Hospital	Excess
High	$250

Corporate Hospital Cover
Level 2

Private hospital cover for included services

Medical cover

Unlimited emergency ambulance

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

Your hospital cover includes	
Accidents after joining[1]	✓
Cardiac and cardiac related services	✓
Hip/knee replacement	✓
All other joint replacements	✓
Knee arthroscopy and meniscectomy procedures	✓
Other joint arthroscopy and meniscectomy procedures	✓
Cataract and eye lens procedures	✓
Renal dialysis for chronic renal failure	✓
Pregnancy and birth related services	✓
IVF and assisted reproductive services	✓
Obesity related procedures and surgeries[2]	✓
Breast reconstruction post cancer	✓
Abdominoplasty & lipectomy	✓
Appendicitis	✓
Removal of tonsils and adenoids	✓
Cancer[3]	✓
Psychiatric services	✓
Rehabilitation services	✓
Palliative care	✓
Back surgery (includes spinal surgery)	✓
Spinal fusion	✓
Reconstructive surgery[2]	✓
All cosmetic surgery[2]	x
All other in-patient treatment receiving Medicare benefits	✓
Unlimited emergency ambulance services	✓
Health subscription refunds	✓
Family in-hospital benefit	✓
Excess options	$250
No hospital excess for kids under 25	✓

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

[1]Benefits for accidents will be paid based on what your hospital cover includes. For Accident definition, please refer to the fund rules at bupa.com.au/fundrules. [2]Refer to Bupa's glossary for definitions at www.bupa.com.au/glossary. [3]Some non PBS drugs may not be covered. Bupa HI Pty Ltd. ABN 81 000 057 590. 10290-04-19

Corporate 90 Extras

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

What's covered

90% of cost at all our recognised providers[1]

Services	Waiting Periods	Yearly Limits[2]
General Dental		Year / Amount ■
Preventative dental check-up payable once every 6 months.	**2 months**	1 $1,200 2 $1,320 3 $1,440 4 $1,560 5 $1,680 6+ $1,800
Major Dental Including dentures, crowns, bridgework and indirect restorations. Denture replacement claimable every 3 years.	**12 months**	Combined with General Dental yearly limit
Orthodontics	**12 months**	
Optical	**2 months**	$300
Physiotherapy		Year / Amount ■
	2 months	1 $550 2 $600 3 $650 4 $700 5 $750 6+ $800
Antenatal and Postnatal Covers selected services.	**2 months**	$400

90% of cost at all our recognised providers[1]

Services		Waiting Periods	Yearly Limits[2]
Chiropractic and Osteopathy		**2 months**	Year / Amount 1 $550 2 $600 3 $650 4 $700 5 $750 6+ $800
Health Management		**6 months**	$100
Speech Therapy		**2 months**	$500
Eye Therapy		**2 months**	
Occupational Therapy		**2 months**	
Dietary		**2 months**	
Pharmacy[3]			Year / Amount
Covers selected items. You pay a set amount as determined by the government, we refund 90% of the balance of the script.		**2 months**	
Mental Health	(includes psychology and counselling)	**2 months**	1 $700 2 $750 3 $800 4 $850 5 $900 6+ $950
Podiatry	(excludes orthotics)	**2 months**	
Health Aids and Appliances[4]	(includes orthotics) Sub-limits apply.	**12 months**	
Hire and repair of Health Aids and Appliances	Sub-limit of $100 applies.	**6 months**	

90% of cost at all our recognised providers[1]

Services		Waiting Periods	Yearly Limits[2]
Natural Therapies			Year Amount ■
Includes massage (remedial massage, myotherapy, and Traditional Chinese Medicine remedial massage), acupuncture and Chinese herbalism.		**2 months**	Combined with Pharmacy yearly limit
Exercise Physiology		**2 months**	Combined with Pharmacy yearly limit
Home Nursing	Covers selected services.	**2 months**	$350
Travel and Accommodation			
Helps pay for travel and accommodation costs for essential medical treatment where that treatment is not available without travelling at least 200km return		**2 months**	Travel: $100 Accommodation: $40 per night up to $150 per year

Yearly limits[2]
The most you can claim per person in a calendar year, depending on your cover.

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

Pay nothing for your kids
If you have combined Corporate 90 Extras with a family hospital cover, we will cover the cost of your kids on most dental, physio, chiro, podiatry consultations, and selected optical packages at Members First providers, up to yearly limits.[5]

Pay nothing for your regular dental check-ups
Pay nothing for your regular dental check-ups and more at Members First Platinum, when you combine Hospital and Extras that include general dental. Up to yearly limits.[6] Find out more at **bupa.com.au/members-first-platinum**

Find a Members First Platinum dentist near you at **bupa.com.au/find-a-provider**

[1]Yearly limits, waiting periods, fund and policy rules apply. [2]Per person, per calendar year unless otherwise stated. [3]Benefits for prescription items that are non-PBS, TGA approved, and not appearing on our exclusions list. [4]Family limits may apply. [5]For most items covering dental, physio, chiro, podiatry consultations and selected optical packages. Available on Corporate 90 Extras when taken with hospital cover on a family membership. Waiting periods, fund and policy rules apply. Child dependants only. Excludes orthodontics, orthotics and hospital treatments. [6]Waiting periods, fund and policy rules apply. Bupa HI Pty Ltd. ABN 81 000 057 590. 10293-04-19

Welcome to Bupa

Your Important Information Guide

Health Insurance

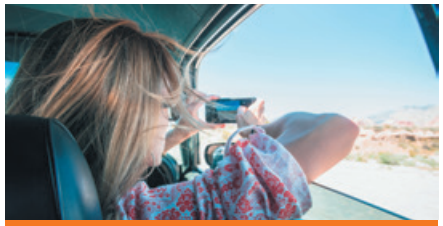
We believe that life is a gift

In everything we do, our focus is to make your life longer, healthier and happier.

That's why we offer a broad range of services and support to take care of your health and wellbeing. From the protection of health, travel, car, home and pet insurance to the reassurance of access to aged care and accredited health-care providers. Plus, a range of projects, tools and programs to promote health, wellbeing and sustainability in the community.

Health Insurance

As one of Australia's leading health insurers, we have agreements with most private hospitals and day surgeries, plus a huge Extras network so you'll know you always have lots of affordable choices.



Other Insurance

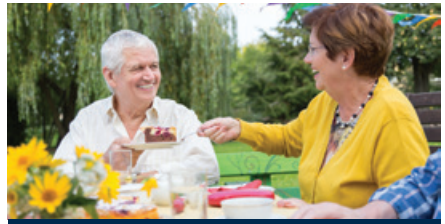
We support you when you need it most, through a range of other insurances, including pet, car, travel and home and contents insurance.

Health Services

Whether you're after dental care, an eye or hearing check, we're all about giving you the personalised help and advice you need quickly and easily. That's why we have accredited health-care providers, who focus on preventative health, and are always there when you need them.

Villages & Aged Care

We are one of Australia's largest residential Aged Care providers, offering a range of respite, residential and specialised dementia care. We help ensure your older family members continue to enjoy life, while having access to support when they need it.



Community

We're also taking care of our community with projects, tools and programs to promote health, wellbeing and sustainability. We're sharing our wealth of knowledge through our online health resource The Blue Room, and innovative health tools like FoodSwitch, mummatters and the Stroke Foundation's enableme. We're also helping to fund breakthrough medical research that enables real health and care improvements for all Australians through our Bupa Health Foundation.

Stay up to date
Click the links below to visit Bupa online.

- bupa.com.au
- Bupa Twitter
- Bupa Facebook
- Bupa YouTube

Effective 1 April 2019

We get it.

Health insurance can be confusing.

That's why we've designed this guide to explain how it works generally. It applies to anyone with full access to public healthcare (from Medicare). This includes Australia citizens, permanent residents and some of those in the process of applying for permanent residency.

If you need more specific information, like the services you're covered for on your policy, please check your policy information.

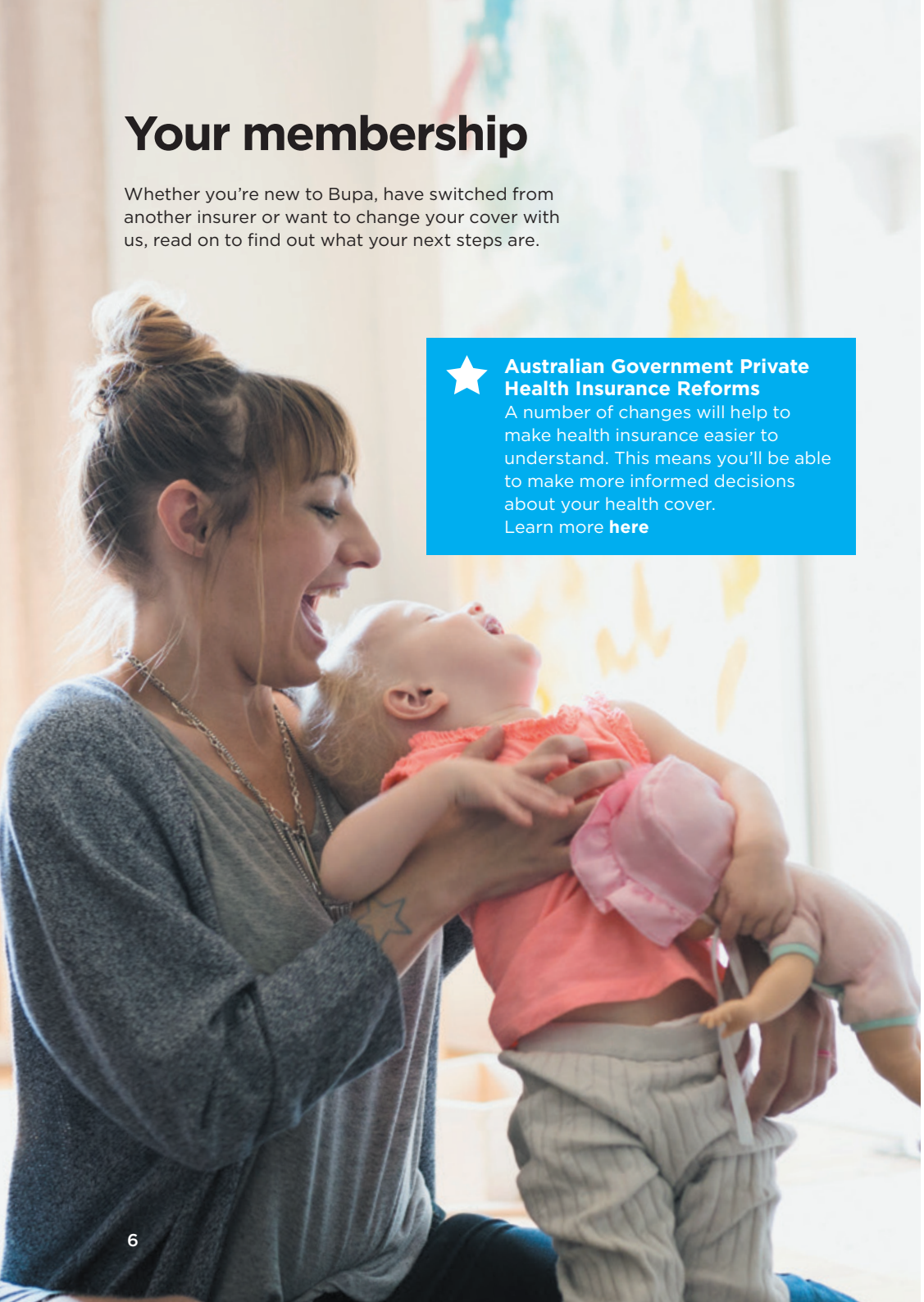
If you'd prefer to speak to us in person, call 134 135 (or +613 9487 6400 if you are overseas).

