Important Information Guide

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

You should refer to our Fund Rules, available online at **bupa.com.au/fundrules** or by calling us, for the full terms and conditions of your cover. The information below applies in addition to our Fund Rules.

Understanding your hospital cover

What is covered?

Hospital costs

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

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

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

At our Members First hospitals, you'll receive a private room if a private room is available. If a private room is not available, you'll receive $50 back per night from the hospital. Please note that the following conditions apply: You must book and request a private room in a Members First hospital at least 24 hours before admission. It applies to overnight admissions only. It excludes 'nursing home type patients', admissions via an Emergency Department, same day admissions or where a private room is medically inappropriate (e.g. medical practitioner requires the patient to an Intensive Care Unit or other particular ward rather than a private room). You'll also get a free daily newspaper and free local calls.

If you are treated in a Members First Day facility, there are no out-of-pocket expenses for medical services (e.g. your specialist's fees). Any co-payment or excess related to your level of cover will still apply. (Not available in NT).

At Member's First Day Hospitals, you have the added benefit of no medical gaps on addition to being covered for hospital costs, provided the treatment is recognised by Medicare and is included in your level of cover.

A small number of network hospitals may charge a fixed daily fee. This fee is capped at a maximum number of days for overnight stays. The hospital should inform you of this fee when you make a booking. This fee is in addition to any excess or co-payment you may have as part of your hospital cover. (This fee does not apply if you are on Ultimate Health Cover).

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

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

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

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

If you elect to be treated as a private patient in a public hospital or are admitted to a private hospital that Bupa does not have an agreement with, you are covered as set out below for any treatment recognised by Medicare unless it is excluded or restricted under your cover.

In these circumstances, you are likely to incur large out-of-pocket expenses for your hospital costs.

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

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

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

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

As a private patient in a public hospital you are entitled to choose your doctor, if they are available. However, it is important to understand that you may still be subject to public hospital waiting lists.

Depending on your illness or condition, this may be the same doctor who would have been allocated to you by the hospital as a public patient. Additionally, whether a doctor provides treatment at a public hospital, or performs a particular procedure in a public hospital, is outside of Bupa's control.

If you elect to be treated as a private patient in a public hospital, we will pay minimum benefits for shared room accommodation as set by the Australian Government. Depending on your level of cover, if you choose to stay in a private room, Bupa may pay an additional fixed benefit towards the cost of your stay. If this benefit is less than the hospital charge, the hospital should let you know what out-of-pocket expenses you will have to pay. Bupa also pays benefits for prostheses up to the benefit in the Government Prostheses List.

The above applies for any treatment recognised by Medicare unless it is excluded or restricted under your cover. It is important to note that in public hospitals, private rooms are generally allocated to people who medically need them.

As a private patient in a public hospital you will also be responsible for personal expenses such as TV hire and telephone

calls together with any Medical Gaps your doctor/surgeon charges above the Medicare Benefits Schedule (MBS) fee and prostheses charges above the approved benefit in the Government Prostheses List.

Medical costs

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

How benefit is calculated

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

Bupa Medical Gap Scheme

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

No Gap

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

Known Gap

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

Without the Gap Scheme

If you are treated as a private patient in hospital by a Medical Provider who does not use the Bupa Medical Gap Scheme, Medicare will cover you for 75% of the MBS fee for associated medical costs and we will cover the remaining 25%. Any charges above this are your responsibility.

Your choice of network

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

What is not covered?

Hospital costs

Situations when you will not be covered include:

- when you have not been admitted into a hospital and are treated as an outpatient (e.g. emergency room treatment, outpatient ante-natal consultations with an obstetrician)
- during a waiting period See page 10 for more information
- when a service is excluded from your cover
- when a service is identified as a minimum benefit service and you are admitted to a public or private hospital, you will not be covered above the minimum benefits for shared room accommodation as set by the Australian Government
- for the fixed fee charged by a fixed fee Network hospital or a Network hospital that has a fixed fee service
- for psychiatric and rehabilitation day programs, at a hospital Bupa does not have an agreement with
- hospital treatment provided by a practitioner not authorised by a hospital to provide that treatment
- hospital treatment for which Medicare pays no benefit, including: medical costs related to surgical podiatry (including the fees charged by the podiatrist); cosmetic surgery where it's not clinically necessary; respite care; experimental treatment and/or any treatment/procedure not approved by the Medical Services Advisory Committee (MSAC)
- personal expenses such as: pay TV, internet access, non-local phone calls,

newspapers, boarder fees, meals ordered for your visitors, hairdressing and any other personal expenses charged to you unless included in your cover

- if you are in hospital for more than 35 days and you have been classified as a 'nursing home type' patient. (In this situation you may receive limited benefits and be required to make a personal contribution towards the cost of your care)
- if you choose to use your own allied health provider rather than the hospital's practitioner for services that form part of your in-hospital treatment (e.g. chiropractors, dieticians or psychologists)
- where compensation, damages or benefits may be claimed by another source (e.g. workers compensation)
- for any amount charged by a public or non-agreement hospital which is not covered by us or which is above the benefit that we pay
- for any treatment or service provided outside Australia
- for some non-PBS, high cost drugs
- for pharmacy items not opened at the point of leaving the hospital.

