

member guide

The Medibank logo is centered within a white rounded rectangle. It features the word "medibank" in a bold, sans-serif font, with "medi" in red and "bank" in blue. Below it, the tagline "For Better Health" is written in a smaller, blue, sans-serif font.

medibank
For Better Health

Working Visa Health Insurance

Effective July 2016

Before you get started...

Here is an explanation of some of the terms commonly used in this Guide:

'We', 'us' and 'our' is Medibank Private.

'You' is any member of Medibank to whom this Guide applies.

'Member' is any person covered under a Medibank membership.

'Membership' is made up of one or more members.

'Policy holder' is the person who 'owns' the membership.

This is the person we contact when we need to communicate about the membership.

To help you make the most of this Guide and understand what you're covered for, we've also prepared a Glossary of useful terms that you can access online at www.medibank.com.au/health-insurance/glossary

Our Member Guide

This Guide is a summary of Medibank's Fund Rules and policies as at the date of this Guide. It is designed to help you understand how your Medibank membership works, and should be read together with the Cover Summary you receive when joining or changing your cover. Your Cover Summary sets out what you're covered for under your particular health insurance cover. You can download a copy of your Cover Summary and our Fund Rules from www.medibank.com.au

- Please read this Guide and your Cover Summary carefully and keep them for your reference.
- If you need further information about your cover or anything in this Guide, please contact us.
- It's important to note that some Working Visa Health Insurance covers do not include any benefits for extras items or services outlined in this Guide.
- We will send correspondence to your email address, or your postal address where you have opted out of email communication. It's important that you let us know if your contact details change.
- It's also important to contact us if you, or anyone else on the membership, are going to need treatment, to check that it's covered. Our contact details are on page 33 of this Guide.
- If you are in Australia on a working-type visa and your visa sub class is not mentioned in this Guide, contact us to find out if you are eligible for Working Visa Health Insurance.
- This Guide only applies to Medibank Working Visa Health Insurance covers. The information in this Guide is only relevant to those covers. If you hold a cover other than a Working Visa Health Insurance cover, please contact us for details of the services covered and membership conditions.

Information for non-Australian residents

- It is your responsibility to inform Medibank immediately if you cease to comply with the Working Visa Health Insurance eligibility requirements as set out on page 5. Please note that Medibank can request proof of your eligibility for Working Visa Health Insurance at any time.
- If you are found to be ineligible for Working Visa Health Insurance, Medibank may take steps including terminating your membership or transferring you to an alternative cover. Medibank may backdate this change and require you to pay any additional premiums and/or repay any higher benefits you received on your Working Visa Health Insurance cover.
- If you become a permanent Australian resident, or otherwise become entitled to full Medicare benefits, Working Visa Health Insurance may no longer be appropriate and you should contact us to discuss alternative health cover.

Medibank Joining Statement

By joining Medibank, you (as the Policy holder) have agreed that you:

- will ensure that all information supplied to Medibank is true and correct
- will keep your membership information up-to-date and notify us of any changes as soon as possible
- will ensure that all members on the membership are aware of and abide by Medibank's Fund Rules, the information in this Guide and Medibank's policies including its Privacy Policy
- will inform Medibank immediately if you cease to comply with the eligibility requirements for Working Visa Health Insurance as set out on page 5
- will advise Medibank if you become eligible for full Medicare benefits so that we can arrange a more suitable health cover
- have the authority to provide the personal information of other members on the membership
- will make, or authorise the making of, all claims under the membership and ensure that any claim that includes sensitive information of a member aged 16 years and over is made having first obtained the consent of that member
- authorise any health service provider to supply to Medibank any information Medibank considers necessary for the assessment of any claim on the membership, and will ensure that members aged 16 years and over have provided the relevant consent
- authorise Medibank to supply to any health service provider any information Medibank considers necessary for the assessment of any claim on the membership, and will ensure that members aged 16 years and over have provided the relevant consent
- will make the minimum advance premium payments required
- are aware that Medibank may terminate your membership in accordance with Medibank's Fund Rules.

Suitability For Working Visa Health Insurance

Working visa and health insurance eligibility requirements

Medibank's Working Visa Health Insurance covers are designed for people who:

- do not hold permanent resident status in Australia;
- are visiting Australia for business purposes;
- are not eligible for full Medicare benefits (including Australians residing permanently overseas); and
- are not eligible for Overseas Student Health Cover (OSHC).

In addition, Medibank Working Visa Health Insurance may be suitable for people who want to supplement any entitlements they may have under Reciprocal Health Care Agreements (RHCA) which exist between Australia and a number of other countries.

Working Visa Sub Classes

Medibank Working Visa Health Insurance may only be purchased by people who are in Australia on certain working-type visas approved by the Department of Immigration and Border Protection and Medibank. This includes but is not limited to the following:

Visa sub class*	Visa Type
400	Temporary Business Short Stay
401	Exchange
402	Training and Research
403	Temporary Work (International Relations)
420	Entertainment
457	Temporary Business Long Stay
485	Temporary Graduate

* Visa sub classes are subject to change by the Australian government from time to time.

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Welcome to Medibank

Your welcome pack

If you've just joined Medibank, you will receive a welcome pack which includes:

- this Guide
- a Cover Summary, which sets out what's included under your cover.

You will also receive a membership card (sometimes referred to as a policy card), either with your welcome pack or shortly after. Use your membership card to make a claim or arrange admission to hospital. You should also keep it handy if you need to make an enquiry about your membership.

Make sure you keep your card safe and advise us immediately if it is lost or stolen. Medibank will not accept liability for any loss to you resulting from the misuse of a lost or stolen membership card.

Transferring from another Australian health fund

Provided that you join Medibank within two months of leaving your previous Australian private health insurance fund, you won't need to re-serve any waiting periods you have already served. This means you will generally only need to serve waiting periods for any treatments or items:

- you weren't previously covered for
- for which you have not fully served the waiting period
- that have an increased benefit (e.g. upgrading from an Excluded to an Included hospital service or increasing an annual limit on an Extras cover). If you've served the waiting periods for the lower benefits on your previous equivalent cover, benefits will be paid at that level until you've served your new waiting periods.

When you transfer to Medibank, we will apply our nearest equivalent cover (to the cover you held with your previous fund) in determining benefit entitlements. It's important to be aware that:

- extras benefits (if applicable) paid by your previous fund/s will be counted towards:
 - annual limits in your first calendar year of Medibank membership
 - lifetime limits
 - benefit replacement periods
- any loyalty bonus or other similar entitlements (e.g. increased annual limits on extras services for orthodontics) built up with your previous fund/s will not apply to your Medibank cover
- if you choose a Medibank Hospital cover with a lower excess, the excess of the equivalent cover will apply until you have served the relevant waiting period
- any excess paid to your previous fund will not be deducted from any excess payable under your Medibank cover (where applicable).

We need a Transfer Certificate from your previous fund to confirm your level of cover, waiting periods served and benefits paid. You may not be able to claim benefits for certain services until we have received your Transfer Certificate.

Where you join Medibank with a break in cover of more than two months, you will be treated as a new member and all waiting periods relevant to your cover will apply.

Membership with overseas funds or travel insurance is not recognised for portability purposes.

Cooling off period

We give you 30 days from the date your new or changed cover commences to review and make sure you're happy with it. If you change your mind during that period, and no claims have been made, we will either give you a full refund or transfer you to a more appropriate cover.

