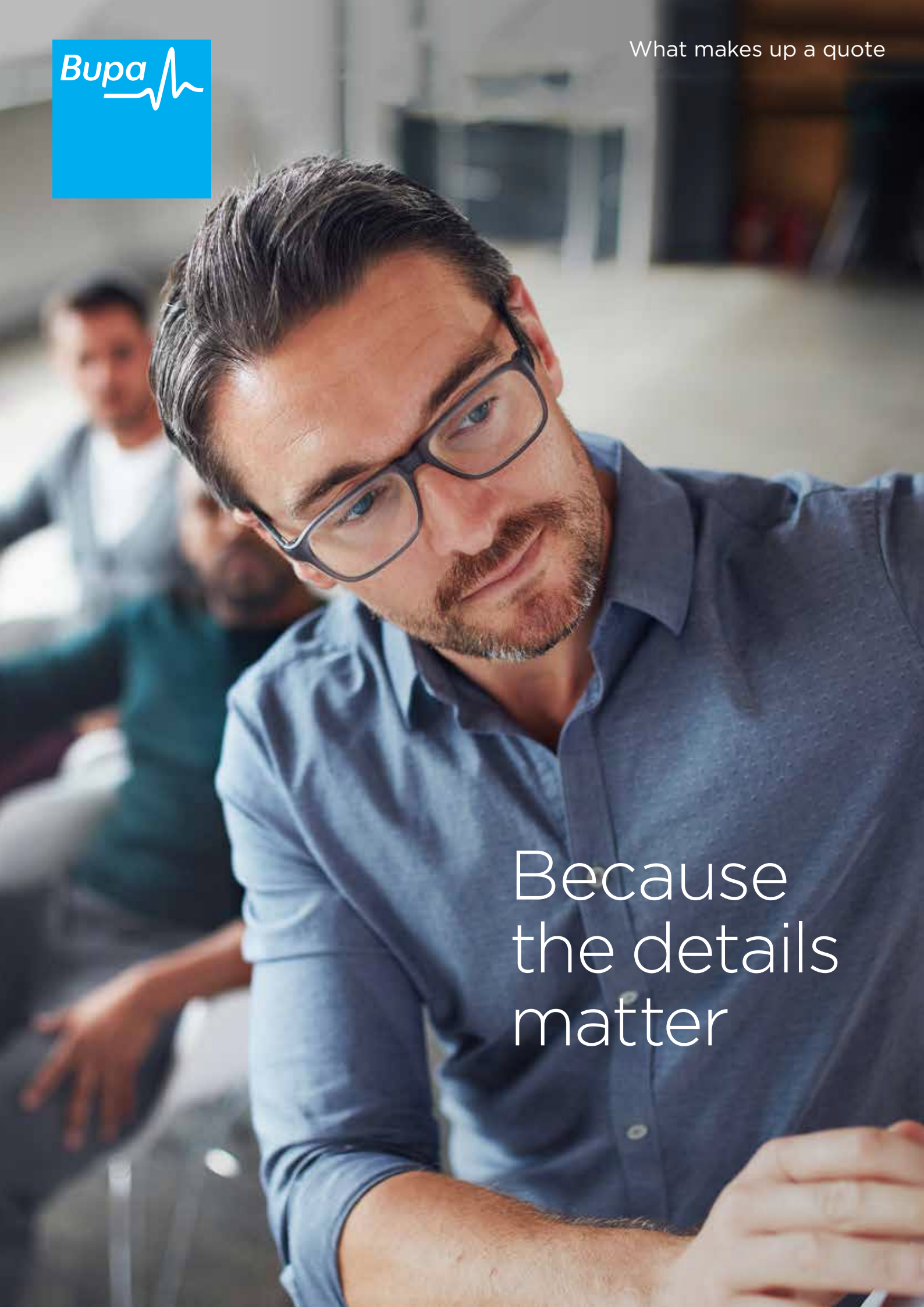


Because the details matter

What makes up a quote

Because it's important to know that your cover is exactly right for your business, we want to give you some guidance on the information we use to provide a quote.

Here we show you what information we use plus details on what we do and don't cover as well as an overview of how our policies work. You should read this guide alongside the products at a glance and policy summary documents which you have been provided with.

