Overseas Student Health Cover Rules

Effective 1 June 2020

A. Introduction

A.1 Rules Arrangement

These Overseas Student Health Cover Rules are the Rules under which we agree to provide you with Overseas Student Health Cover. 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**). We provide Overseas Students with Overseas Student Health Cover under a Deed with the Commonwealth of Australia (ABN 83 605 426 759 as represented by the Department of Health (**Department**)) (**Deed**).

A.2.2 Nothing in these Rules will be inconsistent with the Deed, which will prevail to the extent of any inconsistency.

A.3 No Discrimination

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

A.4 Changes to these Rules

A.4.1 We will give or direct you to a copy of the Rules when you first obtain a Policy and otherwise on request.

A.4.2 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.4.3 A change to the Rules may be a change to any or all of the Rules, Treatments Covered or Benefits payable in relation to a Policy.

A.4.4 We will give you reasonable prior notice of any change to the Rules that would be detrimental to an Adult Insured Person. Where there is more than one Adult Insured Person on the Policy, we may provide such notice to just one of those Adults, such as the Policy Holder.

A.4.5 A notice under this Rule may be given in a publication made general available to Policy Holders.

A.5 Complaint Handling

A.5.1 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.5.2 Notwithstanding the above, you may at any time contact the Ombudsman with a complaint about your Policy.

A.6 Notices

A.6.1 You must notify us of any changes to your personal and contact details.

A.6.2 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).

B. Definitions

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

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.

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

Allied Health Practitioner means a person who is registered with a National Registration and Accreditation Scheme implemented by the Australian Health Practitioner Regulation Agency (AHPRA), or equivalent.

Allied Health Services means services provided by an Allied Health Practitioner.

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, from 1 July 2016, 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.

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

Bridging Visa means a temporary visa granted under the *Migration Act 1958* (Cth).

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.

Commencement Date means the later of the date of issue of your policy or the start date of your policy as indicated on your application form.

Condition, depending on the context, 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.

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.

Country of Origin means a person's country of birth or to which they hold a passport, other than Australia.

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.

Department means the Department of Health of the Australian Government.

Dependent means a person who is a:

(a) Partner of the Policy Holder; or

(b) child or step-child of a Policy Holder who is unmarried and has not turned 18.

Dependent Child means a Dependent who is a child or step-child of a Policy Holder who is unmarried and has not turned 18.

DHA means the Department of Home Affairs, formerly known as the Department of Immigration and Border Protection.

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 gender, race, sexual orientation or religious belief of a person; or

(c) the age of a person; or

(d) where a person lives; or

(e) 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

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

(g) 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.

Emergency Treatment means:

(a) for the purposes of paying ambulance Benefits, Treatment given because there is reason to believe that the patient's life may be in danger or the patient should be attended to without undue delay; and otherwise

(b) Treatment of any of the following conditions:

i. a condition presenting the risk of serious morbidity or mortality and requiring urgent assessment and resuscitation;

ii. suspected acute organ or system failure;

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

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

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

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

vii. acute significant haemorrhaging which requires urgent assessment and Treatment; or

viii. a condition that requires immediate Hospital admission to avoid imminent morbidity or mortality.

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.

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

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-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 Private Health Insurance (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 the 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.

In-patient means a person admitted at a Hospital.

In-patient Medical Benefits means benefits payable with respect to medical costs incurred during admission to Hospital.

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 Dependent.

Insurer means a provider of health insurance to Overseas Students.

Life Altering Illness/Injury means an illness considered to be a serious medical condition leading to a reduction in life expectancy to less than 12 months, a requirement for ongoing care support or continuous inpatient hospitalisation, or any other deficit or health care need as assessed by a Medical Practitioner appointed by Bupa as warranting support for repatriation.

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.

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

Medicare Benefit means a Medicare benefit under Part II of the *Health Insurance Act 1973* (Cth).

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

Medical Treatment means Treatment provided by a Medical Practitioner.

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

Minimum Benefits means the benefit amount equivalent to the amount that the Insurer would have to pay in accordance with the PHI Act.

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

Mortal Remains means the body of the deceased person for the purposes of Repatriation benefits. Does not include cremation or ashes of a deceased person.

