

ABOUT MBF

MBF is a leading name in health insurance and has dedicated more than 60 years to providing Australians with affordable, high-quality health cover.

We are now part of Bupa Australia, which operates under the trusted brands MBF, HBA and Mutual Community. Together we look after the healthcare needs of more than three million Australians.

We provide real value for members across a wide range of health services including: hospital; medical; extras; ambulance and pharmacy. As part of this, our members can save by using our extensive, national network of hospital and extras providers.

More good news—we are about more than health insurance. Our vision is to help our members lead longer, healthier, happier lives. As part of this we have created a range of health programs and online resources, in consultation with experts, to support our members.

If you would like more information please contact us today:

Call

132 623

Visit

mbf.com.au

Pop by

your local MBF centre

PART OF Bupa 



WHY GET PRIVATE HEALTH INSURANCE?

1

Going private may save you money

Taking out private hospital cover may save you money. That's because the Government charges a 1% Medicare Levy Surcharge if you don't have private hospital cover but earn more than \$77,000 a year (for singles) or more than \$154,000 a year* combined (for couples). This is on top of the 1.5% Medicare Levy paid by all eligible taxpayers. You should ask your tax adviser for more information or visit ato.gov.au.

*On a family membership this increases by \$1,500 per child after the first child. Thresholds are effective 1 July 2010 and are indexed annually.

2

Get at least 30% back on your premiums

The Federal Government 30% Rebate on private health insurance makes going private more affordable for you. The Rebate is available to all Australians who have full Medicare rights and applies to all products in this brochure. It's quick and easy to claim too—you can choose to get it as a reduced premium or as a lump sum at tax time.

3

Avoid Lifetime Health Cover Loading

You may be charged a Lifetime Health Cover (LHC) Loading under the Federal Government's LHC initiative depending on what age you first take out hospital cover. The loading increases 2% a year to a maximum of 70% and once attracted will apply for 10 consecutive years. You can avoid paying any loading if you take out hospital cover by 1 July following your 31st birthday and maintain it without a break (or any break less than three years).

4

Private health insurance = choice

Private health insurance covers most private hospital costs. This means you can choose your own doctor and where you are treated without worrying about treatment costs or public waiting lists in most instances. You can also enjoy cover for a wide range of extras services including: dental; optical; physiotherapy and massage, which are often not covered by Medicare.

5

Peace of mind

There are a number of good financial and practical reasons for getting private health insurance. But when it comes down to it, the peace of mind it gives you and your loved ones is just as important. You can rest easy knowing that your health insurance needs are covered.

WHY CHOOSE US?

Our experience

We are a trusted and respected name in health insurance and have spent more than 60 years providing Australians with quality health cover. We are now part of Bupa Australia, which operates under the trusted brands HBA, MBF and Mutual Community.

Save with our Australia-wide provider networks

Our extensive MBF MemberCare and Members First provider networks offer nation-wide access to dental; optical; physiotherapy and chiropractic services. If you have extras cover with us, you can save money by choosing these providers, rather than non-network providers, because their fees and any discounts have been negotiated and agreed upfront. Plus you can expect less out-of-pocket expenses and upfront notice of any gap amounts in most instances.

Visit our website to find a network provider near you. Also, keep an eye out for the following logos at your providers:

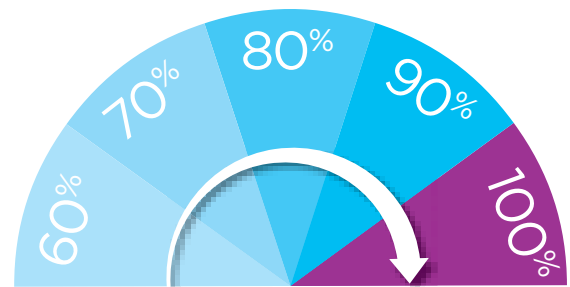


Choose from thousands of network providers across Australia and enjoy on-the-spot claiming!

Get more back on Extras

These are just some of the great benefits you can get by using our MBF MemberCare and Members First network providers:

- up to 100% and at least 60% back on all general dental treatment[^]
- up to 100% and at least 60% back on most physiotherapy and chiropractic services[^]
- higher annual maximums on optical than non-network providers
- a range of fixed-price packages on glasses and contact lenses at no additional cost^{*}
- up to \$100 off a wide range of fashion frames[#]
- 20% off a variety of sunglasses and non-standard contact lenses.[#]



[^]The percentage you get back is dependant on your level of cover and up to your annual maximums (applicable in most instances). ^{*}Optical benefits are subject to your level of cover, annual maximums and waiting periods. [#]Not in conjunction with any other offer.

Other non MBF MemberCare/Members First optical benefits

Our optical partnership means you benefit from a choice of fixed-price frames and lens packages, depending on your level of cover, annual maximums and waiting periods. Visit our website to find an optical partner store near you.

Great Extras product features

- **Loyalty Maximums** – on selected covers, we increase how much you can claim each year by 20% of the initial amount for most services (applies after the first 12 months up to a maximum increase of 100%)
- ☀ **Benefit Bonus** – on selected covers, you get 2% more back on your extras claims each year, up to a maximum of 10% (applies each calendar year after the first 12 months)
- ✳ **Top-up Bonus** – on selected covers, you get a Top-up Bonus which helps cover out-of-pocket costs (applies each calendar year after the first 12 months).

Full cover as a private hospital patient

With us you are fully covered as a private patient in most Members First and Network hospitals, and all public hospitals across Australia⁷. Plus, if you need to be admitted, in most cases you will be covered for all in-hospital medical charges. See page 10 for a list of what's covered.

