BUPA AUSTRALIA PTY LTD

OVERSEAS VISITORS RULES

GENERAL CONDITIONS

Effective from 1 September 2015
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A INTRODUCTION

A1 Rules Arrangement
A1.1 These rules consist of the:
  (a) General Conditions; and
  (b) Schedule of Tables and pricings; and
  (c) Schedule of Contribution Rates
A1.2 Terms which are defined in Rule B2.1 appear in *italics* when used in these rules.

A2 Health Benefits Fund
A2.1 The Company, BUPA Australia Pty Ltd, conducts *health insurance business* and *health related business* under the *PHI Act*.
A2.2 The rules are the terms of the *policy* between the *Company* and each *policy holder* for the provision of *hospital treatment* or *general treatment*.

A3 Obligations to Fund

A4 Governing Principles

A5 Use of Funds
A5.1 The *Company* may apply the assets of the *health benefits fund* in accordance with the *PHI Act*.
A5.2 The *Company* may debit to the *fund* amounts related to its *health insurance business* and *health related business* in accordance with the *PHI Act*.

A6 No Improper Discrimination
A6.1 When making decisions in relation to a person insured under an *overseas visitor’s health insurance policy*, the *Company* must disregard the following matters:

1. the suffering by the person from a chronic disease, illness or other medical condition or from a disease, illness or other medical condition of a particular kind;
2. the frequency with which the person needs *hospital treatment* or *general treatment*;
3. the amount, or extent, of the benefits to which the person becomes, or has become, entitled during a period under an *overseas visitors health insurance policy* (except to the extent allowed under section 66-15 of the *PHI Act*);
4. the gender, race, religious beliefs or sexual orientation of the person;
5. where a person lives, except to the extent allowed under the *PHI Act*; or
6. any other characteristic of a person (including, but not just, matters such as the occupation or leisure pursuits) that are likely to result in an increased need for *hospital treatment* or *general treatment*.
A7 Changes to Rules

A7.1 The Company may change the rules on notice to the policy holder at any time and in accordance with the PHI Act with effect as set out in the relevant notice, whether or not premiums have been paid in advance.

A7.2 The Company must:
   (1) give reasonable advanced notice of any change to the rules that would be detrimental to the adult insured; and
   (2) give a newly insured person an up to date copy of the relevant details about what the policy covers and how benefits are provided, and a statement identifying the referable health benefits fund when they join.

A change to the rules means a change to the amount of premiums payable in respect of an overseas visitor’s health insurance policy, the treatments covered by such a policy or a benefit for treatment covered by such a policy.

If more than one adult is insured under a single overseas visitor’s health insurance policy the Company need only provide this information to one of the adults on the overseas visitor’s health insurance policy.

A7.3 Notification in Publications

The Company may provide details of changes to these rules by providing details of the change in any publication generally made available to policy holders.

A8 Dispute Resolution

A8.1 For any queries regarding an overseas visitors health insurance policy or the Company’s Rules, please contact the Company’s customer service consultants or email the Company’s internet response team. The Company’s consultants will endeavor to resolve any issues or refer the query to the person in the Company’s organisation best placed to deal with it.

A8.2 An insured person/s may submit complaints through the Company's complaint mechanism by telephone or in writing to the Company’s Customer Relations Manager. The Company will address all such complaints and at all times endeavor to operate in the best interests of the individual policy holder after taking into account these rules, governing laws and the best interests of all policy holders.

A8.3 If the policy holder is unhappy with the resolution provided under Rule A8.2, the policy holder may contact the Private Health Insurance Ombudsman for assistance. The Private Health Insurance Ombudsman has been set up by the Commonwealth Government to deal specifically with inquiries and complaints about any aspect of private health insurance and may be contacted on 1800 640 695.

A8.4 Notwithstanding the above, a policy holder, may at any time directly contact the Private Health Insurance Ombudsman about a complaint or otherwise.

A9 Notices

A9.1 Copies of these rules are available to policy holders upon request.

A9.2 Correspondence

The Company will send written notice, where required, to the address last supplied by the policy holder, except as otherwise agreed. Such notice given will be effective even if the policy holder has left the address last notified.
A10 Winding Up

A10.1 The Company’s health benefits fund may be terminated in accordance with the PHI Act.

