



Welcome to Bupa

Your Important Information Guide

Here's what you need to know



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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 here 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 here, 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.

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 **Health Link**. We're helping to fund breakthrough medical research that enables real health and care improvements for all Australians through our **Bupa Foundation**.

Bupa Health Services

Whether you're after dental care or an eye or hearing test, we're all about giving you personalised health advice you need quickly and easily. That's why we've partnered with healthcare providers who focus on preventative health. Any claims for services under your Bupa health insurance policy are subject to any applicable waiting periods, yearly limits, benefit claiming restrictions, fund and policy rules.

Dental · Optical · Audiologist · Telehealth



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.





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 year¹) 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 from recognised providers.² Depending on your cover, you may even be able to claim money back for services like remedial massage and acupuncture.
- 4 Lifetime Health Cover (LHC) loading**

The LHC loading is a Government initiative designed to encourage Australian citizens and permanent residents to take out hospital insurance earlier in life. If you don't have hospital cover by 1 July 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 continuous 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 may 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.³ Refer to **page 37** for more information.

¹ Source: Australian Government Institute of Health and Welfare Report: Elective surgery waiting times 2023-24. ² Extras service providers must meet certain requirements to be recognised by Bupa and for us to pay towards the cost of your treatment. Waiting periods, yearly limits, policy and fund rules apply. Percentage back may vary depending on benefit claiming restrictions. ³ Applicable rebate % and income thresholds are reviewed annually by the Australian Government. Single parents and couples (including de-facto couples) are subject to family tiers. For families with children, the income thresholds are increased by \$1500 for each Medicare Levy Surcharge dependant child after the first child. For more information go to ato.gov.au.

What if you change your existing Bupa cover?

There are a few things to keep in mind

- 1. You might need to wait before claiming new benefits**

If your new Bupa policy includes services not covered by your previous policy, or offers higher benefit limits, a waiting period may apply. During this time, you may only be eligible to claim at the lower benefit level until the waiting period ends.
- 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. Limits on any amount you have claimed are transferred when you change your Bupa cover. For example, any claims you have already made in a year will count towards your new yearly limit if you decide to change cover.
- 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 digital identity 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.



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 dental or physio.
- Unique identification if you're admitted to hospital.

Tap fast. Claim quick

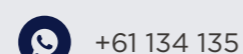
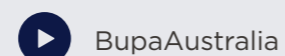
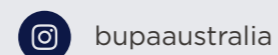
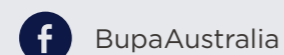
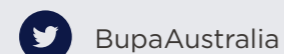
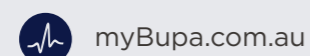
- With just one tap you can claim with iPhone, Apple Watch or Android phone.¹
- Add a digital membership card today, simply follow the steps at bupa.com.au/card

¹ For services included on your cover. Yearly limits, waiting periods, benefit claiming restrictions, fund and policy rules apply. Digital cards may be used at supported terminals only using compatible Apple iOS, Apple watch and Android devices.



Stay up to date

Click the links below to visit Bupa online



Life Rewards

Life Rewards is Bupa's reward and recognition program. It's our way to reward our members every single day. From filling up your fuel tank, savings on everyday essentials, to family outings, you'll be surprised how much you can save with Life Rewards.

With 5 membership tiers, you can unlock more rewards, offers and experiences the longer you're with us.

Visit bupa.com.au/liferewards to find out more



Access our Member Health Support Programs and Services

At Bupa we're here to help you not just when you are in need. 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. It's all part of our commitment to helping you live a longer, healthier, happier, life.²

- Bupa Health Coaching Program
- Dietitian Health Coaching Service
- Osteoarthritis Healthy Weight For Life Program
- Rehab Choices Program

- Mind Care Choices Program
- Parent and Baby Wellbeing Program
- Recovery Support Program
- The COACH Program
- Chemotherapy Choices Program
- Dialysis Choices Program
- Palliative Care Choices Program
- Aged Care Support Line
- Advance care planning
- Advara HeartCare Partnership
- Kids Helpline@School program

² Individual program eligibility, waiting periods, fund and policy rules apply. For full details, please refer to the individual program pages linked above or contact us directly.



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**



Making sense of your health insurance

Learn more about Hospital cover

Hospital cover

Hospital waiting periods

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

To claim you need to have finished any waiting periods that apply. You can't claim for services which are not included on your level of cover. You also can't claim for services that took place during your waiting period, even after you have completed them.