⁷A small number of Members First and Network hospitals may have a service where a fixed fee applies. An excess or co-payment may apply depending on your chosen cover.

Better customer service

Some members prefer to contact us by phone or go online. Others just want to pop into their local centre to get their claims paid on the spot, or talk to us face to face about their existing cover. That's what sets us apart—we are about giving you options for how you do business with us.

Exciting member discounts

Get discounts on movie tickets, theme parks, airfares, fitness programs and much more! See page 32 for more details about our in2life deals.

Ongoing support for members

We are committed to helping our members lead longer, happier, healthier lives. This means giving ongoing support to help you get value from your cover. We also offer preventive health and wellness programs for your long-term benefit such as Living Well and Positive Health. See page 30 for more details.



Get up to 100% and at least 60% back when treated by our network providers[^]

HOSPITAL COVER

At any stage of life, it is important to have the right level of hospital cover to suit your needs and give you peace of mind.



You can save on your premiums by including an excess or co-payment

FAMILY ESSENTIALS HOSPITAL COVER

For families who want an affordable health cover solution. Your whole family has cover for accidents and for all other procedures your children receive a comprehensive level of cover, while you and your partner receive basic cover.

BUDGET HOSPITAL COVER

If you're young and active this cover provides an affordable level of hospital cover by excluding services you may not need. Pregnancy related services (including childbirth) are not covered.

STANDARD HOSPITAL COVER

If you're young and healthy, and want a basic level of hospital cover that includes pregnancy related services (including childbirth), then this cover may be right for your family. This affordable level of cover keeps costs down by excluding services you may not need right now.

ADVANTAGE HOSPITAL COVER

A comprehensive cover without any exclusions, and the flexibility to lower the cost of your premiums by having an excess or co-payment.

TOP HOSPITAL COVER

A comprehensive cover without any exclusions, excesses or co-payments. It also offers additional features including: Special Benefits to help pay for a partner or family member to stay with you in hospital; and Unemployment Cover (subject to eligibility).



Cover for ambulance services

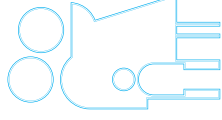
For total peace of mind, we recommend that your family takes out an ambulance subscription with your recognised State Ambulance Provider if it's available in your state (Vic, SA, NT and rural postcodes in WA). All of the covers listed in this brochure already provide you with capped emergency and on-the-spot treatment*. Alternatively, if you don't want hospital or extras cover, our Emergency Only Ambulance cover may be suitable. Also see page 37 for more details.

Emergency Only Ambulance

- Australia-wide emergency ambulance transport services including on-the-spot treatment and access to Air Services Australia
- unlimited emergency services.

Note: If you take out Emergency Only Ambulance cover on its own, you will need to pay the full 12-month premium upfront. *For Your Choice Extras emergency ambulance services must be selected.

HOSPITAL COVER COMPARISON



Planning a family? See page 12 for things you should consider

Want to know more details about what is and isn't covered? See page 10

Services	Family Essentials	Budget Hospital	Standard Hospital	Advantage Hospital	Top Hospital
	+	++	+++	++++	+++++
For Inpatient Services included on cover:					
Accommodation for Overnight and Same-day Stays	▲	✓	✓	✓	✓
Operating Theatre, Intensive Care, Ward Fees	▲	✓	✓	✓	✓
Medical Gap Scheme available	✓	✓	✓	✓	✓
Allied Services (e.g. physiotherapy in hospital)	✓	✓	✓	✓	✓
Inpatient Services included on cover:					
Accidents	✓	✓	✓	✓	✓
Arthroscopy or Meniscectomy (minor knee surgery)	▲	✓	✓	✓	✓
Appendicitis	▲	✓	✓	✓	✓
Removal of Tonsils and Adenoids	▲	✓	✓	✓	✓
Dental Surgery	▲	✓	✓	✓	✓
Minor Gynaecological Surgery	▲	✓	✓	✓	✓
Psychiatric	▲	✓	✓	✓	✓
Rehabilitation	▲	✓	✓	✓	✓
Pregnancy Related Services (including childbirth) and Assisted Reproductive Services	▲	✗	✓	✓	✓
Cardiac and Cardiac Related Services (e.g. open heart and bypass surgery and invasive cardiac procedures)	▲	✗	✓	✓	✓
Renal Dialysis for Chronic Renal Failure	▲	✗	✗	✓	✓
Cataract and Eye Lens Procedures	▲	✗	✗	✓	✓
Hip/Knee Replacement or Arthroplasty (including revisions)	▲	✗	✗	✓	✓
All other Joint Replacement including revisions (e.g. shoulder, elbow)	▲	✗	✗	✓	✓
All other Inpatient Treatments receiving a Medicare benefit					
Additional Items:					
Baby Books (see p39 for details)	✗	✗	✗	✓	✓
Emergency Ambulance Services*	✓	✓	✓	✓	✓
Laser Eye Surgery	✗	✗	✗	✗	✗
Health Subscription Refunds	✗	✗	✗	✗	✓
Special Benefits (see p39 for details)	✗	✗	✗	✗	✓
Unemployment Cover (subject to eligibility, see p39)	✗	✗	✗	✗	✓
Excesses and Co-payments					
Excess Options	None	\$250, \$500	\$250, \$500	\$250, \$500 [#]	None
Co-payments	None	None	None	Choice of excess option or \$50 per day (to a maximum of \$250 per stay) [#]	None

* Children receive full cover for shared-room accommodation in Members First, Network and public hospitals, while parents receive benefits for shared-room accommodation in a public hospital only, with choice of doctor. ✗ Indicates the service is not included. [#]There are different state ambulance arrangements across Australia. Please see page 37 for details. [#]Excess or co-payment do not apply for children on your membership.