New Policy means a new Policy with Bupa.

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

(a) acute care; or

(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 a default benefit declared by the relevant Minister for Nursing Home Type Patients who are Overseas Students, from time to time.

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

Ombudsman means the Private Health Insurance Ombudsman appointed under Part IID of the Ombudsman Act or equivalent.

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

Out-patient means a person who is not admitted to Hospital.

Out-patient Medical Costs means fees charged for medical treatment provided to you as an Out-patient in a hospital out-patient clinic or by a doctor or specialist in private practice anywhere in Australia (including general practitioners (GPs) and includes most diagnostic tests recognised by Medicare (e.g. pathology and radiology).

Out-of-pocket Expenses means costs in excess of the relevant benefit payable under your Cover for a relevant service. You are liable for expenses not covered for a treatment or service or when a minimum or set benefit applies under your Cover.

Overseas Student means a:

(a) person who holds a Student Visa; or

(b) person who:

i. has applied for a Student Visa; and

ii. holds a Bridging Visa; and

iii. immediately before being granted the Bridging Visa, held a Student Visa.

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.

Pharmaceutical Benefits Schedule (PBS) co-payment fee means the fee set by the Australian Government which you may pay in order to obtain benefits for a PBS item under your Cover.

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

PHI Prostheses Rules means the Private Health Insurance (Prostheses) Rules 2007 (Cth).

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

Policy means an overseas student health cover policy.

Policy Holder means an Overseas Student who is the holder of a Policy.

Pre-existing Condition means where an Insured Person has an ailment, illness or condition, and in the opinion of a Medical Practitioner appointed by Bupa, the signs or symptoms of that condition existed at any time in the period of 6 months ending on the later of the day on which the Insured Person arrived in Australia or 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. Arrival in Australia means the time the Overseas Student is first in Australia and holds a Student Visa.

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 Insurer means a body that is registered under Division 3 of Part 2 of the PHI Supervision Act.

Private Practice means a health care practice operating on an independent and self-supporting basis either as a sole trader, partnership or group practice but not under an agreement with, or the subsidy by, another party 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 single or 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.

A **Product** comprises all the Policies that:

(a) Cover the same Treatments;

(b) provide Benefits worked out in the same way; and

(c) have the same Product Rules.

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

Product Schedule means the Product Schedule to these Rules, applying from time to time.

Product Specification means a Product Specification contained in the Product Schedule.

Prostheses List means the list of prostheses contained in the PHI Prostheses Rules.

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

Recognised Practitioner means a health care practitioner other than a Medical Practitioner in respect of whom we will pay Benefits for Treatment rendered 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.

Restricted Cover Period (**RCP**) is a fixed period of time during which we will pay only Minimum Benefits for eligible Claims in relation to the relevant Treatment. Minimum Benefits apply when you acquire or transfer to a New Policy.

Rules means these “Overseas Student Health Cover Rules” including the general terms, Schedules and Product Rules.

State or Territory means a State or Territory of Australia.

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.

Student Visa means a visa entitling a person to reside in Australia for the purposes of studying, as permitted by Australian law.

Terminally Ill means, someone with a life expectancy of less than 6 months as diagnosed by a Medical Practitioner and determined by a Medical Practitioner appointed by Bupa, after consideration of any relevant clinical information.

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

TGA Approved means an item that has been registered on the Australian Register of Therapeutic Goods.

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 means the time when you are not covered for a particular service.

C. General conditions

C.1 Policy Holders

C.1.1 A person who is aged 17 years or older may apply to become a Policy Holder.

C.1.2 A Policy Holder, one other Adult and one or more Dependents 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) add or remove 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 Policy consisting of either:

(a) Cover for Hospital Treatment; or

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

C.1.7 A Policy Holder may not acquire or have more than one of our Products at the same time.

C.2 Eligibility for Membership

C.2.1 You are only eligible to be Covered under a Policy with us only if you are:

(a) not already Covered by an equivalent or corresponding Policy with another Insurer;

(b) a natural person who is currently and legally visiting Australia;

(c) not an Australian permanent resident with full access to Medicare; and

(d) required to hold Overseas Student Health Cover to meet Student Visa requirements.