Different waiting periods apply to different hospital services:

Service/Treatment	Waiting period
Emergency ambulance ¹	1 day
Accidents that occurred after joining Bupa ²	None
Palliative care, rehabilitation and hospital psychiatric services ³	2 months
All other treatments included in your cover	2 months
Pre-existing conditions	12 months
Pregnancy and birth (obstetrics)	12 months

¹ If claimable from another source, a benefit won't be paid by Bupa. Benefits for ambulance transportation is only payable where the provider describes the transportation as an 'Emergency'. For more, see the Important Information Guide. There is a 1 day waiting period for emergency ambulance and on-the-spot treatment.

² For Accidents that occur in Australia after your cover starts. Must meet Bupa's definition of an Accident as defined in the Bupa Fund Rules, must seek medical treatment within 72 hours, and receive any further treatment within 180 days, of the Accident occurring. Out of pockets may apply.

³ Existing members: If you need to discuss how you're covered for urgent mental health treatment in-hospital, please contact us. Policy rules and exclusions apply.

Pre-existing conditions

A pre-existing condition is defined as any ailment, illness, or condition where, in the opinion of a medical adviser appointed by Bupa, the signs or symptoms of that illness, ailment or condition existed at any time in the period of 6 months ending on the day on which you became insured under the policy. This also applies if you upgrade your cover to include new services.

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.

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 there may be 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 if you undergo more than one type of hospital treatment during a hospital admission, we will generally only cover hospital treatment including accommodation, theatre fees and prosthesis for procedures related to treatment covered by your policy that are performed as part of your admission. We will also cover hospital treatment as required under legislation relating to the payment of benefits for Associated Treatments for Complications, Associated Unplanned Treatments, Common Treatments and Support Treatments (as discussed further below).

Outside of these situations, if a member receives multiple hospital treatments during an admission to hospital, that is both included and excluded, we will pay for all the included treatment and may pay any element of treatment that cannot be appropriately allocated to the excluded treatment on an ex-gratia basis. Otherwise, the member will be responsible for all expenses related to the treatment which is excluded on their policy.

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**.

Prostheses costs

The cost of items that are surgically implanted in hospital. For example, artificial hips or cardiac devices like pacemakers.

- You're covered for all prostheses on the Australian Government's Prescribed List of Medical Devices and Human Tissue Products, up to the value stated on the list.

Medical costs

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

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

How fees for medical treatments are set

- The Australian Government recommends the fees for medical services. However, a doctor can charge more than this.

Find out more about how the Australian Healthcare system works at bupa.com.au/healthcare-system

How medical costs are covered

- Medicare has a list of medical services that the government will either pay some or all of the cost of, called the **Medicare Benefit 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 **pages 30 and 31** for more information.
- Remember, you might have to see multiple specialists for one procedure.

Emergency ambulance costs

Emergency ambulance costs are the costs associated with emergency transport services (via air or road) from the place where immediate medical treatment is required to the emergency department of a receiving hospital.

Ambulance services, including air services are only covered where they are conducted by the provider we recognise in the state that you're in.

Your ambulance cover depends on your cover type¹:

Cover type			
★	★★	★★★	★★★★
Selected basic, bronze and silver tier hospital covers, and most Extras covers ¹	Gold tier and selected silver tier Hospital covers, Corporate Hospital cover and Corporate Choice Extras and Emergency Only Ambulance Cover ¹	Corporate Silver Plus Extensive Hospital, ^{1,2} Corporate Gold Comprehensive Hospital ^{1,2} Corporate Hospital Cover Silver Plus ^{1,2} Corporate Hospital Cover Advanced Silver Plus ^{1,2} Corporate Hospital Cover Gold ^{1,2} and Premium Ambulance Cover ³	Gold Ultimate Health Cover ¹
What's included per calendar year			
Unlimited Emergency Ambulance Cover	Unlimited Emergency Ambulance Cover	Unlimited Emergency Ambulance Cover Up to \$5,000 in Non Emergency Ambulance per person	Unlimited Emergency Ambulance Cover Or, we'll refund the costs of an Ambulance subscription from our recognised provider in your state (VIC, SA, and NT only).

Ambulance services across states

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

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

It's worth noting that some states:

- Offer free or subsidised ambulance services to pension and concession card holders. Check your State Government website for more details.
- Have agreements with other states to cover their residents, and vice versa. What's covered under these agreements varies, so if you travel interstate frequently, it might be worth considering private cover or a subscription.

