** the **application form** for **you** and/or **your dependants** if **your membership certificate** states that **we** require your medical history. Until **you** have completed this **we** will not be able to confirm exactly what **your** policy covers **you** and/or **your dependants** for, meaning your claims might take longer for **us** to process or you might not be eligible to claim for **treatment** you need
- **Benefit limits**: these are limits on the amounts **we** will pay and/or restrictions on the cover you have under your **benefits**. Your **membership certificate** shows the benefit limits and/or restrictions that apply to your **benefits**
- **Excess** or **co-insurance**: these are explained in rule E in the section 'Claiming'. Your **membership certificate** shows if an **excess** or **co-insurance** applies to your **benefits**. If one does apply, your benefit limits shown on your **membership certificate** will be subject to your **excess** or **co-insurance**
- **Overall annual maximum benefit**: this is a limit on the overall amount **we** will pay under your **benefits** each **year**. Your **membership certificate** shows if an **overall annual maximum benefit** applies to your **benefits**. If one does apply, your benefit limits shown on your **membership certificate** will be subject to your **overall annual maximum benefit**. Your **excess** and/or **co-insurance** will count towards your **overall annual maximum benefit**
- If the Open Referral service applies to your **benefits**: check within the 'Group Details' section of your **membership certificate** to see if the Open Referral service applies to your **benefits**. If it does, you must be referred for **treatment** either:
 - by **our** Direct Access service (if you have cover for it), or
 - by obtaining an open referral from a **GP**. You should then call **us** to pre-authorise your **treatment** and **we** will help you find:
 - a **fee-assured** consultant in **our** list of Open Referral Network **consultants** that applies to your **benefits**, or
 - a **recognised practitioner** in your local area.

Failure to call **us** to obtain pre-authorisation for your **treatment** means that you will be responsible for paying for all such **treatment** if **we** would not have pre-authorised it. The Open Referral service does not apply to referral for a child. For full details of the Open Referral service please see 'A step-by-step guide to making a claim' in the 'Claiming' section of this membership guide

- Exclusions that apply to your cover: the general exclusions are set out in the section 'What is not covered'. Some exclusions also apply in this section and there may also be exclusions on your **membership certificate** and any **confirmation of special conditions we** send for anyone to whom a **special condition** applies.

Being referred for treatment

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

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

Direct Access service

Important: You are only covered for Direct Access when the benefit table on your **membership certificate** says it is covered and if it is, it will also say which medical conditions this service is available for. If you do not have cover for any part of the Direct Access service you should ignore all references to it in this membership guide.

If you do have cover for **our** Direct Access service, it applies only to certain medical conditions and has two parts to it:

- first, it can help provide a fast and convenient way for you to access **eligible treatment** without the need for a **GP** referral, and
- second, if you already have a **GP** referral, you may also be offered the option to speak to a **therapist**, practitioner or other clinician who specialises in your condition to explore all of your **treatment** options.

Age limits apply to who can use the service. Further details about the Direct Access service, including the age limits that apply, can be found on bupa.co.uk/direct-access or you can contact **us**.

Please note:

- **if you are an underwritten member**, you have access to the Direct Access service. If the Direct Access service refers you for a consultation or **treatment** and you want to make a claim you may need to provide **us** with certain information to establish that your condition is not a **pre-existing condition** (please see 'B2 Providing us with information' in the 'Claiming' section of this guide for full details)
- **if you are a moratorium member**, you have access to the Direct Access service. If the Direct Access service refers you for a consultation or **treatment** and you want to make a claim you will need to follow the standard process for claiming to establish that your condition is not a **moratorium condition** (please see 'If you are a moratorium member' under A1 in the 'Claiming' section of this guide for full details)

- you can use the Direct Access service when your medical condition is not covered by your **benefits**. For example, if you have a **special condition** or general exclusion the Direct Access service will still be available to you for a remote assessment. Any **out-patient** consultations, therapies or **treatment** that is recommended by the Direct Access service for those conditions would not be covered under your **benefits**
- if benefit limits apply to your **benefits for out-patient consultations and therapies** and you have used all the **out-patient benefits** available to you for the **year** you can still use the Direct Access service but any **out-patient** consultations or therapies you are referred for would not be covered under your **benefits**.

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

- erode your **out-patient** benefit limit if you have one, nor
- be subject to your **excess** or **co-insurance** if they apply to your cover.

However, if you have an **overall annual maximum benefit**, the charge will count towards your **overall annual maximum benefit**.

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

Bupa recognised medical practitioners and recognised facilities

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

Please note:

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

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

- if the Open Referral service does not apply to your **benefits**: the person who has overall responsibility for your **treatment** is a **consultant**. If the person who has overall responsibility for your **treatment** is not a **consultant** then none of your **treatment** costs are covered – the only exceptions to this are where the **treatment** being sought is under your digital primary care services benefit or where a **GP** or **our** Direct Access service refers you for **out-patient treatment** by a **therapist, complementary medicine practitioner** or **mental health and wellbeing therapist**
- if the Open Referral service does apply to your **benefits**: the person who has overall responsibility for your **treatment** is a **consultant** in **our** list of Open Referral Network **consultants** that applies to your **benefits**. If the person who has overall responsibility for your **treatment** is not in **our** list of Open Referral Network **consultants** that applies to your **benefits** then none of your **treatment** costs are covered – the only exceptions to this are where the **treatment** being sought is under your digital primary care services benefit or where a **GP** or **our** Direct Access service refers you for **out-patient treatment** by a **therapist, complementary medicine practitioner** or **mental health and wellbeing therapist**

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

Changes to lists

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

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

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

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

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

Reasonable and customary charges

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

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

What you are covered for

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

Benefit 1 Out-patient consultations and treatment

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

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

benefit 1.1 out-patient consultations

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

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

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

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

Out-patient therapies

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

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

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

Charges related to out-patient treatment

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

benefit 1.3 out-patient complementary medicine treatment

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

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

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

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

benefit 1.4 out-patient diagnostic tests

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

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

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

benefit 1.5 out-patient MRI, CT and PET scans

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

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

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

benefit 1.6 out-patient monitoring and management of chronic conditions

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

Call **us** to check that your proposed **treatment** is eligible under your **benefits**. Please remember that any costs you incur for **treatment** that is not eligible under your **benefits** are your responsibility.