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

C.3 Dependents

Despite Rule C2.1, Bupa may, in its sole discretion, allow a Dependent Child to be joined on a Policy Holder's Policy where the Dependent Child is already Covered under another Policy (with Bupa or another Insurer) provided the Policy Holder is the parent or legal custodian of the Dependent Child. Any Benefits paid under the other Policy for such Dependent Child 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 licence or current passport. We may accept other forms of proof of age at our discretion;

(c) 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 about 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 and otherwise comply with these Rules.

C.4.4 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. All cheques and non-cash payments will be sent to the Policy Holder;

(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 or special offers (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 Commencement Date or the date you arrive in Australia, whichever is the later; or an agreed later date, provided all required Premiums have been paid and enrolment procedures completed to our satisfaction; and

(b) continues for the duration of your Student Visa, unless the Policy 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 Treatment 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.

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 A Restricted Cover Period may apply when you acquire a New Policy.

C.6.6 See Rule F for details about Waiting Periods and Restricted Cover Periods.

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.7 Cancellation and Refunds

C.7.1 A Policy Holder may cancel a Policy and we will refund any applicable Premiums after receiving the refund application where the Policy Holder provides evidence to our reasonable satisfaction that he or she:

(a) has not come to Australia to take up studies, in which case we will refund the full amount of the Premium paid;

(b) has paid the Premium based on an extended stay but the DHA has not granted an extension of authorised stay, in which case the Policy may be cancelled and Premiums refunded in respect of that (non-authorised) extension;

(c) is obliged to cease studies and leave Australia before the end of a period of approved stay for reasons beyond his or her control, in which case we will refund an amount in respect of the balance of Cover for which Premiums have been paid;

(d) has been granted permanent residence in Australia, or an Australian visa (other than a Student Visa), in which case we will refund an amount in respect of the balance of Cover for which Premiums have been paid from the date that permanent residence or other visa was granted;

(e) was not resident in Australia for a continuous period of 3 months or more whilst holding a valid Student Visa;

(f) had Cover with another Insurer during the period Covered by us.

C.7.2 We may provide to the DHA the name and contact details of a Policy Holder to whom we have refunded Premiums and who has cancelled his or her Policy.

C.8 Termination of Membership

C.8.1 We may only refund Premiums in the circumstances outlined in clause C7.1.

C.8.2 If required by law, 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).

D. Premiums

D.1 Premium Payments

D.1.1 The Premiums for your Product are determined by us annually or as otherwise permitted under the Deed.

D.1.2 A Premium is paid once we receive it from you.

D.2 Premium Rate Changes

Subject to these Rules and the Deed, we may adjust the Premiums for your Product. Any such change will not affect your Premiums to the extent you have already paid for your Cover.

E. Benefits

E.1 General conditions

E.1.1 The Rules 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 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.1.5 We will not pay Benefits:

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

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

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

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

(e) Treatment of an experimental nature; or

(f) for any Treatment given to you at a time when you do not hold an appropriate visa permitting you to enter or to remain in Australia.

E.1.6 Benefits will be determined based on the State of Residence of the Insured Person who received the Treatment.

E.2 Hospital and General Treatment

E.2.1. Subject to these Rules, we will pay Benefits for the following types of Treatment. The amount of a given Benefit will be equivalent to at least the rate (if any) set out below:

(a) "out-of-hospital" medical services (medical services provided when you are not admitted to Hospital) – the benefit amount as listed in the MBS;

(b) "in-hospital" medical services (medical services provided when you are admitted to Hospital) – 100% of the MBS Fee;

(c) services in a public Hospital constituting:

i. services provided when admitted in shared ward accommodation; or

ii. same day services; or

iii. accident and emergency services; or

iv. outpatient medical and post-operative services:

the rate determined by State and Territory health authorities for services charged to a patient who is not an Australian resident;

(d) surgically implanted prostheses – the rate for "no gap prostheses" and "gap permitted prostheses" as listed in the PHI Prostheses Rules;

(e) services provided when admitted to a private Hospital or registered day Hospital facility – 100% of the charges for all insurable costs raised by an Agreement Hospital with a minimum of shared ward accommodation;

(f) pharmaceutical items prescribed by a Medical Practitioner and dispensed by a registered Recognised Practitioner where the expense exceeds the equivalent of the current PBS patient contribution for general beneficiaries – up to $50 per pharmaceutical item, with a maximum benefit of $300 per calendar year per single membership and $600 per family membership; and

(g) ambulance services provided by or under an arrangement with an approved ambulance service when medically necessary for admission to Hospital or for Emergency Treatment – 100% of the charge for transport.

