HSBC Resident Corporate Health Plan

1. Please complete this form **USING BLACK INK** and write within the boxes in **CAPITAL LETTERS**. Mark appropriate answer boxes with a **CROSS**. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE.**
2. Please complete all details that are relevant to you on all pages of this form.
3. Read the declaration and sign all the relevant signature panels.
4. See Important Information at **bupa.com.au/corporate-info** for all details relating to how you are covered.

ORGX: 2105501

SECTION A: I'm applying to

- [ ] **Join as a new applicant**
- [ ] **Transfer from another health fund**
  You'll also need to fill in the clearance certificate request – see 'Section F: Transferring from another health fund?'
- [ ] **Add someone to my membership** You, as the Policyholder, will need to fill in this form to add someone to your membership.
- [ ] **Change my level of cover, other membership details, or nominate a tier for the Australian Government Rebate on private health insurance.**

SECTION B: Your details

Existing Bupa Membership number *(if relevant)*

Surname

First name

Initial Title Date of birth (D D M M Y Y) [ ] Male [ ] Female

Employee number (if relevant)

Note: *The person named opposite is the Policyholder and has legal responsibility for the membership and for ensuring that premiums are kept up-to-date. Only the Policyholder is authorised to operate the membership and collect benefits on behalf of another insured person, unless they nominate an authorised person (see Section D). All membership correspondence will be directed to the Policyholder unless indicated otherwise.*

NSW/ACT residents only - important
To ensure the correct amount of ambulance levy is paid for the state/territory ambulance insurance plans, please complete the section below. If anyone on your membership holds one of the following concession cards: Health Benefits Card; Pensioner Health Benefits and Transport Concession Card; Pharmaceutical Benefits Concession Card; Social Security Card; or Pensioner Concession Card issued by the Department of Veterans' Affairs (DVA), please provide the name of each concession card holder, the type of concession card and card expiry date (if relevant).

IMPORTANT: please inform us if the concession entitlements for any individuals on your membership change.

SECTION C: Contact details

Residential address

Postcode

Mail address *(if different from residential address)*

Postcode

Home phone *(including area code)*

Work phone *(including area code)*

Mobile

Email

Please let us know how you'd like to hear from us

[ ] Email [ ] Mail

We'll stick to your preferences wherever possible. But we are required to send some things by mail and some aren't available via email.

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ABN 81 000 057 590

SECTION D: Your partner and/or additional family member details

If you need to add more than 5 people to be covered under your policy, please enclose a separate page with the details of the additional person(s). By providing the details of your partner/additional family members, you acknowledge that you have the consent of each person aged 17 or over to provide this information to us.

Surname	First name	Date of birth	Gender (M/F)	Relationship
		D D M M Y Y		
		D D M M Y Y		
		D D M M Y Y		
		D D M M Y Y		
		D D M M Y Y		

All children will be covered under this membership until the age of 21. Any full-time students can continue to be covered under this membership until age 25.

Note: You can continue to cover any non full-time students (aged between 21–24 inclusive) if you purchase our Family Plus or Single Parent Plus membership option.

	Child 1	Child 2	Child 3
Name of tertiary institution			
Expected date of completion	D D M M Y Y	D D M M Y Y	D D M M Y Y

Partner mail address (if different to yours)

Postcode

Home phone (including area code)

Work phone (including area code)

Email

Mobile

Partner communication preferences (if different to yours)

X Email X Mail

Partner Authority

X If you wish to give your partner (as listed on this form) authority to operate this membership please cross this box. By authorising your partner you acknowledge that they will have the same rights and obligations as you, including access to health information, however they will not be able to cancel the policy or remove you from the policy. You also acknowledge that you remain responsible for your membership and for the actions of the authorised person, that authorisation is given at your own risk and that you will have no recourse against Bupa for any acts or omissions by the authorised person. This authority will remain in place until you contact us to revoke it. To authorise someone other than your partner, please contact us.

X We are required to provide some personal communications, for example tax statements, to every adult on your membership (except dependent children). We will provide these communications directly to the Policyholder, combined with their own (via their preferred communication method which they may vary at anytime). **If you would prefer us to issue your personal communications to you separately, please cross this box.**

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SECTION E: Your Cover requirements

Before completing this section, please refer to your brochure for details of the cover that is available under your company's corporate health plan.

Which kind of Cover would you like?

☐ Singles ☐ Couples ☐ Single Parent ☐ Single Parent Plus ☐ Family ☐ Family Plus

Hospital

☒ Corporate Hospital Cover
Level 2 – $250 Excess

Extras

☒ Corporate 90 Extras

Bupa Membership is only effective from the 1st of any month following the commencement of your employment.

☐ from this date in the future 0 1 _ _ _ _

Please refer to your brochure for details of which levels of cover are covered under your company's corporate health plan.
Family Policy covers you, your partner and dependent children not studying to age 21 and children in full-time study to age 25.
Family Plus Policy covers you, your partner and your single children not studying to age 25 as well as those in full-time study to age 25.

SECTION F: Transferring from another health fund?

Clearance certificate request

All Australian registered health funds are required to issue you with a clearance certificate when you cancel your health cover with them. When you transfer from another insurer you'll be able to access the same or equivalent level of benefits once we receive a Clearance Certificate that tells us what you were covered for with your previous insurer.
If you would like us to cancel your existing health fund cover for you and receive the clearance certificate on your behalf, please complete this section. If you have a direct debit arrangement with your existing health fund, please remember to cancel the deductions with your bank. If your partner (if named on this form) is transferring from another fund, they will need to complete a separate "Clearance Certificate Request". They can access this form at bupa.com.au. Benefits will be payable upon receipt of a Clearance Certificate to determine your entitlements.

Name of existing health fund

Existing health fund cover/membership number

Your health cover details with existing health fund

Surname

First name Title

Date of birth (D D M M Y Y) Level of Cover

The other health fund cover relates to:

☐ myself ☐ my partner ☐ my children ☐ my parents

I confirm that I/we have held this cover for a minimum of 12 months from the date I/we request to join Bupa.

If not, date joined: (D D M M Y Y) Date to which health cover is paid: (D D M M Y Y)

I authorise Bupa to terminate my health cover with your organisation (if still current) from the cancellation date and obtain details about my health cover. Please issue a clearance certificate to Bupa. I declare that I have obtained consent from all transferring adults for Bupa to act on their behalf in obtaining their clearance certificate. Please urgently refund any excess premiums owing to the undersigned. Please do not contact me further about this request.