This guide does not replace the Bupa Fund Rules, which outline the terms and conditions of your cover and are available **here.**

Please read this guide carefully and keep it available for reference.

Your membership

Whether you're new to Bupa, have switched from another insurer or want to change your cover with us, read on to find out what your next steps are.



Australian Government Private Health Insurance Reforms
A number of changes will help to make health insurance easier to understand. This means you'll be able to make more informed decisions about your health cover.
Learn more **here**

Health insurance explained

As Australians, we're lucky enough to have access to a quality, public health system. But this system has its limitations. For example, it doesn't cover all treatments and services, and limits things like where and when you're treated.

Private health insurance means:

1. **More control** if you need to go to hospital for a non-emergency procedure. You'll have more choice when it comes to your hospital, your specialist and when you'd like your procedure to take place. You might also be able to request a private room.
2. **Reduced wait times** for non-emergency hospital procedures (like having your tonsils out) at a private hospital. If you're not privately insured, you might have to choose between being on a public hospital waiting list for months (sometimes over a year)+ or paying a hefty fee to go to a private hospital.
3. **The ability to claim money back** on some everyday health services that may not be covered by Medicare, such as dental and physio. Depending on your cover, you may even be able to claim money back for services like remedial massage and acupuncture.
4. **You could avoid or minimise** the Lifetime Health Cover (LHC) loading if you're 31 or over and don't have hospital cover. The LHC loading is a Government initiative designed to encourage Australians to take out hospital insurance earlier in life. If you don't have hospital cover by July 1 following your 31st birthday, but then decide to take it out later in life, you'll pay a 2% loading on top of your premium for every year delayed (up to a maximum of 70%). This extra loading remains in place for 10 years. For example, if you delayed getting hospital cover for 3 years after you turned 31, you'll pay an additional 6% on top of your premium for the next 10 years.
5. **Tax time savings.** Depending on your income, you may have to pay an extra 1-1.5% tax (on top of the Government's Medicare Levy) if you don't have appropriate hospital cover for you and all your dependants over the whole year. That's similar to the cost of some of our hospital covers. The Government will also contribute to the cost of your premium – this is known as a 'rebate'. The amount is based on your age and income and you can choose to get it as a reduced premium or offset in your tax return.*

+ Source: Australian Government Institute of Health and Welfare Report: Elective surgery waiting times 2017-18. * Current rebate percentages are effective for payments made from 1 April 2019 and are indexed annually. The income thresholds will remain the same from 1 July 2015 until 30 June 2021. On a family or single-parent membership, income thresholds increase by $1,500 per child after the first. The family thresholds also apply to single parent families and de facto couples. For more information go to ato.gov.au

Switching from another insurer

Here's what you need to know

1. We handle the paperwork

Just give us permission to get in touch with your old insurer when you apply. We'll make sure your insurance is cancelled and obtain your 'clearance certificate' from your previous fund.

A clearance certificate tells us what type of cover you had, how long you had it, and how much of your limits you have already used at your old fund.

2. You don't have to re-serve waiting periods

You won't have to serve waiting periods again for any treatments you've been previously covered for, as long as your clearance certificate shows that the same services are also offered equivalently on your new Bupa cover, your new cover starts within 60 days of your previous cover's end date, and we've received your clearance certificate to confirm your previous cover. If we don't receive it, you may have to wait until we do before you're able to submit a claim.

3. Your Extras limits will transfer

All insurance policies have limits on the amount of money you can claim. It might be per month, year, by family or over an individual's lifetime. These limits are transferred when you change health funds. For example, any claims you have already made that year will count towards your new yearly limit with us.

4. You may not be able to claim new additions straight away

If your new Bupa insurance policy covers services that your old policy didn't, or allows you to get more money back, there might be a waiting period before you are able to claim, or you may only be able to claim the lower amount until your waiting period is up. The waiting period applies to the date of your treatment, regardless of when you submit the claim.

5. Lower levels of cover apply immediately

If you have chosen to change to a lower level of cover, the lower level of benefits will apply immediately (assuming that we've received the clearance certificate from your previous health fund).

6. Excesses still apply

If you switch from another insurer and have an excess or co-payment on your policy, the excess or co-payment will still apply, even if you have paid an excess or co-payment with your previous fund in the same calendar year.

7. You have a 30-day cooling-off period

If you want to cancel your cover within 30 days, you can, as long as you haven't claimed. After 30 days, you can cancel your cover, but it will only apply from the day you requested to cancel it. It's important to remember that any gaps in your cover could mean that you need to pay the Medicare Levy Surcharge (MLS), or that your cover costs more later on as a result of Lifetime Health Cover Loading (LHC). You can learn more about MLS and LHC on **page 58**.

Changing your existing Bupa cover

Here's what you need to know

1. You may not be able to claim new additions straight away

If your new Bupa policy covers services that your old policy didn't, or allows you to get more money back, there might be a waiting period that you'll need to serve before we will pay claims for the additional services, or you may only be able to claim the lower amount until your waiting period is up.

2. Lower levels of cover apply immediately

If you have chosen to change to a lower level of cover, the lower level of benefits will apply immediately.

3. Your Extras limits will transfer

All insurance policies have limits on the amount of money you can claim. It might be per month, year, by family or over an individual's lifetime. These limits are transferred when you change your Bupa cover. For example, any claims you have already made that year will count towards your new yearly limit.

4. You have a 30 day cooling-off period

If you want to reverse any change to your cover, you can reverse the change within 30 days, as long as you haven't claimed. After 30 days, you can change your cover back, but it will only apply from the day you requested to change it back. If you are going back to a higher level of cover, you may need to wait before you can use any extra benefits.

Your toolbox

There are a few quick steps to complete to make sure you get the most out of your new Bupa membership.

1. Your Bupa card

It will arrive shortly after you join and:

- Contains your membership number and a list of the people who are covered by your policy.
- Allows you to make on-the-spot claims when you have received a treatment or service from many of our recognised Extras providers, such as a dentist or physio.
- Is used as identification if you are admitted to hospital.
- Helps you to redeem member discounts in person. Check these out online **here**

2. myBupa

mybupa.com.au is our online portal. Once you register, simply log in using your secure log-in details to:

- Access your policy documents and tax information.
- Submit an Extras claim and see your claim history.
- Update your personal details.
- Access exclusive health tools and discounts.

3. Our team

Small changes to your circumstances (like new contact details or payment information) can be made online at **mybupa.com.au** Bigger changes, like adding or removing people from your cover or moving interstate can affect the cost and level of cover, including things like ambulance services. In these cases, you're best to speak to us to ensure your cover is still appropriate. We can also clarify what your cover includes.

- Call us on **134 135**
- Find a local Bupa Health Insurance store **here**

Going to hospital

In this section, you'll find out how to navigate going to hospital – from deciding where to go, to choosing your hospital, specialists and more.

Hospital waiting periods

When you first take out or upgrade health cover there's a period of time before you can make a claim on your new level of cover. This is common across the health insurance industry.

You can't claim for services that you receive during this period at your new level of cover, even if you wait to submit the claim once the period is over.

Different waiting periods apply to different hospital services:

Service/Treatment	Waiting period
Emergency ambulance and on the spot treatment	None
Accidents that occurred after joining Bupa	None
Palliative care, rehabilitation and psychiatric services*	2 months
All other treatments included in your cover	2 months
Pre-existing conditions, ailments or illnesses	12 months
Pregnancy and birth related services	12 months

Pre-existing conditions

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

If you knew you weren't well, or had signs of a condition that a doctor would have detected (if you had seen one) during the six months prior to joining or upgrading, then the condition would be classed as pre-existing.

A doctor, appointed by us, decides whether your condition is pre-existing, not you or your doctor. The appointed doctor must consider your treating doctors' opinions on the signs and symptoms of your condition, but is not bound to agree with them.

Planning for a baby

If you are thinking about starting a family we recommend that you contact us to check whether your current level of cover includes pregnancy and birth related services in advance. This is because there's a 12-month waiting period for this.

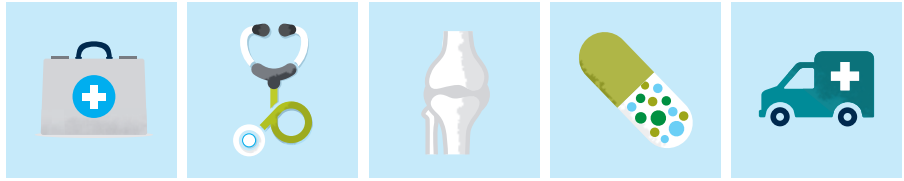
No waiting periods apply to a newborn provided they have been added to your level of cover within 90 days of their birth.

*Existing members: If you need to discuss how you're covered for urgent mental health treatment in-hospital, please contact us.

Costs of going to hospital

What you might have to pay and what can be covered

The five types of costs you might encounter during your hospital stay:



Hospital costs | Medical costs | Prostheses costs | Pharmacy costs | Emergency ambulance costs

The next few pages will help you understand the type of costs you might encounter during your hospital stay (assuming you are covered by your policy for the treatment you're receiving in hospital and that you have served all relevant waiting periods).

Medical costs before you go to hospital

In the lead-up to a hospital admission, customers will generally need appointments with their GP and/or specialist(s). There may also be a need for tests such as blood tests, x-rays, etc. Under health insurance legislation, we are not permitted to cover these appointments through health insurance, so please check with your GP and relevant specialist for the exact costs, as these will be your out-of-pocket costs to pay.

Knowing your hospital costs before you're admitted

If you are in hospital for a pre-booked admission, it is important that you make sure that the hospital or specialist tells you the costs that you can expect to pay yourself, after we have paid our part of your costs. The hospital should make sure they get your consent for these costs before you're admitted. If you have anything to pay yourself, and need clarification, please contact us directly.

Hospital costs:

Charges related to staying in the actual hospital such as the use of the bed, food and operating theatre, plus nursing and allied health services.

