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# THANKS FOR COMPARING HEALTH INSURANCE

It's a good idea to read through the following pages to learn more about this policy. If you have any questions or need more information, chat with one of our health insurance specialists by calling **1800 46 29 55.**

**On the other hand, if you're ready to buy, here's what you need to do:**

1. Review the enclosed policy brochure to ensure it meets your health insurance needs
2. Buy direct at **compare**the**market**.com.au; or
3. Call **1800 46 29 55** to speak to one of our Health Insurance Specialists

Thank you for not getting muddle with **compare**the**meerkat**.com.au

It is much appreciate!

Need assistance?
Call **1800 46 29 55**

Budget Direct Health

# Simply Smarter Health Insurance

## Member Guide

# Contents

# Introduction to Budget Direct Health Insurance

Budget Direct Health Insurance is provided by GMHBA Limited. References to "Budget Direct Health Insurance" and "GMHBA" are references to GMHBA Limited. References to "Budget Direct" are references to Auto & General Services Pty Ltd.

## Application for membership with Budget Direct Health Insurance

The completion of the application process and the payment of any premium constitutes an acceptance of any conditions laid down in the regulations of the fund, including the Fund Rules and any fund policies, in force at that time or as they may be amended from time to time. A copy of the Fund Rules can be accessed on request by emailing Budget Direct Health Insurance at **enquiries@health.budgetdirect.com.au**. Budget Direct Health Insurance reserves the right to refuse admission to membership of any level of health insurance.

When you sign up with Budget Direct Health Insurance it's important that you provide us with all the information requested to allow us to maintain an accurate record of your membership. It is also important that the information you provide is true and correct. Budget Direct Health Insurance will consider your membership void if you provide false or incorrect information on your membership application. If your membership is terminated due to this, then premiums received in advance for coverage beyond the termination date will be refunded.

Budget Direct Health Insurance uses the terms 'member', 'spouse/partner' and 'dependant' to define the people covered by a membership. Only the person nominated as the 'member' can authorise changes to the membership unless the member has previously authorised the spouse/partner to make such changes. Similarly, correspondence issued by Budget Direct Health Insurance will be addressed to the member and it is the member's responsibility to notify Budget Direct Health Insurance of any change of address by maintaining the address records in the online member area. You can make changes to your membership anytime.

In the event of any member or person named on the membership convicted in a court of law of assault or similar offence against a member of staff related to that staff member's performance of their duties, has obtained or attempted to obtain an improper advantage, for themselves or for any other member or is convicted in a court of law of fraud against Budget Direct Health Insurance, the Board may in its discretion, declare the member's membership void. The status of the member's membership will be assessed with any outstanding claims being honoured and any premiums shall be refunded. Any other rights accrued to the member will be forfeited.

## Membership card

After you sign up with Budget Direct Health Insurance, you'll receive a membership card that identifies you as a member. The card shows your membership number and who is covered. Budget Direct Health Insurance's contact details are listed on the back of the card. Have your membership card on hand when you arrange admission to hospital, visit a participating provider or when you call Budget Direct Health Insurance with any questions. Keep your card safe and please advise Budget Direct Health Insurance if your card is lost or stolen.

A new card may be issued when you make changes to your membership. Please note that an existing card will become invalid whenever a new membership card is issued.

## Communications from Budget Direct Health Insurance by webmail

Budget Direct Health Insurance provides you with a great deal of information upon joining, including your:

- Membership certificate
- The Standard Information Statement (SIS) for the product/s you have bought
- A detailed description of the coverage provided by the products you have bought
- A Member Guide relating to your coverage and your membership

This information will be sent to you via webmail so you can access your membership information securely, quickly and easily. Webmail is contained within the

Online Member area and is accessible only with your Member Number (which is on the back of your member card) and password. The information that Budget Direct Health Insurance sends you this way can be viewed onscreen, copied and saved to your hard drive or printed out. Information sent to you via Webmail can be personally sensitive so Budget Direct Health Insurance recommends that you guard your password carefully.

As well as the material listed above, Budget Direct Health Insurance will send to your Webmail account your:

- Annual product and rate change email
- Annual Tax Statement and Lifetime Health Cover Statement
- Any other notifications relevant to your membership

Budget Direct Health Insurance can only communicate with you in writing through webmail and unfortunately is not able to send these notifications to you by email due to security reasons.

## Check your cover

Please contact Budget Direct Health Insurance to check what you're going to get back before having treatment or going into hospital. Budget Direct Health Insurance has a range of health insurance options at different levels to suit everyone's needs.

## Arrears

Budget Direct Health Insurance members are responsible for ensuring their accounts have sufficient funds available on their nominated direct debit date. Membership will cease when premiums fall into arrears of more than two months after the premium due date. To claim benefits a member must be financial at the time of incurring the expense for the service or treatment.

## Liabilities of members to Budget Direct Health Insurance

A member can be liable to Budget Direct Health Insurance for unpaid premiums and for overpayments. Overpayments can be made by Budget Direct Health Insurance to a member, either through an error in completing a claim, or an error in processing a claim.

If an overpayment is made, the member is liable to repay the amount of the overpayments to Budget Direct Health Insurance on demand. If a member is liable to Budget Direct Health Insurance for unpaid premiums or overpayments then Budget Direct Health Insurance has the right to deduct the amount of that liability from any monies due by Budget Direct Health Insurance to the member on any account.

## Audits

Budget Direct Health Insurance undertakes audit activities in order to protect members' assets and contain costs. And as we have online extras claiming with no need to send in receipts we need you to keep your receipts somewhere safe for two years, just in case our Audit team wants to check up. But don't send them to us unless we ask.

And from time to time, in the general interest of members, a Budget Direct Health Insurance representative may contact you with a request for assistance to monitor costs – whether relating to benefits paid or charges raised by health care providers. Your co-operation with such requests is critical to our cost containment efforts, and will be treated in a completely confidential manner.

## Refunds

You may cancel your Budget Direct Health Insurance cover from:

- The date you notify Budget Direct Health Insurance in writing of the cancellation (a transfer certificate will be provided to the insured person within 14 days of request); or
- Your next direct debit date, whichever is the earlier

If you cancel your Budget Direct Health Insurance cover within 30 days of joining, you will receive a full refund of any premiums received by Budget Direct Health Insurance, provided you have not made a claim.

