



Bupa Select

Your Bupa membership guide

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've made this guide as simple as possible. You'll find individual chapters that deal with each aspect of your Bupa cover, including a step-by-step guide to making a claim.

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

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

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

TIP:

Cross-check the benefits listed in your membership certificate with the relevant paragraphs in the guide to make sure that you have the cover that you want.

How do I know what I'm covered for?

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

How does the membership guide work with my membership certificate?

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

How do I contact Bupa?

We're always on hand to help.

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

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

Bupa Anytime HealthLine

If you have any questions or worries about your health call our confidential Bupa Anytime HealthLine on 0345 604 0537†. 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.

Bupa Anytime HealthLine is not regulated by the Financial Conduct Authority.

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

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Your rules and benefits

Effective from 1 April 2018

These are the rules and benefits of Bupa Select

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

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

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

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

This membership guide is a generic guide. It contains the general membership terms that apply to all Bupa Select 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 in your **membership certificate** as 'not covered', or
- do not appear in your **membership certificate**

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

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

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

How your membership works

The agreement between the sponsor and us

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

The documents that set out your cover

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

- **The Bupa Select 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.

And for **underwritten members**:

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

Payment of benefits

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

When you receive private medical treatment you have a contract with the providers of your **treatment**. You are responsible for the costs you incur in having private **treatment**. However, if your **treatment** is **eligible treatment** **we** pay the costs that are covered under your **benefits**. Any costs, including **eligible treatment** costs, 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.

In many cases **we** have arrangements with providers about how much they charge **our** members for **treatment** and how **we** pay them. For **treatment** costs covered under your **benefits** **we** will, in most cases, pay the provider of your **treatment** direct – such as the **recognised facility** or **consultant** – or whichever other person

or facility is entitled to receive the payment. Otherwise **we** will pay the **main member**. **We** will write to tell the **main member** how **we** have dealt with any claim. Please also see the section 'Claiming'.

When your membership starts, renews and ends

Starting membership

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

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

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

Covering a newborn baby

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

If your baby's membership would be as:

- an **underwritten member**, **we** will not apply any **special conditions** to the baby's cover
- a **moratorium member**, **we** will not apply the exclusion for **moratorium conditions** from 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 start date** if their date of birth is before **your start date**).

Renewal of your membership

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

How membership can end

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

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

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

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

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

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. This would allow **you** or them to transfer without any additional **special conditions** if **you** or they transferred within three months of leaving the group scheme, without any break in cover. If **you** would like to consider this option please call **0800 600 500** to discuss it with **us**.†

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

Making changes

Changes to your membership

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

Other parties

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

†We may record or monitor our calls.

General information

Change of address

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

Correspondence and documents

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

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

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

Applicable law

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

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

If **Bupa**, or any representative of **Bupa**, did not sell you this policy and your complaint is about the sale of your policy, please contact the party who sold the policy. Their details can be found on the status disclosure document or the terms of business document they provided to you. If you are a member of a company or corporate scheme please call your dedicated Bupa helpline, this will be detailed on your **membership certificate**.

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

By phone: **0345 609 0111**[‡]

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

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

Please be aware information submitted to us via email is normally unsecure and may be copied, read or altered by others before it reaches **us**.

Via our website: **bupa.co.uk/members/member-feedback**

or via twitter: **@AskBupaUK**

[‡]We may record or monitor our calls.

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

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

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

If you remain unhappy with **our** response, or after eight weeks you do not wish to wait for us to complete our review, you may refer your complaint to the Financial Ombudsman Service. You can write to them at: **Exchange Tower, London E14 9SR** or contact them via email at **complaint.info@financial-ombudsman.org.uk** or call them on **0800 023 4567** calls to this number are now free on mobile phones and landlines or **0300 123 9123** (free for mobile phone users who pay a monthly charge for calls to numbers starting 01 or 02).

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

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

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

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

The Financial Services Compensation Scheme (FSCS)

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

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

Claiming

Step-by-step guide to making a claim

Step
1

Visit your GP

The process generally starts with a visit to your **GP**.

Your **GP** will advise you if you need to see a consultant or healthcare professional.

Step
2

Get a referral for your treatment: check which option applies to your cover

If you need to see a consultant, your **GP** will provide you with a referral letter which will detail the type of specialist your **GP** would like you to see.

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

Check the 'Cover option' within the Group Details section of your **membership certificate** to see whether the Open Referral Service applies to your cover. If your 'Cover option' does not state open referral, then it does not apply to you.