- How you're covered for hospital costs when you're admitted as an 'inpatient' depends on your choice of hospital.See **page 25** for more details. Check with your doctor whether your treatment will require you to be admitted.
- Depending on your level of cover, we might also pay some of the costs for a partner, immediate family member, carer or next of kin to stay in hospital with you and help you with your care.
- If a treatment is listed as having 'restricted cover' on your policy information, we pay less toward your hospital costs. This means you're likely to have more to pay for these services. You can read more about restricted cover on **page 34**.

Prostheses costs:

The cost of things that are surgically implanted like artificial hips or knees or cardiac devices such as pacemakers, and stay implanted when you leave hospital.

- You're covered for all prostheses on the Australian Government's Prosthesis List, up to the value stated on the list.
- Once we have paid for a prosthesis, you will not normally be covered for a replacement, whilst it is still under warranty. The manufacturer should be contacted for any manufacturing defects with the device, depending on the terms of the warranty.

Medical costs:
The fees charged by a surgeon, physician, anaesthetist, or other medical specialist when they are treating you in hospital.

- We make arrangements directly with specialists, separate from our arrangements with hospitals. This means your specialists will bill separately, and in addition to, what the hospital bills for your stay.

Discover the average cost of your procedure
Use our handy online tool to **find out more.**

How fees for medical treatments are set

- The Australian Government sets the fees for medical services. **Find out more** about how the Australian Healthcare system works.

How medical costs are covered

- Medicare and Bupa both pay a portion of this (75% and 25% respectively). However, your specialist may choose to charge more than the set fee. This means you would have a 'gap' to pay yourself. The Bupa Medical Gap Scheme is designed to eliminate or minimise the amount you'll have to pay in cases like this. Go to **page 32** for more information.
- Remember, you might have to see multiple specialists for one procedure.

Pharmacy costs:
The cost of prescribed medication provided to you, or purchased by you, for treatment of your condition. This includes pharmaceuticals listed on the Australian Government's Pharmaceutical Benefits Scheme Schedule (PBS), and, in some cases, non-PBS 'High Cost Drugs'.

Pharmaceuticals listed on the PBS might be covered in one of two ways:

1. **By your Hospital cover.** This is medication you take in hospital (not discharge medications). In most cases, these medications are fully covered by our hospital agreement – this just means that the hospital will bill Bupa directly and you won't have to make a claim.
   - If you're at a private hospital with a Bupa agreement, we pay some of the cost of medications that are not on the PBS (known as High Cost Drugs), if they are provided to you in hospital and are approved by the Therapeutic Goods Administration (TGA) for the treatment of your specific condition.
   - To be eligible, all waiting periods must be served and your membership payments must be up to date at the time you receive the medication.
2. **By your Extras cover.** This is medication you purchase when you're not in hospital or once you've left hospital, as well as unopened medication provided to you when you are discharged from hospital. Go to **page 48** for more information.

We do not cover:
- Over the counter or non-prescription pharmacy items.
- Compounded medications, which are mixed from the individual ingredients to the strength and dosage required for an individual.
- Body enhancing medication (e.g. anabolic steroids).
- Weight loss medication.
- Medication provided by the hospital that isn't essential to your care.

Emergency ambulance costs:
The costs associated with transport services (via air or road) from the place where you are treated, to the emergency department of a receiving hospital.

There are two main categories of ambulance services:

Emergency

For unplanned events where your life may be at risk and you need medical treatment immediately.

For more information about what we define as an emergency, read our fund rules **here.**

Non-Emergency

For times where you may use an ambulance but don't need treatment straight away, or your life is not at risk.

For example:

- Transport from a hospital to your home or nursing home.
- Transport to a hospital, your home, or nursing home for ongoing treatment, like dialysis or chemotherapy.
- Where you've been admitted to one hospital and need to be taken to another (the hospital should include this in the cost of your procedure).

What you're covered for depends on your cover type:

Cover type			
★ Hospital, most Extras Covers	★★ Corporate Hospital Cover & Emergency Only Ambulance Cover	★★★ Premium Ambulance Cover	★★★★ Ultimate Health Cover and Ultimate Corporate Health Cover Only
What's included per calendar year			
• Emergency Cover only • 1 service for Singles • 2 services for Couples and Families	• Unlimited Emergency Cover	• Unlimited Emergency Cover • Up to $5,000 in Non-Emergency per person	• Emergency Cover only • 1 service for Singles • 2 services for Couples and Families Or, we'll refund the costs of an Ambulance subscription from our recognised provider in your state (VIC, SA, and NT only).

Ambulance services across states

When it comes to ambulance services, each state is different. You should consider what you've chosen to be covered for, the state you live in and whether you need cover interstate. The below table compares your options.

State you normally live in	Options at home	Options while interstate
ACT	Private cover	
NSW		
VIC	Private cover OR A subscription	
NT		
Country WA		
Metro WA & Norfolk Island	Private cover	
SA	Private cover OR An SA Ambulance subscription	
TAS	The Government covers you at home	The Government covers you, except for in QLD and SA
QLD	The Government covers you everywhere in Australia	

It's worth noting that some states:

Offer free or subsidised ambulance services to pension and concession card holders. Check your State Government website for more details.

Have agreements with other states to cover their residents, and vice versa. What's covered under these agreements varies, so if you travel interstate frequently, it might be worth considering private cover or a subscription.

When can I use my Ambulance cover?

1. When you can't claim the costs from another source. For example, when your State Government doesn't cover you and you can't claim from a subscription or Government levy. See **page 35** for more information.

2. If your ambulance service was provided by our recognised provider in the state you had that service. These are listed in the table below.

STATE	Recognised provider	State subscription available
VIC	Ambulance Victoria	✓
SA	SA Ambulance Service	✓
NT	St John Ambulance	✓
Country WA	St John Ambulance	✓
Metro WA & Norfolk Island	St John Ambulance	✗
ACT	ACT Ambulance Service	✗
NSW	Ambulance Service of NSW	✗
TAS	Tasmanian Ambulance Service	N/A
QLD	QLD Ambulance Service	N/A

How do I pay my ambulance costs?

If you receive an invoice for ambulance services, and you're covered for ambulance, the table below will show you what to do. If you need to send the invoice to us, check **page 50** for how to claim.

State you normally live in	What do I need to do?
ACT	Send the invoice to us. We'll either organise it with your State Government, or pay it ourselves.
NSW	Send the invoice to us. We'll either organise it with your State Government, or pay it ourselves.
SA VIC NT	If it is included in your subscription – send it to them to pay it. If it is not included in your subscription – send the invoice to us.
QLD	There's nothing for you to pay. Send the invoice to the Queensland Government to pay.
TAS	If you have the service in QLD or SA – send the invoice to us. Otherwise, send it to the Tasmanian Government for payment.
Country WA	If included in your subscription, send it to 'St John's Ambulance' to pay it. If it is not included in your subscription – send the invoice to us.
Metro WA & Norfolk Island	Send the invoice to us.

Deciding whether to go to hospital

Sometimes you need to go to hospital, and other times you might not. For example, if you injure your shoulder, you might be able to manage the injury through physio or other treatments rather than surgery.

When deciding, consider our range of health programs designed to:

Improve your health

Empower you to make informed choices about your health and care

Ensure that you receive the right care, in the right place, at the right time

Some of these programs might help you with your condition or injury, without a trip to hospital.

Find out more

* 'Private room or money back guarantee' means that, at our Members First hospitals, you'll receive a private room when you book and request one at least 24 hours before the overnight admission. If a private room is not available, you'll receive $50 back, per night, from the hospital. You'll also receive a complimentary daily newspaper and complimentary local calls. Applies to overnight admissions only. Excludes 'nursing home type patients', emergency care same-day or occasions where a private room is medically inappropriate.

Choosing a hospital

1 Consider what you're covered for

The amount that we will pay is determined by your level of cover (your policy), the agreement that Bupa has with the hospital you go to, and whether or not you've served the relevant waiting periods.

2 Choose whether or not to go public or private

If you have private hospital cover with Bupa, the choice is yours. You might make your decision based on location, familiarity, cost, urgency or a range of other factors.

Here's a summary of your hospital options

Benefit	Members First hospitals & Day facilities	Network hospitals & Day facilities	Network Fixed Fee hospitals & Day facilities	Non-agreement hospitals	Public hospital	
					Private patient	Public patient
Choice of hospital	✓	✓	✓	✓	✗	✗
Choice of specialist	✓	✓	✓	✓	✓	✗
Reduced waiting time	✓	✓	✓	✓	✗	✗
Covered for hospital costs	✓	✓	MOST	LIMITED	LIMITED	✓ by Medicare
Private room guarantee (overnight)*	✓	✗	✗	✗	✗	✗
Covered for extra services and benefits	✓	SOME	✗	✗	✗	✗

Explore our hospital network

Choosing a private hospital

Private hospitals do vary in cost and the facilities they provide. If cost is important to you, make sure they have an agreement with Bupa.

Provided your cover includes private hospital cover for the treatment you need, and you've served your waiting periods, the table below will help you choose a hospital. These costs and benefits are based on you being admitted to that hospital as a patient.

Find Members First or Network Hospitals near you

Hospital costs and benefits by hospital type

Type of hospital	Cost to you	Member benefits	Important to note
Members First hospital	**Low** – In most instances you'll be covered for hospital costs.	Our 'private room or money back guarantee'.* Plus, complimentary daily newspaper, local phone calls and free-to-air TV. If pregnancy and birth related services are included in your cover, you get: • child-birth, breast-feeding and parenting education classes • postnatal clinics for up to 8 weeks after you leave hospital • parental support services.	To take advantage of the 'private room or money back guarantee',* you'll need to book and request a private room in a Members First hospital at least 24 hours before admission. We have over 100 Members First Hospitals.
Network hospital	**Low** – In most instances you'll be covered for your hospital costs.	You will be covered for a private room if you request one. Plus, complimentary local phone calls and free-to-air TV.	The 'private room or money back guarantee' does not apply.*
Network hospital with a fixed fee. **There's only a small number of these.**	**Medium** – You may be charged a fixed daily fee and generally be covered for your hospital costs (this fee does not apply if you are on Ultimate Health Cover).	You will be covered for a private room if you request one. You'll also receive complimentary local phone calls and free-to-air TV.	At some of these hospitals, a fixed fee applies to all services offered. At others, a fixed fee applies to either a psychiatric or rehabilitation service only. This fee is capped at a maximum number of days per overnight stay. The fixed daily fee charged by the hospital is in addition to any excess or co-payment you may need to make.
Members First Day Facility	**Low** – In most instances you'll be covered for your hospital costs and there will be no gap to pay on your specialist's fees.	You will pay nothing for treatment by a specialist at these facilities. You will also receive complimentary local phone calls and free-to-air TV.	We now have over 80 Members First Day Facilities. (Not available in NT)
Network Day Facility	**Low** – In most instances you'll be covered for your hospital costs.	Complimentary local phone calls and free-to-air TV.	
Non-agreement hospitals and day facilities	**High** – These facilities haven't entered into any agreement with Bupa, meaning we only cover minimal costs.	None. You will be responsible for the cost of your stay and may be charged directly for your hospital accommodation, surgically implanted prostheses and personal expenses such as TV hire. Some of these hospitals bill Bupa directly for the limited benefits we pay. If your specialist/s charge more than what we pay (with Medicare), you're likely to have some medical costs to pay yourself.	If you attend one of these facilities, you are likely to encounter significant expenses. You will not be able to use the Bupa Medical Gap Scheme at these hospitals to lower your out of pocket medical costs. This means the costs for you to pay could be higher at these hospitals.