We pay for eligible monitoring and management received as an **out-patient** for a **chronic condition**, other than an acute flare up of that condition, on the same basis as we pay for **treatment** as an **out-patient** as set out in benefits 1.1, 1.2, 1.3 and 1.4. We only pay as set out in those benefits and we only pay up to the limit that applies to benefit 1.6 as shown in your **membership certificate**.

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

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

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

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

For the purposes of this benefit 1.6 only, eligible monitoring and management means:

- medical services (including investigations and tests such as X-rays or blood tests), together with the products and equipment used as part of those services, that are needed to monitor or manage an ongoing disease, illness or injury and which:
 - are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the **UK**
 - are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided, for example as specified by NICE (or equivalent bodies in Scotland) in its guidance on specific conditions or **treatment** where such guidance is available
 - are demonstrated through scientific evidence to be effective in improving health outcomes, and
 - are not provided or used primarily for the expediency of you or your consultant or other healthcare professional

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

benefit 1.7 Bupa Health Check

If this benefit does not appear on your **membership certificate** then you are not eligible for this benefit.

We will pay for you to have a Bupa Female Health Check or a Bupa Male Health Check (as applicable) at a Bupa Health Centre once each **year**. You must be aged 18 years or over to use this benefit.

The Bupa Female Health Check is intended for those with worries about breast or cervical **cancer**, whether or not they have current symptoms. The check comprises:

- a 30 minute consultation with a doctor including medical history review related to cervical and/or breast **cancer**, and
- if clinically indicated:
 - physical examination – breast and/or pelvic
 - Human Papilloma Virus (HPV) and/or cervical smear testing, and
- where relevant:
 - onward referral either during the appointment or upon receipt of any test results.

The Bupa Male Health Check is intended for those with worries about prostate and/or testicular **cancer**, whether or not they have current symptoms. The check comprises:

- a 30 minute consultation with a doctor including medical history review related to prostate and/or testicular **cancer**
- if clinically indicated:
 - physical examination - prostate and/or testicular
 - Prostate Specific Antigen (PSA) blood test, and
- where relevant:
 - a full consultation, counselling regarding the PSA test and outcome of examination
 - onward referral either during the appointment or upon receipt of any blood test results, and
 - follow up to discuss PSA results.

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

benefit 1.8 diagnosis of gender dysphoria

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

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

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

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

benefit 1.9 Bupa Menopause Plan

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

We will pay for you to have a Bupa Menopause Plan at a Bupa Health Centre once each **year**. You must be aged 18 years or over to use this benefit.

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

The plan comprises:

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

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

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

benefit 1.10 out-patient fertility check

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

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

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

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

benefit 1.11 digital primary care services

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

We will pay for you to have a consultation with a **digital primary care provider** recognised by **us** for the provision of digital primary care consultations under this benefit. A digital primary care consultation may be with a **GP** or with another healthcare practitioner such as a physiotherapist, **nurse** or pharmacist available through the **digital primary care provider**. The number of appointments you can have is unlimited subject to any **overall annual maximum benefit** on your policy.

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

Please note: Claims under this benefit will not erode any **out-patient** benefit limit nor be subject to any **excess** or **co-insurance** that you have on your policy. However, if you have an **overall annual maximum benefit**, the charge for each appointment will count towards your **overall annual maximum benefit**.

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

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

Being treated in hospital

Benefit 2 Consultants' fees for surgical and medical hospital treatment

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

benefit 2.1 surgeons and anaesthetists

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

benefit 2.2 physicians

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

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

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

Benefit 3 Recognised facility charges

This benefit 3 explains the type of facility charges we pay for **eligible treatment**.

The **benefits** you are covered for, including your **facility access** and the amounts we pay are shown on your **membership certificate**. You are not covered for any benefits that are either shown on your **membership certificate** as 'not covered' or do not appear on your **membership certificate**.

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

benefit 3.1 out-patient surgical operations

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

benefit 3.2 day-patient and in-patient treatment

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

Using a non-recognised facility

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

benefit 3.2.1 accommodation

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

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

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

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

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

benefit 3.2.2 parent accommodation

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

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

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

We pay for use of the operating theatre and for nursing care, **common drugs**, **advanced therapies**, **specialist drugs** and surgical dressings when needed as an essential part of your **day-patient treatment** or **in-patient treatment**. **We** do not pay for extra nursing services in addition to those that the **recognised facility** would usually provide as part of normal patient care without making any extra charge.

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

benefit 3.2.4 intensive care

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

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

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

- the **recognised facility** is equipped with a **critical care unit**, and your **intensive care** is carried out in that **critical care unit**, or
- the **recognised facility** is not equipped with a **critical care unit** but has a prior agreement with **us** to follow an emergency protocol agreed with another **recognised**

facility that is equipped with a **critical care unit**, which is either adjacent or is part of the same group of companies, and you are transferred under that prior emergency protocol and your **intensive care** is carried out in that **critical care unit** in which case your **consultant** or **recognised facility** should contact **us** at the earliest opportunity.

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

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

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

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

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

benefit 3.2.5 diagnostic tests and MRI, CT and PET scans

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

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

benefit 3.2.6 therapies

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

benefit 3.2.7 prostheses and appliances

We pay **recognised facility** charges for **prostheses** or **appliances** needed as part of your **day-patient treatment** or **in-patient treatment**.

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

Benefits for specific medical conditions

Benefit 4 Cancer treatment

Benefit 4.1 Cancer cover

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

This benefit 4.1 explains what *we* pay for:

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

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

benefit 4.1.1 out-patient consultations for cancer

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

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

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

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

Out-patient therapies

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

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

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

Other out-patient charges

We pay provider charges for *out-patient treatment* when the *treatment* is related to, and is an integral part of, your *out-patient treatment* or *out-patient* consultation for *cancer*. *We* also pay charges for clinical reviews *we* may request to establish the eligibility of *treatment*.

benefit 4.1.3 out-patient complementary medicine treatment for cancer

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

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

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

benefit 4.1.4 out-patient diagnostic tests for cancer

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

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

benefit 4.1.5 out-patient cancer drugs

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

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

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

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

benefit 4.2 NHS Cancer Cover Plus

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

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

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

Where the criteria set out above do apply, **we** pay for your **eligible treatment** for **cancer** as set out in benefit 4.1 and cash benefits CB6.4 and CB6.5.