- If the Open Referral Service does not apply to you:

We nevertheless recommend that you ask for an 'open referral' which will detail the care your **GP** would like you to have, but will not be addressed to a specific consultant, hospital or healthcare professional. An open referral needs to include your **GP's** assessment of your symptoms, the body area affected and medical speciality required.

By obtaining an open referral **we** can offer you a choice of consultants, as well as help you to make sure you avoid any extra costs (some consultants charge fees which are outside **our** benefit limits and if they do, you may need to pay some of the fees). You'll find a simple open referral form for your **GP** to complete on: bupa.co.uk/referral

If your **GP** does want to provide you with a referral to a specific consultant make sure you confirm with **us** that they charge within **our** benefit limits, to avoid being responsible for any unforeseen costs.

- If the Open Referral Service applies to you:

If the Open Referral Service applies to you, you must obtain an open referral from your **GP** to ensure that your treatment is covered, and to avoid having to return to your **GP** and obtain an open referral.

IMPORTANT: You must call **us** to pre-authorise any claim before arranging or receiving any treatment. Failure to obtain pre-authorisation from **us** means that you will be responsible for paying for all such treatment. **We** will help you find a consultant or healthcare professional within your local area and confirm the benefits available to you under your cover. You'll find a simple open referral form for your **GP** to complete on: bupa.co.uk/referral

Step
3

Call us

Call **us** so that **we** can discuss your options and explain which consultants and healthcare professionals are covered under your Bupa membership.

We will let you know what you need to do next and send you any necessary pre-treatment forms you may need to complete.

Remember – if the Open Referral Service applies to you, you must call **us** before arranging or receiving any treatment.

Step
4

Get a pre-authorisation number

When **we** have confirmed that your **treatment** is covered, **we** will discuss your claim with you and issue you a 'pre-authorisation' number. You can then contact your consultant or healthcare provider to arrange an appointment.

We recommend you give your pre-authorisation number to the consultant or healthcare professional you see so that the invoice for any treatment costs can be sent to **us** directly. If your company has selected the Open Referral Service, then you must call **us** to pre-authorise your **treatment**.

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

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

Claims checklist

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

- **your Bupa membership number**
- **the condition you are suffering from**
- **details of when your symptoms first began**
- **details of when you first consulted your GP about your condition**
- **details of the treatment that has been recommended**
- **date(s) on which you are to receive treatment**
- **the name of the consultant or other healthcare professional involved**
- **details of where your proposed treatment will take place**
- **your expected length of stay in hospital (if applicable)**

A Making a claim

A1 Claims other than Cash benefits

If the Open Referral Service does not apply to your cover **we recommend that you always contact us before arranging or receiving any treatment**. This is the only way that **we** can confirm the **benefits** that are available to you before you incur any costs for your **treatment**. Any costs you incur that are not covered under your **benefits** are your responsibility.

If the Open Referral Service applies to your cover you must ask for an 'open referral' from your **GP** (please see the 'Step-by-step guide to making a claim') and you must call **us** before arranging or receiving any **treatment**. **We** will confirm the medical providers and treatment facilities that you must use. Failure to call **us** to obtain pre-authorisation for your **treatment** means that you will be responsible for paying for all such **treatment**.

Please see the 'Cover option' section of your **membership certificate** – it will state 'Open Referral' if the Open Referral Service applies to your cover.

For moratorium members

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

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:

- if the Open Referral Service does not apply to your cover, confirm whether your proposed **treatment**, medical provider or treatment facility will be eligible under your **benefits**
- if the Open Referral Service applies to your cover, confirm whether your proposed **treatment** will be eligible under your **benefits** and, if so, the medical providers or treatment facilities you must use
- the level of **benefits** available to you, and
- tell you whether you will need to complete a claim form.

Please see the 'Cover option' section of your **membership certificate** – it will state 'Open Referral' if the Open Referral Service applies to your cover.

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

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

For non-moratorium members

When you call **us we** will:

- if the Open Referral Service does not apply to your cover, confirm whether your proposed **treatment**, medical provider or treatment facility will be **eligible** under your **benefits**
- if the Open Referral Service applies to your cover, confirm whether your proposed **treatment** will be eligible under your **benefits** and, if so, the medical providers or treatment facilities you must use
- confirm the level of **benefits** available to you, and
- tell you whether you will need to complete a claim form, if you claim.

