Welcome to Bupa

Your Important Information Guide

Here’s what you need to know

Effective 1 June 2021
Welcome to Bupa
Get more from your health insurance

Because life happens
The good. The bad. The unexpected. It’s all part of living a longer, healthier happier life. That’s why it’s good to know Bupa is helping to look after your health insurance.

We offer a broad range of services and support to take care of your health and wellbeing. From the everyday protection for your health, travel, car, home, pet insurance and aged care, to accredited healthcare providers. Plus, a range of projects, tools, and programs to promote health, wellbeing, and sustainability in the community to give you even greater value.

Health insurance
As one of Australia’s largest health insurers, we have agreements with most private overnight and day hospitals, plus a huge Extras network so you’ll know you always have a wide range of choices.

Mental health
Support when you need it
Your wellbeing is so much more than looking after your physical health alone. And because everyone is different, we offer a range of health programs to support you* - not only when you’re in need but also to help you stay at your best.

To better support you, we have an agreement with This Way Up and include Online CBT (Cognitive Behaviour Therapy) courses under our Mental Health offering to help manage symptoms of anxiety and depression. Online CBT is designed to mimic a course of CBT treatment you’d typically receive when seeing a clinician face-to-face.

*Fund, policy, program eligibility and wait period rules apply.

Other Bupa insurance
Because we’re more than just health insurance. We specialise in all kinds of insurance to help protect your home, car, pets and holidays – and we also offer bundled discounts.

Learn more at bupa.com.au/general-insurance
Your membership

Because Health insurance doesn’t have to be complicated

This guide is designed to answer all of the most common questions we’re asked about health insurance. Everyone is different of course, and you might have specific questions you’d like answered, contact us on 134 135 (+613 9487 6400 if you are overseas) or visit us in one of our Health Insurance stores.

Keep in mind that this guide doesn’t replace the Bupa Fund Rules, which outline the terms and conditions of your cover.

Why have Private Health Insurance explained

As Australians, we’re lucky to have access to a quality, public health system. But it’s not without its limitations. For example, it doesn’t cover all treatments and services, and can limit things like where and when you’re treated.

The Bupa community

We’re taking care of our community with projects, tools, and programs to promote health, wellbeing, and sustainability. We’re sharing our wealth of knowledge through our online health resource Bupa Health Link. We’re helping to fund breakthrough medical research that enables real health and care improvements for all Australians through our Bupa Health Foundation.

Health services

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

Dental · Optical · Audiologist · Telehealth
Private health insurance means:

1. **More control**
   If you need to go to the hospital for a non-emergency procedure. You’ll have more choice when it comes to your hospital, your specialist and when you’d like your procedure to take place. You might also be able to request a private room.

2. **Reduced wait times**
   For non-emergency hospital procedures (like having your tonsils out) at a private hospital. If you’re not privately insured, you might have to choose between being on a public hospital waiting list for months (sometimes over a year)* or paying a hefty fee to go to a private hospital.

3. **The ability to claim money back**
   On some everyday health services, that may not be covered by Medicare, such as dental and physio. Depending on your cover, you may even be able to claim money back for services like remedial massage and acupuncture.

4. **Avoiding or reducing the Lifetime Health Cover (LHC) loading**
   If you’re 31 or over and don’t have hospital cover. The LHC loading is a Government initiative designed to encourage Australians to take out hospital insurance earlier in life. If you don’t have hospital cover by 30 June following your 31st birthday, but then decide to take it out later in life, you’ll pay a 2% loading on top of your premium for every year delayed (up to a maximum of 70%). This extra loading remains in place for 10 years. For example, if you delayed getting hospital cover for 3 years after you turned 31, you’ll pay an additional 6% on top of your premium for the next 10 years. Refer to page 36 for more information.

5. **Tax time**
   Depending on your income, you may have to pay an extra 1-1.5% tax levy, known as the Medicare Levy Surcharge (MLS) (on top of the Australian Government’s Medicare Levy) if you don’t have appropriate hospital cover for you and all your dependants over the whole year. That may be similar to the cost of some of our hospital covers. The Government will also contribute to the cost of your premium – this is known as a ‘rebate’. The amount is based on your age and income and you can choose to get it as a reduced premium or offset in your tax return.* Refer to page 37 for more information.

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

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**What if you change your existing Bupa cover?**

There are a few things to keep in mind:

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

2. **You’ll change to the lower level of cover right away**
   If you have chosen to change to a lower level of cover, the lower level of benefits will apply immediately.

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

4. **You have a 30-day cooling-off period**
   If you want to reverse any change to your cover, you can reverse the change within 30 days, as long as you haven’t claimed. After 30 days, you can change your cover back, but it will only apply from the day you requested to change it back. If you are going back to a higher level of cover, you may need to wait before you can use any extra benefits.
Your Bupa essentials
Connect with us to make the most of your membership.
There are a few quick steps to complete to make sure you get the most out of your new Bupa policy.

myBupa
myBupa.com.au is our member self service area. It helps you easily manage and understand your Health Insurance online. Once you register, simply log in using your secure log-in details to:
- Access your policy documents and tax information.
- Submit an Extras claim and see your claim history.
- Update your personal details.
- Access exclusive health tools and discounts.
- Put Bupa in your pocket with the myBupa App. Download for free via the Google Play Store.¹

¹Digital cards may be used at HICAPS terminals only and are compatible with Android OS 5.0 and higher

Your Bupa card
Your new Bupa card will arrive soon after you join and:
- Contains your membership number and a list of the people who are covered by your policy.
- The ability to make eligible on-the-spot claims when you have received a treatment or service from many of our recognised Extras providers, such as a dentist or physio.
- Unique identification if you’re admitted to hospital.