During the cooling off period, you cannot return to a cover that Medibank has closed. You will need to choose a current cover.

Changes to the Terms and Conditions of your membership

All members of Medibank are subject to our Fund Rules which set out the terms and conditions of cover, as well as the services we pay benefits for. Our Fund Rules may change from time to time. If any changes will have a detrimental effect on a member's entitlement to benefits under their cover, we will provide the Policy holder with reasonable notice in writing before the changes are due to take effect.

Occasionally, Medibank may need to make changes to a health insurance cover. These changes will apply regardless of whether premiums have been paid in advance and may include:

- Closing a cover. If we close a cover that you are on:
 - we may permit you to stay on the cover, but not make any changes to your membership (e.g. adding or removing a member or component of cover). If you want to make a change to your membership, you'll need to select a new cover; or
 - we may not permit you to stay on this cover and will move you to a cover as similar as possible.
- Removing a service or item from a cover.
- Reducing or removing a benefit or benefits under a cover.

If we make a change to your cover and you choose to continue your membership (under the new or changed cover) you will be bound by its terms and conditions. If you do not wish to continue under the new or changed cover you have the option of transferring to a different cover or cancelling the membership.

Medicare eligibility

Your visa status and the colour of your Medicare card indicates your eligibility for Working Visa Health Insurance. A blue (interim) or green Medicare card means you have full access to Medicare and are not eligible to hold a Working Visa Health Insurance cover. If you, or any member on the membership, have full access to Medicare, you should call us to discuss whether the cover you've chosen is the most suitable. Medibank offers a range of resident covers that may be better suited to your needs.

Goods and Services Tax (GST)

Working Visa Health Insurance is subject to Goods and Services Tax (GST), which is included in the premium you pay. Under Medibank's Fund Rules, if you are covered by Working Visa Health Insurance it is assumed you have no entitlement to claim any part of the GST component of the premium as an input tax credit. If you are eligible and intend to claim back part or all of the GST you must notify us in writing.

Managing your Membership

Online Member Services

Medibank Online Member Services (OMS) is a convenient way of managing your membership online. You can sign up at www.medibank.com.au. Once you have signed up you'll be able to:

- View membership details
- Update contact details
- Manage premium payments
- Register bank account details to receive benefits for extras claims by EFT
- Order a replacement membership card
- Send secure emails

All Medibank members aged 16 years and over can use OMS, however, access to some functions may be limited to the Policy holder.

Partner authority

If the Policy holder adds their partner they'll be given authority to manage most aspects of the membership, unless the Policy holder tells us otherwise. This means Medibank may disclose registered membership details to both the Policy holder and their partner.

Partner authority includes:

- Making claims
- Adding or removing dependants
- Changing cover
- Suspending and reactivating the membership
- Changing contact and bank account details
- Changing payment methods
- Requesting and receiving premium refunds

Only the Policy holder can remove themselves or cancel the membership entirely.

Third party authority

Anyone on the membership can nominate a third party to deal with Medibank on their behalf.

There are three ways a member can nominate someone as their authorised third party:

- Verbally over the phone
- By completing a Medibank Authority form – the form can be downloaded at www.medibank.com.au; or
- By giving Medibank a valid Power of Attorney.

A third party can be nominated for a specific timeframe or for the duration of the membership.

Managing your Premiums

When you join a Medibank Working Visa Health Insurance cover, one month's premiums will need to be paid in advance. Generally you cannot pay more than 12 months in advance for any cover.

Premium payment options

We offer a range of options for premium payments, including:

- Financial institution direct debit
- Credit card direct debit
- Manually through direct payment. If you pay using this method, we will send you a Health Cover Account which has instructions on all the ways you can make a payment.

Premium protection

Premiums can change from time to time. Where this occurs we will write to the Policy holder to let them know what the new premium will be.

If you have paid your premiums in advance, the new premium will not apply until your next payment is due. This is known as premium protection. For example, if your premium increases on 1 April and you have paid your current premiums until 1 August, the new premium will apply from 2 August.

However, if you make one of the following changes your premium protection will be lost and the new premium will apply from the date of the change:

- Change your level of cover
- Change your membership category
- Reactivate your membership after a period of suspension.

Where you have paid in advance, the date you have paid up to will be adjusted accordingly.

Premium protection does not protect you against any other changes made to the terms and conditions of your membership.

Premium arrears

A membership is in arrears whenever the premiums are not paid up to date. You will not receive any benefits for services provided or items purchased while your membership is in arrears.

If your premiums remain in arrears for more than two consecutive months, your membership will be closed and you will no longer be eligible to receive any benefits from us.

It's your responsibility to ensure that your premium payments are up to date.

Premium refunds

If you close your membership before you arrive in Australia, you may apply for a refund of premiums paid in advance. To obtain a refund, you must apply in writing to Medibank and provide documentary proof of your circumstances e.g. a letter from an Australian Embassy advising that your visa to Australia has not been approved, or a receipt for the cancellation of your airfare to Australia. Medibank will apply an administration fee for each application, and refund all remaining monies.

If you have already arrived in Australia and wish to close your membership, your refund will be calculated from the date you apply to have your membership closed. An administration fee will also apply in these instances unless application is made within the cooling off period (see page 9).

Changes to your Membership

As your circumstances change you may need to add or remove members on your cover. The following people can be on a Medibank membership:

Policy holder – this is the person who is responsible for the membership. Unless approved by us, the Policy holder must be 16 years of age or older.

Partner – a person who lives with the Policy holder in a marital or de facto relationship.

Child dependant – a child of the Policy holder or their partner who is not married or living in a de facto relationship and is under the age of 21.

Student dependant – a child of the Policy holder or their partner who is not married or living in a de facto relationship, has reached the age of 21 but is under 25 and is undertaking full-time education at an approved educational institution.

If the status of anyone on the membership changes, for example a student dependant ceases to be a student or defers their study, you must notify us immediately as it may mean they're no longer eligible to remain on the membership.

Categories of membership

Adding or removing a member may mean the category of your membership needs to change. This type of change can also affect the premiums you'll need to pay.

We offer the following membership categories:

Single membership – covers the Policy holder.

Couple membership – covers the Policy holder and their partner.

Single parent family membership – covers the Policy holder and any of their child dependants and/or student dependants.

Family membership – covers the Policy holder, their partner and any of their child dependants and/or student dependants.

Not all membership categories are available for all covers. Contact us to find out more.

Adding a child dependant

To cover your child dependant from their date of birth or inclusion in your family unit (e.g. through marriage, adoption or fostering) you'll need to have commenced your Medibank membership no later than that date and add them within the timeframes below.

- For a single or couple membership – **two months**. This change *must* be backdated to the child's date of birth/inclusion in the family unit and means you'll need to change to a family cover and pay higher premiums. Where a child is added outside two months, they will have to serve all waiting periods applicable to the cover.
- For a family membership – **12 months**. This change *can* be backdated to the child's date of birth/inclusion in the family unit, or commence from the date of application or any future date you choose. Where a child is added outside 12 months, their cover will commence from the date of application or any future date you nominate.

Where a child is added within the above timeframes and the membership commenced no later than the child's date of birth they will only have to serve the waiting periods that haven't been served by the Policy holder.