# Product Information

## When to contact Budget Direct Health Insurance

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

## Waiting periods

Waiting periods exist to protect members from claims made by those who join Budget Direct Health Insurance or increase their level of cover because they have a condition or illness that may require treatment.

Waiting periods and benefit limitation periods will apply to:

- New memberships (previously uninsured);
- Additions to a membership (unless the addition/s has already served all waiting and benefit limitation periods with Budget Direct Health Insurance or another insurer) except newborns and adopted and permanent foster children where the family membership has been in existence for at least two months, and where the addition/s has already served all waiting and benefit limitation periods with Budget Direct Health Insurance or another insurer.
- Existing Budget Direct Health Insurance memberships, and transfers to Budget Direct Health Insurance from another insurer where:
  - The level of cover and/or benefit entitlement is upgraded or increased;
  - Any hospital or extras service was not covered by the previous insurer and/or;
  - The waiting and benefit limitation periods have not been completed

Where a member is transferring from another product or from another health insurer, waiting and benefit limitation periods for hospital treatment that was not covered under the old policy are:

- **24 months** – benefit limitation periods apply to gastric banding and all obesity surgeries, psychiatric or renal dialysis (that means you're covered but for public hospital benefits in a shared room after your other waiting periods have been served)
- **12 months** – obstetric or pre-existing condition (other than for psychiatric, rehabilitation or palliative care)
- **2 months** – psychiatric, rehabilitation or palliative care
- **2 months** – any other benefit for hospital treatment
- **1 day** – Emergency Ambulance Cover, accidents

Where a member is transferring from another product or from another health insurer, waiting periods for extras that were not covered under the old policy are:

- **12 months** – major dental, podiatric surgery and orthotics (where offered in the cover)
- **6 months** – optical benefits
- **2 months** – any other extras benefit

The above waiting and benefit limitations also apply to previously uninsured members.

For treatment that was covered under the old policy, at the same or higher level than the new policy, waiting and benefit limitation periods are no longer than the balance of any unexpired waiting or benefit limitation period for the benefit that applied to the person under the policy.

For treatment that was covered under the old policy but at a lower level, the member is entitled to the lower benefits on their old cover during the waiting period. Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover during the waiting or benefit limitation period.

## Benefit limitation periods

Benefit limitation periods are a restriction on what Budget Direct Health Insurance will pay for a hospital treatment for a period of time. It begins the date you join Budget Direct Health Insurance or switch covers. It means Budget Direct Health Insurance pays public hospital

benefits in a shared room, so long as you have served all other waiting periods. A benefit limitation period of 24 months applies to:

- Top Hospital cover for gastric banding and all obesity surgeries, psychiatric or renal dialysis; and
- Mid Hospital cover for psychiatric

## Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing condition rule before your admission. Consequently if you have less than 12 months membership on your current hospital cover you might have to pay for some or all of the hospital and medical charges if:

- You are admitted to hospital and you choose to be treated as a private patient; and
- We later determine that your condition was pre-existing

## Pre-existing conditions (PEC)

A pre-existing condition is one where signs or symptoms of your ailment, illness or condition, in the opinion of a medical practitioner appointed by Budget Direct Health Insurance (not your own doctor), existed at any time during the six months preceding the day on which you purchased your hospital insurance or upgraded to a higher level of hospital cover and/or benefit entitlement.

The only person authorised to decide that a condition is pre-existing is the medical practitioner appointed by Budget Direct Health Insurance. However, the medical practitioner appointed by Budget Direct Health Insurance must consider any information regarding signs and symptoms provided by your treating medical practitioner/s.

The pre-existing condition rule still applies even if your ailment, illness or condition was not diagnosed prior to joining the hospital cover. The only test is whether or not, in the six months prior to joining your current hospital cover signs and symptoms:

- Were evident to you; or
- Would have been evident to a reasonable general practitioner if a general practitioner had been consulted

## Waiting periods – PEC

A special waiting period applies to obtain benefits for hospital treatment for new members who have pre-existing conditions. Waiting and benefit limitation periods also apply to existing members who have recently upgraded their level of hospital cover. If the ailment, illness or condition is considered pre-existing:

- New members must wait 12 months for any hospital benefits (other than psychiatric, rehabilitation and palliative care)
- Members transferring/upgrading to a higher hospital cover must wait 12 months to get the higher hospital benefits (other than psychiatric, rehabilitation and palliative care)
- A 24 month benefit limitation period applies to gastric banding and all obesity surgeries, psychiatric or renal dialysis (where offered in the cover)

Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover.

## Dependants

### 1. Previously insured with Budget Direct Health Insurance

Child and student dependants are covered up until they turn 21 years of age. After their 21st birthday they have 2 months to organise health insurance, but their new membership will start from the date they turned 21. They won't have to serve waiting and benefit limitation periods when transferring to an equivalent or lower level of insurance.

### 2. Previously insured with another insurer

Student dependants whose parents are members of another registered health insurer and were previously insured with their parents, may sign up with Budget Direct Health Insurance within two months of ceasing to be a dependant, on a level of cover equal to or less than that held by their parents, without serving waiting or benefit limitation periods. An acceptable transfer certificate and claims history must be received by Budget Direct Health Insurance.

### 3. Previously uninsured

Previously uninsured dependants may sign up with Budget Direct Health Insurance and receive immediate Public Hospital cover benefits, except for any pre-existing condition/illness (other than for psychiatric, rehabilitation and palliative care) and maternity cases for which a waiting period of 12 months will apply. All waiting and benefit limitation periods must be served for extras benefits and hospital benefits which are higher than those available from the Public Hospital cover.

## Planning a child

If you are thinking about starting a family and your hospital cover does not include obstetrics, you will need to ensure you upgrade your hospital cover to include obstetrics at least 12 months before you have a child to ensure all waiting periods have been served.

If all goes well, a new born baby is not admitted as a patient in hospital, but if you have complications and your baby requires any accommodation or medical attention, you will not be covered for accommodation or medical services unless your child has served the waiting period. So, if you are currently on a singles membership, you will need to change to a family membership at least two months before your baby is born. Budget Direct Health Insurance recommends that you change to family membership three months before your baby is due, (you can add an unborn child as an additional person) in case your baby arrives prematurely.

## Excess – Hospital only

An excess is the fee you pay in return for lower premiums.  An excess applies when you are admitted into hospital as a private patient.

The most you'll pay for excess each calendar year is:

- $450 for Singles
- $900 for Couples and Families
- No excess for child dependents

If one person from a Couple or Family membership goes to hospital, they will have a maximum excess of $450. It's only when more than one person from the membership is hospitalised that the maximum excess is $900.