Digital cards
- Digital card capability is simple and allows secure claiming with a mobile phone. Tap and claim is available at some of our Bupa recognised providers.

Get more with Bupa Plus!
With offers from over 40 partners, Bupa Plus is our way of saying thanks to everyone who chooses Bupa as their health insurer.
Visit myBupa.com.au/offers to find out more!

Access our Member Health Support Programs and Services
At Bupa, we’re here for you not just when you are in need, but also to help you stay at your best. That’s why we’ve developed a range of health support programs and services to help find a healthier you.
These programs and services are designed to help support you and your family’s health and wellbeing at no extra cost to you. It’s all part of our commitment to helping you live a longer, healthier, happier, life*. These programs and services are:
- Advance care planning
- Aged Care Support Line
- Bupa Health Coaching Program
- Chemotherapy Choices Program
- Dietitian Health Coaching Service
- GenesisCare Partnership
- Mind Care Choices Program
- Osteoarthritis Healthy Weight For Life Program
- Palliative Care Choices Program
- Parent and Baby Wellbeing Program
- The COACH Program
- Recovery Support Program
- Rehab Choices Program
- XRHealth Program
- Kids Helpline®@School program

Stay up to date
Click the links below to visit Bupa online
- myBupa.com.au
- BupaAustralia
- BupaAustralia
- @bupaaustralia
- BupaAustralia
- 61134135
- @bupa

We’re never far away
You can update small changes to your membership (like new contact details or payment information) online at myBupa.com.au. But bigger changes, like adding or removing people from your cover, or moving interstate, can affect the cost and level of cover – including things like ambulance services. So it’s always best to speak to us to make sure your cover is still right for you, and we’ll clarify exactly what your cover includes.
- Call us on 134 135
- Find a local Bupa Health Insurance store at bupa.com.au/find-a-centre
- Apple iMessage
- WhatsApp
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.

Planning for a baby

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

No waiting periods apply to a newborn baby, provided your little one has been added to your level of cover within 90 days of their birth.

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

What’s covered and what’s not?

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

- Hospital costs
- Medical costs
- Prostheses costs
- Pharmacy costs
- Emergency Ambulance costs

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

Medical costs before you go to hospital

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

It’s better to know before you go

If you’re in hospital for a pre-booked admission, it is important that you make sure that the hospital or specialist tells you the costs that you’re expected to pay yourself, after we’ve paid our part. The hospital should make sure they get your consent for these costs before you’re admitted. As always, if you’ve got any questions, please just get in touch.

Multiple Treatments during a hospital admission

You’ll note that when you undergo more than one type of hospital treatment during a hospital admission, we will cover accommodation, theatre fees and prosthesis for procedures related to the treatment covered by your policy. If one or some hospital treatments are excluded, no benefits will be paid toward any part of the costs associated with the excluded treatment.

If you’re going in for more than one procedure at the same time, remember that the Medicare multiple operation rule might apply to doctors and specialist’s fees. This could affect the total Medicare Scheduled Fee and might mean significant out-of-pocket costs.

Associated Treatments for Complications and Associated Unplanned Treatments

If you have a hospital treatment that’s covered under your policy, we’ll also cover any associated treatments for complications, if any should happen during your admission. We’ll do the same for any associated unplanned treatments, as long as it is deemed both medically necessary and urgent at the time by the medical practitioner giving the unplanned treatment.

Common Treatments and support Treatments

If you have a hospital treatment that’s covered under your policy, we’ll also cover specific Medicare Benefits Schedule items that are related to treatments covered under your policy.
Hospital costs
Charges related to your hospital admission such as the operating theatre, nursing and allied health services including accommodation and meals.

• How you’re covered for hospital costs when you’re admitted as an ‘inpatient’ depends on your choice of hospital. See page 23 for more details. Check with your doctor whether your treatment will require you to be admitted to hospital.

• Depending on your level of cover, we might also pay some of the costs for a partner, immediate family member, carer or next of kin to stay in hospital with you.

• If a treatment is listed as having ‘restricted cover’ on your policy information, we pay less toward your hospital costs. This means you may have large hospital out of pocket expenses. You can read more about restricted cover on page 33.

Medical costs
The fees charged by a surgeon, physician, or other medical specialist whilst being treated as an inpatient in the hospital.

• Medicare has a list of medical services that the government will either pay some or all of the cost of, called the Medicare Benefits Schedule. Each has a fee that the government thinks is appropriate to charge for that service, which is the amount Medicare will pay for that service.

• Medicare and Bupa both pay a portion of the fee for medical services set by the Australian Government (75% and 25% respectively). However, your specialist may choose to charge more than the set fee. This means you would have a ‘gap’ to pay yourself. The Bupa Medical Gap Scheme is designed to eliminate or minimise the amount you’ll have to pay in cases like this. Go to page 30 and 31 for more information.

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

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


Emergency or non-emergency – what’s the difference?

Emergency
This means an unplanned event where your life may be at risk and you need medical treatment right away.

For more information about what we define as an emergency, read our fund rules at bupa.com.au/fundrules

Non-Emergency
This is when you need to use an ambulance but don’t need treatment straight away, or your life is not at risk.

For example:
• Transport from a hospital to your home or nursing home.
• Transport to a hospital, your home, or nursing home for ongoing treatment, like dialysis or chemotherapy.
• Where you’ve been admitted to one hospital and need to be taken to another (the hospital should include this in the cost of your procedure).
• NSW/ACT Hospital Cover

Through the cost of your Hospital Cover, Bupa collects a levy which contributes towards a NSW/ACT State Ambulance Scheme. As a part of this scheme, you are provided with uncapped emergency transportation when provided by NSW/ACT Ambulance within the State.

