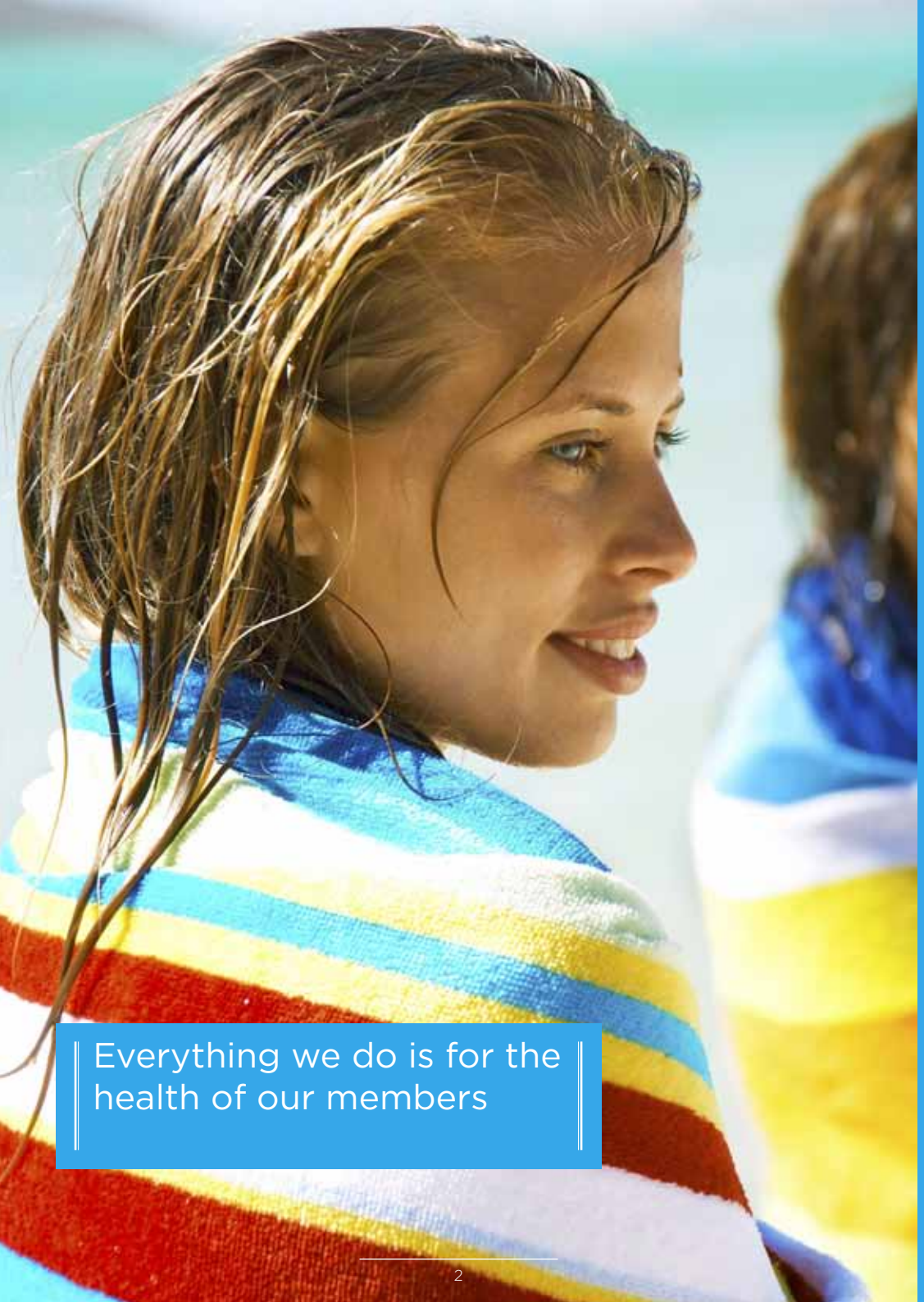

Bupa
BUPA. FIND A
HEALTHIER YOU



Everything we do is for the health of our members

BUPA. FIND A HEALTHIER YOU

Welcome to Bupa – we're glad that you've chosen us.

We're a healthcare leader proudly looking after the needs of more than 3 million members in Australia. We've been around for over 60 years and are part of a global group whose care and expertise now stretches across 190 countries.

It's our purpose that makes us different, we want our members to live longer, healthier, happier lives. Which is why our global family reinvests its profits to provide better services for members and to ensure quality healthcare remains affordable.

We know that everyone wants to be healthier, but sometimes life gets in the way. That's why we support you with health programs, tools and world-class health information to help you take steps towards a healthier you.

So please take the time to read through this brochure to discover where to find the information you need to make the most out of your health cover.

Remember, we're always here to provide support and guidance whenever you may need it.

CONTENTS

YOUR HEALTH, YOUR WAY

To live a longer, healthier, happier life you need to be able to manage your health easily. That's why no matter where you are, you'll be able to access our member services and get all the advice you need.

The right cover for you, at each stage of life

We know every member is different, so we're committed to offering high-quality cover to meet your needs, whatever your situation. And if things change, simply contact us to discuss the options we have available to meet your new requirements.

More choice and convenience

Managing your cover should be easy, so we give you more choice in how you deal with us. At any time of day you can access **bupa.com.au** for information and assistance. Alternatively call us on **134 135** or drop by one of our Bupa centres at over 100 locations across Australia. Whatever time of day, wherever you are, we're here to help.

We know the health system

We understand health insurance can be confusing at times. That's why our consultants are here to help you make sense of it. We'll answer important questions for you, like what to ask your doctor before treatment and how to receive informed financial consent so you know any costs upfront. Whatever your query, we're here to help you understand the healthcare system and make it work for you.

By your side wherever you are

If the unexpected happens while you're travelling overseas, we're always here to provide phone-based support and advice. Our 24-hour overseas health advice line* is exclusive to Bupa and provides you with support and information including:

- basic advice provided by doctors and nurses on simple medical problems
- the name, location and contact details for the nearest medical facilities
- passing telephone messages on to your family
- assistance with reviewing medical bills
- medical translation services and help booking medical appointments.