For example, if Budget Direct Health Insurance's full benefit for a hospital stay was $5,000 the benefit would reduce by a $450 excess and an adjusted benefit of $4,550 would be paid. If the same person is admitted into hospital again in the same year they would not pay another excess. To Budget Direct Health Insurance a 'year' means a calendar year (January 1 to December 31).

## Exclusions

You cannot claim for the following:

- Benefits are only payable on itemised and original account/s. Account/s which have been altered in any way will not be accepted. Providers are required to re-issue any account/s or endorse any alterations.
- Natural remedies (includes Modifast & Optifast)
- Food supplements
- Dental procedures carried out and charged direct to the member/dependant by a dental mechanic, other than an advanced dental technician
- A range of dental procedures when provided on the same day e.g. a filling on a tooth that has been removed
- Dental procedures where a limit on the number you can have has been exceeded
- Dental procedures unless tooth identifications (ID) are supplied by the provider
- Services/treatment for which the member and/or dependant has a right to claim damages or compensation from any other person or body
- Treatment where the member and/or dependant is eligible for free treatment under any Commonwealth or State Government Act
- Services/treatment rendered more than 12 months prior to the date of claiming
- Services/treatment which is not covered by your membership and/or is rendered while the membership is in arrears or is suspended
- Services/treatment rendered by a practitioner not in private practice and/or not recognised by bodies approved by Budget Direct Health Insurance

- Hiring of equipment (unless otherwise stated)
- Services not rendered face to face (e.g. remotely over the phone)
- Foot orthotics unless they are custom made and provided by a registered podiatrist
- Additional medical gap benefits where the medical service is rendered by a medical practitioner employed full-time in the public sector
- Benefits for lifestyle related services that primarily take the form of sport, recreation or entertainment
- Benefits, payable under a hospital or extras cover shall not exceed the fees and/or charges raised for any treatment and/or services covered for benefits under the relevant cover, after taking into account benefits paid from any other source
- Benefits for services on treatment received overseas
- Travel vaccinations not listed on Budget Direct Health Insurance's Approved Travel Vaccinations list
- Travel vaccinations listed on the Pharmaceutical benefits scheme PBS
- Other pharmacy items not listed as a travel vaccination

## Restrictions

Benefits may not be paid or may be paid at a lower level where:

- You have already claimed the maximum allowable benefits during a specified period
- You have transferred to a Budget Direct Health Insurance extras cover from an extras cover by a different insurer and have previously claimed for the service/ treatment
- The health care account has been incompletely, incorrectly or inappropriately itemised
- You have an excess to pay on your chosen level of cover
- Budget Direct Health Insurance believes that a patient, following a review of the case (on the basis of information provided by the hospital either internally or using an agreed independent source), is not receiving acute care after 35 days continuous hospitalisation. If this is the case, Budget Direct

Health Insurance benefits will be reduced to Nursing Home Type Patients benefits and will be paid in accordance with the default benefit determined by the Department of Health & Ageing. All Nursing Home Type Patients are required to pay part of the cost of hospital accommodation.

- The service/s is subject to a waiting and/or benefit limitation period or other limit which has not been served/met
- Surgery is performed in hospital by a registered podiatrist/podiatric surgeon. Contact Budget Direct Health Insurance for details
- No MBS item number is provided by the GP/specialist e.g. cosmetic surgery
- Professional services are provided to the provider or members of the provider's family or to a provider's business partner's family members or any other people not independent from the practice. Family members include: wife/husband, brother/sister, children, parents, grandparents, grandchildren. If this is the case, only wholesale material costs involved in the provision of the service are subject to benefits.
- The claim is for cosmetic surgery. Limited benefits may apply on hospital covers for cosmetic surgery, depending on the medical justification for the surgery.
- The claim is for additional medical gap benefits, where the medical service is rendered by a medical practitioner employed full-time in the public sector
- There is more than one claim made to the same provider on the same day. But you can claim for more than one service on the same day if performed by different providers.

## Suspensions

You can suspend your Budget Direct Health Insurance cover for periods of overseas travel provided you:

- Have at least 12 months continuous unsuspended cover with Budget Direct Health Insurance prior to departure; and
- Plan to be overseas for at least 2 months; and
- Have paid premiums to the date of departure; and
- Apply for suspension of your cover prior to departure

You'll be required to resume your suspended cover within two months of returning to Australia and premiums must be paid from the date of re-entry. Your passport, boarding pass or a statutory declaration may be required to be presented to Budget Direct Health Insurance as proof of travel.

A three year maximum cover suspension period for overseas travel applies. Only the balance of outstanding waiting or benefit limitation periods need to be served upon resumption of your membership.

Please note that your Certified Age of Entry (CAE), for the purposes of calculating Lifetime Health Cover (LHC) loading, may be affected by periods of absence of three years or longer. See the LHC section for details.

## Participating providers

A participating provider is a health care provider, with whom Budget Direct Health Insurance has entered into an agreement relating to direct billing and/or fees and benefits. These agreements aim to maximise your cover and minimise your out-of-pocket costs. Budget Direct Health Insurance's participating private hospitals list can be obtained from the Budget Direct Health Insurance website, however it is subject to change without notice. Check with us on **1300 665 623** before confirming your hospital admission. To view the most recent list of insurers visit **www.health.budgetdirect.com.au**

### a) Participating private hospitals

**1. Top Hospital cover**

- Members who have taken out Budget Direct Health Insurance's Top Hospital cover, who are admitted to a participating private hospital and have served all waiting and benefit limitation periods are entitled to cover for accommodation, theatre, delivery suite, intensive and coronary care and other agreed hospital charges – less any excess (if applicable). Top Hospital Cover has a 24 month benefit limitation period for the following services: gastric banding and all obesity surgeries, psychiatric and renal dialysis. **During a benefit limitation period these services attract public hospital benefits in a shared room**. Members should present their Budget Direct Health Insurance membership card when attending a participating private hospital.

- Public hospitals: Budget Direct Health Insurance's Top Hospital cover provides cover for hospital accommodation costs when you are admitted to a single or shared room (subject to bed availability) as a private patient in a recognised public hospital.