Cancellation date (D D M M Y Y)

Applicant's Signature Date (D D M M Y Y)

Note: *The signatory above must have legal responsibility for the health cover at the 'existing fund'.*

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Join date (D D M M Y Y) Member number

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SECTION G: Paying your premium

Invoice will be sent to your employer

SECTION H: To receive the Australian Government Rebate on private health insurance as a reduced premium

IMPORTANT: You must complete this section or you will not receive the rebate as a reduced premium. All the people listed on the policy must be eligible to claim Medicare for you to receive the rebate as a reduced premium. If you do not complete this section, full premiums apply.

You may be entitled to a Medicare card if you are:

- a person who lives in Australia, **and**
- an Australian citizen, **or**
- a holder of a permanent resident visa, **or**
- a New Zealand citizen, **or**
- an applicant for a permanent resident visa

1. Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?

X **Yes.** *Please complete the remainder of this section.*

X **No.** *You cannot apply for the Rebate until you obtain a Medicare card.*

2. Are you covered by this membership?

X **Yes.**

X **No.** *Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.*

Medicare card number

[ ][ ][ ][ ] – [ ][ ][ ][ ][ ][ ] – [ ]

Your name exactly as it appears on your Medicare card

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Valid to

[M][M][Y][Y][Y][Y]

Some of the information provided on this form will be used for the purpose of registering you for the Australian Government Rebate on private health insurance. Its collection is authorised by law, and information collected will be disclosed to the Department of Health, Department of Human Services and the Australian Taxation Office.

As a condition of your employer's corporate plan you are required to nominate "The Base Tier" as your default tier. This has been pre-selected for you below.

		APPLICABLE REBATE %^			INCOME THRESHOLDS 2015–2018*	
Tier		**Under 65**	**65–69yrs**	**70+**	**Single**	**Couples/ Family~**
Base	X	26.791%	31.256%	35.722%	Up to $90,000	Up to $180,000
Tier 1		17.861%	22.326%	26.791%	$90,001 to $105,000	$180,001 to $210,000
Tier 2		8.930%	13.395%	17.861%	$105,001 to $140,000	$210,001 to $280,000
Tier 3		0%			$140,001 or more	$280,001 or more

^Applicable rebate % changes annually from 1 April. *Income thresholds effective 1 July 2015 – 30 June 2018. For more information visit ato.gov.au. ~Thresholds also apply to single parents and increase by $1500 for each child after the first.

If you are entitled to a Savings Provision Entitlement, a Savings Provision Clearance Certificate must be provided by your previous health fund.

There are no penalties for nominating an incorrect rebate tier. If the applicant claims a rebate tier that is different to their actual entitlement any adjustments required will be made when their annual tax return is completed.

If at any stage you wish to nominate a new income tier or stop receiving the Australian Government Rebate as a reduced premium, you must notify your health fund as soon as possible.

For more information about the Australian Government Rebate on Private Health Insurance, go to humanservices.gov.au/privatehealth. Questions about Medicare eligibility can be made at any Human Services' Service Centre or by calling 132 011.

Note: *Call charges apply – calls from mobile phones may be charged at a higher rate.*

X I'd like to make this change from my first payment on or after: [D][D][M][M][Y][Y]

Applicant's signature

Date [D][D][M][M][Y][Y]

SECTION I: Your Lifetime Health Cover details

1. Do you have a Certified Age of Entry (CAE) of 30 at time of joining? X Yes X No
2. If you answered 'No' to question 1, what is your current CAE? [ ][ ]
3. Does your partner have a CAE of 30 at time of joining? X Yes X No
4. If you answered 'No' to question 3, what is your partner's current CAE? [ ][ ]

If you have had hospital cover since the 1st of July following your 31st birthday, then your Certified Age of Entry (CAE) will be 30. If you take out hospital cover after this date then your CAE will be calculated based on the age you were when you joined. Please contact us if you have any questions.

If you are transferring from another health fund, please complete 'Section F' on this form, or provide a copy of your clearance certificate if you already have one. If you don't, we may need to add the appropriate loading for your age to your premiums.

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Applicant, please read then sign this declaration

Privacy Statement
Your privacy is important to Bupa. This statement summarises how we handle your personal information. For further information about our information handling practices or our complaints handling process, please refer to our *Information Handling Policy*, available on our website at www.bupa.com.au or by calling us on 134 135. When you join, you agree to the handling of your personal information as set out here and in our *Information Handling Policy*.

We will only collect personal information that we require to provide, manage and administer our products and services and to operate an efficient and sustainable business. We are required to collect certain information from you to comply with the *Private Health Insurance Act 2007* (Cth). We may also collect information about you from health service providers for the purposes of administering or verifying any claim, and from your employer, broker or agent if you are on a corporate health plan or have joined through a broker or agent. We may disclose your personal information to our related entities, and to third parties including healthcare providers, government and regulatory bodies, other private health insurers, and any persons or entities engaged by us or acting on our behalf. If we send your information outside of Australia, we will require that the recipient of the information complies with privacy laws and contractual obligations to maintain the security of the data. If you are on a corporate health plan, we may disclose your information to your employer to verify your eligibility to be on that corporate plan. The policy holder is responsible for ensuring that each person on their policy is aware that we handle their personal information as set out here and in our *Information Handling Policy*. Each person on a policy aged 17 or over may complete a *'Keeping your personal information confidential'* form to specify who should receive information about their health claims. You are entitled to reasonable access to your personal information within a reasonable timeframe. We reserve the right to charge a fee for collating such information. If you or any insured person does not consent to the way we handle personal information, or does not provide us with the information we require, we may be unable to provide you with our products and services. We may use your personal (including health) information to contact you to advise you of health management programs, products and services. When you take out cover with us, you consent to us using your personal information to contact you (by phone, email, SMS or post) about products and services that may be of interest to you. If you do not wish to receive this information, you may opt out by contacting us.

Transferring from another fund
I am transferring from another private health insurer and hereby authorise Bupa Australia Pty Ltd to cancel my previous membership with that other insurer and obtain information about my previous policy on my behalf from other private health insurers as applicable.

Terms and Conditions
I accept to be bound by the Fund Rules of Bupa Australia Pty Ltd (available on our website, or by calling us), as amended from time to time. I acknowledge that I have read the brochure in full and understand the terms and conditions of my cover, including those relating to pre-existing conditions, waiting periods, restricted benefit periods or any exclusions that apply to my cover. I declare that the information I have provided is true and correct. I have read and consent to, and have made the other people on this policy aware of, the collection, use and disclosure of my personal information as set out in this Privacy Statement and in the Information Handling Policy (available on our website, or by contacting us). I acknowledge that, where practicable, information is provided with the consent of the individual to whom it relates.

Applicant's signature

Date D D M M Y Y

Just before you send

☐ Check that you have signed all the signature boxes relevant to your application, including the declaration above.
PLEASE DO NOT STAPLE.

Please scan and email your completed application to:
humanresources@hsbc.com.au

If you would like any assistance, please call us on 134 135.