Receiving treatment interstate

Under Working Visa Health Insurance cover, we pay benefits Australia wide. Medibank will pay benefits in accordance with our provider agreements in the state in which you receive treatment (our agreement providers are referred to as Members' Choice providers, see pages 15 and 23 for more details).

Where you receive hospital treatment by a Non-Members' Choice provider, benefits are payable at the level applicable to the state in which treatment is provided.

Suspending your membership

Members can apply to suspend their membership if they're travelling overseas for a period of time. Before a membership can be suspended, premiums must be paid at least two weeks in advance of the date the suspension is due to commence.

If you're considering suspending your membership for overseas travel you should note:

- The suspension application must be made prior to your departure date.
- Benefits are not payable for treatment received, services provided or items purchased during a period of suspension.
- Any period of suspension will not count towards waiting periods or benefit replacement periods.
- Any period of suspension can affect your entitlement to an increase in annual benefit limits for extras items and services.
- The minimum period for which you can suspend your membership is two months i.e. if you leave Australia for less than two months, you cannot suspend your membership.
- The maximum period for which you can suspend your membership is four months.
- There must be six months between suspension periods.

From time to time Medibank may close covers. If your cover is closed while your membership is suspended, you may be transferred to a similar cover. The premium applicable to the new cover will apply from the date your membership reactivates. You may need to provide supporting documentation.

Going to Hospital

It's important to be aware that Working Visa Health Insurance cover may not fully cover all of the costs associated with hospital treatment.

To help understand your potential out-of-pocket expenses, you should contact us prior to any hospital admission. You should also speak to your doctor/s and hospital to confirm any out-of-pocket expenses you may incur.

Inpatient vs outpatient

All Working Visa Health Insurance covers provide benefits when a member is treated as a private hospital inpatient where the treatment is Included under your cover (refer to your Cover Summary).

An inpatient is someone who is admitted to hospital to receive medical care or treatment. Services that are provided where a member is not admitted to hospital are called outpatient services.

Outpatient medical services include things such as visits to an emergency department, a general practitioner (GP) or a specialist. Benefits towards outpatient medical services are only available on some Working Visa Health Insurance covers.

Outpatient medical services

Benefits for outpatient medical services are payable under some Working Visa Health Insurance covers (refer to your Cover Summary).

The benefits we pay for outpatient medical services are based on the Medicare Benefit Schedule (MBS) fee set by the Australian government. If a service is provided by a medical practitioner, listed in the MBS and Included under your cover we will generally pay 100% of the MBS fee.

Informed financial consent

Before going to hospital it's important to ask your doctor/s and the hospital about any potential out-of-pocket expenses you might incur. This information should be provided in writing before your treatment or hospital admission and is known as informed financial consent.

If you're admitted in an emergency, there may not be time for the hospital or doctor/s to seek your informed financial consent. Information about your out-of-pocket expenses should be provided as soon as possible after you receive treatment.

Hospital accommodation benefits

The benefits we pay for hospital accommodation will depend on whether the hospital admission is for an Included or Excluded service and the type of hospital you're admitted to (refer to your Cover Summary), as explained below.

- Included services – we pay benefits towards same day and overnight hospital accommodation and intensive care.
- Excluded services – no benefits are payable.

Hospital accommodation benefits do not include other things such as TV hire, telephone calls, newspapers, parking and take-home items, e.g. crutches. Medibank will not pay benefits for these (or similar) items and services. The hospital should discuss any charges with you.

Choice of hospital

Hospital cover allows you to choose whether you're treated as a private patient at either a private or public hospital. While we pay benefits regardless of where you're treated (if the treatment is Included under your cover) the benefits we pay and the out-of-pocket expenses you may incur for your hospital stay can vary depending on the hospital you choose.

When making a decision about which hospital you'll be treated at, you should be aware that not all doctors have admitting rights to all hospitals, and this may affect where your doctor can treat you. Your doctor will be able to tell you at which hospitals they have admitting rights.

Regardless of whether you're treated at a Members' Choice, Non-Members' Choice or public hospital, the hospital should seek your informed financial consent about any out-of-pocket expenses you'll need to pay. It's also important to be aware that if you have a Working Visa Health Insurance cover with an excess, it will apply regardless of the type of hospital you choose (refer to page 21 for more information about how an excess will apply).

Members' Choice hospitals

Medibank has agreements with most private hospitals and day surgeries in Australia. We refer to our agreement hospitals as Members' Choice hospitals. For an Included service in a Members' Choice hospital, we will pay an agreed rate for your treatment, which includes the cost of a private room (where available) or shared room and any theatre or procedure room costs. Generally this means any out-of-pocket costs you incur for accommodation charges will be limited to any excess applicable to your cover.

By visiting a Members' Choice hospital, you'll get better value for money compared to a Non-Members' Choice hospital as long as the service you receive is covered by our agreement with the hospital and is not Excluded under your cover.

It's important to be aware that Medibank's agreements with Members' Choice hospitals are subject to change. To find a Members' Choice hospital visit www.medibank.com.au

Non-Members' Choice hospitals

Non-Members' Choice hospitals are private hospitals and day surgeries Medibank doesn't have agreements with. The benefits we pay for accommodation in these hospitals are generally lower than those in a Members' Choice hospital and could result in significant out-of-pocket expenses (in addition to any applicable excess).

Public hospitals

If you elect to be treated as a private patient in a public hospital we'll pay benefits for accommodation for a shared room only. You'll be required to pay any difference between the benefit we pay and the amount the hospital charges (in addition to any applicable excess).

Medicare Benefit Schedule (MBS)

The Medicare Benefit Schedule (MBS) is an Australian government list of medical services. These include:

- doctors' services, e.g. GPs and specialists
- diagnostic services, e.g. blood tests, x-rays and ultrasounds provided by pathologists and radiologists.

Each service listed in the schedule has an item number and a corresponding fee that's been set by the government. The benefits we pay for eligible medical services are based on the MBS fee.

If a service is listed in the MBS and Included under your cover we will pay an amount at least equal to the MBS fee. This means where the provider charges no more than the MBS fee, you will not have an out-of-pocket expense for your medical services.

Doctors and providers are not restricted to charging the MBS fee and may choose to charge more for a particular service. Where this occurs you will have an out-of-pocket expense.

Benefits are generally not payable:

- where you are eligible to claim a benefit for a service or treatment from Medicare; or
- for a service or treatment not listed in the MBS.

The MBS is available at www.mbsonline.gov.au

Surgically implanted prostheses

If you need to be hospitalised for a procedure requiring a surgically implanted prosthesis (e.g. a pacemaker or cardiac stent), we'll pay the minimum benefit set out in the government's Prostheses List. The Prostheses List includes over 10,000 items together with a minimum benefit and, in some cases, a maximum benefit that can be charged for each item.

You will have an out-of-pocket expense where (in consultation with your doctor) you choose a prosthesis that:

- is included on the government's list but costs more than the minimum benefit. In that case you will have to pay the difference between the minimum benefit we'll pay and the cost of the item; or
- is not included on the government's list at all. In that case, we will not pay any benefits and you will be responsible for the entire cost of the item.

Your doctor should discuss your prosthesis options with you and seek your informed financial consent regarding additional costs you may have to pay.

Benefits are not payable for any prosthesis associated with an Excluded service under your cover.