If you have cover for benefit CB6.1, CB6.2 and CB6.3: if the above criteria apply and you have **eligible treatment** for **cancer** as set out in benefit 4.1 but have part of your **cancer treatment** provided under the **NHS** we pay NHS cash benefit as set out in benefit CB6.1, CB6.2 and CB6.3 for that part of your **cancer treatment** received in the **NHS** if it would otherwise have been covered under your **benefits** for private **treatment**.

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

Benefit 5 Mental health treatment

You are only covered for this benefit if your *membership certificate* shows it is covered. Cover is subject to the limits shown on your *membership certificate*.

We pay for *eligible treatment* of *mental health conditions* as set out in this Benefit 5.

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

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

What we pay for mental health treatment

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

benefit 5.1 out-patient mental health treatment

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

benefit 5.1.1 out-patient mental health consultants' fees

We pay *consultant* psychiatrists' fees for *out-patient* consultations to assess your *mental health condition* and for *out-patient mental health treatment* and you are referred for the consultation or *treatment* by:

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

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

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

We pay:

- *mental health and wellbeing therapists'* fees for *out-patient mental health treatment*
- for you to have access to an online supported therapy programme/service. The online therapy is based on guided self help and you must use the online programme/service *we* direct you to when the *treatment* or therapy is recommended by:
 - *our* Direct Access service
 - a *GP* (including via a digital *GP* service), or *consultant*, or
 - another healthcare practitioner as explained in 'Being referred for treatment', in the 'Notes on benefits' section.

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

benefit 5.1.3 out-patient mental health diagnostic tests

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

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

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

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

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

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

Consultants' fees

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

Recognised facility charges

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

benefit 5.3 treatment otherwise excluded by the 'What is not covered' section

We pay for *eligible treatment* of mental health symptoms related to or arising from *treatment* otherwise excluded by the following exclusions in the 'What is not covered' section of this membership guide:

- Exclusion 1: Ageing, menopause and puberty
- Exclusion 2: Accident and emergency treatment
- Exclusion 3: Allergies, allergic disorders or food intolerances
- Exclusion 5: Birth control, conception and sexual problems
- Exclusion 6: Chronic conditions
- Exclusion 10: Cosmetic, reconstructive or weight loss treatment
- Exclusion 11: Deafness
- Exclusion 13: Dialysis
- Exclusion 17: Eyesight
- Exclusion 20: Learning difficulties, behavioural and developmental conditions
- Exclusion 24: Pregnancy and childbirth
- Exclusion 25: Screening, monitoring and preventive treatment
- Exclusion 26: Sleep problems and disorders

- Exclusion 28: Speech disorders
- Exclusion 29: Gender dysphoria or gender affirmation
- Exclusion 35: Varicose veins of the legs.

Additional benefits

Benefit 6 Treatment at home

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

This benefit applies when you receive *eligible treatment at home* where this would otherwise require *in-patient treatment* or *day-patient treatment* or *chemotherapy* as an *out-patient*. We will only consider *treatment at home* if all the following apply:

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

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

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*. You are covered on the same basis as set out in benefits 2 and 3. This benefit does not apply to *out-patient treatment* which takes place at *home* as explained in benefit 1.

Benefit 7 Home nursing after private eligible in-patient treatment

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

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

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

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

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

Benefit 8 Private ambulance charges

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

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

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

Benefit 9 Overseas emergency treatment

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

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

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

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

You are not covered for:

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

What we pay for

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

Please note: you will need to settle all accounts direct with the medical providers in the country of *treatment* and, on return to the *UK*, submit the itemised and dated receipted invoices to **us** for assessment.

Important: for the purpose of this benefit 9:

- **we** only pay for Eligible Treatment carried out by a consultant, therapist or complementary medicine practitioner who is:
 - fully trained and legally qualified and permitted to practice by the relevant authorities in the country in which your *treatment* takes place, and
 - is recognised by the relevant authorities in that country as having specialised knowledge of, or expertise in, the *treatment* of the disease, illness or injury being treated

- **we** only pay facility charges for Eligible Treatment when the facility is specifically recognised or registered under the laws of the territory in which it stands as existing primarily for:
 - carrying out major surgical operations, and
 - providing treatment that only a consultant can provide
- where **we** refer to Eligible Treatment **we** mean, **treatment** of an **acute condition** together with the products and equipment used as part of the **treatment** that:
 - are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the country in which the overseas emergency treatment is carried out
 - are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided
 - are demonstrated through scientific evidence to be effective in improving health outcomes, and
 - are not provided or used primarily for the expediency of you or your consultant or other healthcare professional

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

Please also see Exclusion 21, 'Overseas treatment' in the section 'What is not covered'.

Benefit 10 Repatriation and evacuation assistance

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

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

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

We will not consider repatriation or evacuation if any of the following apply:

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

What we pay for

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

- You must provide **us**, and where applicable the **medical assistance company**, with any information or proof that **we** may reasonably ask you for to support your request for repatriation/evacuation.
- **We** only pay costs that **we** consider to be reasonable. This means that the amount **we** will pay will be in line with what the majority of **our** members are charged for similar **treatment** or services. **We** only pay costs incurred for you by the **medical assistance**

company and only when the arrangements have been made in advance of your repatriation/evacuation by the **medical assistance company**. **We** do not pay any costs that have not been arranged by the **medical assistance company**.

- **We** only pay for transport costs incurred during your repatriation and/or evacuation. **We** do not pay any other costs related to the repatriation and/or evacuation such as hotel accommodation or taxis. Costs of any **treatment** you receive are not covered under this benefit.
- **We** may not be able to arrange evacuation or repatriation in cases where the local situation makes it impossible, unreasonably dangerous or impractical to enter the area; for example from an oil rig or within a war zone. **We** also cannot be held responsible for any delays or restrictions associated with the transportation that are beyond **our** control such as weather conditions, mechanical problems, restrictions imposed by local or national authorities or the pilot.

