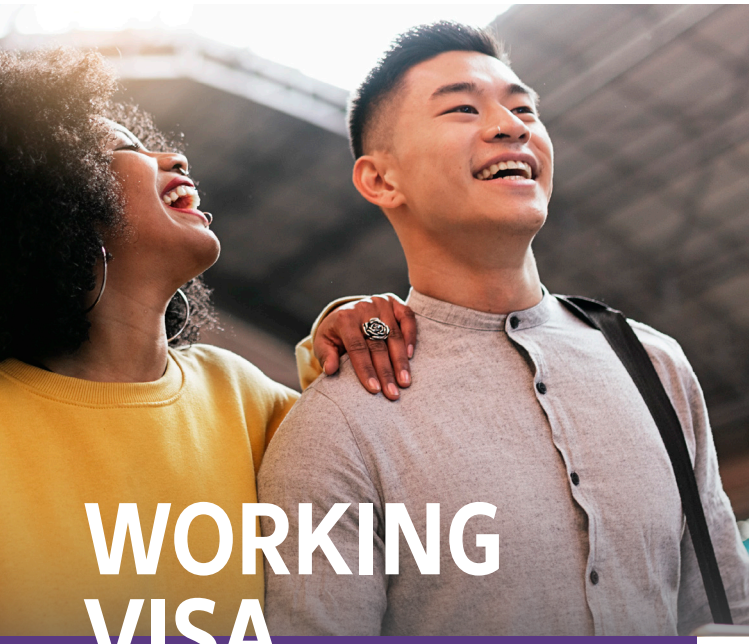


WORKING VISA OVERSEAS HEALTH COVER

Policy document and members guide

Allianz Care

CONTENTS

ALLIANZ CARE AUSTRALIA WELCOMES YOU TO AUSTRALIA

We understand that maintaining your health is an important part of making your stay in Australia as safe and enjoyable as possible.
We provide health cover to look after you while you're working in Australia.

WHAT IS OVHC?

Overseas Visitor Health Cover (OVHC) is health insurance for international visitors which provides cover towards the costs of:

- In hospital medical treatment
- Emergency ambulance transport
- Medical repatriation
- Out of hospital medical treatment *(not included in Budget Working cover)*
- Prescription medicines *(not included in Budget Working cover)*

WHY IS OVHC IMPORTANT?

Hospital and Medical treatment can be expensive

Australia has a public health insurance system, known as Medicare, and a public hospital system, however overseas visitors are generally not eligible for Medicare coverage or free treatment in public hospitals. This means that overseas visitors who need hospital or medical treatment while they are in Australia will have to pay for these services, and the costs can potentially be significant – in most cases hospital treatment will cost more than $1,500 per day.

Visa requirement

If your visa is subject to Visa Condition 8501, you must maintain adequate arrangements for health insurance while you are in Australia. Your visa conditions can be checked on the website of the Australian Government Department of Home Affairs (DoHA) at **www.homeaffairs.gov.au**. Allianz Care Australia's Working OVHC meets all DoHA requirements and will satisfy Visa Condition 8501.

OVHC policyholders who do not maintain their OVHC are at risk of having their visa cancelled if their visa is subject to condition 8501.

If it is a condition of your visa that OVHC must be maintained while in Australia, Allianz Care Australia may provide the Department of Home Affairs with the name and contact details of the Member who has cancelled his or her Policy or who fails to renew their Policy.

DoHA requires holders of student visas to have a particular type of health insurance product, known as Overseas Student Health Cover (OSHC) – if you hold a student visa you should take out OSHC rather than OVHC. Information on Allianz Care Australia's OSHC product is available at **www.allianzcare.com.au**.

WORDS WITH SPECIAL MEANINGS

Some words in this policy have special meanings and are defined below.

agreement hospital means a hospital that we have an agreement with as specified in www.allianzcare.com.au/en/Find-a-Hospital.html

benefit means an amount of money we will pay to you or on your behalf for approved expenses incurred by you in accordance with your policy.

Certificate of insurance means the document we give you which confirms that we have issued a policy to you and sets out details of your cover.

dependant means a person who is:

(a) a spouse or de facto partner of an overseas visitor; or

(b) a child or step-child of an Overseas Worker or their partner, where such child, adopted child or step-child is an eligible family member for the purposes of your Visa.

doctor means a person who is qualified and registered to practise medicine or surgery in Australia. This person cannot be your dependant or a person on whom you are dependent.

eligible visa means a working visa subclass included on our list of eligible visas published on our website **www.allianzcare.com.au**.

emergency treatment means the treatment of any of the following conditions:

(a) risk of serious morbidity or mortality and requiring urgent assessment and resuscitation; or

(b) suspected acute organ or system failure; or

(c) an illness or injury where the viability of function of a body part or organ is acutely threatened; or

(d) a drug overdose, toxic substance or toxin effect; or

(e) psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

(f) severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

(g) acute haemorrhaging and requiring urgent assessment and treatment; or

(h) a condition that requires immediate admission to avoid imminent morbidity or mortality and where a transfer to another facility is impractical.

excess means the amount you are required to pay upfront before receiving a benefit for overnight or same day hospital admissions under your policy (if you have chosen to pay an excess). Your excess is specified on your certificate of insurance.

health aids means items of equipment including blood glucose monitors, blood pressure monitors, CPAP machines, diabetic consumables, leg calipers, nebulisers, orthopaedic shoes, peak flow meters, physiotherapy / chiropractic aids, Synvisc injections, TENS machines and wigs.

health management programs means preventative health programs approved by us that manage or treat a specific health condition, including cover for equipment hire or purchase, fitness programs, health screenings and improvement programs.

hospital means an established hospital registered under Australian legislation that provides in-patient medical care.

injury means bodily injury.

in-patient means a patient who has been formally admitted to a hospital or day facility.

limit means the maximum amount of payment by us. A limit applies per person as long as the maximum benefit has not been used if you have a dual family or multi-family policy.

Medicare Benefits Schedule (MBS) means the table consisting of the tables prescribed under sections 4, 4AA and 4A of the Health Insurance Act 1973 (Cth).

Medicare Benefits Schedule Fee means the amount as determined from time to time by the Australian Government and listed in the Medicare Benefits Schedule as the standard fee for a certain treatment or service.

Medical Devices and Human Tissue Products Rules means the Private Health Insurance (Medical Devices and Human Tissue Products) Rules (No. 1) 2023 made in accordance with section 333-20 of the Private Health Insurance Act 2007 (Cth).

medical practitioner has the meaning given to it in the Health Insurance Act 1973 (Cth).

out of pocket means the difference between the amount charged by the service provider and the amount we will pay to you or on your behalf for a benefit.

out-patient means a person who receives a health service or procedure without being formally admitted to hospital as an in-patient. To remove doubt, out-patient services may be provided in a hospital or other medical facility.

PBS means the Pharmaceutical Benefits Scheme for the payment of pharmaceutical benefits detailed in Part VII of the National Health Act (Cth).

PBS patient co-payment means the out of pocket costs you are required to pay, by law, towards the cost of a prescription before we start to calculate your benefit. The out of pocket costs you have to pay are the same as an Australian who does not receive any concessional payments.