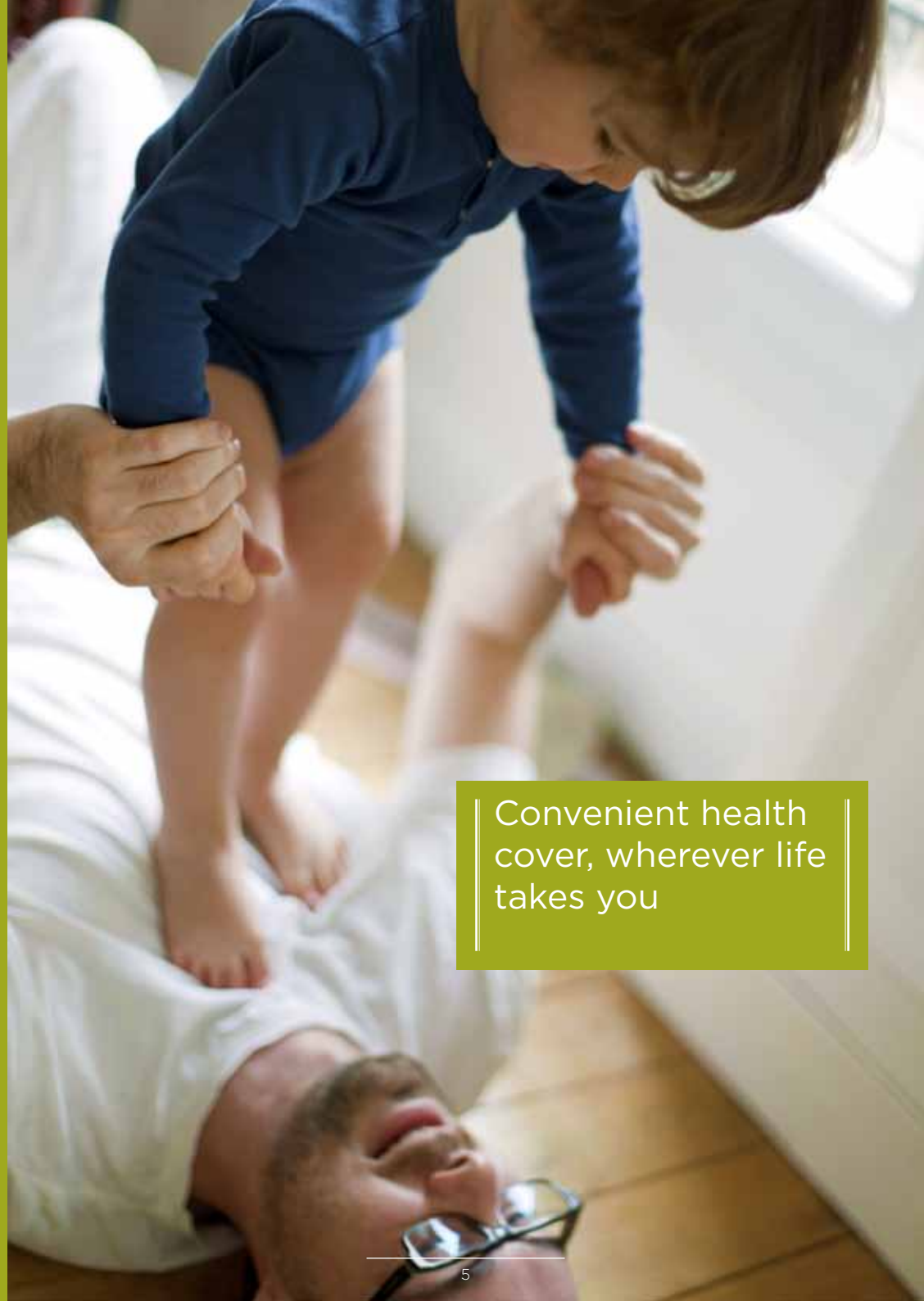
Simply call **+61 3 9937 3999** or look for the number on the back of your membership card. Plus, if you're an overseas visitor you can also use this service whilst in Australia.

*Overseas health advice line is not available on Ambulance Only cover.

Australia's largest provider network#

We pay benefits to all recognised providers around the country, giving you great coverage and peace of mind. And you can choose from over 10,000 Members First providers for dental, optical, physio and chiro services to receive higher benefits. Look out for the Bupa Members First logo.

#As at 1 October 2011 for dental, optical, physio and chiro providers.



Convenient health cover, wherever life takes you

Managing your health has never been easier

GETTING TO A HEALTHIER YOU

At Bupa we want you to get more out of your cover, not just when you're unwell but when you're feeling absolutely fine too. As part of our commitment to helping you achieve this, we've made it easier to access a range of tools and information to assist you on the journey to a healthier you.

myBupa

Our exclusive online area for members, myBupa contains all the tools and information you need to easily manage your health cover, whatever time of day, wherever you are.

With myBupa here are just a few things you can do:

- Make a claim*
- Contact us
- Change payment details#
- Make one off payments#
- Order a membership card
- Find a provider

It really is your own little piece of Bupa. And because we're always looking for ways to make your life easier, you'll soon be able to view your remaining limits, as well as get an estimate of your extras benefits.

To join myBupa simply visit **bupa.com.au** and follow the registration steps. It'll only take a few minutes and once you register you'll find new things being added regularly.

*May not apply to some products. Call us for details.