**2. Mid Hospital cover**

- Members who have taken out Budget Direct Health Insurance's Mid Hospital cover, who are admitted to a participating private hospital and have served all waiting and benefit limitation periods, will be covered for shared accommodation, intensive and coronary care and other agreed hospital charges – less any excess (if applicable).
- Mid Hospital Cover has benefit exclusions for the following services: Obstetrics, IVF and related services, joint replacement, renal dialysis, gastric banding and all obesity surgeries, dental implants, cosmetic surgery and cataract surgery and corneal transplants. **These excluded services do not attract any benefits**.
- Mid Hospital Cover has a 24 month benefit limitation period for psychiatric services. **During a benefit limitation period this attracts a public hospital benefit in a shared room**.
- Public hospitals: Budget Direct Health Insurance's Mid Hospital cover provides cover for hospital accommodation costs when you are admitted to a shared room (subject to bed availability) as a private patient in a recognised public hospital. **Excluded services do not attract any benefits**.
- Co-payments apply of $100 per day up to $700 per admission for single room accommodation in all public and private hospitals.

Members should present their Budget Direct Health Insurance membership card when attending a participating private hospital.

Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included.

### b) Non-participating hospitals

Fixed benefits are payable for hospitalisation in non-participating private hospitals. Please contact Budget Direct Health Insurance on **1300 665 623** for further details as treatment in a non-participating private hospital will result in out-of-pocket expenses. Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included.

### c) Public hospital

Members with public Hospital cover, who are admitted to a **public hospital** and have served all waiting periods are covered for accommodation costs for a shared room. Public Hospital cover has benefit exclusions for the following services: Renal dialysis, gastric banding and all obesity surgeries and cosmetic surgery. **These excluded services do not attract any benefits**.

**Please Note:** Benefits for a single room in a public hospital or for treatment in a private hospital when using Public Hospital cover will result in significant out-of-pocket expenses. For further information on private patient benefits on Public Hospital cover, please call on **1300 665 623**.

## Overseas travel

Budget Direct Health Insurance does not provide benefits for services or treatment received overseas.

Budget Direct Health Insurance advises that you take out travel insurance for the set period of your travel and that it's suitable to the destinations you're visiting.

You can purchase a range of travel insurance options from Budget Direct Travel Insurance, please visit budgetdirect.com.au/travel-insurance.

## Extras services purchased over the internet

Benefits will be paid for optical services purchased over the internet from Australian providers where a script is provided. Benefits for services on treatment received overseas are excluded.

# Budget Direct Health Insurance's Covers

## Public Hospital Cover

Public Hospital Cover provides you with cover as a private patient in a public hospital. This cover is suitable if you want a basic level of hospital cover to avoid the Medicare Levy Surcharge or lock in your certified age of entry for Lifetime Health Cover.

### What's covered

Budget Direct Health Insurance's Public Hospital cover will cover you for:

- Hospital Accommodation (shared room) in a public hospital
- Accidents (that need hospitalisation)
- Emergency Ambulance Cover
- Cardiac surgery and coronary care
- Cataract surgery
- Delivery suite (for babies)
- Eye surgery
- Intensive care (one-on-one care 24/7)
- Joint reconstruction (e.g. knee)
- Joint replacement (e.g. hip)
- Medical Gap (Budget Direct Health Insurance will pay up to the Medical Benefits Schedule fee and 20% more if your doctor is a part of Budget Direct Health Insurance's medical gap cover scheme. See FAQ's on website for more information about the Medical Gap cover scheme.)
- Nursing home type patients (who don't need medical care, but still need to be looked after in hospital)
- Obstetrics (childbirth services)
- Palliative care (e.g. caring for a cancer patient)
- Psychiatric care (mental health care)
- Rehabilitation (e.g. for drug problems or accident recovery)

- Same day treatment (when you're in and out of surgery on the same day)
- Surgically implanted prostheses (up to the Government prescribed benefits)
- Theatre in a public hospital (surgery costs)
- Other agreed charges - additional costs that come from your hospital stay (but not phone or TV, for example)

### What's not covered

Public Hospital doesn't cover:

- Hospital Accommodation (single room) in a Public Hospital
- Full Hospital Accommodation costs in Private Hospitals – Public Hospital pays fixed benefits per day which will leave you out of pocket if you have a stay in a Private hospital
- Cosmetic surgery (unless it's medically necessary and your doctor provides a Medicare item number)
- Gastric banding and all obesity surgeries (for weight loss)
- Renal dialysis (for kidney disorders)
- Theatre in a private hospital

### Other Relevant Information

Please refer to the Product Information Section for other relevant information on Public Hospital Cover.

## Mid Hospital Cover

Some people want the benefit of private without the cost of top cover. Mid Hospital covers you for treatment in participating private hospitals in a shared room. This cover does not include any pregnancy related services.

### What's covered

Budget Direct Health Insurance's Mid Hospital will cover you for:

- Hospital Accommodation (in a shared room)
- Hospital Accommodation in a single room with a co-payment ($100 per day is payable by you, capped at seven days per admission)

- Accidents (that need hospitalisation)
- Emergency Ambulance Cover
- Cardiac surgery and coronary care
- Eye surgery
- Intensive care (one-on-one care 24/7)
- Joint reconstruction (e.g. knee)
- Medical Gap (Budget Direct Health Insurance will pay up to the Medical Benefits Schedule fee and 20% more if your doctor is a part of Budget Direct Health Insurance's medical gap cover scheme. See FAQ's on website for more information about the Medical Gap cover scheme.)
- Nursing home type patients (who don't need medical care, but still need to be looked after in hospital)
- Palliative care (e.g. caring for a cancer patient)
- Psychiatric care (mental health care)
- Rehabilitation (e.g. for drug problems or accident recovery)
- Same day treatment (when you're in and out of surgery on the same day)
- Surgically implanted prostheses (up to the Government prescribed benefits)
- Theatre (surgery costs)
- Other agreed charges - additional costs that come from your hospital stay (but not phone or TV, for example)

## What's not covered

You don't want to pay for what you don't use. So Mid Hospital doesn't cover:

- Cataract surgery and corneal transplants
- Cosmetic surgery (unless it's medically necessary and your doctor provides a Medicare item number)
- Delivery suite (for babies)
- Dental implants performed in a hospital
- Gastric banding and all obesity surgeries (for weight loss)
- IVF and related services

- Joint replacement (e.g. hip)
- Obstetrics (childbirth services)
- Renal dialysis (for kidney disorders)

### Other Relevant Information

Please refer to the Product Information Section for other relevant information on Mid Hospital Cover.

