



YOUR POLICY BOOK

**HEALTHPLAN SUPPORT,
SUPPORT 4 WEEK
WAIT & SUPPORT
6 WEEK WAIT**

SAGA

Experience is everything



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Quick reference guide for important information

Saga HealthPlan Support, Saga HealthPlan Support 4 and Saga HealthPlan Support 6 are underwritten by Bupa Insurance Limited, therefore any reference to 'Bupa, we, us, our' in this document means Bupa Insurance Limited.

Contacting us

While it is important that you read and understand your Policy Book, we understand that it is often easier to call us to obtain information, so we have a Claims Helpline to help you.

You should always call our Claims Helpline on the number provided before starting **treatment**. Please be aware that if you do not obtain authorisation from us before starting **treatment** then we may be unable to pay for the **treatment** you receive in full or in part.

To speak to a healthcare professional

Saga GP Service 0330 018 1618

(operated by HealthHero Solutions Limited)

Available day or night, 365 days a year. You can book an appointment online via www.saga.co.uk/GPService

Anytime HealthLine 0330 018 0779

Available day or night, 365 days a year.

For more information on access to these advice and support lines, please see section 11.

To make a new claim or for help with an existing claim

Claims Helpline 0330 018 0778

If calling from outside the UK

+44 161 527 6165 – international call rates apply.

Available: Monday to Friday 8am-8pm, Saturday 8am-4pm.

Please remember that you should obtain authorisation for your claim from us before starting any **treatment**.

Manage your claim online

You can create an account online by visiting bupa.co.uk or download the My Bupa App. From here you can call or use Webchat to get in touch, pre-authorise **treatment** and view your claims history.

To discuss or make changes to your Saga HealthPlan

Customer Care Team 0330 018 1361

Or call **+44 2082 822946** from abroad

Available: Monday to Friday 8.30am-7pm, Saturday 9am-1pm.

Saga is committed to giving customers different ways to access products. To contact us by Next Generation Text on any of the numbers listed in this Policy Book just prefix the number listed with **18001**.

Sight, speech or hearing difficulties?

Please let us know if you would like a braille, large print or audio copy of your documents. For people with hearing or speech difficulties, you can use the Relay UK service on your smart phone or text phone. For further information visit www.relayuk.bt.com

You can call us with any questions about the Relay UK service on **0800 010 383**.

Calls to all the telephone numbers above may be recorded in case of subsequent query.

WELCOME TO SAGA HEALTHPLAN SUPPORT

Thank you for choosing a Saga HealthPlan underwritten by Bupa Insurance Limited. Saga aims to provide the highest level of care and service possible, so this policy has been designed with your needs in mind.

This Policy Book describes your cover in detail and should provide you with all you need to know about your policy, including how to make a claim. It is organised into sections to help you quickly find the information you need and to make it as straightforward and easy to understand as possible.

Please take the time to read this booklet carefully to make sure you fully understand what you are covered for, that your policy gives you the cover you want and that you are aware of the additional advice and support lines available to you as a Saga Health Insurance customer.

If you have any questions at all, feel free to call Saga's Customer Care Team on the relevant telephone number opposite and one of the team will be happy to help.

1 INTRODUCTION

The purpose of this Policy Book and how to use it

This Policy Book sets out the terms of cover for Saga HealthPlan Support, Support 4 and Support 6. If you are unsure of which particular **policy** you have, please refer to your Policy Schedule. (Please note that Saga HealthPlan Support is not available if you live in the Channel Islands (unless you are an existing customer), and Support 4 and Support 6 are not available if you live in the Channel Islands or Isle of Man.)

Your **policy** is an annual insurance contract which means that prior to the end of any **policy year** Saga will write to the **policyholder** to advise on what terms the **policy** will continue, provided that the **policy** you are on is still available. This will include an 'endorsement' which contains details of any amendments that will apply to this **policy**.

The following documents make up our agreement with you:

- The Saga Policy Book
- Your Policy Schedule
- Important Information

These documents must be read together as a whole – they should not be read as separate documents.

This Policy Book and any endorsements which amend it are important documents as they detail:

- the cover you have (both benefits and limitations);
- how to make a claim;
- how your **policy** is administered; and
- other services provided by your **policy**.

Throughout your Policy Book certain words and phrases appear in **bold type** to indicate they have a special medical or defined meaning. You will find a glossary of these words in section 13 or, if they apply to a specific section, they will be defined there.

Additionally, when we refer to 'you' or 'your' throughout this document, we mean the **policyholder** and any **family members** named on the **policyholder's** Policy Schedule.

Please note:

This Policy Book contains information on more than one policy within the Saga HealthPlan range. Most of the information is relevant to all policies. However, there are instances where information is not relevant to all policies. Where this occurs, we have drawn your attention to which particular policy we are referring to as follows:

When a sentence or paragraph starts with a policy name and is in italics, it means that the information given relates only to the policy name stated.

This Policy Book includes wording for both Saga HealthPlan Support 4 and Saga HealthPlan Support 6. If you have chosen one of these options this will be detailed on your Policy Schedule.

2 YOUR COVER

Please remember that our policies are not intended to cover all eventualities and are designed to complement rather than replace all the services provided by the NHS.

In return for payment of the premium we agree to provide cover as set out in the terms of this **policy**. Please refer to the definition of '**policy**' in the glossary for details of the documents that make up your **policy**.

Summary of Saga HealthPlan Support, Saga HealthPlan Support 4 and Saga HealthPlan Support 6.

The Saga HealthPlan Support, Support 4 and Support 6 policies offer you cover for necessary **treatment** of new **medical conditions** that arise after you join. They do not cover you for **treatment** of **medical conditions** that existed, or you had symptoms of, before joining. However, in some circumstances you may have joined on a different basis, please refer to section 5 'Existing medical conditions' for further information.

There is also no cover for ongoing, recurrent and long-term conditions (also known as **chronic conditions**).

Your cover includes:

- **inpatient and day patient treatment** and associated **specialists'** charges
- **outpatient surgical procedures**
- computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) scans when carried out as part of an **eligible inpatient** or **day patient** stay.

Saga HealthPlan Support 4 and Saga HealthPlan Support 6:

*With a '4 Week Wait' or '6 Week Wait' plan, if the NHS can give you the **hospital treatment** you need within four/six weeks of the date the **specialist** recommends the private **treatment** then you must use the NHS. For more information, please see the '**Benefits table**' section on [page 5](#) and the 'Will my policy cover me for cancer treatment?' section on [page 15](#).*

Please note:

Saga HealthPlan Support 4 and Support 6 are not available if you live in the Channel Islands or Isle of Man.

This **policy** has a No Claim Discount scheme, which entitles you to a No Claim Discount provided you don't make a claim. Please see section 10 'Additional information' for details of how your No Claim Discount is calculated.

Please note:

You can be reassured that the vast majority of **specialists** we recognise are **fee-assured specialists** and we routinely pay their **eligible treatment** charges in full. Please visit <https://codes.bupa.co.uk/procedures> to review the Bupa Schedule of Procedures and Fees.

We support you in identifying a suitable **treatment** provider; however if you choose to receive **treatment** under the direction of a **fee-limited specialist** you may have to make a contribution to your **treatment** costs.

Please see section 8 'Who we pay for treatment and where you can be treated' ([page 15](#)) for full details.

If you have chosen Guided Care (not available if you live in the Channel Islands or Isle of Man):

This **policy** offers you cover for necessary **treatment** of **medical conditions** when **treatment** is received from a **selected provider**. By '**selected provider**' we mean 'a **hospital, day patient unit, outpatient facility** or **specialist** that we have helped you choose to provide your **treatment**'.

Please see section 8 'Who we pay for treatment and where you can be treated' ([page 15](#)) for full details.

Be aware:

Your policy will not cover you for:	Where can I find more information?
Treatment of medical conditions that existed, or you had symptoms of, before joining (in some circumstances you may have joined on a different basis)	Section 5
Treatment of ongoing, recurrent and long-term conditions (chronic conditions)	Section 7
Dental procedures other than those included under the optional Health Cash Benefits Cover	Section 6
Routine pregnancy and childbirth	Section 6
Treatment of mental health conditions	Section 6
Outpatient CT, MRI and PET scans	Section 6
Outpatient treatment other than surgical procedures	Section 6
Non-surgical treatment of cancer , including chemotherapy and radiotherapy	Section 7
Urgent or emergency treatment	Section 4
Charges made when treatment is received outside of the Saga Countrywide Hospital List (unless the treatment has been approved by us in advance)	Section 8
Treatment that we have not first authorised as eligible for payment	Section 4

These are just some of the key limitations that relate to your **policy**, please read this Policy Book for full details.

3 BENEFITS TABLE

The **benefits table** on this page shows the benefits available to you together with the monetary limits of your **policy**. These benefits are explained fully in this Policy Book. You must read this table in conjunction with the rest of your Policy Book.

Please make sure you call us on 0330 018 0778 prior to **treatment** so that we can confirm the extent of your cover and any limitations that may apply.

Please note:

You should obtain authorisation for your claim from us before starting **treatment**. If we ask you to complete a claim form, you must send it to us for confirmation of your cover. If you do not, we may be unable to pay for the **treatment** you receive in full or in part. All **inpatient treatment** and **day patient treatment** must also take place at a **hospital** listed in the **Saga Countrywide Hospital List**.

There is no benefit on these policies for non-surgical **treatment of cancer** including any radiotherapy and chemotherapy.

Alternatively, if you have chosen Guided Care, you must call us in advance of booking any **treatment** so that we can choose the **specialist** with you.

*If you have Saga HealthPlan Support 4 or Saga HealthPlan Support 6: This **policy** will cover the cost of **inpatient** or **day patient treatment** if the NHS could not provide that **treatment** within four/six weeks of the date the **specialist** recommends the private **treatment**. The only exceptions to this provision are **outpatient surgical procedures**.*

*Immediate cover: We will pay as per benefit 1 in the **benefits table** for the **surgical procedures** shown below, whether or not the patient could obtain **treatment** as an NHS patient within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed.*

- varicose veins surgery
- tonsillectomy
- insertion of grommets
- removal of bunions (hallux valgus)
- removal of gall bladder (laparoscopic cholecystectomy)
- haemorrhoidectomy
- adenoidectomy
- correction of squint.

Optional excess information

Excess for each person covered by these **policies** each **year** (as shown in your Policy Schedule):

Option 1:	£100
Option 2:	£250
Option 3:	£500
Option 4:	£750
Option 5:	£1,000

Excesses do not apply to the NHS cash benefit, the **external prosthesis** benefit, consultations through the Saga GP Service, or the optional Health Cash Benefits Cover.

Benefits	Amount payable	For more information
Inpatient and day patient treatment		Section
1. Hospital charges: including charges for accommodation, diagnostic tests , operating theatre charges, nursing care, drugs and dressings, physiotherapy, and surgical appliances used by the specialist during surgery.	No annual maximum at a hospital listed in the Saga Countrywide Hospital List or a hospital we have chosen with you	8
2. Specialists' fees (surgeons, anaesthetists and physicians).	No annual maximum	8
3. Inpatient consultations – benefit for a consultation with a second specialist arranged by the treating specialist .	No annual maximum	8
Outpatient treatment		
4. Surgical procedures .	No annual maximum	6
Other benefits		
5. NHS cash benefit. This benefit is paid for each night you receive free treatment under the NHS when all of the following applies: (i) You are admitted for inpatient treatment before midnight (ii) The treatment you receive under the NHS would have been eligible for benefit privately under this policy . <i>Saga HealthPlan Support 4 and Saga Health Plan Support 6: The four/six weeks waiting period does not apply to NHS cash benefits.</i> There is no requirement for private treatment to have preceded any period in an NHS intensive therapy unit or NHS intensive care unit.	£100 a night, up to £2,000 a year	8
6. External prosthesis benefit.	Up to £5,000 for the lifetime of your policy . We will pay this benefit towards the cost of providing an external prosthesis .	6
7. Anytime HealthLine. Confidential medical information.	Immediate access 24 hours a day, 365 days a year	11
8. Saga GP Service. Access to the confidential GP helpline is available in addition to your policy . You can book an appointment online via www.saga.co.uk/GPService	Immediate access 24 hours a day, 365 days a year	11
Health Cash Benefits Cover (optional cover) The following benefits only apply if you have opted for the Health Cash Benefits Cover and they are available to the policyholder and their spouse/partner only.		
9. Dental care.	Up to £200 per person covered a year	9
10. Optical care.	Up to £150 per person covered a year	9
11. Dental accident.	Up to £200 per person covered a year	9
12. Dental emergency.	Up to £200 per person covered a year	9
13. Health assessment.	Up to £150 per person covered a year	9

Please note: If you have an excess on your **policy**, it will not be affected by the NHS cash benefit, the **external prosthesis** benefit, consultations through the Saga GP Service, or any benefit under the optional Health Cash Benefits Cover.

Your No Claim Discount (NCD) will not be affected by the NHS cash benefit, the **external prosthesis** benefit, consultations through the Saga GP Service, or any benefit under the optional Health Cash Benefits Cover.

4 ARRANGING TREATMENT AND MAKING A CLAIM

If you have chosen the Saga Countrywide Hospital List or our Saga London Upgrade, or you live in the Channel Islands or Isle of Man, the following information and that on [page 8](#) applies:

(If you have chosen Guided Care, see [pages 7-8](#).)

Please remember that you should obtain authorisation for your claim from us before you start any **treatment** (see opposite for the steps to take). If we ask you to complete a claim form, you must send it to us for confirmation of your cover. If you do not, we may be unable to pay for the **treatment** you receive in full or in part. All **inpatient treatment** and **day patient treatment** must also take place at a **hospital** listed in the **Saga Countrywide Hospital List**.

Please note:

There may be occasions when you will not need to complete a claim form.

We have a team who can help you find a **fee-assured specialist**. This service is available if your **GP** has given you an **open referral**, meaning they do not specify the **specialist's** name. To get your claim underway, simply call the Claims Helpline and tell them you have an **open referral**.

We can also support you if you would like an alternative to the **specialist** your **GP** has referred you to. In many cases we can book the appointment with the **specialist** for you.