A11 Other

(1)
B INTERPRETATION AND DEFINITIONS

B1 Interpretation
B1.1 The following rules shall apply to the interpretation of these rules:

(1) These rules shall be interpreted so as not to conflict with the Company's Constitution;

(2) Any terms used in these rules and also in the Constitution shall have the same meaning in these rules as they bear in the Constitution;

(3) Unless otherwise specified, any terms used in these rules defined in the Private Health Insurance Act 2007 (Cth) or in any associated legislation or rules or the Health Insurance Act 1973 (Cth) have the same meaning in these rules;

(4) The masculine gender shall include, where applicable, the feminine gender;

(5) Words in the singular number shall include the plural and words in the plural shall include the singular.

(6) A reference to any legislation will be taken as a reference to that legislation as amended from time to time.

(7) A reference to a State includes a reference to a Territory.

B2 Definitions
B2.1 In these rules unless the intention appears to be otherwise:

(1) "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 body, which requires immediate medical advice or treatment from a registered practitioner other than the policy holder.

(2) "Accident Benefit" means benefits in relation to any Accident occurring after commencement of the overseas visitors health insurance policy resulting in urgent hospital attention as soon as practicable after the Accident;

(3) "adult" means a person who is not a dependent child or a dependent child non-student.

(4) “AMA fees” means the list of Medical Services and Fees provided by the Australian Medical Association to its members.

(5) “Applicable Benefits Arrangement” has the meaning given to an applicable benefits arrangement within the meaning of the National Health Act 1953 as in force before 1 April 2007.

(6) “Associated Professional Services” means professional services rendered to a policy holder by a medical practitioner while undergoing hospital treatment.

(7) “Australia” for the purposes of these Fund Rules:

(a) includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling) Islands and the Territory of Christmas Island, but

(b) excludes Norfolk Island and other Australian external territories;
(8) "Australian Resident" has the same meaning as that in the Health Insurance Act, that is, a person who resides in Australia and who is:

(a) an Australian citizen; or
(b) the holder of a valid permanent entry permit; or
(c) a New Zealand citizen who is lawfully present in Australia; or
(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 Government believes there are special circumstances relating to either asylum seekers, refugees, relatives of permanent entry permit holders, people authorised to work in Australia, or compassionate, humanitarian grounds.

(9) “Company” means BUPA Australia Pty Ltd.

(10) “Cosmetic Surgery” means surgical procedures:

(a) listed in the Plastic and Reconstructive Section (Subgroup13) of the Commonwealth Medicare Benefits Schedule that:
   (i) are not clinically relevant; or
   (ii) do not meet the eligibility conditions for the payment of Medicare benefits; or
(b) of a plastic or reconstructive nature that are not listed in the Commonwealth Medicare Benefits Schedule.

(10A) “Country of Origin” means in relation to an insured person, the country of their birth or to which they hold a passport, other than Australia;

(11) “cover” in relation to an insurance policy has the meaning set out in section 69-5 of the PHI Act.

(12) "dependant child" means a person who does not have a partner and is;
   (i) aged under 21; or
   (ii) is receiving a full time education at a school, college or university recognised by the Company and who is not aged 25 or over

(13) “dependant child non-student” means a dependent child who:
   (i) is aged between 18 and 24 (inclusive); and
   (ii) is not receiving full-time education at a school, college or university.

“dependant” means – dependant child and dependant non student.
B2 Definitions – (contd)

(14) “Emergency” means:

(a) For the purposes of emergency benefits in non contracted hospitals, an emergency is when immediate hospital treatment is required for a patient:
   - at risk of serious morbidity or mortality and requiring urgent assessment and resuscitation; or
   - suffering from suspected acute organ or system failure; or
   - suffering from an illness or injury where the viability of function of a body part or organ is acutely threatened; or
   - suffering from a drug overdose, toxic substance or toxin effect; or
   - experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
   - suffering from severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
   - suffering acute significant haemorrhaging and requiring urgent assessment and treatment.

(b) For the purposes of ambulance benefits, an emergency is when there is reason to believe that the patient’s life may be in danger or the patient should be attended to without undue delay.

(15) "general treatment" has the meaning set out in section 121-10 of the PHI Act and includes ambulance services associated with the provision of treatment intended to manage or prevent a disease, injury or condition to an insured person.

(16) "health benefits fund" has the meaning set out in section131-10 of the PHI Act.

(17) “health care provider” means:

(a) a person who provides goods and services as, or as part of, hospital treatment or general treatment; or

(b) a person who manufactures or supplies good provided as, or as part of hospital treatment or general treatment.

(18) "Health Insurance Act" means the Health Insurance Act 1973 (Cth) as amended from time to time.

(19) "health insurance business” has the meaning set out in Division 121 of the PHI Act.