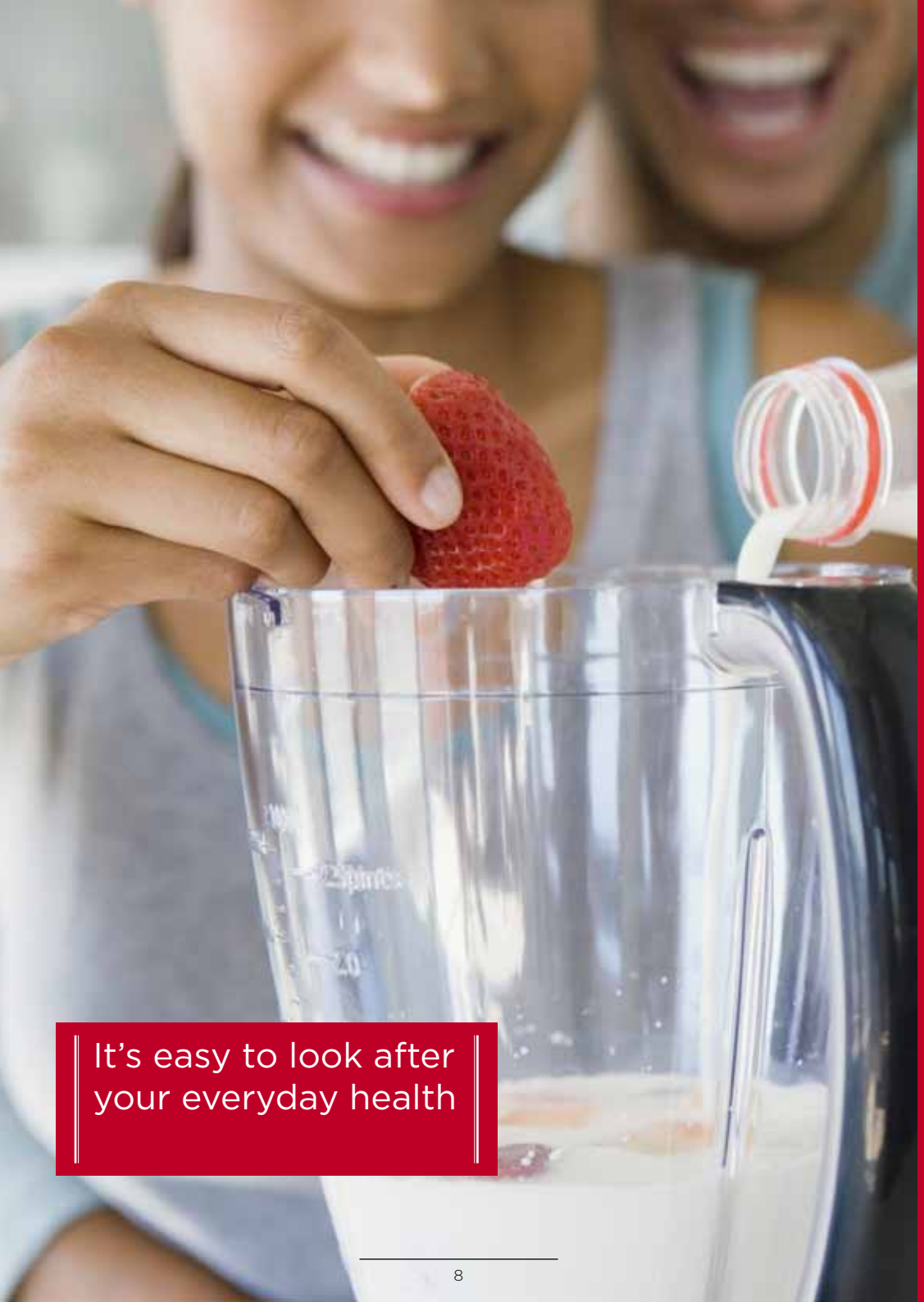
#These options may not be available for some corporate customers.

Our knowledge is your knowledge

Visit **bupa.com.au** to stay in the know on health topics important to you and to take advantage of a range of tools to really allow you take charge of your health, including:

- World-class information from health professionals at **bupa.com.au/Health**
- Health and fitness assessments, including our in-depth Online Health Assessment at **bupa.com.au/OHA**
- Health-related tools, calculators and apps, like our Quick Health Age Check and Bupa Running app at **bupa.com.au/Health**
- Programs and guides to assist you with managing health conditions

Make sure you visit **bupa.com.au** regularly to take advantage of the information available to help you live a longer, healthier, happier life with Bupa.



It's easy to look after your everyday health

TAKE CARE OF YOURSELF, EVERY DAY

Extras cover is one of the easiest ways to ensure that you stay happier and healthier by taking care of your everyday health needs with a range of services not covered by Medicare – including dental, optical, physio and much more.

Better value with Members First

Visit one of over 10,000 Members First providers to get more from your extras cover, with certainty around any gap you may need to pay. Plus you can claim on the spot. Simply look for the Bupa Members First logo or visit **bupa.com.au** to find a provider near you.

Claiming to suit you^

To get the most out of your extras cover we want you to claim more so we've made it easier for you to choose a style of claiming that suits your lifestyle. Once you've had your treatment, simply swipe your membership card on the spot at one of over 40,000†† providers and then pay the gap (if there is one), go online to submit your claim†, visit one of our friendly Bupa centres or pop your claim in the post to us.

Members First optical

You'll receive certainty at Members First providers including BLINK Optical, Kevin Paisley Fashion Eyewear, National Pharmacies Optical, Prevue Eyewear, Stacey and Stacey Optometrists and selected independent retailers. Plus, you'll have access to the 'no gap' range of fixed-priced packages on glasses and contact lenses at no additional cost*, and up to $100 off all fashion frames as well as 20% off non-standard lenses#.

Digital Retinal Photography at BLINK Optical selected stores – for no extra cost.

At our optical partner Specsavers, you can choose from a range of fixed-priced frames and lens packages with no out-of-pocket costs*.

To find out more, including a full list of participating optical outlets, visit **bupa.com.au** and click on 'Find a healthcare provider'.

^May not apply to some products, contact us for details.

††As at 1 October 2011.

†Online claiming not available for Medical Gap, pharmacy, health aids and appliances, ambulance services, orthodontics, travel and accommodation.

*Optical benefits are subject to your level of cover, annual limits and waiting periods. Not available on some extras covers. Contact us for details.

#Not in conjunction with any other offers.

We're here to support you when you need it most

WHATEVER HAPPENS, WE'RE HERE FOR YOU

Hospital cover helps give you peace of mind and reassurance that your health will be taken care of when you really need it. We understand that planning a hospital stay can be a confusing and anxious process, which is why we're here to help you understand the health system and to make the most of your cover.

Call us, we're here to support you

We're committed to making your hospital experience as stress-free as possible and to helping you get the most out of your cover, so before you start planning a visit to hospital – even before selecting your specialist or booking your treatment – call us first on **134 135** for guidance and support. We can discuss what you're covered for, help you understand your options and give you an idea of what to expect before, during and after your hospital stay. You can also visit **bupa.com.au** for more information on your hospital cover and what to expect when going to hospital.

Getting the most from your cover

With our hospital cover, you can choose to be treated in either a private or public hospital, depending on your treatment and level of cover. If you choose to be treated in a private hospital you'll get more from your cover by selecting one of our Members First or Network hospital and day facilities, as we've entered into a special agreement with them to help reduce or eliminate your out-of-pocket hospital expenses. As a Bupa member at our Members First hospitals you will enjoy a single room, or receive $50 cash back* if the pre-booked single room is unavailable, along with access to other benefits including a free daily newspaper and free local phone calls.

Let us guide you

To help make your hospital experience as simple as possible we've also produced a *Going to hospital* guide containing all the information you might need when planning a stay in hospital. From understanding what you're covered for and discussing your treatment, to handy checklists and steps to making a successful recovery, you will find all the information you need to help make your hospital experience easier. Simply visit **bupa.com.au/HealthInsurance**, call **134 135** or drop by your local Bupa centre to obtain a copy of the guide.