UNDERSTANDING HOSPITAL COVER

Please ensure you also read the Important Information section on pages 36-42

What is covered?

Hospital costs

With private health insurance, you can choose to be treated as a private patient in either a public or a private hospital. With us you are fully covered as a private patient in most Members First and Network hospitals, and all public hospitals across Australia. A small number of Members First and Network hospitals may have a service where a fixed fee applies. There are also a small number of 'fixed fee' hospitals that charge a fixed daily fee for a maximum number of days per stay. If you're attending a 'fixed fee' hospital, you should contact them before you book to confirm what the fee will be.

When admitted to hospital, in most cases you will be covered for all in-hospital charges including:

- accommodation for overnight or same-day stays
- operating theatre, intensive care and labour ward fees
- supplied pharmaceuticals approved by the Pharmaceutical Benefits Scheme and provided as part of your in-hospital treatment
- allied services including physiotherapy, occupational therapy and dietetics
- medication, dressings and other consumables
- most diagnostic tests (e.g. pathology, radiology)
- no gap prosthesis that is surgically implanted, Government recognised and remain in-situ upon discharge
- single room where available.

An excess or co-payment may apply depending on your selected cover.

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, our Medical Gap Scheme can help eliminate or reduce the gap for you if your doctor/s choose to use it.

What is not covered?

Hospital costs

Situations when you are likely not to be covered include:

- during a waiting period
- when specific services or treatments are excluded or restricted from your level of cover
- when you are treated at a non-agreement or fixed fee hospital you will not be fully covered

GOT KIDS BETWEEN 21 AND 25?

If you have a child who's aged 21 or over, single and studying full time, they can be covered under a Family or Single Parent membership at no extra cost until age 25. If they are single but no longer a full-time student, you can still cover them until they turn 25 by upgrading to our Family Plus or Single Parent Plus membership options. Contact us for a quote.

- when you have not been admitted into a hospital and are treated as an outpatient (including emergency room treatment)
- hospital treatment provided by a practitioner not authorised by a hospital to provide that treatment
- hospital treatment for which Medicare pays no benefit, including most cosmetic surgery
- if you are in hospital for 35 days and you have been classified as a 'nursing home type' patient. In this situation you may receive limited benefits or be required to make a personal contribution towards the cost of your care
- benefits for pharmaceuticals supplied upon discharge from the hospital
- 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)
- any treatment or service rendered outside Australia.

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.

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, please see below.

- The initial waiting period and the waiting period for palliative care, psychiatric and rehabilitation services is two months.
- The waiting period for pre-existing ailments, illnesses or conditions and pregnancy related services (including childbirth) is 12 months.

Pre-existing ailments

A pre-existing ailment is any ailment, illness, or condition 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.

A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining or upgrading to a higher level of cover.

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

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

Inpatient vs outpatient

An inpatient procedure is where you are admitted into hospital for either a same-day or overnight admission. 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.

Medical Gap

This refers to the difference between what your doctor charges and the amount Medicare pays for inpatient procedures.

If your doctor charges up to the Medicare Benefit Schedule (MBS) fee or is participating in our 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'.

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.

Excess or co-payment

To lower the cost of your hospital cover, on selected covers you can choose to include an excess or co-payment. Excesses or co-payments are only payable on inpatient hospital treatment in any hospital.

An excess is a set amount you pay upfront before your benefit is paid. The excess is paid each time a person on your membership is admitted into hospital, to a maximum of once per person and twice on the entire membership in a calendar year.

A co-payment is an amount you agree to pay towards the cost of your daily hospital bill, in addition to out-of-pocket expenses. A co-payment applies to any overnight or same-day admission to any hospital. No excess or co-payment applies to your children if you hold Advantage Hospital Cover.

Certainty when you go to hospital

We've negotiated with most private hospitals and day surgeries to ensure you get certainty

about the costs associated with the hospital treatment you receive there. Most of the time you will receive a no-out-of-pocket experience when you use our Members First or Network hospitals. At Members First day surgeries, a no-out-of-pocket expenses agreement extends to medical treatment (treatment from medical practitioners) too.

A small number of hospitals may charge a fixed daily fee, capped at a maximum number of days per stay. These hospitals should inform you of this fee when you make a booking.

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.

Planning for a baby

Planning for a baby is a great reason for joining hospital cover or upgrading your existing level of cover. It is very important to consider your hospital cover during the planning stages to ensure you will not be impacted by waiting periods.

When planning for a baby, first check the level of cover you are currently on and ask: "Does it cover pregnancy related services including childbirth?" and "Does it cover the baby once born?"

Cover for the mother and the birth

The majority of our hospital covers include cover for inpatient pregnancy related services and cover for the birth. Please see the table opposite and check which level of cover you are currently on.

Waiting periods

Mother

There is a 12-month waiting period applied to all pregnancy related services (including childbirth) and assisted reproductive services.

Baby

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.

Pregnancy related services included in your hospital cover

	Family Essentials	Budget	Standard	Advantage	Top	Ultimate Health Cover
Cover for pregnancy related services (including childbirth)	✓ [†]	X	✓	✓	✓	✓
Cover for birth (mother only)	✓ [†]	X	✓	✓	✓	✓

[†]Parents receive benefits for shared-room accommodation in a public hospital only, with choice of doctor.



Ambulance services provided on top of your cover

The covers listed in this brochure cover you for two emergency services (including on-the-spot treatment) each calendar year for a family membership*#. If you combine hospital and extras cover you will still receive two services per calendar year.

Please remember you're not covered for non-emergency transport such as trips from a hospital to your home, a nursing home or another hospital.