(20) "health related business” has the meaning set out in section 131-15 of the PHI Act.

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

(22) "hospital cover" has the meaning set out in section 34-15 of the PHI Act.

(23) "hospital-substitute treatment” has the meaning set out in section 69-10 of the PHI Act.

(24) "hospital treatment” has the meaning set out in section 121-5 of the PHI Act.

(25) “improper discrimination” has the meaning set out in section 55-5 of the PHI Act.

(26) “Insured Person” means:

(a) a policyholder;

(b) a partner named on a policy;

(c) a dependant named on a policy;
(27) “insurer” means a private health insurer or other insurer operating in Australia who provides insurance for overseas visitors.

(28) “insurance” means insurance to which paragraph 51(xiv) of the Constitution applies and “insure” has a corresponding meaning.
B INTERPRETATION AND DEFINITIONS – (contd)

B2 Definitions – (contd)

“MBS Fees” means the Medicare Benefits Schedules, which list Medicare services subsidised by the Australian government.

(29) "medical practitioner" means a medical practitioner within the meaning of the Health Insurance Act.

(30) “medicare benefit” means a medicare benefit under Part II of the Health Insurance Act.

(31) “medicare eligibility day” has the meaning set out in subsection 34-25(3) of the PHI Act.

(32) “Minister” means the Federal Minister or his or her delegate with the powers vested in the Minister by the PHI Act.

(33) “Nursing Home Type Patient” has the meaning set out in the Private Health Insurance (Benefit Requirements) Rules.

(34) “Nursing Home Type Patient’s Benefit” means the default benefit declared by the Minister from time to time for Nursing Home Type Patients who are overseas visitors. Where the Minister has not declared a default benefit for Nursing Home Type Patients who are overseas visitors, Nursing Home Type Patient’s Benefit means the default benefit declared by the Minister for Nursing Home Type Patients who are entitled to Medicare benefits.

(36A) "Obstetric Patient" means a patient who is hospitalised in to the management of pregnancy, labour and childbirth, including ante and post-natal care including but not restricted to Obstetrics-related Services

(35) “overseas” has the meaning given to it in section 34-30 of the PHI Act.

(36) “overseas visitors health insurance product” is any product that is set out in the Schedule of Overseas Products and Benefits under these rules

(37) “overseas visitors health insurance policy” is any policy that is set out in the Schedule of Overseas Products and Benefits under these rules

(38) “Overseas visitor” is a person who does not reside in Australia and:
   a) Does not hold an Australian passport;
   b) Does not hold Australian citizenship; and
   c) Holds an appropriate visa that permits entry into Australia

(39) “Partner" means a person of either sex with whom the insured person lives in a bona fide domestic relationship and includes a person to whom the contributor is legally married.


(41) “PHI Act” means the Private Health Insurance Act 2007 (Cth).

(42) "Private Health Insurance Ombudsman" means the Private Health Insurance Ombudsman appointed for the purposes of Part 6-2 of the PHI Act.
“Policy” means an overseas visitors health insurance policy.

"policy holder", of a health benefits fund means a holder of a policy that is referable to the Company.

"pre-existing condition" means where an insured person has an ailment, illness or condition, and in the opinion of a Medical Practitioner appointed by the Company, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under a policy issued by the Company or arrived in Australia.
B2 Definitions – (contd)

(46) "private health insurer" means a person registered under Part 4-3 of the PHI Act.

(47) "private health insurance arrangement" has the meaning set out in Schedule 1 of the PHI Act.

(48) "private health insurance policy" means an insurance policy that covers hospital treatment or general treatment or both (whether or not it also covers any other treatment or provides a benefit for anything else).

(49) "private practice" means a practice operating on an independent and self-sustaining basis either as a sole, 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. Practitioners in practice at public hospitals or any other type of publicly funded facility do not meet the guidelines of private practice.

(50) "product" has the meaning set out in subsection 63-5(2) of the PHI Act.

(51) “product rules” means rules applying to an overseas visitor health insurance product that are not inconsistent with the fund rules.

(52) “product subgroup” has the meaning set out in subsection 63-5(2A) of the PHI Act.

(53) “Prosthesis” means (except in the case of general treatment) an item that is implanted whilst in hospital and is a “listed prostheses” determined by the Minister as described in the Private Health Insurance (Prostheses) Rules. The list provides details of no gap prostheses and gap permitted prostheses, for which the Minister determines the minimum benefits payable. In relation to general treatment, a prosthesis is an external appliance or device approved by the Company, normally associated with a physical replacement of some part of the human body.