* 'Private room or money back guarantee' means that at our Members First hospitals, you'll receive a private room when you book and request a private room at least 24 hours before the overnight admission. If a private room is not available, you'll receive $50 back per night from the hospital. You'll also get a free daily newspaper and free local calls. Applies to overnight admissions only. Excludes 'nursing home type patients', emergency care same-day or where a private room is medically inappropriate.

Choosing a public hospital

As a Bupa member attending a public hospital, you can choose to be treated as a public patient or as a private patient. Each has its pros and cons.

Public patient in a public hospital

Pros	• The cost will usually be covered by Medicare.
Cons	• You won't be able to choose who treats you or when you're treated. • You will be subject to public waitlists which can be lengthy – sometimes over a year long. • Your procedure may be postponed if more urgent cases come up. • You are less likely to get a private room.*

Private patient in a public hospital

Pros	• You'll get your choice of your doctor, if they are available. • We'll pay the cost of you staying in a shared room. (This amount is set by the Australian Government). • If a private room* is available and you choose to stay in it, Bupa may cover some of the additional cost of this, depending on your level of cover. If this won't cover all your costs, the hospital should let you know the amount you will need to pay. • We'll contribute to the cost of prostheses and specialists as we would if you were treated in a private hospital.
Cons	• You may still be subject to public hospital waiting lists. • Depending on your illness or condition, you may get the same doctor who would have been allocated to you if you were a public patient. • You'll be responsible for personal expenses such as TV and telephone calls. • You may experience out of pocket expenses.

* A private room in a public hospital is a room in a hospital which is purpose built and suitable for no one other than a single admitted adult patient; holds one single sized bed; and has a dedicated ensuite.

Things to remember before choosing public

1. **The choice is yours**
   If you need to be admitted to a public hospital, the hospital will provide you with a form where you will elect to be admitted as a private or a public patient. The hospital must clearly explain what both options mean for you.

2. **Once you're admitted, the choice is made**
   Once you decide whether to be a private or public patient, it applies to your whole admission. It generally can't be changed, except in unforeseen circumstances.

Keep in mind
A hospital should not ask you to charge your stay to your private cover after you've already elected to be a public patient. There is no need for you to do this. If you were to do so, you may have out of pocket costs for your treatment.

What should I ask the hospital before I decide?

"What are the benefits to me if I choose to use my private cover?"

"Will there be any difference to my care if I use my private cover?"

"Can I choose my doctor?"

"Can you ensure I will have a private room for my entire stay?"

Choosing a specialist

If you have private health cover, you have more choice as to which specialist treats you. It's important that you feel informed before you make this decision. As with your choice of hospital, your decision may be based on factors such as cost, reputation, how often they've conducted your surgery, their location and how comfortable you feel with them. You should also discuss with your GP whether the recommended specialist is appropriate for your needs.

Medical costs

These are the fees charged by a doctor, surgeon, anaesthetist, or specialist when they are treating you in hospital. The level of cover we provide for medical costs depends on what fee the specialist decides to charge and whether they use the Bupa Medical Gap Scheme.

- We make arrangements directly with specialists, separate to our agreements with hospitals. This means you will be billed by your specialist separately and in addition to your hospital bill. We may cover some or all of this.
- The Government sets a fee for the cost of a medical service. Medicare pay 75% and Bupa pay 25% of that set fee. Some specialists will choose to only charge that set fee. However, your specialist may choose to charge more than the fee. This means you would have a 'gap' to pay yourself.
- The Bupa Medical Gap Scheme is designed to minimise or eliminate the amount you'll have to pay in cases like this. We do this by paying more than the set fee, and we have an arrangement with the specialist on a fixed cost for your treatment. Go to **page 32** to find out more.

Questions to ask when choosing your specialist

You are entitled to be fully informed about your specialist and any associated costs before you start your treatment. Here are some questions that will help you make your decision.

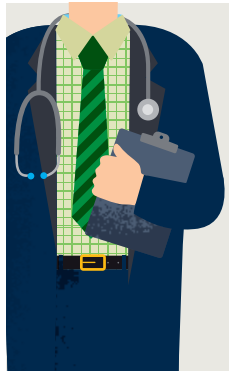
Once you've had your initial consultation with your GP, ask Bupa:

1. **"Can you provide me with a list of specialists who use the Bupa Medical Gap Scheme?"**
2. **"Can these specialists treat me in a hospital that has an agreement with Bupa, and which hospitals are they?"**

Ask your GP:

1. **"Can you refer me to a specialist who uses the Bupa Medical Gap Scheme?"**
2. **"Can you refer me to a specialist who can treat me in a hospital that has an agreement with Bupa?"**

Attending a private hospital that Bupa has an agreement with could help to reduce your hospital and medical costs.



Ask your specialist:

1. **"Do you use the Bupa Medical Gap Scheme?"**
   If not, ask them what you will have to pay.
2. **"Will any other specialists be involved in my treatment?"**
   Sometimes you'll also need the services of specialists like an anaesthetist, pathologist, radiologist or assistant surgeon. If so, ask if they use the Bupa Medical Gap Scheme, or if they are In-Hospital **Pathology** and **Radiology** contracted providers that have 'no gap' arrangements with Bupa.

Find a no gap radiology provider for services in hospital

Find a no gap pathology provider for services in hospital

Reducing your medical costs

The Bupa Medical Gap Scheme

The Bupa Medical Gap Scheme is designed to eliminate or minimise the amount you will have to pay in 'medical costs', or doctors' fees when you're admitted into hospital.

How does it work?

We pay more, so that you pay less.

Where a doctor or specialist has signed up to the Bupa Medical Gap Scheme, and agrees to use it for your treatment, the costs you pay are reduced.
Your doctor or specialist agrees to only charge up to a certain fee.
We then pay a much higher amount than what we normally would.

Where can my doctor use the Bupa Medical Gap Scheme?

Your doctor or specialist can use the Bupa Medical Gap Scheme in:

Public hospitals, or

Private hospitals that have an agreement with Bupa.

Over 96% of all private hospital beds across Australia are in hospitals that Bupa has an agreement with.

What can I expect if my doctor uses the Bupa Medical Gap Scheme?

You will usually have multiple doctors or specialists involved in your treatment.

If each doctor involved in your treatment chooses to use the Bupa Medical Gap Scheme for your treatment:

In a Public Hospital:

If you have a pre-booked admission, you will never have to pay more than $500 per doctor while you're in hospital. If you are admitted any other way such as through the Emergency Department, your doctor will bill Bupa directly and you will pay nothing while you're in that hospital.

In a Private Hospital with which Bupa has an agreement:

You'll never have to pay more than $500 for medical treatment per doctor – we may even pay for the full cost while you're in that hospital.

Find Members First, Network Hospitals and Medical Gap Scheme providers

What happens if my doctor doesn't use the Bupa Medical Gap Scheme?

The specialist or doctor can decide what to charge you and you'll need to pay any 'gap' (or amount above what we pay) in costs yourself.

Here's an example of how it might work:

Scenario 1
Your specialist charges the fee set by the Government

Your specialist's fee is $2,000		
Medicare pays $1,500	Bupa pays $500	You pay $0

Scenario 2
Your specialist uses our Medical Gap Scheme with no gap to pay

Your specialist's fee is $3,000		
Medicare pays $1,500	Bupa pays $1,500	You pay $0

Scenario 3
Your specialist uses our Medical Gap Scheme, which minimises what you pay

Your specialist's fee is $3,500		
Medicare pays $1,500	Bupa pays $1,500	You pay $500

Scenario 4
Your specialist doesn't use our Medical Gap Scheme

Your specialist's fee is $5,000		
Medicare pays $1,500	Bupa pays $500	You pay $3,000

No Gap Cardiac Services

Bupa has partnered with Genesis Heart Care, Australia's largest group of privately practising cardiologists, to help achieve better health outcomes for patients with heart disease.

As a Bupa member, you'll have no out-of-pocket expenses for services from a Genesis Heart Care cardiologist when you're admitted to hospital.
(Not available in NSW, TAS & NT).

Find out more about Genesis Heart Care

Potential ‘out-of-pocket’ costs

1. Excesses

An excess is a one-off payment you make each calendar year if you need to go to hospital. You pay this before you are admitted to hospital and before we will cover the rest of the hospital costs that your policy includes. You will have agreed on this amount when you chose your level of cover and can find it in your policy information, available by logging in to **myBupa.com.au**

An excess is paid once per person, and not by the same person in that year. An excess is only paid twice per policy. This applies even if you change your cover. The exception is that if you change your cover to a policy with a higher excess. In that case, you’d only pay the difference between the smaller and higher excess if you were to be admitted to hospital again that year. Other conditions apply.

Excesses are still payable If you have transferred from a different health fund, regardless of whether you have already paid an excess to your old insurer in the same calendar year.

2. Co-payments

A co-payment is where you pay a set amount each day that you are in hospital, up to the first five days, for each time you are admitted to hospital. Only some Bupa members have co-payments. If you do, you will have agreed to this amount when you first chose your level of cover and can find it in your policy information, available by logging into **myBupa.com.au**

3. A daily, fixed fee

This is a fee charged by a small number of private hospitals that you may have to pay. If they do charge one, they should tell you when you make a booking. This is in addition to any excess or co-payment you may have to pay. It may be charged by the hospital, and is not related to your health insurance. It might influence your choice of hospital.

4. A ‘gap’ for specialist fees

The Australian Government sets an amount for the cost of specialist medical services. Medicare and Bupa both pay a portion of this. However, your specialist may choose to charge more than the set fee. This means you would have a ‘gap’ to pay yourself. The Bupa Medical Gap Scheme is designed to minimise or eliminate the amount you’ll have to pay in cases like this. Go to **page 32** for more information.

5. What is restricted cover?

The Australian Government sets an amount to charge for hospital costs, which is called the ‘minimum benefit’. If your policy says you have ‘restricted cover’ for a type of treatment, it means we will only pay the minimum benefit for your hospital costs. In most cases, if you were to stay in a shared room in a public hospital, you’d be covered but there may be an amount for you to pay. For a private room, or a private hospital, the hospital may charge even more, leaving a significant amount for you to pay.