## Top Hospital Cover

Some people want total peace of mind. That means coverage for many treatment types and private privileges in public and participating private hospitals.

### What's covered

Budget Direct Health Insurance's Top Hospital cover will cover you for:

- Hospital Accommodation (shared or single room, subject to availability)
- Accidents (that require hospitalisation)
- Emergency Ambulance Cover
- Cardiac surgery and coronary care
- Cataract surgery
- Delivery suite (for babies)
- Eye surgery
- Gastric banding and all obesity surgeries (for weight loss)
- Intensive care (one-on-one care 24/7)
- IVF and related services
- Joint reconstruction (e.g. knee)
- Joint replacement (e.g. hip)
- Medical Gap (Budget Direct Health Insurance will pay up to the Medical Benefits Schedule fee and 20% more if your doctor is a part of Budget Direct Health Insurance's medical gap cover scheme. See FAQ's on website for more information about the Medical Gap cover scheme.)
- Nursing home type patients (who don't need medical care, but still need to be looked after in hospital)

- Obstetrics (childbirth services)
- Palliative care (e.g. caring for a cancer patient)
- Psychiatric care (mental health care)
- Rehabilitation (e.g. for drug problems or accident recovery)
- Renal dialysis (for kidney disorders)
- Same day treatment (when you're in and out of surgery on the same day)
- Surgically implanted prostheses (up to the Government prescribed benefits)
- Theatre (surgery costs)
- Other agreed charges - additional costs that come from your hospital stay (but not phone or TV, for example)

### What's not covered

You don't want to pay for what you don't use, so Top Hospital doesn't cover cosmetic surgery (unless it's medically necessary and your doctor provides a Medicare item number).

### Other Relevant Information

Please refer to the Product Information Section for other relevant information on Top Hospital Cover.

**Australia wide ambulance**

Your hospital cover will include Emergency Ambulance Cover. This will cover you for all clinically necessary, emergency ambulance services in Australia.

We recommend checking with your state Ambulance authority to ensure you are correctly covered for all non-emergency ambulance transport within Australia.

## Basic Extras Cover

You want some extras, but you only need enough for dental, optical and the occasional alternative therapy treatment.

Basic Extras is available with benefit options, either 55% back or 85% back. With either variation of Basic Extras, the annual limits are the same.

What's included in Basic Extras:

| Basic Extras Service |
| --- |
| Dental - TOTAL (see Dental Notes below) |
| General Dental |
| Preventative dental – sub limit<br>(e.g. checkups, scale and clean) |
| Major Dental |
| Orthodontic – sub limit (e.g. braces)<br>A limit of $900 per course and lifetime limit of $1,050 applies. |
| Crown and bridgework – sub limit |
| Indirect restorations – sub limit<br>These occur outside of the mouth, e.g. a filling that has been modelled on plaster cast. |
| Implants – sub limit<br>(e.g. a fake tooth that is permanently inserted into your gum) |
| Optical<br>Includes prescription glasses, contact lenses and frames. Doesn't include non-prescription sunglasses or repairs. |
| Other Therapies<br>Chiropractic, Osteopathy, Naturopathy, Homeopathy, Acupuncture, Physiotherapy, Myotherapy, Hydrotherapy, Remedial Massage (combined)<br>Note: benefits will only be paid for one consultation and/or treatment per provider per day. |

## Dental Notes

There are many different dental treatments and rules around what is and isn't covered. It is recommended that you get in touch with Budget Direct Health Insurance before getting treatment so you'll know if you're covered.

**Sub-limits:**

The table above shows the yearly limit for each type of dental service. For example, the annual limit for crown and bridgework is $450. However, there are further sub-limits for each of these services. For example, the individual limit for one crown is $225.

| Waiting Period | Singles Yearly Limit | Couples/Family Yearly Limit |
|---|---|---|
| | $500 | $500 per person (max. $1000 per family) |
| 2 months | | |
| | $250 | $250 per person (max. $500 per family) |
| 12 months | | |
| | $300 | $300 per person |
| | $225 per crown/bridge $450 per person | $225 per crown/bridge $450 per person |
| | $350 | $350 per person (max. $700 per family) |
| | $400 | $400 per person |
| 6 months | $120 | $120 per person (max. $240 per family) |
| 2 months | $400 | $400 per person (max. $800 per family) |

If you're getting treatment, email or chat to Budget Direct Health Insurance first to see if any sub-limits or rules apply to you.

## Other Relevant Information

Please refer to the Product Information Section for other relevant information on Basic Extras Cover.

## Top Extras Cover

Top Extras Cover is for you if you like peace of mind and want lots of coverage, a variety of treatment types and bigger limits.

| Top Extras Service |
| --- |
| Chiropractic / Osteopathy (combined)<br>Includes one chiro x-ray per year<br>**Note:** benefits will only be paid for one consultation and/or treatment per provider per day. |
| **Dental - TOTAL** (see Dental Notes below) |
| General Dental |
| **Preventative dental – sub limit**<br>(e.g. checkups, scale and clean) |
| Major Dental |
| **Orthodontic – sub limit** (e.g. braces)<br>A limit of $2,550 per course and lifetime limit of $2,900 applies. |
| **Crown and bridgework – sub limit** |
| **Indirect restorations – sub limit**<br>These occur outside of the mouth, e.g. a filling that has been modelled on plaster cast. |
| **Implants – sub limit**<br>(e.g. a fake tooth that is permanently inserted into your gum) |
| Naturopathy / Homeopathy / Acupuncture / Remedial Massage (combined)<br>**Note:** benefits will only be paid for one consultation and/or treatment per provider per day. |
| **Optical**<br>Includes prescription glasses, contact lenses and frames. Doesn't include non-prescription sunglasses or repairs. |

Top Extras is available with benefit options, either 55% back or 85% back. With either variation of Top Extras, the annual limits are the same.