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

benefit 10.1 your repatriation/evacuation

We pay for either:

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

benefit 10.2 accompanying partner/relative

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

benefit 10.3 in the event of death

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

To make a claim for repatriation and evacuation assistance

We must be contacted before any arrangements are made for your repatriation or evacuation. **We** will check your cover and explain the process for arranging repatriation or evacuation.

From inside or outside the **UK** please contact **us** using your dedicated helpline.

When your helpline is closed call **us** on: **+44 (0)131 588 0542**. Lines open 24 hours 365 days a year. **We** may record or monitor **our** calls.

Cash benefits

Your *membership certificate* shows which Cash benefits (if any) apply to your *benefits* and the benefit limits that apply. If any Cash benefit does not appear on your *membership certificate* then you are not covered for that benefit.

Important note for Cash benefits CB3 to CB5

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

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

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

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

Except for NHS cash benefit for oral drug treatment for *cancer* as set out in benefit CB6.3 this benefit CB1 is not payable at the same time as any other NHS cash benefit for *NHS in-patient treatment*.

Benefit CB2 Family cash benefit

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

Waiting period

This benefit is only payable if *your benefits* have included cover for Family cash benefit for at least 10 continuous months before the date of *your* child's birth or adoption. If *you* had cover for Family cash benefit under a *previous scheme* *we* take this into account when assessing *your* 10 continuous months cover provided there has been no break in *your* cover between the *previous scheme* and this *scheme*.

What we pay

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

Benefit CB3 Optical cash benefit

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

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

What is covered

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

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

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

What is not covered

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

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

Benefit CB4 Accidental dental injury cash benefit

What is covered

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

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

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

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

Benefit CB5 Prescription cash benefit

What is covered

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

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

What is not covered

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

Benefit CB6 Cash benefit for treatment for cancer

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

Except for NHS cash benefit for oral drug treatment for **cancer** as set out in benefit CB6.3, this benefit CB6.1 is not payable at the same time as any other NHS cash benefit for **NHS in-patient treatment**.

We pay NHS Cash Benefit for each night you receive **NHS in-patient treatment** for **cancer** when it includes one of the following:

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

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

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

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

Except for NHS cash benefit for oral drug treatment for **cancer** as set out in benefit CB6.3, this benefit CB6.2 is:

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

We pay this NHS cash benefit for:

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

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

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

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

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

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

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

benefit CB6.4 Cash benefit for wigs or hairpieces

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

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

benefit CB6.5 Cash benefit for mastectomy bras

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

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

Benefit CB7 Procedure Specific NHS cash benefit

Except for NHS cash benefit for oral drug treatment for **cancer** as set out in benefit CB6.3 Procedure Specific NHS cash benefit is not payable at the same time as any other cash benefit.

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

What is not covered

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

This section does not contain all the limits and exclusions to cover. For example the benefits set out in the section 'Benefits' also describe some limitations and restrictions for particular types of **treatment**, services and charges. There may also be some exclusions on your **membership certificate** and any **confirmation of special conditions** **we** send for anyone to whom a **special condition** applies.

This section does not apply to:

- benefit 1.7 'Bupa Health Check', benefit 1.9 'Bupa Menopause Plan' and benefit 1.11 'digital primary care services' in the section 'Benefits', or
- Cash benefits CB2 to CB5 as set out in the section 'Cash benefits'.

Exclusion 1 Ageing, menopause and puberty

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

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

Exception 2: If your **benefits** include benefit 1.9 Bupa Menopause Plan, **we** pay for advice and support associated to menopause symptoms as set out in benefit 1.9.

Exclusion 2 Accident and emergency treatment

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

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

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

Exclusion 3 Allergies, allergic disorders or food intolerances

We do not pay for **treatment**:

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

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

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

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

Exclusion 5 Birth control, conception and sexual problems

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

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

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

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

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 rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

Exception 1: **We** pay for **eligible treatment** arising out of a **chronic condition**, or for **treatment** of unexpected acute symptoms of a **chronic condition** that flare up. However, **we** only pay if the **treatment** is likely to lead quickly to a complete recovery or to you being restored fully to your previous state of health, without you having to receive prolonged **treatment**. For example, **we** pay for **treatment** following a heart attack arising out of chronic heart disease. **We** do not pay for **treatment** required due to the expected deterioration or flare up of a **chronic condition**. This includes conditions which have a relapsing-remitting nature and require management of recurrent flare-ups, for example, inflammatory bowel disease. In such cases, the flare-ups are an expected part of the normal course of the illness and therefore we do not consider them as acute complications of the disease.

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

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

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

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

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

Exclusion 7 Complications from excluded conditions, treatment and experimental treatment

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

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

Exclusion 8 Contamination, wars, riots and terrorist acts

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

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

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

Exclusion 9 Convalescence, rehabilitation and general nursing care

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

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

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

Exclusion 10 Cosmetic, reconstructive or weight loss treatment

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

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

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

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

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

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

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

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

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

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

- by an accident, or
- if your **benefits** include cover for **cancer treatment**, as a direct result of surgery for **cancer**, or eligible prophylactic surgery (as explained in Exclusion 25 Screening, monitoring and preventive treatment under Exception 1).

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

We only pay if both of the following apply:

- it is part of the original **eligible treatment** resulting from the accident, **cancer** surgery or prophylactic surgery (as explained in Exclusion 25 Screening, monitoring and preventive treatment under Exception 1)

- the accident, **cancer** surgery or the prophylactic surgery took place during your current continuous period under a **Bupa** scheme that includes **benefits** for this type of **treatment**
 - the current continuous period may include being a member of another **Bupa** scheme and/or a beneficiary of a trust administered by **Bupa**, as long as there has been no break in your cover.

