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# UNDERSTANDING YOUR HEALTH COVER

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Here you will find information to help you understand how your health cover with us works. You can also view our online glossary at [bupa.com.au/glossary](https://bupa.com.au/glossary)

Please be aware that these rules apply in addition to our Overseas Visitors Rules.

## UNDERSTANDING YOUR OVERSEAS STUDENT HEALTH COVER AND ADVANTAGE OVERSEAS STUDENT HEALTH COVER

### What is covered?

#### Hospital costs

With Overseas Student Health Cover (OSHC) and Advantage Overseas Student Health 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 OSHC you are 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, capped at a maximum number of days per stay. The hospital should inform you of this fee when you make a booking.

When admitted to hospital, in most cases you will be covered for 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 pharmacy items approved by the Pharmaceutical Benefits Scheme (PBS)
- allied health services including physiotherapy, occupational therapy and dietetics
- pathology and radiology diagnostic tests recognised by Medicare performed in hospital by Bupa contracted providers
- a surgically implanted prostheses up to the government minimum benefit published 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. You can find out if a hospital has an agreement with us by checking our website [bupa.com.au/find-a-provider](https://bupa.com.au/find-a-provider)

^Conditions apply. Contact us for more information.

## **What happens if I choose to go to a public hospital or a private hospital that doesn't have an agreement with Bupa?**

With us, if you are admitted to a public hospital or are admitted to a non-agreement private hospital, you are covered as set out below for any treatment recognised by Medicare unless it is excluded or restricted under your cover.

If you choose to go to 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. In a non-agreement private hospital, you are responsible for the cost of your stay and may be charged directly for your hospital accommodation, doctor's services (including diagnostic tests), surgically implanted prostheses (e.g. artificial hips) and personal expenses such as TV hire and telephone calls. Some of these hospitals bill Bupa directly for the benefits we pay for your hospital stay under your policy.

The amount we will pay towards your accommodation in a non-agreement private hospital is limited to a minimum shared room benefit. For a non-agreement private hospital this will only partially cover the full cost and you will have significant out-of-pocket expenses. If you request a single room in a non-agreement private hospital, and you receive one, you will incur out-of-pocket expenses as the hospital may charge you more for the room than the benefit that Bupa pays. It is important to note that in public hospitals, single rooms are generally allocated to people who medically need them the most. If required we will also cover any prostheses that are surgically implanted in you during your hospital stay up to the minimum benefit listed on the Government's Prostheses List.

We will cover you for your in-hospital medical costs incurred during an admission in public or non-agreement hospital in the same way as set out under the heading "Inpatient Medical Costs" in this guide.

The hospital and the treating doctor should let you know what you'll be billed for and how much you will be charged, i.e. they should obtain your Informed Financial Consent before you receive the treatment – if they don't, make sure to ask for full details. Call us to confirm what benefits we'll pay for your public hospital or non-agreement private hospital stay.

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.

### **Inpatient medical costs**

These are the fees charged by your doctor, surgeon, anaesthetist or other specialist for any treatment given to you when you are admitted to a hospital as an inpatient. Put simply, we pay 100% of the Medicare Benefits Schedule (MBS) fee. The MBS fee is set for each specific service by the Federal Government.

### **Outpatient medical costs**

This is cover for any treatment you receive from a doctor or specialist in private practice, or as an outpatient (i.e. where you are not admitted into hospital) anywhere in Australia. This includes services from General Practitioners (GPs), medical specialists, medical imaging providers (x-rays and ultrasounds), pathology providers, and more. We cover you for 100% of the Medicare Benefits Schedule (MBS). The MBS fee is set for each specific service by the Federal Government.

### **Outpatient pharmacy benefit**

You can also receive benefits on selected pharmacy items prescribed as an outpatient or by a doctor or specialist. Please refer to page 8 for more details.

## 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
- when you are treated at a non-agreement hospital you will not be fully covered
- 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 antenatal consultations with an obstetrician prior to child birth) you may not be covered
- 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, 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
- some hospital-substitute treatment and operative services that are a continuation of care associated with an early discharge from hospital
- for pharmacy items not opened at the point of leaving the hospital unless covered on your OSHC or extras cover
- if you choose to use your own allied health provider (e.g. chiropractors, dieticians or psychologists) rather than the hospital's practitioner for services that form part of your in-hospital treatment
- 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
- treatment for any children on a family membership if they are over 18 years of age
- additional charges applied for private room accommodation in a public hospital
- non-PBS, high cost drugs
- if you do not hold a valid visa at the time of admission to hospital and for the duration of your hospital stay
- any treatment or service rendered outside Australia. This includes:
  - treatment arranged before you arrived in Australia
  - treatment while travelling to or from Australia
  - expenses for treatment outside of Australia
  - transportation into or out of Australia in any circumstance.

### 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
- costs for medical examinations, x-rays, inoculation or vaccinations and other treatments required relating to acquiring a visa for entry into Australia or permanent residency visa.

