

The background of the entire page is a photograph of a man and a woman smiling and looking at each other. The man is on the right, wearing a blue denim jacket over a white t-shirt and tan pants. The woman is on the left, wearing a plaid shirt and sunglasses. They are both smiling and appear to be outdoors in a sunny, open area.

Visitors Insurance

Your Important Information Guide

This guide is here to help you navigate our healthcare system and health cover. For further information on your overseas visitor's health insurance policy with us, please read your policy information.

Effective 15 January 2024

Welcome to Bupa

It's our purpose that makes us different – helping our members to live longer, healthier, happier lives. We focus on your health, so you can get back to your everyday life.

Things to know

Take time to read this guide to further understand and learn about your visitors cover with us. As a Bupa member, knowing how your cover works will help you to get the most value from your health insurance.

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This guide is in addition to our Fund Rules available online or by contacting us.

For working visitor covers, visit bupa.com.au/fundrules/workingcover
or for non-working visitor covers, visit bupa.com.au/fundrules/visitingcover



How Australia's healthcare system works

Australia is said to have one of the best health systems in the world. However, the system is complex and we understand that accessing healthcare can be confusing for new visitors. That's why we aim to provide the best advice and support to help you find what's right for your needs, so you can be confident you are getting the best healthcare services, when you need them.

The Australian Government has arrangements in place to ensure Australian residents have access to public hospitals at minimal cost and to subsidised medical services, pharmacy and some additional services.

The private sector, which includes private health insurance, provides an extensive range of services to complement these.

Bupa makes it possible for an overseas visitor to access a broad range of health services across both the public and private sectors.

What is Medicare?

Medicare is Australia's nationwide system available for Australian citizens and permanent residents and visitors from countries that have reciprocal healthcare agreements (subject to the terms of those agreements). Medicare subsidises medical fees and some services by dentists and allied health professionals.

In addition, under the arrangements between the Australian and State governments, when you're treated as a "public" patient, you may be treated by doctors in training, although under supervision from qualified specialists.

What is private health insurance?

Many Australians pay extra towards the cost of their health care and have private health insurance. This provides access to benefits towards treatment in private hospitals and a range of additional dental and allied health services, not available through Medicare.

When you use your private health insurance you can choose the doctor who will be primarily responsible for your treatment and you will be covered for a private room if you request one and where one is available.

There are two kinds of cover:

- Hospital cover pays benefits towards the costs of hospital treatment as a private patient.
- General treatment ('ancillary' or 'extras') cover for some non-medical health services not covered by Medicare – such as dental, physiotherapy and optical services.

What are you covered for with Bupa?

We pay benefits towards hospital care in private or public hospitals, choice of doctor, out-of-hospital medical and allied health professional fees, pharmacy, and a range of additional services.

What to do when you feel sick

Emergency health issues



Visit your local hospital emergency department



Call 000 (triple zero) for an ambulance

Non-Emergency health issues



Speak to a doctor online using Bluea*

OR

Visit a doctor or medical centre



The doctor will treat you or refer you to a specialist or other health service



Choosing a hospital? Call us first

We recommend you call us first on **134 135** to discuss your hospital options and to get the most out of your visitors cover. You can also find out if a hospital has an agreement with us by visiting bupa.com.au/find-a-provider



Get 24/7 online access to doctors with Bluea*

See a doctor online via a video call anytime of the day or night with Bluea. 100% of fees for Bluea consults are covered by your Overseas Visitors Cover*.

Visit bluea.com.au/book to book an online appointment.

Do some non-residents have access to Medicare?

Yes, the Australian Government has Reciprocal Health Care Agreements (RHCA) with a selected number of countries. These agreements enable residents of these countries to receive Medicare benefits when visiting or working in Australia.

The level of Medicare cover and the period for which you receive it varies depending on which country you are from.

For more information and for a list of countries visit humanservices.gov.au or contact us.

If you're not sure if it's an emergency health issue, it's better to treat it as an emergency. If you need more advice about your health issue, you could also:

- See a GP
- Visit healthdirect.gov.au
- Call the Australian Government's health advice line on **1800 022 222**

If it's a mental health issue, you can also call LifeLine on **13 11 14**.

*Fund and policy rules apply. Yearly limits apply to Essential Lite Visitors cover, but these limits will be waived (only in relation to Bluea consultations) until further notice. 100% of the cost will only be covered for Bluea consults. Members will only be able to book general consultations via Bluea. Consultations with specialists cannot be booked via Bluea. Members who are under 18 years old may need to attend the consultation with a parent or guardian.

Understanding your visitor's health 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?

Depending on your level of cover you are covered 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 excluded or restricted under your cover.