Bupa Australia Pty Ltd ABN 81 000 057 590

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ABN 81 000 057 590

Corporate Hospital Cover Level 2

Enjoy the peace of mind that comes with our comprehensive top hospital cover with an excess that helps to lower your premiums.

Hospital	Excess
Top	$250

Your hospital cover includes:

Private hospital cover | Medical cover | Unlimited emergency ambulance

Accidents sustained after joining~	✓
Cardiac & cardiac related services	✓
Hip/knee replacement	✓
All other joint replacements	✓
Knee arthrosocpy and meniscectomy	✓
Other joint arthroscopy and meniscectomy procedures	✓
Cataract & eye lens procedures	✓
Renal dialysis for chronic renal failure	✓
Pregnancy (including childbirth)	✓
IVF and assisted reproductive services	✓
Minor gynaecological surgery	✓
Gastric banding & obesity related services	✓
Abdominoplasty and Lipectomy	✓
Appendicitis	✓
Removal of tonsils and adenoids	✓
Cancer*	✓
Psychiatric services	✓
Rehabilitation services	✓
Clinically necessary cosmetic surgery	✓
All other in-patient treatment receiving Medicare benefits	✓
Emergency Ambulance	✓
Health subscription refunds	✓
Family in-hospital benefit	✓
Excess option	$250
No excess for kids	✓

Excess

The excess is capped at once per person, twice per membership, per calendar year.

~Benefits for accidents will be paid based on what your hospital cover includes.

*Some non PBS drugs may not be covered. Bupa Australia Pty Ltd. ABN 81 000 057 590. 10290-04-16

Corporate
90 Extras

Corporate 90 Extras is one of our top level extras covers, you'll get back 90% of the cost of your treatment for most services. You receive cover for the services listed below at any health care provider that is recognised by us, up to your yearly limits.

What's covered

90% of cost at all our recognised providers~

Services	Waiting Periods	Yearly Limits^
General dental	2 months	Year 1: $1,200 2: $1,320 3: $1,440 4: $1,560 5: $1,680 6+: $1,800
Major Dental Including dentures, crowns, bridgework and indirect restorations. Denture replacement claimable every three years.	12 months	Combined with General Dental yearly limits
Orthodontics	12 months	
Optical	2 months	$300
Physiotherapy	2 months	Year 1: $550 2: $600 3: $650 4: $700 5: $750 6+: $800
Antenatal and Postnatal	2 months	$400
Chiropractic and Osteopathy	2 months	Year 1: $550 2: $600 3: $650 4: $700 5: $750 6+: $800
Living Well	6 months	$100
Dietary	2 months	$500
Speech Therapy	2 months	
Eye Therapy	2 months	
Occupational Therapy	2 months	

90% of cost at all our recognised providers~		
Services	**Waiting Periods**	**Yearly Limits^**
Pharmacy* Covers selected items. You pay a set amount, we refund 90% of the balance of the script.	**2 months**	
Psychology	**2 months**	
Podiatry (excludes orthotics)	**2 months**	
Health Aids and Appliances** (includes orthotics) Sub-limits apply.	**12 months**	
Hire, Repair and Maintenance of Health Aids and Appliances Sub-limit of $100 applies.	**6 months**	
Natural Therapies Includes: acupuncture, Alexander Technique, Chinese herbalism, exercise physiology, Feldenkrais, homeopathy, iridology, naturopathy, Western herbalism and massage. Massage includes: aromatherapy, Bowen Technique, kinesiology, reflexology, shiatsu and remedial massage.	**2 months**	
Home Nursing	**2 months**	$350
Travel and Accommodation	**2 months**	Travel $100 Accommodation $150

Year	Amount ■
1	$700
2	$750
3	$800
4	$850
5	$900
6+	$950

Yearly limits

The most you can claim per person in a calendar year, depending on your cover.

■ Loyalty Maximums

We increase how much you can claim each year by a fixed amount for some extras services (applies after the first 12 months up to a maximum of 6 years).

Gap free dental for kids

We'll cover the cost of your kids' dental in most instances at Members First providers until they turn 25 up to your yearly limits.†

~Fund and policy rules, waiting periods and yearly limits apply. ^Per person, per calendar year unless otherwise stated. *Benefits for prescription items that are non-PBS, TGA approved, and not appearing on our exclusions list. **Family limits may apply. †When taken with hospital cover on a family membership, when treatment is provided by a Members First dentist. Fund and policy rules, waiting periods and yearly limits apply. Child dependants only. Excludes orthodontics and hospital treatments.

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IMPORTANT INFORMATION (FOR CORPORATE CUSTOMERS)

Here you will find information to help you understand how your health cover with us works. You can also view our online glossary at **bupa.com.au/glossary**

You should also refer to our Fund Rules, available online or by calling us, for the full terms and conditions of your cover. The information below applies in addition to our Fund Rules.

UNDERSTANDING YOUR HOSPITAL COVER

What is covered?

Hospital costs

With private hospital cover, you can choose to be treated as a private patient in either a public or a private hospital.

What if I am treated in a Members First or Network Hospital?

You will be fully covered, in most instances, as a private patient in most hospitals that Bupa has an agreement with, known as Members First and Network hospitals across Australia for any treatment which is recognised by Medicare and is not either restricted or excluded under your cover.

A small number of these hospitals may charge a fixed daily fee. This fee is capped at a maximum number of days for overnight stays. The hospital should inform you of this fee when you make a booking. This fee is in addition to any excess or co-payment you may have as part of your hospital cover.

At Members First Day Hospitals, you have the added benefit of no medical gaps in addition to being covered for hospital costs, provided the treatment is recognised by Medicare and there are no exclusions or restrictions on your level of cover.#

When admitted to hospital, in most cases you will be covered for all in-hospital charges when provided as part of your in-hospital treatment including:

- accommodation for overnight or same-day stays
- operating theatre, intensive care and labour ward fees
- supplied pharmaceuticals approved by the Pharmaceutical Benefits Scheme
- physiotherapy, occupational therapy, speech therapy and other allied health services
- surgically implanted prostheses up to the approved benefits in the Government's Prostheses List
- private room where available.

We recommend you call us first before making a booking to confirm that your hospital of choice gives you certainty of full cover. We can also discuss any excess or co-payment that may be applicable to your level of cover. You can find out if a hospital has an agreement with us by checking our website **bupa.com.au/find-a-provider**

#Not available in NT. Any co-payment or excess related to your level of cover will still apply.

Can I choose to be treated as a private patient in a public hospital or at a private hospital that Bupa does not have an agreement with?

With us, if you elect to be treated as a private patient in a public hospital or are admitted to a private hospital that Bupa does not have an agreement with, you are covered as set out in the following pages for any treatment recognised by Medicare unless it is excluded or restricted under your cover. In these circumstances, you are likely to incur out-of-pocket expenses for your hospital costs.

