Bupa Fund Rules

Effective 2 March 2026

A Introduction

A.1 Rules Arrangement

These Fund Rules (**Rules**) consist of the general terms (Rules A-G) and applicable Product Rules. Certain words and expressions used in these Rules have particular meanings which, unless defined elsewhere, are defined in Rule B.

A.2 Legislation

A.2.1 We conduct Health Insurance Business and Health Related Business under the *Private Health Insurance Act 2007* (Cth) (**PHI Act**).

A.2.2 The Rules are the terms under which we agree to provide you with health insurance.

A.3 Obligations to Insurer

You agree to give us the personal and contact information we request when you apply for a Policy and to notify us of any changes to this information as soon as reasonably possible after the change.

A.4 Governing Principles

These Rules are subject to the laws of Australia, including but not limited to the PHI Act, Health Insurance Act and National Health Act.

A.5 Use of Funds

We operate the Health Benefits Fund in accordance with the PHI Act.

A.6 No Discrimination

We will not Discriminate against you in relation to providing you with a Policy.

A.7 Changes to these Rules

A.7.1 In accordance with the PHI Act, we will:

(a) each year, give a Private Health Information Statement to each Adult Insured Person;

(b) give reasonable prior notice of any change to the Rules that would be detrimental to an Adult Insured Person, whether or not a Private Health Information Statement is required;

(c) give a new Adult Insured Person an up-to-date copy of the relevant Private Health Information Statement, details about the Product Subgroup to which their Policy belongs, what their Policy covers and how Benefits are provided, and a statement identifying the relevant Health Benefits Fund; and

(d) if a person asks about a Product, tell the person that a Private Health Information Statement is available and, if they ask for a copy, give that person an up to date copy of that Private Health Information Statement.

Where more than one Adult Insured Person is under a single Policy, We comply with rules A.7.1(a) – (d) where We give a Private Health Information Statement to only one of those Adult Insured Persons.

A.7.2 We may, on giving you notice, change the Rules at any time, with such

change taking effect from the time specified in the notice.

A.7.3 A change to the Rules may be a change to any or all of the Rules, Premiums, Treatments Covered or Benefits payable in relation to a Policy.

A.7.4 Where there is more than one Adult Insured Person on a Policy, we may provide reasonable prior notice of any change to the Rules that would be detrimental to an Adult Insured Person to just one of those Adults, such as the Policy Holder.

A.7.5 We may, subject to the PHI Act, give a notice under this Rule in a publication made generally available to Policy Holders.

A.8 Dispute Resolution

A.8.1 If you have a complaint about your Policy you may contact our Customer Relations Manager by telephone or in writing. We will attempt to resolve your complaint after taking into account these Rules, applicable laws and the best interests of all Insured Persons. If you are unhappy with our proposed resolution you may contact the Ombudsman for assistance.

A.8.2 Notwithstanding Rule A8.1 (above), you may at any time contact the Ombudsman with a complaint about your Policy.

A.9 Notices

A.9.1 We will give or direct you to a copy of these Rules on request.

A.9.2 If we are required to send you a written notice by postal mail, we will send such notice to the address you most recently supplied to us (even if you have since left that address).

A.10 Winding Up

We may terminate our Health Benefits Fund in accordance with the PHI Act.

B Interpretation and Definitions

B.1.1 The following applies to the interpretation of these Rules:

(a) unless otherwise specified, a term defined in the PHI Act has the same meaning in these Rules;

(b) if applicable, the masculine gender includes the feminine gender;

(c) words in the singular number include the plural and vice versa;

(d) a reference to any legislation is taken as a reference to that legislation as amended from time to time; and

(e) a reference to a State includes a reference to a Territory.

B.2 Interpretation

In these Rules, the following words have the definitions set out below:

Accident means an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or damage to the Insured Person's body, which occurred in Australia and requires medical advice or Treatment from a registered Medical Practitioner (other than anyone on the same Policy) within 72 hours of the event, and if needed, any further Treatment within 180 days of the event.

With regard to a public hospital, an **admission to Hospital** or Hospital **admission** means where the treating medical officer has formally admitted you to the hospital in accordance with the applicable State or Territory rules for an admission, given the applicable clinical circumstances.

Adult means a person who is not a Dependent Child, Dependent Non-Student, Dependent Student or Non-Classified Dependent Person.

Agreement Hospital means a Hospital (including a registered day Hospital facility) with which we have a special agreement.

Associated Treatment for Complications has the meaning as provided by the PHI Complying Product Rules.

Associated Unplanned Treatments has the meaning as provided by the PHI Complying Product Rules.

Australia for the purposes of these Rules includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling) Islands, the Territory of Christmas Island and Norfolk Island, but excludes other Australian external territories.

Australian Resident means a person who resides in Australia and who is any of the following:

(a) an Australian citizen;

(b) the holder of a valid permanent entry permit;

(c) a New Zealand citizen who is lawfully present in Australia;

(d) lawfully present in Australia and whose continued presence in Australia is not subject to any limitation as to time imposed by law; or

(e) the holder of a temporary entry permit and for whom the Australian Government believes special circumstances apply, which relate to asylum seekers, refugees, relatives of permanent entry permit holders, people authorised to work in Australia, or compassionate, humanitarian grounds.

Base Rate has the meaning given in subsection 34-1(2) of the PHI Act.

Benefit means an amount of money payable by us for a Treatment Covered under a Policy.

Bupa, we or **us** means Bupa HI Pty Ltd (ABN 81 000 057 590).

Business Associate means business partner, co-owner, co-shareholder, joint venturer, co-employee, co-contractor or anyone else with a financial interest in the business or work of a person.

Claim means a claim for Benefits.

Common Treatments are treatments listed as Common Treatments in Schedule 6 of the PHI Complying Product Rules.

Depending on the context, **condition** means an ailment, disease, illness, injury or other medical condition.

A **continuous period of hospitalisation** includes any two (2) periods between which there was no break of more than seven (7) days in the provision of Hospital Treatment. Such Hospital Treatment may have been provided in any Hospital.

Co-Payment means an amount you agree to pay towards the cost of:

(a) an overnight or same day admission to Hospital; or
(b) a Hospital outpatient service for which we pay a Benefit.

Cosmetic Surgery means a surgical procedure concerned with altering the appearance of a bodily part or tissue that lies within the bounds of normal variation.

A Policy **Covers** a Treatment if, under that Policy, we agree to pay Benefits for that Treatment. A "**level of Cover**" refers to the amount of Benefits we will pay.