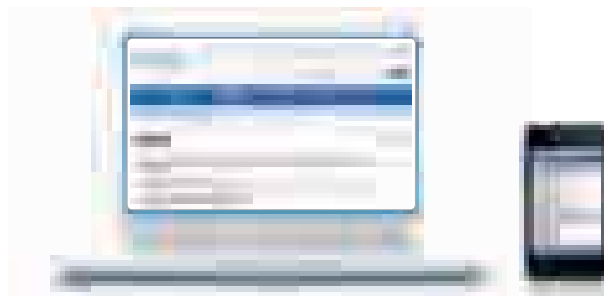
If you're a member on Ultimate Health Cover, depending on your state ambulance arrangement, you can choose to receive a 100% refund on a subscription with your recognised State Ambulance Provider (e.g. Ambulance Victoria or South Australia Ambulance Service).

*For Your Choice Extras emergency ambulance services must be selected. #Emergency Only Ambulance cover includes unlimited emergency services (see page 7 for more details).

Finding a network provider for your Extras services is easy!

Simply go to our website and enter your state and postcode to find one near you. Also, you can now search for a provider using our iPhone application which is available on iTunes.

iPhones, iPod touch, iTunes and App Store are a trademark of Apple Inc.









Benefit Bonus:




On selected covers, you get 2% more back on your extras claims each year, up to a maximum of 10% (applies each calendar year after the first 12 months)




EXTRAS COVER COMPARISON

Services	Waiting Periods	Bronze Extras	Your Choice Extras		Silver Extras	Gold Extras	Platinum Extras
		At least 60% cover [†]	At least 60% cover [†]		At least 60% cover [†]	At least 75% cover [†]	At least 90% cover [†]
General Dental	2 months	\$350	Year	Amount 	Unlimited	Unlimited	Unlimited
			1	\$700			
			2	\$840			
			3	\$980			
			4	\$1,120			
			5	\$1,260			
			6+	\$1,400			
Major Dental	12 months	X	Year	Amount 	\$1,000	\$1,100	\$1,200
			1	\$0			
			2	\$500			
			3	\$600			
			4	\$700			
			5	\$800			
			6	\$900			
			7+	\$1,000			
Orthodontics	12 months	X	Year	Amount 	\$700	\$800	\$900
			1	\$0			
			2	\$450			
			3	\$540			
			4	\$630			
			5	\$720			
			6	\$810			
			7+	\$900			
			Lifetime Limit: \$1,300		Lifetime Limit - \$2,000	Lifetime Limit - \$2,600	Lifetime Limit - \$2,800
Optical	2 months	\$210 (network) \$150 (non-network)	\$260 (network) \$180 (non-network)		\$290 (network) \$200 (non-network)	\$340 (network) \$240 (non-network)	\$380 (network) \$280 (non-network)
Physiotherapy	2 months	\$350 Combined annual maximum	Year	Amount 	\$700	\$800	\$900
			1	\$450			
			2	\$540			
			3	\$630			
			4	\$720			
			5	\$810			
			6+	\$900			
Chiropractic and Osteopathy	2 months	\$350 Combined annual maximum	Year	Amount 	\$500	\$600	\$700
			1	\$350			
			2	\$420			
			3	\$490			
			4	\$560			
			5	\$630			
			6+	\$700			
Antenatal and Postnatal	2 months		\$350 sub-limit. Combined with physiotherapy.		\$350	\$400	\$450

 = Loyalty Maximums (see p14). Other dollar amounts relate to annual maximums which apply per calendar year. [†]For most items at network providers. Annual maximums and waiting periods apply.

Services	Waiting Periods	Bronze Extras	Your Choice Extras	
			Year	Amount 
Natural Therapies Includes acupuncture, Alexander Technique, Chinese herbalism, exercise physiology, Feldenkrais, homeopathy, iridology, naturopathy and Western herbalism. Massage includes aromatherapy, Bowen Technique, kinesiology, reflexology, shiatsu, and remedial massage.	2 months	\$100 sub-limit. Combined with physiotherapy, chiropractic, osteopathy, antenatal and postnatal	1	\$500
			2	\$600
			3	\$700
			4	\$800
			5	\$900
			6+	\$1,000
			Includes sub-limits for massage: \$100 per person	
Living Well (see p30)	6 months	\$50	\$100	
Pharmacy ^{^^}	2 months	\$100	Year	Amount 
			1	\$300
			2	\$360
			3	\$420
			4	\$480
			5	\$540
			6+	\$600
Dietary	2 months	X	X	
Psychology	2 months	X	X	
Podiatry	2 months	X	X	
Speech Therapy	2 months	X	Year	Amount 
			1	\$400
Eye Therapy	2 months	X	2	\$480
			3	\$560
Occupational Therapy	2 months	X	4	\$640
			5	\$720
			6+	\$800
Home Nursing	2 months	X	X	
Health Aids and Appliances (Overall) ⁺	12 months	X	X	
Sub-Limits				
Asthma Pumps				
Blood Glucose Monitors or INR Blood Testing Devices (Coagucheck)				
Defined Appliances [^]				
Surgical Stockings				
CPAP Devices [#]				
Hearing Aids				
TENS Machine				
Blood Pressure Monitors				
Hire, Repair and Maintenance of Health Aids and Appliances	6 months			
Travel and Accommodation	2 months	X	X	
Emergency Ambulance Services [*]	No waiting period	1 service per calendar year	1 service per calendar year	

 = Loyalty Maximums (see p14). Other dollar amounts relate to annual maximums which apply per calendar year. ^^Benefits for prescription items that are non-PBS, TGA approved for the use of that condition and not appearing on our exclusions list. +A combined annual maximum applies to this service category.