What happens if I choose a private hospital that Bupa doesn't have an agreement with?

If you are admitted to a private hospital that Bupa does not have an agreement with, we will pay shared room minimum benefits and benefits for prostheses up to the benefit in the Government Prostheses List. This will apply for any treatment recognised by Medicare, unless it is excluded or restricted under your cover. These benefits will only partially cover the full cost and you will have significant out-of-pocket expenses.

It is important to note that you will be responsible for the cost of your stay and may be charged directly for your hospital accommodation, doctor's services (including any diagnostic tests), surgically implanted prostheses (such as artificial hips) and personal expenses such as TV hire and telephone calls. Some of these hospitals bill Bupa directly for the limited benefits we pay. Please also refer to the Medical Costs section of this guide.

What happens if I choose to be a private patient in a public hospital?

As a private patient in a public hospital you are entitled to choose your doctor, if they are available. Depending on your illness or condition, this may be the same doctor who would have been allocated to you by the hospital as a public patient.

If you elect to be treated as a private patient in a public hospital, we will pay shared room minimum benefits and benefits for prostheses up to the benefit in the Government Prostheses List. This will apply for any treatment recognised by Medicare unless it is excluded or restricted under your cover.

If you choose to stay in a private room for an overnight stay, Bupa will pay a fixed benefit towards the cost of your stay. If this benefit is less than the hospital charge, the hospital should let you know what out of pocket expenses you will have to pay.

It is important to note that in public hospitals, private rooms are generally allocated to people who medically need them.

You will also be responsible for personal expenses such as TV hire and telephone calls and any prostheses charges above the benefit in the Government Prostheses List. Please also refer to the Medical Costs section of this guide.

To ensure peace of mind, ask your doctor about their fees and whether they participate in our Medical Gap Scheme for your hospital treatment prior to admission. Remember to also ask your doctor about the fees for other practitioners that may be involved in your hospital treatment such as: the anaesthetist and assistant surgeons.

Medical costs

These are the fees charged by a doctor, surgeon, anaesthetist or other specialist for any treatment given when you are in hospital. You are covered for the cost of these medical treatments up to the Medicare Benefit Schedule (MBS) fee. The MBS fee is the amount set by the Federal Government for each medical service covered by Medicare. You must be eligible for Medicare in order to be covered up to the MBS fee.

How benefit is calculated

If you choose to be treated as a private patient in a hospital (public or private), Medicare will cover you for 75% of the MBS fee for associated medical costs and we will cover the remaining 25%.

Bupa Medical Gap Scheme

The Bupa Medical Gap Scheme is an arrangement Bupa has with some medical specialists/doctors such as an anaesthetist to help minimise the amount you'll need to pay for your medical costs in hospital.

No Gap

If you see a "No Gap" doctor that uses the Bupa Medical Gap Scheme you won't have to pay any medical costs as your medical specialist or doctor will bill Bupa directly. Check with them that they will use this for your upcoming admission upfront.

Known Gap

If you see a 'Known Gap' doctor that uses the Bupa Medical Gap Scheme with you, you will need to pay up to $500 towards your medical costs.

Without the Gap Scheme

If your doctor is not using the gap scheme, Medicare will pay 75% and Bupa will pay 25% of the MBS fee. Any charge above that will be your gap.

Your choice of network

We are partnered with Genesis Heart Care, a network of cardiologists across VIC, QLD, SA and WA that focus on providing quality, evidence based cardiology services. When you see a cardiologist from Genesis Heart Care you will have certainty of no out-of-pocket expenses for your in-hospital cardiologist treatment. You'll also be provided with information and advice so you can make informed decisions about your treatment and lifestyle.

What is not covered?

Hospital costs

Situations when you will not be covered include:

- when you have not been admitted into a hospital and are treated as an outpatient (e.g. emergency room treatment, outpatient ante-natal consultations with an obstetrician)
- during a waiting period
- when a service is excluded from your cover
- when a service is covered as a minimum benefit and you are admitted to a private hospital, you will not be covered above the minimum benefit
- for the fixed fee charged by a fixed fee hospital or a hospital that has a fixed fee service
- for psychiatric and rehabilitation day programs at a hospital Bupa does not have an agreement with
- hospital treatment provided by a practitioner not authorised by a hospital to provide that treatment
- hospital treatment for which Medicare pays no benefit, including: medical costs related to surgical podiatry (including the fees charged by the podiatric surgeon); cosmetic surgery where not clinically necessary; respite care; experimental treatment and/or any treatment/procedure not approved by the Medical Services Advisory Committee (MSAC)
- personal expenses such as: pay TV, internet access, non-local phone calls, newspapers, boarder fees, meals ordered for your visitors, hairdressing and any other personal expenses charged to you unless included in your cover
- if you are in hospital for more than 35 days and you have been classified as a 'nursing home type' patient. (In this situation you may receive limited benefits and be required to make a personal contribution towards the cost of your care)
- if you choose to use your own allied health provider rather than the hospital's practitioner for services that form part of your in-hospital treatment (e.g. chiropractors, dieticians or psychologists)

- where compensation, damages or benefits may be claimed by another source (e.g. workers compensation)
- for any amount charged by a public or non-agreement hospital which is not covered by us or which is above the benefit that we pay
- for any treatment or service provided outside Australia
- for some non-PBS, high cost drugs
- for pharmacy items not opened at the point of leaving the hospital.

What is not covered?

Medical costs

You will not be covered for medical services for surgical procedures performed by a dentist, surgical podiatrist, or any other practitioner or service that is not eligible for a rebate through Medicare.

Inpatient vs outpatient

If you are admitted as a private inpatient, you will be covered for the services listed in your chosen level of hospital cover. If you receive treatment as an outpatient (i.e. you are not admitted), in most instances you will not be covered by private health insurance. If eligible these services may be claimed from Medicare.

Waiting periods

The following waiting periods apply for hospital cover:

- laser eye surgery, (only covered on the Ultimate Corporate Health Cover) – 12 months
- palliative care, psychiatric and rehabilitation services – two months
- pre-existing conditions, ailments or illnesses and pregnancy (including childbirth) – 12 months
- all other treatments included in your cover – two months.

When to contact us

If you have been a Bupa member for less than 12 months on your current hospital cover, it is important to contact us before you are admitted to hospital and find out whether the pre-existing condition waiting period applies to you. We need about five working days to make the pre-existing condition assessment, subject to the timely receipt of information from your treating medical practitioner/s. Make sure you allow for this timeframe when you agree to a hospital admission date. If you proceed with the admission without confirming benefit entitlements and we (the health fund) subsequently determine your condition to be pre-existing, you will be required to pay all hospital charges and medical charges not covered by Medicare.