The Prostheses List is available at:

www.health.gov.au

Pharmaceutical Benefit Scheme (PBS)

The Pharmaceutical Benefit Scheme (PBS) is funded by the government and makes subsidised prescription medicines available to Australian residents. International visitors to Australia are generally not eligible for subsidised pharmaceuticals under the PBS.

Working Visa Health Insurance cover provides some benefits towards PBS listed drugs that are:

- prescribed according to the PBS approved indication; and
- administered during and form part of your admitted episode of care (including drugs prescribed upon discharge).

For these pharmaceuticals, you must pay:

- an amount equivalent to the current non-concessional PBS co-payment (which is the amount you would have been required to pay if you were eligible for subsidies under the PBS); and
- any costs remaining after the Medibank benefit has been paid.

Pharmaceuticals used in oncology (cancer) and other treatments can be very expensive for people who are not eligible to access subsidised pharmaceuticals under the PBS. It's important to be aware that if high cost pharmaceuticals are required for your treatment, you may incur significant out-of-pocket expenses.

No benefits are payable for PBS listed drugs that relate to a service or treatment that is an Excluded service, are prescribed for a cosmetic purpose or are oral contraceptives.

Unless specifically Included under your Working Visa Health Insurance cover, no benefits are payable for non-PBS pharmaceuticals (refer to your Cover Summary).

The PBS is available at: www.pbs.gov.au

Emergency department fees

Some private and public hospitals charge an Emergency Department facility fee to outpatients. Benefits are only payable for these fees where they are charged by a public hospital and the service leads to an admission or a continuation of care following an admission. No benefits are payable for Emergency Department facility fees charged by private hospitals.

Hospital benefits table

We've prepared this table to help you understand what benefits Medibank pays under Working Visa Health Insurance covers (for Included services) and where potential out-of-pocket expenses may arise. Medibank does not pay any benefits for Excluded services (refer to your Cover Summary).

		Members' Choice Hospital	Non-Members' Choice Hospital	Public Hospital
Accommodation and ICU charges	Included service	<ul style="list-style-type: none"> • Medibank will pay the cost of shared or private room accommodation in hospital or same day facility. • Your potential out-of-pocket expense is limited to any hospital excess applicable to your cover. 	<ul style="list-style-type: none"> • Medibank will pay the minimum hospital benefit set by the government for shared room. • Your potential out-of-pocket expense will be any charge above the minimum benefit set by the government and any excess applicable to your cover. 	<ul style="list-style-type: none"> • Medibank will pay the hospital benefit for accommodation. • Your potential out-of-pocket expense will be any charge above the Medibank benefit and any excess applicable to your cover.
Theatre fees	Included service	<ul style="list-style-type: none"> • Medibank will pay costs as per our contract with the hospital. • Your potential out-of-pocket expense is limited to any hospital excess applicable to your cover. 	<ul style="list-style-type: none"> • Medibank will pay no benefits. • Your potential out-of-pocket expense will be any charge raised by the hospital and any excess applicable to your cover. 	<ul style="list-style-type: none"> • Medibank will pay the hospital benefit for theatre. • Your potential out-of-pocket expense will be any charge above the Medibank benefit and any excess applicable to your cover.
Surgically implanted prostheses	Included service	<ul style="list-style-type: none"> • Medibank will pay the minimum benefit set out in the Government's Prostheses List. • Your potential out-of-pocket expense - if the prosthesis is: <ul style="list-style-type: none"> – listed in the Prostheses List and costs up to the minimum benefit – no out-of-pocket expense. – listed in the Prostheses List and costs more than the minimum benefit – any charge above the minimum benefit. – not listed in the Prostheses List – the full cost of the prosthesis. 		
In-hospital doctors' medical services	Included service	<ul style="list-style-type: none"> • Medibank will pay at least 100% of the MBS fee. • Your potential out-of-pocket expense – any difference between the Medibank benefit and the amount you are charged. 		
In-hospital diagnostics (e.g. bloods tests, scans etc.)	Included service	<ul style="list-style-type: none"> • Medibank will pay 100% of the MBS fee. • Your potential out-of-pocket expense – any difference between the MBS fee and the amount you are charged. 		

Hospital Cover

Working Visa Health Insurance provides benefits towards hospital accommodation, intensive care and medical services that you receive when you're treated in hospital as a private inpatient.

How hospital benefits are assessed

In assessing benefits for hospital charges, Medibank takes the following into account:

- The cover you held at the date the service was provided. This includes whether the service was Included and any excess applicable to your cover (refer to your Cover Summary)
- The type of hospital to which you were admitted, i.e. a Members' Choice, Non-Members' Choice or public hospital
- Whether all relevant waiting periods had been served by the member requiring treatment
- Whether the treatment has been recognised by Medicare
- Whether the premiums were paid up-to-date
- Any legislative requirements governing hospital treatment
- Whether any other exclusions or assessing rules apply.

Same-day hospital benefits

Same-day hospitalisation refers to treatment where the patient is admitted and discharged on the same day. Benefits for certain procedures as specified by the Department of Health may not be payable unless your doctor certifies your need to be admitted to hospital.

For same-day admissions in a public hospital, Medibank will cover the cost of a shared room where the treatment is for an Included service. You will have to pay any additional charges as an out-of-pocket expense.

Long stay hospital patients (nursing home type patients)

If you're admitted to hospital as an inpatient for a period of continuous hospitalisation exceeding 35 days, you'll be regarded as a long stay or nursing home type patient. If your doctor does not certify your need for ongoing acute care after 35 days, we'll pay a lower benefit towards the daily accommodation hospital charge and you will need to pay the difference as an out-of-pocket expense. These charges could be significant depending on your length of stay.

Treatments with no Medicare benefit

Benefits are generally payable only for treatments listed in the MBS. However, under some Working Visa Health Insurance covers we pay limited benefits towards the following treatment when provided to a hospital inpatient (refer to your Cover Summary):

- Surgical removal of wisdom teeth. We will pay benefits towards hospital accommodation charges. We don't pay any benefits towards the dentist's fees under the hospital component of your cover. This means you could incur out-of-pocket expenses for those charges. Where applicable, some benefits (up to applicable limits) may be claimable for the dentist's fees under any Extras component of your cover (refer to your Cover Summary).

Waiting periods

A waiting period is a set amount of time each member must wait before they can receive benefits under their cover. No benefits are payable for items and services obtained while serving a waiting period.

It's important to know that waiting periods apply when each member:

- first takes out cover, is added to an existing membership or changes cover prior to serving all applicable waiting periods
- resumes cover after a break of two months or more (having previously held cover with another Australian health fund)

- changes their cover to include new services or items, or to reduce their excess.

Check your Cover Summary for waiting periods that apply.

Pre-existing conditions (PEC)

Treatment of a pre-existing condition (PEC) has a 12 month waiting period. The only hospital treatments that are not subject to the PEC waiting period are psychiatric care, rehabilitation and palliative care (a two month waiting period applies to these services). Obstetrics-related services are also not subject to the PEC waiting period and always have a 12 month waiting period (refer to page 20).

What is PEC?

An ailment, illness or condition that, in the opinion of a Medical Practitioner appointed by Medibank, the signs or symptoms of which existed at any time in the six month period prior to the day on which the member became insured under the policy or changed their cover.