The **Dental Treatment Claims Guidelines** are Bupa's business rules relating to the payment of dental Benefits.

Department means the Commonwealth Department of Health and Aged Care.

Dependant means a Dependent Child, Dependent Non-Student, Dependent Student or Non-classified Dependent Person of the Policy Holder or their covered Partner.

Dependent Child means a person who is not a Partner and:

(a) is aged under 18; and

(b) is not in a bona fide domestic relationship with someone (including someone to whom the person is legally married).

Dependent Non-Student means a person who is not a Partner and:

(a) is aged between 21 and 31 (inclusive); and

(b) is not receiving full-time education at a school, college or university; and

(c) is not in a bona fide domestic relationship with someone (including someone to whom the person is legally married).

Dependent Student means a person who is not a Partner and:

(a) is aged between 21 and 31 (inclusive); and

(b) is receiving full-time education at a school, college or university; and

(c) is not in a bona fide domestic relationship with someone (including someone to whom the person is legally married).

Discriminate and **Discriminatory** relate to:

(a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or

(b) the age of a person, except in relation to the calculation of a Lifetime Health Cover loading (see Rule D4); or

(c) the frequency with which a person needs Hospital Treatment or General Treatment; or

(d) the amount or extent of the Benefits to which a person becomes entitled during a period under a Policy, as the case may be, except to the extent allowed by the written agreement, between the Department and us; or

(e) the gender, race, sexual orientation or religious belief of a person; or

(f) where a person lives; or

(g) any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for Hospital Treatment or General Treatment; or

(h) any matter set out in the PHI Complying Product Rules.

Emergency solely in relation to the f payment of Benefits in a non-Agreement Hospital, means a situation where immediate Hospital Treatment is required for a person who is:

i. at serious risk of morbidity or mortality and requiring urgent assessment and resuscitation; or

ii. suffering from suspected acute organ or system failure; or

iii. suffering from an illness or injury where the viability of function of a body part or organ is acutely threatened; or

iv. suffering from a drug overdose, toxic substance or toxin effect;

v. experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk;

vi. suffering from severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

vii. suffering acute significant haemorrhaging and requiring urgent assessment and treatment.

Excess means an amount of money you agree to pay before we are liable to pay a Benefit for Hospital Treatment.

Where we state that a Treatment is **Excluded** or subject to an **Exclusion** it means that we do not pay Benefits for that Treatment.

General Treatment has the meaning given in section 121.10 of the PHI Act and, subject to that definition, means Treatment other than Hospital Treatment that is intended to manage or prevent a condition (including the provision of goods and services).

The **General Treatment Claims Guidelines** are Bupa's business rules relating to the payment of Benefits for non-dental General Treatment**.**

Health Benefits Fund means the fund we have established that relates solely to our Health Insurance Business and Health Related Business.

Health Care Provider means a provider of Treatment, including someone who manufactures or supplies goods as part of such Treatment.

Health Insurance Act means the *Health Insurance Act 1973* (Cth).

Health Insurance Business has the meaning set out in Division 121 of the PHI Act.

Health Related Business has the meaning set out in section 131-15 of the PHI Act.

Hospital has the meaning set out in subsection 121-5(5) of the PHI Act.

Hospital Policy means a Policy that Covers Hospital Treatment.

Hospital-Substitute Treatment has the meaning given in section 69.10 of the PHI Act and, subject to that definition, means General Treatment that:

(a) substitutes for an episode of Hospital Treatment; and

(b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a condition; and

(c) is not excluded by the PHI Complying Product Rules.

Hospital Treatment has the meaning given in section 121.5 of the PHI Act and, subject to that definition, is Treatment that is provided at or with the direct involvement of a Hospital and is:

(a) intended to manage a condition; and

(b) provided by a person who is authorised by the Hospital to provide that Treatment or provided under the management or control of such a person.

Hospital Treatment also includes benefits for travel or accommodation relating to the treatment in paragraphs (a) or (b).

Insured Group means any of the following:

(a) employees of a particular business enterprise or group of enterprises;

(b) members of a professional association;

(c) any other group deemed by us to be an Insured Group, or

(d) a group of Insured Persons approved for the purposes of Rule D1.5.

Insured Person means a person insured under a Policy and, depending on the context, means any or all of the Policy Holder, a Partner and a Dependant.

Insurer means a provider of health insurance to Australian Residents.

Lifetime Health Cover Age, in relation to an Adult who acquires a Hospital Policy after his or her Lifetime Health Cover Base Day, means the Adult's age on the 1st of July before the day on which the Adult acquired the Hospital Policy.

Lifetime Health Cover Base Day has the meaning given in section 34-25 of the PHI Act.

Medical Practitioner means a person registered or licensed as a medical practitioner under a law of a State or Territory. This does not include anyone whose registration or licence to practise has been suspended or

cancelled following an inquiry relating to his or her conduct and whose registration or licence has not been reinstated.

Medical Treatment means Treatment provided by a Medical Practitioner.

Medicare means Australia's public health insurance system available to eligible persons, such as Australian Residents.

Medicare Benefit means a Medicare benefit under Part II of the Health Insurance Act.

Medicare Benefit Schedule (MBS) means the schedule of items for which Medicare benefits are payable.

MLS means Medicare Levy Surcharge.

MBS Fee means the fee specified for a given item in the MBS.

Minimum Benefits means the reduced Benefits (sometimes called "default benefits") we will pay for Hospital Treatment (once the applicable Waiting Period has expired), according to your level of Cover. These are equivalent to the amounts set by the Australian Government, which apply to people eligible for Medicare benefit. They are generally not enough to cover the full cost of private Hospital accommodation.

Minister means the Australian Government minister or his or her delegate with the powers vested in the Minister by the PHI Act.

National Health Act means the *National Health Act 1953* (Cth).

Newborn means an infant or child up to the age of one year.

New Policy means a new Policy with Bupa.

Non-Classified Dependent Person means a person who is not a Partner and:

(a) is aged between 18 and 20 (inclusive); and

(b) is not in a bona fide domestic relationship with someone (including someone to whom the person is legally married).

For the purpose of these Rules references to Dependent Child include Non-Classified Dependent Person.

Nursing Home Type Patient means a patient who receives Hospital Treatment whether in the form of:

(a) acute care;

(b) accommodation and nursing care, as an end in itself; or

(c) a mixture of both,

for a continuous period of hospitalisation exceeding 35 days (**35-day period**). A patient receiving acute care immediately after the 35-day period does not, however, become a Nursing Home Type Patient unless the period of acute care ends and the patient is then provided with accommodation and nursing care, as an end in itself, as part of a continuous period of hospitalisation.