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

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

Exclusion 11 Deafness

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

Exclusion 12 Dental/oral treatment

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

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

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

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

Exclusion 13 Dialysis

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

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

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

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

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

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

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

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

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

Exclusion 15 Excluded treatment or medical conditions

We do not pay for:

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

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

Exclusion 16 Experimental drugs and treatment

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

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

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

- the use of this drug **treatment** follows an unsuccessful initial licensed **treatment** where available, and
- you speak regularly to **our** nurse, as **we** may reasonably require in order to allow **us** to effectively monitor your **treatment** and provide support, and
- the drug **treatment** has been agreed by a multidisciplinary team that meets the NHS Cancer Action Team standards defined in The Characteristics of an Effective Multidisciplinary Team (MDT), and
- for the proposed **treatment** **we** are provided with an MDT report, which includes one of the following:
 - evidence that the drug **treatment** has been found to have likely benefit on your condition through a predictive genetic test where appropriate/available, or
 - evidence that the drug has had a health technology assessment with a positive outcome and there is a European Medicines Agency (EMA) licence for the drug with the drug being used within its licensed protocol, or

- evidence that at least one NHS/National Comprehensive Cancer Network (NCCN)/European Society for Medical Oncology (ESMO) protocol exists, with supporting phase III clinical trial evidence, for your exact condition (ie the specific indication including tumour type, staging and phase of **treatment** if relevant), or
- evidence that the drug treatment has published phase III clinical trial results showing that it is safe and effective for your condition.

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

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

Exclusion 17 Eyesight

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

We do not pay for laser-assisted cataract surgery.

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

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

Exclusion 18 Pandemic or epidemic disease

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

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

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

- you have been directly admitted into a **critical care unit** at the point of admission, such as following:
 - an **NHS** transfer to a **recognised facility**
 - an **out-patient** consultation
 - a **GP** referral
 - repatriation
 - private facility to private facility transfer
- it follows a transfer (whether on an emergency basis or not) to an **NHS** hospital or facility from a private **recognised facility**
- it follows a transfer from an **NHS critical care unit** to a private **critical care unit**
- it is carried out in a unit or facility which is not a **critical care unit**.

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

Exclusion 20 Learning difficulties, behavioural and developmental conditions

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

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

Exclusion 21 Overseas treatment

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

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

Exception 2: If the **treatment** you need is not available in the **UK** and would have been **eligible treatment** except for it not being available in the **UK**, **we** will pay you a contribution up to the cost that **we** would have paid to you to have the standard alternative **treatment** available in the **UK**.

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

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

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

Exclusion 22 Physical aids and devices

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

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

Exclusion 23 Pre-existing conditions

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

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

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

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

Exclusion 24 Pregnancy and childbirth

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

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

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

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

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

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

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

Exclusion 25 Screening, monitoring and preventive treatment

We do not pay for:

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

- medication reviews or appointments where you have had no change in your usual symptoms.

Exception 1: If your **benefits** include cover for **cancer**, you are being treated for **cancer** and have strong direct family history of **cancer**, **we** pay for a genetically-based test to evaluate future risk of developing further cancers, if recommended by your **consultant**. If the test shows you are at high risk of developing further cancers **we** pay for prophylactic surgery, if recommended by your **consultant**. **We** will pay for reconstructive surgery following eligible prophylactic surgery as set out in Exclusion 10 Cosmetic, reconstructive or weight loss treatment under Exception 2.

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

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

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

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

Exclusion 26 Sleep problems and disorders

We 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 a **GP** or **consultant**. If you incur costs for providing the clinical details to **us** you are responsible for those costs, they are not covered under your **benefits**.

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

Exclusion 28 Speech disorders

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

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

Exclusion 29 Gender dysphoria or gender affirmation

We do not pay for **treatment** for **gender dysphoria** or gender affirmation

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

Exclusion 30 Temporary relief of symptoms

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

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

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

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

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

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

Please also see the section 'Benefits'.

Exclusion 32 Unrecognised medical practitioners, providers and facilities

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

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

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

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

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

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

Exclusion 33 Moratorium conditions

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

Exception: 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 Advanced therapies and specialist drugs

We do not pay for:

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

Exclusion 35 Varicose veins of the legs

We do not pay for the **treatment** of varicose veins of the legs.

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

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

We also pay:

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

Glossary

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

Word/phrase	Meaning
<i>Accidental dental injury</i>	damage or deformity to teeth or gums arising from an unexpected accidental external impact, including one sustained during participation in a sporting activity.
<i>Activities of daily living</i>	functional mobility, bathing/showering, self-feeding, personal hygiene/grooming, toilet hygiene, fulfilment of work or educational responsibilities.
<i>Acute condition</i>	a disease, illness or injury that is likely to respond quickly to <i>treatment</i> which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
<i>Advanced therapies</i>	gene therapy, somatic-cell therapy or tissue engineered medicines classified as Advanced Therapy Medicinal Products (ATMPs) by the UK medicines regulator to be used as part of your <i>eligible treatment</i> and which are, at the time of your <i>eligible treatment</i> , included (with the medical condition(s) for which we pay for them) on the list of advanced therapies that applies to your <i>benefits</i> as shown on your <i>membership certificate</i> under the heading 'Advanced therapies list'. The list that applies to your <i>benefits</i> is available at bupa.co.uk/policyinformation or you can contact <i>us</i> . The advanced therapies on the list will change from time to time.
<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>Appliances</i>	any appliances which are 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 will change from time to time. Details of the appliances are available on request or at bupa.co.uk/prostheses-and-appliances
<i>Application form</i>	the questionnaire <i>we</i> provide to <i>you</i> when <i>you</i> and/or <i>your dependants</i> first take out or are added as a <i>dependant</i> to a policy with <i>us</i> which requires <i>you</i> and/or <i>your dependants</i> to disclose details of <i>your</i> and their health, medical history and lifestyle. If <i>you</i> no longer have the application form, <i>you</i> may contact <i>us</i> to request a replacement.
<i>Benefits</i>	the benefits specified on 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 Select membership guide including all exclusions.
<i>Bupa</i>	Bupa Insurance Limited. Registered in England and Wales No. 3956433. Registered office: 1 Angel Court, London EC2R 7HJ
<i>Cancer</i>	a malignant tumour, tissues or cells characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
<i>Chemotherapy</i>	Systemic Anti-Cancer Therapies (SACT) excluding anti-hormone therapies. SACT are therapies used to destroy or prevent growth of cancerous cells.