Planning for a baby

If you are thinking about starting a family we recommend that you contact us to check whether your current level of cover includes pregnancy in advance. This is because a 12-month waiting period applies to pregnancy (including childbirth) and assisted reproductive services.

No waiting periods will apply to the newborn provided they have been added to the appropriate family hospital cover within two months of their birth.

UNDERSTANDING YOUR EXTRAS COVER

What is covered?

With extras cover, you can claim benefits for those services listed on your cover and that are not claimable elsewhere (e.g. from a third party like Medicare).

For example, Medicare does not provide benefits for:

- most dental examinations and treatment
- most physiotherapy, occupational therapy, speech therapy, eye therapy, chiropractic services, podiatry or psychology services
- acupuncture (unless part of a doctor's consultation) or other natural therapies
- glasses and contact lenses

- most health aids and appliances
- home nursing.

Extras cover allows you to claim benefits for extras services as long as:

- the treatment is given by a private practice provider who is recognised and registered with us for benefit purposes
- they meet the criteria set out in our Policy and Fund Rules.

We recommend you contact us before making a booking to confirm how much you can claim and to check that your chosen provider is registered with us.

What is not covered?

Extras benefits will not be payable:

- during a waiting period
- where a third party, including Medicare, a Government body, or an insurance company provided a benefit (except for hearing aids and breast prosthesis items)
- for different services within the same service type from the same provider on the same day. For example, if you went to see an acupuncturist and then received a massage from the same provider on the same day, you cannot claim for both services
- when a prescribed treatment for orthotics or surgical shoes is not custom made
- when a provider is not recognised by us for benefit purposes
- for any treatment or service rendered outside Australia
- when you have reached the maximums on your product including annual, lifetime or service limits for the service you are claiming.

Waiting periods

The following waiting periods apply for extras cover:

- initial waiting period – two months
- hire, repair and maintenance of health aids and appliances; and Living Well Programs – six months
- major dental, orthodontics, selected health aids and appliances – 12 months.

UNDERSTANDING YOUR AMBULANCE COVER

Emergency Ambulance definition

When you take out our hospital cover, extras cover or packaged cover, you will receive cover for recognised emergency ambulance transport and on-the-spot treatment. This is capped at one emergency service each calendar year for a singles membership and two for a couples/families membership.

Please Note: Corporate Hospital Cover levels 1, 2 & 3 and Mining and Resources Health Cover levels 1 & 2 offer uncapped emergency ambulance transportation.

An emergency is when there is reason to believe that the patient's life may be in danger or the patient should be attended to without undue delay.

Transportation means a journey from the place where immediate medical treatment is sought to the casualty department of a receiving hospital.

Emergency ambulance transportation is defined as air or road transportation by a Recognised Ambulance Provider of an unplanned and of a non-routine nature for the purpose of providing immediate medical attention to a person.

Benefits are not payable for:

- transportation from a hospital to your home
- transportation from a hospital to a nursing home
- transportation from a hospital to another hospital where the customer has been admitted to the transferring (first) hospital
- transportation from the person's home, a nursing home or hospital for ongoing medical treatment, (e.g. chemotherapy, dialysis).

Ambulance Cover

We recommend that you take out an ambulance subscription with your recognised State Ambulance Provider if it's available in your state (VIC, SA, NT and rural postcodes in WA).

We will only provide ambulance benefits, in accordance with your level of cover, when you do not hold a subscription with an ambulance provider and a state ambulance scheme does not provide cover.

NSW and ACT members: If you reside in New South Wales or the Australian Capital Territory and you have hospital cover, you pay an ambulance levy as part of your premium. This entitles you to free emergency ambulance transport under the State Government ambulance transport schemes. When you receive an account for ambulance transport, simply send it to us and we'll endorse it for you to send back to the appropriate ambulance transport scheme.

QLD and TAS members: If you reside in Queensland or Tasmania, you are covered under your state service scheme.

VIC, SA, WA and NT members: If you reside in Victoria, South Australia, Western Australia or the Northern Territory you will receive cover for recognised emergency ambulance transport and on-the-spot treatment from us. This is as long as you don't have an ambulance subscription with your state ambulance service or cover through a state-based arrangement.

Most state schemes cover their respective residents within their state of residence only. However, some states have entered into reciprocal agreements that allow you to be covered for ambulance services when you travel outside your state of residence. You should check with your state ambulance provider for when these reciprocal arrangements apply and the level of cover offered.

If you fall outside your state-based arrangement (including any reciprocal agreement) and are not covered for emergency ambulance services, you will be covered by Bupa up to the annual cap, as long as your level of cover contains ambulance cover and the services are provided by a recognised provider.

Recognised Ambulance Providers

Bupa will only pay benefits towards ambulance services when they are provided by any of the following recognised providers:

- ACT Ambulance Service
- Ambulance Service of NSW
- Ambulance Victoria
- Queensland Ambulance Service
- South Australia Ambulance Service
- St John Ambulance Service NT
- St John Ambulance Service WA
- Tasmanian Ambulance Service.

Certain types of concession cards issued by Centrelink or the Department of Veterans Affairs (DVA) entitle the cardholders to free ambulance services. These arrangements also vary per state so should be checked directly with Centrelink or the DVA.

CHANGING YOUR COVER

Switching from another health fund

If you're changing from another Australian health fund to Bupa, you'll continue to be covered for all benefit entitlements that you had on your previous cover, as long as these services are offered on your new cover with us. This is referred to as 'continuity of cover'. To receive continuity of cover, you'll need to transfer to us within 60 days of leaving your previous fund and ensure that Bupa has received your clearance certificate (which can be requested from your previous fund).

When changing health funds, extras benefits paid by your previous fund will be counted towards your yearly limits in your first year of membership with us. Any benefits paid by your previous fund also count towards lifetime limits.

It's important to note that when you change to Bupa from another fund you may need to wait before you can access your new benefits. In this situation, your benefit entitlements are based on our nearest equivalent cover to what you previously held. Where your new cover is higher than the cover you held with your previous fund, the lower benefit (including different excess levels) will apply for the waiting period relevant for that service. Please refer to the listed waiting periods included under the Understanding Your Extras Cover and Understanding Your Hospital Cover sections of this guide.

If you choose a lower level of cover than you held previously, then the lower benefits on your new cover will apply immediately. This may include a different excess level or minimum benefits. You may also need to serve waiting periods for services or treatments that weren't covered on your previous cover. In this case you won't be covered during the waiting period.

Changing your cover with us

If you change your health cover, you may need to wait before you can access your new benefits. Where your new level of cover is higher than what you previously held, the lower level of benefit applies. Please refer to the listed waiting periods included under the Understanding Your Extras Cover and Understanding Your Hospital Cover sections of this guide.