Nursing Home Type Patient Benefit means the default benefit declared by the Minister for Nursing Home Type Patients who are entitled to Medicare benefits.

Old Policy means a previous Policy with either Bupa or another Insurer.

Ombudsman Act means the *Ombudsman Act 1976 (Cth)*.

Ombudsman means the Private Health Insurance Ombudsman appointed under section 20C of the Ombudsman Act or equivalent.

Partner means a person of either sex with whom the Policy Holder lives in a bona fide domestic relationship and includes a person to whom the Policy Holder is legally married.

Pharmaceutical Benefits Schedule (PBS) means the Schedule of Pharmaceutical Benefits published by the Department.

PHI Act means the *Private Health Insurance Act 2007* (Cth).

PHI Complying Product Rules means the Private Health Insurance (Complying Product) Rules 2015 (Cth).

PHI Prostheses Rules means the Private Health Insurance (Medical Devices and Human Tissue Products) Amendment (No.2) Rules 2024

Policy has the meaning given in section 63-10 of the PHI Act.

Policy Holder means an Insured Person who holds and is responsible for a Policy.

Pre-existing Condition means where an Insured Person has a condition, illness or ailment, that in the opinion of a Medical Practitioner appointed by Bupa, the signs or symptoms of that condition, illness or ailment existed at any time in the 6 months ending on the day on which Insured Person became insured under the Policy. In forming this opinion, the Medical Practitioner must have regard to any information in relation to the condition given to him or her by the Medical Practitioner who treated the condition, illness or ailment.

Premium means the fee for the Product.

Privacy Policy means our privacy policy (also known as our Information Handling Policy) available on our website at http://www.bupa.com.au or on request.

Private Health Information Statement means the information and form of words prescribed under section 93-5 of the PHI Act.

Private Health Insurer means a body registered under Division 3 of Part 2 of the Prudential Supervision Act.

Private Practice means a health care practice operating on an independent and self-supporting basis either as a sole trader, partnership, corporate or group practice but is not subsidised by another party such as any type of publicly funded facility for the provision of accommodation, facilities or other services or practitioners. The provision of Treatment at a public Hospital or any other type of publicly funded facility is not Treatment provided in Private Practice.

Private Room means, for the purposes of a private room in a public hospital, a room in a hospital which:

(a) is purpose built and suitable for no-one other than a single admitted adult patient;

(b) holds one single sized bed; and

(c) has a dedicated ensuite.

Product has the meaning given in section 63-5 of the PHI Act.

Product Rules means the rules applying to a Product which must not be inconsistent with these Rules.

Product Subgroup has the meaning given in section 63-5(2A) of the PHI Act.

Provider means a Recognised Practitioner, Medical Practitioner or Hospital as the case may be.

Prudential Supervision Act means the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth).

Recognised Practitioner means a health care practitioner other than a Medical Practitioner in respect of whom we will pay Benefits for Treatment provided by that practitioner. We have sole and absolute discretion in determining if someone becomes or remains a Recognised Practitioner and for which of their Treatments we will pay Benefits.

Restricted Cover means Cover where we pay only Minimum Benefits for the relevant types of Treatment.

Rules means these Fund Rules including the general terms (Rules A-G) and applicable Product Rules.

State or Territory means a State or Territory of Australia.

Support Treatments are treatments listed as Support Treatments in Schedule 7 of the PHI Complying Product Rules.

State of Residence means the State or Territory in which the Policy Holder resides for the longest period, either continuously or in broken periods, during any twelve-month period.

Telehealth means delivery of healthcare that involves the diagnosis and treatment of clinical conditions via phone or video link (or similar) that are delivered in real-time and proven to be effective in the treatment or management of a diagnosed clinical condition.

Terminally Ill means, as diagnosed by a Medical Practitioner, someone with a life expectancy of less than 6 months.

TGA means the Therapeutic Goods Administration, an authority that is part of the Department.

TGA Approved means an item that the TGA has registered on the Australian Register of Therapeutic Goods for the condition to be treated.

Transfer Certificate means a certificate under section 99-1 of the PHI.

Treatment refers to health or medical treatment to manage, prevent or alleviate a condition, disease or injury and means the provision of either or both of a good or service.

You, you and **your** refers, depending on the context, to the Policy Holder or an Insured Person or both.

Waiting Period mean the period of time during which a Benefit is not payable for a given Treatment. Subject to these Rules, it applies from the time you become Covered for that Treatment under your Policy and ends at the time specified in the Policy.

C Membership

C.1 General Conditions of Membership

C.1.1 Except as otherwise approved by us, a person who is aged 17 years or older may apply to become a Policy Holder.

C.1.2 Subject to Rule C.1.8, Policy Holder, one or more other Adults and one or more Dependants may become Insured Persons on a Policy.

C.1.3 Subject to Rule C1.4 only the Policy Holder may do any of the following in relation to a Policy:

(a) change any details;

(b) change the level of Cover(s);

(c) apply to add or remove a Policy Holder or an Insured Person;

(d) receive a Benefit; and

(e) terminate the Policy.

C.1.4 A Policy Holder may, in writing or by any other means we approve, request that another person be treated as authorised to operate the Policy as if that person is the Policy Holder. The Policy Holder may withdraw this authority at any time by written notice to Bupa.

C.1.5 The Policy Holder is responsible for paying Premiums.

C.1.6 A Policy Holder may purchase a Product consisting of either:

(a) Cover for Hospital Treatment;

(b) Cover for General Treatment; or

(c) Cover for both Hospital Treatment and General Treatment.

C.1.7 A Policy Holder may not acquire or have more than one equivalent or corresponding Product at the same time except if combining Emergency Only Ambulance Cover with any Product covering General Treatment listed in Rule I.

C.1.8 A Policy may be made available to one or more of the following groups of Insured Persons:

(a) the Policy Holder only (Single);
(b) the Policy Holder and one or more of their Dependent Children and/or Dependent Students (Single Parent);
(c) the Policy Holder, and one or more of their Dependent Non-Students and/or Dependent Children and/or Dependent Students (Single Parent Plus);

(d) Policy Holder and their Partner (Couple);
(e) the Policy Holder, their Partner and one or more of their Dependent Children and/or Dependent Students (Family); or
(f) the Policy Holder, their Partner and one or more of their Dependent Non-Students and/or Dependent Children and/or Dependent Students (Family Plus)

C.2 Eligibility for Membership

C.2.1 You may be Covered under a Policy with us if you are an Australian Resident entitled to Medicare benefits and are not already Covered by an equivalent or corresponding Policy with another Insurer or as otherwise agreed by us.