This example shows what someone with restricted cover might pay in hospital costs. The actual amount depends on a number of factors, including your choice of hospital. Your hospital must let you know the specific amount before you are admitted – this is called ‘Informed Financial Consent’.

The amount we pay for other costs you may incur in hospital (like medical costs), is not lower under restricted cover. See **page 25** for more details.

Log on to **myBupa.com.au** to access your policy information, which shows the services this applies to.

6. Things your Hospital policy doesn’t cover

This varies, but here are some common examples:

Type of service	Covered by
GP visits, blood tests, X-rays and MRIs, when you are not admitted to hospital	Medicare
Non-emergency ambulance transport*	Check **page 19** for more details
Services and treatments specifically excluded from your cover	You
Cosmetic surgery	You
Services covered by another source	For example, travel insurance or workers’ compensation

*If you have Premium Ambulance cover with Bupa, you will be covered for non-emergency ambulance transport, capped at $5,000 per person per calendar year. Waiting periods, fund and policy rules apply.

Paying your hospital expenses

Paying your hospital costs

- **If you're admitted to a private hospital that has an agreement with Bupa,** they will send the bill directly to us, so there's very little paperwork for you. Where applicable, the hospital may ask you to pay any excess, a co-payment or a daily, fixed fee when you're admitted.
- **If you're admitted to a non-agreement hospital,** you may be asked to pay the whole amount up front. In this case, you can submit a claim form to Bupa to be reimbursed for some of these fees. You're likely to have to pay a significant amount yourself if you visit one of these hospitals.
- **If you're admitted to a public hospital as a private patient,** the hospital also sends the bill directly to Bupa.
- **If you're admitted to a public hospital as a public patient,** Medicare will usually fully cover your costs.

These forms are available at any Medicare centre or via the Department of Human Services website. If you can't get to a Medicare centre, contact either Bupa or Medicare and ask for the relevant forms to be sent to you.

Paying your medical costs

- **If your specialist uses our Medical Gap Scheme,** they'll send the bill to us directly. You won't see the paperwork until you receive your Statement of Benefits. If you have had to pay an amount (up to $500), the specialist will bill you for the fee directly.
- **If your specialist doesn't use our Medical Gap Scheme,** the specialist could charge any price and you'll need to pay any 'gap' in cost yourself. You will receive the bill directly and you can make a claim in one of three ways.

1. **Pay in full,** then visit a Medicare office to claim a portion (75% of the set fee). Bring your Medicare receipt to a Bupa store to claim another portion (25% of the set fee).
2. **Pay in full,** then complete a Medicare claim form and a two-way claim form. That means Medicare will liaise with Bupa on your behalf to ensure you receive your refund.
3. **Do not pay –** instead complete both a Medicare and two-way claim form. If Medicare confirm you've not paid, you'll receive two cheques made out to the specialist – one from Medicare and one from Bupa. You can then send these to your specialist as payment for the set fee.

Remember, you might have to see multiple specialists for one procedure.

Paying your prosthesis and pharmacy costs

- **If the prosthesis is on the Australian Government's Prosthesis List,** and you're admitted to a private hospital with a Bupa agreement, then the hospital will bill Bupa directly.
- **If the medication is on the Australian Government's Pharmaceutical Benefits Scheme (PBS),** it's essential to your care and you have taken it or it has been opened for you in hospital, you will be covered and the hospital will bill Bupa directly. Also, if you're at a private hospital with a Bupa agreement, we pay some of the cost of medications that are not on the PBS (known as High Cost Drugs). See **page 17** for more information.

Your Statement of Benefits

After your hospital and medical claims have been processed, we'll send you a statement showing what's been paid on your behalf. This is known as your Statement of Benefits. Please check that these details are correct and contact us straight away if you have any questions.

Your Statement may include costs for specialists you haven't seen in person, but who have still performed a service for you, such as a pathologist.

Sometimes we will also include a cheque made out to your specialist with your Statement. You should simply forward this on to the specialist (usually to the hospital or to their clinic).

Your Extras cover

If you've got Bupa's Extras cover, we've covered just about everything you need to know on the following pages. If you've still got questions, just ask. We're happy to help.

Understanding Extras cover

Not everything that keeps you healthy is covered by Medicare. That's why Extras cover can be a big help. Extras cover is all about covering some of the costs that aren't hospital related. Some of the most common services and treatments that people make Extras claims for include:

- Dental check-ups and cleans
- Physiotherapy, chiropractic, occupational therapy and podiatry
- Optical products, such as prescription glasses and contact lenses
- Health aids and appliances, such as asthma pumps/nebulisers, blood pressure monitors and hearing aids

Providers of Extras services have to be recognised by Bupa in order for us to pay towards the cost of your treatment. The following information is important for you to understand what is required for a claim, and how your choice of provider can affect what we will pay.

Choosing your provider

We all have different priorities when it comes to choosing a health care provider. Your choice could be based on location, recommendations, cost, or other factors that are important to you.

The amount you'll pay for each treatment can depend on:

1. How much the provider charges for the service.

2. Any agreements between the provider and Bupa.

3. The amount you can claim back, determined by your level of cover.

We understand that factors other than cost can be important to you, such as familiarity or location. If your dentist, chiro, podiatrist, physio or optical provider isn't in our Members First network, you can still make a claim. However, you may have a larger out-of-pocket expense when you get the bill.

Click here to visit **bupa.com.au/find-a-provider** to check whether or not your current provider has an agreement with Bupa, or find a Members First provider to visit.

Members First providers

We have agreements with a network of dentists, chiropractors, podiatrists, physiotherapists and optical stores across Australia. We call them our 'Members First' providers.

There are great advantages in visiting a Members First provider:

- You can usually expect to claim more money back than if you go to a provider who doesn't have an agreement with Bupa.
- **Members First Platinum Network**
  Members First Platinum is intended to make common preventative dental treatment available, without any out-of-pocket costs, to eligible members.

  At a Members First Platinum dentist, if you've got Hospital and Extras cover with us, you may be eligible to pay nothing for your regular dental check-up, including consults and dental exams, scale and cleans, bitewing x-rays, mouthguards, and flouride treatments. Plus, you'll get all the benefits of Members First on most other dental services.

  Find out more at **bupa.com.au/members-platinum**
- You'll know how much you can claim and how much you'll be out-of-pocket. Depending on your cover, you'll get from 60% up to 100% of the cost back on most dental, physio, chiro and podiatry consultations, up to your yearly limits. Plus, you'll have access to the 'no gap' range of glasses and contact lenses.
- If your employer pays for your cover, you may be on a level of cover where you can be sure of the percentage you'll get back at any recognised provider. Check your policy information to see if this applies to you.
- If you have kids, depending on your cover, they may be able to access special 'gap free' arrangements where the costs of most services at dentists, chiropractors, physiotherapists and podiatrist consultations will be fully covered, up to your yearly limits. Plus, your kids will have access to the 'no gap' range of glasses and contact lenses.

Note: Some of these benefits depend on your level of Extras cover. Yearly limits, waiting periods and our Fund Rules apply.

Making a claim is really simple, too. At these providers you can usually make your claim on the spot by swiping your Bupa card. You'll know instantly if there's anything extra for you to pay.

Read our Fund Rules

Extras waiting periods

When you first take out or upgrade your health cover there's a period of time before you can make a claim on your new level of cover. This is common across the health insurance industry.

You can't claim for services that you receive during this period at your new level of cover, even if you wait to submit the claim once the period is over.

Service or treatment	Waiting period
Hire and repair of health aids and appliances	6 months
Health Management programs	6 months
Major dental	12 months
Orthodontics	12 months
Purchase of health aids and appliances	12 months
All other Extras services	2 months

You can make claims for services you received up to two years in the past.

Claiming for Extras

You can make a claim for a treatment or service provided in Australia if it's covered by your policy and the provider is recognised by Bupa. For example, you might purchase a pair of glasses, but we might not recognise the provider, so you'll not be able to make a claim. Extras providers must meet certain requirements to be recognised by Bupa – we do this because we are focused on the health and care of our members.

Before you book a treatment or buy a health appliance, it's a good idea to check with us. We can confirm that we recognise the provider and what your cover includes.

Knowing your claim limits

Claim limits are the maximum dollar amounts that we'll pay for specific treatments and services. This is common for most types of insurance. Other health insurers might set the same or different limits to us.

If you move between health funds, your use of limits usually moves with you. For example, most funds have a lifetime limit on orthodontics, so if you have claimed your lifetime limit at your old fund, Bupa would recognise this and you wouldn't be able to make a further claim.

Here are some of the most common limits that might apply to your policy:

Yearly limit

This is the maximum amount you can claim for a service from 1 January to 31 December. If you haven't claimed up to your yearly limit, this doesn't 'roll over' to the next year – it resets on 1 January.

Sub limit

This is like a limit within a limit. It applies to a very specific service, per person, per year. For example, if you have Your Choice Extras, there's a yearly limit of $500 in the first year for natural therapies. A sub limit applies to remedial massages of $100 per person, so once you have reached that limit for remedial massages, you can no longer claim for remedial massages that year. However, you could make up to $400 more in claims for other permitted natural therapies, like acupuncture.

Service limit

For some types of Extras services, there are limits to the number of times that benefits are payable for the same service. For example, you can only claim a scale and clean from your dentist once every six months. These limits apply from the date you receive the service, not from the time you submit the claim.

You can find information about limits in your policy information **here.**

Person limit

This is the maximum amount that each person covered by your Bupa membership can claim in a calendar year. If you're on a policy with a family member, then you'll have your own individual limits.

Membership limit

This is the maximum amount that can be claimed collectively, by everyone covered by your membership within the calendar year, for a specific type of Extras service. Remember, these limits apply in addition to your individual per person limits. Also, the membership limit might not be high enough for all your family members to claim their individual limits. For example, you may have a person limit of $500 for chiropractic services, but a membership limit of $1,000. This could be used by two family members even if you have four people listed on your policy.

Lifetime limit

Health insurers usually have a lifetime limit for orthodontics. This applies to an individual. If you have reached this limit, you can't make any further claims for this at Bupa again. It doesn't reset, even if you leave Bupa and start your cover again with us.

Restrictions on making claims

You need to have served any waiting periods that apply. If you're new to Bupa and Extras cover, it's good to be on top of what waiting periods apply to you and when they will end.

1. You can't claim twice

If you've made a claim with Medicare or another insurance policy, such as Work Cover or travel insurance, then you can't claim the cost under your Extras cover. There are some exceptions, such as hearing aids and breast prostheses, so check with us if you're not sure.

2. You can't claim for multiple services of the same kind from the same provider on the same day

This rule only applies to therapy services. For example, if you went to see an acupuncturist and then received a massage from the same provider on the same day, you can't claim for both services as they are both 'natural therapy' treatments. However, if we recognised that provider as both an acupuncturist and a chiropractor and they provided you with acupuncture and a chiropractic treatment on the same day, then we would recognise both treatments, as they are different types of services.