What's included in Top Extras:

| Waiting Period | Singles Yearly Limit | Couples/Family Yearly Limit |
|---|---|---|
| 2 months | $400 | $400 per person (max. $800 per family) |
| | $2,000 | $2000 per person (max. $4,000 per family) |
| 2 months | | |
| | $500 | $500 per person (max $1,000 per family) |
| 12 months | | |
| | $450 | $450 per person |
| | $300 per crown/bridge $600 per person | $300 per crown/bridge $600 per person |
| | $400 | $400 per person (max $700 per family) |
| | $400 | $400 per person |
| 2 months | $400 | $400 per person (max. $800 per family) |
| 6 months | $250 | $250 per person (max. $500 per family) |

| |
|---|
| Physiotherapy / Myotherapy / Hydrotherapy (combined)<br>Note: benefits will only be paid for one consultation and/or treatment per provider per day. |
| Podiatry - TOTAL |
| General consultations |
| Surgical procedures |
| Orthotics – sub limit<br>(for your feet)<br>Orthotics must be custom made (alterations on off-the-shelf orthotics is not included) |
| Psychology |
| Travel Vaccinations<br>Benefits are only payable towards travel vaccinations listed on Budget Direct Health Insurance's Approved Travel Vaccinations list (see website). |

## Dental Notes

There are many different dental treatments and rules around what is and isn't covered. It is recommended that you get in touch with Budget Direct Health Insurance before getting treatment so you'll know if you're covered.

**Sub-limits:**

The table above shows the yearly limit for each type of dental service. For example, the annual limit for crown and bridgework is $600. However, there are further sub-limits for each of these services. For example, the individual limit for one crown is $300.

If you're getting treatment, email or chat to Budget Direct Health Insurance first to see if any sub-limits apply to you.

| | | |
|---|---|---|
| 2 months | $400 | $400 per person (max. $800 per family) |
| | $400 | $400 per person (max. $800 per family) |
| 2 months | | |
| 12 months | | |
| 12 months | $230 | $230 per person (max. $460 per family) |
| 2 months | $400 | $400 per person (max. $800 per family) |
| 2 months | $50 per vaccination $100 per person | $100 per person (max. $200 per family) |

## Other Relevant Information

Please refer to the Product Information Section for other relevant information on Top Extras Cover.

# Customer Satisfaction and Private Health Information

## Code of Conduct

Budget Direct Health Insurance is brought to you by GMHBA Limited, proud to be a compliant member of the Private Health Insurance Code of Conduct. The Private Health Insurance Code of Conduct is designed to help you by providing clear information and transparency in your relationships with health insurers.

The Code covers four main areas of conduct in private health insurance ensuring:

- You receive the correct information on private health insurance from appropriately trained staff;
- You are aware of the internal and external dispute resolution procedures with Budget Direct Health Insurance;
- Policy documentation contains all the information you require to make a fully informed decision about your purchase and all communications between you and Budget Direct Health Insurance are conducted in a way that ensures appropriate information flows between the parties; and
- All information between you and Budget Direct Health Insurance is protected in accordance with national and state privacy principles

You can download the Code at **http://www.privatehealth.com.au/codeofconduct/**

## Community Rating

Budget Direct Health Insurance is required to comply with Community Rating. Community Rating means Budget Direct Health Insurance will not discriminate between members on the basis of their health or any other reason described below - basically equal opportunity for private health insurance.

When making decisions in relation to members, Budget Direct Health Insurance will disregard the following:

1. The suffering by the member of a chronic disease, illness or any other medical condition

2. The gender, race, sexual orientation or religious belief of a person
3. The age of a member, except in relation to Lifetime Health Cover loadings
4. Any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that are likely to result in an increased need for extras or hospital treatment
5. The frequency with which a person needs extras or hospital treatment
6. The amount, or extent, of the benefits to which a member becomes, or has become, entitled during a period.

## Privacy

We value the relationship between Budget Direct Health Insurance and our members. An important part of this relationship is our commitment to protecting the personal information entrusted to us by our members. This commitment is documented in our Privacy Statement for Members **http://www.health.budgetdirect.com.au**

Please note that Budget Direct is a separate organisation to Budget Direct Health Insurance. Budget Direct's privacy policy is available on the Budget Direct website visit **www.budgetdirect.com.au** to access this.

## Complaints or concerns

Budget Direct Health Insurance's process for dealing with complaints:

1. *How to Make a Complaint.*

   You can make a complaint in whichever is your preferred method. Writing an email is Budget Direct Health Insurance's preferred method to fully understand the complaint before coming up with a resolution, so please email enquiries@health.budgetdirect.com.au or if you prefer, visit **health.budgetdirect.com.au**, **WebChat** about it, or call **1300 665 623**.

   You will receive an acknowledgement response within 24 hours. If the matter is of a more difficult nature and will take some time to resolve, Budget Direct Health Insurance will keep you informed of the ongoing progress.

2. *Unhappy with the resolution of the initial complaint?*

   If after receiving Budget Direct Health Insurance's response you are still unhappy, you can request that it be brought to Budget Direct Health Insurance Business Manager's attention. They will then again review the complaint, possibly contacting you for further information, if needed, and get back to you with a response within five working days.

3. *Free independent advice is available from the Private Health Insurance Ombudsman.*

   You can contact the Ombudsman on freecall **1800 640 695** or **Suit 2 Level 22, 580 George Street, SYDNEY NSW 2000**.

## Insure? Not sure?

If you need more information about private health insurance please refer to the Private Health Insurance Administration Council (PHIAC) guide **"Insure? Not sure?"** which can be found at **http://phiac.gov.au/consumers/private-health-insurance-guide/**

## State of the health funds report

The Private Health Insurance Ombudsman publishes an annual State of the Health Funds Report. This independent report compares service and productivity of private health insurers.

Download the report from **www.phio.org.au/publications/publications/state-of-the-health-funds.aspx**

## Standard Information Statements

A Standard Information Statement (SIS) is available for all Budget Direct Health Insurance products.

Upon joining, the SIS/s for the Budget Direct Health Insurance products which you have purchased will be sent to your Budget Direct Health Insurance Webmail, and you will receive a notification stating that the SISs are available in your Webmail.

An up to date SIS will be forwarded to your Webmail at least once per year from where it can be read or printed.

## Recommendation or endorsement

Budget Direct Health Insurance does not offer health or medical services or advice. Budget Direct Health

Insurance does not recommend or endorse any medical practitioner, dentist, therapist, hospital, health or medical service provider, treatment, therapy or the use of any appliance or prosthetic. Budget Direct Health Insurance does not endorse or make any representation whatsoever as to the appropriateness or effectiveness of any service or goods for which a benefit is paid. Members should make and rely on their own enquiries and seek any assurance or warranties directly from the provider of the service or product.

## Medicare Levy Surcharge

The Medicare levy surcharge (MLS) is a surcharge on individuals and families on higher incomes who don't have eligible private hospital cover.