¹ If claimable from another source, a benefit won't be paid by Bupa. Benefits for ambulance transportation is only payable where the provider describes the transportation as an 'Emergency'. There is a 1-day waiting period for emergency ambulance and on-the-spot treatment. ² If claimable from another source, a benefit won't be paid by Bupa. There is a 1-day waiting period for non-emergency ambulance. ³ If claimable from another source, a benefit won't be paid by Bupa. There is a 1-day waiting period for emergency ambulance and on-the-spot treatment and a 1-month waiting period for non-emergency ambulance.



Your Extras cover explained

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.¹ 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 dental practitioners, chiropractors, podiatrists and physiotherapists 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 could get 50% or more back on most dental, physio, chiro and podiatry consultations at Members First providers, up to your yearly limits.²
- You can usually expect to claim more money back than if you go to a provider who doesn't have an agreement with Bupa.
- 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.

Members First Ultimate and Members First Platinum Network

In addition to Members First providers, we have Members First Ultimate and Members First Platinum providers which help to provide more value when it comes to dental care.

Get 100% back on up to two 6 monthly check-up and cleans per year, claimable outside of your yearly limits³ and 100% back on general dental fillings, up to yearly limits at Members First Ultimate providers.⁴

With Members First Platinum, you could get 100% back on up to two 6-monthly check-up and cleans up to yearly limits on eligible combined products.⁵

Find out more at bupa.com.au/health-insurance/dental-partners

24/7 access to Blua Online Doctor Appointments for eligible Bupa members

100% of the appointment fees covered on up to 3 or 6 Online Doctor Appointments per year to connect you with doctors through Blua, Bupa's digital health platform.⁶ Visit blua.bupa.com.au

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

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

Making a claim is really simple. At these providers you can usually make your claim on the spot by swiping your Bupa card or tapping your Digital card.⁷

¹ Extras service providers must meet certain requirements to be recognised by Bupa and for us to pay towards the cost of your treatment. Waiting periods, yearly limits, policy and fund rules apply. Percentage back may vary depending on benefit claiming restrictions.

² Applies to included services only. Bupa has Members First providers for these services. Not available in all areas. Waiting periods, benefit claiming restrictions, policy and fund rules apply.

³ You 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, benefit claiming restrictions, policy and fund rules apply. Excludes orthodontics and in-hospital treatments. Available on all eligible extras products which includes General Dental (excluding FLEXtras 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. Not available in all areas.

⁴ Select direct restoration and general fillings only. Benefit claiming restrictions, waiting periods, yearly limits, fund and policy rules apply. Available on all Extras products with general dental at Members First Ultimate Providers. Not available in all areas.

⁵ At Members First Platinum providers you can receive up to 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 products or combined hospital and extras products (excluding Freedom 50 Extras, Freedom 60 Extras, Freedom 60 Boost, Extras Saver, Corporate Choice 50, Corporate Benefit 60 Flex, FLEXtras products and Your Choice Extras 60 where General Dental is not included). Waiting periods, benefit claiming restrictions, yearly limits, policy and fund rules apply. Not available in all areas.

⁶ Yearly limits, waiting periods, fund and policy rules apply. Members will only be able to book general doctor appointments via Blua. Appointments with specialists cannot be booked via Blua. Members who are under 18 years old may need to attend the appointments with a parent or guardian. Available on all eligible extras and combined products that include Blua online doctor appointments. Service provided by third party partner. See blua.bupa.com.au for more details. To book online doctor appointments once you've reached your yearly service limit, you'll need to book directly with another provider such as Doctors on Demand.

⁷ For services included on your cover. Yearly limits, waiting periods, benefit claiming restrictions, fund and policy rules apply. Digital cards may be used at supported terminals only using compatible Apple iOS, Apple watch and Android devices.

Special types of Extras services

Health aids and appliances

We provide benefits for a range of evidence-based health aids and appliances prescribed by healthcare professionals to help manage diagnosed health conditions.

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, compression garments and surgical shoes need to be custom-made to fit, not be an 'off-the-shelf' product that is just altered for you.

Please note that in certain products Custom-made foot orthotics are paid under Podiatry. For more information on your cover details please refer to PHIS and fund rules.

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 claim online with **myBupa** or 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. For more information on your cover details please refer to PHIS and fund rules.

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 dental practitioners, physiotherapists, chiropractors, podiatrists, remedial massage therapists, optical outlets and more. After your treatment, swipe or tap 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 4338
Melbourne VIC 3001

Claiming in a Bupa Health Insurance store

Drop into your nearest store and we'll help you claim through myBupa. All benefits payments are by EFT only and are subject to standard processing times. If you're unable to use myBupa, complete a claim form, provide your receipts, and we'll transfer the payment directly to your bank account within 48 hours.