E.2.2 If available under your Policy, we will only pay Benefits for a private room in a public Hospital where such room meets the definition of "Private Room" set out in Rule B.

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 Benefits Not Payable

No Benefits are payable for:

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

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

(c) Treatment arranged in advance of the Policy Holder's or a Dependent

of the Policy Holder's arrival in Australia;

(d) transportation of a Policy Holder or a Dependent of the Policy Holder into or out of Australia in any circumstance;

(e) treatment which is covered by compensation or damages, entitlements or payments of any kind;

(f) elective Cosmetic Surgery; or

(g) Treatment rendered during a Waiting Period as detailed in Rule F.

F. Limitation of Benefits

F.1 Waiting Periods

F.1.1 Subject to Rule C6 or as otherwise stated in these Rules, Waiting Periods commence from the latter of the date that you enter Australia or the Commencement Date.

F.1.2 We will not pay Benefits for certain types of Treatment provided during a Waiting Period. The Waiting Periods apply to the specified types of Treatment are specified in the relevant Product Schedule.

F.2 How Waiting Periods Work

F.2.1 Subject to Rule F1, this Rule F2 sets out how we may apply Waiting Periods.

F.2.2 Where 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.2.3 Where you cease to be Covered as a Dependent 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.2.4 If you add a new Dependent to your Policy (other than a newborn), the new Dependent must serve any Waiting Periods and Restricted Cover Periods that apply under the Policy.

F.2.5 If you add a newborn Dependent 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 or Restricted Cover 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 or Restricted Cover Periods as long as the newborn is added within two (2) months of birth.

F.2.6 A Dependent who re-joins a Policy where one of the Dependent's parents is the Policy Holder will be deemed to have served the same Waiting Periods or Restricted Cover Periods as the Policy Holder.

F.3 Restricted Cover Periods

Subject to these Rules, a Restricted Cover Period may apply to specific types of Treatment.

G. CLAIMS

G.1 General

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

G.1.2 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.1.3 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.

PRODUCTS SCHEDULE

PART 1 – OVERVIEW OF ALL OVERSEAS STUDENT HEALTH COVER PRODUCTS

1. List of Overseas Student Health Cover Products

The following products are Overseas Student Health Cover products:

Overseas Student Health Cover	Advantage Overseas Student Health Cover

2. Benefits

2.1 Hospital Treatments and Medical Benefits

The following Hospital and Medical Benefits apply in accordance with the relevant Product Specification.

HOSPITAL BENEFITS	
Covered Item	**Description**
Accommodation fees	Hospital accommodation, including overnight or same-day hospital stays Shared room or private room where available
Operating theatre, labour ward and critical care fees	Operating theatre, labour ward, and intensive care fees
Emergency department fees	Fees charged by a private or public hospital emergency department for attending the facility including administration fees.
In-patient allied health services	Services provided by an Allied Health Practitioner during hospital admission.
In-patient supplied pharmaceuticals	Medicines listed on the PBS Schedule and provided as part of an inpatient treatment.
Prostheses	Benefits for surgically implanted prostheses on Prostheses List.
IN-PATIENT MEDICAL BENEFITS	
In-patient Medical Expenses	Services provided by doctors, surgeons, anaesthetists, pathologists and radiologists in hospital.
In-patient diagnostic tests	Pathology and radiology tests where recognised by Medicare