3. We have rules around claiming for dental services

We have rules about what you can claim, based on usual clinical practice. It means that specific services may have a limit to the number of times they can be claimed within a certain time frame. For example, we generally only pay for a dental check-up claim every six months. If you're not sure if you're covered for a service, or if your dental condition means you need treatment outside these rules, please give us a call.

Special types of Extras services

Health aids and appliances

These are items that help you return to a normal lifestyle, help to recover from (or prevent further) injury or improve a health condition.

If you need to make a claim for these:

- You may need a referral letter from your doctor or specialist to explain the medical need for your item.
- The provider or manufacturer of the item must be recognised by Bupa.
- Items such as orthotics or surgical shoes need to be custom-made to fit you, and not be an 'off-the-shelf' product that is just altered for you.

For these reasons, you can't make a claim for health aids or appliances purchased overseas or online.

You cannot claim benefits for hire and repair of health aids and appliances within 12 months of purchasing the item, within 12 months of a repair, or on items where hire and repair are deemed inappropriate. We will not pay for replacements or new models of aids or appliances that function correctly or are still under warranty. If a faulty or defective aid or appliance is under warranty you may contact the manufacturer for it to be repaired or replaced (subject to the terms of the warranty).

You can make a claim by completing a form and submitting it in store or by mail.

Some of these requirements apply to just some types of health aids and appliances, but not to all. If you're thinking of claiming for an item, ask us before you purchase so you know where you stand.

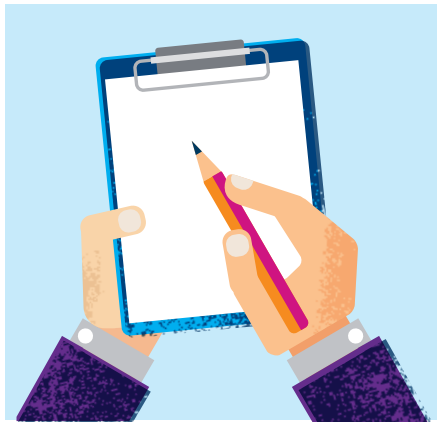
Pharmacy

Many types of Extras cover include cover for pharmacy. This is medication that you buy yourself, or that is provided to you by a hospital but is unopened.

Pharmaceuticals must be approved by the Therapeutic Goods Administration (TGA) and not appear on our exclusion list.

To make a claim for your medication you'll need an official pharmacy receipt with the following information:

- Drug name.
- Date dispensed (or its supply date).
- Strength.
- Quantity.
- Confirmation the medication was not subsidised by the Australian Government's Pharmaceutical Benefits Scheme (PBS).
- Pharmacist's name, address and prescription number.
- Customer's name and address.



We don't cover:

- Over-the-counter or non-prescription pharmacy items.
- Compounded medications, which are mixed from the individual ingredients to the strength and dosage required for an individual.
- Body-enhancing medication (e.g. anabolic steroids).
- Weight loss medication.
- Medication provided by a hospital that isn't intrinsic to your care.

If you're not sure, contact us.

You can make a claim by completing a form and submitting it in store or by mail.

The amount Bupa will pay for medication will depend on your level of cover, and we only cover the amount of the medication cost that exceeds the PBS co-payment, which is an amount set by the Australian Government. As of January 2019, this amount was $40.30. This means if the cost of the drug is less than $40.30, you can't make a claim.

Health Management

Depending on your Extras cover, you might be able to claim some of the cost of health-related programs. We call this Health Management.

- Nicotine replacement therapy
- Weight management programs at Bupa recognised providers.
- Health subscriptions to Diabetes Australia and the Asthma Foundation.

There are specific requirements before you can start making a claim for any of these programs. For more information, visit bupa.com.au/health-management, or call us.

Health-related travel and accommodation

We can help cover the cost of your travel when essential medical or hospital treatment can't be provided nearby. This depends on your level of Extras cover, and whether or not the total return distance is 200 kilometres or more from where you live. We also pay some of your overnight accommodation costs outside of hospital for you and a caregiver.

Check your Extras policy information to determine if you are covered for this. You can claim by completing a form and submitting it in store or by mail.

Making an Extras claim

Claiming on the spot with your Bupa card

Electronic claiming is the fastest way to make your health insurance claims

Recognised dentists, physiotherapists, chiropractors, podiatrists, remedial massage therapists, acupuncturists and optical outlets around Australia provide this service. After your treatment, swipe your Bupa card and the claim will be processed automatically. There are no forms for you to complete and you'll only pay the balance of the account.

Claiming online with myBupa

Log on to **myBupa** and enter the details found on your receipt via the 'make a claim' section. We'll transfer the payment directly to your bank account, so have your BSB and account number ready.

You can't claim online for ambulance, health aids and appliances, orthodontics, travel and accommodation, pharmacy or medical services.

Claiming by post

Claim forms are available to print from our website or you can pick one up in a Bupa store. Fill out a claim form, attach your invoice and receipt and post to:

Bupa
Reply Paid 990
Adelaide SA 5001

If you haven't provided your bank details on the claim form, then we'll post a cheque directly to you.

Health cover and accidental injuries

Waiting periods and accidents

Accidents are just that – accidents. That's why, if you have an accident shortly after you've joined Bupa or upgraded your cover, we'll waive any waiting period. What costs we cover depends on what's included in your policy, as shown in the example below.

What do I need to do if I have an accident?

We'll waive the waiting period for any treatment you need because of an accident, if you:

- Get medical advice or treatment from a registered medical practitioner within 72 hours of the accident.
- Submit an 'Accident Injury Report Form' (available **here**).
- Continue to hold a policy which covers the accident-related treatment.
- Have all the treatment you need within 180 days of the accident.

Here's an example

Say you recently joined Bupa, or upgraded your cover, and your new policy covers hip replacements. If you fell and needed a hip replacement, we'd waive the waiting period and you'd be covered for the surgery.

Hip replacement cover	Waiting period waived?	Covered?
Included	Yes	Yes
None	N/A	No

We consider something an accident if:

- It was unforeseen and occurred by chance.
- It happened because of an external force, but wasn't intentional.
- It happened in Australia.

What's not considered an accident?

- A sudden illness.
- Surgical procedures.
- Injuries due to alcohol or drug use, or drugs not prescribed by a registered practitioner.
- Pregnancy.
- Aggravation of an existing condition.
- Damage to teeth caused by eating.

Accident Inclusion means upgraded cover

We understand that no one sees an accident coming, so you might not have thought to include some things on your cover. That's why, on some policies, we'll cover you in a private hospital for treatments that are excluded or restricted on your cover if you need them because of an accident. We call this Accident Inclusion. Check your policy information to see if this is included in your cover.

Utilising our 'Accident Benefit'

On some covers, our Accident Benefit can help reduce the costs you pay in hospital, and on extras services in the case of an accident (up to a limit). How the limits apply varies between products, so check your policy information.

If you've had an accident, you can use your Accident Benefit:

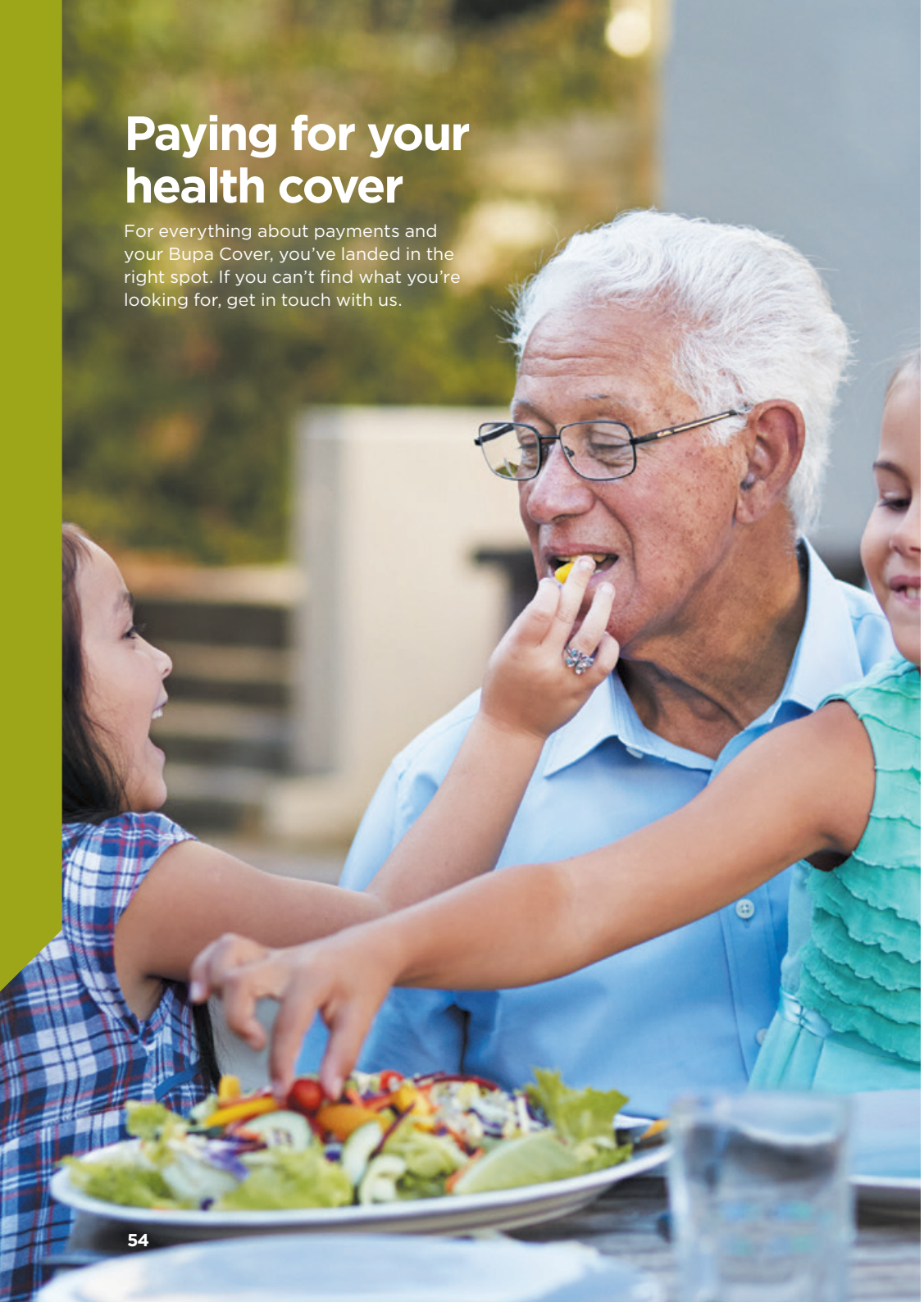
In hospital

to claim back your excess or co-payment if you are admitted for related treatment.