C.2.2 A grant of permanent residency of Australia or of Medicare benefits will be taken to be effective from the date of the official advice notifying you of such grant.

C.3 Dependants

C.3.1 We may elect not to make a Product available to a category of Insured Persons that includes Dependants.

C.3.2 Despite Rule C3.1, Bupa may, in its sole discretion, allow a Dependant to be joined on a Policy Holder's Policy where the Dependant is already Covered under another Policy (with Bupa or another Insurer) provided the Policy Holder is the parent or legal custodian of the Dependant. Any Benefits paid under the other Policy for such Dependant will be taken into account in calculating any Benefit limits on the Policy Holder’s level of Cover.

C.4 Membership Applications

C.4.1 When applying for a Policy, the Policy Holder must provide us with all relevant information we require regarding each Insured Person to be Covered including the following:

(a) proof of identity;

(b) proof of age, such as original birth certificate, current driver's license or current passport. We may accept other forms of proof of age at our discretion;

(c) details of any existing condition; and

(d) details of any actual or potential claims against any third party regarding any illness, ailment or injury.

C.4.2 The Policy Holder must advise us as soon as possible of a change in any of the above information.

C.4.3 We must not refuse to insure you:

(a) for any Discriminatory reasons; or

(b) if you meet the eligibility requirements described in Rule C and otherwise comply with these Rules.

C.4.4 We will maintain a current Private Health Information Statement for the Product Subgroup applying to your Product.

C.4.5 By accepting a Policy you consent to us collecting, using and disclosing your personal and health information and the personal and health information of all Insured Persons Covered under the Policy according to our Privacy Policy. Unless otherwise specified in the Privacy Policy, you agree that:

(a) we will only collect personal and health information about you that is necessary for the purposes of providing the appropriate Cover and verifying that it has been provided according to law. This may include health information collected from Health Care Providers;

(b) we may need to disclose your personal and health information to other parties, such as Health Care Providers and associations, business partners, government authorities, other health funds or other industry bodies. Bupa may also use information for internal purposes, such as staff training, Claims auditing and compliance monitoring;

(c) the Policy Holder is responsible for ensuring every Insured Person is aware that we may collect, use and disclose their personal and health information for the purposes of providing Cover and verifying that appropriate Benefits are paid;

(d) an Insured Person who is aged 18 and over must complete a confidentiality form made available by Bupa indicating their preferences regarding who should receive information about their Claims. If not completed, all Claim information will be sent to the individual to whom it relates;

(e) you may request reasonable access to your personal and health information in our possession and we may charge an administration fee for providing such access;

(f) if you do not consent to how we collect, use or disclose your personal and health information, we may not be able to provide you with Cover; and

(g) we may contact you about new Bupa products or services, special offers or to solicit feedback (including by telephone, email or SMS when these details are provided to us) for an indefinite period after you join a Policy. If you do not wish to receive information about new products or services or special offers you may opt out at any time by calling us.

C.5 Duration of Membership

Your Policy:

(a) commences on the date you apply for the Policy or, provided all required Premiums have been paid and enrolment procedures completed to our satisfaction, a later date agreed by you and Bupa; and

(b) continues until the date it is cancelled under Rule C7 or terminated under Rule C8.

C.6 Transfers and Waiting Periods

C.6.1 If you change to a new level of Cover with us, Waiting Periods will apply to any Treatments not Covered on the previous level of Cover.

C.6.2 If you transfer from an Old Policy to a New Policy, Waiting Periods will apply to Treatments not Covered under the Old Policy.

C.6.3 If the Treatment was Covered under the Old Policy – the balance of any unexpired Waiting Period for that Treatment under the Old Policy will apply under the New Policy.

C.6.4 If, for a given Treatment, the Old Policy had a higher Excess or higher Co-Payment than the New Policy, any period during which the higher Excess or higher co-payment applied under the Old Policy will continue to apply under the New Policy but will be no longer than the Waiting Period allowed under these Rules.

C.6.5 Minimum Benefits may apply to Hospital Treatment or Hospital-Substitute Treatment covered by a New Policy.

C.6.6 See Rule F for details about Waiting Periods and Exclusions (which apply to Treatments with Restricted Cover – where Minimum Benefits apply).

C.6.7 Where limits to Benefits apply, we may, in determining the Benefits payable under the New Policy, take

into account any Benefits paid under the Old Policy.

C.6.8 For the purposes of these Rules, you transfer from an Old Policy to a New Policy where:

(a) you were Covered under the Old Policy at the time you became Covered under the New Policy; or

(b) you ceased to be Covered under the Old Policy for no more than seven (7) days, or a longer number of days allowed by us, before becoming insured under the New Policy; and

(c) your Premium payments under the Old Policy were up to date at the time you became Covered under the New Policy.

C.6.9 If 60 or more days elapse between your coverage under an Old Policy and your coverage under a New Policy, we will treat you as a new Policy Holder for all purposes except those relating to Lifetime Health Cover (see Rule D4) and may apply all relevant Waiting Periods as set out in Rule F.

C.7 Cancellation and Refunds

C.7.1 Subject to this Rule C7, the Policy Holder may cancel a Policy by advising us in writing or as otherwise agreed by us. The date of cessation of the Policy will be the later of the:

(a) the date requested by the Policy Holder (provided the Policy is paid to that date); or

(b) the date of the most recent Claim paid in respect of the Policy.

If the Policy Holder does not nominate a date of cessation, it will be the date on which we received your request for cancellation.

C.7.2 Subject to Rules C7.4 and C7.5, if you cancel the Policy before the date on which the next Premium is due, we will reimburse any Premiums paid in advance of that date.

C.7.3 Subject to Rules C7.4 and C7.5, you may not retrospectively cancel a Policy.

C.7.4 If a Policy is to be cancelled due to an Insured Person's death, and they were the only person on the Policy, the cancellation will take effect from the date after his or her death, and we will refund any Premiums paid in respect of the period after this date.

C.7.5 You may cancel your Policy (including retrospectively) if your cancellation request is within the first 30 days of commencing the Policy or in other circumstances determined by us at our discretion. Provided you haven't made a Claim under the Policy, we will refund the Premium(s) you have paid. If, however, you wish to cancel within the first 30 days of your Policy commencing and you have made a Claim within this period, the date of cessation will be the date of the most recent Claim made and we will only refund Premium(s) paid in respect of the period after that date.