A 1 day waiting period applies to emergency ambulance and on-the-spot treatment on Premium Ambulance and Emergency Only Ambulance covers.

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

<table>
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<th>Cover type</th>
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What’s included per calendar year

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

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

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It’s worth noting that some states:
Offer free or subsidised ambulance services to pension and concession card holders. Check your State Government website for more details.

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

Hospital covers
Charges related to your hospital admission such as the operating theatre, nursing and allied health services including accommodation and meals.

How fees for medical treatments are set
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What are Extras?

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

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

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

Members First Extras providers

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

There are great advantages in visiting a Members First provider:

- You’ll know how much you can claim and how much you’ll be out-of-pocket. Depending on your cover, you’ll get from 50% - 100% of the cost back on most dental, physio, chiro and podiatry consultations, up to your yearly limits.1 Plus, you’ll have access to the ‘no gap’ range of glasses and contact lenses. Find out more at bupa.com.au/find-a-provider/membersfirstoptical.
- Depending on your level of cover, you can usually expect to claim more money back than if you go to a provider who doesn’t have an agreement with Bupa.
- If your employer pays for your cover, you may be on a level of cover where you can be sure of the percentage you’ll get back at any recognised provider. Check your Private Health Insurance Statement (PHIS) to see if this applies to you.
- If you have kids, depending on your cover, they may be able to access special ‘gap free’ arrangements where the costs of most services at dentists, chiropractors, physiotherapists and podiatrist consultations will be fully covered, up to your yearly limits.2 Plus, your kids (Child dependants only) will have access to the ‘no gap’ range of glasses and contact lenses.

Members First Platinum Network

Members First Platinum is intended to make common preventative dental treatment available, without any out-of-pocket costs, to eligible members.

At a Members First Platinum dentist, if you’ve got Hospital and Extras cover with us, you may be eligible to pay nothing for your regular dental checkup, including consults and dental exams, scale and cleans, bitewing x-rays, mouthguards, and fluoride treatments.3 Up to yearly limits. Plus, you’ll get all the benefits of Members First on most other dental services.

Find out more at bupa.com.au/members-platinum

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

To read our Fund Rules visit bupa.com.au/fundrules

Making a claim is really simple, too. At these providers you can usually make your claim on the spot by swiping your Bupa card or Digital card if a HICAPS terminal is available.

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1 Waiting periods, fund and policy rules apply.
2 Excludes orthodontics, orthotics and hospital treatments.
3 Members First Platinum (pay nothing for dental check-up) benefits are only available where general dental services are included on the Extras component and are not available on Freedom 50 Extras and Freedom 60 Extras products and Your Choice Extras 60 where general dental is not included.
Special types of Extras services

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

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

Custom-made foot orthotics are paid under Podiatry on Corporate Mid Extras, Corporate Family Extras and Corporate Total Extras.

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

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

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

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

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

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

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

Using your health insurance

Making an Extras claim

Claiming on the spot with your Bupa card
Electronic claiming is the fastest way to make your health insurance claims

Many Bupa recognised providers around Australia provide this service, such as dentists, physiotherapists, chiropractors, podiatrists, remedial massage therapists, optical outlets and more. After your treatment, swipe your Bupa card and the claim will be processed automatically. If your claim is accepted, there are no forms for you to complete and you’ll only pay the balance of the account.

Claiming online with myBupa
Log in to myBupa.com.au and enter the details found on your receipt via the ‘make a claim’ section. We’ll transfer the payment directly to your bank account, so have your BSB and account number ready.

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

Bupa
GPO BOX 990
Adelaide SA 5001

Claiming in a Bupa Health Insurance store
Drop into your nearest store and provide your receipts and we’ll transfer the payment directly to your bank account.

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

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

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

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

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

<table>
<thead>
<tr>
<th>Yearly limit</th>
<th>This is the maximum amount you can claim for a service from 1 January to 31 December. If you haven’t claimed up to your yearly limit, this doesn’t ‘roll over’ to the next year – it resets on 1 January.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub limit</td>
<td>This is like a limit within a limit. It applies to a very specific service, per person, per year. For example, if you have Your Choice Extras 60, there’s a yearly limit of $500 in the first year for natural therapies. A sub limit applies to massage therapy of $100 per person, so once you have reached that limit for massage therapy, you can no longer claim for massage therapy that year. However, you could make up to $400 more in claims for other permitted natural therapies, like acupuncture.</td>
</tr>
<tr>
<td>Service limit</td>
<td>For some types of Extras services, there are limits to the number of times that benefits are payable for the same service. For example, you can only claim a scale and clean from your dentist once every six months. These limits apply from the date you receive the service, not from the time you submit the claim.</td>
</tr>
<tr>
<td>Person limit</td>
<td>This is the maximum amount that each person covered by your Bupa membership can claim in a calendar year. If you’re on a policy with a family member, then you’ll have your own individual limits.</td>
</tr>
<tr>
<td>Membership limit</td>
<td>This is the maximum amount that can be claimed collectively, by everyone covered by your membership within the calendar year, for a specific type of Extras service. Remember, these limits apply in addition to your individual per person limits. Also, the membership limit might not be high enough for all your family members to claim their individual limits. For example, you may have a person limit of $500 for chiropractic services, but a membership limit of $1,000. This could be used by two family members even if you have four people listed on your policy.</td>
</tr>
<tr>
<td>Lifetime limit</td>
<td>Health insurers usually have a lifetime limit for orthodontics. This applies to an individual. If you have reached this limit, you can’t make any further claims for this at Bupa again. It doesn’t reset, even if you leave Bupa and start your cover again with us.</td>
</tr>
</tbody>
</table>

You can find information about limits in your policy information available at myBupa.com.au
Restrictions on making claims
You need to have finished any waiting periods that apply. If you’re new to Bupa and Extras cover, it’s good to be on top of what waiting periods apply to you and when they will end.