Please note:

Saga HealthPlan Support 4 and Saga HealthPlan Support 6:

*If **inpatient** or **day patient treatment** is necessary we will need to establish that **treatment** is not available on the NHS within four/six weeks of the date the **specialist** recommends the private **treatment** (unless the **surgical procedure** is one specified in the list in section 3 'Benefits table'). The only exceptions to this provision are **outpatient surgical procedures**.*

Self-referral service

There are some conditions that we offer a self-referral service for. This means you do not need a **GP** referral. If you are concerned about:

- symptoms or changes in your breast(s)
- mole or skin lesion(s)
- blood in urine
- coughing up blood
- raised Prostate Specific Antigen test (PSA)

call the Claims Helpline who will check your cover and ask you some questions to establish whether the service can help. If they believe it can and you consent to go ahead, the adviser will transfer you to the service who will ask relevant questions and provide support depending on outcome of that questioning.

If the service is not suitable, or if you prefer not to use it, you should make an appointment with your **GP** as soon as possible for further advice.

Please note:

Family members under the age of 18 will need a **GP** referral.

What happens if I require emergency treatment?

Conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**. As you will appreciate, if you have a serious or life-threatening condition which needs urgent **treatment** the NHS will treat that condition. Your **policy** therefore will not offer cover because of its urgent or emergency nature.

Most private **hospitals** are not set up to receive emergency admissions. In an emergency you should call for an NHS ambulance or visit the accident and emergency department at the local NHS hospital. This means that conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**.

However, if you are admitted as an **inpatient** at an NHS hospital, please ask somebody to telephone us as you may be able to claim for the NHS cash benefit shown on the **benefits table**.

*Saga Healthplan Support 4 and Saga HealthPlan Support 6: These policies will only provide benefit for **inpatient treatment** or **day patient treatment** if the NHS can't provide that **treatment** within four/six weeks of the date the **specialist** recommends the private **treatment**.*

To ensure your claim proceeds smoothly, please follow these simple steps. (If you have selected the Health Cash Benefits Cover as detailed in the benefits table, please refer to section 9 for details of how to make a claim under this cover.)

Step One	Being referred for treatment Your consultation or treatment must follow an initial referral by: a GP (including via a digital GP service) or dentist or another healthcare practitioner. The situations in which we will accept such a referral are set out on bupa.co.uk/referrals . (For skin, breast or prostate concerns, see the 'Self-referral service' explanation on this page.)
Step Two	You need to call us on 0330 018 0778 or you can contact us digitally by visiting bupa.co.uk or download the My Bupa App. To help us make the claims process as simple and swift as possible, please have the following information close to hand when you call us: <ul style="list-style-type: none">• your policy number• details of the condition you are suffering from• details of when your symptoms first began• details of when you first consulted a GP about your condition• details of the treatment that has been recommended.
Step Three	We will explain which nearby specialists, facilities and healthcare professionals are available under your benefits and provide you with a pre-authorisation number so your healthcare provider can send the bill directly to us. If your specialist recommends further tests or treatment , it is important you check back with us to obtain further pre-authorisation. We strongly advise you to call us before arranging or receiving any treatment to pre-authorise it, as you will be responsible for paying any fees or charges that are not covered under your benefits.
Step Four	Usually, we will pay the providers of your treatment directly.

Please send any correspondence to: Bupa Claims, Bupa Place, 102 The Quays, Salford M50 3SP.

If you have chosen Guided Care (not available if you live in the Channel Islands or Isle of Man) the following information applies:

(If you have chosen the Saga Countrywide Hospital List or our Saga London Upgrade, or you live in the Channel Islands or Isle of Man, please see [pages 6 and 8](#).)

When you require **treatment** we will support you by choosing a **selected provider** to treat you. To enable us to do this you should contact us before booking or receiving any **treatment**. We can support you when booking the appointment with a **specialist**.

Please remember that you should obtain authorisation for your claim from us before you start any **treatment** (see opposite for the steps to take). If we ask you to complete a claim form, you must send it to us for confirmation of your cover. If you do not, we may be unable to pay for the **treatment** you receive in full or in part.

Please note:

There may be occasions when you will not need to complete a claim form.

Be aware:

Once you have started making a claim, unless we have advised you otherwise, you should contact us prior to each stage of **treatment**. If you do not do this or do not receive **treatment** with the provider we helped you choose, we may refuse payment for the **treatment** you receive and you could be liable for the whole cost of **treatment**.

GP open referral

To use Guided Care you must ensure your **GP** provides an **open referral** or refer to the Bupa referral site bupa.co.uk/referrals before you contact us. An **open referral** is where your **GP** states that **treatment** is necessary and which type of **specialist** you require that **treatment** from, but does not specify the **specialist's** name. For example, if you have a heart condition you will need an **open referral** for **treatment** with a cardiologist.

Be aware:

If, when you call us, your **GP** has provided a referral to a named healthcare provider, we will still support you by finding a **selected provider** to treat you and assist you in arranging **treatment** with them. In some cases we may require additional information from your **GP** in order to do this.

If you have an appointment booked with a named provider prior to contacting us, we will let you know if you need to cancel this appointment. We will not be liable for any cancellation or missed appointment charges which are incurred.

Arranging your appointments

We have a team who can help you find a **selected provider**. By 'selected provider' we mean 'a **hospital, day patient unit, outpatient facility** or **specialist** that we have helped you choose to provide your **treatment**'.

Please note:

Saga HealthPlan Support 4 and Saga HealthPlan Support 6:

If **inpatient** or **day patient treatment** is necessary we will need to establish that **treatment** is not available on the NHS within four/six weeks of the date the **specialist** recommends the private **treatment** (unless the **surgical procedure** is one specified in the list in section 3 'Benefits table'). The only exceptions to this provision are **outpatient surgical procedures**.

Self-referral service

There are some conditions that we offer a self-referral service for. This means you do not need a **GP** referral. If you are concerned about:

- symptoms or changes in your breast(s)
- mole or skin lesion(s)
- blood in urine
- coughing up blood
- raised Prostate Specific Antigen test (PSA)

call the Claims Helpline who will check your cover and ask you some questions to establish whether the service can help. If they believe it can and you consent to go ahead, the adviser will transfer you to the service who will ask relevant questions and provide support depending on outcome of that questioning.

If the service is not suitable, or if you prefer not to use it, you should make an appointment with your **GP** as soon as possible for further advice.

Please note:

Family members under the age of 18 will need a **GP** referral.

To ensure your claim proceeds smoothly, please follow these simple steps. (If you have selected the Health Cash Benefits Cover as detailed in the benefits table, please refer to section 9 for details of how to make a claim under this cover.)

Step One

Being referred for **treatment**

Your consultation or **treatment** must follow an initial **open referral** by: a **GP** (including via a digital GP service), or dentist or another healthcare practitioner. The situations in which we will accept such a referral are set out on bupa.co.uk/referrals. (For skin, breast or prostate concerns, see the 'Self-referral service' explanation on this page.)

Step Two

You need to call us on **0330 018 0778** or you can contact us digitally by visiting bupa.co.uk or download the My Bupa App.

To help us make the claims process as simple and swift as possible, please have the following information close to hand when you call us:

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

Step Three

We will explain which nearby **specialists, facilities** and healthcare professionals are available under your benefits and provide you with a pre-authorisation number so your healthcare provider can send the bill directly to us.

If your **specialist** recommends further tests or **treatment**, it is important you check back with us to obtain further pre-authorisation. We strongly advise you to call us before arranging or receiving any **treatment** to pre-authorise it, as you will be responsible for paying any fees or charges that are not covered under your benefits.

Step Four

Usually, we will pay the providers of your **treatment** directly.

Please send any correspondence to: Bupa Claims, Bupa Place, 102 The Quays, Salford M50 3SP.

What happens if I require emergency treatment?

Conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**. As you will appreciate, if you have a serious or life-threatening condition which needs urgent **treatment** the NHS will treat that condition. Your **policy** therefore will not offer cover because of its urgent or emergency nature.

Most private **hospitals** are not set up to receive emergency admissions. In an emergency you should call for an NHS ambulance or visit the accident and emergency department at the local NHS hospital. This means that conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**.

However, if you are admitted as an **inpatient** at an NHS hospital, please ask somebody to telephone us as you may be able to claim for the NHS cash benefit shown on the **benefits table**.

*Saga Healthplan Support 4 and Saga HealthPlan Support 6: These policies will only provide benefit for **inpatient treatment** or **day patient treatment** if the NHS can't provide that **treatment** within four/six weeks of the date the **specialist** recommends the private **treatment**.*

The following points are relevant for the Saga Countrywide Hospital List, Saga London Upgrade and Guided Care:

How are my medical bills settled?

We normally receive bills for **treatment** directly from **specialists** or **hospitals**. Medical bills for **treatment** that have been pre-authorised should be sent to us directly from **specialists** or **hospitals**.

If you receive a bill for payment please contact the Claims Helpline as we can settle **eligible** bills directly with the **hospital** or **specialist**, subject to any excess. If for any reason you have paid a medical bill yourself, please call the Claims Helpline to make the necessary arrangements to reimburse you.

Do I need to tell the place where I have my treatment that I have private medical insurance with Saga?

Yes, you must tell the place where you have your **treatment** that you have private medical insurance with Saga (which is underwritten by Bupa Insurance Limited). This will mean that the fees charged for your **treatment** are those Bupa have agreed with the **facility**.

What happens if I've paid the bills myself already or if I receive a bill?

If you paid your medical bills yourself and your **treatment** is covered, we will refund you the rates we have agreed with the **hospital** or centre, minus any excess. Please send the original receipts from the **specialist** or **hospital** to Bupa Claims, Bupa Place, 102 The Quays, Salford M50 3SP.

You should send us any receipts for **treatment** within 6 months after you've had your **treatment**, unless this is not reasonably possible.

If you receive a bill, please call us and we'll explain what to do next.

What must I provide when making a claim?

- 4.1 Before we can consider a claim you must ensure that:
- you provide us with the necessary information and necessary legal permissions to handle your medical information and to assess your claim. You will need to do this before starting any **treatment** in order to obtain authorisation for your claim from us; and
 - we receive original invoices for **treatment** costs either from you or directly from whoever has provided your **treatment**; and
 - you give us all the information we request.

Do I need to provide any other information?

- 4.2 It may not always be possible to assess the eligibility of your claim from the pre-authorisation request alone. In such situations we will require additional information. Where we request that you provide additional information it is your responsibility to provide any reasonable additional information to enable us to assess your claim.

Be aware:

In order to establish the eligibility of any claim, we may request access to your medical records including medical referral

letters. If you unreasonably refuse to agree to such access we will refuse your claim and will recoup any previous monies that we have paid in respect of that **medical condition**.

- 4.3 There may be instances where we are uncertain about the eligibility of a claim. If this is the case, we may at our own cost ask a **specialist**, chosen by us, to advise us about the medical facts relating to a claim or to examine you in connection with the claim. In choosing a relevant **specialist** we will take into account your personal circumstances. You must co-operate with any **specialist** chosen by us or we will not pay your claim.

What should I do if another party is responsible for some of my claims costs?

- 4.4 When you claim for **treatment** you need because of an injury or **medical condition** that **was** caused by or was the fault of someone else (a 'third party') it is your responsibility to notify us as soon as reasonably possible and ensure our interests are protected in any legal action required so that we are able to recover any costs that we have paid for your **treatment**. This includes:
- Notifying us as soon as you become aware that you require (or may require) **treatment** that was caused by or was otherwise the fault of a third party. You can contact us with this information on 0800 028 6850 (we may record or monitor calls) or email infothirdparty@bupa.com. If you need to send us sensitive information you can email us securely using Egress. For more information and to sign up for a free Egress account, go to <https://switch.egress.com>. You will not be charged for sending secure emails to a Bupa email address using the Egress service.
 - Taking steps we ask of you to recover from the third party the cost of the **treatment** paid for by us. This includes ensuring that we are able to liaise with you and your legal representative (if you appoint one) in relation to this and that you or your legal representative regularly keep us updated as to progress with any recovery action.
 - Ensuring that where you agree settlement with a third party, the settlement includes the cost of **treatment** that we have paid for you in full, and that you pay such sum (and applicable interest) to us as soon as reasonably possible.

Other insurance cover

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

5 EXISTING MEDICAL CONDITIONS

Please note:

The following defined terms apply to this section:

Medical condition – any disease, illness or injury, including mental health conditions.

Pre-existing condition – any disease, illness or injury for which:

- you have received medication, advice or **treatment**; or
 - you have experienced symptoms;
- whether the condition has been diagnosed or not in the three years before the start of your cover.

Please note: when you joined, you may have been able to choose to include cover for **eligible treatment** of pre-existing hypertension and **specified conditions**. If this applies to you it will be shown on your Policy Schedule.

Specified condition – the **medical conditions** listed in the table on [page 10](#) that we will not cover if you have the following **pre-existing conditions**: diabetes, raised blood pressure (hypertension) or you are undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test.