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.¹

Knowing your claim limits

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

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

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

Yearly limit	This is the maximum amount you can claim for a service from 1 January to 31 December. If you haven't claimed up to your yearly limit, this doesn't 'roll over' to the next year - it resets on 1 January.
Sub limit	This is a limit within a limit. It applies to a very specific service, per person, per year. For example, if you have Gold Ultimate Health Cover, there's a yearly limit of \$1,000 for natural therapies. A sub limit applies to massage therapy of \$250 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 \$750 more in claims for other permitted natural therapies, like acupuncture.
Benefit claiming restrictions	For some types of Extras services, there are limits to the number of times that benefits are payable for the same service. These are called benefit claiming restrictions. For example, you can only claim a scale and clean from your dentist or oral health practitioner once every six months. This is called a benefit claiming restriction. These limits apply from the date you receive the service, not from the time you submit the claim.
Person limit	This is the maximum amount that each person covered by your Bupa membership can claim in a calendar year. If you're on a policy with a family member, then you'll have your own individual limits.
Membership limit	This is the maximum amount that can be claimed collectively, by everyone covered by your membership within the calendar year, for a specific type of Extras service. Remember, these limits apply in addition to your individual per person limits. Also, the membership limit might not be high enough for all your family members to claim their individual limits. For example, you may have a person limit of \$500 for chiropractic services, but a membership limit of \$1,000. This means that only two family members can maximise the \$500 person limit even if you have four people listed on your policy.
Lifetime limit	Health insurers usually have a lifetime limit for orthodontics. This applies to an individual. If you have reached this limit, you can't make any further claims for this at Bupa again. It doesn't reset, even if you leave Bupa and start your cover again with us.

You can find information about limits in your policy information available at myBupa.com.au

¹ Extras service providers must meet certain requirements to be recognised by Bupa and for us to pay towards the cost of your treatment. Waiting periods, yearly limits, policy and fund rules apply. Percentage back may vary depending on benefit claiming restrictions.

Restrictions on making claims

You need to have finished any waiting periods that apply and cannot claim for services that took place during your waiting periods, even after you have completed them. 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 benefit claiming restrictions for our Extras services

We have rules about what you can claim. This 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, such as an Optical Partners agreement or Members First agreement with participating Dental, Physio, Chiro or Podiatry providers. To find out more about Optical Partners, go to: www.bupa.com.au/campaigns/optical/optical-partners to find out more about Members First, go to www.bupa.com.au/health-insurance/members-first
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 dental practitioner, chiro, podiatrist or physio isn't in our Members First network, you can still make a claim, as long as they are Bupa recognised and the service is included on your level of cover.¹ 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 to find a Members First provider or Optical Partner.

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 can search for a specialist at bupa.com.au/find-a-provider. 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 **pages 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 radiology provider for services in hospital at bupa.com.au/no-gap-radiology

Find a no gap pathology provider for services in hospital at bupa.com.au/no-gap-pathology

¹ Extras service providers must meet certain requirements to be recognised by Bupa and for us to pay towards the cost of your treatment. Waiting periods, yearly limits, policy and fund rules apply. Restrictions may apply on your policy which are limited benefits for certain services.



Choosing a hospital

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 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

Benefit	Members First Overnight & Day hospitals	Network Overnight & Day Hospitals	Network Fixed Fee Hospitals	Non-agreement hospitals	Public hospital	
					Private patient	Public patient
Choice of hospital	✓	✓	✓	✓	X	X
Choice of specialist	✓	✓	✓	✓	✓	X
Reduce waiting time	✓	✓	✓	✓	X	X
Covered for hospital costs	✓	✓	Most	Limited	Limited	✓ by Medicare
Private room guarantee (overnight) ¹	✓	X	X	X	X	X
Cover for extra services and benefits	✓	Some	X	X	X	X

Explore our hospital network at bupa.com.au/help/hospital-cover/finding-the-right-hospital

¹ Subject to availability and eligibility. Private room guarantee only applied to Members First Overnight hospital. You must book and request a private room in a Members First hospital at least 24 hours before admission. If you don't get a private room, you'll receive \$50 a day from the hospital for every day you're not in a private room. Applies to overnight admissions only. Excludes 'nursing home type patients', emergency care, same day stays, occasions where a private room is medically inappropriate, treatment which is excluded or restricted, and treatment for a pre-existing condition during waiting periods.