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

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

3. There are service limits for our Extras modalities
We have rules about what you can claim, based on usual clinical practice. It means that specific services may have a limit to the number of times they can be claimed within a certain time frame. For example, we generally only pay for a dental check-up claim every six months. Another example, you can only claim a CPAP machine once every two years. If you’re not sure if you’re covered for a service, or if your dental condition means you need treatment outside these rules, please contact us.

4. You have up to two years to submit a claim
We allow customers two years from the date of service to submit any claims for benefits to be paid. The two-year claim rule is in place as it is consistent with Medicare’s claim rules.

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

The amount you’ll pay for each treatment can depend on:
1. How much the provider charges for the service
2. Any agreements between the provider and Bupa
3. The amount you can claim back, determined by your level of cover

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

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

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

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

- We make arrangements directly with specialists, separate to our agreements with hospitals. This means you will be billed by your specialist separately and in addition to your hospital bill. We may cover some or all of this.
- The Australian Government sets a fee for the cost of a medical service. Medicare pay 75% and Bupa pay 25% of that set fee. Some specialists will choose to only charge that set fee. However, your specialist may choose to charge more than the fee. This means you would have a ‘gap’ to pay yourself.
- The Bupa Medical Gap Scheme is designed to minimise or eliminate the amount you’ll have to pay in cases like this. We do this by paying more than the set fee, and we have an arrangement with the specialist on a fixed cost for your treatment. Go to page 30 and 31 to find out more.

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

Once you’ve had your initial consultation with your GP, ask Bupa:
“Can you provide me with a list of specialists who use the Bupa Medical Gap Scheme?”
“Can these specialists treat me in a hospital that has an agreement with Bupa, and which hospitals are they?”

Ask your GP:
“Can you refer me to a specialist who uses the Bupa Medical Gap Scheme?”
“Can you refer me to a specialist who can treat me in a hospital that has an agreement with Bupa?”

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

Ask your specialist:
“Do you use the Bupa Medical Gap Scheme?”
“If not, ask them what you will have to pay.
“Will any other specialists be involved in my treatment?”

Sometimes you’ll also need the services of specialists like a pathologist, radiologist or assistant surgeon. If so, ask if they use the Bupa Medical Gap Scheme, or if they are In-Hospital Pathology and Radiology contracted providers that have ‘no gap’ arrangements with Bupa.

Informed financial consent
If your hospital stay involves any out-of-pocket hospital charges, the hospital (whether private or public) must disclose the cost and obtain your agreement in writing before your admission. If your doctors’ fees include any out-of-pocket charges, your specialist should disclose the cost and obtain your agreement before your admission to hospital. They should provide advice on fees charged not only by themselves but also by other specialists or surgeons as well as by anaesthetists, assistant surgeons, pathologists and radiologists.

Find a no gap pathology provider for services in hospital at bupa.com.au/no-gap-pathology
Find a no gap radiology provider for services in hospital at bupa.com.au/no-gap-radiology
1. **Know what you’re covered for**

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

2. **Choose whether or not to go public or private**

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

3. **Check your hospital options**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Members First Overnight &amp; Day hospitals</th>
<th>Network Overnight &amp; Day Hospitals</th>
<th>Network Fixed Fee Hospitals</th>
<th>Non-agreement hospitals</th>
<th>Public hospital private patient</th>
<th>Public hospital public patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice of hospital</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Choice of specialist</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Reduce waiting time</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Covered for hospital costs</td>
<td>✓</td>
<td>✓</td>
<td>Most</td>
<td>Limited</td>
<td>Limited</td>
<td>✓ by Medicare</td>
</tr>
<tr>
<td>Private room guarantee (overnight)*</td>
<td>✓</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cover for extra services and benefits</td>
<td>✓</td>
<td>Some</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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


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**Choosing a hospital**

[Image]
### Choosing a private hospital

Private hospitals do vary in cost and the services they provide. If cost is an issue, make sure you choose a hospital that has an agreement with Bupa.

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

#### Hospital costs and benefits by hospital type

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Cost to you</th>
<th>Member benefits</th>
<th>Important to note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members First</strong></td>
<td>Low - In most instances you’ll be covered for hospital costs. Any excess or co-payments as per your policy will still apply.</td>
<td>Our ‘private room or money back guarantee’ for an overnight stay.* Plus, complimentary daily newspaper, local phone calls and free-to-air TV. If pregnancy and birth services are included in your cover, you get: breast-feeding and parenting education classes postnatal clinics for up to 8 weeks after you leave hospital parental support services.</td>
<td>To take advantage of the ‘private room or money back guarantee’ for an overnight stay.* You’ll need to book and request a private room in a Members First hospital at least 24 hours before admission. We have over 120 Members First Hospitals.</td>
</tr>
<tr>
<td><strong>Network hospitals</strong></td>
<td>Low - In most instances you’ll be covered for hospital costs.</td>
<td>You will be covered for a private room if you request one and where one is available. You’ll also receive complimentary local phone calls and free-to-air TV.</td>
<td>The ‘private room or money back guarantee’ does not apply.*</td>
</tr>
<tr>
<td><strong>Network hospital with a fixed fee</strong></td>
<td>Medium – You may be charged a fixed daily fee and generally be covered for your hospital costs (this fee does not apply if you are on Ultimate Health Cover).</td>
<td>You will be covered for a private room if you request one and where one is available. You’ll also receive complimentary local phone calls and free-to-air TV.</td>
<td>At some of these hospitals, a fixed fee applies to all services offered. At others, a fixed fee applies to either a psychiatric or rehabilitation service only. This fee is capped at a maximum number of days per overnight stay. The fixed daily fee charged by the hospital is in addition to any excess or co-payment you may need to make.</td>
</tr>
</tbody>
</table>