C.7.6 A Dependant who is aged 18 or over may remove themselves from a Policy by notifying us in writing. The date of cessation will be the later of the date requested by the Dependant and the date we receive the notice.

C.7.7 We may charge you an administration fee for processing any refunds made under Rules C7.2 or C7.5.

C.7.8 We will give you a Transfer Certificate within 14 days of you ceasing to be Covered under a Policy with us (and you don't become Covered under another Bupa Policy).

C.8 Termination of Membership

C.8.1 Subject to these Rules, we may, by written notice, terminate part or all of your Policy, giving you our reason(s)

for the termination, if, in our reasonable opinion:

(a) you have been involved in any fraudulent, negligent and/or criminal act in relation to our business or company; or

(b) you have acted in a way that could be construed as threatening to one of our employees or as negatively affecting the working environment of our employees.

C.8.2 We may, without prior notice, terminate your Policy immediately in the following circumstances:

(a) your Premiums are overdue by 2 months or more; or

(b) an Insured Person has reached the maximum suspensions for overseas travel provided under Rule C9.4.

We will, however, subsequently notify you of the reason for terminating your Policy.

C.8.3 If we terminate your Policy before the date on which the next Premium is due, we will reimburse any Premiums paid in advance of that date. We may charge you an administration fee for processing the refund.

C.8.4 We will give you a Transfer Certificate within 14 days of you ceasing to be Covered under a Policy with us (and you don't become Covered under another Bupa Policy).

C.9 Temporary Suspension of Membership

C.9.1 Subject to this Rule C9, we will, on your request, suspend your Policy for reasons of overseas travel, financial hardship or imprisonment, provided:

(a) you have had your Policy for 12 months or more;

(b) you apply to us using the current form we prescribe from time to time;

(c) in the case of overseas travel, you provide us with documentation (to our reasonable satisfaction) verifying your departure and arrival dates; and

(d) in the case of financial hardship, you provide us with any documentation we reasonably request to substantiate your financial hardship.

C.9.2 Subject to the following, we will allow up to two (2) suspensions per calendar year:

(a) A suspension for overseas travel may last from two (2) months to a maximum of two (2) years. You may have up to three (3) maximum suspension periods during the lifetime of the Policy. There must be a period of at least one month of resuming the Policy (and paying the applicable Premiums) between any two suspensions; and

(b) A suspension for financial hardship must be for at least one (1) month, with the total of all such periods of suspension not to exceed 12 months during the period of the Policy.

C.9.3 A suspension for imprisonment may be for a continuous period of up to four (4) years.

C.9.4 A suspension for overseas travel will begin on the later of the day after the date of departure and the date you apply for the suspension. If your application for suspension for overseas travel specifies the date of your return, your Policy will recommence on this date and you must pay the relevant Premium to confirm the recommencement of the Policy. If your application doesn't specify an end date, you must recommence the Policy within one month of the earlier of:

(a) the date of your return to Australia; and

(b) the date on which the maximum suspension period has been reached.

C.9.5 A suspension for financial hardship will begin on the day after we receive and accept your application for suspension. Your Policy will recommence on the date following the cessation of financial hardship or, if you elect to recommence the Policy earlier, a period not less than one month from the commencement of the suspension period.

C.9.6 A suspension for imprisonment will continue until the date of your release, as evidenced by a release form issued by the Department of Correctional Services.

C.9.7 Once your Policy recommences you must pay all due Premiums.

C.9.8 If your level of Cover is no longer available after the suspension, you may transfer to another level of Cover and Rule C.6 will apply to that transfer

C.9.9 No Benefits are payable for Treatment received during a suspension. Any Waiting Periods, Restricted Cover Periods and Exclusions that applied before the suspension will apply on resumption of the Policy.

C.9.10 Periods of suspension do not count towards:

(a) the serving of Waiting Periods;

(b) periods where Exclusions or Restricted Cover applies; or

(c) days covered for the purposes of exemption from the MLS.

D Contributions

D.1 Payment of Contributions

D.1.1 A Premium is paid once we receive it from you.

D.1.2 You must pay all Premiums at least one calendar month in advance (unless Premiums are paid by payroll deduction, in which case the minimum payment period may be one week in advance).

D.1.3 If and when your State of Residence changes, your Premiums will become those applicable in the new State of Residence.

D.1.4 You must pay Premiums for your applicable Insured Group and level of Cover.

D.1.5 We may approve any group of Insured Persons as an Insured Group.

D.2 Contribution Rate Changes

We may adjust the Premiums for your Product in accordance with the PHI Act. Such adjustment will apply, on a pro rata basis, from the date the change becomes effective and your next Premium due after the change will be increased or decreased accordingly.

D.3 Contribution Discounts

We may only offer a discount on any Premiums as permitted by the PHI Act.

D.4 Lifetime Health Cover

D.4.1 Subject to this Rule D4, we must increase the Hospital Policy Premiums applying to an Adult if:

(a) the Adult was not Covered by a Hospital Policy on his or her Lifetime Health Cover Base Day; or

(b) the Adult ceases to be Covered by a Hospital Policy after his or her Lifetime Health Cover Base Day.

D.4.2 Any increase in Premiums under this Rule D4 must be calculated based on the Adult's Lifetime Health Cover Age as specified in Division 34 of the PHI Act. An Adult is taken to be Covered by a Hospital Policy at any time during which the Adult holds a "gold card" within the meaning of subsection 34-15(3) of the PHI Act.

D4.2 We must stop increasing Premiums under this Rule D4 where required by Division 34 of the PHI Act.

D.4.3 We must not increase Premiums under this Rule D4 if:

(a) at the time the Adult first took out a Hospital Policy with a Private Health Insurer, the 1st of July following the Adult's 31st birthday had not arrived; or

(b) the Adult was Covered by a Hospital Policy on and since 1 July 2000; or

(c) the Adult was born on or before 1 July 1934; or

(d) an Adult who turned 31 on or before 1 July 2000 was overseas on 1 July 2000; or

(e) the Adult is the subject of a determination (with effect immediately before 1 April 2007) under clause 10 of Schedule 2 of the National Health Act.

D.4.4 The Premium payable:

(a) under rule D4.1(a) increases by 2% of the *Base Rate* for each year the Adult's Lifetime Health Cover Age is above 30 up to 70% of the Base Rate; and

(b) under rule D4.1(b) increases by 2% for each year the Adult is not Covered by a Hospital Policy (calculated in accordance with section 34-5 of the PHI Act).