Trouble free – when you:

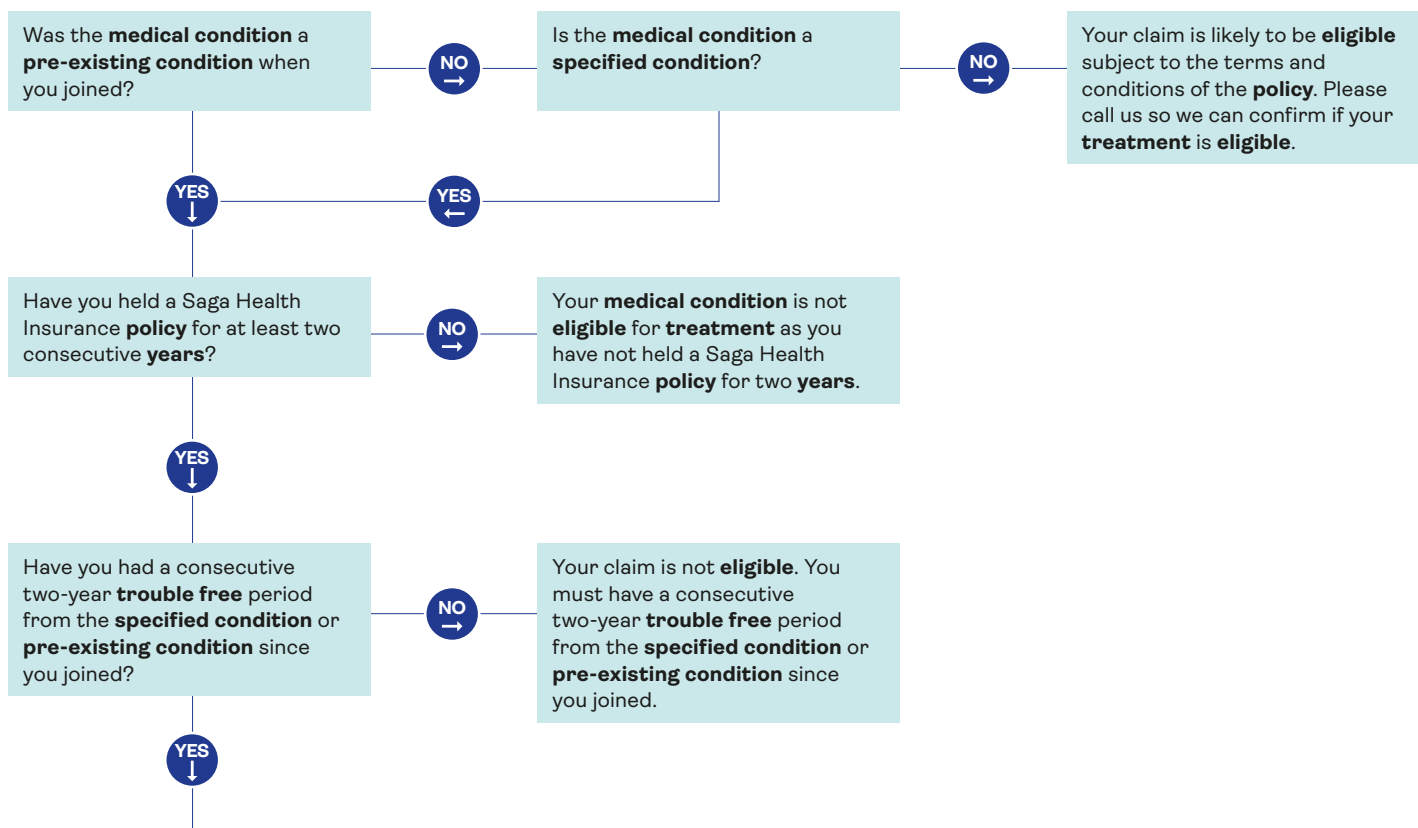
- have not had any medical opinion from a medical practitioner including **GPs** or **specialists**; or
- have not taken any medication (including over the counter drugs) or followed a special diet; or
- have not had any medical **treatment**; or
- have not visited a **practitioner, physiotherapist, therapist, acupuncturist, optician or dentist**; for the **medical condition**.

What cover is there for treatment of any medical conditions that I had prior to joining?

Medical insurance is designed primarily to provide cover for **treatment** of new **medical conditions** that arise after you join. This is the usual position. However, you may have joined on a different basis, particularly if you joined this **policy** from another insurer. Additionally, when you joined, you may have been able to choose to include cover for **eligible treatment** of pre-existing hypertension and **specified conditions** to it. If these apply to you they will be shown on your Policy Schedule.

If you completed a medical history declaration when you joined, your Policy Schedule will show the **medical conditions** for which we will not cover you for **treatment** and whether we can review that exclusion.

If you did not provide your medical history when you joined, the following diagram shows how your **policy** works and the process we go through when assessing your claim.



Your claim is likely to be **eligible** subject to the terms and conditions of the **policy**. Please call us so we can confirm if your **treatment** is **eligible**.

Please note: We will exclude **specified conditions** from your cover for at least two **years** after you join if:

- you had diabetes when you joined, or
- you were already aware that you had raised blood pressure (hypertension) when you joined, or
- you were already being investigated, monitored or treated as a result of a PSA (Prostate Specific Antigen) test to do with the prostate, when you joined.

The **specified conditions** we will not cover are listed in the table on the next page. We will not cover **treatment** for these **specified conditions** whatever the cause, even if they are not related to the **pre-existing condition** or they develop after you join.

We will provide cover for **treatment** of **medical conditions** that arise after you join. However, in the first two **years** of cover there is no cover for the **treatment** of **pre-existing conditions** or for **treatment** of **specified conditions** where you have one of the **pre-existing conditions** shown in the table below.

If you have the following pre-existing condition:	We will not pay for treatment of the following specified condition/s:
Diabetes	<ul style="list-style-type: none"> • Diabetes • Ischaemic heart disease • Cataract • Diabetic retinopathy • Diabetic renal disease • Arterial disease • Stroke
Have had treatment for raised blood pressure (hypertension) in the three years before you joined*	<ul style="list-style-type: none"> • Raised blood pressure (hypertension) • Ischaemic heart disease • Stroke • Hypertensive renal failure
Have been under investigation, had treatment or undergone monitoring as a result of a Prostate Specific Antigen (PSA) test in the three years before you joined	<ul style="list-style-type: none"> • Any disorder of the prostate

*When you joined, you may have been able to choose to include cover for **eligible treatment** of pre-existing hypertension and **specified conditions** to it. If these apply to you they will be shown on your Policy Schedule

Once you have held a Saga Health Insurance **policy** for two consecutive **years**, you may be able to claim for **treatment** of **pre-existing conditions** and **specified conditions** as long as you have had a **trouble free** period of two consecutive **years** for the **pre-existing condition** since your cover started.

There are some **medical conditions** – those that continue or keep recurring – that you will never be able to claim for. This is because you will never be able to have a consecutive two-year **trouble free** period.

What happens when I want to make a claim?

If you completed a medical history declaration when you joined, your Policy Schedule will show any specific exclusions that apply to your **policy**. You should call us to confirm that the **treatment** you need is **eligible**.

If you did not provide your medical history when you joined, we will need to assess your medical history before we can authorise your **treatment**. We may do this by asking for a claim form from your **GP** or **specialist**, or by asking for your **GP** notes.

Be aware:

Because we need to assess your medical history, it is possible that we will not be able to authorise your **treatment** straight away. There may be a short delay before we can confirm if your **treatment** is **eligible**.

5.1 We pay for **eligible**:

- (a) **Treatment** of a new **medical condition** that arises after you join.
- (b) **Treatment** of **pre-existing conditions** and where applicable their **specified conditions** once you have held a Saga Health Insurance **policy** for at least two consecutive **years** and have had a consecutive two-year **trouble free** period.

5.2 What we do not pay for:

- (a) **Treatment** of **pre-existing conditions** and **specified conditions** where that **pre-existing condition** is diabetes, raised blood pressure (hypertension) or you have been undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test for the first two **years** after you join.
- (b) If you completed a medical history declaration when you joined: we will not pay for **treatment** of any **medical condition** which you already had when you joined and about which you should have told us, but did not tell us at all or did not tell us everything. This includes any such **medical condition(s)** or symptoms, whether or not being treated, and any previous **medical condition(s)** which recurs or which you should reasonably have known about even if you had not consulted a doctor.
- (c) **Treatment** of any other **medical condition** detailed on your Policy Schedule as excluded for benefit.

6 YOUR COVER FOR CERTAIN TYPES OF TREATMENT

What is eligible treatment?

Your **policy** covers **eligible treatment**. We consider **treatment** of a **medical condition** to be **eligible** when:

- the **treatment** falls within the benefits of your **policy** and is not excluded from cover by any term in this Policy Book
- it is **treatment** of an **acute condition**
- it is **conventional treatment**
- it is not preventive
- it does not cost more than an equivalent **treatment** that is as likely to deliver a similar therapeutic or diagnostic outcome
- it is not provided or used primarily for the convenience, financial or other advantage of you, your **specialist** or other health professional.

Will my policy cover me for preventive treatment?

No, these policies are designed to provide cover for necessary **treatment** of disease, illness or injury. Therefore, we do not pay for preventive **treatment** or for tests to establish whether a **medical condition** is present when there are no apparent symptoms.

Please note:

We do not pay for genetic tests, when those tests are undertaken to establish whether you have a **medical condition** when you have no symptoms or a genetic risk of developing or passing on a **medical condition**. We will pay for genetic testing when it is proven to help choose the best **eligible treatment** for your **medical condition**. Please call us before you have any genetic tests to confirm that we will cover them. Your **specialist** might want to do a variety of tests and they might not all be covered. The cost to you might be significant if the tests are not covered by your **policy**.

What other treatments are not covered?

There is no cover under this **policy** for **treatment** of mental health conditions, for non-surgical **treatment** of **cancer** including radiotherapy or chemotherapy or for any **outpatient treatment** except as allowed under benefit 4 in the **benefits table**. There are also a number of other **treatments** (listed below) that your **policy** does not cover. These include **treatments** that may be considered a matter of personal choice (such as cosmetic **treatment**) and other **treatments** that are excluded from cover to keep premiums at an affordable level (such as **outpatient** drugs and dressings).

What happens if I require emergency treatment?

Conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**. As you will appreciate, if you have a serious or life-threatening condition which needs urgent **treatment** the NHS will treat that condition. Your **policy** therefore will not offer cover because of its urgent or emergency nature.

Most private **hospitals** are not set up to receive emergency admissions. In an emergency you should call for an NHS ambulance or visit the accident and emergency department at the local NHS hospital. This means that conditions for which urgent or emergency **treatment** is needed are not covered by the **policy**.

However, if you are admitted as an **inpatient** at an NHS hospital, please ask somebody to telephone us as you may be able to claim for the NHS cash benefit shown on the **benefits table**.

*Saga Healthplan Support 4 and Saga HealthPlan Support 6: These policies will only provide benefit for **inpatient treatment** or **day patient treatment** if the NHS can't provide that **treatment** within four/six weeks of the date the **specialist** recommends the private **treatment**.*

6.1 We pay for eligible:

- (a) **Inpatient** and **day patient diagnostic tests** ordered or performed by a **specialist**.
- (b) Oral **surgical procedures** listed in the Saga Schedule of Procedures and Fees. If you would like a copy of the Schedule of Procedures and Fees, please contact our Claims Helpline.
- (c) Cash benefit towards dental and optical care, dental

accident, dental emergency and a health assessment if you have chosen the optional Health Cash Benefits Cover, as shown in the **benefits table**.

- (d) First reconstructive surgery to restore function or appearance after an accident or following surgery for a **medical condition**, that was covered by your Saga Health Insurance, provided that:
 - we agree the cost of the **treatment** before it is done (see also 6.2(p)).

In the case of breast **cancer** your first reconstructive surgery following a **surgical procedure** for breast **cancer**. We will cover:

- one planned **surgical procedure** to reconstruct the diseased breast
- one planned **surgical procedure** to reconstruct the nipple
- up to two sessions of nipple tattooing.

After the completion of your first reconstructive surgery, we will also cover:

- one further planned **surgical procedure** to the other breast, when it has not been operated on, to improve symmetry.
- two planned fat transfer surgeries. The fat must be taken from another part of your body and cannot be donated by someone else. Symmetry and fat transfer operations must take place within three years of the first reconstructive **surgical procedure**.
- one planned **surgical procedure** to remove and exchange implants damaged by radiotherapy **treatment** for breast **cancer**. The removal and exchange must take place within five years of you completing your radiotherapy **treatment**.
- if you choose not to have reconstructive surgery following **treatment** of breast **cancer**, we will cover the cost of one planned **surgical procedure** to the unaffected breast to improve symmetry. There is no cover for any further reconstructive surgery on either the diseased or the unaffected breast.

We will only pay for each of these operations once (or two fat transfer surgeries), regardless of how long you remain a Saga Health Insurance **policyholder**.

- (e) **Treatment** of varicose veins: one **surgical procedure** per leg for the lifetime of your **policy**, for example foam injection (sclerotherapy), ablation or other surgery.
- (f) Up to £5,000 for the lifetime of your **policy** towards the cost of an **external prosthesis** needed following an accident or surgery for a **medical condition**, provided that:
 - you had a Saga HealthPlan **policy** at the time of the accident or surgery that led to the need for a prosthesis and that you have had continuous cover with us ever since; and
 - all claims are made within 12 months of the amputation or removal of the body part.

If you want to claim this benefit please call our Claims Helpline so we can explain what to do next. Please remember to ask the provider of your **external prosthesis** for full receipts as we cannot pay claims without a receipt.

- (g) Genetic testing when it is proven to help choose the best **eligible treatment** for your **medical condition**. Please see the rest of this section for details of **eligible treatment**, **conventional treatment** and **unproven treatment**.
- (h) Gene therapy, somatic-cell therapy or tissue engineered medicines classified as Advanced Therapy Medicinal Products (ATMPs) by the UK medicines regulator to be used as part of your eligible treatment and which are, at the time of your eligible treatment, included (with the medical condition(s) for which we pay for them) on our list of advanced therapies that applies to your benefits. The list is available at bupa.co.uk/policyinformation or you can contact us. The advanced therapies on the list will change from time to time.