Peoplecare means Peoplecare Health Limited, a private health insurer under the Private Health Insurance Act 2007 (Cth).

premium means the premium payable for your OVHC policy, including all taxes and charges, and is calculated based on the product you choose and the excess you may have chosen to pay.

prescription medicines means medicines that require a prescription completed by a doctor or other medical practitioner in order to be dispensed by a registered pharmacist.

start date means the start date on your certificate of insurance.

we, us and **our** means AWP Australia Pty Ltd (trading as Allianz Care Australia) as the manager of this Overseas Visitors Health Cover product.

you or **your** means the insured person or persons named in your certificate of insurance.

SECTION ONE
OVHC BENEFITS

HOSPITAL COVERAGE

This policy includes cover for inpatient services and treatment for the following clinical categories:

Clinical Categories	Coverage*
Rehabilitation	✓ Included
Hospital psychiatric services	✓ Included
Palliative care	✓ Included
Brain and nervous system	✓ Included
Eye (not cataracts)	✓ Included
Ear, nose and throat	✓ Included
Tonsils, adenoids and grommets	✓ Included
Bone, joint and muscle	✓ Included
Joint reconstructions	✓ Included
Kidney and bladder	✓ Included
Male reproductive system	✓ Included
Digestive system	✓ Included
Hernia and appendix	✓ Included
Gastrointestinal endoscopy	✓ Included
Gynaecology	✓ Included
Miscarriage and termination of pregnancy	✓ Included
Chemotherapy, radiotherapy and immunotherapy for cancer	✓ Included
Pain management	✓ Included
Skin	✓ Included
Breast surgery (medically necessary)	✓ Included
Diabetes management (excluding insulin pumps)	✓ Included
Heart and vascular system	✓ Included
Lung and chest	✓ Included
Blood	✓ Included
Back, neck and spine	✓ Included
Plastic and reconstructive surgery (medically necessary)	✓ Included
Dental surgery	✓ Included
Podiatric surgery (provided by a registered podiatric surgeon)	✓ Included

Clinical Categories	Coverage*
Implantation of hearing devices	✓ Included
Cataracts	✓ Included
Joint replacements	✓ Included
Dialysis for chronic kidney failure	✓ Included
Pregnancy and birth	✓ Included
Assisted reproductive services	× Excluded
Weight loss surgery	✓ Included
Insulin pumps	✓ Included
Pain management with device	✓ Included
Sleep studies	✓ Included

* Subject to benefit limits, exclusions, and excess (if applicable).

If you are admitted to hospital for an excluded service, no benefits are payable under this policy.

These inclusions and exclusions do not apply to out-of-hospital benefits. Out-patient benefits are shown on page 7-24.

More information on clinical categories and their definitions can be found on www.privatehealth.gov.au/health_insurance/howitworks/clinical_categories.htm

Waiting Periods apply to treatment and services received under this policy

The following waiting periods apply before these services are covered under your policy:

Service	Waiting period
Psychiatric, rehabilitative or palliative care	2 months
Pregnancy or pregnancy related conditions	12 months
Pre-existing conditions	12 months

For further information on waiting periods, see page 28.

BUDGET WORKING COVER

HOSPITAL ONLY BENEFITS COVERED UNDER YOUR BUDGET WORKING POLICY

In the event of medical treatment being required by you or any dependants covered under your policy during the period of cover, we will pay benefits for the following:

*You may incur out of pocket costs for hospital expenses above your benefit amount. Payment of benefit subject to the same rules/ criteria as payment of a Medicare benefit for the same service.
^For services covered under your policy (see pages 5-6). Subject to excess (if applicable).

Service	Benefit per service*
In-patient medical services^	
Admitted medical services provided in hospital.	100% of the MBS fee.
Public hospital – admitted patient treatment including: - overnight and day only hospital accommodation (including theatre, intensive care, labour wards, ward drugs); - emergency department treatment that leads to an admission; and - post-operative services that are a continuation of care associated with an early discharge from hospital. Includes PBS listed drugs (including discharge medications) that form part of the episode of hospital care.	The rate determined by State and Territory health authorities for services charged to a patient who is not eligible for Medicare. For admission-related PBS listed drugs, the benefit is equal to the Australian Government's PBS list price less the current PBS patient co-payment.
Private hospital/registered day hospital facility.	100% of the contracted charges for all insurable costs raised by one of our agreement hospitals with a minimum of shared ward accommodation. For more information see 'Private Admission' on page 40.
Medical Devices and Human Tissue Products included on the Federal Government's Prescribed List.	100% of the minimum benefit as listed on the Federal Governments Medical Devices and Human Tissue Products Rules.
Ambulance services	
When medically necessary for admission to hospital or for emergency treatment or for inter-hospital transfer for clinical reasons.	100% of the charge for transport by an ambulance provided by or under an arrangement with an approved ambulance service.
Medical repatriation benefit	
Cover for you or your dependants' repatriation to your home country in the event of a: (1) serious illness, injury or medical condition; or (2) death, we will cover the costs approved by a medical practitioner appointed by us.	We will cover the costs approved by a medical practitioner appointed by us up to a maximum benefit of $20,000 per policy.

STANDARD WORKING COVER

MEDICAL AND HOSPITAL BENEFITS COVERED UNDER YOUR STANDARD WORKING POLICY

In the event of medical treatment being required by you or any dependants covered under your policy during the period of cover, we will pay benefits for the following:

*You may incur out of pocket costs for hospital expenses above your benefit amount. Payment of benefit subject to the same rules/criteria as payment of a Medicare benefit for the same service.
^For services covered under your policy (see pages 5-6). Subject to excess (if applicable).

Service	Benefit per service*
Out-patient medical services	
Medical services provided by a doctor.	100% of the MBS fee.
All other medical services such as pathology and radiology (including specialists).	85% of the MBS fee.
In-patient medical services^	
Admitted medical services provided in hospital.	100% of the MBS fee.

Public hospital –
- Admitted patient treatment including:
  - overnight and day only hospital accommodation (including theatre, intensive care, labour wards, ward drugs); and
  - post-operative services that are a continuation of care associated with an early discharge from hospital.
- Emergency department treatment;
- PBS listed drugs (including discharge medications) that form part of the episode of hospital care.
	The rate determined by State and Territory health authorities for services charged to a patient who is not eligible for Medicare.
	
	For admission-related PBS listed drugs, the benefit is equal to the Australian Government's PBS list price less the current PBS patient co-payment.

Private hospital/registered day hospital facility.	100% of the contracted charges for all insurable costs raised by one of our agreement hospitals with a minimum of shared ward accommodation. For more information see 'Private Admission' on page 40.

MEDICAL AND HOSPITAL BENEFITS COVERED UNDER YOUR STANDARD WORKING POLICY

In the event of medical treatment being required by you or any dependants covered under your policy during the period of cover, we will pay benefits for the following:

*You may incur out of pocket costs for hospital expenses above your benefit amount. Payment of benefit subject to the same rules/criteria as payment of a Medicare benefit for the same service.

^For services covered under your policy (see pages 5-6). Subject to excess (if applicable).