The PEC waiting period will apply even if an ailment, illness or condition was not diagnosed before the date of commencing membership or changing cover.

Where a member requires hospital treatment, their condition will be assessed for a PEC if:

- they have held their cover for less than 12 months; or
- they have changed their cover to include a new or upgraded service and they haven't been covered for that service for 12 months.

Medibank's Medical Practitioner is the only person authorised to determine if an ailment, illness or condition is pre-existing. To have a determination made, the member will be required to provide two PEC certificates completed by their treating practitioners (e.g. their GP and their admitting specialist).

Medibank will apply the PEC waiting period if:

- the member does not authorise the release of medical or paramedical evidence relating to their claim; or
- despite the member's authorisation, their provider does not release that evidence.

Medibank will not pay for the member or a provider to supply this information.

We need up to 10 working days after receiving all required information to make a PEC assessment. Members should allow time for a determination to be made before agreeing to a hospital admission date. However, it's important to be aware that a condition requiring hospitalisation will still be assessed for a PEC (and the 12 month waiting period may still apply), even where a member is admitted to hospital in an emergency.

If a member:

- is admitted to hospital and chooses to be treated as a private patient;
- has been covered for the required service or treatment for less than 12 months; and
- our Medical Practitioner determines (either prior or subsequent to the admission) the member's condition to be pre-existing,

Medibank will not pay any benefits. This means the member will be required to pay **all** hospital and medical charges.

Medibank reserves the right to apply, or not to apply, the PEC waiting period to individual claims. This means we can refuse or reduce benefits on later claims even if the PEC waiting period has not been applied to any earlier claims for that ailment, illness or condition.

If you are coming to Australia specifically for medical treatment, the PEC waiting period will apply to treatment you receive in the first 12 months of your cover and Medibank will not pay any benefits during this period.

You can download the PEC certificates at www.medibank.com.au

Having a baby?

If you are considering having a baby we recommend you contact us to ensure your cover includes obstetrics-related services. This is because there is a 12 month waiting period for those services that the mother will need to have served before the baby is born.

This waiting period applies regardless of the baby's due date or whether the member was pregnant at the time of taking out or upgrading their cover to include obstetrics-related services.

What are obstetrics-related services?

Services and treatment provided in hospital that deal with the care of women during pregnancy, childbirth and following delivery.

In addition, once the baby is born, it's important to ensure they're added to your cover from birth, in case they require hospital treatment immediately.

Ensuring your newborn is covered

Generally, a healthy newborn is not separately admitted to hospital as an inpatient (this is because the baby comes under the mother's admission). Because the baby is not an inpatient, it's important to be aware that any treatment, tests or doctor's visits (e.g. a pre-release check-up by a paediatrician) are outpatient services. This means you may be out-of-pocket if your Working Visa Health Insurance cover does not include benefits for outpatient medical services (refer to your Cover Summary).

In some cases a newborn may need to be admitted to hospital in their own right, for example where they require treatment in a special care nursery or an intensive care unit. This type of admission can be very expensive. To ensure your newborn will be covered in the event they need these services, we strongly advise you to add them to your membership from their date of birth. If a newborn is not added within Medibank's required timeframes (refer page 13), you will be responsible for any costs associated with their admission.

You should also be aware that if you're expecting a multiple birth (e.g. twins) your second or subsequent babies will always be separately admitted to hospital as inpatients. This means that an accommodation charge will be raised by the hospital, so it's important to make sure they're covered.

Accident waiting period waiver and accident override

What is an accident?

An unforeseen event, occurring by chance and caused by an external force or object, resulting in involuntary injury to the body requiring immediate treatment.

Accident does not include any unforeseen conditions the onset of which is due to medical causes nor does it include pre-existing conditions, falling pregnant or accidents arising from surgical procedures. Condition means a state of health for which treatment is sought.

Accident waiting period waiver

Where a two month waiting period applies to a hospital service or treatment (refer to your Cover Summary), it may be waived for claims resulting from an accident. This only applies to Included services under the hospital component of your cover. All other waiting periods will continue to apply.

Accident override

Under some Working Visa Health Insurance covers, benefits are payable for services which would normally be Excluded, where treatment is required for injuries sustained in an accident. This is known as Accident Override (refer to your Cover Summary to check if Accident Override applies).

The following conditions apply to Accident Override on all applicable covers:

- It is limited to hospital treatment and does not give you coverage for any extras services or items that may be applicable to your cover.
- It only applies to treatment for which a Medicare benefit would normally be payable for Australian residents.

To make a claim under Accident Override, you will need to submit the Accident form for assessment. The form can be downloaded at www.medibank.com.au

Hospital covers with an excess

What is an excess?

An amount that you must contribute towards your hospital treatment and is deducted from the benefits we pay when you make a hospital claim. Some hospitals may require you to pay this amount at the time of admission.

If your cover has an excess, the excess will apply:

- per hospital admission, including same day admissions and overnight admissions
- only where the Policy holder or partner is hospitalised – it will not apply to hospital admissions for child dependants or student dependants on family memberships
- regardless of the type of hospital you're admitted to (e.g. Members' Choice, Non-Members' Choice or public hospital).

For most covers the excess will apply per member per calendar year. For some other covers the excess will apply to each episode of hospital treatment up to an annual maximum. Refer to your Cover Summary for details.

Where a member is re-admitted to hospital for the same or a related condition within seven days of discharge, the excess will not be applied to the second admission, even if the admissions stretch across two calendar years.

Contact us to check whether an excess applies to your cover.

Claiming for a CPAP-type device

Benefits are payable under some of our Working Visa Health Insurance covers for CPAP-type devices (refer to your Cover Summary to see if you're entitled to benefits).

What is a CPAP-type device?

These devices include Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (BiPAP) or similar devices, as approved by Medibank.

Benefits for a CPAP-type device are only payable when:

- the member has served the 12 month waiting period
- the member has undergone an overnight investigation for sleep apnoea for which a Medicare benefit would normally be payable for Australian residents
- the device is requested by a Medical Practitioner; and
- the device is purchased or hired within 12 months of undergoing the investigation.

If the CPAP-type device costs more than the benefit we pay, you will be responsible for paying the remaining amount. A benefit replacement period of five years applies (refer to page 24 for details about benefit replacement periods).

Hospital benefit exclusions

Benefits are not payable:

- for any treatments or services that are:
 - Excluded under your cover (refer to your Cover Summary)
 - arranged prior to coming to Australia
 - subject to a PEC or other waiting period or benefit replacement period
 - rendered while premiums are in arrears or the membership is suspended
 - rendered, or items purchased, outside Australia (including medical appliances, pharmaceuticals and other items purchased by mail order or over the Internet direct from a supplier outside Australia) or prior to joining
 - provided in an aged care service
 - not covered, or not fully covered, by the Medibank agreement (if any) with the hospital or extras provider