The MLS is an additional tax that Australians need to pay if they don't have eligible private hospital cover and earn over $90,000 as a single or $180,000 as a couple/family. It used to be an extra 1% tax for all high-income earners, but now it can be up to 1.5% extra tax depending on your income. The surcharge is in addition to the normal 2% Medicare Levy.

People may have to pay the Medicare levy surcharge if they or any of their dependants do not have eligible cover and they are:

- A single person – without dependent children – with a taxable income (including any reportable fringe benefits of $1,000 or more) greater than $90,000
- A family – including a couple and single parent – with a combined taxable income (including any reportable fringe benefits of $1,000 or more) greater than $180,000 (increasing by $1,500 per dependent child, after the first child)

| | Nothing to pay | Tier 1 | Tier 2 | Tier 3 |
|---|---|---|---|---|
| Singles | $90,000 or less | $90,001-$105,000 | $105,001-$140,000 | $140,001 or more |
| Couples/Families (Increases by $1,500 per child after your first) | $180,000 or less | $180,001-$210,000 | $210,001-$280,000 | $280,001 or more |
| **Medicare Levy Surcharge** | | | | |
| All ages | 0.0% | 1.0% | 1.25% | 1.5% |

If you're thinking about cancelling your hospital cover, be aware if you do change your mind and want to take it out again then you may need to re-serve your waiting periods plus Lifetime Health Cover loading may apply with whichever health insurer you join (read following section about Lifetime Health Cover loading).

Contact your tax adviser or the Australian Taxation Office for further details about the Medicare levy surcharge www.ato.gov.au.

## Australian Government Rebate on Private Health Insurance

The Australian Government Rebate on Private Health Insurance is available to those who have full Medicare eligibility and earn under $140,001 for singles and $280,001 for families/couples or single parents. The table below gives you the full details.

| | Unchanged from before 1st July 2013 | Tier 1 | Tier 2 | Tier 3 |
|---|---|---|---|---|
| Singles | $90,000 or less | $90,001-$105,000 | $105,001-$140,000 | $140,001 or more |
| Couples/ Families (Increases by $1,500 per child after your first) | $180,000 or less | $180,001-$210,000 | $210,001-$280,000 | $280,001 or more |
| **Australian Government Rebate on Private Health Insurance** | | | | |
| Under 65 years | 27.820% | 18.547% | 9.273% | 0.000% |
| 65-69 Years | 32.457% | 23.184% | 13.910% | 0.000% |
| 70 years & over | 37.094% | 27.820% | 18.547% | 0.000% |

You can claim the rebate as a reduction to your premiums, as a tax rebate when you lodge your annual tax return or as a direct payment from the Government through any Medicare office.

The easiest way for you to claim the rebate is to complete the application form for the Australian Government Rebate on Private Health Insurance during the application process with Budget Direct Health Insurance. Budget Direct Health Insurance will then deduct the rebate from your premiums.

## Lifetime Health Cover loading

The Federal Government introduced the Lifetime Health Cover (LHC) initiative on the 1st of July 2000. From this date, anyone who joins a hospital cover of a registered health fund will be given a Certified Age at Entry (CAE) status - which represents their age when they first joined a hospital cover after the 1st of July 2000.

If you joined a hospital cover before this date you are assigned a CAE of 30 and you'll pay the base rate (the lowest premium) for your hospital cover. The premiums returned on the Quick Quote are quoted at base rates. If you joined after this date and are aged 31 or over, and therefore have a CAE of over 30, you'll pay a 2% loading for each year your CAE is above 30 to a maximum loading of 70%. Where you have had to pay a LHC loading, and have done so for a continuous period of 10 years, the loading will no longer apply on the day after the last day of the 10 year period. If you're over the age of 30, the sooner you take out hospital cover, the less you'll pay later.

In summary, the Federal Government's LHC loading applies if you were aged 31 or over on the 1st of July just passed and are taking out hospital cover for the first time. Under LHC, in addition to the rates on the Quick Quote, a 2% loading is applied for each year you are aged over 30 when you join. The Australian Government Rebate on private health insurance may apply to your total premiums depending on your income, including any LHC loading. Lifetime health cover applies to hospital cover and does not apply to extras.

## Periods of absence

As members may need to discontinue their hospital cover membership for brief periods, lifetime health cover allows a period or periods of absence through a member's lifetime without affecting their CAE. However, after a total of 1094 days absence, their CAE will increase by one year for each additional full year of absence. Members will need to re-serve waiting and benefit limitation periods when they return to Budget Direct Health Insurance.

## Membership suspension

Approved periods of suspension, which will not affect a member's CAE are explained under 'Suspensions' in the Product Information section.

# All about Claiming

## Damages or compensation

Where you or your dependants have a right to claim damages or compensation from any other person or body, you are required to pursue that entitlement prior to lodging a claim for benefits with your Budget Direct Health Insurance. A claim should only be lodged with Budget Direct Health Insurance if action at law is unsuccessful. A letter of denial is required. This includes WorkCare, TAC, public liability and third party claims.

## Claiming procedure

How to claim with Budget Direct Health Insurance:

### Hospital claims

- Are paid from Budget Direct Health Insurance direct to the hospital. You will need to present your membership card upon admission, and you will not need to contact Budget Direct Health Insurance in most cases. Details of all claims paid on your behalf can be viewed in your online member area.

### Extras Claims

- When you have Budget Direct Health Insurance extras cover you can use your membership card to claim electronically on-the-spot when this facility is available at your health care provider. After the service has been provided, your membership card will be swiped through the terminal, your claim details entered and your claim will usually be processed electronically within seconds. Once your claim is authorised by Budget Direct Health Insurance, you simply pay any difference between the full fee for the treatment and the amount paid by Budget Direct Health Insurance. If there is an unexpected rejection of your claim at the point of service, your provider should contact Budget Direct Health Insurance on **1300 665 623** to clarify the issue at the time of the service taking place.

- If your service provider does not have an electronic terminal, you will need to pay your account with your service provider in full and then claim online with Budget Direct Health Insurance. Simply visit health.budgetdirect.com.au and log in to your member area. You will need to keep your receipt for two years and send to Budget Direct Health Insurance if requested during an audit in this time.
- In some situations you may not be able to claim on-line, and you will need to submit your claim via mail. You will need to submit your claim via mail if the service occurred more than six months before the date of claiming, or the service was for orthodontic treatment.