Please see the 'Cover option' section of your **membership certificate** – it will state 'Open Referral' if the Open Referral Service applies to your cover.

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

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

A2 Claims for Cash benefits

For benefits CB1, NHS cash benefit and CB6, NHS cancer cash benefit

◦ For moratorium members

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

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

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

◦ For non-moratorium members

Call the helpline to check your **benefits**. **We** will confirm your **benefits** and send you a claim form which you will need to take with you to the hospital and ask them to complete the hospital sections. You will need to return your fully completed form to **us** as soon as possible and in any event within six months of receiving your **treatment** unless this was not reasonably 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 outside the **UK** – or inside the **UK** 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'), for example, an injury suffered in a road accident in which you are a victim, all of the following conditions apply when you make such a claim:

- you agree you are responsible for the payment of any costs which may ultimately be recovered from the third party
- you must notify **us** as soon as possible that your **treatment** was needed as a result of a third party. You can notify **us** either by writing to **us** or completing the appropriate section on your claim form. You must provide **us** with any further details that **we** reasonably ask you for
- you must take any reasonable steps **we** ask of you to recover from the third party the cost of the **treatment** paid for by **us** and claim interest if you are entitled to do so
- you (or your solicitor) must keep **us** fully informed in writing of the progress and outcome of your claim
- if you recover the cost of any **treatment** paid for by **us**, you must repay the amount and any interest to **us**.

A5 Other insurance cover

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

B How we will deal with your claim

B1 General information

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

Except for NHS cash 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 break any of the terms and conditions of your membership.

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

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

B2 Providing us with information

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

- 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.

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

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

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

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

2. You can give your consent, but ask to see the report before it is sent to **us**, in which case you will have 21 days, after **we** notify you that **we** have requested a report from the doctor, to contact your doctor to make arrangements to see the report. If you fail to contact the doctor within 21 days, **we** will request they send the report direct to **us**. If however you contact your doctor with a view to seeing the report, you must give the doctor written consent before they can release it to **us**. You may ask your doctor to change the report if you think it is misleading. If your doctor refuses, you can insist on adding your own comment to the report before it is sent to **us**.

3. You can withhold your consent, but if you do, please bear in mind that **we** may be unable to progress with your claim. Whether or not you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask them within six months of the report having been supplied to **us**. Your doctor is entitled to withhold some or all of the information contained in the report if, in their opinion, this information (a) might cause serious harm to your physical or mental health or that of another person, or (b) it would reveal the identity of another person without their consent (other than that provided by a healthcare professional in their professional capacity in relation to your care).

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

B3 How we pay your claim

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

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

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 in the **UK's** Financial Times on the Monday of the week in which the first day of your **treatment** takes place.

C If you want to withdraw a claim

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

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

D Ex-gratia payments

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

E If you have an excess or co-insurance

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

- the amount
- who it applies to
- what type of **treatment** it is applied to, and
- the period for which the **excess** 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 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** to tell them who you should pay the **excess** or **co-insurance** to, for example, your **consultant, therapist** or **recognised facility**. The **excess** or **co-insurance** must be paid direct to them – not to **Bupa**. **We** will also write to tell the **main member** the amount of the **excess** or **co-insurance** that remains (if any).

You should always make a claim for eligible **treatment** costs even if **we** will not pay the claim because of your **excess** 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 in 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 Cash benefits.

Benefits

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

Notes on benefits

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

Restrictions and/or limitations to benefits

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

- 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 in 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 in your **membership certificate** will be subject to your **overall annual maximum benefit**. Your **excess, co-insurance** and any amounts **we** pay to you on an ex-gratia basis will count towards your **overall annual maximum benefit**
- if you are an **underwritten member** or a **moratorium member**
- if the Open Referral Service applies to your cover you must obtain an "open referral" from your **GP** and you must call **us** before arranging or receiving any **treatment**. **We** will confirm the medical providers or treatment facilities you must use. Failure to call **us** to obtain pre-authorisation for your **treatment** means that you will be responsible for paying for all such **treatment**. Please see the 'Cover option' section of your **membership certificate** – it will state 'Open Referral' if the Open Referral Service applies to your cover
- 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 in your **membership certificate**.

Being referred for treatment and Bupa recognised medical practitioners and recognised facilities

Your consultation or **treatment** must in most cases follow an initial referral by a **GP** after you have seen the **GP** in person. However, for **day-patient treatment** or **in-patient treatment** provided by a **consultant** such referral is not required in the case of a medical emergency.

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

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 can change from time to time.