On Extras

that will aid your recovery – even if you've already reached your limit.

Check your policy information to see if this is included in your cover.



Paying for your health cover

For everything about payments and your Bupa Cover, you've landed in the right spot. If you can't find what you're looking for, get in touch with us.

Community rating

Private health insurance is 'community rated', which means that every Australian resident can buy the same health cover at the same price, regardless of their age, gender, ethnicity or medical condition. This is different from other types of insurance such as life or disability insurance, which are 'risk rated'.

Under these rules, no health fund can refuse to insure you or deny you buying a health insurance policy based on your health or how likely you are to make a claim. This means that health funds can't charge some people more than other people.

The only exceptions to this are:

- Due to different health care costs, insurance premiums can vary between different States and Territories.
- If you are aged 18-29 years of age from 1 April 2019, you'll be eligible for an up to 10 per cent Age-Based Discount on Hospital Cover. This is due to the Australian Government Private Health Insurance reforms. Bupa will offer this across all our Hospital covers. Other insurers may not offer this. This is is to encourage greater participation, to help ease the pressure on health insurance premiums.
- The Australian Government's Lifetime Health Cover (LHC) initiative means that the price of hospital cover may be higher for people who didn't take out Hospital cover earlier in life.
- Depending on your income, the Australian Government may contribute to the cost of your health cover through a rebate. If you're eligible, it may decrease the cost of your premium. Find out more on **page 58**.

Why your premium goes up every year

With the increasing cost of medical technology, healthcare delivery and Australia's ageing population, the cost of paying for customers' treatments is rising. This is why health insurers consider changes to the price of health insurance.

However, the health insurance industry in Australia is regulated and health funds aren't able to simply change their prices whenever they wish. Health insurance premiums can only change once a year, with Federal Government approval.

Health insurers go through a pricing review process where they submit a proposal to the Australian Government along with a justification for any new prices. We contact you directly to explain the change, and we only do it with Federal Government approval.

Late and overdue payments

If your health insurance premiums are late or overdue, you'll be affected if you try to make a claim after the date that your membership is paid to.

- When your payments are overdue by less than two months, we'll accept any outstanding payments and you'll be able to claim as usual once the arrears have been paid.
- When you're overdue for more than two months, it's at our discretion whether or not to accept payment and allow your membership to continue.

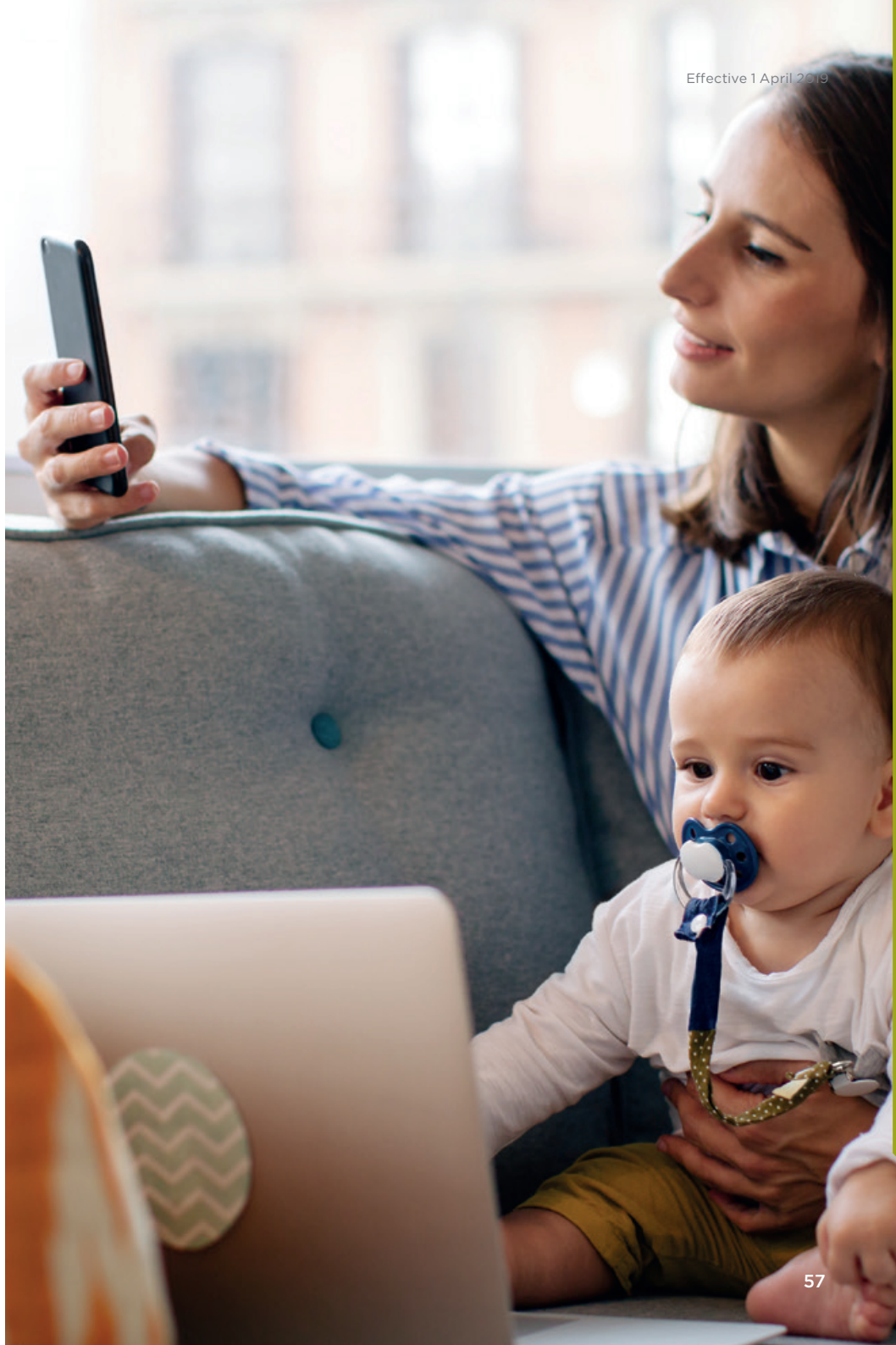
If your payments are late or overdue for a period of more than two months, you might need to take out a new policy and re-serve your waiting periods.

Depending on how long the gap in your policy is you may be charged:

- the additional Medicare Levy Surcharge (MLS) as part of your tax return, in addition to the Medicare Levy; or,
- more for your cover through Lifetime Health Cover Loading.

For more on these Government considerations, see **page 58**.

If you're struggling to make your payments, please contact us to discuss your situation.



Government policies and tax considerations

Lifetime Health Cover (LHC)

Lifetime Health Cover (LHC) is an Australian Government initiative to encourage Australian residents with full access to Medicare to take out Hospital cover earlier in life and to keep it.

If you don't have hospital cover before 1 July following your 31st birthday, you'll pay an additional 2% on your Hospital cover premium every year you delay – up to a maximum of 70%. This extra cost will remain in place until you've had appropriate private hospital cover for 10 continuous years.

To avoid the LHC loading you'll need to take out Hospital cover by 30 June following your 31st birthday and maintain your cover.

After you take out cover, your LHC loading won't be affected if there are short gaps in your cover (for example, if you switch health insurers). You just need to make sure those gaps don't add up to be more than 1,094 days (3 years minus a day) or the loading will apply. These are known as 'permitted days without cover'.

Government rebate

Depending on your age and income, the Australian Government contributes an amount (known as a 'rebate') towards the cost of your private health insurance premium. If you're eligible, it may reduce the cost of your yearly premium.

You can choose to receive the rebate as a reduction to your premium to lower your upfront costs, or it can be calculated when you lodge your tax return.

The rebate percentages change yearly from 1 April. The Australian Government announced that, from 1 April 2014 and every year thereafter, the rebate will be linked to the Consumer Price Index (CPI) growth or the industry average health insurance premium increase, whichever is less.

Age-Based Discount

If you're aged 18–29, you'll be eligible for up to 10 per cent off your hospital insurance premiums. This reform is optional for insurers, but all existing and new Bupa members in the age bracket will receive the discount from 1 April 2019. The discount will apply to your hospital cover until you turn 41. From 41 years of age, the discount will reduce by 2% each year until It reaches 0%.

If your cover entitles you to the Australian Government rebate on private health insurance, you'll receive a tax statement from Bupa each year along with a document called a Summary of Cover. Your Summary of Cover will show how much loading each person on the membership is paying, and is stored in myBupa for up to 7 years. Be sure to check that your LHC loading is correct.

Medicare Levy Surcharge

To have access to Australia's public health insurance system (Medicare), most Australian residents pay a Medicare Levy of 2% of their taxable income. Non-Australian residents generally don't pay the Medicare Levy as they don't access Medicare benefits.

If you're single and earn over $90,000 per annum, or a couple/family and earn over $180,000 per annum and don't have appropriate hospital cover for you and all your dependants over the whole year, you may be charged the additional Medicare Levy Surcharge (MLS) as part of your tax return, in addition to the Medicare Levy.

You could choose to pay the Medicare Levy Surcharge as part of your tax return.

An example comparison

No Private Health Cover

You pay

$970

to cover the Medicare Levy Surcharge

You get nothing more

Bupa Hospital and Extras cover

You pay

$1146.95*

per year

You get

- Peace of mind
- Cover for some common hospital procedures
- Private hospital room, where available
- $1,000 to spend on a range of extras
- Much more

*Based on Active Saver Hospital and Extras cover from 1 April 2019 $1,146.95 yearly. For singles with an adjusted taxable income of $90,001-$105,000 p.a. under the age of 65, with a 16.706% rebate in NSW. Assumes no LHC loading. Includes $100 co-payment per day, capped at $500 per hospital stay.

Can you avoid paying the MLS?

Check the table below to see if you are liable to pay the MLS and the amount it would be if you didn't have private hospital cover.

	Singles	Families	Medicare Levy Surcharge rate
Standard	Up to $90,000	Up to $180,000#	0%
Tier 1	$90,001 - $105,000	$180,001 - $210,000#	1%
Tier 2	$105,001 - $140,000	$210,001 - 280,000#	1.25%
Tier 3	More than $140,001	More than 280,000#	1.5%

Current rebate percentages are effective for payments made from 1 April 2019 and are indexed annually.
#The income thresholds will remain the same from 1 July 2015 until 30 June 2021. On a family or single-parent membership, income thresholds increase by $1,500 per child after the first. The family thresholds also apply to single parent families and de facto couples. For more information go to ato.gov.au.

Things to note

Fund Rules

Everything we do is governed by our Fund Rules. These are available **here.**

Privacy and personal data

Your privacy is important to us. This statement summarises how we handle your personal information. For full information about our information handling practices, please refer to our Information Handling Policy (available **here**). When you join Bupa, you agree to the handling of your personal information as set out in this document.