To submit a claim by mail, Budget Direct Health Insurance needs the following information:

- A completed claim form; and
- The fully itemised health care account/s, and the original receipt/s. Photocopies/facsimiles of accounts and/or receipts cannot be accepted.

An orthodontic treatment plan certificate, completed by the treating orthodontist/dentist, is also required before orthodontic benefits will be paid. You can obtain an orthodontic treatment plan certificate by calling our customer service centre on **1300 665 623**. For the purpose of benefit payments, orthodontic treatment is regarded as commencing on the date the appliance is originally fitted. Limits apply every calendar year.

This paperwork should be sent to:

**Budget Direct Health Insurance Claims**
**PO Box 761. Geelong, VIC, 3220.**

Budget Direct Health Insurance reserves the right to take the following actions against any member or persons where improper, fraudulent or indiscretion occurs whilst making claims from Budget Direct Health Insurance.

Actions that may be taken are:

- Suspension of electronic claiming for the period of time determined by Budget Direct Health Insurance depending on the severity of the incident
- Restitution (voluntary or negotiated)
- Prosecution

## Paid accounts/bills

Benefits for paid accounts will be deposited directly into the members' previously nominated bank account.

## Unpaid accounts (other than hospital accounts)

Claims for unpaid accounts will not be paid.

## Medical benefits

Medical benefits cover your fees payable to surgeons, anaesthetists and other professionals who may bill you separately from your hospital bills. Claims for medical benefits can only be paid after your claim for medical services has been assessed by Medicare (except in the case of claims made through our medical gap cover) and your claim for hospital benefits has been assessed and paid. Our benefits are not payable for services rendered when the patient is not a hospital inpatient.

# Important Information prior to signing up

## Transferring from another health insurer

You can transfer your health insurance from another health insurer to Budget Direct Health Insurance without serving any new waiting periods or benefit limitation periods provided that you:

- Have served all waiting periods or benefit limitation periods with your previous health insurer; and
- Transfer to any equivalent or lower level of cover within 30 days of your membership ceasing with your previous health insurer

Budget Direct Health Insurance recommends that your cover starts immediately after your previous cover ends. If your new cover with Budget Direct Health Insurance provides higher benefits or benefits for services not covered by your previous health insurer, you'll be regarded as a new member for those higher benefits, and/or additional services, and will be required to serve the waiting and benefit limitation periods - but only for the higher benefits/additional services.

If you transfer to Budget Direct Health Insurance from another health insurer before completing the waiting periods or benefit limitation periods with your previous health insurer, you'll need to serve the balance of the waiting periods or benefit limitation periods with Budget Direct Health Insurance (see earlier heading 'waiting periods' and 'benefit limitation periods').

When you transfer to Budget Direct Health Insurance your benefit entitlements may be adjusted by benefits already paid by your previous health insurer. Under lifetime health cover, continuity of a member's/partner's certified age at entry (CAE) is possible when transferring from another Australian registered private health insurer.

## Membership for non-residents of Australia

Budget Direct Health Insurance hospital covers are designed for people who have full Medicare eligibility. These covers will not meet the cost of public or private hospital treatment, medical treatment or diagnostic services for people who do not have full Medicare eligibility. People who do not have full Medicare eligibility should contact Budget Direct Health Insurance on **1300 665 623** to discuss appropriate health insurance arrangements.

## Migrants

Migrants who sign up with Budget Direct Health Insurance within two months of arriving in Australia shall receive the following concessions:

- No two month waiting period for any level of hospital cover
- No 12 month waiting period for pre-existing conditions/illnesses will apply to Public Hospital cover

All other waiting and benefit limitation periods for hospital and extras will apply. Proof of residency may be required by Budget Direct Health Insurance. Lifetime health cover regulations also apply to migrants. Contact Budget Direct Health Insurance for details.

# Confirmation of Terms and Conditions of your membership

When you signed up, you agreed to certain terms and conditions. These Terms and Conditions are provided below:

## New Membership Join Process

### Acknowledgement

In these terms, "you" or "your" refers to Budget Direct Health Insurance (brought to you by GMHBA Limited), and "I" or "my" refers to you as the Policy Holder.

By typing "yes" I acknowledge and declare that:

1. I have read and accept your terms and conditions of membership (as outlined in the Important Information);
2. I understand the conditions relating to pre-existing conditions/illnesses, waiting and benefit limitation periods;
3. I have read and accept your Privacy Statement for Members and I consent to the use and disclosure of my personal information in accordance with this policy;
4. The information I have provided to you via this online application for membership is true and correct;
5. The information in this online application for membership is provided with the consent of the individual(s) to whom it relates. I confirm that I have the authority to act on behalf of the individual(s) named in this online application and I have brought your Privacy Statement for Members to their attention;
6. I will make all claims under this policy and will ensure that each claim includes the sensitive information of a spouse/partner or dependant aged 16 years and over only with their consent;
7. I understand that my application for membership at the payment of benefits may be declined if any of the information I have provided to you is false;

8. I understand that you have the right to accept or refuse my application for membership and upon acceptance of my application for membership I will have engaged you to provide health insurance to me in accordance with my chosen level of cover;
9. I understand that cover does not commence until payment is received;
10. I am responsible for this policy and I will communicate to all current and future individuals covered by it, the information contained in your terms and conditions of membership, the existence of the Fund Rules, and the fact that those terms, conditions and rules apply to all of your members; and
11. I understand that you have the right to amend your terms and conditions of membership and your Privacy Statement for Members.

## Need to get in touch with us?

**Customer Service**
1300 665 623 (within Australia)
enquiries@health.budgetdirect.com.au

**Sales**
1800 234 004 (within Australia)

**Claims and Online Member Area**
budgetdirect.com.au

**Budget Direct Health Insurance**
PO Box 761, Geelong VIC 3220

Budget Direct Health Insurance is brought to you
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## Why **compare**the**market**.com.au?

It's simple; we're here to help you save time and money off your next household bill. One quick search with **compare**the**market**.com.au can bring you results from some of Australia's award winning insurance and utility brands, so you can compare them side-by-side. We don't mark up policies, so if you do choose to purchase a product or service, you'll only be charged the provider's premium or fee.

So whether you're looking for car insurance, home and contents insurance or perhaps a better deal on your energy bill, compare with us. Visit our website for more information.

- HEALTH
- INCOME
- CAR
- ENERGY
- TRAVEL
- ROADSIDE
- LIFE
- FUEL
- HOME