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

- the person who has overall responsibility for your **treatment** is a **consultant**. If the person who has overall responsibility for your **treatment** is not a **consultant** then none of your **treatment** costs are covered – the only exception to this is where a **GP** refers you (or where **we** refer you when **we** have told you that a **GP** referral is not required for your condition) 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
- if the Open Referral Service applies to your cover, you use the medical providers and treatment facilities **we** refer you to when **we** pre-authorise your **treatment** (see below).

Important

If the Open Referral Service does not apply to your cover, you should always call **us** before arranging any **treatment** to check your **benefits** and whether your chosen medical practitioner or other healthcare professional or **recognised facility** is recognised by **us** for both treating the medical condition you have and for providing the type of **treatment** you need. Any **treatment** costs you incur that are not covered under your **benefits** are your responsibility.

If the Open Referral Service applies to your cover you must obtain an 'open referral' from your **GP** and you must call **us** before arranging or receiving any **treatment**. **We** will confirm the medical providers or treatment facilities you must use. Failure to call **us** to obtain pre-authorisation for your **treatment** means that you will be responsible for paying for all such **treatment**.

Please see the 'Cover option' section of your **membership certificate** – it will state 'Open Referral' if the Open Referral Service applies to your cover.

Reasonable and customary charges

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

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 in your **membership certificate**.

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 your **GP** or **consultant**.

We may agree to pay a **consultant** or **recognised facility** charge for the use of a consulting room used during your consultation, where **we** do agree **we** pay the charge under this benefit note 1.1.

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 your **GP** or **consultant** or where **we** have told you that a **GP** referral is not required for your condition, by **us**.

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

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

Charges related to out-patient treatment

We pay provider charges for **out-patient treatment** which is related to and is an integral part of your **out-patient treatment**. **We** treat these charges as falling under this benefit 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 your **GP** or **consultant**.

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 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 (including the charge for interpretation of the results) for **diagnostic tests**.

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

benefit 1.5 out-patient MRI, CT and PET scans

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

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

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

Being treated in hospital

Benefit 2 Consultants' fees for surgical and medical hospital treatment

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

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 in 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 in 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.

If the Open Referral Service does not apply to your cover, you should always call **us** before arranging any **treatment** to check whether your chosen treatment facility is recognised by **us** for both treating your medical condition and carrying out your proposed **treatment**.

If the Open Referral Service applies to your cover you must obtain an 'open referral' from your **GP** and you must call **us** before arranging or receiving any **treatment**. **We** will confirm the medical providers or treatment facilities you must use. Failure to call **us** to obtain pre-authorisation for your **treatment** means that you will be responsible for paying for all such **treatment**.

Please see the 'Cover option' section of your **membership certificate** – it will state 'Open Referral' if the Open Referral Service applies to your cover.

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**. When you contact **us** **we** will check your cover and help you to find a suitable alternative **Bupa** recognised treatment facility.

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

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

or

- if unforeseen circumstances arise from a medical or surgical procedure which does not routinely require **intensive care** as part of the **treatment** and:
 - you are receiving private **eligible treatment** in a **recognised facility** equipped with a **critical care unit**, and
 - the **intensive care** is carried out in the **critical care unit**

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

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

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

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

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

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

benefit 3.2.5 diagnostic tests and MRI, CT and PET scans

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

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

benefit 3.2.6 therapies

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

benefit 3.2.7 prostheses and appliances

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

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

Benefits for specific medical conditions

Benefit 4 Cancer treatment

benefit 4.1 cancer cover

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

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 your **GP** or **consultant**.

We may agree to pay a **consultant** or **recognised facility** charge for the use of a consulting room used during your **out-patient** consultation, where **we** do agree **we** pay the charge under this benefit 4.1.1.

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 your **GP** or **consultant**.

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

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

Charges related to out-patient treatment

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

benefit 4.1.3 out-patient complementary medicine treatment for cancer

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

We do not pay for any complementary or alternative products, preparations or remedies – 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 (including the charge for interpretation of the results) for **diagnostic tests**. **We** do not pay charges for **diagnostic tests** that are not from the **recognised facility**.

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

benefit 4.1.5 out-patient cancer drugs

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

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 or 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 or **surgical operation** you need to treat your **cancer** is not available to you from your **NHS**, and
- you receive your **treatment** for **cancer** in a **recognised facility**.

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

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

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

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

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

Benefit 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 in 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 problems.