## Waiting periods

The following waiting periods apply to Overseas Student Health Cover:

- pre-existing conditions, ailments or illnesses of a psychiatric nature – two months (Not applicable to Advantage OSHC customers)
- all other pre-existing conditions, ailments or illnesses – 12 months
- pregnancy related services (including childbirth) – 12 months.<sup>^</sup>

If you receive treatment that falls within a waiting period, you will have to pay for some or all of the hospital and medical charges unless the treatment is classed as Emergency Treatment. Situations when you will not be covered during a waiting period include:

- treatment provided in the first two months of membership for pre-existing ailments, illnesses or conditions of a psychiatric nature, unless classed as Emergency Treatment
- treatment provided in the first 12 months of membership for all other pre-existing ailments, illnesses or conditions, unless classed as Emergency Treatment
- treatment provided in the first 12 months of membership for pregnancy related services including childbirth, premature births, miscarriages or terminations, unless classed as Emergency Treatment<sup>^</sup>
- treatment provided in the first 12 months of membership for secondary conditions or disabilities directly arising from a pre-existing condition, ailment or illness unless classed as Emergency Treatment.

## When to contact us

If you have been a Bupa member for less than 12 months on your current OSHC, it is important to contact us before you are admitted to hospital and find out whether the pre-existing condition waiting period applies to you. We need about five working days to make the pre-existing condition assessment, subject to the timely receipt of information from your treating medical practitioner/s. Make sure you allow for this 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 that you will be covered for 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).

No waiting periods will apply to the newborn provided they have been added to the appropriate family cover within 60 days of their birth.

# UNDERSTANDING YOUR AMBULANCE COVER

## Emergency Ambulance Cover

As part of your cover you receive unlimited emergency only ambulance cover for emergency ambulance air and road transportation and on-the-spot emergency treatment by a Recognised Ambulance Provider.

You'll receive cover for ambulance transport provided by an approved ambulance service where medically necessary for admission to hospital or for Emergency Treatment. You're not covered for non-emergency transportation from a hospital to your home, a nursing home or another hospital. Whether the transportation is deemed an emergency is determined by the paramedic and usually recorded on the account.

If you need to make a claim for emergency ambulance benefits, we will give you a Patient Ambulance Transportation Form to complete.

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

<sup>^</sup>Not applicable to OSHC members who joined before 1 July, 2011.

## 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.

## UNDERSTANDING YOUR EXTRAS COVER

If you have chosen to take out extras cover together with your OSHC with us, please read this section to better understand how you'll be covered.

### 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 Overseas Visitors Rules 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 for Extras

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.

# CHANGING YOUR COVER

## Switching from another health fund

If you're changing from another OSHC provider 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'.

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.

## Changing your visa

If you change your overseas student visa to another visa which allows you to continue your stay in Australia, you will no longer be eligible for OSHC. You can however, change to one of our overseas visitor covers. You will continue to be covered for all benefit entitlements on your old cover, as long as you change over within 60 days of ceasing your OSHC. Contact us for more details.

## Becoming a permanent resident

If you become a permanent Australian resident, you can change to one of our domestic health covers. You will continue to be covered for all benefit entitlements on your old cover, as long as you change over within 60 days of ceasing your OSHC.

Don't forget that you will need to transfer to a domestic health cover policy within 12 months of becoming eligible for full Medicare benefits. Otherwise you may be required to pay the Lifetime Health Cover (LHC) Loading. Ask us for more details.

## 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 earlier in 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 waiting periods, just contact us.

## Ending your membership

It is a condition of your student visa that you maintain a current OSHC policy while you are studying in Australia. Bupa will only refund any premium paid for your OSHC policy under the following circumstances:

- you decide not to come to Australia to commence your studies
- your student visa extension is refused by the Department of Immigration and Border Protection (DIBP)
- you are transferring to another visa type (e.g. temporary or permanent residency)
- you are ceasing your studies and going back home overseas early
- you are transferring to another OSHC provider
- if your student visa is cancelled.

You will need to provide proof of any of the above circumstances along with your refund request. For example, a copy of a letter from DIBP explaining that your student visa is cancelled, or proof of membership with another OSHC provider.

To cancel your OSHC membership, and obtain a refund, simply complete a refund form and attach any relevant supporting documents. We are obligated to inform DIBP if your OSHC membership is cancelled and/or we refund your premium\*.

\*Not applicable to OSHC members who joined before 1 July, 2011.

# 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.

## Agents

A third party such as a broker or agent may establish and administer your policy or OSHC plan. In these cases, some information about you such as your name, address and other policy information will be given and received from the agent to help Bupa Australia administer your policy or OSHC plan. This will not include personal claims information (also see Privacy Statement).

## 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').

Under this scheme some doctors can charge you a known gap which means you have some out-of-pocket expenses to pay but they are limited to a defined amount.

Doctors need to agree to participate in this scheme for it to apply so make sure you ask them about it before you are treated. Otherwise our medical benefits are limited to the Medicare Benefits Schedule (MBS) fee and if your doctor charges above the MBS fee you will have a gap to pay.