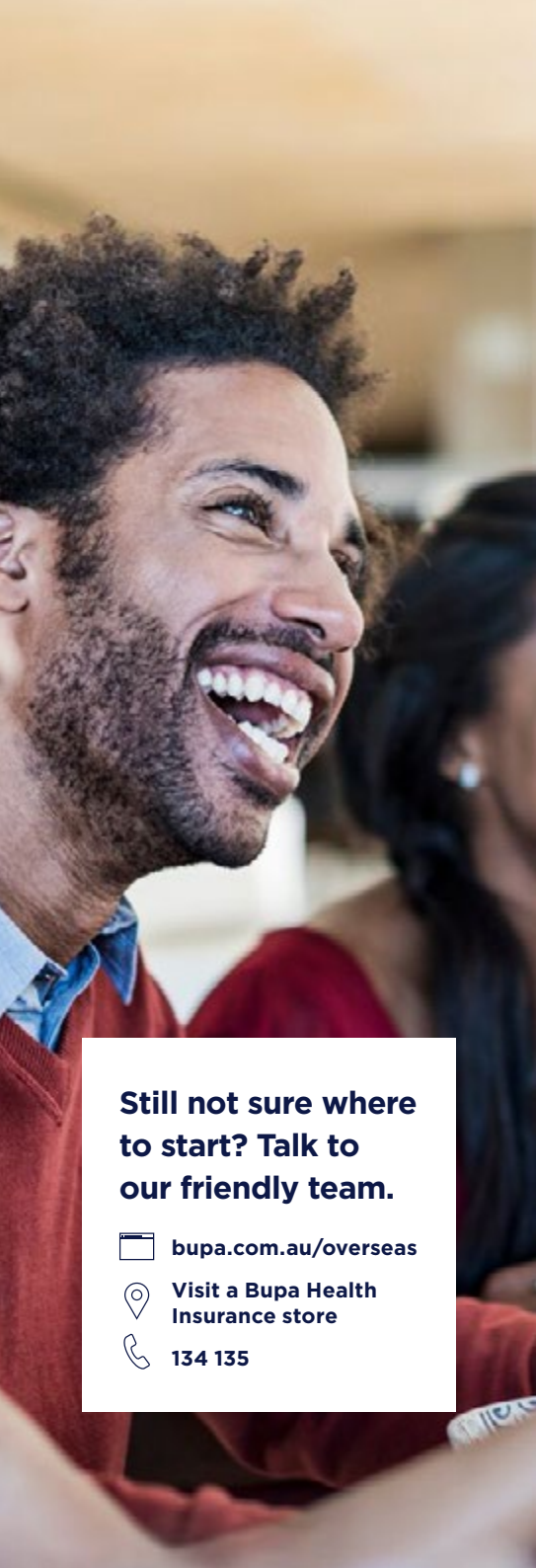
At our Members First hospitals, you'll receive a private room if a private room is available. If a private room is not available, you'll receive \$50 back per night from the hospital. Please note that the following conditions apply: You must book and request a private room in a Members First hospital 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 be in an Intensive Care Unit or other particular ward rather than a private room). You'll also get complimentary local calls, TV usage and a daily newspaper.

At a small number of Network Hospitals, an additional set amount or 'fixed fee' may be charged by the hospital, capped at a maximum number of days per stay. 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.

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

- Accommodation for overnight or same-day stays.
- Operating theatre, intensive care and labour ward fees.
- Reimbursement on emergency department fees at any private or public hospital, including administration fees, if admitted (or in all circumstances depending on your level of cover).
- Supplied pharmaceuticals approved for the condition to be treated by the Australian Government's Pharmaceutical Benefits Scheme (PBS) Schedule, and provided as part of your inpatient hospital treatment.
- Physiotherapy, occupational therapy, speech therapy and other allied health services.
- Surgically implanted prosthesis in accordance with the minimum benefit published on the Australian Government's List of Medical Devices and Human Tissue Products.
- Private room in most private hospitals across Australia for the services included in your cover (not including restricted cover services)*.

*At Bupa agreement hospitals only. Room availability and eligibility criteria apply. Only where medically appropriate.



Still not sure where to start? Talk to our friendly team.



bupa.com.au/overseas



Visit a Bupa Health Insurance store



134 135

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, you will have restricted cover for your hospital costs, and cover for prosthesis in accordance with the minimum benefit published on the Australian Government's List of Medical Devices and Human Tissue Products. This will apply for any treatment recognised by Medicare, unless it is excluded or restricted under your level of cover. The amount we pay 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 prosthesis (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 Inpatient and Outpatient Medical Costs section of this guide.

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

Whether a public hospital will accept or admit a patient, or whether a doctor provides treatment at a public hospital, or performs a particular procedure in a public hospital, is outside of Bupa's control.

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.

If you are admitted as a private patient in a public hospital, you will have restricted cover for your hospital costs, and cover for prosthesis in accordance with the minimum benefit published on the Australian Government's List of Medical Devices and Human Tissue Products. 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 prosthesis in accordance with the minimum benefit published on the Australian Government's List of Medical Devices and Human Tissue Products. The above applies for any treatment recognised by Medicare unless it is excluded or restricted under your level of 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 fee doctor/surgeon charges above the benefit Bupa pays and prosthesis charges above the minimum benefit published on the Australian Government's List of Medical Devices and Human Tissue Products.

Please also refer to the Inpatient and Outpatient Medical Costs section of this guide.

Inpatient medical costs

These are the fees charged by your doctor, surgeon, anaesthetist or other specialist for any treatment given to you when you are admitted to a hospital as an inpatient. Depending on your level of cover, we cover you for either 100% or 200% of the Medicare Benefits Schedule (MBS) Fee, or the cost of treatment. The MBS fee mentioned above is the amount determined by the Australian Government for a specific service for Australian residents. Please check your level of cover to determine the benefits that apply. If your doctor or specialist charges more than the MBS fee there will be a 'gap' for you to pay.