*You must book and request a single room in a Members First hospital at least 24 hours before admission. If you don't get a single room you'll receive $50 from the hospital. Applies to overnight admissions only. Excludes 'nursing home type patients', emergencies, same day admissions or where a single room is medically inappropriate (i.e. ICU). Not available to members on Standard or Classic Visitors Cover.

EVEN MORE MEMBER BENEFITS FOR YOU

Health is about more than doctors and diets. It's also a state of mind. The more positive your attitude, the closer you get to a healthier you, so we have developed a range of benefits especially for our members to complement your health cover.

More benefits with Bupa

With our Member Discounts, you'll enjoy savings on a range of activities, from entertainment and optical, to travel and health & fitness. For further information on the range of discounts available just visit **bupa.com.au/MemberExclusives** where you'll find even more of a reason to smile.

And for more tips on how to live a longer, happier, healthier life, keep an eye out for *Shine*^ – your exclusive member magazine packed full of topical articles from travel, nutrition and exercise to profiles and giveways.

^Not available on overseas visitors covers.

Travel, home and car insurance

We're more than a health insurance provider. Through our partnership with CGU, we're able to offer you a full range of insurance products from travel insurance, home and contents insurance, to motor vehicle and caravan insurance. What's more, just for being a Bupa member, you'll also get a 10% discount on your home and contents insurance or motor vehicle insurance premiums, plus a 15% discount on travel insurance*.

*Insurance is issued by CGU Insurance Limited (CGU) ABN 27 004 478 371 AFSL 238291. This is general advice only and does not take into account your individual circumstances. Product Disclosure Statements are available at bupa.com.au and should be considered before making any decision on these products. Bupa Australia Pty Ltd ABN 81 00 057 590 and Bupa Australia Health Pty Ltd ABN 50 003 098 655 (together Bupa) are authorised representatives of CGU.

Life insurance

As a Bupa member you'll get a healthy 10% discount on your Life insurance premium#.

#Life insurance products issued by ClearView Life Assurance Limited. Before making a decision about one of these products consider the relevant Product Disclosure Statement available by calling 134 135.

To find out more go to **bupa.com.au/Insurance**, call **134 135** or drop by your local Bupa centre.

IMPORTANT INFORMATION ABOUT YOUR COVER

Over the next few pages you will find information to help you understand how your health cover with us works. We recommend you keep this information in a safe place so that you can always refer to it.

From time to time, things can change. Before you seek any treatment call us so we can give you the most complete and up-to-date information.

Please be aware that these rules apply in addition to our Fund and Policy Rules.

UNDERSTANDING YOUR COVER

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. With us you are fully covered as a private patient in most Members First and Network hospitals, and all public hospitals across Australia. A small number of hospitals may charge a fixed daily fee, capped at a maximum number of days per stay. These hospitals 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.

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
- allied services including physiotherapy, occupational therapy and dietetics
- medication, dressings and other consumables
- most diagnostic tests (e.g. pathology, radiology)
- a surgically implanted prosthesis up to the applicable benefit on the Government's Prostheses List
- single 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

Medical costs

These are the fees charged by a doctor, surgeon, anaesthetist or other specialist for any treatment given to you in hospital. Private health insurance provides you with the choice of your own doctor, and you decide whether you will go to a public or a private hospital that your doctor attends. You may also have more choice as to when you are admitted to 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. 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%. If your specialist charges more than the MBS fee there will be a 'gap' for you to pay. However, the *Bupa Medical Gap Scheme* can help eliminate or reduce the gap for you if your doctor/s choose to use it.

At Members First day facilities, not only will you be fully covered for the facility accommodation and theatre fees but there are no *out-of-pocket expenses* for medical treatments (e.g. your specialist's fees).

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.

What is not covered?

Hospital costs

Situations when you are likely not to be covered include:

- during a waiting period
- when specific services or treatments are excluded or restricted from your level of cover
- when you are treated at a non-agreement hospital you will not be fully covered
- for the fixed fee charged by a fixed fee hospital
- 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 prior to child birth)
- 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 in relation to surgical podiatry (including the fees charged by the podiatric surgeon); most cosmetic surgery; experimental treatment and/or any treatment/procedure not approved by the Medical Services Advisory Committee (MSAC)
- you will not be fully covered for hospital charges related to surgical podiatry and follow-up admissions to earlier cosmetic procedures where the follow-up procedure is recognised by Medicare
- personal expenses such as: pay TV, 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
- for pharmacy items not opened at the point of leaving the hospital
- 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)
- any treatment or service rendered outside Australia
- some non-PBS, high cost drugs.

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

You are an inpatient if you are admitted into hospital for either a same-day or overnight admission. 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:

- palliative care, psychiatric and rehabilitation services – two months
- pre-existing conditions, ailments or illnesses and pregnancy related services (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 planning for a family we recommend that you contact us to check whether your current level of cover includes pregnancy and other related services in advance. This is because there is a 12-month *waiting period* applied to all pregnancy related services (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 policies 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 is not fully custom made (e.g. orthotics, surgical shoes)
- 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
- laser eye surgery, covered only under Ultimate Health Cover – three years.

UNDERSTANDING YOUR AMBULANCE COVER

Emergency Ambulance definition

When you or your partner take out our hospital cover, extras cover (emergency ambulance services must be selected on Your Choice Extras) or packaged cover, you will receive capped cover for recognised emergency ambulance transport and on-the-spot treatment.

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 will mean 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 transportation of an unplanned and of a non-routine nature for the purpose of providing immediate medical attention to a person.

Whether the transportation is deemed an emergency is determined by the paramedic and usually recorded on the account.

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 old 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 old fund.

When changing health funds, extras *benefits* paid by your old fund will be counted towards your *annual maximums* in your first year of membership with us. Any benefits paid by your old fund also count towards lifetime maximums.

It's important to note that when you change to Bupa from another fund you may need to wait before you can receive 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 what you had with your old 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 *restricted 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 receive 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 *restricted 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.

Annual maximums and service limits

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, annual maximums also apply on the number of times that benefits are payable for the same service (e.g. initial consultations). These maximums apply from the date of service or purchase. Some services also have lifetime limits or periodic annual maximums (e.g. orthodontics). Per person annual maximums are not transferable to any other member on your policy.

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 or co-payment

To lower the cost of your hospital cover, on selected covers you can choose to include an excess or co-payment. Excesses or co-payments are only payable on overnight and same-day inpatient hospital admissions in any hospital.