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 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 your **GP**.

benefit 5.1.2 mental health and wellbeing therapists' fees

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

benefit 5.1.3 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 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: AIDS/HIV
- Exclusion 3: Allergies or allergic disorders
- Exclusion 5: Birth control, conception, sexual problems and gender reassignment
- Exclusion 6: Chronic conditions
- Exclusion 10: Cosmetic, reconstructive or weight loss treatment
- Exclusion 11: Deafness
- Exclusion 13: Dialysis
- Exclusion 17: Eyesight
- Exclusion 24: Pregnancy and childbirth
- Exclusion 25: Screening, monitoring and preventative treatment
- Exclusion 26: Sleep problems and disorders
- Exclusion 28: Speech disorders

Additional benefits

Benefit 6 Treatment at home

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

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

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

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

Benefit 7 Home nursing after private eligible in-patient treatment

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

We pay for home nursing immediately following private **in-patient treatment** if 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 agreement before the **treatment** starts and **we** need full clinical details from your **consultant** before **we** can make **our** decision.

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

Benefit 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 only pay repatriation and evacuation assistance benefit at **our** discretion.

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 are reasonable. **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 outside the **UK** – or inside the **UK** 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 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 the **renewal date** following **your** or their 16th birthday and then only if the **sponsor** includes that Cash benefit in **your** or their cover from that **renewal 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 your **NHS**. **We** only pay NHS cash benefit if your **treatment** would otherwise have been covered for private **in-patient treatment** under your **benefits**.

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

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 non-disposable 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** or orthodontist and which you need as a result of an **accidental dental injury** that you suffer while:

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

We only pay for **dental treatment** that takes place:

- within six months of the date on which you received the **accidental dental injury** for which your **dental treatment** is needed
- while you are member under the **agreement**, and
- accidental dental injury cash benefit is covered under your **benefits**.

What is not covered

We do not pay for any dental or oral surgical or medical services that are not specified as being covered under this benefit including but not limited to:

- **dental treatment** where the teeth or gums have been decayed, diseased, repaired restored or treated (other than scaling or polishing) before the **accidental dental injury** occurred
- **dental treatment** to repair damaged dentures or implants.

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 your **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 NHS cash benefit for treatment for cancer

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

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

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

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

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

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

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

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

We pay NHS cash benefit as follows:

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

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

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

We only pay this benefit once even if you have more than one **eligible treatment** on the same day.

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 in your **membership certificate**.

This section does not apply to 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.

Exclusion 2 AIDS/HIV

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

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

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

Exclusion 3 Allergies or allergic disorders

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

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

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

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

We do not pay for **treatment**:

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

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

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

Exclusion 6 Chronic conditions

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

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

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

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

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

Exclusion 7 Complications from excluded conditions, treatment and experimental treatment

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

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

Exclusion 8 Contamination, wars, riots and terrorist acts

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

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

Exclusion 9 Convalescence, rehabilitation and general nursing care

We do not pay 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**.

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

- is an integral part of **in-patient treatment**
- starts within 42 days from and including the date you first receive that **in-patient treatment**, and
- takes place in a **recognised facility**.

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

Exclusion 10 Cosmetic, reconstructive or weight loss treatment

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

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

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

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

whether or not the **treatment** it 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: **We** pay for an **eligible surgical operation** to restore your appearance after:

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

We only pay if the accident or the **cancer** surgery takes place during your current continuous period of cover under this **scheme** and any other **Bupa** scheme provided there has been no break in your cover between this **scheme** and the other **Bupa** scheme. **We** will only pay if this is part of the original **eligible treatment** resulting from the accident or **cancer** surgery and you have obtained **our** written agreement before receiving the **treatment**.

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

- put a natural tooth back into a jaw bone after it is knocked out or dislodged in an unexpected accidental injury
- treat a jaw bone cyst, but not if it is related to a cyst or abscess on the tooth root or any other tooth or gum disease or damage.

Exception 2: **We** pay for an **eligible surgical operation** carried out by a **consultant** to surgically remove a complicated, buried or impacted tooth root, such as an impacted wisdom tooth, but not if the purpose is to facilitate dentures or the **acute condition** relates to a **pre-existing condition** or a **moratorium condition**.

Exclusion 13 Dialysis

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

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

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

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

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

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

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

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

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

Exclusion 15 Excluded treatment or medical conditions

We do not pay for:

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

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

Exclusion 16 Experimental drugs and treatment

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

Exception: **We** may pay for this type of **treatment** of an **acute condition**. 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 '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.