D.4.5 Where a Hospital Policy Covers more than one Adult the amount of increased Premiums is calculated by averaging the increased Premiums applicable to each Adult in accordance with section 37-20 of the PHI Act.

D.4.6 The Private Health Insurance (Lifetime Health Cover) Rules 2017 contain special provisions for certain groups of people including the following:

(a) people who have health services provided by the Australian Antarctic Division of the Department of the Environment and Heritage; and

members of the Australian Defence Forces (and their Adult dependants) on continuous full time service and whose health services are provided by or through the Australian Defence Force.

D.5 Arrears in Contributions

D.5.1 Your Premiums are overdue if you do not pay the last due Premium by the due date.

D.5.2 Subject to Rule D.5.3, if your Premiums were overdue but you pay the overdue amount, we will continue to pay Benefits for Treatment for which you are Covered.

D.5.3 No Benefits are payable and we may terminate your Policy if your Premiums become overdue by two (2) months or more.

E Benefits

E.1 General conditions

E.1.1 The Rules and Benefits applying at the time you receive a Treatment will determine if you are eligible for a Benefit and the amount of that Benefit.

E.1.2 We may recover from you, or from a Provider whom we have paid a Benefit on your behalf, any Benefit we pay as a result of:

(a) an error, as long as we notify you of the erroneous payment within 2 years of that payment;

(b) incorrect information supplied on your application form, Claim form, CPOS claim form or any other official Bupa form;

(c) incorrect information supplied or claimed by a Provider;

(d) the provision of clinically unnecessary or excessive Treatment; or

(e) incorrect information regarding a Claim that is identified in an audit.

E.1.3 We may offset any amounts recoverable under these Rules against any Benefits that we would otherwise pay.

E.1.4 We may, in our sole discretion, make ex-gratia payments in respect of Claims that would not otherwise attract Benefits under these Rules.

E.1.5 We will not be liable for any losses, costs, damages, suits or actions arising as a result of or in any way related to Treatment you receive.

E.1.6 We will not pay Benefits:

(a) for Claims made before the Treatment has been provided in its entirety;

(b) in excess of the charge for the relevant Treatment;

(c) for the same Treatment Claimed under more than one Policy;

(d) where the Product Rules determine no payment is payable;

(e) for Treatment that, in the reasonable opinion of a clinical advisor appointed by us, is clinically unnecessary or excessive; or

(f) Treatment of an experimental nature.

E.1.7 Benefits will be determined based on the State of Residence of the Insured Person who received the Treatment.

E.1.8 Instead of monetary benefits, we may, in our sole discretion, apply services or appliances to an Insured Person.

E.2 Hospital Treatment

E.2.1 We will only pay Benefits for Hospital Treatment provided by a person authorised by the relevant Hospital to provide that Hospital Treatment.

E.2.2 We will not pay Benefits for Hospital Treatment in any of the circumstances outlined in Rule E4.

E.2.3 The length of stay in Hospital is calculated from the date of admission to the date of discharge.

E.2.4 We will only pay Medical Benefits for Hospital Treatment or Hospital-Substitute Treatment where a Medicare benefit is payable for that Treatment.

E.2.5 We may pay Benefits that differ from those specified in these Rules where we have a special arrangement with an Agreement Hospital or Medical Practitioner.

E.2.6 We will pay Benefits for PBS listed drugs that are:

(a) prescribed and administered to treat a condition/indication listed on the PBS for that drug; and

(b) prescribed and administered to you while admitted to an Agreement Hospital; and

(c) administered during and forming part of an episode of Hospital Treatment.

We will not pay a Benefit where the cost of the PBS listed drug is less than the pharmaceutical benefit co-payment determined by the Department from time to time.

E.2.7 We will:

(a) pay Benefits for drugs that are not listed on the PBS that you receive while admitted to an Agreement Hospital where such drugs are prescribed for the condition to be treated and are TGA Approved;

(b) not pay Benefits for non-PBS listed drugs that you receive while admitted to a non-Agreement Hospital.

E.2.8 For the purposes of this Rule E2:

(a) a course of Treatment of the same drug is regarded as the prescription of one drug; and

(b) to be eligible for a Benefit, a drug must be:

i. intrinsic to the Hospital Treatment;

ii. clinically indicated;

iii. essential to meet satisfactory health outcomes;

iv. directly related to the Treatment for which you are admitted to Hospital;

v. a non-experimental drug or compound item;

vi. provided by the Hospital during your Hospital admission and not upon or after discharge from the Hospital; and

vii. prescribed as part of but not as the sole reason for the reason for admission to Hospital.

E.2.9 We will pay Benefits for prostheses surgically implanted as part of Hospital Treatment. We will pay an amount equal to the full cost of “no gap” prostheses and an amount equal to the Minimum Benefit for “gap permitted” prostheses.

E.2.10 We will only cover Hospital-Substitute Treatment that is provided by a Recognised Practitioner who is a general or specialist nurse where:

(a) a Medical Practitioner has certified that the Treatment being provided replaces hospitalisation; and

(b) a Medical Practitioner appointed by us assesses such certification to be medically reasonable and appropriate.

E.2.11 If you become a Nursing Home Type Patient, we will pay Nursing Home Type Patient Benefits for the duration of your classification as a Nursing Home Type Patient. You must make a contribution to the cost of your care as declared by the Minister from time to time. We may request an Acute Care Certificate and any additional supporting information from your medical record to verify whether or not you are not a Nursing Home Type Patient.

E.2.12 Where an Insured Person undergoes more than one type of Hospital Treatment during an admission to Hospital, We will generally only cover accommodation, theatre fees and procedures related to the covered Treatment performed as part of that admission. However, We will also cover treatment as required under the PHI Act and the PHI Complying Product Rules relating to the payment of benefits for Associated Treatments for Complications, Associated Unplanned Treatments, Common Treatments and Support Treatments. Outside of these situations, if you receive Hospital Treatment during an admission to Hospital that is both covered and not covered, We will pay for all the covered treatment and any element of treatment that cannot be appropriately allocated to the uncovered treatment on an ex-gratia basis.

E.2.13 If one or some Hospital Treatments are covered as Restricted Cover, We will pay Minimum Benefits toward any part of the costs associated with that Treatment. If the admission relates to Hospital Treatments that are excluded, no Benefits will be paid toward any part of the costs associated with any such excluded Treatment.