- An excess is a set amount you pay upfront before your benefit is paid. The excess is paid each time a person on your membership is admitted into hospital, to a maximum of once per person and twice on the entire membership each calendar year unless otherwise specified.
- A co-payment is an amount you agree to pay towards the cost of your daily hospital bill. A co-payment is charged per day and capped after five days for each hospital admission.
- No excess or co-payment applies to your children on certain hospital covers. Please contact us for further details.

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.

Health aids and appliances

To receive benefits for health aids and appliances 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 is not fully custom made (e.g. orthotics). 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.

Home nursing

Benefits are payable towards some home nursing services that do not need to take place in a hospital and are provided in the home. Please contact us to find out more.

Living Well Programs

Our Living Well Programs help cover health-related programs from approved, recognised providers. You can visit our website for a list of our recognised providers. A Living Well Programs approval form must be completed by your doctor for gym memberships, yoga and Pilates to confirm that the program is medically necessary. Other benefit and recognition criteria apply. Visit our website or contact us to find out more.

Bupa Medical Gap Scheme

This refers to the difference between what your doctor charges and the amount Medicare pays for inpatient procedures. If your doctor charges up to the Medicare Benefits Schedule (MBS) fee or is participating in the Bupa Medical Gap Scheme, in most cases you will have no medical gap costs to pay.

For doctors who are not participating in our Medical Gap Scheme and are charging above the MBS fee, we will pay the difference between the Medicare benefit and the MBS fee. Any amount above the MBS fee will be the amount you are required to pay and this is referred to as the 'Medical Gap'.

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.

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. A copy of our Fund Rules can be found on our website or in our retail centres. 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 and pharmaceuticals

Your extras pharmacy entitlement covers you for prescription items that are non-PBS (Pharmaceutical Benefits Scheme) listed drugs and are TGA (Therapeutic Goods Administration) approved for that condition.

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.

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

- over the counter items
- compounded items
- non-prescription items
- weight loss medication (some weight loss medications are covered under the Living Well Programs)
- body enhancing medications (e.g. anabolic steroids); and
- erectile dysfunction drugs, unless prescribed by a specialist.

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

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.

A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining or upgrading to a higher level of cover.

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.

Restricted cover/benefits

For restricted services there will be full cover in a shared room with your choice of doctor in a public hospital and restricted/default benefits in a private hospital which would not be adequate to cover all hospital costs and are likely to result in large out-of-pocket expenses.

Special Benefits

If you're on a cover that provides Special Benefits cover, 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, kiosk or patient meal menu. A $1,000 per person, per calendar year annual maximum applies to pecial Benefits.

Suspension rules

A membership may be suspended when travelling overseas for work or leisure. If you are travelling overseas, you may choose to suspend your membership during this period of time. You can suspend your cover for the following period of time:

- a minimum period of two months travel; and
- a maximum period of two years per suspension.

You can only suspend your policy twice per calendar year. Your membership will be cancelled if not resumed.

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
- apply for suspension prior to the departure date
- provide overseas travel documentation showing your departure and return dates
- notify us of your return to Australia within 30 days of your arrival; and
- complete an overseas travel suspension form.

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 300 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 when you joined us and when you are covered for a service or treatment. If you receive a service or treatment during this time, 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.

CORPORATE COVER

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. With us you are fully covered as a private patient in most Members First and Network hospitals, and all public hospitals across Australia. A

small number of hospitals may charge a fixed daily fee, capped at a maximum number of days per stay. These hospitals should inform you of this fee when you make a booking. This fee is in addition to any excess you may have as part of your hospital 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
- allied services including physiotherapy, occupational therapy and dietetics
- medication, dressings and other consumables most diagnostic tests (e.g. pathology, radiology)
- a surgically implanted prosthesis up to the applicable benefit on the Government's Prostheses List
- single 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 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

Medical costs

These are the fees charged by a doctor, surgeon, anaesthetist or other specialist for any treatment given to you in hospital. Private health insurance provides you with the choice of your own doctor, and you decide whether you will go to a public or a private hospital that your doctor attends. You may also have more choice as to when you are admitted to 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. 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%. If your specialist charges more than the MBS fee there will be a 'gap' for you to pay. However, the Bupa Medical Gap Scheme can help eliminate or reduce the gap for you if your doctor/s choose to use it.

At Members First day facilities, not only will you be fully covered for the facility accommodation and theatre fees but there are no out-of-pocket expenses for medical treatments (e.g. your specialist's fees).

What is not covered?

Hospital costs

Situations when you are likely not to be covered include:

- during a waiting period
- when specific services or treatments are excluded or restricted from your level of cover
- when you are treated at a non-agreement hospital you will not be fully covered
- for the fixed fee charged by a fixed fee hospital
- 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 prior to child birth)
- 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 in relation to surgical podiatry (including the fees charged by the podiatric surgeon); most cosmetic surgery; experimental treatment and/or any treatment/procedure not approved by the Medical Services Advisory Committee (MSAC)
- you will not be fully covered for hospital charges related to surgical podiatry and follow-up admissions to earlier cosmetic procedures where the follow-up procedure is recognised by Medicare
- personal expenses such as: pay TV, 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
- for pharmacy items not opened at the point of leaving the hospital
- if you choose to use your own allied health provider (e.g. chiropractors, dieticians or psychologists) rather than the hospital's practitioner for services that form part of your in-hospital treatment
- where compensation, damages or benefits may be claimed by another source (e.g. workers compensation)
- any treatment or service rendered outside Australia
- some non-PBS, high cost drugs.

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

You are an inpatient if you are admitted into hospital for either a same-day or overnight admission. 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:

- palliative care, psychiatric and rehabilitation services – two months
- pre-existing conditions, ailments or illnesses and pregnancy related services (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 planning for a family we recommend that you contact us to check whether your current level of cover includes pregnancy and other related services in advance. This is because there is a 12-month waiting period applied to all pregnancy related services (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 policies 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 is not fully custom made (e.g. orthotics, surgical shoes)
- 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
- laser eye surgery, covered only under Ultimate Corporate Health Cover – three years.

UNDERSTANDING YOUR AMBULANCE COVER

Emergency Ambulance definition

When you take out our hospital cover, extras cover or packaged cover, you will receive capped cover for recognised emergency ambulance transport and on-the-spot treatment. 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 will mean 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 transportation of an unplanned and of a non-routine nature for the purpose of providing immediate medical attention to a person. Whether the transportation is deemed an emergency is determined by the paramedic and usually recorded on the account.

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 old 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 old fund.

When changing health funds, extras benefits paid by your old fund will be counted towards your annual maximums in your first year of membership with us. Any benefits paid by your old 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 receive 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 what you had with your old 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.