Product

Select

- Key
- Enhanced
- Complete

See products at a glance or policy summary

Excess

You can add an excess to the policy, which is a monetary contribution that your employee would make towards the cost of treatment.

£0, £100, £150, £200, £500

Company details

- Company name
- Contact name
- Contact email
- Contact telephone number
- Company registered trading address (we need this to verify your business)

Ways to pay

Subscriptions can be paid in the following ways:

- Monthly by direct debit only
- Quarterly, bi-annually, annually by Direct Debit, cheque or BACS

Member details

- Title
- First name
- Surname
- Date of birth
- Employees' addresses (should you wish to purchase cover)

Type of underwriting

- Full medical underwriting (FMU)
- Moratorium
- Medical history disregarded (MHD)
- No further underwriting (NFU)
- Moratorium switch (MSW)

See pages 5 and 6 for more information.

How claiming works

The claiming process you and your team members need to follow depends on your choice of underwriting.

Fully medically underwritten claiming journey

Your claim journey normally starts with a visit to your GP for a referral, although for some conditions this usually isn't necessary – please contact us for details.* If you need to see a consultant, you must call us for pre-authorisation before making any arrangements.

There are two types of referral:

- your GP refers you to a named consultant
- your GP details the type of care required – in this case, we'll guide you to a suitable healthcare professional who will be fee-assured (ie they will charge within Bupa benefit limits). You can choose your own consultant instead, but you may face extra charges for your treatment.

There may be times where we write to your GP requesting further information regarding your claim, but we'll always let you know before doing this.

If you need to make a claim in the first year

We want you to feel better knowing that you can have access to private treatment should you need it. If you do have to make a claim in the first year of your membership or if your symptom date is within the first year of your membership, we need to take a few extra steps to check your claim doesn't relate to any pre-existing symptoms or conditions.† Some conditions will require an early claims process period of more than 12 months so please check by contacting us.

To help us authorise your treatment as quickly as possible we may ask you to do one or more of the following:

- talk to one of our medical assessment advisers who may need to ask you a few health-related questions and send a history and onset form direct to your GP/consultant for them to complete^
- request copies of medical reports and documentation about the treatment or services you're claiming for.^

Rolling moratorium claiming journey

Your claim journey normally starts with a visit to your GP for a referral, although for some conditions this usually isn't necessary – please contact us for details.** If you need to see a consultant, you must call us for pre-authorisation before making any arrangements.

Following a telephone assessment with one of our medical assessment advisers, we'll decide whether the treatment can be authorised or if your GP needs to complete a pre-treatment form.

Where a form is needed, it will be sent to you to take to your GP for completion. (If they charge for doing this, you will need to cover the cost). We'll then assess the completed form and let you know the outcome.

- If the condition is eligible, it will be added to your policy so you won't need to repeat the process again for the same condition.
- If the condition is not eligible, it will be noted in your policy as excluded for at least two years after joining Bupa.

A rolling moratorium will continue to apply until two years after joining without any incident for each condition.

*Not available in the first 12 months of membership due to the early claims process.

**A rolling moratorium will continue to apply until at least two years after joining without any incident, for each pre-existing condition.

†Mental health conditions will follow this process as described above in the first five years of membership.

^We will contribute £15 towards the cost of this report if the condition is seen as not pre-existing.

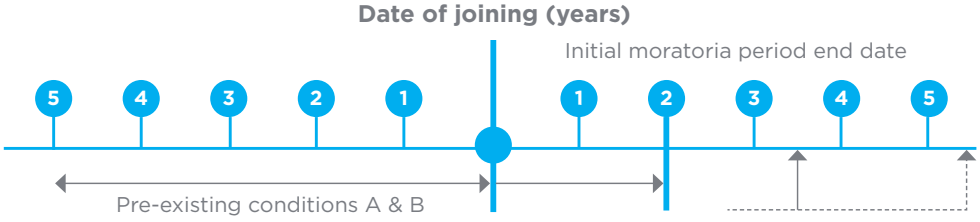
Your underwriting choices explained

Underwriting for health insurance is the process by which an insurer decides on what terms it will cover a person based on the information they supply.

