IMPORTANT INFORMATION GUIDE

UNDERSTANDING YOUR HEALTH COVER

Over the next few pages you will find information to help you understand how your health cover with us works. We recommend you keep this information in a safe place so that you can always refer to it.

You should also refer to our Fund Rules, available online or by calling us, for the full terms and conditions of your cover.

The information below applies in addition to our Fund and Policy Rules.

UNDERSTANDING YOUR HOSPITAL COVER

What is covered?

Hospital costs

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

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

With us, you are fully covered as a private patient in most hospitals that Bupa has an agreement with known as Members First and Network hospitals across Australia for any treatment which is recognised by Medicare and is not either restricted or excluded under your cover.

A small number of these hospitals may charge a fixed daily fee. This fee is capped at a maximum number of days for overnight stays. The hospital should inform you of this fee when you make a booking. This fee is in addition to any excess or co-payment you may have as part of your hospital cover.

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

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

- accommodation for overnight or same-day stays
- operating theatre, intensive care and labour ward fees
- supplied pharmaceuticals approved by the Pharmaceutical Benefits Scheme
- allied services including physiotherapy, occupational therapy and dietetics
- dressings and other consumables
- pathology and radiology diagnostic tests performed in hospital by Bupa contracted providers
- surgically implanted prostheses up to the approved benefits in the Government's Prostheses List
- private room where available.

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

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

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

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

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

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

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

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

As a private patient in a public hospital you are entitled to choose your doctor, if they are available. Depending on your illness or condition, this may be the same doctor who would have been allocated to you by the hospital as a public patient.

If you elect to be treated as a private patient in a public hospital, we will pay shared room minimum benefits and benefits for prostheses up to the benefit in the Government Prostheses List. This will apply for any treatment recognised by Medicare unless it is excluded or restricted under your cover.

If you choose to stay in a private room for an overnight stay, Bupa will pay a fixed benefit in addition to the shared room minimum benefit. It is important to note that in public hospitals, private rooms are generally allocated to people who medically need them.

If the hospital charges are greater than the Bupa benefit, you will be required to pay the balance as an out-of-pocket expense. The hospital should let you know what these expenses will be before you elect to be a private patient.

You will also be responsible for personal expenses such as TV hire and telephone calls and any prostheses charges above the benefit in the Government Prostheses List. Please also refer to the Medical Costs section of this brochure.

To ensure peace of mind, ask your doctor about their fees and whether they participate in our Medical Gap Scheme for your hospital treatment prior to admission. Remember to also ask your doctor about the fees for other practitioners that may be involved in your hospital treatment, such as the anaesthetist and assistant surgeons.

Medical costs

These are the fees charged by a doctor, surgeon, anaesthetist or other specialist for any treatment given to you in hospital. Private health insurance provides you with the choice of your own doctor, and you decide whether you will go to a public or a private hospital that your doctor attends. You may also have more choice as to when you are admitted to hospital.

You are covered for:

- the cost of these medical treatments up to the Medicare Benefit Schedule (MBS) fee.

The MBS fee is the amount set by the Federal Government for each medical service covered by Medicare. You must be eligible for Medicare in order to be covered up to the MBS fee. If you choose to be treated as a private patient in a hospital (public or private), Medicare will cover you for 75% of the MBS fee for associated medical costs and we will cover the remaining 25%. If your specialist charges more than the MBS fee there will be a 'gap' for you to pay. However, the Bupa Medical Gap Scheme can help eliminate or reduce the gap for you if your doctor/s choose to use it.

At Members First day facilities, not only will you be fully covered for the facility accommodation and theatre fees but there are no out-of-pocket expenses for medical treatments (e.g. your specialist's fees).

What is not covered?

Hospital costs

Situations when you are likely not to be covered include:

- during a waiting period
- when a service is excluded from your level of cover
- when a service is covered as a minimum benefit and you are admitted to a private hospital, you will not be covered above the minimum benefit
- for the fixed fee charged by a fixed fee hospital or a hospital that has a fixed fee service
- when you have not been admitted into a hospital and are treated as an outpatient (e.g. emergency room treatment, outpatient ante-natal consultations with an obstetrician)
- for psychiatric and rehabilitation day programs, at a hospital Bupa does not have an agreement with
- hospital treatment provided by a practitioner not authorised by a hospital to provide that treatment
- hospital treatment for which Medicare pays no benefit, including: medical costs in relation to surgical podiatry (including the fees charged by the podiatric surgeon); cosmetic surgery where not clinically necessary; respite care; experimental treatment and/or any treatment/procedure not approved by the Medical Services Advisory Committee (MSAC)
- personal expenses such as: pay TV, internet access, non-local phone calls, newspapers, boarder fees, meals ordered for your visitors, hairdressing and any other personal expenses charged to you unless included in your cover
- if you are in hospital for more than 35 days and you have been classified as a 'nursing home type' patient. (In this situation you may receive limited benefits and be required to make a personal contribution towards the cost of your care)
- if you choose to use your own allied health provider rather than the hospital's practitioner for services that form part of your in-hospital treatment (e.g. chiropractors, dieticians or psychologists)
- where compensation, damages or benefits may be claimed by another source (e.g. workers compensation)
- for any amount charged by a public or non-agreement hospital which is not covered by us or which is above the benefit that we pay
- for any treatment or service rendered outside Australia
- for some non-PBS, high cost drugs
- for pharmacy items not opened at the point of leaving the hospital.