During this time you will be covered, however you will receive the lower benefits of the two covers (this includes any applicable excess).

If you choose a lower level of cover than you previously held, then the lower benefits on your new cover will apply immediately and may include different excess levels or minimum benefits. You may also need to serve waiting periods for services or treatments that weren't covered on your previous cover. In this case you won't be covered during the waiting period.

If you have any questions about transfers or waiting periods, just contact us.

Ending your membership

We have the right to end a person's membership as set out in our Fund Rules, including where premiums have not been paid or on notice at the reasonable discretion of Bupa.

DEFINITIONS

Accidents

An accident is an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or damage to the body, which requires immediate (within 72 hours) medical advice or treatment from a registered practitioner other than the policyholder.

Bupa Medical Gap Scheme

The Bupa Medical Gap Scheme is an arrangement Bupa has with some medical specialists/doctors such as an anaesthetist to help minimise the amount you'll need to pay for your medical costs in hospital.

Calendar year

A calendar year is 1 January to 31 December.

Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing condition rule before your admission. Consequently, if you have been a Bupa member for less than 12 months you might have to pay for some or all of the hospital and medical charges if you are admitted to hospital and you choose to be treated as a private patient, and we later determine that your condition was pre-existing.

Excess

On selected covers there is an option to choose an excess which will lower the amount that you pay for your cover. Excesses are only payable on overnight and same-day inpatient hospital admissions in any hospital.

- the total excess amount is paid each time a person on your membership is admitted into hospital, to a maximum of once per person and twice per membership each calendar year unless otherwise specified
- if the total excess amount for an individual is not reached in a single hospital admission, the remaining balance of that excess is payable in any subsequent hospital admission
- no excess applies to your children on certain hospital covers.

Exclusions

If you require treatment for a specific procedure or service that is excluded under your level of cover you will not receive any benefits towards your hospital and medical costs and you may have significant out-of-pocket costs.

If a service is not covered by Medicare there will be no benefit payable from your hospital cover so you should always check with us to see if you're covered before receiving treatment.

Family In-Hospital Benefit

If you're on a cover that provides Family In-Hospital Benefit, you could receive benefits for accommodation and meal costs if your partner, immediate family member, carer or next of kin is required to stay at hospital with you or a person on your membership. They will be covered for $60 per night for accommodation in hospital and up to $30 a day for hospital meals. Hospital meals are covered when provided at a hospital cafeteria or patient meal menu. A $1,000 per person, per calendar year yearly limit applies to Family In-Hospital Benefits.

Health aids and appliances

To receive benefits for health aids and appliances such as orthotics, TENS machines and blood glucose monitors, you'll need to visit one of our recognised providers. You'll also need to meet the eligibility criteria, provide proof of purchase and a clinical referral where required. It is important to note that benefits are not payable when a prescribed treatment for orthotics or surgical shoes is not custom made. Visit our website or contact us to find out more.

Benefits for hire, repair and maintenance of health aids and appliances are not payable in the first 12 months after purchasing an item; within 12 months following a repair; or on items where hire and repair are deemed inappropriate.

Living Well Programs

Our Living Well Programs help cover health-related programs from approved, recognised providers. A Living Well Programs approval form must be completed for gym memberships, children's swimming programs (eligible products only), yoga and Pilates to confirm that the program is medically necessary. Other benefit and recognition criteria apply. Visit **bupa.com.au/livingwell** or contact us to find out more.

Minimum Benefits

For hospital services where minimum benefits apply in a private hospital we will pay minimum shared room benefits, and you will have your choice of doctor. These benefits would not be adequate to cover all hospital costs and are likely to result in large out-of-pocket expenses.

For hospital services paid at minimum benefits in a public hospital, we will pay minimum shared room benefits you will have your choice of doctor. If these benefits are less than the public hospital charges, you will have out-of-pocket expenses to pay.

Out-of-pocket expenses

You are likely to experience out-of-pocket expenses when you are not fully covered for services and benefits, or when a set benefit applies. You should refer to what is and isn't covered for your relevant level of cover to determine when an out-of-pocket expense may occur. You should also refer to our Fund Rules for any additional information on benefits payable. It is important to ensure when being admitted to hospital that Informed Financial Consent is provided to you for a pre-booked admission to allow you to understand any out-of-pocket expenses upfront. If you have received any out-of-pocket expenses and require clarification, please contact us directly.

Pharmacy

Your extras pharmacy entitlement covers you for prescription only items that are not supplied under the PBS (Pharmaceutical Benefits Scheme); are TGA (Therapeutic Goods Administration) approved; are prescribed by a registered medical practitioner; supplied by a Bupa recognised, registered pharmacist; and not otherwise excluded by Bupa.

When you make a claim, we will deduct a pharmacy PBS co-payment and pay the remaining balance up to the set amount under your chosen level of cover.

There are some additional items that are not covered by our pharmacy benefit and these include:

- over the counter or non-prescription items
- compounded items
- body enhancing medications (e.g. anabolic steroids).

Pharmacy in-hospital

When in hospital, if you are treated with drugs that are not PBS approved, you may not be fully covered and the hospital may charge you for all or part of the cost. You should be advised by the hospital of any charges before treatment.

Pre-existing conditions

A pre-existing condition is any condition, ailment or illness that you had signs or symptoms of during the six months before you joined or upgraded to a higher level of cover with us. It is not necessary that you or your doctor knew what your condition was or that the condition had been diagnosed.

If you knew you weren't well, or had signs of a condition that a doctor would have detected (if you had seen one) during the six months prior to joining or upgrading, then the condition would be classed as pre-existing. A doctor appointed by us decides whether your condition is pre-existing, not you or your doctor. The appointed doctor must consider your treating doctors' opinions on the signs and symptoms of your condition, but is not bound to agree with them.

Premium and benefits

You must pay the premium and the Lifetime Health Cover Loading that applies to you. Premiums differ from state to state due to different state charges. If you move to another state your premium will change too. Therefore you must let us know about any change of address.

To receive the benefits available on your cover, you need to:

- fully complete the application process and pay your premiums one month in advance. Or, if you're on a corporate plan, it's up to you to make sure payments are made during times of unpaid leave or if your employment ends
- ensure that newborns are enrolled onto a family membership within two months of their birth to avoid any waiting periods for your baby
- enrol your adult children under their own names within 60 days after they no longer qualify under your cover (to avoid a break in their cover)
- provide proof of purchase of what you have spent before we can reimburse you for any services received
- submit your claims within two years of when the service was given (we don't pay benefits for any claims that are older than this).

Proof of identity and/or age

Bupa may require you to provide proof of identity and/or age when joining, changing your level of cover or in relation to any other transaction with us.