Service	Benefit per service*
Prescription Medicines	
For medicines prescribed by your doctor or other medical practitioner and dispensed by a registered pharmacist.	Prescription medicines benefit for expenses exceeding the equivalent of the current PBS patient co-payment for general beneficiaries up to a: - maximum benefit of $50 per prescribed item - maximum amount per calendar year for Single cover of $300 - maximum amount per calendar year for Dual family and Multi family cover of $600 For Dual family and Multi family cover, each individual member of a family has a limit equivalent to a person with Single cover as long as the family maximum benefit has not been reached. Limits do not apply to admission-related PBS listed drugs.
Medical Devices and Human Tissue Products^	
Medical Devices and Human Tissue Products included on the Federal Government's Prescribed List.	100% of the minimum benefit as listed on the Federal Governments Medical Devices and Human Tissue Products Rules.
Ambulance services	
When medically necessary for admission to hospital or for emergency treatment or for inter-hospital transfer for clinical reasons.	100% of the charge for transport by an ambulance provided by or under an arrangement with an approved ambulance service.
Medical repatriation benefit	
Cover for you or your dependants' repatriation to your home country in the event of a: (1) serious illness, injury or medical condition; or (2) death, we will cover the costs approved by a medical practitioner appointed by us.	We will cover the costs approved by a medical practitioner appointed by us up to a maximum benefit of $20,000 per policy.

MID WORKING COVER

MEDICAL AND HOSPITAL BENEFITS COVERED UNDER YOUR MID WORKING POLICY

In the event of medical treatment being required by you or any dependants covered under your policy during the period of cover, we will pay benefits for the following:

*You may incur out of pocket costs for hospital expenses above your benefit amount. Payment of benefit subject to the same rules/ criteria as payment of a Medicare benefit for the same service.
^For services covered under your policy (see pages 5-6). Subject to excess (if applicable).

Service	Benefit per service*
Out-patient medical services	
Medical services provided by a doctor.	100% of the MBS fee.
All other medical services such as pathology and radiology (including specialists).	85% of the MBS fee.
In-patient medical services^	
Admitted medical services provided in hospital.	100% of the MBS fee.

Public hospital –
- Admitted patient treatment including:
  - overnight and day only hospital accommodation (including theatre, intensive care, labour wards, ward drugs); and
  - post-operative services that are a continuation of care associated with an early discharge from hospital.
- Emergency department treatment;
- PBS listed drugs (including discharge medications) that form part of the episode of hospital care.
	The rate determined by State and Territory health authorities for services charged to a patient who is not eligible for Medicare.
	
	For admission-related PBS listed drugs, the benefit is equal to the Australian Government's PBS list price less the current PBS patient co-payment.

Private hospital/registered day hospital facility.	100% of the contracted charges for all insurable costs raised by one of our agreement hospitals with a minimum of shared ward accommodation. For more information see 'Private Admission' on page 40.

MEDICAL AND HOSPITAL BENEFITS COVERED UNDER YOUR MID WORKING POLICY

In the event of medical treatment being required by you or any dependants covered under your policy during the period of cover, we will pay benefits for the following:

*You may incur out of pocket costs for hospital expenses above your benefit amount. Payment of benefit subject to the same rules/ criteria as payment of a Medicare benefit for the same service.
^For services covered under your policy (see pages 5-6). Subject to excess (if applicable).

Service	Benefit per service*
Prescription Medicines	
For medicines prescribed by your doctor or other medical practitioner and dispensed by a registered pharmacist.	Prescription medicines benefit for expenses exceeding the equivalent of the current PBS patient co-payment for general beneficiaries up to a: - maximum benefit of $50 per prescribed item - maximum amount per calendar year for Single cover of $300 - maximum amount per calendar year for Dual family and Multi family cover of $600 For Dual family and Multi family cover, each individual member of a family has a limit equivalent to a person with Single cover as long as the family maximum benefit has not been reached. Limits do not apply to admission-related PBS listed drugs.
Medical Devices and Human Tissue Products^	
Medical Devices and Human Tissue Products included on the Federal Government's Prescribed List.	100% of the minimum benefit as listed on the Federal Federal Governments Medical Devices and Human Tissue Products Rules.
Ambulance services	
When medically necessary for admission to hospital or for emergency treatment or for inter-hospital transfer for clinical reasons.	100% of the charge for transport by an ambulance provided by or under an arrangement with an approved ambulance service.
Medical repatriation benefit	
Cover for you or your dependants' repatriation to your home country in the event of a: (1) serious illness, injury or medical condition; or (2) death, we will cover the costs approved by a medical practitioner appointed by us.	We will cover the costs approved by a medical practitioner appointed by us up to a maximum benefit of $20,000 per policy.

EXTRAS PROVIDED UNDER YOUR MID WORKING POLICY

Please note:

This is a summary only and does not provide a full list of services covered. It's always best to give us a call before having any treatment to check exactly what you're covered for.

Services		Benefits + Annual Limits	
Benefit	**Services**	**Benefit**	**Annual Limit**
Dental	General Dental - Preventative, X-rays, Basic Restorations, Basic Surgery & Extractions	50%	$500 Per Person $1,000 Per Family
	Major Dental - Periodontics, Endodontics, Crowns & Bridges, Implants & Dentures	X	X
	Orthodontics	X	X
Optical	Glasses Contact Lenses	100%	$150 Per Person $300 Per Family
	Laser Eye Surgery	X	X
Physiotherapy	Physiotherapy Occupational Therapy Orthoptics (eye therapy)	Initial: $35 Standard: $25	$300 Per Person $600 Per Family
	Exercise Physiology Hydrotherapy	50%	
Chiropractic	Chiropractic Osteopathic Services	Initial: $35 Standard: $25	$300 Per Person $600 Per Family
Complementary Therapies	Acupuncture Natural Therapy Remedial Massage Dietetics Chinese Medicine consultation	Initial: $35 Standard: $25	$150 Per Person $300 Per Family
Podiatry	Podiatry (Chiropody)	X	X
Psychology	Psych/Group Therapy	X	X
Speech Therapy	Speech Therapy	X	X
Health Management Programs	Preventative Health	50%	$100 Per Person $200 Per Family
Health Aids & Wellness	Equipment (1 every 3 years) Health Services (allergy treatments) Orthotics (1 every 2 years)	X	X
Hearing Aids	Hearing & Audiology	X	X

MEDICAL AND HOSPITAL BENEFITS COVERED UNDER YOUR TOP WORKING POLICY

In the event of medical treatment being required by you or any dependants covered under your policy during the period of cover, we will pay benefits for the following:

*You may incur out of pocket costs for hospital expenses above your benefit amount. Payment of benefit subject to the same rules/criteria as payment of a Medicare benefit for the same service.
^For services covered under your policy. Subject to excess (if applicable).

Service	Benefit per service*
Out-patient medical services	
Medical services provided by a doctor.	100% of the MBS fee.
All other medical services such as pathology and radiology (including specialists).	85% of the MBS fee.
In-patient medical services^	
Admitted medical services provided in hospital.	100% of the MBS fee.