Family In-Hospital Benefit

If you are on Ultimate Corporate Visitors Cover, Top 90 Corporate Visitors Cover, Top Corporate Visitors Cover or Mid 60 Visitors Cover which 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 for the non-admitted person staying with the patient in hospital only.

Crutches and wheelchairs benefit

If you are on Ultimate Corporate Visitors Cover, Top 90 Corporate Visitors Cover, Top Corporate Visitors Cover or Mid 60 Visitors Cover, you will receive a benefit for crutches and wheelchairs.

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

Outpatient medical services (when you're not admitted into hospital)

Also known as outpatient medical services, this is cover for treatment by a General Practitioner (GP), specialist in private practice, or at a hospital when you're not admitted (including diagnostic services such as radiology and pathology).

You're covered for:

- Depending on what is set out in your level of cover we will cover you for up to either 100% or 200% of the Medicare Benefits Schedule Fee (MBS Fee) for outpatient services or for Ultimate Corporate Visitors Cover only, the cost of treatment. The MBS Fee is the amount determined by the Australian Government for a specific service for Australian residents. If your doctor or specialist charges more than the MBS Fee there will be a gap for you to pay.
- We will determine the appropriate MBS item number for the service that has been provided, which may, in limited cases, be different from the item number provided. This can mean the amount we cover is lower than the benefit for the item number on your treatment bill, and there may be an additional cost to you.

- On Essential Lite Visitors Cover, a \$300 annual limit applies for outpatient medical services per person, up to \$600 annual limit per policy.

Please check your level of cover to determine which (if any) benefits apply.

To find out the Medicare Benefit Schedule (MBS) fee visit **mbsonline.gov.au**

Medicines

You can also receive benefits on selected pharmacy items including discharge medication prescribed as an outpatient by a doctor or specialist. This is provided the item's usage is approved by the Therapeutic Goods Administration (TGA). Please check your level of cover to determine the benefits that apply.

Repatriation benefit

If you are on Ultimate Corporate Visitors Cover, Top 90 Corporate Visitors Cover, Top Corporate Visitors Cover, Mid 60 Visitors Cover, Essential 50 Visitors Cover, Essential Visitors Cover or Essential Lite Visitors Cover, you will receive cover for repatriation to your country of origin if you become terminally ill or if you suffer a substantial life altering illness/injury up to \$100,000. Or for the return of mortal remains up to \$10,000. Benefits are only payable once approved by Bupa.

No Repatriation Benefit will be paid if, within six months prior to the date your policy commenced, the insured was:

- first diagnosed as Terminally Ill; or,
- a reasonable person would have first become aware of the Terminal Illness; or,
- suffering a substantial Life Altering Illness/ Injury.

Travel and accommodation

We can help cover the cost of travel for essential medical or hospital treatment not available close to home on your Hospital cover, where the total return distance is 200 kilometres or more from where you live. Up to \$100 per person, per trip for travel expenses and \$50 per night up to \$150 per person, per trip for accommodation. 2 month waiting period and eligibility criteria apply.



Help reduce your medical costs with the Bupa Medical Gap Scheme

Bupa's Medical Gap Scheme helps to remove or reduce the costs you pay for your treatment in hospital.

Where a doctor chooses to use the scheme for your treatment, they agree to only charge up to a certain fee. We'll then pay a much higher amount than we normally would to help cover the extra cost. If a doctor uses the no-gap option, we cover all of the extra charges, so you pay nothing for that doctor's medical fees. Otherwise, for each doctor choosing to use the Gap Scheme, the most you'll pay is up to \$500 out-of-pocket on medical costs for in-hospital treatment. Each doctor involved in your treatment can choose to use the Bupa Medical Gap Scheme for your admission in a Public Hospital, or a Private Hospital with which Bupa has an agreement.

For more info visit
bupa.com.au/medicalgapscheme



Hospital Cover

The below is a guide on the in-hospital treatments on sale visitors cover provides. For further information, including off sale products, refer to your policy information.

Working Cover				
Hospital* & Medical services	Essential Lite Visitors Cover	Essential Visitors Cover	Essential 50 Visitors Cover	Mid 60 Visitors Cover
Rehabilitation*	✓	✓	✓	✓
Hospital psychiatric services	✓	✓	✓	✓
Palliative care	✓	✓	✓	✓
Brain and nervous system	✓	✓	✓	✓
Blood	✓	✓	✓	✓
Bone marrow transfusion or transplant	x	x	x	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	✓	✓	✓	✓
Eye (not cataracts)	✓	✓	✓	✓
Cataracts	✓	✓	✓	✓
Ear, nose and throat	✓	✓	✓	✓
Implantation of hearing devices	✓	✓	✓	✓
Tonsils, adenoids and grommets	✓	✓	✓	✓
Bone, joint and muscle	✓	✓	✓	✓
Joint reconstructions	✓	✓	✓	✓
Joint replacements (other than Hip and Knee)	✓	✓	✓	✓
Joint replacements (Hip and Knee)	✓	✓	✓	✓
Back, neck and spine	✓	✓	✓	✓
Kidney and bladder	✓	✓	✓	✓
Organ transplant	x	x	x	✓
Dialysis for chronic kidney failure	✓	✓	✓	✓
Digestive system	✓	✓	✓	✓
Hernia and appendix	✓	✓	✓	✓
Gastrointestinal endoscopy	✓	✓	✓	✓
Weight loss surgery	✓	✓	✓	✓
Heart and vascular system	✓	✓	✓	✓
Lung and chest	✓	✓	✓	✓
Gynaecology	✓	✓	✓	✓
Miscarriage and termination of pregnancy	✓	✓	✓	✓
Pregnancy and birth	✓	✓	✓	✓
Assisted reproductive services	x	x	x	x
Male reproductive system	✓	✓	✓	✓
Diabetes management (excluding insulin pumps)	✓	✓	✓	✓
Insulin pumps	✓	✓	✓	✓
Pain management	✓	✓	✓	✓
Pain management with device	✓	✓	✓	✓
Breast surgery (medically necessary)	✓	✓	✓	✓
Plastic and reconstructive surgery (medically necessary)	✓	✓	✓	✓
All cosmetic surgery	x	x	x	x
Skin	✓	✓	✓	✓
Dental surgery	✓	✓	✓	✓
Sleep studies	✓	✓	✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)*	✓	✓	✓	✓