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 restricted 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 receive 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 restricted 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.

Annual maximums and service limits

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, annual maximums also apply on the number of times that benefits are payable for the same service (e.g. initial consultations). These maximums apply from the date of service or purchase. Some services also have lifetime limits or periodic annual maximums (e.g. orthodontics). Per person annual maximums are not transferable to any other member on your policy.

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

To lower the cost of your hospital cover, on selected covers you can choose to include an excess. Excesses are only payable on overnight and same-day inpatient hospital admissions in any hospital. An excess is a set amount you pay upfront before your benefit is paid. Unless otherwise specified as part of your corporate plan the excess is paid each time a person on your membership is admitted into hospital, to a maximum of:

- $250 for singles and $500 for couples and families memberships on Corporate Hospital Cover level 2.
- $500 for singles and $1000 for couples and families memberships on Corporate Hospital Top/Intermediate/Saver levels 2 & 3.
- once per person, twice per family per membership on Healthlink Hospital and packages.
- no excess applies to your children on Corporate Hospital Cover level 2 and Corporate Hospital Top/Intermediate/Saver level 2.
- excess waivers apply for first one or two admissions on Corporate Hospital Top/Intermediate/Saver levels 2.

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.

Health aids and appliances

To receive benefits for health aids and appliances 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 is not fully custom made (e.g. orthotics). 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.

Home nursing

Benefits are payable towards some home nursing services that do not need to take place in a hospital and are provided in the home. Please contact us to find out more.

Living Well Programs

Our Living Well Programs help cover health-related programs from approved, recognised providers. You can visit

our website for a list of our recognised providers. A Living Well Programs approval form must be completed by your doctor for gym memberships, yoga and Pilates to confirm that the program is medically necessary. Other benefit and recognition criteria apply. Visit our website or contact us to find out more.

Bupa Medical Gap Scheme

This refers to the difference between what your doctor charges and the amount Medicare pays for inpatient procedures. If your doctor charges up to the Medicare Benefits Schedule (MBS) fee or is participating in the Bupa Medical Gap Scheme, in most cases you will have no medical gap costs to pay. For doctors who are not participating in our Medical Gap Scheme and are charging above the MBS fee, we will pay the difference between the Medicare benefit and the MBS fee. Any amount above the MBS fee will be the amount you are required to pay and this is referred to as the 'Medical Gap'.

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.

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. A copy of our Fund Rules can be found on our website or in our retail centres. 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 and pharmaceuticals

Your extras pharmacy entitlement covers you for prescription items that are non-PBS (Pharmaceutical Benefits Scheme) listed drugs and are TGA (Therapeutic Goods Administration) approved for that condition. 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.

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

- over the counter items
- compounded items
- non-prescription items
- weight loss medication (some weight loss medications are covered under the Living Well Programs)
- body enhancing medications (e.g. anabolic steroids); and
- erectile dysfunction drugs, unless prescribed by a specialist.

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

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.

A condition can still be classed as pre existing even if you hadn't seen your doctor about it before joining or upgrading to a higher level of cover. 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 or your employer (in case of company paid plans) 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 company paid 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.

Restricted cover/benefits

For restricted services there will be full cover in a shared room with your choice of doctor in a public hospital and restricted/default benefits in a private hospital which would not be adequate to cover all hospital costs and are likely to result in large out-of-pocket expenses.

Special Benefits

If you're on a cover that provides Special Benefits cover, 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, kiosk or patient meal menu. A $1,000 per person, per calendar year annual maximum applies to Special Benefits.

Suspension rules

A membership may be suspended when travelling overseas for work or leisure. If you are travelling overseas, you may choose to suspend your membership during this period of time. You can suspend your cover for the following period of time:

- a minimum period of two months' travel; and
- a maximum period of two years per suspension.

You can only suspend your policy twice per calendar year. Your membership will be cancelled if not resumed. 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

- apply for suspension prior to the departure date
- provide overseas travel documentation showing your departure and return dates
- notify us of your return to Australia within 30 days of your arrival; and
- complete an overseas travel suspension form.

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 300 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 when you joined us and when you are covered for a service or treatment.

If you receive a service or treatment during this time, 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.

VISITORS COVER

UNDERSTANDING YOUR COVER

What is covered?

Hospital costs

With private visitors cover, you can choose to be treated as a private patient in either a public or a private hospital. Depending on your chosen level of cover you can be fully covered as a private patient in most Members First and Network hospitals, and all public hospitals across Australia. A small number of hospitals may charge a fixed daily fee, capped at a maximum number of days per stay. These hospitals should inform you of this fee when you make a booking. This fee is in addition to any excess you may have as part of your visitors 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
- allied services including physiotherapy, occupational therapy and dietetics
- medication, dressings and other consumables
- most diagnostic tests (e.g. pathology, radiology)
- a surgically implanted prosthesis up to the applicable benefit on the Government's Prostheses List
- single room where available, and if applicable under your chosen level of visitors cover.

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 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

Inpatient medical costs

These are the fees charged by your doctor, surgeon, anaesthetist or other specialist for any treatment given to you when you are admitted to a hospital as an inpatient. Put simply, we pay 100% of a schedule fee. Depending on your level of cover, we cover you for either the Australian Medical Association (AMA) Schedule fee or the Medicare Benefits Schedule (MBS) fee. These are the fees determined by the AMA and the Federal Government respectively, as the appropriate fee for a specific service. Please check your level of cover to determine which schedule of fees apply. This excludes Ultimate Corporate Visitors Cover as we will pay for 100% of the cost of treatment.

Outpatient medical costs

This is cover for any treatment you receive from a doctor or specialist in private practice, or as an outpatient (i.e. where you are not admitted into hospital) anywhere in Australia. Depending on what is set out in your level of cover we cover you for 100% to 150% of the Medicare Benefits Schedule (MBS) fee. The MBS fee is set for each specific service by the Federal Government. This excludes Ultimate Corporate Visitors Cover as we will pay for 100% of the cost of treatment. Outpatient medical cover is available on all of our visitors covers within this brochure.

Repatriation benefit

If you are on Ultimate Corporate, Platinum, Gold or Classic Visitors Cover, you will receive full cover for repatriation if terminally ill to your country of origin or return of mortal remains once authorised by Bupa Australia. You will also receive cover for repatriation if you suffer a substantial life altering illness or injury to your country of origin. This is up to a commercially reasonable amount once the repatriation is authorised by Bupa Australia.