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

Type of hospital	Cost to you	Member benefits	Important to note
Members First	Low – in most instances you'll be covered for hospital costs. Any excess or co-payments as per your policy will still apply.	Our 'private room or money back guarantee' for an overnight stay. ¹ 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.	To take advantage of the 'private room or money back guarantee', ¹ you'll need to book and request a private room in a Members First hospital at least 24 hours before admission.
Network hospitals	Low – in most instances you'll be covered for hospital costs. Any excess or co-payments as per your policy will still apply.	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.	The 'private room or money back guarantee' does not apply. ¹
Network hospital with a fixed fee There's only a small number of these.	Medium – You may be charged a fixed daily fee and generally be covered for your hospital costs (we reimburse this fee for customers who hold Ultimate Health Cover). Any excess or co-payments as per your policy will still apply.	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.	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.

Please note: You may still experience out-of-pocket costs for specialist fees. To help reduce your in hospital or inpatient medical costs, consider the Bupa Medical Gap Scheme. Visit bupa.com.au/medicalgapscheme for more.

Type of hospital	Cost to you	Member benefits	Important to note
Network Day hospital	Low – In most instances you'll be covered for your hospital costs. Any excess or co-payments as per your policy will still apply.	Complimentary local phone calls and free-to-air TV.	
Non-agreement hospital	High – These hospitals haven't entered into any agreement with Bupa, meaning we only cover a portion of the cost. Any excess or co-payments as per your policy will still apply.	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 set amount we pay. If your specialist/s charge more than what we pay (with Medicare), you're likely to have some medical costs to pay yourself.	If you attend one of these 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. Make sure you ask for cost estimates from the hospital and your treating specialist/s.

Network Hospitals near you at bupa.com.au/find-a-provider

¹ Subject to availability and eligibility. Private room guarantee only applied to Members First Overnight hospital. You must book and request a private room in a Members First hospital at least 24 hours before admission. If you don't get a private room, you'll receive \$50 a day from the hospital for every day you're not in a private room. Applies to overnight admissions only. Excludes 'nursing home type patients', emergency care, same day stays, occasions where a private room is medically inappropriate, treatment which is excluded or restricted, and treatment for a pre-existing condition during waiting periods.

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	<ul style="list-style-type: none"> All costs relating to your admission will be covered by Medicare, including prosthesis and all medical costs.
Cons	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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?"

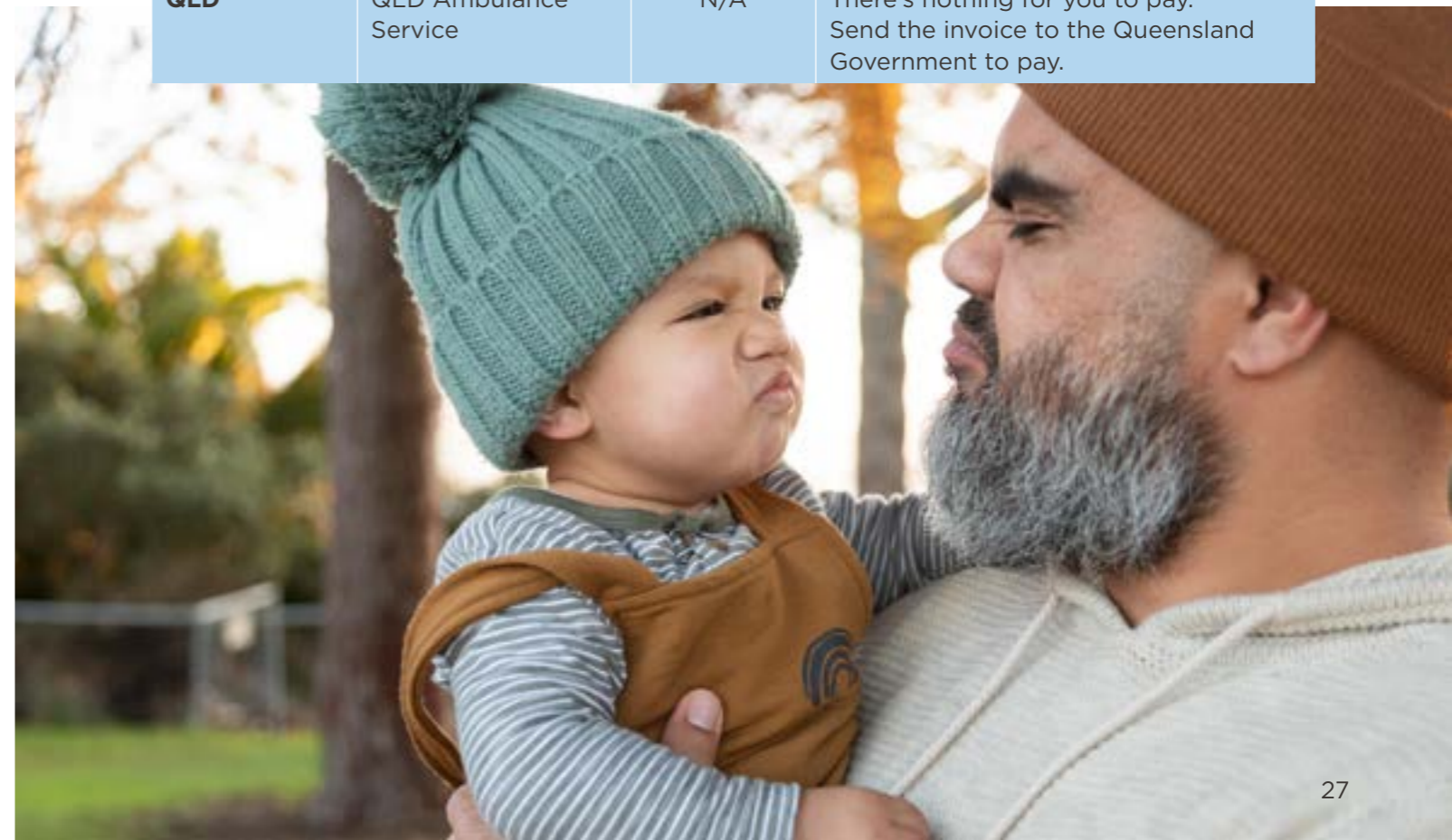
When can I use my Ambulance cover?