Public hospital –
- Admitted patient treatment including:
  - overnight and day only hospital accommodation (including theatre, intensive care, labour wards, ward drugs); and
  - post-operative services that are a continuation of care associated with an early discharge from hospital.
- Emergency department treatment;
- PBS listed drugs (including discharge medications) that form part of the episode of hospital care.
	The rate determined by State and Territory health authorities for services charged to a patient who is not eligible for Medicare.
	
	For admission-related PBS listed drugs, the benefit is equal to the Australian Government's PBS list price less the current PBS patient co-payment.

Private hospital/registered day hospital facility.	100% of the contracted charges for all insurable costs raised by one of our agreement hospitals with a minimum of shared ward accommodation. For more information see 'Private Admission' on page 40.

MEDICAL AND HOSPITAL BENEFITS COVERED UNDER YOUR TOP WORKING POLICY

In the event of medical treatment being required by you or any dependants covered under your policy during the period of cover, we will pay benefits for the following:

*You may incur out of pocket costs for hospital expenses above your benefit amount. Payment of benefit subject to the same rules/ criteria as payment of a Medicare benefit for the same service.
^For services covered under your policy. Subject to excess (if applicable).

Service	Benefit per service*
Prescription Medicines	
For medicines prescribed by your doctor or other medical practitioner and dispensed by a registered pharmacist.	Prescription medicines benefit for expenses exceeding the equivalent of the current PBS patient co-payment for general beneficiaries up to a: - maximum benefit of $50 per prescribed item - maximum amount per calendar year for Single cover of $300 - maximum amount per calendar year for Dual family and Multi family cover of $600 For Dual family and Multi family cover, each individual member of a family has a limit equivalent to a person with Single cover as long as the family maximum benefit has not been reached. Limits do not apply to admission-related PBS listed drugs.
Medical Devices and Human Tissue Products^	
Medical Devices and Human Tissue Products included on the Federal Government's Prescribed List.	100% of the minimum benefit as listed on the Federal Governments Medical Devices and Human Tissue Products Rules.
Ambulance services	
When medically necessary for admission to hospital or for emergency treatment or for inter-hospital transfer for clinical reasons.	100% of the charge for transport by an ambulance provided by or under an arrangement with an approved ambulance service.
Medical repatriation benefit	
Cover for you or your dependants' repatriation to your home country in the event of a: (1) serious illness, injury or medical condition; or (2) death, we will cover the costs approved by a medical practitioner appointed by us.	We will cover the costs approved by a medical practitioner appointed by us up to a maximum benefit of $20,000 per policy.

TOP WORKING COVER (CONTINUED)

EXTRAS PROVIDED UNDER YOUR TOP WORKING POLICY

Please note:

This is a summary only and does not provide a full list of services covered. It's always best to give us a call before having any treatment to check exactly what you're covered for.

Services		Benefits + Annual Limits	
Benefit	**Services**	**Benefit**	**Annual Limit**
Dental	General Dental - Preventative, X-rays, Basic Restorations, Basic Surgery & Extractions	70%	$1,000 Per Person $2,000 Per Family
	Major Dental - Periodontics, Endodontics, Crowns & Bridges, Implants & Dentures	70%	$1,000 Per Person $2,000 Per Family
	Orthodontics	70%	$800 Per Person $2,400 Lifetime Limit
Optical	Glasses Contact Lenses	100%	$250 Per Person $500 Per Family
	Laser Eye Surgery	70%	$500 per eye $2,000 per family
Physiotherapy	Physiotherapy Occupational Therapy Orthoptics (eye therapy)	Initial: $51 Standard: $41	$500 Per Person $1,000 Per Family
	Exercise Physiology Hydrotherapy	70%	
Chiropractic	Chiropractic Osteopathic Services	Initial: $45 Standard: $35	$500 Per Person $1,000 Per Family
Complementary Therapies	Acupuncture Natural Therapy Remedial Massage Dietetics Chinese Medicine consultation	Initial: $45 Standard: $35	$350 Per Person $700 Per Family
Podiatry	Podiatry (Chiropody)	Initial: $45 Standard: $35	$400 Per Person $800 Per Family
Psychology	Psych/Group Therapy	Initial: $90 Standard: $70	$400 Per Person $800 Per Family
Speech Therapy	Speech Therapy	70%	$400 Per Person $800 Per Family

EXTRAS PROVIDED UNDER YOUR TOP WORKING POLICY

Please note:

This is a summary only and does not provide a full list of services covered. It's always best to give us a call before having any treatment to check exactly what you're covered for.

Services		Benefits + Annual Limits	
Benefit	**Services**	**Benefit**	**Annual Limit**
Health Management Programs	Preventative Health	70%	$200 Per Person $400 Per Family
Health Aids & Wellness	Equipment (1 every 3 years) Health Services (allergy treatments) Orthotics (1 every 2 years)	70% 70% up to $150 70% up to $150	$500 Per Person $1,000 Per Family
Hearing Aids	Hearing & Audiology	70%	$1,000 every 5 years

SECTION TWO YOUR POLICY GUIDE

YOUR HOSPITAL AND MEDICAL COVER

This section explains your and our rights and responsibilities under this policy.

WAITING PERIODS FOR YOUR HOSPITAL AND MEDICAL BENEFITS

A waiting period is the time you need to wait after purchasing your policy and before cover is available for certain medical conditions. You cannot claim for medical treatment that is provided during the waiting period.

The waiting period is calculated as commencing from:

- the date you or your dependant (as the case may be) arrived in Australia; or
- the date your eligible visa was granted; or
- the date your policy commenced,

whichever is the later date. The following waiting periods apply before these services are covered under your policy:

Service	Waiting period
Psychiatric, rehabilitative or palliative care	2 months
Pregnancy or pregnancy related condition	12 months
Pre-existing condition	12 months

Waiting periods do not apply to emergency treatment by an approved ambulance service, under the Ambulance services benefit. Waiting periods will however apply to any subsequent hospital or medical costs.

If you are an existing member upgrading your cover from your current level of benefits to a higher level of benefits, you will need to serve the applicable waiting period for any benefits not covered under your existing policy.

If you are an existing member removing the applicable excess from your existing policy, you will need to serve a 2 month waiting period where your previous excess will apply. The 2 month waiting period will also apply if you are transferring to Allianz Care Australia from a similar policy held with another fund and your previous fund had an excess.

If you transfer to Allianz Care Australia from a similar policy held with another Fund and there has not been a gap in your coverage of more than 30 days, then provided you can provide documentary proof of the period you had cover with the other Fund, we will take this period of cover into account when

assessing the waiting periods with us. If you are transferring to Allianz Care Australia, we require that you obtain a clearance certificate from your current Fund.

If you have previously held OVHC or OSHC with us and:

- you terminated your policy and 30 days have since passed during which time you did not hold health insurance; or
- your policy was lawfully cancelled by us,

new waiting periods will apply upon commencement of any new policy you take out with us.