Surgically implanted prostheses

You will be covered up to the benefit set out in the Government's Prostheses List for a listed prosthesis which is surgically implanted as part of your hospital treatment.

The Prostheses List includes: pacemakers, defibrillators, cardiac stents, joint replacements, intraocular lenses and other devices. If a hospital proposes to charge you a 'gap' for your prosthesis, they need your informed financial consent. Please contact us for further details.

Suspension rules

If you are travelling overseas for work or leisure, you can suspend your membership under the following circumstances:

- for a minimum period of two months
- for a maximum period of two years
- you can only suspend your policy twice per calendar year
- one month contributions are required between each suspension period.

To be eligible to suspend your cover you must:

- have been a financial member for at least 12 months
- have a financial membership at the time of suspension
- apply for suspension prior to the departure date
- notify us of your return to Australia within 30 days of your arrival
- complete an overseas travel suspension form.

Your membership will be cancelled if not resumed.

Travel and accommodation

On select levels of extras cover, if you're travelling for essential medical or hospital treatment because treatment you need cannot be provided by your own doctor, we will help cover the cost when the total return distance is 200 kilometres or more from your normal place of residence.

We also give a benefit towards your overnight accommodation outside of hospital for you and a caregiver. Check your extras cover to determine if you are covered for these benefits.

Waiting periods

A waiting period is the time between the start date of your membership and when you are covered for a service or treatment. If you receive a service or treatment during a waiting period, you are not eligible to receive a benefit payment from us, regardless of when you submit the claim. Different waiting periods apply for different services.

Yearly limits and service limits

A yearly limit (sometimes known as an annual maximum) is the maximum amount you can claim in a service category per person and per calendar year (unless otherwise stated). For certain services, service limits also apply on the number of times that benefits are payable for the same service (e.g. initial consultations). These limits apply from the date of service or purchase. Some services also have lifetime limits or periodic yearly limits (e.g. orthodontics). Per person yearly limits are not transferable to any other member on your policy.

OTHER IMPORTANT INFORMATION

Direct Debit Service Agreement

If you've chosen to pay your premiums by direct debit then you've accepted the terms of our Direct Debit Service Agreement.

This agreement outlines the responsibilities of Bupa Australia Pty Ltd ("we", "us", our") and you. We will confirm the direct debit arrangements prior to the first drawing (including the premium amount and frequency) and debit your nominated account. Deductions will occur on the nominated day, except for deductions nominated for the 28th, 29th, 30th or 31st, which will occur on the first day of the following month. If the nominated day falls on a weekend or public holiday, deductions will be made on the closest business day. We will debit all payments in advance and will automatically vary the deduction amount if your premiums or level of cover change. If we vary the deduction amount, we will give you at least 14 days written notice, except when the previous deduction is dishonoured, when we will deduct the previous period's payment together with the current amount due. If you pay premiums at three, six, and 12 month intervals, then should your financial institution dishonour a drawing, we will draw the payment on the nominated day of the following month. If two or more drawings are returned unpaid by your financial institution, we will also stop deducting your premiums from your nominated account and will start sending you renewal notices, pending further instructions from you. We will maintain the privacy and confidentiality of your billing information (unless you have requested or consented that we can disclose it to a third party or the law requires or allows us to do so). We may provide information to our or your financial institution to resolve a dispute on your behalf. You must ensure your nominated account permits direct debiting and that sufficient cleared funds are available in that account on the due date to cover the premiums due. Your financial institution may charge a fee if the payment cannot be met. You must ensure the authorisation given to draw on the nominated account is identical to the account signing instruction held by the financial institution where the account is based. You must notify us if the nominated account is transferred or closed. You must pay your premium by an alternative method if either you or we cancel the direct debit arrangements. You must ensure your payments are up-to-date, whether a notice is received from us or not.

If paying by credit card, you need to advise us of your new expiry date prior to expiry. You may request that we cancel or alter the debit drawing arrangements by contacting us and providing at least five working days notice of any requested changes. These changes may include deferring the debit, altering the debit dates, stopping an individual debit, suspending the direct debit arrangement or cancelling the direct debit completely. You can dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than seven days before the next scheduled debit drawing. If you have any queries about your direct debit agreement, please contact us. We undertake to respond to queries concerning disputed transactions within five working days of notification.

Privacy and your personal information

Your privacy is important to Bupa. This statement summarises how we handle your personal information. For further information about our information handling practices or our complaints handling process, please refer to our *Information Handling Policy*, available on our website at **bupa.com.au** or by calling us on 134 135. When you join, you agree to the handling of your personal information as set out here and in our *Information Handling Policy*.

We will only collect personal information that we require to provide, manage and administer our products and services and to operate an efficient and sustainable business. We are required to collect certain information from you to comply with the *Private Health Insurance Act 2007* (Cth). We may also collect information about you from health service providers for the purposes of administering or verifying any claim, and from your employer, broker or agent if you are on a corporate health plan or have joined through a broker or agent. We may disclose your personal

information to our related entities, and to third parties including healthcare providers, government and regulatory bodies, other private health insurers, and any persons or entities engaged by us or acting on our behalf. If we send your information outside of Australia, we will require that the recipient of the information complies with privacy laws and contractual obligations to maintain the security of the data. If you are on a corporate health plan, we may disclose your information to your employer to verify your eligibility to be on that corporate plan. The policy holder is responsible for ensuring that each person on their policy is aware that we handle their personal information as set out here and in our *Information Handling Policy*. Each person on a policy aged 17 or over may complete a 'Keeping your personal information confidential' form to specify who should receive information about their health claims. You are entitled to reasonable access to your personal information within a reasonable timeframe. We reserve the right to charge a fee for collating such information. If you or any insured person does not consent to the way we handle personal information, or does not provide us with the information we require, we may be unable to provide you with our products and services.
We may use your personal (including health) information to contact you to advise you of health management programs, products and services. When you take out cover with us, you consent to us using your personal information to contact you (by phone, email, SMS or post) about products and services that may be of interest to you. If you do not wish to receive this information, you may opt out by contacting us.

Can we help?

If you have any questions we're always happy to help. Simply refer to the back cover for our contact details and call us, visit our website or pop by your local centre. If you would like more information about our Fund Rules or the Federal Government's Private Health Insurance Industry Code of Conduct, you can find this information on our website. The Federal Government's Private Patient's Hospital Charter is available at **privatehealth.gov.au**

Resolution of problems

If you have any concerns or you don't understand a decision we have made, we'd like to hear from you.