*Private room or money back guarantee’ means that at our Members First hospitals, you’ll receive a private room when you book and request a private room at least 24 hours before the overnight admission. If a private room is not available, you’ll receive $10 back per night from the hospital. You’ll also get a free daily newspaper and free local calls. Applies to overnight admissions only. Excludes ‘nursing home type patients’, emergency care same-day or where a private room is medically inappropriate.

#### Type of hospital

<table>
<thead>
<tr>
<th>Type of hospital</th>
<th>Cost to you</th>
<th>Member benefits</th>
<th>Important to note</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members First Day hospital</strong></td>
<td>Low - In most instances you’ll be covered for your hospital costs. and there will be no gap to pay on your specialist’s fees.</td>
<td>You will pay nothing for treatment by a specialist at these hospitals. You will also receive complimentary local phone calls and free-to-air TV.</td>
<td>We now have over 100 Members First Day Hospitals. (Not available in NT)</td>
</tr>
<tr>
<td><strong>Network Day hospital</strong></td>
<td>Low - In most instances you’ll be covered for your hospital costs.</td>
<td>Complimentary local phone calls and free-to-air TV.</td>
<td></td>
</tr>
<tr>
<td><strong>Non-agreement hospital</strong></td>
<td>High – These hospitals haven’t entered into any agreement with Bupa, meaning we only cover minimal costs.</td>
<td>None. You will be responsible for the cost of your stay and may be charged directly for your hospital accommodation, surgically implanted prostheses and personal expenses such as TV hire. Some of these hospitals bill Bupa directly for the limited benefits we pay. If your specialist’s charge more than what we pay (with Medicare), you’re likely to have some medical costs to pay yourself.</td>
<td>If you attend one of these hospitals, you are likely to encounter significant expenses. You will not be able to use the Bupa Medical Gap Scheme at these hospitals to lower your medical costs. This means the costs for you to pay could be higher at these hospitals.</td>
</tr>
</tbody>
</table>

Choosing a public hospital

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

### Public patient in a public hospital

**Pros**
- All costs relating to your admission will be covered by Medicare, including prostheses and all medical costs.

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

### Private patient in a public hospital

**Pros**
- You’ll get your choice of your doctor, if they are available.
- We’ll pay the cost of you staying in a shared room. (This amount is set by the Australian Government).
- If a private room* is available and you choose to stay in it, Bupa may cover some of the additional cost of this, depending on your level of cover. If this won’t cover all your costs, the hospital should let you know the amount you will need to pay.
- We’ll contribute to the cost of prostheses and specialists as we would if you were treated in a private hospital.

**Cons**
- You may still be subject to public hospital waiting lists.
- Depending on your illness or condition, you may get the same doctor who would have been allocated to you if you were a public patient.
- You’ll be responsible for personal expenses such as TV and telephone calls.
- You may experience out of pocket expenses.

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

### Things to remember before choosing public

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

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

### Keep in mind

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

### What should I ask the hospital before I decide?

- "What are the benefits to me if I choose to use my private cover?"
- "Will there be any difference to my care if I use my private cover?"
- "Can I choose my doctor?"
- "Can you ensure I will have a private room for my entire stay?"

### When can I use my Ambulance cover?

1. When you can’t claim the costs from another source. For example, when your State Government doesn’t cover you and you can’t claim from a subscription or Government levy. See page 35 for more information.
2. If your ambulance service was provided by our recognised provider in the state you had that service. These are listed in the table opposite.

### How do I pay my ambulance costs?

If you receive an invoice for ambulance services, and you’re covered for ambulance, the table below will show you what to do. If you need to send the invoice to us, check page 18 for how to claim.

<table>
<thead>
<tr>
<th>State you normally live in</th>
<th>Recognised provider</th>
<th>State subscription available</th>
<th>What do I need to do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIC</td>
<td>Ambulance Victoria</td>
<td>✓</td>
<td>If it is included in your subscription – send it to them to pay it.</td>
</tr>
<tr>
<td>SA</td>
<td>SA Ambulance Service</td>
<td>✓</td>
<td>If it is not included in your subscription – send the invoice to us.</td>
</tr>
<tr>
<td>NT</td>
<td>St John Ambulance</td>
<td>✓</td>
<td>If included in your subscription, send it to ‘St John’s Ambulance’ to pay it. If it is not included in your subscription – send the invoice to us.</td>
</tr>
<tr>
<td>Country WA</td>
<td>St John Ambulance</td>
<td>✓</td>
<td>If included in your subscription, send it to ‘St John’s Ambulance’ to pay it. If it is not included in your subscription – send the invoice to us.</td>
</tr>
<tr>
<td>Metro WA &amp; Norfolk Island</td>
<td>St John Ambulance</td>
<td>X</td>
<td>Send the invoice to us.</td>
</tr>
<tr>
<td>ACT</td>
<td>ACT Ambulance Service</td>
<td>X</td>
<td>Send the invoice to us. We’ll either organise it with your State Government or pay it ourselves.</td>
</tr>
<tr>
<td>NSW</td>
<td>Ambulance Service of NSW</td>
<td>X</td>
<td>Send the invoice to us. We’ll either organise it with your State Government or pay it ourselves.</td>
</tr>
<tr>
<td>TAS</td>
<td>Tasmanian Ambulance Service</td>
<td>N/A</td>
<td>If you have the service in QLD or SA – send the invoice to us. Otherwise, send it to the Tasmanian Government for payment.</td>
</tr>
<tr>
<td>QLD</td>
<td>QLD Ambulance Service</td>
<td>N/A</td>
<td>There’s nothing for you to pay. Send the invoice to the Queensland Government to pay.</td>
</tr>
</tbody>
</table>