Silver Extras	Gold Extras	Platinum Extras
\$400 Includes sub-limits for massage: \$150 per person	\$500 Includes sub-limits for massage: \$200 per person	\$500 Includes sub-limits for massage: \$200 per person
\$100	\$100	\$100
\$500	\$600	\$700
\$400	\$500	\$500
\$400	\$500	\$500
\$400	\$500	\$500
\$400	\$500	\$500
\$400	\$500	\$500
\$400	\$500	\$500
\$400	\$500	\$500
\$350	\$350	\$400
\$800	\$1,000	\$1,200
1 claim every 2 years up to \$200	1 claim every 2 years up to \$300	1 claim every 2 years up to \$400
1 claim per year up to \$400	1 claim per year up to \$500	1 claim per year up to \$600
\$500	\$800	\$1,000
\$100	\$100	\$100
1 claim every 2 years up to \$500	1 claim every 2 years up to \$750	1 claim every 2 years up to \$1,000
1 claim every 3 years up to \$500	1 claim every 3 years up to \$800	1 claim every 3 years up to \$850
\$125 per item	\$150 per item	\$200 per item
\$125 per item	\$150 per item	\$200 per item
\$100	\$100	\$100
\$100 - Travel \$150 - Accommodation	\$100 - Travel \$150 - Accommodation	\$100 - Travel \$150 - Accommodation
1 service per calendar year	1 service per calendar year	1 service per calendar year

^Defined appliances includes: insoles; orthopaedic and corrective footwear; pressure garments; braces and artificial limbs. Annual maximums apply per item. #Subject to eligibility. Call us for details. *There are different state ambulance arrangements across Australia. Please see p39 for details.

UNDERSTANDING EXTRAS COVER

Please ensure you also read the Important Information section on pages 38–44

What is covered?

Extras cover provides you with benefits for services that are not claimable by a third party (e.g. Medicare).

Medicare does not provide benefits for the below:

- 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.

With extras cover you can claim benefits for extras services which are listed as part of your chosen level of cover.

You will receive benefits as long as:

- the treatment is given by a private practice provider who is recognised by us
- the provider meets the criteria set out in our policies and Fund Rules.



GET A PAIR ON US

Check out our premium and benefits guide to see how you can get a pair of spectacles or a supply of contact lenses completely covered by us![†]

[†]Conditions apply. Please refer to the premium and benefits guide for full details.

What is not covered?

Extras benefits will not be payable:

- where a third party, including Medicare or another Government body, has provided a benefit (except for hearing aids and breast prosthesis items)
- for different services within the same modality 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 is not custom made (e.g. orthotics, surgical shoes)
- when they do not meet the criteria set out in our policies and Fund Rules.

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, please see below:

- 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, and pre-existing ailments – 12 months.

Pre-existing ailments

A pre-existing ailment is any ailment, illness, or condition 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.

A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining or upgrading to a higher level of cover.

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

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

HEALTH PROGRAMS

Positive Health Programs

If you have a chronic health condition, we'd like to help you get on the road to recovery as soon as possible. Our Positive Health Programs provide valuable information on how to better manage your condition together with your doctor or health professional.

Our programs are created using evidence-based medicine and research, in consultation with health experts and top national health organisations. They include action plans to further assist you in managing your condition; help you reduce the symptoms you may experience; and minimise any impact on your everyday life.

The following programs are available on selected levels of hospital cover:

- Arthritis Management Program
- Asthma Management Program
- Back Pain Management Program
- Chronic Obstructive Pulmonary Disease Management Program
- Congestive Heart Failure Management Program
- Coronary Artery Disease and Angina Management Program
- Depression Management Program
- Diabetes Management Program
- Osteoporosis Management Program.

Living Well Programs

Our Living Well Programs help cover health related programs from approved, recognised providers on selected extras covers.

These programs include:

- first aid courses
- nicotine replacement therapy
- weight management programs (benefit for fees only and some weight loss drugs)
- gym membership fees
- yoga courses
- Pilates.

Please note that a Living Well Programs approval form must be completed by your doctor for gym memberships, yoga and Pilates to confirm the program is medically necessary. Other benefit and recognition criteria apply. Subject to annual maximums.