6.2 What we do not pay for:

- (a) Any **outpatient** consultations, **outpatient diagnostic tests**, **outpatient** CT, MRI or PET scans or any other **outpatient treatment** except as detailed in the **benefits table**.
- (b) Any dental procedure or orthodontics including referrals to dental specialists such as periodontists, endodontists, prosthodontists or orthodontists (except as allowed under Health Cash Benefits Cover, as shown in the **benefits table**, if you have chosen this optional cover).
- (c) **Treatment** of thread veins or superficial veins.
- (d) Any accident and emergency **treatment**, including immediate care, provided by an NHS or private accident and emergency (A&E) department, urgent care or walk-in clinic.
- (e) Any urgent **treatment** or **treatment** you need immediately when you are admitted to hospital, including accommodation costs, isn't covered if you are admitted directly after and in connection with:
- attending an NHS private A&E department, an urgent care centre or a walk in clinic, or
 - a consultation with a **GP** or **specialist**.
- (f) **Treatment** or **medical conditions** that are excluded from your cover.
- (g) **Treatment** for complications of **medical conditions** that are excluded from your cover.
- (h) **Treatment** for complications from **treatment** that is excluded from your cover.
- (i) **Treatment** which is not medically necessary or which may be considered a matter of personal choice.
- (j) Any **treatment** of warts of the skin.
- (k) Vaccinations, routine preventive examinations and check-ups or preventive screening or tests.
- (l) Preventive **treatment**, such as preventative mastectomy or YAG laser iridotomy for narrow angles in isolation.
- (m) Genetic tests:
- to check whether you have a **medical condition** when you have no symptoms; or
 - you have a genetic risk of developing a **medical condition** in the future; or
 - to find out if there is a genetic risk of you passing on a **medical condition**; or
 - where the result of the test wouldn't change the course of **eligible treatment**. This might be because, the course of **eligible treatment** for your symptoms would be the same regardless of the result of the test or what **medical condition** has caused your symptoms; or
 - when the tests themselves are not **conventional treatment** or where they are used to direct **treatment** that is not **eligible treatment**.
- (n) Genetic tests must be:
- listed in the NHS England National genomic test directory and used for the purposes listed in the directory; and
 - carried out at a testing laboratory which is accredited by the United Kingdom Accreditation Service (UKAS) or an equivalent agreed in advance of testing by Bupa Insurance Limited.
- (o) Drugs, dressings or prescriptions that:
- you are given to take home following **inpatient**, **day patient** or **outpatient treatment**; or
 - could be prescribed by a **GP** or bought without a prescription; or
 - are taken or administered when you attend a **hospital**, consulting room or clinic for **outpatient treatment**.
- (p) Advanced therapy medicinal products (ATMPs) that are not on our list at the time you need the **treatment**. (See also 6.1(h)).
- (q) Any **treatment** costs to plan or facilitate **treatment**,
- medical or surgical intervention or body modification that is not **eligible** under your **policy**.
- (r) The costs of the purchase, hire or fitting of any external appliance, such as crutches, joints supports, braces, mechanical walking aids or other mobility aids, any external device such as **treatment** or monitoring devices, or any **external prosthesis**, except as allowed in benefit 6.
- (s) The costs of maintaining, refitting or replacing an **external prosthesis** or appliance if you don't have acute symptoms that are directly related to the **external prosthesis**.
- (t) The costs of any replacement teeth or hair, including wigs or hair transplants.
- (u) Charges for general chiropody or foot care (including but not limited to gait analysis and the provision of orthotics), even if this is carried out by a surgical podiatrist.
- (v) Cosmetic (aesthetic) surgery or **treatment**, or any **treatment** relating to previous cosmetic or reconstructive **treatment** including any cosmetic operation to a reconstructed breast (see also 6.1(d)).
- (w) Any **treatment** that is connected with the use of cosmetic (beauty) products or is needed as a result of using a cosmetic (beauty) product.
- (x) Any reconstructive treatment following breast **cancer** not detailed in 6.1(d).
- (y) The removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons (including but not limited to breast reduction).
- (z) Any **treatment** of refractive errors.
- (aa) Any **treatment** to correct long or short-sightedness.
- (bb) Costs incurred for, or related to, any kind of bariatric surgery, regardless of the reason the surgery is needed. This includes but is not limited to the fitting of a gastric band or creation of a gastric sleeve.
- (cc) **Treatment** relating to learning disorders, speech delay, educational problems, behavioural problems, physical development or psychological development, including assessment or grading of such problems. This includes, but is not limited to, problems such as dyslexia, dyspraxia, autistic spectrum disorder, attention deficit hyperactivity disorder (ADHD).
- (dd) Any charges which you incur for social or domestic reasons (such as travel or home help costs) or for reasons which are not directly connected with **treatment**.
- (ee) Any charges for primary care services, such as any services that would typically be carried out by a **GP** or dentist (except as allowed under Health Cash Benefits Cover, as shown in the **benefits table**, if you have chosen this optional cover).
- (ff) Any **treatment** needed as a result of nuclear contamination, biological contamination or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed.
Please note, for clarity: There is cover for **treatment** required as a result of a **terrorist act** providing that the **terrorist act** does not result in nuclear, biological, or chemical contamination.
- (gg) **Treatment** of any mental health condition.
- (hh) Non-surgical **treatment** of **cancer**, including radiotherapy and chemotherapy.
- (ii) **Treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.
- (jj) **Treatment** of, or **treatment** which arises from or is in any way connected with, alcohol abuse, drug abuse or

6.2 What we do not pay for (Cont.):

- substance abuse.
- (kk) Costs associated with the implementation of a mechanical heart pump (Ventricular Assist Device (VAD) or Artificial Hearts) or the device itself.
- (ll) Any **treatment** costs incurred as a result of engaging in or training for any sport for which you receive a salary or monetary reimbursement, including grants or sponsorship (unless you receive travel costs only).
- (mm) Any **treatment** if you live outside the **United Kingdom** or any **treatment** received outside the **United Kingdom**.
- (nn) Any surgery or **treatment** required to receive an organ, donate an organ, **treatment** needed in preparation or as a result of a transplant the cost of collecting donor organs, tissue or harvesting cells from a donor, or any related administration costs.
- (oo) Bone marrow transplant or stem cell transplant.
- (pp) **Treatment** of symptoms generally associated with the natural process of ageing. This includes **treatment** for the symptoms of puberty or the routine management of menopause.
- (qq) *Saga HealthPlan Support 4 and Saga HealthPlan Support 6: Anything outside the terms of cover, which for clarity includes any urgent or emergency **treatment**. We also do not pay for **treatment** of any **medical condition** unless recommended **treatment** is not available under the NHS within four/six weeks of the **specialist** who would oversee the private **treatment** confirming that it is needed. This requirement does not apply to those **surgical procedures** listed in section 3 'Benefits table'.*

Will my policy cover me for new or unproven treatments?

Your **policy** covers you for **treatment** and **surgical procedures** that are **conventional treatments**.

We define **conventional treatment** as **treatment** that:

- is established as best medical practice and is practised widely within the **UK**; and
 - is clinically appropriate in terms of necessity, type, frequency, extent, duration and the **facility** or location where the **treatment** is provided;
- and has either:
- been approved by NICE (the National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice; or
 - been proven to be effective and safe for the **treatment** of your **medical condition** through high quality clinical trial evidence (full criteria available on request).

Are there any additional requirements for drug treatments?

If the **treatment** is a drug, the drug must be:

- licensed for use by the Medicines and Healthcare products Regulatory Agency; and
- used according to that licence.

Are there any additional requirements for surgical treatments?

If the **treatment** is a **surgical procedure** it must also be listed and identified in our technical document, called the Schedule of Procedures and Fees, which includes all the **surgical procedures** we pay benefits for. If you would like a copy of the Schedule of Procedures and Fees please contact our Claims Helpline.

Are there any additional requirements for medical devices?

If the **treatment** involves a **medical device** (including surgical devices and implants), it must:

- be approved by current EU Medical Device Regulations; and

- have moderate or high quality evidence of safety and effectiveness from either:
 - systemic reviews of randomised controlled trials; or
 - clinical trial evidence with three years of follow-up data.

Will the policy cover me for unproven treatment?

We define **unproven treatment** as surgery, **treatment** and **diagnostic tests** which are not **conventional treatment**.

If your **specialist** wants to carry out treatment that is not **conventional treatment**, your **policy** covers it if we agree that:

- You are not able to have **conventional treatment**, and
- There is sufficient evidence the **unproven treatment** is safe, and
- There is sufficient evidence the **unproven treatment** will be effective in improving health outcomes, in your specific circumstances.

If your **specialist** wants to carry out **treatment** that is not **conventional treatment**, it must be authorised by us before it takes place and it must take place in the **UK**. We will need to agree that the **unproven treatment** is a suitable equivalent to **conventional treatment** and the **treatment** must have high-quality evidence of its safety.

Are there restrictions on what you pay for unproven treatment?

If we agree to cover your **unproven treatment** (as described above), you are covered as you would be for **conventional treatment**, including **treatment** for complications related to the **unproven treatment**.

If we do not agree to cover your **unproven treatment**, we will not pay for any **treatment** for any complications related to the **unproven treatment**.

Do I need to let you know if I want unproven treatment?

Yes, if you would like **unproven treatment** you or your **specialist** should try and contact us at least 10 working days before you book that **treatment**. This is so we can:

- obtain full details of the **unproven treatment** and the supporting clinical evidence;
- support you with additional information and questions for your **specialist**, before you have **treatment**.

Childbirth, pregnancy and sexual health

Our policies are designed to provide cover for necessary and active **treatment** of a **medical condition** (which we define as a disease, illness or injury). This means for pregnancy and childbirth that we will only pay for **eligible** additional **treatment** made necessary by a **medical condition** that is experienced during that pregnancy and/or childbirth. Your **policy** is not intended to provide cover for preventive **treatment**, antenatal and postnatal monitoring or screening. We do not pay for the interventions required during pregnancy or childbirth as they are not **treatments** of a **medical condition**.

Be aware:

As the extent of cover is limited in pregnancy and childbirth it is important to call our Claims Helpline so we can confirm the extent of the cover we will provide before you undertake any **treatment**.

6.3 We pay for eligible:

- (a) Additional costs incurred for the **treatment** of **medical conditions** when they occur during pregnancy or childbirth. As an illustration we would consider **treatment** of the following:
 - ectopic pregnancy (where the foetus is growing outside the womb)
 - hydatidiform mole (abnormal cell growth in the womb)
 - retained placenta (afterbirth retained in the womb)
 - eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
 - post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
 - miscarriage requiring immediate surgical **treatment**.

6.4 What we do not pay for:

- (a) Any costs related to pregnancy or childbirth except the additional costs incurred for **eligible treatment** of a **medical condition**.
- (b) Investigations into assisted reproduction.
- (c) Investigations into and **treatment** of infertility, or **treatment** designed to increase fertility (including **treatment** to prevent future miscarriage).
- (d) Contraception or sterilisation (or its reversal) or any consequence of any of them or of any **treatment** for them.
- (e) **Treatment** of or related to sexual dysfunction, or any consequence of it.
- (f) Gender re-assignment operations or any other surgical or medical **treatment** directly or indirectly associated with, gender re-assignment.

7 RECURRENT, CONTINUING AND LONG-TERM TREATMENT

Will my policy cover me for recurrent, continuing or long-term treatment?

Your **policy** covers **treatment** of **medical conditions** that respond quickly to **treatment** – defined in our glossary as **acute conditions**. This **policy** is not intended to cover you against the costs of recurrent, continuing or long-term **treatment** of **chronic conditions**.

We define a **chronic condition** in the glossary as:

A disease, illness or injury that has one or more of the following characteristics:

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

Please note:

Your **policy** will cover you for the following phases of **treatment** for a **chronic condition**:

- the initial investigations to establish a diagnosis
- **treatment** for a period of a few months following diagnosis to allow the **specialist** to start **treatment**
- the **treatment** of acute exacerbations or complications (flare-ups) in order to quickly return the **chronic condition** to its controlled state.

What happens if I require recurrent or long-term treatment?

In the unfortunate event that the **treatment** you are receiving becomes recurrent, continuing or long-term, so you need consultations over a long period, checks on your medication, long-term therapy or **treatment** to ease symptoms, your condition may fall within the definition of a **chronic condition**.

What if my condition is chronic and gets worse?

We will pay for short-term **treatment** of acute exacerbations or complications (flare-ups) in order to bring the condition back to its controlled state. However, there are certain conditions that are likely to require ongoing **treatment** or recur – such as Crohn's disease (inflammatory bowel disease) – which require management of recurrent episodes where the condition's symptoms deteriorate. Because of the ongoing nature of these conditions we will write to tell you when the benefit for that condition will stop. Exclusions that would normally apply to long-term or **chronic conditions** may not apply to **cancer**. You will find a further explanation of how we deal with payment for **cancer treatments** later in this section.

7.1 We pay for eligible:

- (a) **Treatment** of an **acute condition** and the short-term **inpatient treatment** intended to stabilise and bring under control a **chronic condition**.
- (b) **Inpatient** rehabilitation of up to 28 days when it is part of **treatment** of an **acute condition** that is covered by your **policy**; and:
 - it follows an acute brain injury, such as a stroke; and
 - it is carried out by a **specialist** in rehabilitation; and
 - it is carried out in a recognised rehabilitation **hospital** or unit which is either listed in the **Saga Countrywide Hospital List** or which we have written to confirming it is recognised by us; and
 - it could not be carried out on a **day patient** or **outpatient** basis or in another appropriate setting; and
 - the costs have been agreed by us before the rehabilitation begins.

We will extend **inpatient** rehabilitation to a maximum of 180 days in cases of severe central nervous system damage caused by an external trauma.

8 WHO WE PAY FOR TREATMENT AND WHERE YOU CAN BE TREATED

If you have chosen the Saga Countrywide Hospital List or our Saga London Upgrade, or you live in the Channel Islands or Isle of Man, the following information applies:

(If you have chosen Guided Care, please see [page 17](#).)

You should call us before receiving any **treatment**. This will allow us to review our records to check or identify someone to treat you who is **eligible** for benefit and confirm that the place where **treatment** is being carried out is also covered.

In addition to the explanation throughout this section, the table below shows which services are **eligible** for benefit and who can refer you for **treatment**.

What services provided by specialists are eligible for benefit?

We will pay charges for eligible treatment from:	If you are referred by your GP	If you are referred by a specialist	If you are referred by your dentist
Specialists*	✓	✓	✓
*Includes consultations, diagnostic tests and treatment in hospital and surgical procedures .			

Your **GP** may have made an **open referral**, stating what **treatment** is necessary and the type of **specialist** you require that **treatment** from, but not specifying the **specialist's** name.

What services under the direction of a fee-assured specialist are eligible for benefit?

We pay **eligible treatment** charges made by a **fee-assured specialist** for **inpatient** and **day patient treatment** in **hospital** and **surgical procedures** when you are referred for **specialist treatment** in that medical specialty by your **GP, specialist** or dentist.

You can be reassured that the vast majority of **specialists** we recognise are **fee-assured specialists**, so please contact us before receiving any **treatment** and we will help identify a **fee-assured specialist** to treat you.

What services under the direction of a fee-limited specialist are eligible for benefit?