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#Limited hospital accommodation and approved prostheses benefits only.
*The services provided under our health insurance policies are defined and these defined terms may not have their ordinary meaning. For more information about what is covered under a treatment or service, contact us or go to bupa.com.au/glossary



Non-Working Cover

Corporate Working Cover

*Rehabilitation is not covered following an inpatient care for an acute condition on Explorer and Explorer 50 Visitors Cover.

What is not covered

Hospital costs

(including prosthesis and pharmacy costs)

Situations when you are likely not to be covered or to have significant additional expenses include:

- During a waiting period.
- When a service is excluded or restricted under your level of cover.
- When you are treated at a non-agreement private hospital you will not be fully covered.
- For the fixed fee charged by a fixed fee hospital or a hospital that has a fixed fee service. This does not apply to Ultimate Corporate Visitors Cover as any fixed fee will be reimbursed.
- Depending on your level of cover, if 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) you may not be covered.
- For hospital psychiatric and rehabilitation day programs, at a hospital that 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 in relation to surgical podiatry (including the fees charged by the podiatrist); cosmetic surgery; respite care; experimental treatment and/or any treatment/procedure not approved by the Medical Services Advisory Committee (MSAC).
- Personal expenses such as: pay TV, non-local phone calls, newspapers, boarder fees, meals ordered for your visitors, hairdressing and any other personal expenses charged to you unless included in your level of 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.
- Some hospital-substitute treatment and operative services that are a continuation of care associated with an early discharge from hospital.
- For pharmaceuticals items supplied upon discharge from the hospital unless covered on your visitors or Extras cover.
- If you choose to use your own allied health provider (e.g. chiropractors, dieticians or psychologists) rather than the hospital's practitioner for services that form part of your inpatient hospital treatment.
- 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 treatments or services rendered outside Australia.
- For any treatments or services arranged in advance of your arrival in Australia.
- Non-PBS, high cost drugs.
- If you do not hold a valid visa at the time of admission to hospital and for the duration of your hospital stay.
- Cosmetic surgery.

Check your Policy Information and definitions on **page 20** for more information.

Medical costs

Situations when you are likely not to be covered or to have significant additional expenses include:

- Medical services for surgical procedures performed by a dentist, surgical podiatrist, or any other practitioner or service that is not eligible for a rebate through Medicare.
- Costs for medical examinations, x-rays, inoculation or vaccinations and other treatments required relating to acquiring a visa for entry into Australia or permanent residency visa.
- When a service is excluded or restricted under your level of cover.
- When you have reached the limits on your product including yearly, lifetime or service limits for the service you are claiming.
- Cosmetic surgery. Please refer to your Policy Information and our definitions on **page 20** for more information.

For Ultimate Corporate Visitors Cover we will pay for all actual, necessary and reasonable expenses incurred by you and any other person covered by your membership.

Should your doctor, surgeon, anaesthetist or other specialist charge us an unreasonable fee (compared to standard practice) for your medical costs, we reserve the right to investigate the fee. In the unlikely event that this occurs, we will contact you to advise if payment of your claim is delayed.

Waiting periods

A waiting period is the time when you are not covered for a particular service. It starts on the date that you enter Australia or the date that you start your membership, whichever is the later date.

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're switching from another private health insurer, you may be eligible to have some waiting periods that you've previously served honoured on your new level of cover.

Check **page 18** for details.

Ultimate Corporate Visitors Cover, Top 90 Corporate Visitors Cover, Top Corporate Visitors Cover, Mid 60 Visitors Cover, Essential 50 Visitors Cover, Essential Visitors Cover and Essential Lite Visitors Cover waiting periods

The following waiting periods apply to these covers:

Hospital cover	Waiting period
Palliative care, rehabilitation and hospital psychiatric services	2 months
Assisted reproductive services ¹	2 months
Pre-existing conditions, ailments or illnesses	12 months
Pregnancy and birth (obstetrics)	12 months

See **page 23** for more information on pregnancy and birth related services.