Medical costs

You will not be covered for:

- medical services for surgical procedures performed by a dentist, surgical podiatrist, or any other practitioner or service that is not eligible for a rebate through Medicare.

Inpatient vs outpatient

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

Waiting periods

The following waiting periods apply for hospital cover:

- palliative care, psychiatric and rehabilitation services – two months
- pre-existing conditions, ailments or illnesses and pregnancy related services (including childbirth) – 12 months
- all other treatments included in your cover – two months.

When to contact us

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

Planning for a baby

If you are thinking about starting a family we recommend that you contact us to check whether your current level of cover includes pregnancy and other related services in advance. This is because there is a 12-month waiting period applied to all pregnancy related services (including childbirth) and assisted reproductive services.

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

UNDERSTANDING YOUR EXTRAS COVER

What is covered?

With extras cover, you can claim benefits for those services listed on your cover and that are not claimable elsewhere (e.g. from a third party like Medicare).

For example, Medicare does not provide benefits for:

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

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

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

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

What is not covered?

Extras benefits will not be payable:

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

Waiting periods

The following waiting periods apply for extras cover:

- initial waiting period – two months
- hire, repair and maintenance of health aids and appliances; and Living Well Programs – six months
- major dental, orthodontics, selected health aids and appliances – 12 months
- laser eye surgery, covered only under Ultimate Health Cover – three years.

UNDERSTANDING YOUR AMBULANCE COVER

Emergency Ambulance definition

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

An emergency is when there is reason to believe that the patient's life may be in danger or the patient should be attended to without undue delay.

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

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

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

Benefits are not payable for:

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

Ambulance Cover

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

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

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

QLD and TAS members: If you reside in Queensland or Tasmania, you are covered under your state service scheme.

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

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

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

Recognised Ambulance Providers

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

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

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

CHANGING YOUR COVER

Switching from another health fund

If you're changing from another Australian health fund to Bupa, you'll continue to be covered for all benefit entitlements that you had on your old cover, as long as these services are offered on your new cover with us. This is referred to as 'continuity of cover'. To receive continuity of cover, you'll need to transfer to us within 60 days of leaving your old fund.

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

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

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

Changing your cover with us

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

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

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

If you have any questions about transfers or waiting periods, just contact us.

Ending your membership

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

DEFINITIONS

Accidents

An accident is an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or damage to the body, which requires immediate (within 72 hours) medical advice or treatment from a registered practitioner other than the policyholder.

Annual maximums and service limits

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

Bupa Medical Gap Scheme

This is a direct billing arrangement between Bupa and your doctor/s that in most instances eliminates your out-of-pocket expenses for in-hospital doctors' fees (the 'gap').

If your doctor charges up to the Medicare Benefits Schedule (MBS) fee or is participating in the Bupa Medical Gap Scheme, in most cases you will have no medical gap costs to pay.

For doctors who are not participating in our Medical Gap Scheme and are charging above the MBS fee, we will pay the difference between the Medicare benefit and the MBS fee. Any amount above the MBS fee will be the amount you are required to pay and this is referred to as the 'Medical Gap'.

Calendar year

A calendar year is 1 January to 31 December.

Emergency admissions

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

- you are admitted to hospital and you choose to be treated as a private patient, and we later determine that your condition was pre-existing.

Excess or co-payment

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

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

Exclusions

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

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

Health aids and appliances

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

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

Living Well Programs

Our Living Well Programs help cover health-related programs from approved, recognised providers. A Living Well Programs approval form must be completed for gym memberships, children's swimming programs (eligible products only), yoga and pilates to confirm that the program is medically necessary. Other benefit and recognition criteria apply. Visit our website or contact us to find out more.

Minimum Benefits

For services paid at minimum benefits in a private hospital we will pay minimum shared room benefits, and you will have your choice of doctor. These benefits would not be adequate to cover all hospital costs and are likely to result in large out-of-pocket expenses.

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

Out-of-pocket expenses

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

Pharmacy

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

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

- over the counter or non-prescription items
- compounded items
- weight loss medication (some weight loss medications are covered under the Living Well Programs)
- body enhancing medications (e.g. anabolic steroids).

Pharmacy in-hospital

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

Pre-existing conditions

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

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

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

Premium and benefits

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

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

- fully complete the application process and pay your premiums one month in advance
- ensure that newborns are enrolled onto a family membership within two months of their birth to avoid any waiting periods for your baby
- enrol your adult children under their own names within 60 days after they no longer qualify under your cover (to avoid a break in their cover)
- provide proof of purchase of what you have spent before we can reimburse you for any services received
- submit your claims within two years of when the service was given (we don't pay benefits for any claims that are older than this).