Special Benefits

If you are on Ultimate Corporate, Platinum, Gold, or Top Visitors Cover, you 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, kiosk or patient meal menu. A $1,000 per person, per calendar year annual maximum applies to Special Benefits.

What is not covered?

Hospital costs

Situations when you are likely not to be covered include:

- during a waiting period
- when specific services or treatments are excluded or restricted from your level of cover
- when you are treated at a non-agreement hospital you will not be fully covered
- for the fixed fee charged by a fixed fee hospital
- when you have not been admitted into a hospital and are treated as an outpatient and are charged an emergency room fee
- 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 in relation to surgical podiatry (including the fees charged by the podiatric surgeon); most cosmetic surgery; experimental treatment and/or any treatment/procedure not approved by the Medical Services Advisory Committee (MSAC)
- you will not be fully covered for hospital charges related to surgical podiatry and follow-up admissions to earlier cosmetic procedures where the follow-up procedure is recognised by Medicare
- personal expenses such as: pay TV, 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

- for pharmacy items not opened at the point of leaving the hospital unless covered on your visitors or extras cover
- if you choose to use your own allied health provider (e.g. chiropractors, dieticians or psychologists) rather than the hospital's practitioner for services that form part of your in-hospital treatment
- where compensation, damages or benefits may be claimed by another source (e.g. workers compensation)
- any treatment or service rendered outside Australia
- experimental treatment and some non-PBS, high cost drugs.

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
- costs for medical examinations, x-rays, inoculation or vaccinations and other treatments required relating to acquiring a visa for entry into Australia or permanent residency visa.

Ultimate Corporate, Platinum, Gold and Classic Visitors Cover waiting periods

The following *waiting periods* apply to these covers:

- palliative care, psychiatric and rehabilitation services – two months
- pre-existing conditions, ailments or illnesses – 12 months
- pregnancy related services (including childbirth) – 12 months.

Short Stay Education Cover waiting periods

The following *waiting periods* apply to this cover:

- palliative care, psychiatric and rehabilitation services – 12 months.

Top, Advantage and Standard Visitors Cover waiting periods

The following *waiting periods* apply to these covers:

- psychiatric and rehabilitation services – 12 months*
- pre-existing conditions, ailments or illnesses – 12 months
- pregnancy related services (including childbirth) – 12 months.

*Applies to Standard Visitors Cover only

When to contact us

If you have been a Bupa member for less than 12 months on your current visitors 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. Please note: Short Stay Education Cover excludes *pre-existing conditions*.

Planning for a baby

If you are thinking about planning for a family we recommend that you contact us to check whether your current level of cover includes pregnancy and other related services in advance. This is because there is a 12-month *waiting period* applied to all pregnancy related services (including childbirth) and assisted reproductive services unless excluded on your cover.

No *waiting periods* will apply to the newborn provided they have been added to the appropriate family visitors 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 policies and Overseas Visitors Rules 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 is not fully custom made (e.g. orthotics, surgical shoes)
- 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

Full Ambulance Cover

On most visitors covers, you'll receive full ambulance cover, including uncapped emergency and non-emergency transportation and on-the-spot treatment. If you need to make a claim for ambulance benefits, we will give you a Patient Ambulance Transportation Form to complete.

Emergency Ambulance Cover

If you are on Short Stay Education Cover you'll receive unlimited emergency only ambulance cover, including ambulance transportation and on-the-spot treatment. If you need to make a claim for emergency ambulance benefits, we will give you a Patient Ambulance Transportation Form to complete. You'll receive cover for ambulance transport with an approved ambulance service where medically necessary for admission to hospital or for Emergency Treatment. You're not covered for non-emergency

transportation from a hospital to your home, a nursing home or another hospital.

'Emergency Treatment' is any treatment required where a person:

- is in a life threatening situation and requires urgent assessment and resuscitation;
- has suspected acute organ or system failure;
- has an illness or injury where the function of a body part or organ is acutely threatened;
- has a drug overdose, toxic substance or toxin effect;
- has psychiatric disturbance whereby the health of the person or other people are at immediate risk;
- has severe pain and the function of a body part or organ is suspected to be acutely threatened;
- has acute haemorrhaging and requires urgent assessment and treatment; or
- has a condition that requires immediate admission to avoid imminent threat to their life and where a transfer to another facility is impractical.

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.

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 old 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 old fund.

When changing health funds, extras *benefits* paid by your old fund will be counted towards your *annual maximums* in your first year of membership with us. Any benefits paid by your old fund also count towards lifetime maximums.

It's important to note that when you change to Bupa from another fund you may need to wait before you can receive 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 what you had with your old 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 Visitors 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 *restricted 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*.

Switching from an overseas Bupa health fund

If you're changing from an overseas Bupa health fund you will be required to cancel the policy yourself, however all you have to do is provide us with your overseas Bupa membership details and we can ensure continuity of your cover on an equivalent level of cover.

Changing from a recognised overseas health insurer or general insurer

If you had previous cover with an overseas health insurer recognised under the International Federation of Health Funds or general insurer recognised by our fund, you will be required to cancel the policy yourself and provide us with a Certificate of Currency. We will also provide continuity of cover on an equivalent level of cover.

Changing your cover with us

If you change your health cover, you may need to wait before you can receive 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 Visitors 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 *restricted 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.

Becoming a permanent resident

If you become a permanent Australian resident, you can change to one of our domestic health covers. You will continue to be covered for all benefit entitlements on your old cover, as long as you change over within 60 days of ceasing your visitors cover.

Don't forget that you will need to transfer to a domestic health cover policy within 12 months of becoming eligible for full Medicare benefits. You may otherwise be required to pay the Lifetime Health Cover (LHC) Loading. Ask us for more details.

Ending your membership

You can contact us to cancel your health cover at any time and you'll receive a refund of any premiums paid in advance from the date you've contacted us to cancel. We have the right to end a person's membership as set out in our Overseas Visitors 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.

Agents

A broker or agent may administer your corporate health plan. In these cases, some information about you such as your name, address and other policy information will be given and received from the agent to help Bupa Australia administer your corporate health plan. This will not include personal claims information (also see Privacy statement).

Annual maximums and service limits

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, annual maximums also apply on the number of times that benefits are payable for the same service (e.g. initial consultations).

These maximums apply from the date of service or purchase. Some services also have lifetime limits or periodic annual maximums (e.g. orthodontics). Per person maximums are not transferrable to any other member on your policy.

Bupa Medical Gap Scheme

This refers to the difference between what your doctor charges and the amount we will pay for inpatient and outpatient services.