Explorer Visitors Cover and Explorer 50 Visitors Cover waiting periods

The following waiting periods apply to these levels of cover:

Hospital cover	Waiting period
Hospital psychiatric services	12 months
Pre-existing conditions, ailments or illnesses	12 months
All other inpatient treatments	14 days
Accidents ² sustained after joining	No waiting period
Emergency ambulance and on-the-spot treatment and non-emergency ambulance transportation	1 day

See **page 22** for more information on pre-existing conditions, ailments or illnesses.

¹A 2 month waiting period applies to assisted reproductive services on Ultimate Corporate Visitors Cover, Top 90 Corporate Visitors Cover and Top Corporate Visitors Cover. ²Accidents in this document is as defined in the Glossary - for more information please refer to bupa.com.au/glossary.

Short Stay Visitors Cover waiting periods

The following waiting periods apply to this cover:

Hospital cover	Waiting period
Palliative care, rehabilitation and hospital psychiatric services	12 months

Short Stay Visitors Cover does not cover any pre-existing conditions, illnesses or ailments.

When to contact us

If you have been a Bupa member for less than 12 months on your current visitors cover, it is important to contact us before you are admitted to hospital and find out whether the pre-existing condition waiting period applies to you. Please note: Short Stay Visitors Covers exclude benefits for pre-existing conditions. 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 and birth in advance. This is because there is a 12-month waiting period applied to pregnancy and birth.

No waiting periods will apply to the newborn provided they have been added to the appropriate family visitors cover within 90 days of their birth.



Still not sure where to start? Talk to our friendly team.

 bupa.com.au/overseas

 **Visit a Bupa Health Insurance store**

 **134 135**

Ambulance Cover

Ambulance Cover for all visitors cover (other than Short Stay Visitors Cover)

For all visitors cover (other than Short Stay Visitors Cover), you will receive unlimited emergency ambulance services. That means we will pay 100% of the charges for emergency transportation when medically necessary for admission to hospital, and emergency treatment on-site, by our Recognised Ambulance Providers.

You will also receive limited non-emergency ambulance services. This means your cover will be limited to three times per person, per calendar year, for non-emergency transportation from a hospital to your home, a nursing home or another hospital, by our Recognised Ambulance Providers.

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

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

If you need to make a claim for ambulance benefits, we will give you a Patient Ambulance Transportation Form to complete.

Emergency Ambulance Cover for Short Stay Visitors Cover

As part of your cover under Short Stay Visitors Cover, you will receive unlimited emergency only ambulance services. That means we will pay 100% of the charges for emergency transportation when medically necessary for admission to hospital, and emergency treatment on-site, by our Recognised Ambulance Providers.

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

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

On Short Stay Visitors Cover, you are not covered for non-emergency Ambulance transportation or on the spot treatment.

Recognised Ambulance Providers

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

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

Working Visa Members

We will also pay ambulance costs (as per your policy), where the services are provided by an Australian Government approved ambulance service.

Extras Cover

In addition to your Overseas Visitors Cover you can also purchase Extras cover.

What is covered?

With Extras cover, you can claim benefits for services that may not be covered by Medicare.¹ You can claim for those services listed on your cover as long as benefits are not claimable from a third party, the provider is in a private practice and recognised by us and the service meets our Overseas Visitors Rules and Fund Rules. We recommend you contact us before booking with a provider, so we can check how much you can claim and these details for you.

For example, Medicare may not provide benefits for:



Dental examinations and treatment



Physiotherapy



Chiropractic services



Occupational therapist



Speech therapy



Podiatry²



Mental health Services³
(Includes psychology and counselling)



Acupuncture⁴ or other natural therapies⁵



Eye therapy



Glasses and contact lenses



Health aids and appliances



Home nursing

¹Extras services providers must meet certain requirements to be recognised by Bupa and for us to pay towards the cost of your treatment. Before you book a treatment or service, it's a good idea to check with us so we can confirm whether we recognise the provider you're planning to visit. Yearly Limits, waiting periods, service restrictions (clinical reasonability rules), fund and policy rules apply. ²Does not include Orthotics, where applicable, benefits may be payable under Health Aids and Appliances. ³Benefits for Accredited Mental Health Social Workers apply. ⁴Unless part of a doctor's consultation. ⁵Natural Therapies includes massage (remedial massage, myotherapy, traditional Chinese Medicine remedial massage), acupuncture and chinese herbalism. ⁶You can receive 100% back on dental check-up and cleans (select dental items only) once every 6 months at Members First Ultimate Providers. Waiting periods, service restrictions (clinical reasonability rules), policy and fund rules apply. Excludes orthodontics and in-hospital treatments. Available on all eligible extras products which includes General Dental (excluding FLEExtras and Your Choice Extras 60 where General Dental is not included). If you choose or require any additional dental services, any health insurance benefits will also be subject to your yearly limits. ⁷You can receive 100% back on direct restorations or fillings (select dental items only), up to yearly limits, at Members First Ultimate Providers. Waiting periods, service restrictions (clinical reasonability rules), policy and fund rules apply. Benefits are payable up to yearly limits or on available remaining limits in relation to your product. Some out of pocket costs may apply if a claim exceeds your yearly limits. Excludes orthodontics and in-hospital treatments. Available on all eligible extras products which includes General Dental (excluding Simple Start - Basic Plus, OSHC Extras, FLEExtras and Your Choice Extras 60 where General Dental is not included). If you choose or require any additional dental services, an out-of-pocket cost may apply. ⁸At Members First Platinum providers you can receive 100% back on dental check-up and cleans (select dental items only) once every 6 months, up to your yearly limits. Available on eligible packaged or combined hospital and extras products which include general dental (excluding Freedom 50 Extras, Freedom 60 Extras, Freedom 60 Boost, Extras Saver, Corporate Benefit 60 Flex, FLEExtras products, and Your Choice Extras 60 where General Dental is not included). Waiting periods, service restrictions (clinical reasonability rules), yearly limits, policy, and fund rules apply.