Subscription refunds

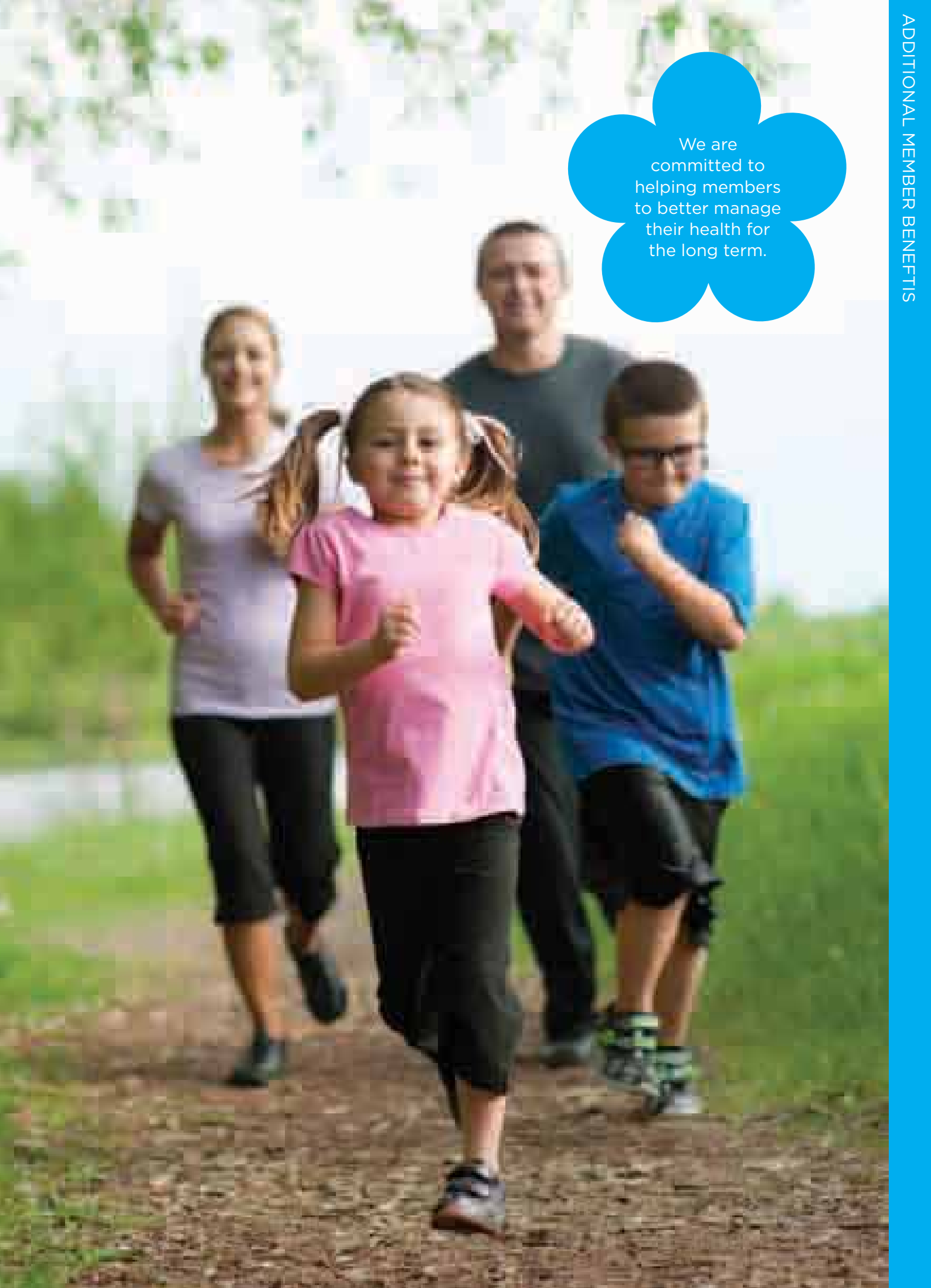
Depending on your level of hospital cover, you can also access benefits for the following:

- Asthma Foundation membership fees
- Diabetes Australia membership fees.

To find out more visit us online or talk to one of our customer service consultants.

Bowel cancer is the most frequently occurring cancer in Australia to affect both men and women. The good news is that it's one of the most curable types of cancer if detected early.* We will pay a benefit towards selected bowel cancer screening kits. Contact us for details.

* Sourced from the Bowel Cancer Australia website.



We are committed to helping members to better manage their health for the long term.

ADDITIONAL MEMBER BENEFITS

in2life partners

in2life brings you a range of discounts and deals from specially selected partners to help you enjoy some health and wellness perks at an affordable price. Whether it's fitness and sports you're interested in or rest, relaxation and travel—you can choose what suits your needs from our range of in2life partner discounts.

For a complete list of in2life partner discounts and full terms and conditions, visit one of the following websites:

MBF members mbf.com.au/in2life

HBA members hba.com.au/in2life

Mutual Community members - mutualcommunity.com.au/in2life

25% OFF



Get great value with up to 25% off Hoyts, Event Cinemas, Greater Union, Birch, Carroll & Coyle and Village Cinemas tickets when you purchase online through in2life (website listed above).

10% OFF



Receive a 10% discount on a 12-month membership, three months membership at a reduced price OR a free health assessment and personal training session at Goodlife Health Clubs. Visit in2life (website listed above) for more information.

UP TO 10%

BRITISH AIRWAYS



Save up to 10% on selected fares when you book online and fly with British Airways. Visit in2life (website listed above) for more information.

20% OFF



Take a self-help approach to health and fitness with 20% off tailored home fitness programs when you purchase online at guyleechfitness.com. Visit in2life (website listed above) for more information.

\$30 OFF



Enjoy \$30 off any RedBalloon experience when you spend \$129 or more and purchase online through in2life (see web address on opposite page).

20% OFF



Simply present your membership card to receive a 20% discount off the usual retail price on a range of sunglasses displayed at any Blink Optical or National Pharmacies Optical store.

20% OFF



Simply present your membership card to receive up to 20% off the usual retail price on selected frames, lenses and contact lenses; and up to 10% off the usual price of sunglasses.

25% OFF



Simply present your membership card and enjoy two full-priced games and shoe hire with 25% off at any AMF Bowling Centre.

10% OFF



Warner Village theme parks will give you a 10% discount on day admission for adults, children and pensioner passes. Just present your membership card at the entry gate.

15% OFF



Receive a 15% discount on the admission price to Dreamworld and WhiteWater World on the Gold Coast, when you purchase tickets online through in2life (see web address on opposite page).

Another benefit for members

15% OFF

Travel Insurance

As a member you can receive up to 15% off your travel insurance. See the back of the brochure for contact details.

TOP 5 REASONS TO JOIN NOW:

- going private may save you money
- get at least 30% back on your premiums
- avoid Lifetime Health Cover Loading
- private health insurance = choice
- peace of mind.

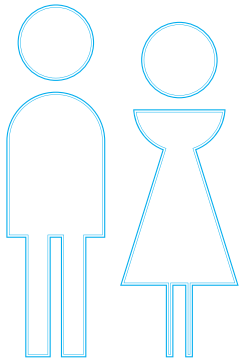
See page 3 for more information.