- for any claims:
 - submitted more than two years after the date of service
 - for services in respect of which you have received, or are entitled to receive, compensation (see page 31)
 - that are fully covered by another party
 - containing false or misleading information or where the service or treatment has been incompletely or incorrectly itemised
 - for charges by your doctor in excess of the Medibank benefit payable under your cover
- where the treatment is rendered by providers who are not recognised by Medibank for the purpose of paying benefits (see page 31)
- for procedures not recognised for Medicare benefit purposes
- for cosmetic treatment
- for podiatric surgery performed by a non-accredited podiatrist
- for treatment not considered medically necessary (e.g. health screening services as required for employment or visa renewal purposes)
- for pharmaceuticals that are:
 - prescribed for cosmetic purposes
 - oral contraceptives
 - provided on discharge from hospital and do not form part of your admitted episode of care
 - not covered by Medibank’s agreement (if any) with the hospital
 - subsidised pharmaceuticals you receive under the PBS (if eligible)
- for surgically implanted prostheses and other items not included on the government’s Prosthesis List or for any charge that exceeds the minimum benefit set out in the government’s Prosthesis List
- for items such as newspapers, TV hire, etc. not covered by Medibank’s agreement (if any) with the hospital
- outpatient accident and emergency facility fees raised by a private hospital, or raised by a public hospital where the services do not lead to an admission or are not a continuation of care following an admission
- for same-day procedures determined by the Australian government as not requiring hospitalisation where the doctor has not provided suitable certification that treatment is required as an admitted inpatient in hospital
- where we consider that one service forms part of another service
- where the number of services performed or items provided exceeds a pre-determined number of services or items over a certain period or course of treatment
- where a provider has charged for two or more consultations on the same day, except where it can be shown that two separate attendances took place, and that these attendances are clearly identifiable on the member’s account as separate consultations
- where the service is performed in stages and a separate benefit cannot be claimed for each stage
- where the member has reached their annual limit, sub-limit or lifetime limit for the particular item or service, or a group of items or services
- where the treatment is rendered by a provider to their partner, dependant, business partner or business partner’s partner or dependant
- where the treatment is otherwise excluded by the operation of a Fund Rule.

Extras Cover

Extras services (this includes items such as physiotherapy, dental treatment and prescription lenses) are **not** included on all Working Visa Health Insurance covers. This means that some covers do not provide any benefits for extras items or services. Please refer to your Cover Summary to check whether extras services are included.

If you wish to be covered for the cost of extras items or services you should contact us.

How extras benefits are assessed

In assessing benefits for extras items or services, Medibank takes the following into account:

- The cover you held at the date the service was provided or item purchased. This includes whether the service or item was included under your cover.
- Whether the service or item is subject to a waiting period or benefit replacement period.
- Whether any annual limit, sub-limit or lifetime limit (where applicable) has been reached.
- Whether the item is purchased from, or the service is provided by, a Medibank recognised provider. This includes whether you received the service from a Members' Choice provider. Refer to page 31 for more information about recognised providers.
- Whether the premiums were paid up-to-date.
- Whether any other exclusions or assessing rules apply.

Members' Choice extras providers

Medibank has agreements with a number of extras providers, including dentists, physiotherapists, chiropractors, podiatrists, acupuncturists and more. We refer to our agreement providers as Members' Choice providers. By visiting a Members' Choice provider for included extras services you'll generally get better value for money, as we've negotiated the maximum amount you can be charged for their services.

It's important to be aware that Medibank's agreements with Members' Choice extras providers are subject to change. To find a Members' Choice provider visit www.medibank.com.au

Non-Members' Choice extras providers

Non-Members' Choice providers are providers we don't have an agreement with. As long as the provider is a Medibank recognised provider, benefits are still payable for services or items included under your cover.

Waiting periods

A waiting period is a set amount of time each member must wait before they can receive benefits under their cover. No benefits are payable for items and services obtained while serving a waiting period.

It's important to be aware that waiting periods apply when each member:

- first takes out cover, is added to an existing membership, or changes cover prior to serving all applicable waiting periods
- resumes cover after a break of two months or more (having previously held cover with another Australian health fund)
- changes their cover to include new items or services or higher annual limits.

Check your Cover Summary for waiting periods that apply.

Benefit replacement periods

A benefit replacement period applies to some extras items. Please refer to your Cover Summary to check whether these items are included under your level of cover.

What is a benefit replacement period?

A set period of time you need to wait from the date of purchase for an item included under your cover before you can receive another benefit to replace the item. This is separate to the waiting period for the item.

Where a benefit is payable under your cover, the following benefit replacement periods apply. Unless otherwise shown, benefit replacement periods apply per member.

12 months	<ul style="list-style-type: none">external mammary prostheses and repairs of external prostheses and health appliances
2 years	<ul style="list-style-type: none">wigship protectorsinsulin delivery pens
3 years	<ul style="list-style-type: none">blood glucose monitorsblood pressure monitorsbreathing appliances<ul style="list-style-type: none">nebuliserspeak flow meters (per member or per membership, depending on your cover)spacing devicesmouthguards (a benefit may be payable for a replacement mouthguard each calendar year for members under 18 years of age)dentures, crowns and bridgesother health appliances and external prostheses
5 years	<ul style="list-style-type: none">hearing aidsCPAP-type devices (claimable under some Hospital covers)

Applicable limits

Where a benefit is payable under your cover, the benefits we pay for extras items and services will generally be subject to one or more of the following limits:

- Annual limits
- Sub-limit
- Lifetime limits

In most cases the benefits we pay for a particular claim will be less than the applicable limits and less than your provider's charge. This means you may have out-of-pocket expenses.

You should refer to your Cover Summary to confirm what limits apply to your cover.

Annual limit

An annual limit is the maximum amount of benefits payable for particular items or services, or a group of services and/or items within a calendar year (i.e. 1 January to 31 December).

In most cases the limit will apply per member, but it can apply per membership.

Sub-limit

A sub-limit is the maximum amount of benefits you can receive for a particular item or service within the overall annual limit. Sub-limits generally apply per calendar year. For example, an Extras cover may have an annual limit of \$500 for Natural Therapies, with a \$400 sub-limit for acupuncture.

Lifetime limit

A lifetime limit is the maximum cumulative benefit we pay over your lifetime towards an item or service, or a group of items or services.

Consultations

The following requirements apply to payment of benefits for initial and subsequent consultations:

- The consultation must be with a Medibank recognised provider.
- Benefits are payable for the consultation only, unless otherwise stated.
- The consultation must be face-to-face (i.e. telephone, internet or video consultations aren't eligible for benefits).
- Generally benefits are only payable once per day for the same provider.

Prescription pharmaceuticals – non-PBS

Non-PBS pharmaceuticals are drugs that are not subsidised by the Australian government under the Pharmaceutical Benefit Scheme (PBS). If your cover includes benefits for non-PBS pharmaceuticals (refer to your Cover Summary), we will pay benefits for pharmaceuticals that:

- are not available under the PBS or legislation relating to other schemes, e.g. Veterans' Affairs
- are not oral contraceptives
- are not prescribed for cosmetic purposes; and
- legally require a prescription in order to be dispensed and are supplied by a registered pharmacist, medical practitioner or dentist.

Where eligible, benefits are paid up to a set amount for each prescription pharmaceutical. Before paying any benefits, we'll deduct an amount equivalent to the current non-concessional PBS co-payment amount. This means that you will be out of pocket for the co-payment amount plus any cost above the set benefit we'll pay for the pharmaceutical. Where your prescription pharmaceutical costs less than the co-payment amount, we will not pay any benefits.

It's important to be aware that even where you are eligible for benefits under your cover (refer to your Cover Summary) Working Visa Health Insurance covers pay limited benefits for non-PBS pharmaceuticals. This means you may incur significant out-of-pocket expenses if high cost pharmaceuticals are required for your treatment.