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

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

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

By your Hospital cover
This is medication you take in hospital (not discharge medications) required to treat and manage the condition for which you are in hospital. In most cases, these medications are fully covered by our hospital agreement – this just means that the hospital will bill Bupa directly and you won’t have to make a claim.

• If you’re at a private hospital with a Bupa you won’t have to make a claim. There aren’t any claims to be made – the hospital will bill Bupa directly and fully covered by our hospital agreement – this just means that the hospital will bill Bupa directly.
• If there’s a waiting period, you must have served your waiting period before you’ll be covered.

By your Extras cover
This is medication you purchase when you’re not in hospital or once you’ve left hospital, as well as unopened medication provided to you when you are discharged from hospital.

Many types of Extras cover include cover for pharmacy. This is medication that you buy yourself, or that is provided to you by a hospital but is unopened. Pharmaceuticals must be approved by the Therapeutic Goods Administration (TGA) and not appear on our exclusion list.

To make a claim for your medication you’ll need an official pharmacy receipt with the following information:
• Drug name.
• Date dispensed (or its supply date).
• Strength.
• Quantity.
• Confirmation the medication was not subsidised by the Australian Government’s Pharmaceutical Benefits Scheme (PBS).
• Pharmacist’s name, address and prescription number.
• Customer’s name and address.

Accidental injuries
Waiting periods and accidents
Accidents are just that – accidents. That’s why, if you have an accident shortly after you’ve joined Bupa or upgraded your cover, we’ll cover you immediately for accidents you’ve sustained (limited to what’s covered in your policy).

We consider something an accident if:
• It was unforeseen and occurred by chance.
• It happened because of an external force, but wasn’t intentional.
• It happened in Australia.

What’s not considered an accident?
• A sudden illness.
• Surgical procedures.
• Injuries due to alcohol or drug use, or drugs not prescribed by a registered practitioner.

What do I need to do if I have an accident?
We’ll waive the waiting period for treatment you need due to an accident, if you:
• Get medical advice or treatment from a registered medical practitioner within 72 hours of the accident.
• Continue to hold a policy which covers the accident-related treatment.
• Have all the treatment you need within 180 days of the accident.

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

Accident Inclusion means upgraded cover
We understand that no one sees an accident coming, so you might not have thought to include some things on your cover. That’s why, on some policies, we’ll cover you in a private hospital for treatments that are excluded or restricted on your cover if you need them because of an accident.

We call this Accident Inclusion. Check your policy information to see if this is included in your cover.

Utilising our ‘Accident Benefit’
On some covers, our Accident Benefit can help reduce the costs you pay. In hospital, to claim back your excess or co-payment if you are admitted for related treatment. On Extras that will aid your recovery - even if you’ve already reached your limit. How the limits apply varies between products, so check your policy information.

Utilising our ‘Accidents Happen Refund’
On some covers, when requiring hospital treatment as the result of an accident, Bupa will refund you the hospital excess you paid for that admission. So check your policy for more information.

We do not cover:
• Over-the-counter or non-prescription pharmacy items.
• Compounded medications, which are mixed from the individual ingredients to the strength and dosage required for an individual except in exceptional circumstances, with a supporting letter from the treating medical practitioner.
• Body-enhancing medication (e.g. anabolic steroids).
• Weight loss medication.
• Medication provided by a hospital that isn’t intrinsic to your care.

If you’re not sure, contact us.
You can make a claim by completing a form and submitting it in-store or by mail.

The amount Bupa will pay for medication will depend on your level of cover, and we only cover the amount of the medication cost that exceeds the PBS co-payment, which is an amount set by the Australian Government. As of January 2021, this amount was $41.30. This means if the cost of the drug is less than $41.30, you can’t make a claim.

By your Hospital cover
This is medication you purchase when you’re not in hospital or once you’ve left hospital, as well as unopened medication provided to you when you are discharged from hospital.

Many types of Extras cover include cover for pharmacy. This is medication that you buy yourself, or that is provided to you by a hospital but is unopened. Pharmaceuticals must be approved by the Therapeutic Goods Administration (TGA) and not appear on our exclusion list.

To make a claim for your medication you’ll need an official pharmacy receipt with the following information:
• Drug name.
• Date dispensed (or its supply date).
• Strength.
• Quantity.
• Confirmation the medication was not subsidised by the Australian Government’s Pharmaceutical Benefits Scheme (PBS).
• Pharmacist’s name, address and prescription number.
• Customer’s name and address.

We do not cover:
• Over-the-counter or non-prescription pharmacy items.
• Compounded medications, which are mixed from the individual ingredients to the strength and dosage required for an individual except in exceptional circumstances, with a supporting letter from the treating medical practitioner.
• Body-enhancing medication (e.g. anabolic steroids).
• Weight loss medication.
• Medication provided by a hospital that isn’t intrinsic to your care.

If you’re not sure, contact us.
You can make a claim by completing a form and submitting it in-store or by mail.