⁹Only applicable to Top 90 Corporate Visitors Cover and Mid 60 Visitors Cover. ¹⁰Waiting periods, fund and policy rules apply.

Save with out network of dental providers

Thousands of dental practitioners have joined our Members First, Members First Platinum and Members First Ultimate network to help provide more value when it comes to dental care.

Get 100% back on up to two check-up and cleans per year, claimable outside of your yearly limits⁶ and 100% back on select general dental fillings, up to yearly limits at Members First Ultimate providers.⁷

With Members First Platinum, you'll get 100% back on up to two check-up and cleans per year, claimable up to your yearly limits.⁸

Find out more at:

bupa.com.au/health-insurance/dental-partners

What is not covered?

Extras benefits will not be payable:

- During a waiting period.
- Where a third party, including Medicare, an Australian 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 remedial 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. Please check your policy for more information.
- Where the service is not covered under your product.
- 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:

Extras cover	Waiting period
Hire and repair of health aids and appliances and health management	6 months ⁹
Major dental, orthodontics, selected health aids and appliances	12 months ⁹
All other Extras services	2 months

Optical Partners

Optical Partners give you access to flexibility and choice as well as discounts and offers (up to your yearly limits¹⁰). You can choose where to shop at over 500 locations Australia-wide and have access to offers that suit your individual optical needs. Details of these offers may change from time to time.

Visit bupa.com.au/opticalpartners for more.

Additional benefits

myBupa

myBupa.com.au is our member self service area. It helps you easily manage and understand your Health Insurance online. In addition, if you register for myBupa you will get access to an exclusive range of discounts, experiences, tools and information to help you get more out of every day.

24 hour advice line

- Advice on simple medical problems.
- Medical translation services.
- Contact details and location of the nearest medical facilities.

Call **+61 3 9937 3999**

Changing your cover

Switching from another health fund

If you're changing from another Australian health fund or general insurer 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, and start claiming, 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 old fund, the lower benefit (including different excess levels) will apply for the waiting period relevant for that service. Please refer to the listed waiting periods earlier in this guide.

If you choose a lower level of cover than you held previously, then the lower benefits on your new cover will apply immediately. This may include a different excess level or restricted cover. 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 from Bupa overseas

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

Changing from any registered international insurer or Australian insurer

If you had previous cover with any registered international insurer or Australian insurer, you will be required to cancel the policy yourself and provide us with a Clearance/ Member Certificate, a Certificate of Currency or a document on an official letterhead confirming your membership. We will also provide continuity of cover on an equivalent level of cover, when you've joined us within 60 days of your end date. Please note: if you are transferring to a non-working visa cover from any recognised overseas health insurer or general insurer, you will need to re-serve all waiting periods.

Changing your cover with us

If you change your health cover, you may need to wait before you can access your new benefits and limits. 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 earlier in this guide.

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

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

Changes to Medicare Access

If you obtain full access to Medicare benefits, you can change to one of our domestic health covers. This may occur when you apply for or obtain permanent residency. You will continue to be covered for all benefit entitlements on your old cover, as long as you change over within 60 days of ceasing your visitors cover.

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

If you have reciprocal access to Medicare, or obtain full access to Medicare benefits and are a high income earner, you may be required to pay the Medicare Levy Surcharge if you do not have an appropriate level of private hospital cover. Check with your tax agent if this applies to you.

Ending your membership

You can contact us to cancel your health cover and a refund will be provided for any premiums paid in advance from the date you've contacted us. We will not, however, refund the first months premium paid on our range of Overseas Visitors Covers. We have the right to end a person's membership as set out in our Overseas Visitors Rules, including where premiums have not been paid or on notice at the reasonable discretion of Bupa.

Definitions

Accidents

An 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.

Admissions to a public hospital

With regard to a public hospital, an admission to Hospital or Hospital admission means where the treating medical officer has formally admitted you to the hospital in accordance with the applicable State or Territory rules for an admission, given the applicable clinical circumstances.

For the purposes of a private room in a public hospital, this 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.

Agents

A third party such as a broker or agent may establish and administer your policy or corporate health plan. In these cases, some information about you such as your name, address and other policy information will be given and received from the agent to help Bupa administer your policy or corporate health plan. This will not include personal claims information (also see Privacy Statement on **page 26**). Once the policy has been set up, the third party or agent will need to obtain your authority to administer the policy.

Calendar year

A calendar year is 1 January to 31 December.

Cosmetic Surgery

A cosmetic treatment is one which is concerned with altering the appearance of a body part or tissue which lies within the bounds of normal variation.

