Understanding Your Health Cover

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**

Please be aware that from 1 June 2017 these rules apply in addition to our Overseas Student Health Cover Rules. These rules can be found at **http://www.bupa.com.au/staticfiles/BupaP3/pdfs/oshc-fund-rules.pdf**

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 private or a public 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 an excluded service or a minimum benefit service under your cover.

At our Members First hospitals, you'll receive a private room if a private room is available. If a private room is not available, you'll receive $50 back per night from the hospital. Please note that the following conditions apply: You must book and request a private room in a Members First hospital at least 24 hours before admission. It applies to overnight admissions only. It excludes 'nursing home type patients', admissions via an Emergency Department, same day admissions or where a private room is medically inappropriate (e.g. medical practitioner requires the patient to an Intensive Care Unit or other particular ward rather than a private room). You'll also get a free daily newspaper and free local calls.

If you are treated in a Members First Day Facility, there are no out-of-pocket expenses for medical services (e.g. your specialist's fees). Any co-payment or excess related to your level of cover will still apply. (Not available in NT).

A small number of network 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. This fee is in addition to any excess you may have as part of your hospital cover.

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 pharmaceuticals approved for the condition to be treated by the Pharmaceutical Benefits Scheme (PBS) and provided as part of your in hospital treatment
- Physiotherapy, occupational therapy, speech therapy and other allied health services provided as part of an inpatient admission
- Surgically implanted prosthesis up to the Government minimum benefit published on the Government's Prosthesis List
- Private room where available and clinically appropriate.^

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.**

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

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

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

^Conditions apply. Contact us for more information.

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

Whether a public hospital will accept or admit a patient, or whether a doctor provides treatment at a public hospital, or performs a particular procedure in a public hospital, is outside of Bupa's control.

As a private patient in a public hospital you are entitled to choose your doctor, if they are available. However, it is important to understand that you may still be subject to public hospital waiting lists.

Depending on your illness or condition, this may be the same doctor who would have been allocated to you by the hospital as a public patient.

If you are admitted as a private patient in a public hospital, we will pay minimum benefits for shared room accommodation as set by the Australian Government, and benefits for prostheses up to the approved benefit in the Government Prostheses List.

Depending on your level of cover, if you choose to stay in a private room, Bupa may pay an additional fixed benefit towards the cost of your stay.

If this benefit is less than the hospital charge, the hospital should let you know what out-of-pocket expenses you will have to pay. Bupa also pays benefits for prostheses up to the benefit in the Government Prostheses List.

The above applies for any treatment recognised by Medicare unless it is excluded or restricted under your cover. It is important to note that in public hospitals, private rooms are generally allocated to people who medically need them.

As a private patient in a public hospital you will also be responsible for personal expenses such as TV hire and telephone calls together with any fee doctor/surgeon charges above the benefit Bupa pays and prostheses charges above the benefit in the Government Prostheses List.

For the purposes of a private room in a public hospital, this is a room in a hospital which is purpose built and suitable for no one other than a single admitted adult patient; holds one single sized bed; and has a dedicated ensuite.

Please also refer to the Inpatient and Outpatient Medical Costs section of this guide.

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. This includes most inpatient diagnostic tests recognised by Medicare as medically necessary (e.g. pathology, radiology). We cover you for 100% of the Medicare Benefits Schedule (MBS). This is the amount determined by the Federal Government for a specific service for Australian residents. If your doctor or specialist charges more than the MBS Fee there will be a 'gap' for you to pay.

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 most outpatient diagnostic tests recognised by Medicare as medically necessary (e.g. pathology, radiology). We cover you for 100% of the Medicare Benefits Schedule (MBS). This is the amount determined by the Federal Government for a specific service for Australian residents. If your doctor or specialist charges more than the MBS Fee there will be a 'gap' for you to pay.

Outpatient pharmacy benefit

You can also receive benefits on selected pharmacy items including discharge medication prescribed as an outpatient 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 identified as a minimum benefit service and you are admitted to a public or private hospital, you will not be covered above the minimum benefits for shared room accommodation as set by the Australian Government
- 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 podiatrist); cosmetic surgery where it's 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
- cosmetic surgery when not clinically necessary.

Medical costs

You will not be covered for:

- medical services for surgical procedures performed by a dentist, 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
- cosmetic surgery when not clinically necessary.

Waiting periods

The following waiting periods apply to Overseas Student Health Cover:

- pre-existing conditions, aliments or Illnesses – 12 months
- pregnancy related services (including childbirth) – 12 months
- pre-existing conditions, aliments or illnesses of a psychiatric nature – 2 months.

No waiting period applies to a pre-existing condition, ailment or illness of a psychiatric for Advantage OSHC customers.

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 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
- 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
- treatment provided in the first 2 months of membership for pre-existing ailments, illnesses or conditions of a psychiatric nature, 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 two months of their birth.