Pre-existing conditions:

A pre-existing condition is an ailment, illness or condition the signs or symptoms of which (in the opinion of a medical practitioner appointed by us) existed at any time during the period of 6 months prior to your cover commencing (determined in accordance with the above rules). In forming such an opinion, the medical practitioner must have regard to any information in relation to the ailment, illness or condition that the medical practitioner who treated the ailment, illness or condition gives him or her.

This includes an ailment, illness or condition that was present, but had not been diagnosed by a medical practitioner prior to your cover commencing.

Hospital Excess:

If your policy has an excess, the excess is the amount you are required to pay upfront before receiving a benefit for overnight or same day hospital admissions under your policy. The excess is payable once per adult, per financial year (1 July – 30 June). The excess does not apply to any dependant children under the age of 18 on your policy. For same day hospital admissions, you only pay half the excess per admission. For subsequent admissions in the same financial year, the balance of the excess will be payable. Excess payments made to your previous fund will not be recognised.

We will not pay you a benefit for an overnight or same day hospital admission if the cost of the medical treatment you receive is less than the excess. However, we will pay you a benefit for a hospital admission if:

- the cost of your medical treatment when combined with any previous medical treatment you had in the same financial year is more than the excess; or
- you pay the balance of your excess.

You can remove an excess by contacting us and agreeing to pay the additional premium. We will advise you of the additional premium payable. If you claim for medical treatment that was provided to you as an admitted patient while an excess was payable on your policy, you must pay the excess upfront before receiving a benefit, even if you have since removed the excess.

Waiting periods apply when removing the hospital excess component from your policy. Please refer to the Waiting periods for your Hospital and Medical benefits section on page 28.

WHAT'S NOT COVERED UNDER YOUR HOSPITAL AND MEDICAL BENEFITS

Benefits are not payable for:

(a) services and treatment rendered as part of an assisted reproductive program, including but not limited to in-vitro fertilisation;

(b) bone marrow and organ transplants;

(c) treatment rendered outside of Australia, whether or not in connection with a course of study and including treatment necessary en route to or from Australia;

(d) treatment arranged in advance of your or your dependants or overseas visitor's arrival in Australia;

(e) treatment rendered to you or your dependants in the first 12 months, other than psychiatric, rehabilitative or palliative care, where the treatment is for a pre-existing condition;

(f) treatment rendered to you or your dependants in the first 2 months where that treatment is psychiatric, rehabilitative or palliative care and is for a pre-existing condition;

(g) treatment rendered to you or your dependants in the first 12 months, where the treatment is for a pregnancy-related condition;

(h) transportation of you or your dependants into Australia in any circumstance, or for transportation out of Australia except in the circumstances and to the extent covered by our "Medical Repatriation Benefit";

(i) services and treatment which are covered by compensation or damages provisions of any kind;

(j) elective cosmetic surgery;

(k) personal costs, including but not limited to, telephone, personal pharmacy, internet, personal items, in-patient boarder, television hire, and costs for any relative/companion;

(l) general non-medical administrative expenses, including but not limited to prosthetic, medical consumable, and medical document handling fees;

(m) services provided by physiotherapists, osteopaths, chiropractors, naturopaths or any other ancillary services*;

(n) medications, drugs or other treatments not prescribed by a doctor or other medical practitioner and dispensed by a registered pharmacist;

(o) any costs associated with dental treatment, unless the treatment is covered on the MBS*;

(p) optical charges, unless the treatment is covered on the MBS*;

(q) any out of pocket costs payable by you;

(r) service fees charged by a medical practitioner or hospital which are not included in the benefits covered under your policy;

(s) costs towards an emergency room visit in a private hospital where we do not have an agreement with that hospital;

(t) Any bank or transfer costs associated with the refund of premium or claim payment for benefits to an overseas financial institution;

(u) Ambulance charges otherwise covered by a third party, or under an arrangement with a government approved ambulance service, or for hospital transfers due to patient preference;

(v) services and treatments undertaken when you do not hold an eligible visa; or

(w) treatment and services provided more than two years ago.

(x) treatment provided for an overnight or same day hospital admission where you have not paid the entirety of your excess unless you have paid half the excess for a same day hospital admission.

(y) benefits for hospital services and treatment not included under your policy;

For the purposes of these exclusions, the start date for calculating the relevant period of 12 months or 2 months, and whether or not the condition is a pre-existing condition, will be determined in accordance with the section ***"Waiting periods for your hospital and medical benefits"*** on page 28 and the section ***"Pre-medical conditions"*** on page 29.

*If you have purchased Mid or Top Working Cover, some benefits will be payable for these services under your extras cover. Please refer to the table of benefits on pages 17 & 18 for Mid Working Cover and pages 23 to 26 for Top Working Cover for a summary of your coverage. Exclusions apply to extras cover. See page 32 under the heading "***What's not covered under your Extras benefits"***.

YOUR EXTRAS COVER

Important information

- Annual limits are based on the financial year (1 July – 30 June), and are per person (unless it says otherwise).
- Health management program benefits are available for approved services that manage or treat a specific health condition, and include blood pressure testing, cholesterol checks, mammograms and hearing tests. To find out if you can claim for a service, please contact us.
- Please keep in mind that we aren't able to pay benefits towards goods and services that are used for sport, recreation or entertainment (like gym memberships or sports shoes).

WAITING PERIODS FOR YOUR EXTRAS

The following waiting periods apply before these services are covered under your policy, and commence from the start date of your policy:

Extras	Waiting period
- Services covered by another fund (when transferring directly to a similar level of cover)	Continuation of cover, with only the need to serve remainder of waiting period
- Joining the fund - Upgrading your cover - General dental, physiotherapy, chiropractic, podiatry, psychology, speech therapy, health aids and complementary therapies	2 months
- Optical and health management programs	6 months
- Major Dental – including crowns, bridgework, implants, orthodontics, endodontics, periodontics and dentures	12 months
- Laser eye surgery & hearing aids	24 months

If you are switching to Allianz Care Australia from a similar policy held with another insurer, we will count the time you were covered under your previous policy towards any waiting period which applies to your coverage with us.

If you are an existing member upgrading your cover from Mid to Top Working cover, you will need to serve the applicable waiting period for any benefits not covered under your existing policy.

What's not covered under your Extras

Benefits are not payable under your extras cover for:

1. treatment & services provided by providers that aren't registered with the Australian Health Practitioner Regulation Agency;
2. treatment & services provided within your waiting periods;
3. treatment & services provided outside Australia;
4. treatment & services covered by compensation or another type of insurance (like third party or sports club insurance);
5. treatment & services provided more than 2 years ago;
6. complementary therapy benefits provided by providers not registered with either Medicare or the Australian Regional Health Group (ARHG);

7. naturopathic & herbal medicines;
8. first aid kits & courses;
9. non-prescription glasses, contacts & sunglasses;
10. treatment & services provided by a family member, relative, business partner or yourself;
11. treatment & services you weren't charged for;
12. services for sport, recreation or entertainment;
13. receipts issued by a third party, like group buying website or group deals;
14. if you're using a gift voucher, we can't pay the difference between the cost of the service and the value of the voucher. For example, if you use a $60 voucher to pay for a $40 service, you can only claim back the $40 as the official fee for that service;
15. benefits higher than the amount you paid for the service. For example, if you receive treatment that's discounted from $65 to $30, we only pay a benefit towards the fee you paid (e.g. $30); or
16. surcharges, delivery costs and credit card processing fees.

