

Bupa EmployeeChoice Essential policy summary



This policy summary contains key information about Bupa EmployeeChoice Essential. You should read this carefully and keep it in a safe place afterwards. Please note that it does not contain the full terms and conditions and exclusions of cover which you will find in your Bupa Personal Membership Guide. Please also refer to your membership certificate. Copies of these documents are available on request.

The provider

Bupa EmployeeChoice Essential is provided by Bupa Insurance Limited, a subsidiary of the British United Provident Association Limited. Other services are provided by or via other subsidiary companies.

The insurance and the cover that it provides

Bupa EmployeeChoice Essential offers you private medical insurance which aims to fund medical treatment. It will cover the costs of your eligible treatment in the UK, up to the limits of your chosen cover, by Bupa recognised consultants and therapists. There is no overall maximum amount paid out in any year, although there are set limits for certain particular benefits.

Bupa EmployeeChoice Essential provides cover for eligible hospital treatment at hospitals in the national network of Bupa partnership network hospitals. Partnership network hospitals may change from time to time.

No claims discount

Bupa EmployeeChoice Essential gives you the benefit of an immediate no claims discount on joining.

Any claims you make during your membership year will be reflected in your no claims discount which applies in future years.

Your no claims discount should not stop you from having necessary medical treatment due to concerns about losing your discount.

Summary of cover

The summary of cover overleaf sets out the eligible:

- out-patient consultations, diagnostic tests and hospital in-patient and day-patient treatment; and
- therapies

which are covered.

Summary of cover

Bupa EmployeeChoice Essential	Benefits	Notes
In-patient and day-patient treatment		
Hospital charges	✓	In a Bupa partnership network hospital
Consultants'/specialists' fees	✓	In a Bupa partnership network hospital - Bupa benefit limits apply if the consultant is not a Bupa partnership consultant
Diagnostic tests	✓	In a Bupa partnership network hospital
Radiotherapy/chemotherapy	✓	In a Bupa partnership network hospital. Benefit limits apply if the consultant oncologist is not a Bupa partnership consultant
Psychiatric treatment	X	
Out-patient treatment		
Consultations with a consultant/specialist	Up to £500 a year ^Δ	With a Bupa recognised consultant when following within six months and directly related to eligible in-patient/day-patient treatment. For consultations with a consultant we only pay for up to two such consultations during the six months period
Diagnostic tests	✓	MRI, CT and PET scans in a Bupa recognised out-patient diagnostic imaging centre
Radiotherapy/chemotherapy	✓	In a Bupa partnership network hospital or, for certain conditions, a Bupa specialist treatment centre. Benefit limits apply if the consultant oncologist is not a Bupa partnership consultant
Physiotherapy (and other therapies)	Up to £500 a year ^Δ	On a GP or Bupa recognised consultant referral to a Bupa recognised therapist when following within six months and directly related to eligible in-patient/day-patient treatment
Psychiatric treatment	X	
Additional benefits		
Nursing at home	Up to £600 a year	Following eligible private in-patient treatment covered by your scheme
Private ambulance	Up to £120 a year	£60 maximum for any one trip
Parent accommodation	✓	When staying with a child under 12 receiving eligible private in-patient treatment, one parent only
NHS cash benefit	X	
Complementary medicine	X	

Wide range of cover

Please note Bupa EmployeeChoice Essential covers eligible treatment of acute medical conditions including:

- surgery
- hospital accommodation and nursing
- diagnostics
- out-patient consultations and therapies
- treatment for cancer
- private hospital treatment following an accident or emergency admission
- injuries from dangerous hobbies
- self-inflicted injuries.

What your policy does not cover

Exclusions (See 'What is not covered' section of the policy membership guide for full details)

There are a number of conditions and treatments which Bupa EmployeeChoice Essential does not cover. Amongst these are:

- conditions you had before your policy started (commonly known as 'pre-existing conditions')
- services you receive from your GP
- long-term illnesses which cannot be cured (usually referred to as 'chronic conditions')
- accident and emergency admission (although Bupa EmployeeChoice Essential does cover any eligible hospital treatment that you receive afterwards)
- treatment for conditions or symptoms arising from physiological or natural causes (such as ageing, menopause or puberty) or desensitisation of allergies
- convalescence
- routine health checks or dental/oral treatment (such as fillings and treatment for gum disease)
- treatment relating to learning, behavioural and developmental problems
- sleep-related breathing disorders
- overseas treatment or repatriation
- intensive care, except when routinely needed after private treatment
- psychiatric treatment
- complementary medicine
- organ transplant surgery
- sexually transmitted diseases
- neo-natal care.

Policy excesses (See 'Claiming' section of the policy membership guide for full details).

You can choose to pay a policy excess of £250 of your eligible treatment costs in any year and your Bupa EmployeeChoice Essential policy will then pay the rest. The higher your policy excess, the lower will be your subscription costs. The excess is payable per person, per

membership year on the cover. Details of the excess option that you have chosen is shown in your registration certificate.

How long your cover will last

Bupa EmployeeChoice Essential is an annual contract that is automatically renewed each year and will continue until:

- you stop paying subscriptions to it
- you cease to live in the UK
- you die.

Bupa has the right to make changes to the terms and conditions of your cover on any annual anniversary date after your policy has started or to end the scheme.

Where cover extends to dependants' cover it may end at a different date to the main member's. Cover for dependants will always end when the main member's cover ends. (See 'How your membership works' section of the policy membership guide for full details).

Changing your mind

You can change your mind within 21 days:

- of the day when your policy starts or, if later,
- the day when you receive your policy membership guide and your membership certificate

As long as you have not made any claims, we will refund all your subscriptions.

After this time, if you decide for any reason, that you do not want your Bupa EmployeeChoice Essential policy after all, we will refund any subscriptions you have paid which relates to a period after your cover ends.

(See 'How your membership works' section of the policy membership guide for full details).

Getting in touch

The Bupa helpline is always the first number to call if you need help or support or if you have any comments or complaints. Please call us on **0845 60 90 1111**[†] between 8am and 8pm, Monday to Friday and 8am to 6pm on Saturdays. Alternatively you can write to us at: Bupa, Staines, TW18 4XF or fax us on 01784 465 232.

How to make a claim

You should always call Bupa on 0845 60 90 111[†] before you see a consultant or therapist and before your treatment begins. You will also need to have your Bupa membership number handy when you call. Lines are open 8am to 8pm Monday to Friday and 8am to 6pm Saturday. (See 'Claiming' section of the policy membership guide for full details).

Making a complaint

If we have not been able to resolve a problem and you wish to take your complaint further, you can contact our Head of Customer Relations. Please write to:
The Customer Relations Department, Bupa, Staines
TW18 4XF. Fax on 01784 893175 or phone
0845 606 6726[†] between 8:30am and 5:30pm Mondays to Fridays.

It is rare that we are unable to settle a complaint but if this does happen, you may refer your complaint to the Financial Ombudsman Service. You can write to them at:
South Quay Plaza, 183 Marsh Wall, London E14 9SR or
call them on 0845 080 1800.

For members with special needs

For hearing and speech impaired members who have a textphone, please call on:

0845 6066 863

between 9am to 5pm Monday to Friday. We can also offer a choice of braille, large print or audio for correspondence.

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 020 7892 7300 or on its website <http://www.fscs.org.uk/>

[†]Calls to this number may be recorded and may be monitored.



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