If a doctor proposes to charge you a 'gap' they need your informed financial consent. Please contact us for details.

## Calendar year

A calendar year is 1 January to 31 December.

## Direct billing doctors

Direct billing doctors charge Bupa directly for the cost of your medical treatment\* - so you won't see a bill or have to make a claim. A list of our direct billing doctors is available on our website.

## 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 we later determine that your condition was pre-existing and not classed as Emergency Treatment.

## Emergency Treatment

Emergency Treatment is any treatment required where a person:

- is in a life threatening situation and requires urgent assessment and resuscitation
- has suspected acute organ or system failure
- has an illness or injury where the function of a body part or organ is acutely threatened
- has a drug overdose, toxic substance or toxin effect
- has psychiatric disturbance whereby the health of the person or other people are at immediate risk
- has severe pain and the function of a body part or organ is suspected to be acutely threatened
- has acute haemorrhaging and requires urgent assessment and treatment
- has a condition that requires immediate admission to avoid imminent threat to their life and where a transfer to another facility is impractical.

If you believe your admission may be deemed as Emergency Treatment, please ensure that you have your treating doctor provide us with all relevant information that we may require to assess and process your claims promptly.

\*You may be asked to pay a Medical Gap to the doctor that is not claimable under OSHC.

## 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 recognised by Medicare there will be no benefit payable from your OSHC so you should always check with us to see if you're covered before receiving treatment.

## Minimum benefits

For services paid at minimum benefits there will be full cover in a shared room with your choice of doctor in a public hospital and minimum benefits in a private hospital which would not be adequate to cover all hospital costs and are likely to result in large out-of-pocket expenses.

## 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 on your OSHC and any extras cover you hold to determine when an out-of-pocket expense may occur. You should also refer to our Overseas Visitors Rules for any additional information on benefits payable. A copy of our Overseas Visitors Rules can be found on our website or in our local Bupa centres. 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

On OSHC you will receive benefits for selected prescription items prescribed as an outpatient that are PBS (Pharmaceutical Benefits Scheme) and non-PBS and TGA (Therapeutic Goods Administration) approved. Refer to your cover details for more information.

If you take out optional extras cover, your extras pharmacy entitlement pays benefits on prescription items that are only non-PBS listed and TGA approved.

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

There are some items that are not covered by our OSHC or extras pharmacy benefits and these include:

- over the counter and 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 approved by the Pharmaceuticals Benefits Scheme (PBS), 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.

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 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 for OSHC

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

- complete the application process and pay your premium in full before the start date of your cover
- advise us of any change of address
- ensure that newborns are enrolled onto a family membership within two months of their birth to avoid any waiting periods for your baby
- contact us to remove your adult children from your OSHC membership when they turn 18 years of age as they no longer qualify under your 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, visa details and/or age when joining, changing your level of cover or in relation to any other transaction with us.

## 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.

Please note: for family memberships, if some family members on the policy remain in Australia while others leave the country, then the membership must be kept financial.

You can suspend your cover under the following circumstances:

- for a minimum period of one month
- for a maximum period of nine months
- you can suspend your policy up to three times per calendar year.

To be eligible to suspend your cover you must:

- apply for suspension prior to the departure date
- have a financial membership at the time of suspension
- provide overseas travel documentation showing your departure and return dates
- notify us of your return to Australia within 14 days of your arrival
- complete an overseas travel suspension form.

Your membership will be cancelled if not resumed.

## Waiting periods

A waiting period is the time between the latter of your arrival in Australia or the start date of your membership 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 is important to Bupa. This statement summarises how we handle your personal information. For further information about our information handling practices or our complaints handling process, please refer to our *Information Handling Policy*, available on our website at [bupa.com.au](http://bupa.com.au) or by calling us on 134 135. 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 that we require to provide, manage and administer our products and services and to operate an efficient and sustainable business. We are required to collect certain information from you to comply with the *Private Health Insurance Act 2007* (Cth). We may also collect information about you from health service providers for the purposes of administering or verifying any claim, and from your employer, broker or agent if you are on a corporate health plan or have joined through a broker or agent. We may disclose your personal information to our related entities, and to third parties including healthcare providers, government and regulatory bodies, other private health insurers, and any persons or entities engaged by us or acting on our behalf. If we send your information outside of Australia, we will require that the recipient of the information complies with privacy laws and contractual obligations to maintain the security of the data. If you are on a corporate health plan, we may disclose your information to your employer to verify your eligibility to be on that corporate plan. The policy holder is responsible for ensuring that each person on their policy is aware that we handle their personal information as set out here and in our *Information Handling Policy*. Each person on a policy aged 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 within a reasonable timeframe. We reserve the right to charge a fee for collating such information.

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

## 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 Overseas Visitors 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](http://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](mailto: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](http://privatehealth.gov.au)

Bupa Australia Pty Ltd  
ABN 81 000 057 590

Effective 1 January 2015  
11542-01-15E