E.3 General Treatment

E.3.1 (a) We will pay Benefits for General Treatment (other than Hospital-Substitute Treatment) up to any limit per period (if any) that applies to your Cover.

(b) Any limit that applies to General Treatment relates to the period that the relevant service is provided.

E.3.2 We will only pay Benefits for General Treatment (but not where provided as part of Hospital Treatment) where it is provided by or on behalf of a Recognised Practitioner in Private Practice:

(a) on premises registered with us, unless we otherwise approve; or

(b) by way of Telehealth, where provision of the relevant General Treatment has been approved by Bupa to be provided by way of Telehealth.

For the avoidance of doubt, Bupa will not pay Benefits for Treatment provided by someone who was not a Recognised Practitioner at the time that person provided the Treatment. Bupa has sole and absolute discretion in determining if someone becomes or remains a Recognised Practitioner and for which of their Treatments we will pay Benefits. Bupa may choose to "de-recognise" someone from being a Recognised Practitioner for reasons including, but not limited to, where they no longer meet Bupa's recognition criteria or the agreement governing the relationship between Bupa and that person comes to an end.

E.3.3 We will not pay Benefits for General Treatment in any of the circumstances outlined in Rule E4.

E.3.4 We will pay Benefits in accordance with your level of Cover, our schedule of benefits and our General Treatment Claims Guidelines subject to the following – we will pay for:

(a) dental Treatment in accordance with our schedule of dental Benefits and our Dental Treatment Claims Guidelines;

(b) major dental services including crowns, bridgework, complete dentures, partial dentures, denture repairs, prosthodontic services, implant prostheses, periodontics, oral surgery, endodontics in accordance with our schedule of dental Benefits and our Dental Treatment Claims Guidelines;

(c) oral appliances for sleep apnoea in accordance with our schedule of dental Benefits and Dental Treatment Claims Guidelines;

(d) prescription drugs dispensed by an Australian Registered Pharmacist who is a Recognised Practitioner in Private Practice. Such drugs must be TGA Approved and prescribed by a registered Medical Practitioner for the condition to be treated, except where approved by Bupa. They must not be otherwise supplied under or funded by a public arrangement or scheme, such as the PBS, nor otherwise excluded by us;

(e) asthma pumps that are approved by us;

(f) blood glucose monitors that are approved by us;

(g) health aids and appliances listed in the schedule of benefits when provided by a Recognised Practitioner, and, in relation to orthoses and surgical shoes, are fully custom made; and

(h) prescription spectacles or contact lenses provided by a Recognised Practitioner that are designed and manufactured with the sole purpose of correcting a refractive error or to ameliorate a refractive abnormality or defect of sight.

E.3.5 The Benefits for Treatment available as part of a Product may only differ from one Policy to another based on the State of Residence of the relevant Policy Holder.

E.3.6 We may, from time to time, enter into agreements with providers of General Treatment. The Benefits that apply under these agreements may differ from, and will take precedence over, those shown in general information about our Products. Lists of providers of General Treatment with whom we have agreements are available on our website.

E.3.7 If applicable under your Policy, we will pay:

(a) an Accident Benefit, provided you can supply, on request, proof of the occurrence of the Accident and documentary evidence of admission to hospital or to the emergency department of a hospital.

E.3.8 We will only pay Benefits for:

(a) one type of service of General Treatment provided by a Recognised Practitioner in Private Practice per day; or

(b) more than one type of service of General Treatment provided by a Recognised Practitioner in Private Practice per day where we recognise the Recognised Practitioner as a Recognised Practitioner of each of the professions corresponding to the relevant services.

E.4 Where Benefits are Not Payable

E.4.1 We will not pay Benefits for:

(a) Treatment not included under your level of Cover;

(b) costs incurred as a result of criminal activity;

(c) Treatment given by a practitioner who:

i. has been suspended or expelled by the practitioner's relevant professional board or association; or

ii. is not a Recognised Practitioner;

(d) Treatment (including Hospital Treatment) given by a Recognised Practitioner to someone who is an employee or contractor of the Recognised Practitioner;

(e) Treatment that may be paid or provided by the Australian Government, a State or Territory Government, a local governing body, or an authority established by law;

(f) Treatment given more than two years ago (unless we, in our absolute discretion, choose to pay Benefits in cases of hardship or unsuccessful compensation or damages cases);

(g) Treatment provided by a Recognised Practitioner to:

i. that Recognised Practitioner or the Recognised Practitioner's Partner or Dependant;

ii. a person Covered by the same Policy as the Recognised Practitioner; or

iii. that Recognised Practitioner's Business Associate, the Business Associate's Partner or the Business Associate's Dependant or anyone else Covered by the same Policy as the Business Associate,

unless otherwise approved by us in our sole discretion;

(h) any Treatment provided contrary to the law of the Commonwealth, State or Territory in which the Treatment was provided;

(i) any Treatment that was not provided as Claimed or is insufficiently described in the Claim;

(j) any Treatment we reasonably believe was not provided or was excessive and not reasonable in the circumstances.

(k) any Treatment provided overseas;

(l) any Treatment for which, in Bupa's reasonable opinion, you may receive any compensation, damages, or benefits from another source (even if the compensation, damages, or benefits are stated to exclude any medical expenses);

(m) Hospital Treatment for which no Medicare Benefits are payable, including any Cosmetic Surgery or experimental or clinical trials of pharmaceuticals or devices;

(n) unless otherwise specified in these Rules, Treatment provided to you when you are an "outpatient", that is, you not admitted to Hospital;

(o) Treatment provided by someone to that person's spouse or child; or

(p) any Treatment provided by someone who is not recognised by Bupa.

F Limitation of Benefits

F.1 Co-Payments

F.1.1 Your Policy may include Cover for Hospital Treatment that includes a Co-Payment.

F.1.2 If applicable, you will have to pay the relevant Co-Payment towards the cost of an overnight or same day admission to Hospital.

F.2 Excesses

F.2.1 Your Policy may include Cover for Hospital Treatment that includes an Excess.

F.2.2 If applicable, we will deduct the Excess from the Benefits payable for Hospital Treatment.

F.3 Waiting Periods

F.3.1 We will not pay Benefits for certain types of Hospital Treatment and Hospital-Substitute Treatment provided during a Waiting Period.

(a) The following Waiting Periods apply to the specified types of Hospital Treatment and Hospital-Substitute Treatment:

i. 12 months for the following:

- pregnancy related conditions; and
- Pre-existing Conditions.

ii. 2 months for:

- Psychiatric, rehabilitation or palliative care, including where the condition being treated is a Pre-existing Condition; and
- all other conditions.