The amount Bupa will pay for medication will depend on your level of cover, and we only cover the amount of the medication cost that exceeds the PBS co-payment, which is an amount set by the Australian Government. As of January 2021, this amount was $41.30. This means if the cost of the drug is less than $41.30, you can’t make a claim.
Managing and reducing your medical costs

The Bupa Medical Gap Scheme

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

How does it work?

We pay more, so that you pay less.

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

Where can my doctor use the Bupa Medical Gap Scheme?

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

- Public hospitals, or
- Private hospitals that have an agreement with Bupa.

Bupa has agreements with almost all private hospitals across Australia.

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

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

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

In a Public Hospital:

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

In a Private Hospital with which Bupa has an agreement:

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

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

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

Find Members First, Network Hospitals and Medical Gap Scheme providers at bupa.com.au/find-a-provider

Below is an example of how it might work.

Scenario 1

Your specialist charges the fee set by the government

<table>
<thead>
<tr>
<th>Your specialist’s fee is $2,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare pays $1,500</td>
</tr>
<tr>
<td>Bupa pays $500</td>
</tr>
<tr>
<td>You pay $0</td>
</tr>
</tbody>
</table>

Scenario 2

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

<table>
<thead>
<tr>
<th>Your specialist’s fee is $3,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare pays $1,500</td>
</tr>
<tr>
<td>Bupa pays $1,500</td>
</tr>
<tr>
<td>You pay $0</td>
</tr>
</tbody>
</table>

Scenario 3

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

<table>
<thead>
<tr>
<th>Your specialist’s fee is $3,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare pays $1,500</td>
</tr>
<tr>
<td>Bupa pays $1,500</td>
</tr>
<tr>
<td>You pay $500</td>
</tr>
</tbody>
</table>

Scenario 4

Your specialist doesn’t use our Medical Gap Scheme

<table>
<thead>
<tr>
<th>Your specialist’s fee is $5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare pays $1,500</td>
</tr>
<tr>
<td>Bupa pays $500</td>
</tr>
<tr>
<td>You pay $3,000</td>
</tr>
</tbody>
</table>
Potential ‘out-of-pocket’ costs

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

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

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

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

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

4. A ‘gap’ for specialist fees
The Australian Government sets an amount for the cost of specialist medical services. Medicare and Bupa both pay a portion of this. However, your specialist may choose to charge more than the set fee. This means you would have a ‘gap’ to pay yourself. Go to page 30 and 31 for more information.

5. Exclusions
Sometimes specific services or treatments are excluded under your level of cover. In these cases, you’ll be responsible for all expenses related to your hospital admission for that procedure or service.

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

Visit mybupa.com.au

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

The amount we pay for other costs you may incur in hospital (like medical costs), is not lower under restricted cover. See page 23 for more details.

Log in to mybupa.com.au to access your policy information, which shows the services this applies to.

7. Things your hospital policy doesn’t cover
This varies, but here are some common examples:

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Covered by</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP visits, blood tests, X-rays and MRIs, when you are not admitted to hospital</td>
<td>Medicare</td>
</tr>
<tr>
<td>Non-emergency ambulance transport</td>
<td>Check page 14 for more details</td>
</tr>
<tr>
<td>Services and treatments specifically excluded from your cover</td>
<td>You</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>You</td>
</tr>
<tr>
<td>Services covered by another source</td>
<td>For example, travel insurance or worker’s compensation.</td>
</tr>
</tbody>
</table>

If you have Corporate Silver Plus Extensive Hospital, Corporate Gold Hospital and Premium Ambulance Cover with Bupa, you will be covered for non-emergency ambulance transport, capped at $5,000 per person per calendar year. Waiting periods,fund and policy rules apply.
Paying your hospital expenses

These forms are available at any Medicare centre or via the Department of Human Services website. If you can’t get to a Medicare centre, contact either Bupa or Medicare and ask for the relevant forms to be sent to you. Remember, you might have to see multiple specialists for one procedure.

### Paying your hospital costs

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

### Paying your medical costs

If your specialist uses our Medical Gap Scheme, they’ll send the bill to us directly. You won’t see the paperwork until you receive your Statement of Benefits. If you have had to pay an amount (up to $500), the specialist will bill you for the fee directly.

If your specialist doesn’t use our Medical Gap Scheme, the specialist could charge any price and you’ll need to pay any ‘gap’ in cost yourself. You will receive the bill directly and you can make a claim in one of three ways.

1. Pay in full
   - you have two Medicare forms to fill out. The first is the Medicare Claim form and the second is the Medicare Two-way Claim form. Once you’ve completed both these forms, you can submit them to Medicare by post, in a Medicare branch, online or by using the Express Plus Medicare smartphone app.
2. Pay in full
   - then complete a Medicare claim form and a two-way claim form. That means Medicare will liaise with Bupa on your behalf to ensure you receive your refund.
3. Do not pay
   - instead complete both a Medicare and two-way claim form. If Medicare confirm you’ve not paid, you’ll receive two cheques made out to the specialist – one from Medicare and one from Bupa. You can then send these to your specialist as payment for the set fee.

### Paying your prosthesis and pharmacy costs

If the prosthesis is on the Australian Government’s Prostheses List and you’re admitted to a private hospital with a Bupa agreement, then the hospital will bill Bupa directly.

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

### Check your Statement of Benefits

After your hospital and medical claims have been processed, your statement will be available in myBupa, showing what’s been paid on your behalf. This is known as your Statement of Benefits. Please check that these details are correct and contact us straight away if you have any questions.