If you have **eligible treatment** with a **fee-limited specialist** we will only pay up to the amount shown within the Schedule of Procedures and Fees towards their personal charges. If you would like a copy of the Schedule of Procedures and Fees, please contact our Claims Helpline.

If you receive **treatment** with a **fee-limited specialist** you are likely to need to make a contribution to the fees charged by that **specialist**.

Be aware:

Very occasionally the arrangement we have with a **specialist** may change, for example a **fee-assured specialist** may move to the **fee-limited specialist** category. This means that what we will pay for **treatment** with that **specialist** may also change. It's important you contact us before you see the **specialist** or have any **treatment** so that we can tell you what you're covered for.

There are some medical providers who we do not recognise at all. If you receive **treatment** from one of these medical providers we will not pay those fees or any other fees for **treatment** costs under the direction of that provider.

What if an anaesthetist becomes involved in my treatment?

Before receiving surgical **treatment** it is advisable to establish which anaesthetist your **specialist** intends to use. This will mean we can tell you if that anaesthetist is a **fee-assured specialist**. However, if you don't know when you call us which anaesthetist your **specialist** intends to use we will make every effort to notify you whether they commonly work with an anaesthetist who we do not pay in full. If you choose to receive **treatment** with an anaesthetist who is a

7.2 What we do not pay for:

- (a) Ongoing, recurrent or long-term **treatment** of any **chronic condition**.
- (b) The monitoring of a **medical condition**.
- (c) Any **treatment** which only offers temporary relief of symptoms rather than dealing with the underlying **medical condition**.
- (d) Routine follow-up consultations.
- (e) Regular or long-term dialysis in the case of chronic organ failure.
- (f) Any hormone replacement therapy (HRT).

Will my policy cover me for cancer treatment?

Your **policy** covers the investigation and surgical **treatment** of **cancer**, whether this is a new **cancer** or a recurrence of an earlier one. If you have exclusions because of your past medical history which relate to a **cancer**, then you will not be covered for any recurrence of that **cancer**. Please refer to section 5 'Existing medical conditions' for further information on your cover for pre-existing conditions.

The **policy** does not cover non-surgical **treatment** of **cancer** including any radiotherapy or chemotherapy, or treatments such as bone marrow or stem cell transplants and is subject to restrictions on **outpatient treatment**.

However, if you are diagnosed with **cancer** you will be referred to one of our specialist nurses in our **Cancer Care Team**. They will be able to give you information on the **treatment** options open to you and support you through your **treatment**.

If your **treatment** would be **eligible** under your **policy** as a private patient, but after discussion with our specialist nurses you choose to have NHS **treatment** instead, our specialist nurses will also be able to offer other services to support you whilst you are receiving NHS **cancer treatment**, for example domestic help or assistance with travel costs to and from the hospital.

*If you have Saga HealthPlan Support 4 or Saga HealthPlan Support 6 please note that this cover is subject to the restrictions on this **policy** on **treatment** that is available under the NHS within four/six weeks of the date the **specialist** recommends the private **treatment**.*

*Some **cancer** patients may need follow-up procedures, such as colonoscopies or cystoscopies, which are needed not in order to provide **treatment**, but to monitor the patient as part of the planned management. These procedures can be scheduled in advance on the NHS for whenever they are needed and are not covered by these **policies**, as they would be available under the NHS within four/six weeks from the date on which they should take place.*

*At the time of going to print the NHS was commonly providing surgical **treatment** of **cancer** within 31 days and therefore it is unlikely that there will be cover on these **policies** for such surgical **treatment**.*

fee-limited specialist, we will pay up to the amount shown within the Schedule of Procedures and Fees. Please visit <https://codes.bupa.co.uk/procedures> to review the Bupa Schedule of Procedures and Fees. This list is subject to change.

Which hospitals and day patient units do I have cover for?

The **Saga Countrywide Hospital List** lists the **hospitals** and **day patient units** in the **United Kingdom** for which we provide cover.

Please note:

It may be necessary from time to time for us to suspend the use of a **hospital** or **day patient unit** listed in the **Saga Countrywide Hospital List** so as to protect the interests of all our customers.

You need to call us before receiving any **treatment**. This will allow us to check our database and confirm whether the **hospital** you have been referred to is **eligible** for benefit.

If it is medically necessary for you to use a hospital or **day patient unit** not listed in the **Saga Countrywide Hospital List** and we have specifically agreed to this before the **treatment** begins, then we will pay those hospital charges.

What happens if I choose to have treatment at a hospital that is not in the Saga Countrywide Hospital List?

If you have **inpatient treatment** or **day patient treatment** in any hospital which we do not list in the **Saga Countrywide Hospital List** then you will be entirely responsible for paying the hospital bills.

If you have **eligible inpatient treatment** as an NHS patient incurring no charges at all, then we will pay any NHS cash benefit as shown under benefit 5 in the **benefits table**.

Which outpatient facility charges are covered?

We will pay in full for **eligible treatment** charges made by an authorised **outpatient facility**, as long as the **treatment** is covered by your **policy**, a **specialist** is overseeing it and the **facility** is recognised by us to provide **outpatient** services. Please always check with us beforehand to make sure the **facility** you want to go to is recognised. We do not pay for **outpatient** drugs or dressings.

8.2 What we do not pay for:

- (a) Any drugs or **treatment** when the person who refers you is a member of your family, or if the person who is treating you is a member of your family.
- (b) **Treatment** charges made by a **fee-assured specialist** who we have identified to you as someone whose fees we will pay in full if, without our prior agreement, they charge significantly more than their usual amount for **treatment**.
- (c) Any charges from health spas, spas, nature cure clinics or any similar place, even if it is registered as a hospital.
- (d) Special nursing in hospital unless we have agreed beforehand that it is necessary and appropriate.
- (e) Any charges made by, or incurred in, an NHS hospital for ITU **treatment**, except as allowed for by 8.1(a).
- (f) Any charges made for written reports or any administrative costs, apart from charges made by a **GP** to complete your claim form, which we do pay for.

Where can I find more information about the quality and cost of private treatment?

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

8.1 We pay for eligible:

- (a) Charges made by, or incurred in, a private **hospital** or any NHS hospital for ITU (Intensive Therapy Unit, sometimes called Intensive Care Unit) **treatment** only when:
 - you are already having **eligible** private **treatment**; and
 - the ITU **treatment** immediately follows **eligible** private **treatment**; and
 - you or your next of kin have asked for the ITU **treatment** to be received privately; and
 - we have agreed the costs before you start the intensive care **treatment**. (See also section 4 for emergency **treatment**.)
- (b) NHS cash benefit, as shown on the **benefits table**, for each night you receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

If you have chosen Guided Care (not available if you live in the Channel Islands or Isle of Man) the following information applies:

(If you have chosen the [Saga Countrywide Hospital List](#) or our Saga London Upgrade, or you live in the Channel Islands or Isle of Man, please see [pages 15-16](#).)

You should contact us before making any appointments so we can understand your **treatment** requirements and help you choose a **selected provider** to receive your **treatment** with.

What happens on Guided Care if I do not call the Claims Helpline prior to my treatment?

If you do not contact us to authorise **treatment** with a **selected provider** we may not pay for the **treatment** you receive and you could be liable for the cost of **treatment**.

If you have **eligible inpatient treatment** as a National Health Service (NHS) patient incurring no charges at all, then we will pay any NHS cash benefit shown in the **benefits table**.

What services under the direction of a specialist are eligible for benefit with Guided Care?

We pay **eligible treatment** charges made by a **specialist** for **inpatient** and **day patient treatment** and **surgical procedures** when **treatment** is received at a **hospital, day patient unit** or **outpatient facility** that we have helped you choose, following a referral to that type of **specialist** by your **GP**.

Will treatment charges be met in full with Guided Care?

When you receive **eligible treatment** from a **selected provider**, we can normally meet the **treatment** charges in full, subject to any excess and specific benefit limits of this **policy**. There may be rare occasions when we will not be able to pay a **selected provider's** fees in full and if this is the case we will let you know when you call us to pre-authorise your **treatment**. This is why it is important you call us each time you need any **treatment**, as on these rare occasions we can support you in finding a **selected provider** whose **treatment** charges can be met in full.

8.3 With Guided Care we pay for eligible:

- (a) Charges made by, or incurred in, a private **hospital** or any NHS hospital for ITU (Intensive Therapy Unit, sometimes called Intensive Care Unit) **treatment** only when:
 - you are already having **eligible private treatment**; and
 - the ITU **treatment** immediately follows **eligible private treatment**; and
 - you have asked for the ITU **treatment** to be received privately; and
 - we have agreed the costs before you start the intensive care **treatment**. (See also section 4 for emergency **treatment**.)
- (b) NHS cash benefit, as shown on the **benefits table**, for each night you receive free **treatment** in an NHS Intensive Therapy Unit or NHS Intensive Care Unit.

8.4 With Guided Care we do not pay for:

- (a) **Treatment** which is not received from, or under the control of, a **selected provider**.
- (b) **Treatment** received from a **selected provider** that we did not choose for you.
- (c) Any charges from health hydros, spas, nature cure clinics or any similar place, even if it is registered as a hospital.
- (d) Special nursing in hospital unless we have agreed beforehand that it is necessary and appropriate.
- (e) Any charges made by, or incurred in, an NHS hospital for ITU **treatment**, except as allowed for by 8.3(a).
- (f) Any charges made for written reports or any administrative costs, apart from charges made by a **GP** to complete your claim form which we do pay for.

Where can I find more information about the quality and cost of private treatment?

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

9 HEALTH CASH BENEFITS COVER

In addition to the cover on your **policy** shown in section 6 'Your cover for certain types of treatment', you may have also selected Health Cash Benefits Cover. The Health Cash Benefits Cover provides cash back towards the cost of dental care, optical care, dental accident, dental emergency and a health assessment, as shown below.

There is no waiting period for pre-existing conditions so section 5 'Existing medical conditions' does not apply to Health Cash Benefits Cover.

We will not pay for dental **treatment**, which to the best of your knowledge and belief you were aware was needed before you joined this **policy**. We may request additional information from you as part of your claim.

We will reimburse you towards the cost of **treatment** under each benefit limit up to the maximum amounts payable for each person covered per **year** as stated in your **benefits table**.

Please note:

These benefits are not available to any children included under the **policy** – they are available to the **policyholder** and their spouse/partner only (for a definition of spouse or partner, please refer to 'family member' in the 'Glossary' section).

Dental care

9.1 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

- (a) Dental **treatment**.
- (b) Dental examination.
- (c) Dentures.

9.2 We do not pay the cash benefit for:

- (a) Veneers, bleaching or other tooth whitening.
- (b) Prescription charges.
- (c) Denture repairs.
- (d) Consumables such as mouthguards and toothbrushes.
- (e) Premiums in respect of any form of dental insurance/contract scheme or dental admin fees.

Optical care

9.3 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

- (a) Eyesight tests, prescribed spectacles, lenses or contact lenses paid for by the **policyholder** or spouse/partner, where payment has been made to a qualified optician who is registered with the General Optical Council.
- (b) Laser eye surgery received at a registered laser eye clinic.

9.4 We do not pay the cash benefit for:

- (a) Frames only, repairs, cleaning solutions, and other optical care items.
- (b) Cataract surgery (although you may be able to claim for this condition using your other Saga HealthPlan benefits, so please call us to check).
- (c) Lenses or spectacles purchased under an optical care insurance policy/contract scheme.
- (d) Sunglasses that are not prescription sunglasses.
- (e) Any other optical specialist.

Dental accident

9.5 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

- (a) Dental **treatment** needed due to injury to the teeth or supporting structures (including damage to dentures while being worn) caused suddenly and unexpectedly by means of direct external impact.

9.6 We do not pay the cash benefit for:

- (a) Repair or replacement bridges, crowns, or dentures unless damaged as described in 9.5(a) above.
- (b) Damage to dentures except while being worn.
- (c) Any injury caused by eating and/or drinking.
- (d) Sporting injuries where a mouthguard or other recommended protection is not worn.
- (e) Normal wear and tear.

Dental emergency

9.7 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

- (a) Dental **treatment** provided at the initial emergency appointment urgently required for the relief of significant pain, arrest of haemorrhage, management of acute infection or a condition which causes a severe threat to your general health.

9.8 We do not pay the cash benefit for:

- (a) Any follow-up dental appointments or **treatment** required after the initial dental emergency visit – these would need to be claimed for under the benefit for dental care up to the maximum amounts payable under that benefit.
- (b) Denture repairs.
- (c) Prescription charges.
- (d) Normal wear and tear.

Health assessment

9.9 We pay for **eligible** cash benefit in line with the **benefits table** up to the maximum benefit per person a **year** towards:

- (a) A health assessment, which is a package of medical and non-invasive tests that give you a clear picture of your health and wellbeing.
- (b) A health assessment when it takes place at a screening **facility** in a registered **hospital** or in a mobile screening **facility** under contract with a registered **hospital** by medically qualified staff.

9.10 We do not pay the cash benefit for:

- (a) Health assessments, other than as stated in 9.9(a) and (b) (including tests completed at a retail outlet or health club).
- (b) Tests which have been received in order to further legal/industrial action related to employment or emigration or as part of a pension scheme or insurance claim.
- (c) Additional tests or screens which fall outside your chosen health assessment package.

How to make a claim under your Health Cash Benefits Cover

To ensure your Health Cash Benefits Cover claim proceeds smoothly, please follow these simple steps

Step One	Arrange for a Health Cash Benefits Cover claim form to be completed and send it to us with the original receipted account(s) showing a full description and date of the consultation, treatment or service provided, and the name of the person the charges apply to. If you do not have a claim form, you can print one from our website at saga.co.uk/health-insurance , alternatively please request one by calling our Claims Helpline on 0330 018 0778 (Monday to Friday 8am-8pm, Saturday 8am-4pm).
Step Two	The claim form should be received by us with: <ul style="list-style-type: none">• the original receipted account for consultation and associated charges; or• the original receipted account for charges made.
Step Three	Once we have received your completed claim form we will assess the claim and reimburse you by cheque up to the maximum amount payable as stated in the benefits table .