(b) The following Waiting Periods apply to the specified types of General Treatment:

i. 3 years for laser eye correction surgery;

ii. 12 months for:

- major dental Treatment;
- orthodontics;
- purchase of health aids and appliances; and
- heart screening tests;

iii. 6 months for:

- if applicable, Bupa's Health Management program or equivalent; and
- the hire and repair of health aids and appliances;

iv. 2 months for all other types of General Treatment.

F.3.2 No Waiting Periods apply in relation to the Treatment of an Accident, where the Accident occurs after the commencement of the Policy.

F.3.3 Certain Insured Persons may be eligible for a one-off exemption from the Waiting Period for psychiatric care indicated in F.3.1 (a), subject to meeting the relevant criteria specified by the Department.

F.4 How Waiting Periods Work

F.4.1 Subject to this Rule F, this Rule F.4 sets out how we may apply Waiting Periods.

F.4.2 When you transfer to a New Policy from an Old Policy, we may require you to serve a Waiting Period where:

(a) the New Policy includes Cover for a Treatment that was not Covered under the Old Policy; or

(b) for a certain type of Treatment Covered under both Policies, the New Policy pays a higher Benefit than was payable under the Old Policy. In this case we will pay the Benefit payable under the Old Policy during the Waiting Period.

F.4.3 Where you cease to be Covered as a Dependant under a Bupa Policy and, within 60 days, become the Policy Holder of a New Policy:

(a) if the New Policy pays the same or a lower Benefit for a Treatment than under the Old Policy, you will be deemed to have served the same Waiting Periods as under the Old Policy; but

(b) if the New Policy pays a higher Benefit than was payable under the Old Policy, we will pay the Benefit payable under the Old Policy during the Waiting Period.

F.4.4 If you add a new Dependant to your Policy (other than a newborn), the new Dependant must serve any Waiting Periods and Restricted Cover Periods that apply under the Policy.

F.4.5 If you add a newborn Dependant to a family or sole parent Policy:

(a) where the Policy Holder held the Policy before the birth of the newborn, the newborn will not be required to serve Waiting Periods;

(b) where the Policy Holder did not hold the Policy before the birth of the newborn, the newborn will not be required to serve Waiting Periods as long as the newborn is added within two (2) months of birth.

F.4.6 A Dependent Student who re-joins a Policy where one of the Dependant's parents is the Policy Holder will be deemed to have served the same Waiting Periods and Restricted Cover Periods as the Policy Holder.

F.5 Exclusions

Exclusions may apply to Hospital Treatment.

F.6 Restricted Cover

F.6.1 We may pay Minimum Benefits in relation to any of the following types of Hospital Treatment:

(a) Rehabilitation services;

(b) Hospital Psychiatric services; and

(c) Palliative care.

F.7 Compensation, Damages and Provisional Payment of Claims

F.7.1 We will not pay Benefits for Treatment of a condition where you have claimed and received, or established a right to receive, compensation or damages from a third party, to pay for the Treatment of that condition.

F.7.2 Where the amount of a claim for compensation or damages is, in our opinion, less than the Benefits we would normally pay, we will pay the difference between such Benefits and the amount of compensation or damages.

F.7.3 Where we reasonably believe you have a right to claim compensation or damages to pay for the Treatment of a condition, we may require you to sign an undertaking in a form acceptable to us before paying any (further) Benefits. The undertaking may, among other things, require you to: make a claim for compensation or damages; pursue the claim with all due diligence; and include in such claim all Hospital, medical, dental, paramedical and related expenses. You must use any proceeds from the claim to reimburse us for any Benefits we have paid for the Treatment of the relevant condition.

F.7.4 We will not pay Benefits where, in our reasonable opinion, you may be entitled to compensation or damages to cover the cost of Treatment of a condition, but have not yet established the right to such payment. We will, however, pay Benefits if, after taking action to do so, you fail to establish such a right.

F.7.5 We will not pay Benefits where you establish a right to compensation or damages and accept a settlement, and:

(a) such settlement includes terms specifying that moneys paid do not relate to past or future expenses in respect of which Benefits would otherwise be payable; or

(b) you abandon or compromise part of the claim so that such expenses are excluded or represented by a nominal amount.

F.7.6 You must immediately notify us if you receive compensation to pay for the Treatment of a condition as a result of the settlement of a claim for compensation.

F.7.7 Where in our opinion you have a right to claim compensation or damages to pay for Treatment of a condition but have not established that right, we may withhold payment of Benefits in relation to such Treatment.

F.7.8 Where you are in the process of making a claim for compensation or damages to pay for the Treatment of a condition but the Claim has not yet been determined, we may in our absolute discretion make a provisional payment of Benefits in respect of such Treatment.

F.7.9 We may require you to sign an undertaking or agree to other conditions in order for us to make a provisional payment of Benefits.

F.7.10 If you do not comply with the terms of the undertaking or any other conditions we impose, we may discontinue any provisional payments of Benefits and require you to repay to us any provisional payments already paid.

F.7.11 Any provisional payment of Benefits by us is a debt you owe us.

F.7.12 Where the Insured Person is under 18 years of age, the Policy Holder must sign and will be principally responsible for the undertaking mentioned in this Rule F.

F.7.13 Where an Insured Person and a Policy Holder each complete an undertaking mentioned in this Rule F, both parties may be liable for any provisional payment of Benefits.

F.7.14 References to an Insured Person receiving compensation includes:

(a) Compensation paid to another person at the direction of the Insured Person; and

(b) Compensation paid to another Insured Person on the same Policy in connection with an injury suffered by the Insured Person.

G CLAIMS

G.1 General

G.1.1 You must submit Claims within two (2) years of the date of Treatment, otherwise Benefits are not payable.

G.1.2 We may, however, in our absolute discretion, waive Rule G1.1 in cases of hardship or for claims relating to unsuccessful compensation or damages cases.

G.1.3 Claims for Benefits must be:

(a) made in a manner we approve; and

(b) supported by accounts and/or receipts on the Health Care Provider's letterhead or showing the Health Care Provider's official stamp, showing the following information:

i. the Health Care Provider's name, number and address;

ii. the Insured Person's full name and address;

iii. the date and description of service;

iv. the amount(s) charged; and

v. any other information that we may reasonably request.

G.1.4 You consent to us accessing, reviewing and discussing a Provider's clinical and payment records about you, in order to verify that we have correctly paid a Benefit