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

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

### Understanding your premium

#### Community rating

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

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

The only exceptions to this are:
- Due to different healthcare costs, insurance premiums can vary between different States and Territories.
- Aged-Based Discount on Hospital cover.
- The Australian Government’s Lifetime Health Cover (LHC) initiative.
- The Australian Government Rebate.

Find out more on page 36.

#### Late and overdue payments

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

When your payments are overdue by less than two months, we’ll accept any outstanding payments and you’ll be able to claim as usual once the arrears have been paid.

When you’re overdue for more than two months, it’s at our discretion whether or not to accept payment and allow your membership to continue.

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

Depending on how long the gap in your policy is you may be charged:
- the additional Medicare Levy Surcharge (MLS) as part of your tax return, in addition to the Medicare Levy; or,
- more for your cover through Lifetime Health Cover Loading.

For more on these Government considerations, see page 36.

#### Financial Hardship

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

Government policies and tax considerations

Lifetime Health Cover (LHC)

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

If you don’t have hospital cover before 30 June following your 31st birthday and then decide to take out our Hospital cover, you’ll pay an additional 2% on top of your Hospital cover premium every year you delay - up to a maximum of 70%.

This extra cost will remain in place until you’ve had appropriate private hospital cover for 10 continuous years.

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

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

Government rebate

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

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

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

Age-based discount

If you’re aged 18-29, you are entitled to receive an age-based discount on your domestic Hospital cover. The discount is calculated at 2% for each year you’re aged under 30, when you first purchase your domestic Hospital cover. The maximum discount is 10% for 18 to 25 year olds.

Continuity of the age-based discounts

If you currently have health insurance with another fund, we’ll verify your level of discount once we’ve received a clearance certificate from your old health insurer – but don’t worry, we’ll manage this process behind the scenes, so there’s no need for you to do a thing.

Here’s an example of how it might work:

• If you’re a single aged between 18 and 25, you may be entitled to the full 10% discount on your domestic Hospital cover, until you turn 41.
• If you’re a couple aged 25 and 29, you may be eligible to receive the applicable discount for your age. The discount for a couple’s policy will be applied as an average to the total premium. The partner aged 25 may be eligible for a 10% discount on their domestic Hospital cover, while the partner aged 29 may be eligible for a 2% discount, resulting in a 6% average discount each year they hold domestic Hospital cover until they turn 41.

Medicare Levy and Medicare Levy Surcharge

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

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

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

Can you avoid paying the MLS?

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

<table>
<thead>
<tr>
<th>Tier</th>
<th>Singles</th>
<th>Families</th>
<th>Medicare Levy Surcharge rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Tier</td>
<td>Up to $90,000</td>
<td>Up to $180,000</td>
<td>0%</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$90,001–$105,000</td>
<td>$180,001–$210,000</td>
<td>1%</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$105,001–$140,000</td>
<td>$210,001–$280,000</td>
<td>1.25%</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$140,001</td>
<td>More than $280,000</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

*Based on Basic Plus Active Saver – hospital and extras cover from 1 October 2020. £ refers to the total premium. The income thresholds will remain the same from 1 July 2015 until 30 June 2021. On a family or single-parent membership, income thresholds increase by $1,500 per child after the first. The family thresholds also apply to single parent families and de facto couples. For more information go to atos.gov.au. 

An example comparison

<table>
<thead>
<tr>
<th>Without private cover</th>
<th>With Bupa Hospital and Extras cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupa Hospital</td>
<td>You pay $1,192.90* per year</td>
</tr>
<tr>
<td>You get</td>
<td>nothing more</td>
</tr>
</tbody>
</table>

You get

• Cover for some common hospital procedures
• Private hospital room, where available
• $1,000 to claim back on a range of extras
• Up to 60% back at Members First Platinum
• Much more
Let’s wrap things up

**Fund rules**

Everything we do is governed by our Fund Rules. These are available online at [bupa.com.au/fundrules](http://bupa.com.au/fundrules).

**Privacy and personal data**

Your privacy is important to us. This statement summarises how we handle your personal information.

For full information about our information handling practices, please refer to our Information Handling Policy (available at [bupa.com.au/info-handling-policy](http://bupa.com.au/info-handling-policy)). When you join Bupa, you agree to the handling of your personal information as set out in this document.

**Information Policy**

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

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

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

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

**Health cover and overseas travel**

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

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

- Belgium
- Finland
- Ireland
- Italy
- Hungary
- Norway
- The Netherlands
- Slovakia
- Sweden
- United Kingdom

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

**Suspending your membership when you go overseas**

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

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

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

To be eligible for a suspension, you must:

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

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

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

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

**Things to consider**

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

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

While you’re on suspension you’ll be considered as not holding an appropriate level of Hospital cover. At the end of the financial year, if your income is over the thresholds set for the Medicare Levy Surcharge, you may need to pay the surcharge in addition to the Medicare Levy, for the period of your suspension. For more information, speak to your tax advisor.

**Complaints and feedback**

If you have any concerns, or you don’t understand a decision we’ve made, we’d like to hear from you. To find out how to contact us, or to understand how we’ll manage your complaint, you can read our full complaints and feedback process at [bupa.com.au/complaints-feedback](http://bupa.com.au/complaints-feedback).

The Private Health Insurance Code of Conduct

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

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

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


**More Information**


**Bupa health cover made easy**


We’re here to help

We get that there’s a lot of info to take in when it comes to health insurance but that’s what we’re here for.

Get in touch whenever you need to and we’ll answer any questions you might have.

Bupa Health Insurance

Give us a call us on 134 135, visit bupa.com.au or head into a Bupa Health Insurance store.

Apple iMessage

WhatsApp