Word/phrase	Meaning
Chronic condition	a disease, illness or injury which has one or more of the following characteristics: <ul style="list-style-type: none"> ▪ it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests ▪ it needs ongoing or long-term control or relief of symptoms ▪ it requires rehabilitation or for you to be specially trained to cope with it ▪ it continues indefinitely ▪ it has no known cure ▪ it comes back or is likely to come back.
Co-insurance	the percentage of the cost of eligible treatment that you have to pay that would have otherwise have been payable under your benefits . The amount you have to pay is subject to a set maximum amount. For details please see rule E in the 'Claiming' section of this guide and your membership certificate .
Common drugs	commonly used medicines, such as antibiotics and painkillers that in our reasonable opinion based on established clinical and medical practice should be included as an integral part of your eligible treatment .
Complementary medicine practitioner	an acupuncturist, chiropractor or osteopath who is a recognised practitioner . You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.
Confirmation of special conditions	the most recent confirmation of special conditions that we issue for any member to whom special conditions apply, for your current continuous period of cover under the policy.
Consultant	a registered medical or dental practitioner who, at the time you receive your treatment : <ul style="list-style-type: none"> ▪ is recognised by us as a consultant and has received written confirmation from us of this, unless we recognised him or her as being a consultant before 30 June 1996 ▪ is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and ▪ is in our list of consultants that applies to your benefits. <p>You can ask us if a medical or dental practitioner is recognised by us as a consultant and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</p>
Consultant fees schedule	the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants' fees based on: <ul style="list-style-type: none"> ▪ the type of treatment carried out ▪ for surgical operations, the type and complexity of the surgical operation according to the schedule of procedures ▪ the Bupa recognition status of the consultant, and ▪ where the treatment is carried out both in terms of the treatment facility and the location. <p>The schedule will change from time to time. Details of the schedule can be found at bupa.co.uk/codes</p>
Contributing member	a main member who contributes to the costs of subscriptions for themselves and/or any of their dependants .

Word/phrase	Meaning
Cover end date	<p>the date on which your current period of cover under the scheme ends. This is either the date:</p> <ul style="list-style-type: none"> shown as 'Cover end date' on your membership certificate <p>or if this is not displayed on your membership certificate,</p> <ul style="list-style-type: none"> the day before your renewal date.
Cover start date	<p>the date on which your current period of cover under the scheme starts, shown as 'Cover start date' on your membership certificate.</p>
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 will change from time to time. For details of a hospital or a treatment facility, centre or unit in your recognised facility network visit our consultants and facilities website at finder.bupa.co.uk</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>
Dental treatment	<p>dental or oral surgical or medical services (including diagnostic tests) which are needed to diagnose, relieve or cure an accidental dental injury.</p>
Dentist	<p>any general dental practitioner who is registered with the General Dental Council at the time you receive your dental treatment.</p>
Dependant	<p>your partner and any child for whom you or your partner hold responsibility and who is, with the sponsor's approval, a member of the scheme and named on your membership certificate.</p>
Diagnostic tests	<p>investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.</p>
Digital primary care provider	<p>services provided via a digital primary care provider we recognise for providing a digital consultation in a primary care setting, this can include a GP and other healthcare practitioners registered with the digital primary care provider.</p>
Effective underwriting date	<p>if you are an underwritten member, the date you started your continuous period of cover under the scheme. This is:</p> <ul style="list-style-type: none"> the date shown as 'Effective underwriting date' on your membership certificate, <p>or if this is not displayed on your membership certificate</p> <ul style="list-style-type: none"> your cover start date shown on the first membership certificate we provided that lists you as a member under the scheme or if you joined the scheme from a previous scheme and we have agreed with the sponsor that no further underwriting would apply, the date of underwriting by the insurer or administrator of your previous scheme. <p>If you are unsure of your effective underwriting date contact us and we can tell you.</p>
Eligible surgical operation	<p>eligible treatment carried out as a surgical operation.</p>

Word/phrase	Meaning
Eligible treatment	<p>treatment of:</p> <ul style="list-style-type: none"> an acute condition, or a mental health condition <p>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, for example as specified by NICE (or equivalent bodies in Scotland) in its guidance on specific conditions or treatment where such guidance is available are demonstrated through scientific evidence to be effective in improving health outcomes, and are not provided or used primarily for the expediency of you or your consultant or other healthcare professional <p>and the treatment, services or charges are 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 . For details please see rule E in the 'Claiming' section of this guide and your membership certificate .
Facility access	the network of recognised facilities for which you are covered under your benefits as shown on your membership certificate and being either: <ul style="list-style-type: none"> participating facility, or partnership facility.
Fee-assured consultant	<p>a consultant who, at the time you receive your treatment, is:</p> <ul style="list-style-type: none"> recognised by us as a fee-assured consultant, and in the list of fee-assured consultants that applies to your benefits. <p>You can ask us if a consultant is a fee-assured consultant and if they are in the list of consultants that apply to your benefits or you can access these details at finder.bupa.co.uk</p>
Fertility check facility	a fertility check facility that, at the time you receive a fertility check, is in Bupa's list of such facilities that applies to your benefits . Details of the facilities in the list are available on request or at finder.bupa.co.uk
Gender dysphoria	a condition where a person experiences discomfort or distress because there is a mismatch between their biological sex and gender identity, sometimes known as gender identity disorder, gender incongruence or transgenderism.
GP	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.
Home	either: <ul style="list-style-type: none"> the place where you normally live, or another non-healthcare setting where you want to have your treatment.
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 .
Intensive care	eligible treatment for intensive care, intensive therapy, high dependency care, coronary care or progressive care.