Examples of Cosmetic Surgery:

- Rhinoplasty (nose reconstruction) without previous trauma or congenital defect.
- Breast enlargement.
- Liposuction.

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 22**.

Emergency Treatment

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

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

Excess

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

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

Please contact us for further details.

Exclusions

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

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

Health aids and appliances

Health aids and appliances are items prescribed by a health care provider, such as a doctor, medical specialist, physiotherapist or podiatrist, to treat or help manage a health condition.

Some health aids are used to help a person to deal with a physical impairment, such as an orthosis (a brace/splint) to support an injured part of the body. Other health aids and appliances help with treating or managing a specific condition, such as a compression garment to help with the management of Lymphoedema.

We pay benefits for a range of evidence-based health aids and appliances designed to help our customers manage a diagnosed health condition. To access benefits for health aids and appliances you'll need to visit or purchase from 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.

Health Management

Depending on your Extras cover, you might be able to claim some of the cost of approved health-related programs. We call this 'Health Management'. A 6 month waiting period applies.

- Nicotine replacement therapy.
- Weight management programs by specified recognised providers only.
- Health subscriptions to Diabetes Australia and the Asthma Foundation.
- Gym memberships¹
- Personal training¹
- Mole mapping services, including skin checks

For information about how to claim, please see bupa.com.au/healthmanagement

Life Altering Illness/Injury

An illness/injury considered to be a serious medical condition leading to a reduction in life expectancy to less than 12 months, a requirement for ongoing care support or continuous inpatient hospitalisation, or any other deficit or health care need as assessed by a Medical Practitioner appointed by Bupa as warranting support for repatriation.

¹Gym memberships and personal training will only be claimable when the exercise program is designed to address or improve a specific health or medical condition - for example, diabetes.

Medical Practitioner

A person registered or licensed as a medical practitioner under a law of a State or Territory. This does not include anyone whose registration or licence to practise has been suspended or cancelled following an inquiry relating to his or her conduct and whose registration or licence has not been reinstated.

Mortal Remains

The body of the deceased person for the purposes of Repatriation benefits. Does not include cremation or ashes of a deceased person.

Out-of-pocket expenses

You are likely to experience out-of-pocket expenses when you are not fully covered for services and benefits, or when a set benefit applies. You should refer to what is and isn't covered for your relevant level of cover to determine when an out-of-pocket expense may occur. You should also refer to our Overseas Visitors Rules for any additional information on benefits payable.

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 – Visitors cover

On most visitors covers you receive benefits for selected prescription items prescribed as an outpatient that are Australian Government's Pharmaceutical Benefit Scheme (PBS) Schedule listed or non-PBS listed and TGA approved, prescribed by a doctor or a specialist and not appearing on our exclusions list. Refer to your cover details for more information. A co-payment may apply to your level of cover.

Pharmacy – Extras cover

Your extras pharmacy entitlement pays benefits on prescription items that are only non-PBS listed and TGA approved and not appearing on our exclusions list. When you make a claim, we will deduct a pharmacy co-payment and pay the remaining balance up to the set amount under your chosen level of Extras cover.

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

- Over-the-counter and non-prescription items.
- Compounded items.
- Weight loss medication.
- Body enhancing medications (e.g. anabolic steroids).

Pharmacy in-hospital

We pay for all drugs that are PBS listed for your condition, when the drugs are administered in hospital. If you are treated with a drug that is not PBS listed (which may include some private prescriptions) we will not pay benefits and the hospital may charge you. You should be advised by the hospital of any charges before treatment.

Pharmacy Saver

Add Pharmacy Saver to your chosen visitors cover with extras and enjoy savings on your pharmaceutical and healthcare purchases all year round at National Pharmacies stores.

You'll get a 20% discount on a variety of health-related products. Pharmacy Saver is not available for prescriptions on which the Australian Government does not allow discounts. Visit a National Pharmacies store for more information (outlets located in VIC, SA and NSW; online discounts available nationally).

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. Keep in mind that a doctor appointed by us will decide whether your condition is pre-existing.

That said, the appointed doctor must consider your treating doctors' opinions on the signs and symptoms of your condition, although they're not bound to agree with them.

Pregnancy and birth

Pregnancy and birth are services and treatment provided for the care of women during pregnancy, the delivery of your baby and following delivery.

Any treatment or services that you are not admitted to hospital for, like consultations with your obstetrician, are part of out-patient medical cover.

Pregnancy complications such as ectopic pregnancy, termination and miscarriage are considered gynecological services.

Anything related to helping you conceive is an "Assisted Reproductive Service" and is not considered as pregnancy and birth.

Premium and benefits

You or your employer (in the case of company paid plans) must pay the premium that applies to you. In addition, if you have Extras cover as an add-on to visitors cover, please note premiums for extras differ between states due to different state charges. If you move to another state your premium will change too. Therefore you must let us know about any change of address. To access the benefits available on your cover, you need to:

- Complete the application process and ensure your premiums are paid one month in advance. (It is up to you to make sure payments are made during times of unpaid leave or if your employment ends).
- Ensure that newborns are enrolled onto a family membership within 90 days of their birth to avoid any waiting periods for your baby.
- Enrol your adult children under their own policy within 60 days after they no longer qualify under your cover (to avoid reserving 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).

We will not refund the first months premium paid to Bupa under any circumstance.