Exception: **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.

Exclusion 18 Pandemic

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

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

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

- it follows an unplanned or an emergency admission to an **NHS** hospital or facility
- 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**.

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

Exception: **We** pay for **eligible treatment** for **intensive care** but only as set out in benefit 3 in the section 'Benefits'.

Exclusion 20 Learning difficulties, behavioural and developmental problems

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

Exclusion 21 Overseas treatment

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

Exception: 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'.

Exclusion 22 Physical aids and devices

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

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

Exclusion 23 Pre-existing conditions

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

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

- **you** have been sent **your membership certificate** which lists the person with the **pre-existing condition** (whether this is **you** or one of **your dependants**)
- **you** gave **us** all the information **we** asked **you** for, before **we** sent **you your** first membership certificate listing the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**
- neither **you** nor the person with the **pre-existing condition** knew about it before **we** sent **you your** first membership certificate which lists the person with the **pre-existing condition** for their current continuous period of cover under the **scheme**, and

- **we** did not exclude cover (for example under a **special condition**) for the costs of the **treatment**, when **we** sent **you your membership certificate**.

Exclusion 24 Pregnancy and childbirth

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

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

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

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

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

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

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

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

Exclusion 25 Screening, monitoring and preventive treatment

We do not pay for:

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

- tests or procedures which, in **our** reasonable opinion based on established clinical and medical practice, are carried out for screening or monitoring purposes, such as endoscopies when no symptoms are present
- preventive **treatment**, procedures or medical services.

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

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

Exclusion 26 Sleep problems and disorders

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

Exclusion 27 Special conditions

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

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

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

Exclusion 28 Speech disorders

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

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

Exclusion 29 Remote consultations

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

Exclusion 30 Temporary relief of symptoms

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

Exception: **We** may pay for this type of **treatment** if you need it to relieve the symptoms of a terminal disease or illness.

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**
- 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.

Glossary

Words and phrases printed in bold and 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 injury, including one sustained during participation in a sporting activity.
<i>Acute condition</i>	a disease, illness or injury that is likely to respond quickly to <i>treatment</i> which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.
<i>Advanced therapies</i>	new and innovative targeted/bespoke therapies using advanced materials and methods to be used as part of your <i>eligible treatment</i> that are at the time of your <i>eligible treatment</i> included on <i>our</i> list of advanced therapies that applies to your <i>benefits</i> , which is available at <i>bupa.co.uk/policyinformation</i> and on request. The advanced therapies on the list may change from time to time.
<i>Agreement</i>	the agreement between the <i>sponsor</i> and <i>us</i> under which you have cover for your <i>benefits</i> .
<i>Appliance</i>	any appliance which is in <i>our</i> list of appliances for your <i>benefits</i> at the time you receive your <i>treatment</i> . The list of appliances may change from time to time. Details of the appliances are available on request.
<i>Benefits</i>	the benefits specified in your <i>membership certificate</i> for which you are entitled as an individual under the <i>scheme</i> subject to the terms and conditions that apply to your membership in this Bupa 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>Chronic condition</i>	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.

Word/phrase	Meaning
Co-insurance	the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits .
Common drugs	commonly used medicines, such as antibiotics and painkillers that in our reasonable opinion based on established clinical and medical practice should be used as part of your eligible treatment .
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.
Consultant	<p>a registered medical or dental practitioner who, at the time you receive your treatment:</p> <ul style="list-style-type: none"> ◦ is recognised by us as a consultant and has received written confirmation from us of this, unless we recognised him or her as being a consultant before 30 June 1996 ◦ is recognised by us both for treating the medical condition you have and for providing the type of treatment you need, and ◦ is in our list of consultants that applies to your benefits. <p>You can contact us to find out if a medical or dental practitioner is recognised by us as a consultant and the type of treatment we recognise them for.</p>
Consultant fees schedule	<p>the schedule used by Bupa for the purpose of providing benefits which sets out the benefit limits for consultants' fees based on:</p> <ul style="list-style-type: none"> ◦ the type of treatment carried out ◦ for surgical operations, the type and complexity of the surgical operation according to the schedule of procedures – the benefits available for consultant surgeons and consultant anaesthetists may differ for the same surgical operation, ◦ 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 may change from time to time. Details of the schedule are available on request.</p>
Critical care unit	any intensive care unit, intensive therapy unit, high dependency unit, coronary care unit or progressive care unit which is in our list of critical care units and recognised by us for the type of intensive care that you require at the time you receive your treatment . The units on the list and the type of intensive care that we recognise each unit for may change from time to time. Details of these critical care units are available on request.
Day-patient	a patient who is admitted to a hospital, treatment facility or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
Day-patient treatment	eligible treatment that, for medical reasons, is received as a day-patient .
Dental treatment	dental or oral surgical or medical services (including diagnostic tests) which are needed to diagnose, relieve or cure an accidental dental injury .