What is not covered?

Medical costs

You will not be covered for medical costs services for:

- cosmetic surgery that is not clinically necessary
- where compensation, damages or benefits may be claimed by another source (e.g. workers compensation)
- for any treatment or service provided outside Australia when you have not been admitted into a hospital and are treated as an outpatient (e.g. emergency room treatment, outpatient ante-natal consultations with an obstetrician)
- during a waiting period
- when a service is excluded from your cover
- medical services for surgical procedures performed by a dentist, podiatrist, or any other practitioner or service that is not eligible for a rebate through Medicare.

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

Waiting periods

The following waiting periods apply for hospital cover:

- palliative care, psychiatric and rehabilitation services – two months
- pre-existing conditions, ailments or illnesses – 12 months See page 9 for more information
- pregnancy (including childbirth) – 12 months
- Laser Eye Correction Surgery that is not due to a pre-existing condition (Ultimate Health Cover & Corporate Ultimate Health Cover only) – 2 months
- Laser Eye Correction Surgery that is due to a pre-existing condition (Ultimate & Corporate Ultimate Health Cover only) – 12 months
- all other treatments included in your cover other than accidents – two months.

When to contact us

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

Planning for a baby

If you are thinking about starting a family we recommend that you contact us to

check whether your current level of cover includes pregnancy in advance. This is because a 12-month waiting period applies to pregnancy (including childbirth).

No waiting periods will apply to the newborn provided they have been added to the appropriate family hospital cover within 60 days of their birth.

Assisted reproductive services

Generally the circumstances in which assisted reproductive services are required are due to an underlying pre-existing condition. Therefore, in most instances, a 12 month pre-existing waiting period applies before you can receive benefits for these services.

Understanding your Extras Cover

What is covered?

With extras cover, you can claim benefits for those services that may not be covered by Medicare. You can claim for those services listed on your cover as long as those benefits are not claimable from a third party.

For example, Medicare may not provide benefits for:

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

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

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

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

What is not covered?

Extras benefits will not be payable:

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

Waiting periods

The following waiting periods apply for extras cover:

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

Understanding your Ambulance Cover

Emergency Ambulance definition

When you, your partner or your family take out our hospital cover, extras cover or packaged cover, you will receive capped cover for recognised emergency ambulance transport and on the spot treatment from a recognised provider.

An emergency is when there is reason to believe that the patient's life may be in

danger or the patient should be attended to without undue delay.

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

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

Benefits are not payable for:

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

Ambulance Cover

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

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

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

QLD and TAS members: If you reside in Queensland or Tasmania, you are covered under your state service scheme. This applies to services provided within your state of residence.

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

Interstate Ambulance Arrangements

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

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

Recognised Ambulance Providers

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

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

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

Changing your cover

Switching from another health fund

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

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

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

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

Changing your cover with us

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

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

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

Ending your membership

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

Definitions

Accidents

An unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or damage to the body, which occurred in Australia and requires within 72 hours of the event, medical advice or treatment from a registered practitioner other than the policy holder and, if necessary, any further medical treatment where such admission (including any readmission) or treatment must be within 180 days of the event.

Bupa Medical Gap Scheme

The Bupa Medical Gap Scheme is an arrangement Bupa has with many medical surgeons and specialists who operate in hospitals, to help minimise the amount you'll need to pay for your medical costs in hospital.

Calendar year

A calendar year is 1 January to 31 December.

Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing condition rule before your admission. Consequently, if you have been a Bupa member for less than 12 months you might have to pay for some or all of the hospital and medical charges if you are admitted to hospital and you choose to be treated as a private patient, and we later determine that your condition was pre-existing. We tell you more about pre-existing conditions on page 9.

Excess or co-payment

On selected covers there may be an excess or co-payment option which may lower the amount that you pay for your cover. Excesses or co-payments are only payable on overnight and same-day inpatient hospital admissions in any hospital.

- the total excess amount is paid each time a person on your membership is admitted into hospital, to a maximum of once per person and twice per membership each calendar year unless otherwise specified
- if the total excess amount for an individual is not reached in a single hospital admission, the remaining balance of that excess is payable in any subsequent hospital admission
- a co-payment is an amount you agree to pay towards the cost of your daily hospital bill. A co-payment is charged per day and capped after five days for each hospital admission
- no excess or co-payment applies to your children on certain hospital covers up to the age of 25. Please contact us for further details.

Exclusions

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

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

Family In-Hospital Benefit

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

Health aids and appliances

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

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

Living Well Programs

From 1 June 2017, this extras service is changing. Our Living Well Programs help cover health-related programs from approved, recognised providers. A Living Well Programs approval form must be completed for gym memberships, children's swimming programs (eligible products only), yoga and pilates to confirm that the program is medically necessary. Other benefit and recognition criteria apply. Visit **bupa.com.au/livingwell** or contact us to find out more.