Proof of identity and/or age

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

Special Benefits

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

Surgically implanted prostheses

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

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

Suspension rules

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

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

To be eligible to suspend your cover you must:

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

Your membership will be cancelled if not resumed.

Travel and accommodation

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

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

Waiting periods

A waiting period is the time between when you joined us and when you are covered for a service or treatment. If you receive a service or treatment during this time, you are not eligible to receive a benefit payment from us, regardless of when you submit the claim. Different waiting periods apply for different services.

OTHER IMPORTANT INFORMATION

Direct Debit Service Agreement

If you've chosen to pay your premiums by direct debit then you've accepted the terms of our Direct Debit Service Agreement.

This agreement outlines the responsibilities of Bupa Australia Pty Ltd ("we", "us", our") and you. We will confirm the direct debit arrangements prior to the first drawing (including the premium amount and frequency) and debit your nominated account. Deductions will occur on the nominated day, except for deductions nominated for the 28th, 29th, 30th or 31st, which will occur on the first day of the following month. If the nominated day falls on a weekend or public holiday, deductions will be made on the closest business day. We will debit all payments in advance and will automatically vary the deduction amount if your premiums or level of cover change. If we vary the deduction amount, we will give you at least 14 days written notice, except when the previous deduction is dishonoured, when we will deduct the previous period's payment together with the current amount due. If you pay premiums at three, six, and 12 month intervals, then should your financial institution dishonour a drawing, we will draw the payment on the nominated day of the following month. If two or more drawings are returned unpaid by your financial institution, we will also stop deducting your premiums from your nominated account and will start sending you renewal notices, pending further instructions from you. We will maintain the privacy and confidentiality of your billing information (unless you have requested or consented that we can disclose it to a third party or the law requires or allows us to do so). We may provide information to our or your financial institution to resolve a dispute on your behalf. You must ensure your nominated account permits direct debiting and that sufficient cleared funds are available in that account on the due date to cover the premiums due. Your financial institution may charge a fee if the payment cannot be met. You must ensure the authorisation given to draw on the nominated account is identical to the account signing instruction held by the financial institution where the account is based. You must notify us if the nominated account is transferred or closed. You must pay your premium by an alternative method if either you or we cancel the direct debit arrangements. You must ensure your payments are up-to-date, whether a notice is received from us or not.

If paying by credit card, you need to advise us of your new expiry date prior to expiry. You may request that we cancel or alter the debit drawing arrangements by contacting us and providing at least five working days notice of any requested changes. These changes may include deferring the debit, altering the debit dates, stopping an individual debit, suspending the direct debit arrangement or cancelling the direct debit completely. You can dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than seven days before the next scheduled debit drawing. If you have any queries about your direct debit agreement, please contact us. We undertake to respond to queries concerning disputed transactions within five working days of notification.

Privacy and your personal information

Your privacy and maintaining the confidentiality of your personal information is important to Bupa Australia Pty Ltd ("we", "us", "our"). This statement provides a summary of how we handle your personal and health information. For further information about how we handle your personal information, you should refer to our Information Handling Policy, available on our website or by calling us. When you join, you agree to the handling of your personal information as set out here and in our Information Handling Policy. We will only collect personal information (including health information) about you and those people insured under your policy to provide, manage and administer our products and services to you and to operate an efficient and sustainable business. We are required to collect and maintain certain information about you and those on your policy to comply with the Private Health Insurance Act 2007 (Cth) and related legislation. We may also collect personal and health 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 bodies corporate, or to third parties such as healthcare providers, government and regulatory bodies, other private health insurers and any persons or entities engaged by us or acting on our behalf. 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. If you are the policyholder, you're responsible for ensuring that each person on your policy is aware that we collect, use and disclose their personal information as set out here and in our Information Handling Policy. Each person on a policy aged 17 or over may complete a 'Keeping your personal information confidential' form to specify who should receive information about their health claims. You are entitled to reasonable access to your personal information. We reserve the right to charge a reasonable fee for collating such information. If you or any other person on your membership do not consent to the way we handle personal information, or do not provide us with the information we require, we may be unable to provide you with our products and services. We may use your personal (including health) information to offer you health management programs and services. When you take out cover with us, you consent to us using your personal information to contact you (by phone, email, SMS or post) about products and services that may be of interest to you. If you do not wish to receive this information, you may opt out by contacting us.

Can we help?

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

Resolution of problems

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

You can contact us by:

Telephone: 1800 802 386

Fax: 1300 662 081

Email: customerrelations@bupa.com.au

Mail: Customer Relations
Manager Bupa Australia
PO Box 14639
Melbourne VIC 8001

If you're not satisfied with the outcome from Bupa you may contact the Private Health Insurance Ombudsman on **1800 640 695** or visit them at **privatehealth.gov.au**

FOR MORE INFORMATION

Call us on 134 135

Visit bupa.com.au

Drop by your local Bupa centre

HBA mbf Mutual Community are part of Bupa

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