EASY WAYS TO CLAIM

Save time and effort by claiming on the spot at around 40,000 provider locations throughout Australia

Claiming for Extras

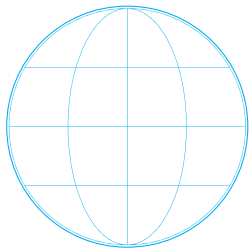


On the spot

On-the-spot electronic claiming is the easiest way to claim on your extras cover. Simply swipe your membership card after your treatment at one of 40,000 provider locations around Australia, and your claim is processed automatically. You may be asked to then pay the balance of the bill.



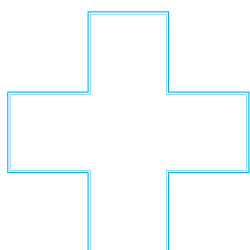
iSOFT
An IBA Health Group Company



Online claiming

Our online claims service is a quick and convenient way for you to claim on selected extras where you have paid the provider in full*. In many instances you'll receive fast payment into your bank account. Claiming is subject to the standard conditions of your cover including waiting periods and annual maximums.

Claiming for Hospital



Medical Gap Scheme

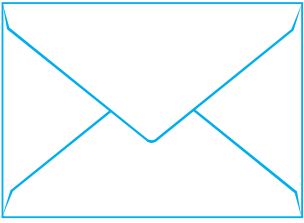
Our Medical Gap Scheme is a direct billing system designed to help our members reduce or eliminate any out-of-pocket expenses for hospital treatment.

If your specialist uses our Medical Gap Scheme they will bill us directly. So you either won't pay any out-of-pocket expenses or you'll know about any 'gap' payable for that specialist prior to treatment.

All specialists who are registered with us can choose to use the Medical Gap Scheme. Ask your specialist about it before undergoing treatment.

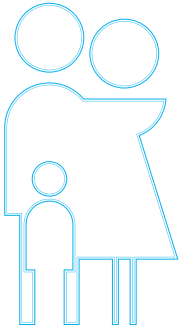
* The following services are not claimable online: Medical Gap, pharmacy, health aids and appliances, ambulance services, orthodontic, travel & accommodation and hospital claims.

Claiming for both Hospital and Extras



By mail

You can make a hospital or extras claim by mail. Simply print out a claim form from our website and complete it, then attach the original account(s) or receipt(s) that you received from your health care provider(s). Then mail it to us at: GPO Box 9809 Brisbane QLD 4001.



In person

You can submit your claims at your local centre. Most centres are able to process claims on the spot and provide you with benefits, either by cash (limits apply), cheque or bank transfer.



Claim queries

Remember that claims can only be paid within two years of the date that the service was provided.

Contact us if you have a question about:

- the status of your claim
- how to fill in a claim form
- what documents you need to attach to your claim form.

See the back of this brochure for full contact details.



IMPORTANT INFORMATION

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.

From time to time, things can change. Before you seek any treatment call us so we can give you the most complete and up-to-date information.

Please be aware that these rules apply in addition to our Fund and Policy Rules.

1. 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. Or, if you're on a corporate plan, it's up to you to make sure payments are made during times of unpaid leave or if your employment ends
- ensure that newborns are enrolled onto a family membership within 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).

2. 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.

3. Suspension Rules

A membership may be suspended when travelling overseas for work or leisure.

If you are travelling overseas, you may choose to suspend your membership during this period of time. You can suspend your cover for the following period of time:

- a minimum period of two months travel; and
- a maximum period of two years per suspension.

A maximum of three continuous suspension periods of two years is allowed before your membership will be cancelled.

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
- apply for suspension prior to the departure date
- provide overseas travel documentation showing your departure and return dates
- notify us of your return to Australia within 30 days of your arrival; and
- complete an overseas travel suspension form.

4. Emergency Ambulance definition

When you or you partner take out our hospital cover, extras cover (emergency ambulance services must be selected on Your Choice Extras) 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 will mean 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 transportation 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.

5. Ambulance Cover

We recommend that your family takes 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 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 ambulance services, you will be covered by Bupa Australia as long as your level of cover contains ambulance cover and the services are provided by a recognised provider.

6. Recognised Ambulance Providers

Bupa Australia 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.

7. No Gap or Known Gap prostheses

Surgically implanted prostheses are classified by the Government as No Gap or Known Gap prostheses. Prostheses, include pacemakers, defibrillators, cardiac stents, joint replacements, intraocular lenses and other devices that are surgically implanted during a stay in hospital. If your doctor chooses a No Gap prosthesis you will not have any out-of-pocket expenses where the prosthesis item is implanted as part of hospital treatment. If the prosthesis item used is listed as a Known Gap prosthesis you'll have to pay any gap charged by the hospital. You can ask your specialist to choose a No Gap prosthesis as there is one available for every surgical treatment.

8. 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 read the section on what is and what isn't covered within this brochure 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. A copy of our Fund Rules can be found on our website.

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.

9. Exclusions

Exclusions for specific procedures or services means you will not be covered and may have significant out-of-pocket costs should you require treatment for an excluded service.

No hospital cover provides any benefits for services not covered by Medicare. Always check with us to determine if your treatment will be covered.

10. Restricted cover/benefits

If you are covered with restricted benefits this means you are covered for shared-room accommodation in a public hospital only, with your choice of doctor. If you go into a private hospital it is likely you'll incur large out-of-

pocket expenses, and the restricted benefit amount set by the Government will not be enough to cover your costs in a private hospital.

11. Pharmaceuticals

If you choose to be treated with drugs that are not approved by the Pharmaceuticals Benefits Scheme you may not be fully covered and the hospital may charge you for part of the cost. You'll be advised by the hospital of any charges before treatment.