- 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.
- 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.

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





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 agreement, we pay some of the cost of medications that are not on the PBS (known as High-Cost Drugs), if they are provided to you in hospital and are approved by the Therapeutic Goods Administration (TGA) for the treatment of your specific condition.
- To be eligible, all waiting periods must be served and your membership payments must be up to date at the time you receive the medication.

By your Extras cover

Some Extras cover includes cover for pharmacy. 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.

Pharmaceuticals must be approved by the Therapeutic Goods Administration (TGA), category S4 or S8 medicines (prescription only or controlled drugs), and not on Bupa's 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.

You can make a claim with **myBupa** or 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 for the medication cost that exceeds the PBS co-payment, which is an amount set by the Australian Government.

Visit **Pharmacy Cover FAQs** for more information.

We do not cover:

- Items not approved by the TGA.
- 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.
- Performance or body-enhancing medication (e.g. anabolic steroids).
- Medication provided by a hospital that isn't intrinsic to your care.
- Any items on Bupa's Exclusions List.

If you're not sure, **contact us**.

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). What costs we cover depends on what's included in your policy.¹

We consider something an accident if:

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

What's not considered an accident?

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

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,¹ if you:

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

Accident Inclusion feature

Some of our hospital products include the Accident Inclusion feature. This means we'll cover urgent medical treatment resulting from an accident in a hospital (as further defined in the Bupa Fund Rules), irrespective if the treatment is usually restricted or is an exclusion under your level of cover.¹

This means we'll cover urgent medical treatment resulting from an accident in a hospital (as further defined in the Bupa Fund Rules), irrespective if the treatment is usually restricted or is an exclusion under your level of cover.

Utilising our 'Accident Benefit'

On some covers, our Accident Benefit feature can help reduce the costs you pay in hospital, and on extras services in the case of an accident (up to a limit). How the limits apply varies between products, so check your policy information.¹

Utilising our 'Accidents Happen Refund'

On some of our corporate covers, when requiring hospital treatment as the result of an accident, Bupa will refund you the hospital excess you paid for the admission.¹

¹ For Accidents that occur in Australia after your cover starts. Must meet Bupa's definition of an Accident as defined in the Bupa Fund Rules, must seek medical treatment within 72 hours, and receive any further treatment within 180 days, of the Accident occurring. Out of pockets may apply.



Managing and reducing your medical costs

The Bupa Medical Gap Scheme

The Bupa Medical Gap Scheme is all about reducing the medical costs you need to pay for treatment when you're admitted to hospital. If your specialist uses our scheme, you'll never pay more than \$500 out-of-pocket per doctor 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.

The 'gap' is the amount you'll need to pay yourself if your doctor or specialist charges more than what Bupa and Medicare will pay (Health funds pay 25% of this fee, and Medicare pays 75%). The Bupa Medical Gap Scheme reduces or eliminates this difference, or 'gap'. Bupa provides two different arrangements - either 'no gap' or a 'known gap'.