OUT-PATIENT MEDICAL BENEFITS	
Medical services in private clinics and by providers	Treatment provided by doctors and specialists in private clinics, including services provided by: doctors, medical specialists, medical imaging providers and pathology providers.
Hospital Out-patient medical treatment	Treatment provided at a public hospital out-patient clinic, including Accident and Emergency, when the Insured is not an admitted patient.
Pharmaceuticals and medicines	Selected pharmacy items prescribed by a doctor or specialist which are TGA approved for the condition for which the item is being claimed.
Psychology, Counselling and Online-CBT	Psychology, counselling and online-CBT benefits provided by a Bupa recognised provider.
EMERGENCY AMBULANCE COVER AND OTHER BENEFITS	
Emergency Ambulance cover	Emergency transportation or on-the-spot treatment provided by a Bupa recognised ambulance provider.
Repatriation benefits	Repatriation to the Insured's country of origin if the Insured becomes Terminally Ill or suffers a substantial Life Altering Illness/Injury or for the return of Mortal Remains. Benefits are only payable once approved by Bupa. No repatriation benefits will be paid if, within six months prior to the date this policy commenced, the Insured was: - first diagnosed as Terminally Ill; or, - a reasonable person would have first become aware of the Terminal Illness; or - if the insured suffered a substantial Life Altering Illness /Injury

2.2 General Treatment

General Treatment Benefits are covered under an Overseas Student Health Cover product only if listed in the relevant Product Specification.

PART 2 – PRODUCT SPECIFICATION

Product 1 – Overseas Student Health Cover

1.1 Eligibility

On sale

1.2 Hospital Treatments and Medical Benefits

1.2.1 Benefit Limit

Covered Item	Benefit Limit
HOSPITAL COSTS – When admitted to a Members First or Network private hospital or to a public hospital in Australia, in most cases you will be covered for in-hospital charges including:	
Accommodation fees	Covered in full, except for services where Restricted Cover or an exclusion applies.
Operating theatre, labour wards and critical care fees	Covered in full, except for services where Restricted Cover or an exclusion applies
Emergency department fees	Covered in full
In-patient allied health services	Covered in full, except for services where an exclusion applies
In-patient supplied pharmaceuticals	Covered in full except for services where an exclusion applies and as otherwise stated below: **Note: Other medicines (including high cost drugs)** may not be covered or only partially covered. **Cost of pharmaceuticals supplied upon discharge** from hospital will not be covered under In-patient supplied pharmaceutical. In some circumstances, discharge medication may be covered under Out-patient Medical Benefit.
Prostheses	Covered up to the relevant amount on the Prostheses List except for services where an exclusion applies. If the charge is greater than the minimum prostheses benefit, the Insured will have to pay the difference between the minimum benefit and the charge incurred.
IN-PATIENT MEDICAL BENEFITS	
In-patient medical expenses	Up to 100% of MBS fee, except for services where an exclusion applies
In-patient diagnostic tests	Covered in full when performed by contracted providers. Tests by non-contracted providers at 100% of MBS fees.
OUT-PATIENT MEDICAL BENEFITS	
Medical services in private clinics and by providers	Up to 100% of MBS fee, except for services where an exclusion applies

Hospital out-patient medical treatment	Up to 100% of MBS fee, except for services where an exclusion applies
Pharmaceuticals and medicines	Selected pharmacy items including discharge medication. You receive up to $50 per script item, up to a maximum of $300 per person ($600 per family) per calendar year, after you pay the PBS patient co-payment fee. This is provided the item's usage is approved by the TGA
Psychology, Counselling and Online-CBT	Not covered under this product.
EMERGENCY AMBULANCE COVER AND OTHER BENEFITS	
Emergency Ambulance cover	Unlimited for emergency transportation
Repatriation benefits	Not covered under this product.

1.2.2 Excess

Nil

1.2.3 Restricted Cover

In accordance with F.4 of these Overseas Student Health Cover Rules, Restricted Cover applies for the duration of this cover for the following services:

- Podiatric surgery (provided by an accredited podiatric surgeon)

Please Note – Restricted Cover does not apply when admitted to a Public Hospital.

1.2.4 Exclusions

In addition to Rule E.4 of the Overseas Student Health Cover Rules, the following services are not covered under this product:

- Assisted reproductive services
- Elective cosmetic surgery.