INFORMATION ABOUT YOUR POLICY

WHO MAY BE SUITABLE FOR OVHC?

OVHC is health insurance for international visitors wishing to work in Australia on certain visa types, including visa types subject to visa condition 8501.

Eligible Visas

You must hold an eligible visa to be covered under your Allianz Care Australia OVHC policy. Please refer to our website for details of the eligible visa types: **www.allianzcare.com.au/ovhc**.

Your policy will not be valid for any times that you do not hold an eligible visa.

Single or Family Cover

Your certificate of insurance will indicate which type of OVHC policy you have purchased. Your policy may be any of the following:

Single

Covering the primary overseas visitor visa holder (you) only;

Dual family

Covering the primary overseas visitor visa holder (you) and one of:

- your dependent spouse or de facto partner; or
- one or more of your dependent children or step-children who are not married; if:
- they are authorised to enter Australia under your visa, and
- they live with you.

Multi family

Covering the primary overseas visitor visa holder (you) and:

- your dependent spouse or de facto partner; and
- one or more of your dependent children or step-children who are not married; if:
- they are authorised to enter Australia under your visa, and
- they live with you.

Single	Dual family	Multi family
		

If you are not sure if you have the right cover, or your circumstances have changed including ceasing to hold an eligible visa, then please contact us immediately.

We do not cover other family members such as parents, grand-parents, brothers, sisters, uncles or aunts on the same policy. They will need to arrange their own health cover. Please visit: **www.allianzcare.com.au/ovhc**

HOW LONG DO I HAVE TO BE COVERED?

For relevant visa types subject to visa condition 8501, the Australian Government requires that you and your dependants have adequate arrangements for health insurance for the entire length of your and your dependants stay in Australia.

Periods of cover:

1. Your Allianz Care Australia OVHC Policy is only valid whilst you hold a current eligible visa and have paid the full premium required. Payment of the premium is required in advance, with the first payment being a minimum of one month's premium.
2. Your cover starts on the later of the start date shown on your certificate of insurance, the date your eligible visa is granted, or the date of your arrival in Australia.
3. Your cover ceases on the date of your departure from Australia, the date you cease to hold an eligible visa or the date we or you cancel your policy, whichever occurs first. To check if your visa type is an eligible visa, please refer to our website: **www.allianzcare.com.au/ovhc**.

4. You may temporarily leave Australia and return without re-serving waiting periods, provided that:
   - You return to Australia on an eligible visa; and
   - You have paid the full premium required.

   No benefits are payable for services provided to you during the period you were not in Australia.
5. If you are paying your policy by instalments, we will allow for payment of premiums within 60 days after the due date of each payment. If we do not receive your payment within 60 days, your cover will cease and we will cancel your policy.
6. We are not obligated to pay benefits for services provided to you during any period that your payments are not up to date.

TRANSFERRING FROM ANOTHER HEALTH INSURER (FUND)

If you transfer to Allianz Care Australia from a similar policy held with another Fund and there has not been a gap in your coverage of more than 30 days, then provided you can provide documentary proof of the period you had cover with the other Fund, we will take this period of cover into account when assessing the waiting periods with us. If you are transferring to Allianz Care Australia, we require that you obtain a clearance certificate from your current Fund.

To arrange your policy:

- visit us at **www.allianzcare.com.au/ovhc**;
- or call 1300 727 193;
- or email us at **OVHC@allianzcare.com.au**.

PREMIUM REFUNDS

You can apply in writing for a pro-rata refund of premium for the unexpired portion of your policy if:

(a) you paid your premium and did not come to Australia

(b) you paid your premium on the basis of an extended stay but the extension of authorised stay was not granted by the Department of Home Affairs

(c) you have been granted permanent residence in Australia

(d) you can provide proof of OVHC provided by another organisation which includes the period covered by the organisation.

***Please note*:**

- Refunds are calculated on a monthly pro-rata basis, with a minimum refund of one month.

- Any bank or transfer costs associated with the refund of premium to an overseas financial institution will be borne by you and deducted from the premium refund.
- *If it is a condition of your visa that OVHC must be maintained while in Australia, Allianz Care Australia may provide the Department of Home Affairs with the name and contact details of the Member who has cancelled his or her Policy.*

ADDING A NEWBORN CHILD

To add a newborn child to your existing policy, you must provide us with their details within 60 days of their birth.

This might require your policy to be upgraded to a dual or multi family cover with additional premium payable. We will advise you of the additional premium when you provide your child's details.

If we are advised of your child's details within 60 days of their birth, cover for your child will commence from the child's date of birth and once you have paid the additional premium. Waiting periods are considered to be served for the same period that currently applies to the policyholder.

If we are advised of your child's details after 60 days from their birth, cover for the child will commence from the date we are advised of your child's birth and you have paid the additional premium (date of addition). We will not be obliged to pay benefits for any services provided to your child prior to the date of addition. Waiting periods will need to be served from the date of addition.

For further information, please refer to our website: **www.allianzcare.com.au/ovhc**.

HOSPITALISATION

If you or a dependant covered under your policy is hospitalised, you or the hospital must advise us as soon as possible.

YOU MUST HELP US RECOVER ANY MONEY WE HAVE PAID

If a claim made by you and paid by us under this policy is subject to recovery action by us against a third person, you must do the following:

- Assign your rights in relation to the recovery of any amount we have paid under this policy.
- Assist us in recovering payments made by us, including providing us with contact details for the third person; and
- Reimburse us for any amounts paid to you as part of a settlement for claims paid by us.

YOU MUST PROVIDE ADDITIONAL INFORMATION UPON REQUEST

You must provide all information and details that we may require in order to process any medical and hospital claims including medical reports, GP notes, surgical notes and hospital discharge summaries.

COMPENSATION FUND

Benefits are not payable if your claim is for a loss which is recoverable by compensation under any workers compensation or transport accident laws or by any government sponsored fund, plan, or medical or health benefit scheme like Medicare, or any other similar type of legislation required to be effected under law.

RECIPROCAL HEALTH CARE AGREEMENTS

Reciprocal Health Care Agreements (RHCA) are agreements between countries that allow visitors to access medical services under Australia's Medicare scheme while staying in Australia. To be eligible individuals must meet specific criteria, such as being a resident of a participating country and having adequate health insurance in your home country.

Benefits are not coverable under your OVHC policy that have been covered under Medicare via a Reciprocal Health Care Agreement.