Word/phrase	Meaning
Dentist	any general dental practitioner who is registered with the General Dental Council at the time you receive your dental treatment .
Dependant	your partner and any child of yours who, with the sponsor's approval, is a member under the agreement .
Diagnostic tests	investigations, such as X-rays or blood tests, to find or to help to find the cause of your symptoms.
Eligible surgical operation	eligible treatment carried out as a surgical operation .
Eligible treatment	treatment of: <ul style="list-style-type: none"> an acute condition or a mental health condition together with the products and equipment used as part of the treatment that: <ul style="list-style-type: none"> are consistent with generally accepted standards of medical practice and representative of best practices in the medical profession in the UK are clinically appropriate in terms of type, frequency, extent, duration and the facility or location where the services are provided, 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 treatment, services or charges are not excluded under your benefits.
Excess	the amount that you have to pay towards the cost of treatment that you receive that would otherwise have been payable under your benefits .
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.
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, and <ul style="list-style-type: none"> has seen you whilst practising in the NHS primary care setting as an NHS GP, or is a private sector GP who is recognised by us as an independent general practitioner for the purposes of your scheme.
Home	either: <ul style="list-style-type: none"> the place where you normally live, or any other establishment, including a non-healthcare setting, which we may decide to treat as a home for the purpose of your benefits.
In-patient	a patient who is admitted to a hospital or treatment facility and who occupies a bed overnight or longer for medical reasons.

Word/phrase	Meaning
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.
Main member	the person who is covered under the agreement by virtue of being eligible in his or her own right rather than as a dependant .
Medical assistance company	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.
Medical treatment provider	a person or company who is recognised by us as a medical treatment provider for the type of treatment at home that you need at the time you receive your treatment . These medical treatment providers and the type of treatment we recognise them for may change from time to time. Details of these medical treatment providers and the type of treatment we recognise them for are available on request.
Membership certificate	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.
Mental health and wellbeing therapist	<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 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.
Mental health condition	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 to be 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.
Mental health day-patient treatment	eligible treatment of a mental health condition which for medical reasons means you have to be admitted to a recognised facility because you need a period of clinically-supervised eligible treatment of a mental health condition as a day case but do not have to occupy a bed overnight and the mental health treatment is provided on either an individual or group basis.

Word/phrase	Meaning
Mental health in-patient treatment	eligible treatment of a mental health condition that, for medical reasons, is received as an in-patient .
Mental health treatment	eligible treatment as set out in Benefit 5 Mental health treatment in the 'Benefits' section of this guide.
Moratoria start date	the moratoria start date shown on your membership certificate .
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. We may take your cover under a previous scheme into account when assessing if a condition is a moratorium condition but we will only do this if we have specifically agreed with the sponsor that we will do this under the agreement and you have provided us with evidence of your continuous cover under the previous scheme.</p>
Moratorium member	a member whose membership certificate shows the underwriting method applied to them is moratorium.
Moratorium qualifying period	the moratorium qualifying period described in the further details section of your membership certificate .
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 under age 70 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 start date 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.