Information Policy

We'll only collect personal information that we require to provide, manage and administer our products and services and to operate an efficient and sustainable business.

We are required to collect certain information from you to comply with the Private Health Insurance Act 2007 (Cth). We may also collect information about you from health service providers for the purposes of administering or verifying any claim, and from your employer, broker or agent if you are on a corporate health plan or have joined through a broker or agent. We may disclose your personal information to our related entities, and to third parties including healthcare providers, Government and regulatory bodies, other private health insurers, and any persons or entities engaged by us or acting on our behalf. If we send your information outside of Australia, we will require that the recipient of the information complies with privacy laws and contractual obligations to maintain the security of the data. If you are on a corporate health plan, we may disclose your information to your employer to verify your eligibility to be on that corporate plan.

The policy holder is responsible for ensuring that each person on their policy is aware that we handle their personal information as set out here and in our Information Handling Policy. Each person on a policy aged 15 or over may complete a 'Keeping your personal information confidential' form to specify who should receive information about their health claims. You are entitled to reasonable access to your personal information within a reasonable time frame. We reserve the right to charge a fee for collating such information. If you or any insured person does not consent to the way we handle personal information, or doesn't provide us with the information we require, we may be unable to provide you with our products and services.

We may use your personal (including health) information to contact you to advise you of health management programs, products and services. When you take out cover with us, you consent to us using your personal information to contact you (by phone, email, SMS or post) about products and services that may be of interest to you. If you do not wish to receive this information, you may opt out by contacting us.

Health cover and overseas travel

When you travel overseas you're not covered by your private health cover or Medicare. To provide assistance to Australian residents travelling abroad, the Australian Government has signed Reciprocal Health Care Agreements with a number of countries.

These agreements offer Australian residents assistance with the cost of medically necessary treatment while travelling in:


Belgium


Finland


Ireland


Italy


Malta


New Zealand


Norway


The Netherlands


Slovenia


Sweden


United Kingdom

These agreements aren't a substitute for travel insurance. Even if you're travelling to a Reciprocal Health Care Agreement country, travel insurance with cover for medical treatment is still important to have.

Suspending your membership when you go overseas

Suspending your membership means that you won't be covered for any service or treatment for the duration of your suspension.

If you're travelling outside of Australia for any reason, you can suspend your membership:

- For a minimum of two months.
- For a maximum of two years at a time.
- If you re-suspend a two-year suspension, you can only do this up to a maximum of six years.
- Up to two suspensions per calendar year.
- At least one month of active, paid cover must occur between each suspension period.

To be eligible for a suspension, you must:

- Have held your cover for at least twelve months.
- Be up to date in your payments at the time you want to suspend (to at least one day after the date you want the suspension to kick in).
- Apply for a suspension before you want the suspension period to begin (we can't do it retrospectively).
- Notify us via phone, email or letter.
- Notify us of your return to Australia within 30 days of arriving.

You can change your recommencement date, as long as you notify us in advance.

If your suspension period is less than four months, your direct debit arrangement will continue when your policy resumes.

If your period of suspension is more than four months, you need to notify Bupa if you would like your direct debit payment arrangements to start again – otherwise you will receive a renewal notice requesting membership payment.

Things to consider

If we don't hear from you and you don't resume your cover within 30 days of when you return, the policy will be reinstated and ultimately cancelled if no premiums are received.

If you return from suspension within two years and you've made a payment on your membership, your new premium won't incur the Lifetime Health Cover (LHC) loading. After you resume your membership, any period for which it is not paid will be classed as absent days, so it's important to keep your membership active.

While you're on suspension you'll be considered as not holding an appropriate level of Hospital cover. At the end of the financial year, if your income is likely to be subjected to means testing for the Medicare Levy Surcharge (MLS) as part of your tax return, you may need to pay the surcharge in addition to the Medicare Levy, for the period of your suspension. For more information, speak to your tax advisor.

Complaints and feedback

If you have any concerns, or you don't understand a decision we've made, we'd like to hear from you. To find out how to contact us, or to understand how we'll manage your complaint, you can read our full complaints and feedback process **online.**

The Private Health Insurance Code of Conduct

Private Healthcare Australia's Code of Conduct (the Code) was developed by the private health insurance industry. It aims to enhance industry standards of practice and service. As a signatory to the Code, we undertake to do a number of things that will benefit you as a member. These include:

- Working to enhance our service standards.
- Providing information to you in plain language.
- Helping you make better informed decisions about our products.
- Letting you know how to resolve any concerns that you may have.
- Protecting the privacy of your information in line with the privacy legislation and our Information Handling Policy.

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

Read the Private Health Insurance Code of Conduct

Find out more about Australia's healthcare system

Bupa health cover made easy

Unsure of any words? Visit: **bupa.com.au/glossary**

Go to **bupa.com.au/fundrules** to see our fund rules.

To find out more about what the Australian Government Rebate on private health insurance means for you, visit: **bupa.com.au/rebate**

For more information


134 135


bupa.com.au


Visit a Bupa store

Bupa
PO Box 14639
Melbourne VIC 8001

Bupa HI Pty Ltd
ABN 81 000 057 590

Effective 1 April 2019
1880-04-19

HSBC Residents Corporate Health Plan

The below premiums include the Base Tier 25.059% Australian Government Rebate on private health insurance which applies to individuals aged under 65.

25.059% REBATE HOSPITAL COVER	SINGLE	COUPLE/FAMILY
	YEARLY	YEARLY
NSW: Corporate Hospital Cover Level 2	$1,549.89	$3,099.83
NT: Corporate Hospital Cover Level 2	$979.29	$1,958.63
QLD: Corporate Hospital Cover Level 2	$1,759.54	$3,519.12
SA: Corporate Hospital Cover Level 2	$1,645.41	$3,290.86
TAS: Corporate Hospital Cover Level 2	$1,735.02	$3,470.09
VIC: Corporate Hospital Cover Level 2	$1,896.06	$3,792.16
WA: Corporate Hospital Cover Level 2	$1,412.13	$2,824.25
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$1,276.02	$2,552.04

The below premiums do not include an Australian Government Rebate.

0% REBATE HOSPITAL COVER	SINGLE	COUPLE/FAMILY
	YEARLY	YEARLY
NSW: Corporate Hospital Cover Level 2	$2,068.19	$4,136.38
NT: Corporate Hospital Cover Level 2	$1,306.79	$2,613.58
QLD: Corporate Hospital Cover Level 2	$2,347.94	$4,695.87
SA: Corporate Hospital Cover Level 2	$2,195.66	$4,391.31
TAS: Corporate Hospital Cover Level 2	$2,315.22	$4,630.44
VIC: Corporate Hospital Cover Level 2	$2,530.11	$5,060.21
WA: Corporate Hospital Cover Level 2	$1,884.33	$3,768.65
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$1,702.72	$3,405.44

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

The above annual premiums have been calculated with a 6% discount & 2018 Rates. The premiums reflected do not take into account the HSBC employer subsidy towards the cost of your private health insurance. Contact Payroll for details of premiums applicable to you.

FOR MORE INFORMATION

Call us on 134 135

Visit bupa.com.au

Drop by your local Bupa centre

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

HSBC Residents Corporate Health Plan

The below premiums include the Base Tier 25.059% Australian Government Rebate on private health insurance which applies to individuals aged under 65.

25.059% REBATE HOSPITAL COVER	SINGLE PARENT	FAMILY PLUS
	YEARLY	YEARLY
NSW: Corporate Hospital Cover Level 2	$2,619.26	$4,032.21
NT: Corporate Hospital Cover Level 2	$1,738.44	$2,459.06
QLD: Corporate Hospital Cover Level 2	$2,945.11	$4,581.25
SA: Corporate Hospital Cover Level 2	$2,715.60	$4,198.32
TAS: Corporate Hospital Cover Level 2	$2,869.04	$4,502.65
VIC: Corporate Hospital Cover Level 2	$3,178.02	$4,816.28
WA: Corporate Hospital Cover Level 2	$2,336.91	$3,668.72
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$2,552.04	$3,527.55

The below premiums do not include an Australian Government Rebate.

0% REBATE HOSPITAL COVER	SINGLE PARENT	FAMILY PLUS
	YEARLY	YEARLY
NSW: Corporate Hospital Cover Level 2	$3,495.11	$5,380.56
NT: Corporate Hospital Cover Level 2	$2,319.74	$3,281.36
QLD: Corporate Hospital Cover Level 2	$3,929.96	$6,113.20
SA: Corporate Hospital Cover Level 2	$3,623.70	$5,602.22
TAS: Corporate Hospital Cover Level 2	$3,828.44	$6,008.30
VIC: Corporate Hospital Cover Level 2	$4,240.72	$6,426.78
WA: Corporate Hospital Cover Level 2	$3,118.36	$4,895.52
EXTRAS COVER		
NATIONAL: Corporate 90 Extras	$3,405.44	$4,707.15

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

The above annual premiums have been calculated with a 6% discount & 2018 Rates. The premiums reflected do not take into account the HSBC employer subsidy towards the cost of your private health insurance. Contact Payroll for details of premiums applicable to you.

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

HSBC Residents Corporate Health Plan

The below premiums include the Base Tier 25.059% Australian Government Rebate on private health insurance which applies to individuals aged under 65.

25.059% REBATE HOSPITAL COVER	SINGLE PARENT PLUS YEARLY
NSW: Corporate Hospital Cover Level 2	$3,548.28
NT: Corporate Hospital Cover Level 2	$2,303.09
QLD: Corporate Hospital Cover Level 2	$3,900.76
SA: Corporate Hospital Cover Level 2	$3,689.46
TAS: Corporate Hospital Cover Level 2	$3,953.61
VIC: Corporate Hospital Cover Level 2	$4,192.42
WA: Corporate Hospital Cover Level 2	$3,121.81
EXTRAS COVER	
NATIONAL: Corporate 90 Extras	$3,527.55

The below premiums do not include an Australian Government Rebate.

0% REBATE HOSPITAL COVER	SINGLE PARENT PLUS YEARLY
NSW: Corporate Hospital Cover Level 2	$4,734.78
NT: Corporate Hospital Cover Level 2	$3,073.24
QLD: Corporate Hospital Cover Level 2	$5,205.16
SA: Corporate Hospital Cover Level 2	$4,923.16
TAS: Corporate Hospital Cover Level 2	$5,275.66
VIC: Corporate Hospital Cover Level 2	$5,594.32
WA: Corporate Hospital Cover Level 2	$4,165.71
EXTRAS COVER	
NATIONAL: Corporate 90 Extras	$4,707.15

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

The above annual premiums have been calculated with a 6% discount & 2018 Rates. The premiums reflected do not take into account the HSBC employer subsidy towards the cost of your private health insurance. Contact Payroll for details of premiums applicable to you.

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