Please send correspondence to: Bupa Claims, Bupa Place, 102 The Quays, Salford M50 3SP.

10 ADDITIONAL INFORMATION

When can I add other family members or change my cover?

You can apply to add a **family member** to your **policy** at any time. Also, you may be able to change your cover at your renewal. Call Saga on 0330 018 1587 to discuss the options open to you and we will send you any relevant forms to complete. You must keep Saga fully informed of any changes which take place between sending in any form and receiving written confirmation that the change has been made.

Can I add my new baby to my policy?

You can apply to add newborn babies (who are born to, or adopted by, the **policyholder** or the **policyholder's** partner) to the **policy** from their date of birth and they will be covered until your next renewal at no extra premium. This can normally be done without filling out details of their medical history provided you add them within three months of their date of birth.

In addition to this, as long as the mother has been covered for at least ten months before the birth and you add your child within these first three months, then we will not apply the exclusion for **medical conditions** they had prior to joining (as detailed in section 5 'Existing medical conditions') or require the child to be medically underwritten.

Can I cancel my policy?

You have a 14 day cooling-off period when you join and at each renewal in which to cancel your **policy** and receive a refund of your premium. After the 14 day cooling-off period, you may cancel your **policy** and we will refund any premium for unused cover.

Please see 12.1(g) and 12.1(h) in the section 'Complaint and regulatory information'.

How can I pay my premium?

This **policy** lasts for one **year** and at the start of each **policy year** we will calculate your new premium and let you know how much it is. We offer a choice of monthly, quarterly or annual premiums which can be paid by Direct Debit. In addition, we offer a choice of annual premiums which can be paid by cheque, debit or credit card.

Your **policy** is an annual insurance contract and lasts for one **year**. We will pay for covered costs under the terms of this **policy** when **treatment** takes place in a period for which premium has been paid.

If you pay by Direct Debit, we will collect the first premium when your **policy** starts and subsequent premiums when they fall due.

Be aware:

Important – you must pay your premium when it is due. If you do not we will cancel your **policy** and will not pay for any **treatment** or benefit entitlement arising after that date.

Please note that if you amend or cancel your **policy** during the **policy year** and have paid by credit card or cheque, we will be unable to refund any amounts of £5 or less. Similarly, if you make any changes to your **policy** during the **policy year**, we will only request any charges from you if the amount is over £5.

Why do you make changes to my premium?

We make every effort to maintain premiums at as low a level as possible, without compromising the range and quality of the cover provided. We review premiums each **year** to take account of a range of statistical factors. Typically the cost of premiums has increased at a level higher than the Retail Price Index (RPI). You will receive reasonable notice of any changes in premium.

Your premium will also include the amount of any insurance premium tax or other taxes or levies which are payable by law in respect of your **policy**.

How does the No Claim Discount scale operate?

This **policy** has a No Claim Discount (NCD) and your current NCD level is shown on your Policy Schedule, this means that in any NCD year:

Where nobody covered on the **policy** makes a claim

The NCD for the **policy** is increased by one level at the following **policy** renewal date until level 10 is reached.

For each claim made on the **policy**

The NCD for the **policy** is reduced by two levels at the following **policy** renewal date for each claim made until level 0 is reached.

Level	0	1	2	3	4	5	6	7	8	9	10
% discount on basic premium rate	0	10	20	25	30	35	40	45	50	55	60

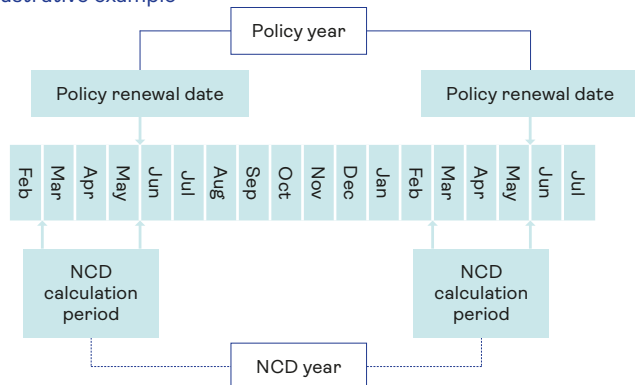
What is a claim?

- We will consider any **treatment** for the same **medical condition**, received within 12 months of the date that **treatment** first started, as one single claim;
 - For the purposes of the NCD a claim is any amount of money we pay for providing **treatment** for one **medical condition**, no matter how small or how many **eligible** surgical or medical services form part of the **treatment**;
 - The NCD will not be affected by the following:
 - Claims paid for NHS cash benefit;
 - Claims under the **external prosthesis** benefit;
 - Consultations through the Saga GP Service;
 - Claims under the optional Health Cash Benefits Cover;
- Please note:**
- While the **treatments** listed above do not affect your NCD, if you should claim additional **treatments**, for example you undergo an **eligible outpatient surgical procedure**, your NCD will be affected.
- The claim is recorded based on the date the **treatment** is received

When do you calculate the NCD?

Your NCD level is calculated up to 3 months prior to your **policy** renewal date. This means that a claim paid in the NCD calculation period may not impact on your NCD until the following **year's** renewal. The following diagram shows how the NCD calculation period works for a customer whose **policy** renews in June. Please refer to your Policy Schedule for confirmation of when your **policy** renews.

Illustrative example



within a reasonable period, you will reach or exceed the limit of those benefits that have monetary limits.

- We will not apply the excess against medical costs for **treatment** that your **policy** does not cover.

Should I pay for treatment myself to maintain my NCD level?

If you pay for your **treatment** yourself or have it on the NHS, this will not affect your discount level. If your **treatment** only costs a small amount, when you come to renew your **policy**, you can choose to pay us back for any claims paid during the previous year. If you do this within 30 days of the **policy** renewal date we will recalculate your premium so you continue to benefit from the NCD.

Can I protect my NCD?

We may offer this option on the **policy** for an additional premium, if no claims have been made in the last two years. If so, this will be shown on your Policy Schedule at renewal and you must accept this offer within 30 days of the renewal date.

If you accept this offer, it currently operates in this way for NCD protection:

- 1) If we have not paid a claim during the previous NCD year, we will work out your renewal premium using the discount for the next level up from your current discount. The maximum discount is 60%. You will retain your No Claim Discount protection.
- 2) If we have paid one claim during the previous NCD year, you retain your current No Claim Discount level. We will work out your renewal premium using this same level (please note, as your premium is based on a number of factors, your premium will still increase). Your No Claim Discount protection will be removed.
- 3) For each additional claim paid during the previous NCD year, you will move two levels back from your current level. You will never pay more than the basic premium rate, no matter how many claims we pay.

How can an excess help to reduce my premium?

Choosing an excess on your **policy** may help to reduce your premiums. If you would like to find out how to add an excess or change your existing excess level please call the Saga Customer Care Team on 0330 018 1361.

I have an excess on my policy – how does this work?

If you have an excess on your **policy**, this is how it is applied:

- The excess (that is, the amount of money you have to pay towards the cost of **eligible treatment**) applies to every person covered by the **policy** in each **policy year**.
- We will not pay any claim or part of a claim which is subject to an excess. In this case we will only pay the balance of the claim after we have deducted the excess amount.
- The excess is deducted from any **eligible treatment** costs you incur.
- The excess is a single deduction that is made regardless of the number of individual **medical conditions** claimed for in that **policy year**. Should **treatment** continue beyond your **policy's** renewal date then we will apply the excess once against the costs incurred before this date, and again against the costs incurred on or after the renewal date. We will do this irrespective of whether the costs relate to **treatment** for the same **medical condition**.
- If the first claim relates to a benefit with a monetary limit, then we will reduce the monetary limit by the total cost incurred before we apply the excess. If you have a high excess then you may find that,

11 ADVICE AND SUPPORT LINES

Saga GP Service

Some GP surgeries are unable to provide appointments immediately or at a time which fits in with busy lives. Maybe it's difficult to get to the surgery during their opening hours or perhaps appointments are not readily available for several days, causing an unwanted delay. If this is the case for you, then you may find that the Saga GP Service can help.

The Saga GP Service is available 24 hours a day, 365 days a year and allows you to speak, in confidence, with a qualified, practising GP at a time convenient for you. You may call as often as you need, knowing that the information you receive is given by GPs who are in touch with the latest advances in medical care.

There are many things that the doctors are able to talk to you about. Some of them are:

- Your symptoms – a persistent ache or pain – giving you advice and discussing possible **treatments**
- Explanations of diagnosis or **treatment** that you may already have been prescribed
- Sensitive or confidential concerns
- Side effects of any medication you are taking
- Possible after-effects of surgery
- Vaccinations you may need when you're travelling abroad and other health precautions relevant to your own medical history.

Your call will be answered by a specially trained operator. The operator will take some details from you and arrange for a GP to call you back at a convenient time. If you'd like to book an appointment online, you can do this via www.saga.co.uk/GPService

Many callers find that they receive the advice, reassurance and, where appropriate, the diagnosis they need from the Saga GP Service without having to go to their own GP. The service is completely confidential. However, in some cases the doctor may think it is advisable, and subject to your agreement, that a record of your consultation is sent to your own NHS GP, in order to keep him/her informed, also allowing your NHS records to be updated.

The doctors on the Saga GP Service can give advice, but if you have symptoms, which mean that you need a physical examination, or you need a prescription, then you may need to see a GP in person.

Saga GP Service – 0330 018 1618

Saga GP Service is available to you any time – day or night, 365 days a year.

If calling from outside the UK, phone +44 330 018 1618 – international call rates apply.

Please remember to have your policy number to hand before you call. You can also book an appointment online via www.saga.co.uk/GPService

Please note:

In an emergency situation, you should contact your own NHS GP or the emergency services directly so as not to delay the appropriate treatment.

Access to the Saga GP Service is provided in addition to your policy. This service is provided to you by a third party, HealthHero Solutions Limited, whose registered address is 10 Upper Berkeley Street, London W1H 7PE.

Anytime HealthLine

With the Anytime HealthLine, you have access to a qualified nursing team 24 hours a day, 365 days a year.

Whether you are calling because you have late night worries about a child's health, or because you have concerns about an ongoing **medical condition** that you would like to discuss; or maybe you have some questions that you did not think to ask at the time, then it's likely that the Anytime HealthLine will be able to provide you with the help you need.

Our qualified nursing team is on hand to give you the benefit of their expertise. They can answer your questions and give you all the latest information on specific illnesses, **treatments** and medications as well as details of local and national organisations.

Anytime HealthLine – 0330 018 0779

Anytime HealthLine is available to you any time – day or night, 365 days a year.

If calling from outside the UK, phone **+44 1925 361 340** – international call rates apply.

Please remember to have your policy number to hand before you call.

Please note:

The Anytime HealthLine can provide you with valuable information to help put your mind at rest. It does not diagnose or prescribe and is not designed to take the place of your GP.

As the Anytime HealthLine and the Saga GP Service are confidential services, any information you discuss is not shared with our Claims Helpline.

If you wish to authorise **treatment** or enquire about a claim, our Claims Helpline will be happy to help you.

12 COMPLAINT AND REGULATORY INFORMATION

Not happy with our service?

We hope you're happy with the service you've received so far and that this continues. However, if you do have a complaint about our services, the most important thing for us is to help you resolve this as quickly and easily as possible. We'll do all we can to address your concerns when they are first raised to us, but if we can't do this, we'll contact you within five working days to acknowledge your complaint and explain the next steps. Letting us know you're unhappy with our service gives us the opportunity to put things right for you and improve our service for everybody.

No matter how you decide to communicate your concerns, we'll listen.

To help us resolve your complaint, we'll need the following:

- Your name and **policy** details
- A contact telephone number
- A description of your complaint
- Any relevant information relating to your complaint that we may not have already seen.

For queries and complaints not related to a claim

If you have a query or complaint about private health insurance that is not regarding a claim, you can call Saga on: 0330 018 0796 or write to Saga at: The Customer Relations Department

Saga Services Limited
PO Box 253
Seaham DO, SR7 1BN

Email: services.customer-relations@saga.co.uk

For queries and complaints related to a claim

How do I complain to Bupa?

If you have a complaint, please follow the guidance below and our team will help as soon as possible.

Talk to us: Webchat is open Monday to Friday 9am-5pm.

Email us: customerrelations@bupa.com

Please be aware that information you send to this email address may not be secure unless you send us your email through Egress.

For more information and to sign up for a free Egress account, go to <https://switch.egress.com>. You will not be charged for sending secure emails to a Bupa email address using the Egress service.

Call us: 0345 606 6739

(We may record or monitor our calls. Our opening hours are Monday to Friday 8am-6pm.)

For people with hearing or speech difficulties you can use the Relay UK service on your smartphone or textphone. For further information visit www.relayuk.bt.com. We also offer documents in braille, large print or audio. Write to us: Customer Relations, Bupa, Bupa Place, 102 The Quays, Salford M50 3SP

Financial Ombudsman Service

We will generally issue our final response within eight weeks from when you originally contacted us. However, we will respond sooner than this if we are able.

If it looks as though our review of your complaint will take longer than this, we will let you know the reasons for the delay and will keep you updated.

You may be entitled to refer your complaint to the Financial Ombudsman Service. The ombudsman service can liaise with us directly about your complaint and if we can't fully respond to a complaint within eight weeks or if you are unhappy with our final response, you can ask the Financial Ombudsman Service for an independent review.

How to contact the Financial Ombudsman Service

Financial Ombudsman Service

Exchange Tower

Harbour Exchange Square

London E14 9SR

Telephone: 0800 023 4567 or 0300 123 9123

Email: complaint.info@financial-ombudsman.org.uk

Website: financial-ombudsman.org.uk

None of these procedures affect your legal rights.

What regulatory protection do I have?

The Financial Conduct Authority

Saga Services Limited is authorised and regulated by the Financial Conduct Authority. Bupa Insurance Limited is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Bupa Insurance Services Limited is authorised and regulated by the Financial Conduct Authority.

Saga Services Limited Financial Services Register Number is 311557. Bupa Insurance Limited Financial Services Register Number is 203332. Bupa Insurance Services Limited Financial Services Register Number is 312526.

The FCA have set out rules which regulate the sale and administration of general insurance which all of the above parties must follow when they deal with you.