Minimum Benefits

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

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

Out-of-pocket expenses

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

Pharmacy

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

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

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

Pharmacy in-hospital

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

Pre-existing conditions

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

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

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

Premium and benefits

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

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

- fully complete the application process and pay your premiums one month in advance
- ensure that newborns are enrolled onto a family membership within 60 days of their birth to avoid any waiting periods for your baby
- enrol your adult children under their own names within 60 days after they no longer qualify under your cover (to avoid re-serving waiting periods)

- provide proof of purchase of what you have spent before we can reimburse you for any services received
- submit your claims within two years of when the service was given (we don't pay benefits for any claims that are older than this).

Proof of identity and/or age

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

Surgically implanted prostheses

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

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

Suspension rules

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

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

To be eligible to suspend your cover you must:

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

Your membership will be cancelled if not resumed.

Travel and accommodation

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

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

Waiting periods

A waiting period is the time between the start date of your membership and when you are covered for a service or treatment. If you receive a service or treatment during a waiting period, you are not eligible to receive a benefit payment from us, regardless of when you submit the claim. Different waiting periods apply for different services. If you are switching your cover from a previous insurer, we will honour waiting periods previously served at an equivalent level of cover. See page 5 for more information.

Yearly limits and service limits

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

Other important information

Direct Debit Service Agreement

This agreement outlines the responsibilities of Bupa HI Pty Ltd ("we", "us", "our") and you with regard to direct debiting your nominated financial account for the payment of premiums. Direct debiting through the Bulk Electronic Clearing System (BECS) is not available on all financial accounts and you should contact your financial institution to confirm if your account is eligible or for help in completing this agreement. We will confirm the direct debit arrangements prior to the first drawing (including the premium amount and frequency) and debit your nominated account. Deductions will occur on the nominated day, except for deductions nominated for the 28th, 29th, 30th or 31st, which will occur on the first day of the following month. If the nominated day falls on a weekend or public holiday, deductions will be made on the closest business day. We will debit all payments in advance and will automatically vary the deduction amount if your premiums or level of cover change. If we vary the deduction amount, we will give you at least 14 days written notice, except when the previous deduction is dishonoured, when we may deduct the previous period's payment together with the current amount due. Should your financial institution dishonour a drawing, we may draw the payment plus any other overdue amounts 14 days from the date the last payment was due. If your financial institution dishonours this attempted drawing we may make another attempt to do so 14 days from the date of the first attempt. If, due to an account or debit card closure or other technical reasons, we are unable to attempt a second drawing or, in any other case, after two or more drawings are returned unpaid by your financial institution, we will stop deducting your premiums from your nominated account and will start sending you renewal notices, pending further instructions from you. We will maintain the privacy and confidentiality of your billing information (unless you have requested or consented that we can disclose it to a third party or the law requires or to do so).

We may provide information to our or your financial institution to resolve a dispute on your behalf. You must ensure your nominated account permits direct debiting and that sufficient cleared funds are available in that account on the due date to cover the premiums due. Your financial institution may charge a fee if the payment cannot be met. You must ensure the authorisation given to draw on the nominated account is identical to the account signing instruction held by the financial institution where the account is based. You must notify us if the nominated account is transferred or closed. You must pay your premium by an alternative method if either you or we cancel the direct debit arrangements. You must ensure your payments are up-to-date, whether a notice is received from us or not. If paying by credit card, you need to advise us of your new expiry date prior to expiry. You may request that we cancel or alter the debit drawing arrangements by contacting us and providing at least five working days' notice of any requested changes. These changes may include deferring the debit, altering the debit dates, stopping an individual debit, suspending the direct debit arrangement or cancelling the direct debit completely. You can dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than seven days before the next scheduled debit drawing or by notifying your financial institution. We may change the terms of this agreement by giving you at least 14 days written notice or such further period as required under the Bupa Fund Rules. If you have any queries about your direct debit agreement, please contact us. We undertake to respond to queries concerning disputed transactions within five working days of notification.

Privacy and your personal information

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

We will only collect personal information that we require to provide, manage and administer our products and services and to operate an efficient and sustainable business. We are required to collect certain information from you to comply with the *Private Health Insurance Act 2007* (Cth). We may also collect information

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

Can we help?

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

Resolution of problems

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

You can contact us by:

Telephone: 1800 802 386
Fax: 1300 662 081
Email: customerrelations@bupa.com.au
Mail: Customer Relations Manager
Bupa
GPO Box 9809
Brisbane QLD 4001

If you're not satisfied with the outcome from Bupa you may contact the Private Health Insurance Ombudsman on **1300 362 072** or visit them at **ombudsman.gov.au**

Private Health Insurance Code of Conduct

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

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

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

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

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

Bupa HI Pty Ltd
ABN 81 000 057 590

Effective 1 April 2017
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