Word/phrase	Meaning
<i>Main member</i>	the person who is covered under the agreement by virtue of being eligible in his or her own right rather than as a dependant .
<i>Medical assistance company</i>	the company who is appointed by Bupa as a medical assistance company for the purpose of its medical insurance schemes for arranging repatriation and/or evacuation at the time that you need repatriation and/or evacuation. The medical assistance company may change from time to time and current details are available on request.
<i>Medical treatment provider</i>	a person or company who is recognised by us as a medical treatment provider for the type of treatment at home that you need at the time you receive your treatment . The list of medical treatment providers and the type of treatment we recognise them for will change from time to time. Details of these medical treatment providers and the type of treatment we recognise them for are available on request or you can access these details at finder.bupa.co.uk
<i>Membership certificate</i>	either: <ul style="list-style-type: none"> the most recent membership certificate that we issue to you for your current continuous period of membership under the agreement, or if we do not issue a membership certificate to you the most recent Group Certificate that we issue to your sponsor that provides the details of the cover that applies to you under the agreement.
<i>Mental health and wellbeing therapist</i>	<ul style="list-style-type: none"> a psychologist registered with the Health Professions Council a psychotherapist accredited with UK Council for Psychotherapy, the British Association for Counselling and Psychotherapy or the British Psychoanalytic Council a counsellor accredited with the British Association for Counselling and Psychotherapy, or a cognitive behavioural therapist accredited with the British Association for Behavioural and Cognitive Psychotherapies <p>who is a recognised practitioner. You can ask us if a practitioner is a recognised practitioner and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</p>
<i>Mental health condition</i>	a condition which is a mental health condition according to a reasonable body of medical opinion, and/or which is diagnosed and treated and managed as a mental health condition by a consultant psychiatrist or a mental health and wellbeing therapist . We do not pay for treatment of dementia, behavioural or developmental problems once diagnosed.
<i>Mental health day-patient treatment</i>	eligible treatment of a mental health condition which for medical reasons means you have to be admitted to a recognised facility because you need a period of clinically-supervised eligible treatment of a mental health condition as a day case but do not have to occupy a bed overnight and the mental health treatment is provided on either an individual or group basis.
<i>Mental health in-patient treatment</i>	eligible treatment of a mental health condition that, for medical reasons, is received as an in-patient .
<i>Mental health treatment</i>	eligible treatment as set out in Benefit 5 Mental health treatment in the 'Benefits' section of this guide.

Word/phrase	Meaning
Moratoria start date	<p>if you are a moratorium member, the date you started your continuous period of cover under the scheme. This is:</p> <ul style="list-style-type: none"> the date shown as 'Moratoria start date' on your membership certificate, or if this is not displayed on your membership certificate your cover start date shown on the first membership certificate we provided that lists you as a member under the scheme, or if you joined the scheme from a previous scheme and we have agreed with the sponsor that no further underwriting would apply, the date identified by the insurer or administrator of your previous scheme for determining moratorium conditions under your previous scheme. <p>If you are unsure of your moratoria start date contact us and we can tell you.</p>
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 moratoria start date. By a related condition we mean any symptom, disease, illness or injury which reasonable medical opinion considers to be associated with another symptom, disease, illness or injury.</p>
Moratorium member	a member whose membership certificate shows the underwriting method applied to them is moratorium.
Moratorium qualifying period	the number of years stated in the 'Further details' section of your membership certificate as being your moratorium qualifying period.
NHS	<ul style="list-style-type: none"> the National Health Service operated in Great Britain and Northern Ireland, or the healthcare system that is operated by the relevant authorities of the Channel Islands, or the healthcare scheme that is operated by the relevant authorities of the Isle of Man.
Nurse	a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.
Optician	an ophthalmic optician or optometrist who is registered with the General Optical Council.
Optical benefit period	<p>a period of two consecutive years, the entire period of which Optical cash benefit must have been covered under your benefits. Each optical benefit period shall not start until your last optical benefit period expires, this means that:</p> <ul style="list-style-type: none"> your second optical benefit period will start on the second renewal date following either your original date of joining the scheme or the renewal date on which your first optical benefit period began (as applicable) your third and any subsequent optical benefit periods will start on the second renewal date following the renewal date on which your immediately preceding optical benefit period began.
Oral chemotherapy	chemotherapy which is taken by mouth.
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 .

Word/phrase	Meaning
<i>Out-patient surgical operation</i>	an eligible surgical operation received as an out-patient .
<i>Out-patient treatment</i>	eligible treatment that, for medical reasons, is received as an out-patient .
<i>Overall annual maximum benefit</i>	<p>the total amount we pay up to each year for eligible treatment covered under your benefits. This is the amount we pay up to collectively each year for all your eligible treatment and not for each type of treatment individually. Your excess and/or co-insurance all count towards your overall annual maximum benefit.</p> <p>If an overall annual maximum benefit applies to your benefits, this will be shown on your membership certificate.</p>
<i>Participating facility</i>	<p>a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our participating facility list that applies to your benefits, and is recognised by us for both:</p> <ul style="list-style-type: none"> ▪ treating the medical condition you have, and ▪ carrying out the type of treatment you need. <p>The hospitals, treatment facilities, centres or units in the list and the medical conditions and types of treatment we recognise them for will change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request or at finder.bupa.co.uk</p>
<i>Partner</i>	your husband or wife or civil partner or the person you live with in a relationship similar to that of a husband and wife whether of the opposite sex or not.
<i>Partnership facility</i>	<p>a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our partnership facility list that applies to your benefits and is recognised by us for both:</p> <ul style="list-style-type: none"> ▪ treating the medical condition you have, and ▪ carrying out the type of treatment you need. <p>The hospitals, treatment facilities, centres and units in the list and the medical conditions and types of treatment we recognise them for will 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 or at finder.bupa.co.uk</p>
<i>Pre-existing condition</i>	<p>any disease, illness or injury for which in the seven years before your effective underwriting date:</p> <ul style="list-style-type: none"> ▪ you have received medication, advice or treatment, or ▪ you have experienced symptoms <p>whether the condition was diagnosed or not.</p>
<i>Previous scheme</i>	<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 <p>that we specifically agree with the sponsor will be treated as a previous scheme for the purpose of assessing waiting periods, moratoria start date, effective underwriting date or continuous periods of cover as applicable provided that:</p> <ul style="list-style-type: none"> ▪ the member has provided us with evidence of their continuous cover under the previous scheme, and ▪ there is no break in a member's cover between the previous scheme and their scheme.