The Financial Services Compensation Scheme

Bupa Insurance Limited is also a participant in the Financial Services Compensation Scheme established under the Financial Services and Markets Act 2000. The scheme is administered by the Financial Services Compensation Scheme Limited (FSCS). The scheme may act if it decides that an insurance company is in such serious financial difficulties that it may not be able to honour its contracts of insurance. The scheme may assist by providing financial assistance to the insurer concerned, by transferring policies to another insurer, or by paying compensation to eligible **policyholders**. Further information about the operation of the scheme is available on the FSCS website: fscs.org.uk

What we do with your personal data

Here is a summary of the data privacy policy that you can find on our websites at: saga.co.uk/privacy-policy and bupa.co.uk/privacy

Please make sure that everyone covered by this **policy** reads this summary and the full data privacy policy on our websites. If you would like a copy of either of our full notices call us on the contact numbers contained in this Policy Book and we'll send you one. We want to reassure you we never sell your personal information to third parties. We will only use your information in ways we are allowed to by law, which includes collecting only as much information as we need. We will get your consent to process information such as your medical information when it's necessary to do so.

Where use of your information by us relies on your consent you can withdraw your consent, but if you do we may not be able to process your claims or manage your **policy** properly. Much of the personal information Saga and the underwriter of your **policy**, Bupa Insurance Limited, hold about you is obtained when you apply for a Saga Health Insurance **policy**, and when a claim is made. This may include medical information we obtain from medical practitioners and other health consultants. We may also obtain information from third party suppliers of information such as credit reference agencies.

Saga will keep your information securely and use it to provide the highest standard of service in the administration of this **policy** and other products that you hold with Saga. Saga will also use it for audit, underwriting and pricing purposes and, in certain circumstances, claims mediation and market research, and to maintain management information for business analysis.

Bupa Insurance Limited will handle your information on a confidential basis and use it to process claims, for underwriting and pricing purposes, to maintain management information for business analysis, for research and to find out more about you. They will disclose your information, including your health information, to Saga only to the extent necessary for the purposes of audit, managing your **policy** and claims. Saga may also use the health information shared with them for other purposes but they will only do so in line with data protection legislation.

In the event of a claim, Bupa Insurance Limited may have to give some information about you and/or any named **family member** to those involved in your/their **treatment** or care, but this will be done confidentially. With your/their consent Bupa Insurance Limited may also disclose information to a representative you/

your named family member have chosen. The fact that a **family member** has claimed (but not the full details of the claim) may be disclosed to the **policyholder** in order for Saga to properly manage the **policy**. For example to provide the correct No Claim Discount. If an endorsement is added to the **policy** at any stage which excludes **treatment** of a specific condition, then this information will be available to the **policyholder** regardless of which insured **family member** the exclusion relates to. You should be aware that Saga and Bupa Insurance Limited do not supply any information about you to anyone unless we believe it is lawful to do so, or when we are requested to do so by you and have your consent in advance. We may, at our discretion, appoint third parties to service the **policy** and claims, including other companies based outside the European Economic Area, and which may be in a country that does not offer the same level of data protection as within the European Economic Area. We will always use every reasonable effort to ensure sufficient protections are in place to safeguard your personal information.

Marketing policy

Saga may share your personal information, and your medical data, with other Saga Group (Saga plc and its subsidiaries) companies. Saga uses the data they collect from you, including sensitive personal data, to contact you and personalise their communication. Saga and Bupa Insurance Limited also use it for administrative purposes to provide the service you requested and for preparing quotations. If Saga has obtained your permission to do so, they will also contact you by post, telephone, email or other means to tell you about offers, products and services that may be of interest to you. At any time you can opt out of receiving such information, revise the products you would like to hear about or change the method they use to communicate with you. You can update these preferences by calling 0330 018 1587. For further information about how the Saga Group uses your personal information, please visit www.saga.co.uk/privacy-policy or contact the Saga Group Data Protection Officer by email: data.protection@saga.co.uk or post: Saga Services Limited, 3 Pancras Square, London N1C 4AG.

Obtaining a copy of the information we hold about you

You have rights to access your information and to ask for it to be corrected, erased and for its use to be restricted. You also have the right to object to your information being used; to ask for it to be transferred; to withdraw any permission you have given regarding its use; and the right for it not to be subjected to automated decisions which produce legal effects on you. If you wish to access your personal information, or have any questions, comments, complaints or any other concerns about the way in which we process information about you, including to exercise any of your rights, please contact:

The Data Protection Officer at Saga Group via 0330 018 1587 (for Saga). Alternatively you can write to Saga at: Saga Services Limited, 3 Pancras Square, London N1C 4AG or contact The Data Protection team at Bupa via dataprotection@bupa.com. You can also use this email address to contact Bupa's Data Protection Officer. Alternatively you can write to Bupa at: Bupa Data Protection, 1 Angel Court, London, EC2R 7HJ.

You also have a right to make a complaint to your local privacy supervisory authority.

Our main office is in the UK, where the local supervisory authority is the Information Commissioner, who can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF, United Kingdom. Phone: 0303 123 1113 (local rate).

Crime prevention and detection and legal requirements

Saga and Bupa Insurance Limited are required by law, in certain circumstances, to disclose information to law enforcement agencies about suspicions of fraudulent claims and other crime. Saga and Bupa Insurance Limited will disclose information to third parties including other insurers for the purposes of prevention or investigation of crime including reasonable suspicion about fraud or otherwise improper claims. This may involve adding non-medical information to a database that will be accessible by other insurers and law enforcement agencies. Additionally, Bupa Insurance Limited will investigate possible medical malpractice and is obliged to notify the General Medical Council or other relevant regulatory body about

any issue where they have reason to believe a medical practitioner's fitness to practise may be impaired.

Keeping information

Saga and Bupa Insurance Limited will hold your personal information in accordance with the principles of the General Data Protection Regulation (and associated legislation) and in line with our Data Retention Policies. We are entitled and permitted by law and regulation to retain certain types of data for a reasonable period of time. We will then dispose of your information in a responsible way.

Future underwriter changes

Your Saga Health Insurance **policy** is currently provided and underwritten by Bupa Insurance Limited as part of an agreement between Saga Services Limited and them. If you have selected any additional cover options, these may be provided by different insurers. At some time in the future Saga Services Limited may enter into an agreement with a new provider for all or part of your **policy**, in which case this new provider will offer you health insurance to replace your current **policy**. If this is the case, Saga Services Limited will write to you to confirm the details of the new provider and give you details of any changes to the Terms and Conditions of your **policy**. At this stage you will be given the option to refuse transferral to the new provider. For further information, please see Saga's Privacy Policy at saga.co.uk/privacy-policy

Legal rights and responsibilities

12.1 Your rights and responsibilities

- (a) Your **policy** is an annual insurance contract and lasts for one **year**. We will pay for covered costs under the terms of this **policy** when **treatment** takes place in a period for which premium has been paid. We will not pay any costs for **treatment** or services received after the end of your period of cover under the **policy**. We will not pay for **treatment** that happens outside your period of cover even if we had pre-authorised it during your period of cover under the **policy**.

The provision of the **treatment** itself, including the date(s) of the **treatment**, will be the subject of a separate agreement between you and your **treatment** provider.

Prior to the end of any **policy year** Saga will write to the **policyholder** to advise on what terms the **policy** will continue, provided the **policy** you are on is still available. If Saga does not hear from the **policyholder** in response they will renew your **policy** on the new terms. Where you have opted to pay premiums by Direct Debit, Saga may continue to collect premiums by such method for the new **policy year**. Please note that if Saga does not receive your premium, you will not be covered. If the **policy** you were on is no longer available we will do our best to offer you cover on an alternative **policy**.

- (b) You must make sure that whenever you are required to give us any information all the information you give us and Saga is sufficiently true, accurate and complete so as to present to us fairly the risk we are taking on. If we discover later it is not then we can cancel the **policy** or apply different terms of cover in line with the terms we would have applied had the information been presented to us fairly in the first place.
- (c) You and we are free to choose the law that applies to this **policy**. In the absence of an agreement to the contrary, the law of England and Wales will apply. The terms and conditions and all other information concerning this insurance are supplied in the English language and we undertake to communicate in this language for the duration of the **policy**.
- (d) You must write and tell Saga if you change your address.
- (e) Only the **policyholder** and we have legal rights under this **policy** and it is not intended that any clause or term of this **policy** should be enforceable, by virtue of the Contract (Rights of Third Parties) Act 1999, by any other person including any **family member**.
- (f) You must pay your premium when it is due.
- (g) The **policyholder** may cancel this **policy** by contacting Saga during the 14 day cooling-off period. The 14 day cooling-off period begins on either the start date or renewal date of the **policy** or the day that the **policyholder** receives the full

policy terms and conditions, whichever is the later. The 14 day cooling-off period also applies from each renewal date. If the **policy** is cancelled during the 14 day cooling-off period we will provide a full refund providing a claim has not been made. If you have made a claim during the 14 day cooling-off period you will receive a pro-rata refund. If the **policyholder** does not cancel the **policy** during the 14 day cooling-off period the **policy** will continue on the terms described in your Policy Book for the remainder of the **policy year**.

- (h) After the 14 day cooling-off period the **policyholder** may cancel this **policy**, at any time by notifying us verbally or in writing. We'll refund any premiums the **policyholder** has paid for the period after your cover ends. If for any reason you decide to cancel your **policy**, let Saga know by calling 0330 018 1260 or writing to Saga's Customer Care Team, Saga Services Limited, PO Box 253, Seaham DO, SR7 1BN. They will then write to you and confirm when your **policy** has been cancelled.

12.2 Saga and Bupa's rights and responsibilities

- (a) Saga will tell the **policyholder** in writing the date the **policy** starts and any special terms which apply to it.
- (b) We can refuse to add a **family member** to the **policy** and we will tell the **policyholder** if we do.
- (c) We will pay for **eligible** costs incurred during a period for which the premium has been paid.
- (d) If you break any of the terms of the **policy** which we reasonably consider to be fundamental, we may (subject to 12.2(f)) do one or more of the following:
- refuse to make any benefit payment or if we have already paid benefits we can recover from you any loss to us caused by the break;
 - refuse to renew your **policy**;
 - impose different terms to any cover we are prepared to provide;
 - end your **policy** and all cover under it immediately.
- (e) We do not have to pay a claim if you or a dependant break any of the terms and conditions of your cover, which are related to the claim. If there is reasonable evidence that you or a dependant didn't take reasonable care answering our questions correctly (for example, you gave false information or kept important information from us) the following will apply.
- If this was intentional, we may treat your or your dependants (or both of your) cover as if it never existed and not pay any claims and we may keep any premiums you have paid.
- If this was careless, depending on what we would have done if you or they had answered our questions correctly, we may treat your or your dependants (or both of your) cover as if it never existed and refuse to pay all claims, change your or their cover, or reduce any claim payment we make. (If we refuse to pay all claims, you may need to repay any claims we've already paid, and we'll return any premiums you've paid for your or your dependants cover.)
- (f) We will not do business with any individual or organisation that appears on an economic sanctions list or is subject to similar restrictions from any other law or regulation. This includes sanction lists, laws and regulations of the European Union, United Kingdom, United States of America or under a United Nations resolution. We will immediately end cover and stop paying claims on your policy if you or a **family member** are directly or indirectly subject to economic sanctions, including sanctions against your country of residence. We will do this even if you have permission from a relevant authority to continue cover or premium payments under a policy. In this case, we can cancel your policy or remove a **family member** immediately without notice, but will then tell you if we do this. If you know that you or a **family member** are on a sanctions list or subject to similar restrictions you must let us know within seven days of finding this out.

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

expose us to the risk of being sanctioned by any relevant

authority or competent body; and/or expose us to the risk of being involved in conduct (either directly or indirectly) which any relevant authority, banks we transact through, or competent body would consider to be prohibited.

- (g) We can change all or any part of the **policy** from any renewal date. We will give you reasonable notice of changes to your **policy** terms.

13 GLOSSARY

Throughout this Policy Book certain words and phrases appear in **bold**. Where these words appear they have a special medical or legal meaning. These meanings are set out below.

Some sections of this Policy Book have defined terms specific to that section, in which case the definition is provided in the relevant section rather than in the main glossary.

Please note: Some of these words and phrases may not be applicable to your chosen plan.

To aid customer understanding certain words and phrases in this glossary have been approved by the Association of British Insurers and the Plain English Campaign. These particular terms will be commonly used by most medical insurers and are highlighted below by a **◇** symbol.

Acute condition ◇ – a disease, illness or injury that is likely to respond quickly to **treatment** 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.

Benefits table – the table applicable to this **policy** showing the maximum benefits we will pay you.

Cancer ◇ – a malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chronic condition ◇ – a disease, illness, or injury that has one or more of the following characteristics:

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

Conventional treatment – **treatment** that:

- is established as best medical practice and is practised widely within the **UK**; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the **facility** or location where the **treatment** is provided; and has either:
 - been approved by NICE (the National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice; or
 - been proven to be effective and safe for the **treatment** of your **medical condition** through high quality clinical trial evidence (full criteria on request).

Day patient ◇ – a patient who is admitted to **hospital** or **day patient unit** because they need a period of medically supervised recovery but does not occupy a bed overnight.

Day patient unit – a centre in which **day patient treatment** is carried out. The units we recognise for benefit purposes are listed in the **Saga Countrywide Hospital List**.

If you have opted for Guided Care, the **Saga Countrywide Hospital List** does not apply and we must help you choose where your **treatment** takes place.

Diagnostic tests ◇ – investigations, such as x-rays or blood tests, to find or to help to find the cause of your symptoms.

Eligible – those **treatments** and charges which are covered by your **policy**. In order to determine whether a **treatment** or charge is covered all sections of your **policy** should be read together, and are subject to all the terms, benefits and exclusions set out in this **policy**.

External prosthesis – an artificial, removable replacement for a part of the body.

Facility – a private **hospital** or a centre with which we have an agreement to provide a specific range of medical services and which is listed in the **Saga Countrywide Hospital List**.

In some circumstances, **treatment** may be carried out at an establishment which provides **treatment** under an arrangement with a **facility** listed in the **Saga Countrywide Hospital List**.