Appliances requiring referrals

A referral is required to claim benefits for the following items. The referral must be in writing and provided by a medical practitioner unless otherwise indicated below:

- blood glucose monitors
- blood pressure monitors
- breathing appliances
 - nebulisers
 - peak flow meters
 - spacing devices
- orthotic appliances for shoes (can also be referred by podiatrists, physiotherapists and chiropractors)
- wigs
- pressure therapy garments (can also be referred by physiotherapists)
- pressure stockings
- braces, splints and orthoses (can also be referred by orthotists, physiotherapists, occupational therapists and podiatrists)
- custom-made footwear (can also be referred by podiatrists and physiotherapists)
- modifications to footwear (can also be referred by podiatrists)
- external prostheses and health appliances
- hip protectors
- insulin delivery pens.

Generally a letter of referral is valid for 12 months. Where a member requires another item after 12 months, they will need a new referral. You should refer to your Cover Summary to check whether benefits are payable for any of the above items under your level of cover.

Extras benefit exclusions

Benefits are not payable:

- for any items or services that are:
 - not included under your cover (refer to your Cover Summary)
 - subject to a waiting period or benefit replacement period
 - purchased or provided while premiums are in arrears or the membership is suspended
 - rendered, or items purchased, outside Australia (including medical appliances, pharmaceuticals and other items purchased by mail order or over the Internet direct from a supplier outside Australia) or prior to joining
 - provided in an aged care service
 - provided at a public hospital or publicly funded facility
- for any claims:
 - submitted more than two years after the date of service
 - for services in respect of which you have received, or are entitled to receive, compensation (see page 31)
 - that are fully covered by another party
 - containing false or misleading information or where the service or treatment has been incompletely or incorrectly itemised
- where there is an entitlement to a Medicare benefit e.g. under Allied Health Services
- for treatment rendered by a provider who is not recognised by Medibank for the purpose of paying benefits (see page 31)
- for treatment not considered medically necessary (e.g. health screening services as required for employment or visa renewal purposes)
- for pharmaceuticals that:
 - are oral contraceptives
 - are prescribed for cosmetic purposes
 - are available under the PBS or legislation relating to other schemes, e.g. Veterans' Affairs
 - do not legally require a prescription in order to be dispensed
- where the treatment is rendered by a provider to their partner, dependant, business partner or business partner's partner or dependant
- where we consider that one service forms part of another service
- where the number of services performed or items provided exceeds a pre-determined number of services or items over a certain period or course of treatment
- where a provider has charged for two or more consultations on the same day, except where it can be shown that two separate attendances took place, and that these attendances are clearly identifiable on the member's account as separate consultations
- where the service is performed in stages and a separate benefit cannot be claimed for each stage
- where the member has reached their annual limit, sub-limit or lifetime limit for the particular item or service, or a group of items or services
- where treatment is otherwise excluded by the operation of a Fund Rule.

Ambulance Services

Benefits for ambulance services (as outlined under 'What is covered?') are included under all Medibank Working Visa Health Insurance covers.

What is covered?

Where you need an ambulance and your medical condition is such that you can't be transported any other way, you'll be covered for services provided by a Medibank approved ambulance provider:

- when ambulance transportation to a hospital or other approved facility is required to receive immediate professional attention
- when an ambulance is called to provide immediate professional attention but transport by ambulance is not needed
- when, as an admitted patient, the hospital requires you to be transferred from one hospital to another (excluding transfers between public hospitals)
- for transport by air ambulance, where pre-approval has been obtained from Medibank by the air ambulance provider.

What is not covered?

Medibank does not pay benefits for any ambulance service not described under 'What is covered?'. This includes:

- ambulance services where immediate professional attention is not required (e.g. general patient transportation)
- any ambulance transport required after discharge from hospital (e.g. transport from hospital to home)
- inter-hospital transfers when, as an admitted patient, you're transferred from one public hospital to another public hospital
- any ambulance costs that are fully covered by a third party arrangement, such as an ambulance subscription or federal/state/territory ambulance transportation scheme, WorkCover or the Transport Accident Commission
- any air ambulance services that are fully subsidised, such as South Care or NRMA Care Flight.

Repatriation

If you or any other member included on your membership has to be repatriated to your home country due to a substantial life-altering disability or a serious medical condition, as determined by Medibank, we may arrange and pay the reasonable cost of return travel with the appropriate medical supervision.

In the unfortunate event of death, your mortal remains or those of any other member on your membership may be repatriated to your home country if legally permissible.

The provision of any repatriation benefit is at the discretion of Medibank and is payable only once per person per lifetime.

The waiting period applicable for repatriating a sick or injured member will be the waiting period appropriate to the medical condition determining the need for repatriation.

Some covers have a maximum repatriation benefit. Refer to your Cover Summary for more information.

Making a Claim

There are a number of ways you can make a claim with Medibank for hospital, medical and extras services.

Hospital claims

Medibank has arrangements with most hospitals for benefits to be paid direct to the hospital on a member's behalf. This means generally it won't be necessary for you to submit a separate claim for hospital benefits. If needed, hospital claims can be submitted via post with a completed claim form or at a Medibank store. Where claims are submitted in store, we'll assess them separately (at a later date) and pay benefits to you or the hospital, as appropriate.

Extras and medical claims

Most extras and some medical providers offer the convenience of electronic claiming using your membership card. Where available, the claim will be processed automatically and you will just need to pay the remaining balance to the provider.

If electronic claiming is not available one of the following options can be used:

- **OMS**

A claim can be submitted online for most extras services and GP claims using an OMS account. We'll pay the benefit to you, and if your claim relates to an unpaid invoice, you'll need to pay the service provider.

- **Post**

Fill in and submit a claim form – the form can be downloaded at www.medibank.com.au Make sure to attach the original invoices or receipts. As these won't be returned, we recommend you keep a copy for your records.

Claims documentation

Medibank retains all account and receipt documentation for the period required by law.

Benefit payments are accompanied by a statement that contains all information relevant to each service claimed. This statement should be retained for taxation purposes.

Medibank will, on request, provide a financial year consolidated Statement of Benefits which may assist you for taxation purposes.

For online claims, members are required to retain receipts for a specified period for verification purposes.

Time limit for submitting a claim

A claim for benefits must be submitted within two years of the date of service or the date the item was purchased. No benefits will be paid for any claims submitted outside that timeframe.

Government Initiatives

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is applied to Australian tax payers who do not hold a required level of resident private hospital cover and who earn above a certain income (individual and couple/family income tiers apply).

Important: You may be liable to pay the MLS if you are an Australian resident for taxation purposes. Working Visa Health Insurance covers will not exempt you from the MLS.

For more information about the MLS visit the Australian Taxation Office at www.ato.gov.au

Lifetime Health Cover loading

The Lifetime Health Cover (LHC) loading will generally not apply to overseas visitors, unless they become eligible for full Medicare benefits (blue or green Medicare card).

If you become eligible for full Medicare benefits, you will have until your LHC base day to take out an Australian resident private hospital cover. Your LHC base day will be the later of:

- 1 July following your 31st birthday; or
- the first anniversary of your full Medicare registration.

If a person becomes eligible for full Medicare benefits and does not hold a resident hospital cover on their LHC base day, they will pay a 2% loading on their premium (upon taking out an eligible resident hospital cover), up to a maximum of 70%, for each year (or part year) they are aged over 30.