12. Pre-existing ailments

A pre-existing ailment is any ailment, illness, or condition 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.

A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining or upgrading to a higher level of cover.

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

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

13. When to contact us

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 ailment waiting period applies to you.

We need about five working days to make the pre-existing ailment 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.

14. Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing ailment 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:

- someone covered under your membership is admitted to hospital and chooses to be treated as a private patient; and we later determine that the condition was pre-existing.

15. 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 \$1000 per person, per year annual maximum applies to Special Benefits.

16. Baby books

On selected covers you'll receive a special gift of two free parent-friendly books. These include the prenatal book *What to expect when you're expecting* when you tell us you're having your first baby and *Toddler Taming* following your child's 1st birthday. Just visit a centre to collect your books.

17. Unemployment Cover

If you have Unemployment Cover and you're involuntarily retrenched or made redundant from full-time employment, from the start of your second month of unemployment your health insurance premiums will be covered (at the same level of cover) for up to 12 months while you remain unemployed. To be eligible for Unemployment Cover the following conditions apply:

- if you have a family or couples membership only the main income earner is eligible.

The main income earner must:

- have been employed for at least six months with the same company prior to your involuntary retrenchment or redundancy
- not be a contractor or in self-employment

- have held health cover for 12 months before your involuntary retrenchment or redundancy; and
- provide proof of unemployment to our reasonable requirements, every three months providing you still remain unemployed.

18. Extras Cover

With extras cover, you can claim benefits for services which are listed on your cover and not claimable elsewhere. To receive benefits for your extras services, you must visit professionals who are recognised by us. If you would like to check that your provider is registered with us please call us, drop into a local centre, or visit our website.

You're also able to claim more than once in a day at the same provider for different services, as long as that provider is recognised by us in each profession. For example, if you went to see a practitioner for a dietary consultation and then a massage, you could claim for both services as long as your practitioner is a recognised provider with us in both the dietary and massage professions. However, you cannot claim for two or more of the same services, for example two chiropractic consultations or two natural therapies consultations at the same provider on the same day.

No benefits are payable for items that are not custom-made as a result of a prescribed treatment.

19. Calendar year

We pay benefits based on the calendar year and between the periods of 1 January to 31 December.

20. 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 or purchase and a clinical referral where required. It is important to note that benefits are not payable when a prescribed treatment is not custom made (e.g. orthotics). Visit our website for more information.

21. Hire, repair and maintenance of health aids and appliances

Benefits are not payable in the first 12 months after purchasing an item; within 12 months following the repair; or on items where hire and repair are deemed inappropriate.

22. Home nursing

Benefits are payable towards some home nursing services that do not need to take place in a hospital and are provided in the home.

23. Living Well Programs

Our Living Well Programs help cover health-related programs from approved, recognised providers. You can visit our website for a list of our recognised providers. A Living Well Programs approval form must be completed by your doctor for gym memberships, yoga and Pilates to confirm that the program is medically necessary. Other benefit and recognition criteria apply.

24. Pharmacy

Pharmacy covers you for prescription items that are non PBS (Pharmaceutical Benefits Scheme) listed drugs and are TGA (Therapeutic Goods Administration) approved for that condition.

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

- over the counter items
- compounded items
- non-prescription items
- weight loss medication (some weight loss medications are covered under the Living Well Programs)
- body enhancing medications (e.g. anabolic steroids); and
- erectile dysfunction drugs, unless prescribed by a specialist.

When you make a claim, we will deduct a pharmacy co-payment and pay the remaining balance up to the set amount under your chosen level of cover.

25. Travel and accommodation

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 300 kilometres or more. 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 this benefit.

26. Changing from another health fund

If you're changing from another Australian health fund to Bupa Australia, 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 yearly maximums in your first year of membership with us.

It's important to note that when you change to Bupa Australia from another fund you may need to wait before you can receive 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 as follows:

For extras cover:

When changing to a higher level of extras cover, a lower level of benefit applies for:

- the initial two-month waiting period
- six months for Living Well Program benefits; and hire, repair and maintenance of health aids and appliances; and
- 12 months on pre-existing ailments, illnesses or conditions; major dental; orthodontics; and health aids and appliances.

For hospital cover:

When changing to a higher level of hospital cover, a lower level of benefit applies for:

- the initial two-month waiting period
- two months for palliative care, psychiatric and rehabilitation services; and
- 12 months on pre-existing ailments, illnesses or conditions and pregnancy related services (including childbirth).

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

Important Information continues on page 41.

27. Changing your cover with us

If you change your health cover, you may need to wait before you can receive your new benefits. Where your new level of cover is higher than what you previously held, the lower level of benefit applies as follows:

For extras cover:

When changing to a higher level of extras cover, a lower level of benefit applies for:

- the initial two-month waiting period
- six months for Living Well Program benefits and hire, repair and maintenance of health aids and appliances; and
- 12 months on pre-existing ailments, illnesses or conditions; major dental; orthodontics; and health aids and appliances.

For hospital cover:

When changing to a higher level of hospital cover, a lower level of benefit applies for:

- the initial two-month waiting period
- two months for palliative care, psychiatric and rehabilitation services; and
- 12 months on pre-existing ailments, illnesses or conditions and pregnancy related services (including childbirth).

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

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

28. Proof of identity and/or age

Bupa Australia 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.

29. 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.

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. 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 the policy holder, 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 it 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 contacting 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.

30. 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 twelve 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.

31. Ending your membership

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

32. 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

33. 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
PO Box 14639
Melbourne VIC 8001

If you're still not satisfied with your outcomes from Bupa Australia you may contact the Private Health Insurance Ombudsman on 1800 640 695.