Word/phrase	Meaning
Out-patient	a patient who attends a hospital, consulting room, out-patient clinic or treatment facility and is not admitted as a day-patient or an in-patient .
Out-patient surgical operation	an eligible surgical operation received as an out-patient .
Out-patient treatment	eligible treatment that, for medical reasons, is received as an out-patient .
Overall annual maximum benefit	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, co-insurance and any amounts we pay to you on an ex-gratia basis all count towards your overall annual maximum benefit.
Participating facility	<ul style="list-style-type: none"> a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our participating facility list that applies to your benefits, and is recognised by us for both: <ul style="list-style-type: none"> treating the medical condition you have, and carrying out the type of treatment you need any other establishment which we may decide to treat as a participating facility for the purpose of the scheme. <p>The hospitals, treatment facilities, centres or units in the list and the medical conditions and types of treatment we recognise them for may change from time to time.</p> <p>Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>
Partner	your husband or wife or civil partner or the person you live with in a relationship similar to that of a husband and wife whether of the opposite sex or not.
Partnership consultant	a consultant who, at the time you receive your treatment , is recognised by us as a partnership consultant. You can contact us to find out if a consultant is a partnership consultant.
Partnership facility	<ul style="list-style-type: none"> a hospital or a treatment facility, centre or unit that, at the time you receive your eligible treatment, is in our partnership facility list that applies to your benefits and is recognised by us for both: <ul style="list-style-type: none"> treating the medical condition you have, and carrying out the type of treatment you need any other establishment which we may decide to treat as a partnership facility for the purpose of the scheme. <p>The hospitals, treatment facilities, centres and units in the list and the medical conditions and types of treatment we recognise them for may change from time to time. Details of the facilities in the list and the medical conditions and types of treatment we recognise them for are available on request.</p>
Pre-existing condition	any disease, illness or injury for which in the seven years before your start date : <ul style="list-style-type: none"> you have received medication, advice or treatment, or you have experienced symptoms whether the condition was diagnosed or not.

Word/phrase	Meaning
Previous scheme	<ul style="list-style-type: none"> ○ another Bupa private medical insurance scheme or Bupa administered medical healthcare trust ○ a private medical insurance scheme or medical healthcare trust provided or administered by another insurer <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 or continuous periods of cover provided that there is no break in a member's cover between the previous scheme and their scheme.</p>
Prosthesis	<p>any prosthesis which is in our list of prostheses for both your benefits and your type of treatment at the time you receive your treatment. The prostheses on the list may change from time to time. Details of the prostheses covered under your benefits for your type of treatment are available on request.</p>
Recognised facility	<p>either a:</p> <ul style="list-style-type: none"> ○ participating facility, or ○ partnership facility <p>according to the facility access that applies to your benefits.</p>
Recognised practitioner	<p>a healthcare practitioner who at the time of your treatment:</p> <ul style="list-style-type: none"> ○ is recognised by us for the purpose of our private medical insurance schemes for treating the medical condition you have and for providing the type of treatment you need, and ○ is in our list of recognised practitioners that applies to your benefits.
Renewal date	<p>the date each year agreed between the sponsor and us on which the group cover is due for renewal.</p>
Schedule of procedures	<p>the schedule used by Bupa for the purpose of providing benefits which classifies surgical operations according to their type and complexity. The schedule may change from time to time. Not all procedures listed in the schedule are covered under Bupa schemes. Further information on the schedule is available on request.</p>
Scheme	<p>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.</p>
Session	<p>periods of 24 hours during which the specified type of treatment is received for an acute condition.</p>
Special condition	<p>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 in the 'Special conditions' section for that underwritten member in your membership certificate.</p>
Specialist drugs	<p>drugs and medicines to be used as part of your eligible treatment, which are not common drugs and are at the time of your eligible treatment included on our list of specialist drugs that applies to your benefits that is available at bupa.co.uk/policyinformation and on request.</p> <p>The specialist drugs on the list may change from time to time.</p>

Word/phrase	Meaning
Sponsor	the company, firm or individual with whom we have entered into an agreement to provide cover.
Start date	the date you started your current continuous period of cover under the scheme .
Surgical operation	a surgical procedure or complex investigative/diagnostic procedure including all medically necessary treatment related to the procedure and all consultations carried out from the time you are admitted to a 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, or ○ a Royal College of Speech and Language Therapists registered speech and language therapist <p>who is Health Professions Council Registered and is a recognised practitioner. You can contact us to find out if a practitioner is a recognised practitioner and the type of treatment we recognise them for.</p>
Treatment	surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.
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 in your membership certificate .
We/our/us	Bupa .
Year	<ul style="list-style-type: none"> ○ when you first become a member under the scheme this is the period beginning on your start date and ending on the day before the renewal date ○ for continuing members this is the period beginning on the renewal date and ending on the day before the next renewal date.
You/your	this means the main member only.

Your information and privacy

We recognise that when you choose Bupa for your treatment or care that you are also trusting us to take good care of your personal information. For this reason we want to be open with you about how Bupa collects, uses and protects your information. Please read the privacy notice made available to you (by electronic means or enclosed with your guide) and regularly check **bupa.co.uk/privacy** for the latest version. If you have any questions about how we handle your information, or you have any other privacy concerns, you can contact us at **dataprotection@bupa.com**

Financial crime and sanctions

Financial crime

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

Sanctions

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

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