Example: Simon became eligible for full Medicare benefits on 1 January 2015. Simon took out an Australian resident hospital cover on 1 January 2017 at age 55. Because he didn't hold a resident hospital cover on his LHC base day (i.e. 1 January 2016), Simon pays an LHC loading of 50% on top of his hospital cover premium. This equates to 2% for each year Simon is aged over 30.

The LHC loading is removed once a person has held hospital cover (and paid the loading) for 10 continuous years.

For more information about LHC and to use the LHC calculator to find out whether you will need to pay a loading, visit www.privatehealth.gov.au

Other Important Information

Members' Choice Network

Medibank has entered into agreements with most private hospitals and many extras providers. These agreement providers form our Members' Choice network. Visiting a Members' Choice provider means you may be able to access services at a capped fee and/or receive higher benefits.

It's important to be aware that our agreements with Members' Choice providers are subject to change without notice. You should confirm prior to receiving treatment whether your provider is part of our Members' Choice network.

To find a Members' Choice provider visit:
www.medibank.com.au

Recognised providers

To be eligible for benefits, a service or treatment must have been rendered by a provider recognised by Medibank. Medibank recognised providers include hospitals and extras providers and are not limited to providers in our Members' Choice Network. Recognition of providers is at Medibank's discretion. Recognised providers must meet criteria set by Medibank and Medibank may at its discretion cease to recognise a provider it has previously paid benefits for. Members should check whether their provider is recognised by Medibank prior to treatment.

Disclaimer

Medibank encourages providers to offer high quality products and services at competitive prices to members.

However, where Medibank recognises a provider, advertises on behalf of a provider, or appears (by reference to its logo or otherwise) in an advertisement of any provider, to the fullest extent allowed by law such advertising or reference should not be construed as:

- an endorsement by Medibank; or
- an acknowledgment or representation by Medibank as to fitness for purpose; or
- a recommendation or warranty by Medibank of, for or in relation to the provider's products and/or services. Accordingly, Medibank neither takes nor assumes any responsibility for the product and/or service provided.

Members should rely on their own enquiries and seek any assurance or warranties directly from the provider in relation to the service or product.

The health care providers who participate in our Members' Choice network, and the providers whose services we pay benefits for, may change from time to time.

Members' Choice providers may not be available in all areas. Benefits and other arrangements with those providers may vary depending on their location.

To check if your provider is a Medibank recognised provider, contact us.

Compensation and damages

Benefits are not payable for expenses relating to treatment of a condition for which you have received, or are entitled to receive, compensation from a third party (e.g. your state's Workers' Compensation authority or motor vehicle accident authority). This includes treatment of a condition caused by an accident.

Where you appear to have a right to make a claim for third party compensation in relation to a medical condition (including where it is caused by an accident), Medibank expects you to make reasonable enquiries to pursue the third party claim. Medibank may elect not to assess your claim for benefits until you have done so.

You must provide Medibank with timely information and copies of documents relating to any claim you make for compensation from a third party.

In some circumstances, we may agree to make provisional benefit payments to you, subject to our normal benefit conditions and assessing rules, and certain other conditions. If you have been paid any Medibank benefits, on a provisional basis or otherwise, for a medical condition for which you subsequently receive compensation, you must use the compensation to refund to Medibank the benefits we have paid in relation to that condition.

Medibank Privacy Statement

We collect and use your personal and sensitive Information to enable us, other Medibank Group Companies and our third party suppliers and partners to provide you with products and services, including insurance, health-related services and partner offerings, and to give you information on other products and services.

If we do not collect this information, we may not be able to provide you with these services.

We may collect your information from you, another person on your membership, a person authorised to provide us this information on your behalf, another Medibank Group company or a third party.

Where you give us personal information about others, you must ensure that you let them know what information you are giving us and that you have their consent to do so. You should also let them know about this Statement.

We may disclose your personal information to persons or organisations in Australia or overseas, including other Medibank Group Companies, our service providers and professional advisers, health service providers, our suppliers and partners, government agencies, financial institutions, your employer (if you have a corporate product) and your educational institution, migration agent or broker (if you have overseas student health cover or a visitors cover). We may also disclose your information to other persons covered under your policy or your agents and advisers.

We may disclose your personal information overseas to other Medibank Group Companies or third parties who provide services to us including in India, the United States and New Zealand.

Our Privacy Policy contains more information about our privacy practices, including how we use your information and how you may opt-out of receiving promotional material from us. The Policy also details how you may request access to, or correction of, personal information we hold about you, how you can lodge a privacy

complaint and how we manage such complaints. You can obtain the latest version of our Privacy Policy by contacting us or by visiting www.medibank.com.au

You can also write to our Privacy Officer at: Privacy Officer, Medibank Private Limited, GPO Box 9999 (your capital city) or e-mail privacy@medibank.com.au

Private Health Insurance Code of Conduct



Medibank is a signatory to the Private Health Insurance Code of Conduct. The code was developed by the health insurance industry and aims to promote the standards of service to be applied throughout the industry. The code is designed to help you by ensuring that:

- information we provide to you is written in plain language
- Medibank employees are competently trained to deal with your enquiries
- Medibank protects the privacy of your information in line with the Australian Privacy Principles
- you have access to a reliable and free system of addressing complaints with Medibank.

A copy of the code is available online at www.privatehealth.com.au/codeofconduct

Private Patients' Hospital Charter

The Private Patients' Hospital Charter is a guide to what it means to be treated as a private patient in hospital. It sets out what you can expect from your doctors, the hospital and your private health insurer.

To download a factsheet about the charter please visit www.health.gov.au

Contact Us

At Medibank we value your comments on our products and services. If you have any feedback for us or require further explanation of any matter affecting your membership, you can contact us by:

- Phone** **132 331** (if calling in Australia)
+61 3 8622 5780 (if calling from outside Australia)
- Email** **ask_us@medibank.com.au**
- OMS** using the secure form from your OMS account
- Mail** Medibank Private, GPO Box 9999
in your capital city
- In person** visiting one of our stores. Visit our website at **www.medibank.com.au/locations/** to find a store near you.

Complaints

At Medibank we aim to resolve all enquiries and concerns the first time you talk to us. If your concern is still unresolved, our Customer Resolutions team is here to help. You will need to provide us with sufficient information to enable us to investigate your concern.

You can contact our Customer Resolutions team by:

- Phone** **132 331** (if calling in Australia)
+61 3 8622 5780 (if calling from outside Australia)
- OMS** using the secure form via your OMS account
- Mail** Medibank Private Customer Resolutions,
GPO Box 9999, Melbourne, VIC 3000

If you are still dissatisfied with the outcome of your complaint, you can receive free, independent advice from the Private Health Insurance Ombudsman:

- Phone** **1800 640 695**
- Online** **phio.org.au**

Talk to us today



132 331



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call +61 3 8622 5780 if outside Australia

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For Better Health



Medibank Private is a signatory to the Private Health Insurance Code of Conduct.

The Private Health Insurance Code of Conduct logo is a trademark of, and is used under authorisation from, Australian Health Insurance Association Limited.

The information contained in this guide is current at the time of issue, July 2016. It applies only to Medibank branded products and supersedes all previously published material.

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