If you have opted for Guided Care, the **Saga Countrywide Hospital List** does not apply and we must help you choose where your **treatment** takes place.

Family member – (1) the **policyholder's** current spouse or civil partner or any person (whether or not of the same sex) living permanently in a similar relationship with the **policyholder**.

(2) any of their or the **policyholder's** children. Children cannot stay on your **policy** after the renewal date following their 21st birthday (or 25th birthday if in full-time education).

Fee-assured specialist – a **specialist** who, at the time you receive your **treatment**, is recognised by us as a fee-assured specialist. You can contact us to find out if a **specialist** is a fee-assured specialist or use finder.bupa.co.uk

Fee-limited specialist – a **specialist** who we have identified as someone to whom we will only pay up to the amount shown within the Schedule of Procedures and Fees towards their **eligible treatment** charges. If you would like a copy of the Schedule of Procedures and Fees, please contact our Claims Helpline.

GP – a general practitioner on the General Medical Council (GMC) **GP** register.

We will only accept referrals from your NHS **GP** practice or a Saga **GP** Service **GP**.

Hospital – a hospital listed in the current **Saga Countrywide Hospital List**.

If you have opted for Guided Care, the **Saga Countrywide Hospital List** does not apply and we will support you to choose where your **treatment** takes place.

Inpatient ◇ – a patient who is admitted to **hospital** and who occupies a bed overnight or longer, for medical reasons.

Medical condition – any disease, illness or injury, including mental health conditions.

Medical device – any instrument, apparatus, appliance, software implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings.

Nurse ◇ – a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.

Open referral – where your **GP** states that **treatment** is necessary and which type of **specialist** you require that **treatment** from, but does not specify the **specialist's** name.

Outpatient ◇ – a patient who attends a **hospital**, consulting room, or outpatient clinic and is not admitted as a **day patient** or an **inpatient**.

Physiotherapist – a medical practitioner who practises physiotherapy and who meets our recognition criteria for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as a physiotherapist for benefit purposes. When such persons provide such services to you as part of your **inpatient** or **day patient treatment**, those services will form part of the private **hospital** charges.

Policy – the insurance contract between you and us.

Its full terms are set out in the current versions of the following documents as sent to you from time to time:

- the Saga Policy Book
- your Policy Schedule
- Important Information
- any endorsements.

Policyholder – the first person named on the Policy Schedule who must be 50 or over.

Practitioner – a practising member of certain professions allied to medicine who, in all cases, meets our recognition criteria for benefit purposes in their field of practice and who we have told in writing that we currently recognise as a practitioner for benefit purposes.

When such persons provide such services to you as part of your **inpatient** or **day patient treatment** those services will form part of the private **hospital** charges.

The professions concerned are dietitians (<https://www.bda.uk.com/>), nurses, orthoptists, speech therapists, audiologists, psychologists and psychotherapists. A full explanation of the criteria we use to determine these matters is available on request.

Saga Countrywide Hospital List – a document Saga publishes which lists the **hospitals, day patient** units and **scanning centres** in the **United Kingdom** covered by the **policy**. The facilities listed may change from time to time so you should always check with us before arranging **treatment**. If you have opted for Guided Care, the **Saga Countrywide Hospital List** does not apply and we will support you to choose where your **treatment** takes place.

Selected provider – a **hospital, day patient unit, outpatient facility** or **specialist** who we choose to provide your **treatment**.

Specialist – a medical practitioner with particular training in an area of medicine (such as consultant surgeons, consultant anaesthetists and consultant physicians) with full registration under the Medical Acts, who meets our criteria for specialist recognition for benefit purposes, and who we have told in writing that we currently recognise as a specialist for benefit purposes in their field of practice.

For **outpatient treatment** only: a medical practitioner with full registration under the Medical Acts, who is registered under the relevant Act and who, in all cases, meets our criteria for limited specialist recognition for benefit purposes in their field of practice, and who we have told in writing that we currently recognise as a specialist for benefit purposes in that field for the provision of **outpatient treatment** only.

A full explanation of the criteria we use to decide these matters is available on request.

If you have opted for Guided Care, we must help you choose who provides your **treatment**.

Surgical procedure – an operation or other invasive surgical intervention listed in the Schedule of Procedures and Fees.

Terrorist act – any clandestine use of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal.

Treatment ◇ – surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

United Kingdom (UK) – Great Britain and Northern Ireland, including the Channel Islands and the Isle of Man.

Unproven treatment – surgery, **treatment** and **diagnostic tests** which are not **conventional treatment**.

Year – twelve calendar months from when your **policy** began or was last renewed.

14 APPENDIX

MORATORIUM UNDERWRITING

This section applies to policyholders who did not provide their medical history on joining and have chosen the Moratorium method of underwriting for their cover. Your Policy Schedule will indicate if this applies to you. Full information on how the Moratorium method of underwriting works is shown in section 5 'Existing medical conditions' of this Policy Book.

Frequently asked questions

What is the advantage of Moratorium underwriting?

With this option, we ask you to give only basic information about yourself and any members of your family you wish to insure. We will not ask you to give details of your medical history, but it relies on you to understand that we will not cover treatment of any medical condition which was in existence at any time during the last three years immediately before your policy started or any specified conditions to pre-existing diabetes, prostate conditions or hypertension, as shown in section 5.

To help you understand how the Moratorium method of underwriting works in practice we have set out a series of model questions and answers to the typical queries often raised:

I suffer from high blood pressure for which I have to take tablets every day. How does this affect my cover?

As you will never be able to go for the period of two consecutive years without medication, cover for this or any specified condition would be permanently excluded. Please note that if you have chosen to include cover for eligible treatment for pre-existing hypertension and related conditions, this does not apply to you. Your Policy Schedule will indicate if this cover is included on your policy.

Some time after my cover begins I go to my doctor for a routine visit. A heart condition is diagnosed and it must have started to develop before my policy began. What is the position?

You would be covered provided that there were no symptoms evident at the time your policy commenced and it was not a specified condition, as shown in the table under section 5 'Existing medical conditions', nor a pre-existing condition.

What if I suspect that I am suffering from a condition (for example, I have abdominal pain) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts? Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?

You would not be covered under a Moratorium for any treatment you would need to have because of the abdominal pain. This is because symptoms were evident when you took out the policy - making this a pre-existing condition.

I had an operation on my knee recently. Will I be covered for any further treatment to it after my policy starts?

During your first two years of continuous cover with us you would not be covered for any further treatment relating to your knee operation, or the condition for which it was performed. After that time, provided you have been trouble-free (see definition under section 5 'Existing medical conditions'), for a consecutive two-year period after joining in relation to your knee problem, you would be covered for further eligible treatment.

What if I am uncertain whether treatment I received before the start of my policy is related to the condition for which I later wish to claim?

Before undergoing any private treatment for which you wish to make a claim under your policy, you must gain pre-authorisation for your claim. This way we will be able to establish the full facts about your condition and proposed course of treatment and will confirm our decision to you before you incur the costs of treatment.

How do regular check-ups affect the Moratorium?

It depends on what check-ups are for. For example:

- 1) If you have a medical condition before your policy starts and your doctor or specialist recommends that you continue to have check-ups for that medical condition, then we will not cover the cost of private treatment received for your medical condition for a period of two years from the time your policy started. If the medical condition is one of these shown in the pre-existing condition table in section 5 'Existing medical conditions', you would not be covered for it either. Cover would only be available once you have been discharged from care and have no further treatment, medication, special diets or advice for a continuous period of two years.
- 2) In the same situation described above, if you chose to continue having check-ups for your own peace of mind even though you have been discharged from care, we will cover you for that condition (though not the routine check-ups) after joining, if you are trouble-free for a continuous period of two years after joining from your last appointment to discharge.
- 3) If you have general health check-ups simply in the interest of maintaining good health and not for any particular condition, we ignore them when applying the restrictions of pre-existing conditions.

Note: We do not pay for check-ups in any of the circumstances described above.

Please note:

The preceding questions and answers provide broad guidance to the operation of the Moratorium method of underwriting. Each claim is dealt with and treated on its own merits. How the clause is interpreted depends entirely on the facts presented. When we receive a fully completed claim form, we will be pleased to tell you whether cover is available before you have treatment.

Will my choice of underwriting method affect my premium?

Choosing between Moratorium and Full Medical Underwriting will not affect your premium.

FULL MEDICAL UNDERWRITING

This option is similar to Moratorium in that we provide cover for new medical conditions that arise after the policy begins. However, when it comes to exclusions for pre-existing and specified conditions, we will base these on the answers you provide in response to our full medical history assessment.

Your Policy Schedule will indicate if this applies to you. Full information on how the Full Medical Underwriting method of underwriting works is shown in section 5 'Existing medical conditions' of this Policy Book.

Frequently asked questions

What is the advantage of Full Medical Underwriting?

The benefit of this option is that we will state, in writing, which medical conditions we will exclude. As with the Moratorium option, we may later cover a pre-existing medical condition if you ask us to review the exclusion and we agree to remove it. Important note: If necessary, we may ask your doctor for any further information required to help us determine which medical conditions we should exclude from your policy.

Sometime after my cover starts, I go to my doctor for a routine visit. A heart condition is diagnosed that must have started to develop before my policy started. What is the position?

You would be covered provided that there were no symptoms evident at the time your policy commenced, and it was not a specified condition, as shown in the table under section 5 'Existing medical conditions', or a pre-existing condition.

What if I suspect I am suffering from a condition (for example, I have abdominal pain) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts. Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?

You would not be covered with Full Medical Underwriting for any treatment you would have to have because of the abdominal pain. This is because symptoms were evident when you took out the policy – making it a pre-existing condition.

I had an operation on my right knee recently. Will I be covered for any further treatment to it after my policy starts?

During your first two years of continuous cover with us you would not be covered for any further treatment relating to your knee operation, or the condition for which it was performed. After that time, provided you have been trouble-free (see definition under section 5 'Existing medical conditions') for a consecutive two-year period in relation to your knee problem, if you ask us to review your exclusion, we may be able to offer any cover for the knee condition.

How do regular check-ups affect my Full Medical Underwriting?

It depends what the check-ups are for. For example:

- 1) If you have a medical condition before your policy starts and your doctor, or specialist, recommends that you continue to have check-ups for that medical condition, then we will not cover the cost of private treatment received for that medical condition for a period of two years from the time your policy started. If the medical condition is one of those shown in the pre-existing condition table in section 5: 'Existing medical conditions', you would not be covered for it either. Cover will only be available once you have been discharged from care and have no further treatment, medication or advice for a continuous period of two years after joining, and if we have agreed to remove the exclusion.

- 2) In the same situation, if you choose to continue having check-ups for your own peace of mind even though you have been discharged from care, we will cover you for the condition (but not the routine check-ups) if, after joining, you are trouble-free for a continuous period of two years from your last appointment prior to discharge.
- 3) If you have general check-ups simply to maintain good health, and not for any particular medical condition, we ignore them when applying the restrictions for treatment of pre-existing conditions.

Will my choice of underwriting method affect my premium?

Choosing between Full Medical Underwriting and Moratorium will not affect your premium. However, selecting the Full Medical Underwriting method enables you to declare your medical history up-front making any exclusions clear at the start of your cover.

CONTINUED PERSONAL MEDICAL EXCLUSIONS

This option is only available if you already have cover with another insurer, subject to your medical history over the previous 12 months. Your Policy Schedule will indicate if this applies to you. Full information on how this method of underwriting works is shown in the 'Existing medical conditions' section of this Policy Book.

Frequently asked questions

What is the advantage of Continued Personal Medical Exclusions?

Continuation of cover for pre-existing medical conditions.

Sometime after my cover starts, I go to my doctor for a routine visit. A heart condition is diagnosed that must have started to develop before my policy started. What is the position?

You would be covered providing the routine visit was for a general check-up and not in respect of any symptoms or pre-existing conditions, and you have no exclusions carried over from your previous insurer in respect of this.

What if I suspect I am suffering from a condition (for example, I have abdominal pain) but have not seen a doctor about it, nor received any firm diagnosis before my cover starts. Will I be covered if I need to have any investigations or treatment for the condition once my policy has started?

In respect of Continued Personal Medical Exclusions, if you planned to see a medical practitioner about this condition when you enrolled with us, an exclusion may apply. We may need to seek further medical information about this condition before we advise about eligibility.

I had an operation on my right knee recently. Will I be covered for any further treatment to it after my policy starts?

If you had treatment in hospital or consulted a specialist in the last 12 months, or had any treatment, consultations, investigations or diagnostic tests planned or pending at the start of cover, then an exclusion is likely to apply for this condition and it would not be eligible for at least two years on the policy. If not and it does not fall under any of the underwriting carried over from your previous insurer, then it would be eligible.

I have continuation cover from my previous insurance company, but you have also added a further term on my policy for treatment I had in the last year. Why is this?

If you had treatment in hospital or consulted a specialist in the 12 months before joining, or had any treatment, consultations, investigations or diagnostic tests planned or pending at the start of cover, then an exclusion is likely to apply for at least two years on the policy. This is in addition to any underwriting that you carried over from your previous insurer and will be detailed on your membership statement. The exclusion(s) may be reviewed two years after the start of cover.

How do regular check-ups affect my cover?

It depends what the check-ups are for and who they are with.

- 1) If you have only seen your GP for an annual monitoring review of an ongoing condition, then this will not affect your cover. If however, the GP is still actively investigating or stabilising a change or elevation in levels, or a flare up of new symptoms then this would need to be declared when joining and an exclusion for this condition may apply.
- 2) If you have seen a specialist in the last year or plan to see a specialist, an exclusion for this condition may apply. Any exclusions applied would be reviewable in two years after your enrolment date, subject to a medical report confirming you have been two years free of any medication, treatment, investigations or consultations for this condition.

Note: We do not pay for check-ups in any of the circumstances described above.

Will my choice of underwriting method affect my premium?

If you choose Continued Personal Medical Exclusions, your premium will be more than the Moratorium and Full Medical Underwriting options. This is because both the Moratorium and the Full Medical Underwriting you do not have cover for pre-existing conditions, which you may have under the Continued Personal Medical Exclusions option.

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