No Gap

If your specialist is registered with the Bupa Medical Gap Scheme with no gap, they'll bill Bupa directly and you won't have to pay anything for your specialist's services provided in hospital. The Bupa Medical Gap Scheme, it is an opt-in service, so you will need to ask your specialist if they will participate in the Bupa Medical Gap Scheme for your treatment.

Known Gap

If your specialist is registered with the Bupa Medical Gap Scheme with a known gap, they'll bill Bupa directly, but they're able to charge you a gap up to a maximum of \$500 for your specialist services provided in hospital.

How does it work?

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.

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



Advara HeartCare

Bupa has partnered with Advara HeartCare, Australia's largest group of private cardiologists, to help achieve better health outcomes for patients with heart disease.

Eligible Bupa members¹ may have no out-of-pocket expenses for services from an Advara HeartCare cardiologist when you're admitted to hospital for a procedure related to heart disease.

Find out more about Advara HeartCare at bupa.com.au/health-programs/advara-heartcare-partnership

Potential 'out-of-pocket' costs

1. Excesses

The excess is your contribution to your hospital treatment. You can choose from set excess amounts and your choice of excess will affect your premium. 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

You'll pay an excess once per person per calendar year. If your policy covers more than one person, the excess is capped at two payments per year – even if you change your cover.

If you switch to a policy with a higher excess, you'll only pay the difference if you're admitted to hospital again that year.

If you've transferred from another health fund, you may still need to pay an excess – even if you've already paid one with your previous insurer.

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.

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 [pages 30 and 31](#) for more information.

5. Exclusions

Sometimes specific services or treatments are excluded under your level of cover. In these cases, subject to what is set out below, you'll be responsible for all expenses related to your hospital admission for that procedure or service.

Bupa will cover treatment as required under the legislation relating to the payment of benefits for Associated Treatments for Complications, Associated Unplanned Treatments, Common Treatments and Support Treatments.

Outside of these situations, if a member receives multiple hospital treatments during an admission to hospital, that is both included and excluded, we will pay for all the included treatment and may pay any element of treatment that cannot be appropriately allocated to the excluded treatment on an ex-gratia basis. Otherwise, the member will be responsible for all expenses related to the treatment which is excluded on their policy.

6. What is restricted cover?

If your cover is restricted for a treatment, Bupa pays the minimum amount set by the government for hospital costs. This usually covers a shared room in a public hospital.

If you go to a private hospital or request a private room, you may have to pay a large out-of-pocket cost. Your hospital will let you know the costs upfront – this is called Informed Financial Consent.

Restricted cover doesn't affect how much we pay for medical costs during your hospital stay.

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:

Type of service	Covered by
GP visits, blood tests, X-rays and MRIs, when you are not admitted to hospital	Medicare
Non-emergency ambulance transport ²	Check page 14 for more details
Services and treatments specifically excluded from your cover	You and/or Medicare
Cosmetic surgery	You
Services covered by another source	For example, travel insurance or worker's compensation.

¹ The customer must hold an eligible Bupa hospital cover that includes cover for heart and vascular system. Out-of-pocket costs may apply. Waiting periods, fund, policy and program eligibility rules apply. Access to services is also subject to the provider's terms and conditions

² For more information on your cover details please refer to PHIS and fund rules.

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

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

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 to pay a known gap (up to \$500), the specialist will bill you for the fee directly.
If your specialist doesn't use our Medical Gap Scheme¹	Your doctor may submit the claim to Medicare and Bupa on your behalf and ask you to just pay the gap. If not, you can choose to pay upfront and then claim using a Medicare Claim Form and Medicare two-way claim form. This means Medicare will liaise with Bupa on your behalf to ensure your claim is processed. Alternatively, you can choose not to pay upfront . You will still need to complete the process above to receive benefits payable by Bupa and Medicare. You will need to forward any cheques or EFT payment you receive to your doctor or specialist as payment toward your medical costs, along with any gap payments outstanding.

The specialist or doctor can decide what to charge you and you'll need to pay any 'gap' (or amount above what we and Medicare pay) yourself. The 'gap' is the amount over the Medicare Benefit Schedule (MBS) fee. Health funds and Medicare together pay 100% of the fee. Health funds pay 25% of this fee, and Medicare pays 75%.

Paying your prosthesis and pharmacy costs

If the prosthesis is on the Australian Government's Prescribed List of Medical Devices and Human Tissue Products	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)	and 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.