With Bupa, you usually have a choice of five options, depending on the scheme you've chosen.

Underwriting	Explanation	What do I do?	How do I claim?	Things to consider
Full medical underwriting	Full medical underwriting means we'll consider the applicant's medical history when they join. Any condition declared is assessed by our medical assessment team. Usually, we won't cover the individual (or any family members on the policy) for conditions that existed before the date on which the cover began.	When choosing full medical underwriting the applicant will be asked to complete a health questionnaire (also called a medical history declaration) featuring questions about their medical history over the past seven years.	The member will need to call member services in order to pre-authorise their treatment to ensure that their claim is eligible under their policy. We may check with the member's GP to confirm that the condition is not pre-existing. Mental health conditions will follow this process as described above in the first five years of membership.	A full application is needed containing the last seven years' medical history. Exclusions may be applied to the policy and these will remain unless a review is requested (subject to certain criteria). If we don't receive the fully completed application the member won't be able to claim.
Rolling moratorium	Moratorium underwriting means the applicant won't need to fill in a health questionnaire before joining. If they have had a medical condition in the five years prior to joining Bupa, then this wouldn't be considered eligible for cover for at least the first two years of their policy. The member must have remained treatment, symptom, medication and advice free for at least two years after joining before the condition can be considered eligible.	When choosing moratorium underwriting the applicant will only be asked to provide basic information and we won't need details of their medical history or that of any family members to be covered under their policy. Instead, they'll be asked to provide information each time they claim.	The member will need to call to pre-authorise their treatment and if it's a new claim, will go through a telephone assessment to decide whether a pre-treatment form is needed.	It may be necessary for the member to ask their GP/consultant to fill in a form. They may have to pay for this service, at the discretion of the GP/ consultant.

Rolling moratorium example



Any claim/notification of symptom/treatment related to any pre-exisiting condition during the relevant moratoria period will not be covered and will result in the moratoria end date being extended by 2 years for the condition.

Claim for condition 'A' (pre-exisiting). If there has been a continuous 2 year period symptom/treatment free at anytime since the date of joining, then the claim is eligible. If not, the claim is not eligible and the moratoria period for this condition is extended by 2 years from this date.

Please note! You should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under your policy.

Underwriting	Explanation	What do I do?	How do I claim?	Things to consider
Medical history disregarded (20 employees or more)	Medical history disregarded (MHD) means that we won't take into account the applicant's previous medical history.	When choosing medical history disregarded you will only be asked to provide basic information about the applicants and you won't need to give us details of their medical history or that of any family members to be covered.	The member will need to call Member Services to pre-authorise their treatment to ensure that their claim is eligible under their policy.	Medical history disregarded (MHD) can only be offered for groups with 20+ members. In general, it's more expensive than other types of underwriting.
No further underwriting	No further underwriting means that if you have health insurance through another insurer we may transfer the group over with no further underwriting applied (subject to completion of a Group Secretary Medical Declaration Form). This means that members can carry on with their previous underwriting. Any new joiners not previously insured will be subject to full medical underwriting.	Completion of a Group Secretary Medical Declaration form is required along with copies of each member's most recent certificate of insurance.	The member will need to call Member Services in order to pre-authorise their treatment to make sure that their claim is eligible under their policy.	This is only available if you have had insurance with another provider for a minimum of one year. We do not guarantee that exclusions won't be applied. If we don't receive previous certificates of insurance, members won't be able to claim.
Moratorium switch	Moratorium switch means that if you have health insurance through another insurer on moratorium terms we may transfer the group over and they may keep their original moratorium start date rather than it starting again (subject to completion of a Group Secretary Medical Declaration Form). Any new joiners not previously insured will be subject to rolling moratorium underwriting.	Completion of a Group Secretary Medical Declaration form is required along with copies of each member's most recent certificate of insurance.	The member will need to call Member Services in order to pre-authorise their treatment to make sure that their claim is eligible under their policy.	This is only available if you have had insurance with another provider for a minimum of one year. We do not guarantee that exclusions won't be applied. If we don't receive previous certificates of insurance, members won't be able to claim.