For more information of Reciprocal Health Care Agreements please visit www.servicesaustralia.gov.au/reciprocal-health-care-agreements

FRAUD

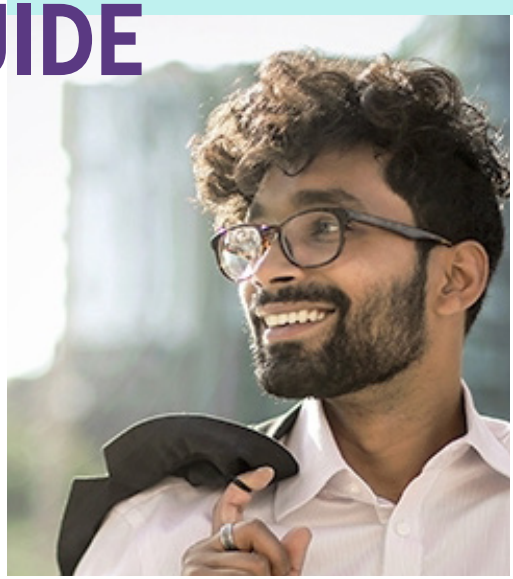
Insurance fraud places additional costs on honest policy holders. Fraudulent claims force insurance premiums to rise.

We encourage the community to assist in the prevention of insurance fraud.

You can help by reporting insurance fraud. All information will be treated as confidential. Report insurance fraud by calling 1800 453 937.

Any fraudulent misuse of your policy or card may result in your policy being cancelled and your details passed onto the relevant authorities. We will not be responsible for any expenses arising from the misuse of your card.

SECTION THREE MEMBER'S GUIDE



OVHC 24 HOUR HELPLINE - 1800 814 781

In the event of a medical or personal situation, we will assist you with:

(a) medical advice and assistance

(b) referrals to a doctor for medical treatment

(c) access to an interpreting service

In a medical emergency situation call triple zero (000).

AWP Australia Pty Ltd trading as Allianz Care Australia has been appointed by Peoplecare to administer all assistance services. Please note that the provision of assistance services to you is not deemed to be acceptance of cover in circumstances where no cover is otherwise available to you under this OVHC policy.

This helpline is for assistance only. We may be unable to confirm eligibility at the time of the call, and claims are subject to assessment.

THE AUSTRALIAN HEALTHCARE SYSTEM

It is very important that you have a good understanding of the Australian healthcare system. If you understand the healthcare system in Australia, you will be better placed to access the best and most effective treatment for you. For information about the Australian healthcare system, visit: **www.humanservices.gov.au**.

GENERAL PRACTITIONERS (BENEFITS APPLY TO STANDARD, MID AND TOP WORKING COVER ONLY)

If you are not in a medical emergency situation, the first point of contact is a doctor, also known as a general practitioner, medical practitioner or local health/medical centre. You can access many services at your local health centre. Some of the services available are:

- General medicine and simple diagnostic screenings.
- Assessment and treatment of health problems and injuries.
- First aid services as needed.
- Women's and men's health.
- Referrals to specialist services.

In most cases, it is necessary for you to make an appointment to see your doctor.

ACCIDENT AND EMERGENCY TREATMENT

Many hospitals have a 24 hour accident and emergency department. Accident and emergency departments should only be accessed in the case of emergency situations. When you visit an accident and emergency department, a nurse will assess you and if your illness or injury is not deemed as an emergency, you may need to wait a long time to see a doctor.

If you hold a Budget Working policy and your attendance at an accident and emergency department does not lead to you being admitted as an in-patient, no cover is provided under your policy for any costs charged for your accident and emergency attendance.

You may not be covered for the costs at the accident and emergency department of a private hospital - cover will depend on which hospital you attend. Please contact us before attending a private hospital to see if you will be covered for the costs.

HOSPITAL TREATMENT

If you have been admitted for emergency treatment, contact Allianz Care Australia immediately on 1800 814 781. If you have been referred to hospital for treatment on a non-emergency basis, contact the claims department on 1300 727 193 prior to admission. You will need to provide Allianz Care Australia with the details of your treatment and hospital stay. We will then be able to confirm your cover and assist you with making arrangements for payment to the hospital.

If you have chosen a policy that contains an excess, you must pay the excess before you can receive a benefit for hospital admission.

Public admission

Generally, OVHC pays for the total cost of your stay and treatment as an in-patient in a shared ward of a public hospital. As a patient in a public hospital, your doctors will be nominated by the hospital. After your hospital discharges you, your care will be carried out in either the out-patient clinic, by one of the hospital's specialists in his/ her private rooms or you will be referred to your local general practitioner.

Private admission

You can choose to be treated in a private hospital. Through our relationship with Peoplecare, we have agreements in place with most private hospitals in Australia. These agreement hospitals ensure that an agreed schedule of fees (including in-patient accommodation, theatre and special unit accommodation fees as appropriate but not emergency department fees) is charged by the hospital and paid by Allianz Care Australia on a member's behalf. You may incur out of pocket costs for private hospital expenses.

If you are admitted to one of these hospitals, we will not cover the full cost of your hospitalization.

However, if you call us for a discussion before you go into hospital we'll tell you how much you are covered for under your policy. Members who choose a non-agreement hospital may incur out of pocket expenses for hospital related services.

For more information on hospital admissions and for details on hospitals that we have agreements with, please visit www.allianzcare.com.au/en/getting-medical-help/find-a-hospital.html

FIND A DOCTOR

Direct billing services

You can attend a health service or doctor that direct bills Allianz Care Australia.

You can find your closest direct billing service on our website at **www.allianzcare.com.au**. You simply have to show your valid Allianz Care Australia OVHC membership card, and the bill for the covered portion of your service will be sent directly to Allianz Care Australia.

Other medical providers

You can attend any other medical practice or doctor in Australia. In most cases, you will be required to pay the bill, and submit a claim to Allianz Care Australia in order to get your benefit reimbursed. Some doctors may charge more than the benefit payable, in which case there will be an out of pocket cost to you for the part that is not covered by your policy.

Your claiming options

Submission of claims time limits

Claims must be lodged with us within 2 years of when you received the service or treatment.

Step 1	Register for Online Member Services using your policy number - https://oms.ovhcallianzassistance.com.au/
Step 2	Select **Submit Claim** from the menu. Read through the instructions and ensure you provide all the information required
Step 3	Attach photos of receipts or relevant documents, complete required information, and submit your claim.

For assistance using Online Member Services, visit our FAQ page - www.allianzcare.com.au/en/faqs/ovhc-oms-faqs.html

It is important that you keep a copy of all your invoices and receipts.

Claims reimbursement

Paid accounts

If you have paid your medical or hospital bill, your benefit will be reimbursed in Australian dollars by:

Direct credit - into your nominated Australian bank account.

Unpaid accounts

If you have not paid your medical or hospital bill, the benefit will be paid:

- to the nominated health care provider (eg. doctor or hospital).

You are responsible for any 'out of pocket' costs payable to the provider. In some instances our claims officers will contact you to request more information.

We will endeavour to process your claim within 10 working days of receiving a completed claim form and all required documents. If we need additional information, a written request will be sent to you within 10 working days. For hospital claims, payment and remittance can take up to 30 days to process.

Making an Extras claim

Claiming couldn't be easier!

HICAPS - just swipe your membership card at participating providers and we'll pay your benefits straight to the provider. You'll only have to pay the difference between what they charge and our benefit, and you won't have to submit a claim form.

If you aren't claiming by HICAPS, you can also lodge a claim form by email or post.

HELPFUL SERVICES

Online services and information

Simple and easy to use services and important information can be found on our website: **www.allianzcare.com.au/ovhc**.