Private room in a public hospital

For the purposes of a private room in a public hospital, this 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.

Proof of identity and/or age

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

Reconstructive Surgery

Surgery to restore function or typical appearance by reconstructing defective organs or parts. The reason for the surgery is what's important. It would usually follow a previous medically necessary surgery, a traumatic event that caused a change in the appearance and/or function of a part of the body or a significant congenital problem (something you were born with), that created problems with how your body works. For example, after a mastectomy for breast cancer, there may be a desire to reconstruct the breast back to an acceptable appearance for you, whereas changing the appearance of the breast for most other reasons would be cosmetic in nature and intent.

Other examples of 'Reconstructive Surgery':

- Repairing a scar resulting from an accident or previous surgery (unless it was cosmetic surgery).
- Facial reconstructive surgery following severe trauma, cancer surgery or a major congenital problem (from birth).
- Repairing a body part after a trauma injury.

Restricted Cover

Guardian 60 Visitors Cover and Working Visa Customers

Restricted Cover means we will only pay minimum benefits (an amount set by the State Government). If a treatment is listed as Restricted Cover, it means that during the restricted cover period, if you go to a public or a private hospital for these treatments, most of the time, the hospital will charge a lot more than what we will pay, so you are likely to have a large amount to pay yourself.

For all other Non-working Visa Covers

Restricted Cover means we will only pay minimum benefits (an amount set by the Government for Australian residents). If a treatment is listed as Restricted Cover, it means that during the restricted cover period, if you go to a public or a private hospital for these treatments, most of the time, the hospital will charge a lot more than what we will pay, so you are likely to have a large amount to pay yourself.

Surgically implanted prosthesis

You will be covered in accordance with the minimum benefit published on the Australian Government's List of Medical Devices and Human Tissue Products 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.

For more terms explained visit
bupa.com.au/glossary

Suspension rules

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

- For a minimum period of one month.
- For a maximum period of nine months.
- You can suspend your policy up to two times per calendar year.
- Six months contributions are required between each suspension period.

To be eligible to suspend your cover you must:

- Have been a financial member for at least two 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 14 days of your arrival
- Complete an overseas travel suspension form.

Your membership will be cancelled if not resumed.

Terminally Ill

Someone with a life expectancy of less than 6 months as diagnosed by a Medical Practitioner and determined by a Medical Practitioner appointed by Bupa, after consideration of any relevant clinical information.

Travel and accommodation

We can now help cover the costs of your travel and accommodation expenses, if you need to travel 200km or more for medically essential treatment not available in your local area. The benefit is per person, per trip (limits apply), and can be used as many times as needed throughout the year. If you have an extras cover with us, we'll only pay the travel and accommodation benefit on your hospital cover. See your policy information for more details.

Yearly limits and service limits

A yearly limit (also 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 (clinical reasonability rules) also apply to the number of times that benefits are payable for the same service (e.g. dental check-ups).

These limits apply from the date of service or purchase. Some services also have lifetime 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, 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 us to do so).

We may provide information to our or your financial institution to resolve a dispute on your behalf. You must ensure your nominated account permits direct debiting and that sufficient cleared funds are available in that account on the due date to cover the premiums due. Your financial institution may charge a fee if the payment cannot be met. You must ensure the authorisation given to draw on the nominated account is identical to the account signing instruction held by the financial institution where the account is based. You must notify us if the nominated account is transferred or closed. You must pay your premium by an alternative method if either you or we cancel the direct debit arrangements. You must ensure your payments are up-to-date, whether a notice is received from us or not. If paying by credit card, you need to advise us of your new expiry date prior to expiry. You may request that we cancel or alter the debit drawing arrangements by contacting us and providing at least five working days’ notice of any requested changes. These changes may include deferring the debit, altering the debit dates, stopping an individual debit, suspending the direct debit arrangement or cancelling the direct debit completely. You can dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than seven days before the next scheduled debit drawing 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, Australian 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 specify who should receive information about their health

claims, by nominating a preference in myBupa or completing a 'Keeping your personal information confidential' form.

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.

Here to 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 into your local Health Insurance store. If you would like more information about our Overseas Visitors Rules or the Federal Government's Private Health Insurance Industry Code of Conduct, you can find this information on our website. The Federal Government's Private Patient's Hospital Charter is available at privatehealth.gov.au

Complaints or feedback

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:

Email: **customerrelations@bupa.com.au**

Phone: **134 135**

Fax: **1300 662 081**

Mail: **Customer Relations Manager Bupa
GPO Box 9809
Brisbane QLD 4001**

If you're still not satisfied with your outcomes from Bupa you may contact the Commonwealth Ombudsman on **1300 362 072** or visit them at **ombudsman.gov.au**

If your concerns aren't resolved when you first raise them, and you'd like to discuss it further, you can find our full complaints process online for how to go about it.



Bupa health cover made easy

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

This guide is in addition to our Fund Rules.

For working visitor covers, visit

bupa.com.au/fundrules/workingcover

or for non-working visitor covers, visit

bupa.com.au/fundrules/visitingcover

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



bupa.com.au/overseas



Visit a Bupa Health Insurance store



134 135

Bupa HI Pty Ltd
ABN 81 000 057 590

Effective 15 January 2024
10746-01-24