What you need to know about your policy

Our health insurance covers the cost of private eligible consultations, tests and treatment for the ‘acute conditions’ listed on your policy. Here are some jargon busting explanations to help you understand your cover better.

Excess

Adding an excess to your team members’ policy could reduce the premium they pay. It means they may need to make a contribution to the cost of any care they receive. The options are £0, £100, £150, £200 and £500, and you can specify a different excess amount for different team members.

As the excess cost applies to a specific benefit year, this means that a team member could pay twice if their course of treatment spans the renewal date.

If the first eligible claim is in relation to out-patient treatment, this will erode your out-patient benefit if you have chosen a limit.

Out-patient

This is where a customer is required to go to hospital but does not have to stay overnight. Examples of an out-patient appointment are initial consultations, scans and tests, and follow-up consultations.

Out-patient appointments are not the same as day-patient procedures.

Day-patient

This is where someone makes a planned admission into a hospital to get treatment. They may require a bed but they will not stay in the hospital overnight. Day-patient procedures do not come out of a customer’s out-patient allowance. Eligible day case procedures are paid in full on all of our policies*.

In-patient

The term in-patient care refers to care provided by a consultant while the member is in hospital. It can be provided by a surgeon during the period before or after surgery, or by a physician such as a consultant in general medicine for medical treatment.

*When we say benefits are paid in full – this is for eligible treatment on your core health insurance when you use a healthcare facility within your chosen Bupa network using a Bupa recognised consultant who agrees to charge within Bupa limits (a fee-assured consultant).

What’s not covered in your policy

General exclusions

There are some conditions and treatments which we do not cover. Among these are:

- ageing, menopause and puberty
- AIDS/HIV
- allergies
- birth control, conception, infertility, sexual problems or gender reassignment
- chronic conditions
- chronic mental health conditions
- complications from excluded conditions
- treatment resulting from contamination, wars, riots or terrorist acts
- pandemic or epidemic disease
- convalescence care, rehabilitation or general nursing care
- cosmetic, reconstructive or weight loss treatment
- treatment for deafness or to correct eyesight
- dental or oral treatment
- dialysis
- experimental drugs and treatment
- intensive care (other than routinely needed after private day-patient treatment or in-patient treatment)
- learning difficulties, behavioural and developmental problems
- pregnancy and childbirth
- screening, monitoring and preventive treatment
- sleep problems and disorders
- speech disorders
- temporary relief of symptoms
- out-patient drugs and dressings
- physical aids and appliances

More details on what isn’t covered can be found in the membership guide.

Emergency and unplanned treatment – such as a trip to A&E or transfer to a private critical care unit – is not covered. Pre-existing conditions are also not normally covered. Please read the 'Important Points' section at bupa.co.uk/policyinformation for more details about the extent of your cover.

Chronic conditions

There are certain rules that apply to our policies if a member develops a 'chronic condition' while they're with us – you should always check the terms of your policy for more details of what is and isn't covered. In general, the member will be covered for eligible specialist consultations up to the diagnosis of a chronic condition but will need to go back to the care of their GP and the NHS for the on-going management, screening and monitoring of the condition.

What is a chronic condition?

A chronic condition is defined as a disease, illness or injury that has one or more of the following characteristics: it needs long term monitoring, on-going or long-term control or relief of symptoms, it requires rehabilitation, it continues indefinitely, and it has no known cure or is likely to come back.

What if the condition gets worse?

If the long-term condition gets worse, the member may be having what's known as an 'acute flare-up'. This is when a condition suddenly and unexpectedly deteriorates. We'll cover eligible, short-term treatment of an acute flare-up when the condition is likely to respond quickly to treatment and aims to restore the member to the state of health they were in immediately before suffering the acute flare-up. If, at any point, urgent medical attention is needed to help stabilise or treat this flare-up, the member should access the emergency care services through the NHS as we do not cover emergency treatment. However, when the condition has been stabilised and planned treatment is required, we'll cover this provided it is eligible under the terms of your policy. Following this, the on-going management of the condition will be returned to the care of the member's GP and the NHS.

Because you care

Talk to us about your healthcare needs

03457 515 515

bupa.co.uk/business

We may record or monitor our calls.

SME/1663/MAR18 BHF 06903