Members services

If you need assistance with any matter, contact our friendly and helpful member service officers on 1300 727 193, who will be able to assist you.

RESOLVING YOUR CONCERNS

Any enquiry or concerns relating to this policy should be referred to:

Allianz Care Australia
Overseas Visitors Health Cover
Locked Bag 3004
TOOWONG QLD 4066
Telephone 1300 727 193

Commonwealth Ombudsman

The Commonwealth Ombudsman has responsibility to assist with enquiries and complaints about any aspect of private health insurance. The Ombudsman is independent of private health funds, private and public hospitals and the Government. Information may be obtained or complaints lodged about health insurance by telephoning the Ombudsman's office toll free on 1300 362 072 or at **www.ombudsman.gov.au**.
For general information about private health insurance, see **www.privatehealth.gov.au**.
Email: **phio.info@ombudsman.gov.au**

SECTION FOUR PRIVACY NOTICE

Your privacy

Your privacy is important to us. To arrange, offer, and provide you with our products and services (or those we may offer or provide to you on behalf of our business partners) and for the purposes set out below, we, namely AWP Australia Pty Ltd ABN 52 097 227 177 trading as 'Allianz Care Australia', collect, store, use, process, and disclose your personal information including sensitive information such as medical information in accordance with the requirements of privacy laws. For full details of our privacy policy, please visit our website at www.allianz-assistance.com.au and click on the Privacy & Security link.

When we collect your personal information, we are responsible for ensuring it is processed and protected in accordance with applicable privacy laws such as the Privacy Act 1988 (C'th), and sometimes European Law such as the GDPR where our activities fall within its scope. Personal information we collect includes, for example, your name, address, date of birth, email address, your medical information, passport details, and bank account details. We also collect information through devices such as 'cookies' when you visit our website or use our mobile apps, in order to improve our website functionality and user experience.

Data collection

We usually collect your personal information directly from you but sometimes from others depending upon the circumstances and the product involved. For example, to quote, arrange, or provide our health insurance products and services, we may collect your personal information from you, your agents, our agents, your broker, other insurers, universities and learning institutions, Government departments managing Immigration, health, and foreign affairs including for visa purposes, family members including your partner or spouse, travelling companions, as well as from doctors, hospitals, and other health service providers if you require medical assistance. We may collect your personal information from our business partners and agents whom you may have approached or who distribute or help provide or arrange our products and services.

Purposes & uses

We use your personal information to arrange, offer, and provide our products and services (or those we may offer or provide to you on behalf of our business partners) and to manage your and our rights and obligations in connection with any products and services you have inquired about or acquired. For instance, we use it to assess, process, and investigate health insurance claims, and to liaise with Government Departments such as immigration, health, and foreign affairs where it relates to your cover or your application for private health insurance cover. We may also use it for product development, marketing (where permitted by law or with your consent), customer data analytics, research, IT and related systems maintenance and development, recovery against third parties, fraud investigations, to comply with requests from regulatory bodies and government departments, and for other purposes with your consent or where permitted by law. We do not sell your personal information to any other person or entity for marketing purposes.

Disclosures & overseas transfers

Your personal information may be disclosed to your family members, co-insured on the same policy, your spouse or partner, as well as to third parties who assist us to carry out the activities set out in the 'Purposes & Uses' paragraph above, such as claims management providers, our agents and intermediaries, insurers, investigators, cost containment providers, medical and health service providers, universities and other education institutions, overseas data processing and 'cloud' storage providers, legal and other professional advisers, your agents and broker, your travel group leader if you travel in a group, your employer or sponsor, insurance reference bodies, and our related entities in the Allianz group of companies including Allianz Partners. Some of these third parties to whom your personal information may be disclosed and transferred, will be located in other countries including in Europe, the UK and Ireland, Asia, Canada, or the USA. We also, where necessary, disclose your personal information to Government Departments that manage immigration, health, and foreign affairs, as well as to regulatory bodies including those involved in the health insurance industry. We also disclose and transfer your personal information to our private health insurer that underwrites your policy, namely Peoplecare Health Limited, which is a registered private health insurer, ABN 95 087 648 753. When we disclose or transfer your personal information to third parties, we take steps binding those entities to comply with privacy law.

Marketing

We may, where permitted by law or with your consent, contact you by telephone, normal mail, email, electronic messages such as SMS, and via other means with promotional material and offers of products or services from us, our related companies, and business partners that we or they consider may be relevant and of interest to you. Where we contact you as a result of obtaining your consent, you can withdraw your consent at any time by calling us on 1800 023 767 or by contacting us – see below.

Other individuals/dependants

Except where you have legal authority to provide personal information on behalf of another, such as in your capacity as a parent or legal guardian, when you provide personal information to us about another individual on your policy such as your spouse, partner, family member, dependant, or adult children, we rely on you and you warrant to us that you have first obtained that individual's consent, and have made them aware of the matters set out in this Privacy Notice.

Access to and correction of personal information

You may also seek access to your personal information (or that of another on your policy where you are authorised to do so) and ask us to correct or update it, and to obtain details about our data processing activities in respect of your personal information. You may have further rights in respect of your personal information where the GDPR law applies, and depending upon the circumstances, you may request a restriction on processing, request it be deleted, and to receive it in a portable form, amongst other things.

Withdrawal of consent

Where your personal information is used or processed with your specific consent as the sole basis for such use and processing (rather than on a contractual basis or legitimate interests of the company), you may withdraw your consent at any time. Just contact us as set out below.

Contact us

If you wish to make a complaint about your data privacy, or have a request for access or correction, or any query about your personal information, please contact: The Privacy Officer, Allianz Care Australia, PO Box 162, Toowong, QLD 4066, or email DataPrivacyAU@allianzassistance.com.au or phone us on +61 7 3305 7000.

You can also contact the Privacy Commissioner at the Office of The Australian Information Commissioner, GPO Box 5218, Sydney, NSW, 2001 if you have a complaint.

Without your agreement to the matters set out above, we may not be able to provide you with our products or services including the assessment and payment of any claims.

IMP3617

Allianz Care Australia
Overseas Visitors Health Cover

Online services and information
www.allianzcare.com.au

Members services and general enquiries
1300 727 193

Claims
1300 727 193

OVHC 24 hour helpline 1800 814 781
Medical assistance and interpreting services
In a medical emergency call triple zero (000)

This insurance is arranged and managed by
AWP Australia Pty Ltd
ABN 52 097 227 177
Trading as Allianz Care Australia
Level 16, 310 Ann Street Brisbane QLD 4000
Locked Bag 3004, Toowong QLD 4066
Australia
Phone: in Australia 1300 727 193
From overseas: +61 7 3305 8833
OVHC@allianzcare.com.au
www.allianzcare.com.au/ovhc

Allianz Care Australia Working Visa Overseas Health Cover policies are managed by AWP Australia Pty Ltd ABN 52 097 227 177 trading as Allianz Care Australia. Peoplecare Health Limited ABN 95 087 648 753, a private health insurer under the Private Health Insurance Act 2007 (Cth), is the underwriter of Allianz Care Australia Working Visa Overseas Health Cover policies.

Peoplecare