Word/phrase	Meaning
Prostheses	any prostheses which are 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 or at bupa.co.uk/prostheses-and-appliances
Recognised facility	either a: <ul style="list-style-type: none"> ▪ participating facility, or ▪ partnership facility according to the facility access that applies to your benefits . Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request or at finder.bupa.co.uk
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. You can ask us if a practitioner is a recognised practitioner and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk
Renewal date	for each period of your cover the date agreed between the sponsor and us on which the group cover is due for renewal. Cover is generally renewed annually. Depending on the month in which you first join the scheme , your initial period of cover may not be a full twelve months. Your benefits and, if you are a contributing member , your subscriptions may change at the renewal date .
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 will 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. Detail of the schedule can be found at bupa.co.uk/codes
Scheme	the cover we provide as shown on your membership certificate together with this Bupa Select membership guide subject to the terms and conditions of the agreement .
Session	periods of 24 hours during which the specified type of treatment is received for an acute condition .
Special condition	for underwritten members , any exclusions or restrictions to cover that are personal to an individual based on the medical history given to us for that individual. If special conditions apply to an underwritten member's cover these are shown on any confirmation of special conditions we send for anyone to whom a special condition applies.
Specialist drugs	drugs and medicines to be used as part of your eligible treatment , which are not common drugs and are at the time of your eligible treatment , included on our list of specialist drugs that applies to your benefits . The list is available at bupa.co.uk/policyinformation or you can contact us . The specialist drugs on the list will change from time to time.

Word/phrase	Meaning
Sponsor	the company, firm or individual with whom we have entered into an agreement to provide cover.
Surgical operation	a surgical procedure or complex investigative/diagnostic procedure including all medically necessary treatment related to the procedure and all consultations carried out from the time you are admitted to a recognised facility until the time you are discharged, or if it is carried out as out-patient treatment , all medically necessary treatment related to the operation and any consultation on the same day which is integral to the operation.
Therapist	<ul style="list-style-type: none"> ▪ a chartered physiotherapist ▪ a British Association of Occupational Therapists registered occupational therapist ▪ a British and Irish Orthoptic Society registered orthoptist ▪ a Royal College of Speech and Language Therapists registered speech and language therapist ▪ a Society of Chiropractors and Podiatrists registered podiatrist, or ▪ a British Dietetic Association registered dietitian <p>who is Health and Care Professions Council Registered and is a recognised practitioner. You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for or you can access these details at finder.bupa.co.uk</p>
Treatment	surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.
Underwritten member	a member 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, Northern Ireland, the Channel Islands and the Isle of Man.
Waiting period	a period of continuous cover during which benefits are not payable. The length of any waiting periods that apply to your benefits are shown under the 'Waiting periods' section on your membership certificate .
We/our/us	Bupa .
Year	for each period of your cover, the period beginning on your cover start date and ending on your cover end date for that period of cover. Depending on the month in which you join the scheme your initial year may not be a full twelve months. Your benefits and, if you are a contributing member , your subscriptions may change at the renewal date .
You/your	this means the main member only.

Privacy notice – in brief

We are committed to protecting your privacy when dealing with your personal information. This privacy notice provides an overview of the information we collect about you, how we use it and how we protect it. It also provides information about your rights. The information we process about you, and our reasons for processing it, depends on the products and services you use. You can find more details in our full privacy notice available at bupa.co.uk/privacy. If you do not have access to the internet and would like a paper copy, please write to **Bupa Data Protection, Willow House, 4 Pine Trees, Chertsey Lane, Staines-upon-Thames, Middlesex TW18 3DZ**. If you have any questions about how we handle your information, please contact us at dataprotection@bupa.com

Information about us

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

1. Scope of our privacy notice

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

2. How we collect personal information

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

3. Categories of personal information

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

4. Purposes and legal grounds for processing personal information

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

We process special categories of information because it is necessary for an insurance purpose, because we have your permission or as described in our full privacy notice.

We may process information about your criminal convictions and offences (if any) if this is necessary to prevent or detect a crime.

5. Marketing and preferences

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

6. Processing for profiling and automated decision-making

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

7. Sharing your information

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

8. International transfers

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

9. How long we keep your personal information

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

10. Your rights

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

11. Data-protection contacts

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

You also have a right to make a complaint to your local privacy supervisory authority. Our main office is in the UK, where the local supervisory authority is the Information Commissioner, who can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, United Kingdom.

Phone: 0303 123 1113 (local rate).

Financial crime and sanctions

Financial crime

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

Sanctions

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

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

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

Bupa Health Checks, Bupa Anytime HealthLine, Family Mental HealthLine, Bupa Menopause Plan and Digital primary care services are not regulated by the Financial Conduct Authority or the Prudential Regulation Authority.

Bupa Health Checks, Bupa Anytime HealthLine and Bupa Menopause Plan are provided by:

Bupa Occupational Health Limited.

Registered in England and Wales No. 631336.

Registered office: 1 Angel Court,
London EC2R 7HJ

Digital primary care services are provided by Babylon Healthcare Services Limited.

Registered in England and Wales

number: 09229684. Registered office:

60 Sloane Avenue, London SW3 3DD

Bupa health insurance is provided by:

Bupa Insurance Limited. Registered in England

and Wales No. 3956433. Bupa Insurance

Limited is authorised by the Prudential

Regulation Authority and regulated by the

Financial Conduct Authority and the Prudential

Regulation Authority. Financial Services

Register No. 203332.

Bupa insurance policies are arranged and administered by:

Bupa Insurance Services Limited. Registered

in England and Wales No. 3829851. Bupa

Insurance Services Limited is authorised and

regulated by the Financial Conduct Authority.

Financial Services Register No. 312526.

You can check the Financial Services Register

by visiting: <https://register.fca.org.uk> or by

contacting the Financial Conduct Authority

on 0800 111 6768.

Registered office: 1 Angel Court,

London EC2R 7HJ

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