You can contact us by:

Telephone: 1800 802 386

Fax: 1300 662 081

Email: customerrelations@bupa.com.au

Mail: Customer Relations Manager
Bupa Australia
PO Box 14639
Melbourne VIC 8001

If you're not satisfied with the outcome from Bupa you may contact the Private Health Insurance Ombudsman on **1800 640 695** or visit them at **privatehealth.gov.au**

Private Health Insurance Code of Conduct

The Private Health Insurance Code of Conduct (the Code) was developed by the private health insurance industry and it aims to enhance the standards of practice and service throughout the industry.

As a signatory to the Code, we undertake to do a number of things that will benefit you as a member. These include:

- working to enhance our service standards
- providing information to you in plain language
- helping you make better informed decisions about our products
- letting you know how to resolve any concerns that you may have
- protecting the privacy of your information in line with the privacy legislation and our Information Handling policy.

We're proud to be a signatory to the Code and we are committed to continually reviewing our operations to ensure compliance.

A copy of the Code is available online at **bupa.com.au/code-of-conduct**

Bupa Australia Pty Ltd
ABN 81 000 057 590

Effective 1 April 2014
11215-04-15E

HSBC Residents Corporate Health Plan Premiums

The below premiums include the Base Tier 26.791% Australian Government Rebate on private health insurance which applies to individuals aged under 65.

26.791% REBATE HOSPITAL COVER	SINGLE YEARLY	COUPLE/FAMILY YEARLY
NSW: Corporate Hospital Cover Level 2	$1,401.65	$2,803.30
NT: Corporate Hospital Cover Level 2	$871.45	$1,742.95
QLD: Corporate Hospital Cover Level 2	$1,583.05	$3,166.10
SA: Corporate Hospital Cover Level 2	$1,474.55	$2,949.15
TAS: Corporate Hospital Cover Level 2	$1,537.80	$3,075.65
VIC: Corporate Hospital Cover Level 2	$1,716.60	$3,433.20
WA: Corporate Hospital Cover Level 2	$1,232.10	$2,464.20
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$1,088.45	$2,176.90

The below premiums do not include an Australian Government Rebate.

0% REBATE HOSPITAL COVER	SINGLE YEARLY	COUPLE/FAMILY YEARLY
NSW: Corporate Hospital Cover Level 2	$1,914.60	$3,829.20
NT: Corporate Hospital Cover Level 2	$1,190.40	$2,380.80
QLD: Corporate Hospital Cover Level 2	$2,162.40	$4,324.80
SA: Corporate Hospital Cover Level 2	$2,014.20	$4,028.40
TAS: Corporate Hospital Cover Level 2	$2,100.60	$4,201.20
VIC: Corporate Hospital Cover Level 2	$2,344.80	$4,689.60
WA: Corporate Hospital Cover Level 2	$1,683.00	$3,366.00
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$1,486.80	$2,973.60

The rebate percentage changes annually from 1 April, based on the Rebate Adjustment Factor (CPI). For more information go to ato.gov.au. Find out what the Rebate means for you at bupa.com.au/rebate.

The above annual premiums have been calculated with 2015 Rates.

FOR MORE INFORMATION

Call us on 134 135

Visit bupa.com.au

Drop by your local Bupa centre

Bupa Australia Pty Ltd
ABN 81 000 057 590
11113-04-14EDITABLE

HSBC Residents Corporate Health Plan Premiums

The below premiums include the Base Tier 26.791% Australian Government Rebate on private health insurance which applies to individuals aged under 65.

26.791% REBATE HOSPITAL COVER	SINGLE PARENT	FAMILY PLUS
	YEARLY	YEARLY
NSW: Corporate Hospital Cover Level 2	$2,368.90	$3,646.25
NT: Corporate Hospital Cover Level 2	$1,617.30	$2,264.35
QLD: Corporate Hospital Cover Level 2	$2,628.90	$4,121.05
SA: Corporate Hospital Cover Level 2	$2,477.35	$3,872.00
TAS: Corporate Hospital Cover Level 2	$2,543.25	$3,991.50
VIC: Corporate Hospital Cover Level 2	$2,877.10	$4,447.85
WA: Corporate Hospital Cover Level 2	$2,108.85	$3,210.50
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$2,176.90	$3,008.85

The below premiums do not include an Australian Government Rebate.

0% REBATE HOSPITAL COVER	SINGLE PARENT	FAMILY PLUS
	YEARLY	YEARLY
NSW: Corporate Hospital Cover Level 2	$3,235.80	$4,980.60
NT: Corporate Hospital Cover Level 2	$2,209.20	$3,093.00
QLD: Corporate Hospital Cover Level 2	$3,591.00	$5,629.20
SA: Corporate Hospital Cover Level 2	$3,384.00	$5,289.00
TAS: Corporate Hospital Cover Level 2	$3,474.00	$5,452.20
VIC: Corporate Hospital Cover Level 2	$3,930.00	$6,075.60
WA: Corporate Hospital Cover Level 2	$2,880.60	$4,385.40
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$2,973.60	$4,110.00

The rebate percentage changes annually from 1 April, based on the Rebate Adjustment Factor (CPI). For more information go to ato.gov.au. Find out what the Rebate means for you at bupa.com.au/rebate.

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HSBC Residents Corporate Health Plan Premiums

The below premiums include the Base Tier 26.791% Australian Government Rebate on private health insurance which applies to individuals aged under 65.

26.791% REBATE HOSPITAL COVER	SINGLE PARENT PLUS YEARLY
NSW: Corporate Hospital Cover Level 2	$3,208.30
NT: Corporate Hospital Cover Level 2	$2,142.65
QLD: Corporate Hospital Cover Level 2	$3,581.20
SA: Corporate Hospital Cover Level 2	$3,402.90
TAS: Corporate Hospital Cover Level 2	$3,463.05
VIC: Corporate Hospital Cover Level 2	$3,890.90
WA: Corporate Hospital Cover Level 2	$2,851.20
EXTRAS COVER	
NATIONAL: Corporate 90 Extras	$3,008.85

The below premiums do not include an Australian Government Rebate.

0% REBATE HOSPITAL COVER	SINGLE PARENT PLUS YEARLY
NSW: Corporate Hospital Cover Level 2	$4,382.40
NT: Corporate Hospital Cover Level 2	$2,926.80
QLD: Corporate Hospital Cover Level 2	$4,891.80
SA: Corporate Hospital Cover Level 2	$4,648.20
TAS: Corporate Hospital Cover Level 2	$4,730.40
VIC: Corporate Hospital Cover Level 2	$5,314.80
WA: Corporate Hospital Cover Level 2	$3,894.60
EXTRAS COVER	
NATIONAL: Corporate 90 Extras	$4,110.00

The rebate percentage changes annually from 1 April, based on the Rebate Adjustment Factor (CPI). For more information go to ato.gov.au. Find out what the Rebate means for you at bupa.com.au/rebate.

The above annual premiums have been calculated with 2015 Rates.

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