If your doctor charges up to the Medicare Benefits Schedule (MBS) fee or is participating in our Medical Gap Scheme, in most cases you will have no medical gap costs to pay.

For doctors who are not participating in our Medical Gap Scheme and are charging above the MBS fee, we will cover up to the schedule fee (MBS or AMA – Australian Medical Association, depending on your chosen cover) and any amount above the schedule fee we cover will be the amount you are required to pay. This is referred to as the 'Medical Gap'.

Calendar year

A calendar year is 1 January to 31 December.

Crutches and wheelchairs benefit

For a benefit to be payable on crutches or wheelchairs, the hire or purchase must be linked to an inpatient admission resulting in the requirement of the item. We will not pay benefits without evidence of a hospital admission. If eligible, we will pay 100% of the cost up to a maximum limit of $500 per person per calendar year for any hire or purchase of crutches or wheelchairs on selected visitors covers – please check your cover for eligibility.

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

If applicable on your cover, excesses are only payable on overnight and same-day inpatient hospital admissions in any hospital.

- An excess is a set amount you pay upfront before your benefit is paid. The excess is paid each time a person on your membership is admitted into hospital, to a maximum of $500 for single memberships and $1,000 for couples or family memberships, per calendar year on Platinum, Top and Gold Visitors Cover. On Short Stay Education Cover, the maximum is $250 for single memberships or $500 for couple memberships per calendar year
- No excess applies to your dependent children on all visitors covers, excluding Short Stay Education Cover. Please contact us for further details.

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 expenses.

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

Health aids and appliances

To receive benefits for health aids and appliances 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 is not fully custom made (e.g. orthotics). 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.

Home nursing

Benefits are payable towards some home nursing services that do not need to take place in a hospital and are provided in the home. Please contact us to find out more.

Living Well Programs

Our Living Well Programs help cover health-related programs from approved, recognised providers. You can visit our website for a list of our recognised providers. A Living Well Programs approval form must be completed by your doctor for gym memberships, yoga and Pilates to confirm that the program is medically necessary. Other benefit and recognition criteria apply. Visit our website or contact us to find out more.

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 Overseas Visitors Rules for any additional information on benefits payable. A copy of our Overseas Visitors Rules can be found on our website or in our retail centres. 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

On selected visitors covers you will receive benefits for selected prescription items prescribed as an outpatient that are PBS (Pharmaceutical Benefits Scheme) and non-PBS listed and are TGA (Therapeutic Goods Administration) approved.

Your extras pharmacy entitlement covers you for prescription items that are only non-PBS listed and are TGA approved for that condition.

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

- over the counter items
- compounded items
- non-prescription items
- weight loss medication (some weight loss medications are covered under the Living Well Programs)
- body enhancing medications (e.g. anabolic steroids); and
- erectile dysfunction drugs, unless prescribed by a specialist.

When you make a claim, we will deduct a pharmacy co-payment and pay the remaining balance up to the set amount under your chosen level of cover. This excludes Ultimate Corporate Visitors Cover as we will reimburse you for the full amount of each script, up to the annual limit.

Pharmaceuticals

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.

A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining or upgrading to a higher level of cover.

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. Please note: Pre-existing conditions are not covered by Short Stay Education Cover.

Premium and benefits

You must pay the premium that applies to you. In addition, if you have extras cover as an add-on to visitors cover, please note premiums for extras differ between states 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. For visitors on corporate subsidised health plans, it's up to you to make sure payments are made during times of unpaid leave or if your employments ends
- ensure that newborns are enrolled onto a family membership within two months of their birth to avoid any waiting periods for your baby*
  *Excludes Short Stay Education Cover
- enrol your adult children under their own policy 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.

Restricted cover/benefits

For restricted services or visitors covers with restricted benefit periods for specific services, you will be fully covered in a shared room with your choice of doctor in a public hospital. Restricted/default benefits in a private hospital during a restricted benefit period would not be adequate to cover all hospital costs and are likely to result in large out-of-pocket expenses. Once you have served your restricted benefit period, you will be entitled to full benefits for those services in a private hospital.

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

A membership may be suspended when travelling overseas for work or leisure. If you are travelling overseas, you may choose to suspend your membership during this period of time. You can suspend your cover for the following period of time:

- a minimum period of one month's travel; and
- a maximum period of three months' travel per suspension.

You can only suspend your policy once per calendar year, with no further suspensions allowed after the fifth year of membership. Your membership will be cancelled if not resumed.

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 six months
- apply for suspension prior to the departure date
- provide overseas travel documentation showing your departure and return dates
- notify us of your return to Australia within 14 days of your arrival; and
- complete an overseas travel suspension form.

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 300 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 when you joined us and when you are covered for a service or treatment. If you receive a service or treatment during this time, 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.

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 and maintaining the confidentiality of your personal information is important to Bupa Australia Pty Ltd ("we", "us", "our"). This statement provides a summary of how we handle your personal and health information. For further information about how we handle your personal information, you should refer to our Information Handling Policy, available on our website or by calling us.

We will only collect personal information (including health information) about you and those people insured under your policy to provide, manage and administer our products and services to you and to operate an efficient and sustainable business. We are required to collect and maintain certain information about you and those on your policy to comply with the Private Health Insurance Act 2007 (Cth) and related legislation. We may also collect personal and health information about you from health service providers for the purposes of administering or verifying any claim. We may disclose your personal information to our related entities and bodies corporate, or to third parties such as healthcare providers, government and regulatory bodies, other private health insurers and any persons or entities engaged by us or acting on our behalf. If you are the policyholder, you're responsible for ensuring that each person on your policy is aware that we collect, use and disclose 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 it confidential' form to specify who should receive information about their health claims. You are entitled to reasonable access to your personal information. We reserve the right to charge a reasonable fee for collating such information. If you or any other person on your membership do not consent to the way we handle personal information, or do 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 offer you health management programs 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, Overseas Visitors 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 still not satisfied with your outcomes from Bupa you may contact the Private Health Insurance Ombudsman on **1800 640 695** or email them at **privatehealth.gov.au**

FOR MORE INFORMATION

Call us on 134 135

Visit bupa.com.au

Drop by your local Bupa centre

Mailing details:
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GPO Box 14639
MELBOURNE VIC 3001

Bupa Australia Pty Ltd
ABN 81 000 057 590

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The World of Bupa

Health Insurance
Corporate Health Services
Health Assessments
Health Coaching
Health Programs
International Private Medical Insurance
Overseas Visitors Health Insurance
Optical Services
Travel Insurance
Aged Care
Car and Home Insurance
Life Insurance