¹ Doctors are not obligated to participate in gap arrangements and may choose to do so on a patient by patient basis. Members should ask their doctor whether they'll use our gap scheme for their treatment: **Bupa Medical Gap Scheme**

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 certain factors including 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 63 days, 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 63 days, 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 63 days, you might need to take out a new policy and re-serve your waiting periods.

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

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

For more on these Government considerations, see **page 36**.

Financial Hardship

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

bupa.com.au/help/payments/behind-in-payments

Government policies and tax considerations

Lifetime Health Cover (LHC)

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

If you don't have hospital cover before 1 July following your 31st birthday and then decide to take 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.

You could avoid health insurance premiums becoming more expensive by taking out private hospital cover before you turn 31.¹

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.

¹ Australian citizens and permanent residents: 1 July following their 31st birthday. New migrants: 1 July following their 31st birthday, or 12 months from full Medicare registration (if already past their 31st birthday).

Age-based discount

Bupa offers people under 30 a discount on domestic hospital products as part of an Australian government initiative. For each year you are under 30, you receive a 2% discount when you first purchase private hospital cover (up to 10%). This means if you're aged between 18-25, you're entitled to the full 10% discount.

If you're already insured by another provider and receiving the age-based discount, we will match your current discount when you join Bupa within 60 days of the end date of your previous cover. 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.

How does it work?

The younger you are when you purchase Hospital cover, the more discount you may be entitled to. 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.
- When a person turns 41 this discount will gradually start to decrease by 2% each year.

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 \$101,000 per annum, or a couple, single parent or family and earn over \$202,000 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.

*Based on Basic Plus Starter Hospital \$750 Excess from 1 April 2025 \$1,172.64 yearly. For singles living in NSW with Australian Government Rebate and earning \$101,001 to \$118,000. Assumes no LHC loading and no age-based discount. For singles with an adjusted taxable income of \$103,000 p.a. under the age of 65, on a Tier 1 rebate in NSW.

An example comparison

No private Health Cover

You pay
\$1,010

to cover the Medicare Levy Surcharge

You get
nothing more

Basic Plus Starter Hospital*

You pay
\$1,172.64*

per year

You get

- Hospital cover for limited hospital services to help protect you from the unexpected.
- Private hospital room, where available
- Cover for uncapped emergency ambulance transport or on-the-spot treatment by our recognised providers in each state of Australia.²
- The Accident inclusion feature, for accidents sustained after joining, treatment which is restricted or is an exclusion is covered in the same way as an included service.³

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.

Tier	Single	Family	Medicare Levy Surcharge rate ⁴
Base	\$101,000 or less	\$202,000 or less	0%
Tier 1	\$101,001 – \$118,000	\$202,001 – \$236,000	1%
Tier 2	\$118,001 – \$158,000	\$236,001 – \$316,000	1.25%
Tier 3	\$158,001 or more	\$316,001 or more	1.5%

² Cover for uncapped emergency ambulance transport or on-the-spot treatment by our recognised providers in each state of Australia.

³ For accidents sustained after joining, treatment which is restricted or is an exclusion on your cover, will be payable in the same way as an included service. Must meet Bupa's definition of an Accident as defined in the Bupa Fund Rules, must seek medical treatment within 72 hours, and receive any further treatment within 180 days, of the Accident occurring. Out of pockets may apply.

⁴ Applicable rebate % and income thresholds are reviewed annually by the Australian Government. Single parents and couples (including de-facto couples) are subject to family tiers. For families with children, the income thresholds are increased by \$1,500 for each Medicare Levy Surcharge dependant child after the first child. For more information go to ato.gov.au.

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

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). When you join Bupa, you agree to the handling of your personal information as set out in this document.

Information Policy

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

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

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

way we handle personal information, or doesn't provide us with the information we require, we may be unable to provide you with our products and services.

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

Health cover and overseas travel

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

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



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 continuous cover for at least twelve months.
- To suspend your cover, your payments must be up to date - at least until two days after the date you want the suspension to start.
- Apply for a suspension before you want the suspension period to begin (we can't do it retrospectively).
- Notify us via phone on 134 135 or visit your nearest Bupa store
- 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

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.

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



More Information

To find out more about Australia's healthcare system visit bupa.com.au/healthcare-guide today.

Bupa health cover made easy

Unsure of any words? Visit our Bupa Glossary at: bupa.com.au/glossary

To see our fund rules, visit: bupa.com.au/fundrules

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



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

Bupa HI Pty Ltd
ABN 81 000 057 590

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