Eligibility and Types of membership

To be eligible for OSHC, you must hold a student visa, be in a process of applying for a student visa or be on a bridging visa whilst applying to extend your student visa. There are 3 different types of OSHC membership available:

- Single – Cover for student only. Student is defined as the primary student visa holder
- Couples – Cover for the student and their partner as listed on the student's dependant visa
- Family – Cover for student, their partner and their dependent children under 18 years of age if they live with the student in Australia.

Note, student's partner and/or dependent children as listed on the student's dependant visa must be on the same membership as the student.

Understanding your extras cover

The following applies to OSHC extras only. If you have a different extras cover, other conditions may apply. For more information visit bupa.com.au or contact us.

What is covered?

With OSHC extras cover, you can claim benefits for some services that may not be covered by Medicare. You can claim for the services listed on your cover as long as benefits are not claimable from a third party.

For example, Medicare may not provide benefits for:

- dental examinations and treatment
- 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
- health aids and appliances
- home nursing.

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

- the treatment is given by a provider in private practice provider who is recognised by 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 recognised by 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 orthoses, orthotics or surgical shoes are 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 limits on your product including yearly, lifetime or service limits for the service you are claiming.

Waiting periods

An initial waiting period of two months apply for OSHC extras cover.

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 an Ambulance Claim Form to complete.

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

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/NEPT
- Ambulance Victoria
- Queensland Ambulance Service
- South Australia Ambulance Service
- St John Ambulance Service NT
- St John Ambulance Service WA
- Tasmanian Ambulance Service.

Changing your cover

Switching from another OSHC provider

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, and there is no gap between your previous OSHC and your Bupa cover. This is referred to as 'continuity'.

When changing health funds, extras benefits paid by your old fund will be counted towards your yearly limits 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 your OSHC end date. 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 your OSHC end date. Don't forget that, unless you transfer to a domestic health cover policy within 12 months of becoming eligible for full Medicare benefits, 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.

Definitions

Agents

A third party such as a broker or agent may establish and administer your policy or corporate health 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 HI administer your policy or corporate health plan. This will not include personal claims information (also see Privacy Statement).

Calendar year

A calendar year is 1 January to 31 December.

Bupa-friendly doctors

A Bupa-friendly doctor has a direct billing agreement with Bupa to help reduce or eliminate your out-of-pocket expenses. A list of our Bupa-friendly 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 you choose to be treated as a private patient, and we later determine that your condition was pre-existing. We tell you more about pre-existing conditions on page 8.

Emergency Treatment

'Emergency Treatment' means treatment of any of the following conditions:

- a risk of serious morbidity or mortality and requiring urgent assessment and resuscitation; or
- suspected acute organ or system failure; or
- an illness or injury where the viability of function of a body part or organ is acutely threatened; or
- a drug overdose, toxic substance or toxin effect; or
- psychiatric disturbance whereby the health of the patient or other people are at immediate risk; or
- severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- acute haemorrhaging and requiring urgent assessment and treatment;or
- a condition that requires immediate admission to avoid imminent morbidity or mortality.

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 expenses.

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

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 Student Health Cover Rules for any additional information on benefits payable. A copy of our Overseas Student Health Cover 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
- 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.

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).

Private room in a Public hospital

From 1 October 2017, for the purposes of a private room in a public hospital, this is a room in a hospital which is purpose built and suitable for no one other than a single admitted adult patient; holds one single sized bed; and has a dedicated ensuite.

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 approved benefits set out in the Government's Prostheses List for a listed prosthesis which is surgically implanted as part of your hospital in-patient 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
- 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

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** 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**

Resolution of problems

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

You can contact us by:

Telephone: 1800 802 386

Fax: 1300 662 081

Email: customerrelations@bupa.com.au

Mail: Customer Relations Manager
Bupa
GPO Box 9809
Brisbane QLD 4001

If you're still not satisfied with your outcomes from Bupa you may contact the Private Health Insurance Ombudsman on **1300 362 072** or visit them at **ombudsman.gov.au**

Private Health Insurance Code of Conduct

The Private Health Insurance Code of Conduct (the Code) was developed by the private health insurance industry and it aims to enhance the standards of practice and service throughout the industry.

As a signatory to the Code, we undertake to do a number of things that will benefit you as a member. These include:

- working to enhance our service standards
- providing information to you in plain language
- helping you make better informed decisions about our products
- letting you know how to resolve any concerns that you may have
- protecting the privacy of your information in line with the privacy legislation and our Information Handling policy.

We're proud to be a signatory to the Code and we are committed to continually reviewing our operations to ensure compliance.

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

Bupa HI Pty Ltd
ABN 81 000 057 590

Effective 1 June 2017
11542-06-17E