1.2.5 Waiting periods

In accordance with Rules F.1 and F.2, the following Waiting Periods apply:

Pre-existing conditions, ailments, or illnesses of a psychiatric nature	2 months
All other pre-existing conditions, ailments, or illnesses	12 months
Pregnancy and birth	12 months

Subject to the above, no Waiting Periods apply for conditions, ailments or illnesses that are not Pre-Existing Conditions.

Waiting periods also do not apply when treatment is required as a result of an accident sustained after joining or treatment which is defined as Emergency Treatment.

1.3 General Treatment Benefits

Not covered under this Product.

Product 2 – Advantage Overseas Student Health Cover

2.1 Eligibility

On sale

2.2 Hospital Treatments and Medical Benefits

2.2.1 Benefit Limit

Covered Item	Benefit Limit
HOSPITAL COSTS – When admitted to a Members First or Network private hospital or to a public hospital in Australia, in most cases you will be covered for in-hospital charges including:	
Accommodation fees	Covered in full, except for services where Restricted Cover or an exclusion applies.
Operating theatre, labour wards and critical care fees	Covered in full, except for services where Restricted Cover or an exclusion applies
Emergency department fees	Covered in full
In-patient allied health services	Covered in full, except for services where an exclusion applies
In-patient supplied pharmaceuticals	Covered in full except for services where an exclusion applies and as otherwise stated below: **Note: Other medicines (including high cost drugs)** may not be covered or only partially covered. **Cost of pharmaceuticals supplied upon discharge** from hospital will not be covered under In-patient supplied pharmaceutical. In some circumstances, discharge medication may be covered under Out-patient Medical Benefit.
Prostheses	Covered up to the relevant amount on the Prostheses List except for services where an exclusion applies. If the charge is greater than the minimum prostheses benefit, the Insured will have to pay the difference between the minimum benefit and the charge incurred.
IN-PATIENT MEDICAL BENEFITS	
In-patient medical expenses	Up to 100% of MBS fee, except for services where an exclusion applies
In-patient diagnostic tests	Covered in full when performed by contracted providers. Tests by non-contracted providers at 100% of MBS fees.
OUT-PATIENT MEDICAL BENEFITS	
Medical services in private clinics and by providers	Up to 100% of MBS fee, except for services where an exclusion applies
Hospital out-patient medical treatment	Up to 100% of MBS fee, except for services where an exclusion applies

Pharmaceuticals and medicines	Selected pharmacy items including discharge medication. You receive up to $60 per script item, up to a maximum of $600 per person ($1200 per family) per calendar year, after you pay the PBS patient co-payment fee. This is provided the item's usage is approved by the TGA
Psychology, Counselling and Online-CBT	You'll receive up to $75 per consultation for psychology, up to $40 for counselling and online-CBT, up to a maximum of $150 per person per calendar year.
EMERGENCY AMBULANCE COVER AND OTHER BENEFITS	
Emergency Ambulance cover	Unlimited for emergency transportation
Repatriation benefits	Up to $100,000 if the Insured becomes Terminally Ill or suffers a Life Altering Illness/Injury. Up to $10,000 for the return of Mortal Remains.

2.2.2 Excess

Nil

2.2.3 Restricted Cover

In accordance with F.4 of this Overseas Student Rule, Restricted Cover applies for the duration of this cover for the following services:

- Podiatric surgery (provided by an accredited podiatric surgeon)

Please Note – Restricted Cover does not apply when admitted to a Public Hospital.

2.2.4 Exclusions

In addition to Rule E.4 of the Overseas Student Health Cover Rules, the following services are not covered under this product:

- Assisted reproductive services
- Elective cosmetic surgery.

2.2.5 Waiting periods

In accordance with Rules F.1 and F.2, the following Waiting Periods apply:

Pre-existing conditions, ailments, or illnesses (excluding psychiatric)	12 months
Pregnancy and birth	12 months

No Waiting Periods apply for conditions, ailments or illnesses that are not Pre-Existing Conditions.

Waiting periods also do not apply when treatment is required as a result of an accident sustained after joining or treatment which is defined as Emergency Treatment.

2.3 General Treatment Benefits

Not covered under this Product.