(54) “PBS” means the Pharmaceutical Benefits Scheme.

(55) “PBS item” means any drug listed in the Pharmaceutical Benefits Schedule.

(56) "recognised practitioner" means a practitioner other than a registered medical practitioner in respect of whom the Company will pay benefits for particular services rendered by that practitioner. The Company has sole and absolute discretion in determining whether an individual remains or becomes a recognised practitioner and which particular services the Company will pay benefits for in respect of any recognised practitioner.

(57) “restricted benefits” means the reduced benefits that apply for a service once the relevant waiting periods have been served, being the minimum default benefits determined by the Minister from time to time for that service.

(58) "rules", means the body of rules established by the Company that relate to the day-to-day operation of its health insurance business and (if any) health related business.

(59) "State of Residence" means the state in which the policy holder resides for the greatest period, either continuously or in broken periods, in any twelve-month period.

(60) “Terminally Ill” means, in the case of an insured person, diagnoses of a medical practitioner that the insured person has a life expectancy of less than 6 months;
(61) “TGA Approved” means an item that has been ‘registered’ on the Australian Register of Therapeutic Goods

(62) "transfer", in relation to a person, has the meaning set out in section 75-10 of the PHI Act.

(63) "transfer certificate" has the meaning set out in section 99-1 of the PHI Act.

(64) "waiting period" has the meaning set out in section 75-5 of the PHI Act.

B3 Other
C MEMBERSHIP

C1 General Conditions of Membership

C1.1 A person or persons may join as a policy holder in one of the following categories of insured groups:

(1) only one person;

(2) 2 adults (and no one else);

(3) 2 or more people, only one of whom is an adult;

(4) 3 or more people, only 2 of whom are adults;

(5) such other categories of insured groups as are permitted under the Private Health Insurance (Complying Product) Rules 2007 from time to time (including until 31 December 2008, a policy that covers dependant child non-students).

C1.1A Subject to Fund Rule C1.1B, in relation to an overseas visitor health insurance policy a policy holder is the only insured person authorized by the Company to perform all of the following:

(1) Change any of the details of the policy;

(2) Change the level of cover or level of cover(s);

(3) Apply to add or remove a person as dependent or a policy holder;

(4) Receive a benefit for an insured person;

(5) Terminate the policy.

C1.1B The Company will permit a policy holder to request in writing, or by any other means approved by the Company, that their partner or another person (nominated person) be treated as authorised to operate the policy as though the partner or the nominated person is the policy holder. The authority provided by the policy holder may be withdrawn by the policy holder at any time by notification to the Company in writing.

C1.1C The Company will treat the policy holder as responsible for ensuring that the premiums are paid and that the policy remains financial at all times
C1.2 The Company offers the following types of overseas visitor’s health insurance products:

(1) stand-alone products that only cover hospital treatment as set out in Schedule H;

(2) combined and pre-packaged products that consist of both hospital treatment and general treatment set out in Schedules J.

Policy holders can choose to take out a product from Schedule H and a product from Schedule I or Schedule J.

Policy holders are not permitted to take out more than one product that covers hospital treatment and/or one product that covers general treatment offered by the Company.

C2 Eligibility for Membership

C2.1 Except as otherwise approved by the Company, any person who is aged 17 or over may apply to become a policy holder of the Company’s overseas visitors health insurance products.

C2.2 A person may not be covered by an overseas visitor health insurance policy with the Company if that person has an equivalent or corresponding overseas visitor’s health insurance policy with another private health insurer.

C2.3 Eligibility to hold a Policy

(1) Subject to these rules, the Company will treat any natural person currently legally visiting Australia as eligible to be a policy holder; or registered as an insured person under a policy on any level of cover,

(2) Where an insured person is officially advised that their permanent Australian residency or Medicare entitlements have been granted from a date prior to the date of the advice, for the purposes of these rules, the permanent residency or Medicare entitlement is taken to be effective only from the date of the official advice.

(3) Once a policy holder becomes eligible for Medicare entitlements they are no longer eligible to purchase an overseas visitor health insurance policy.

C2.4 An insured person may only be covered under a policy in respect of the policy holder’s State of Residence.
C3 Dependants

C3.1 The Company may elect not to make an overseas visitor health insurance product available to a category of insured group that includes dependent children.

C3.2 Notwithstanding C2.2 of these rules, the Company may, at its absolute discretion, permit a policy holder to register as a dependant child, a person already registered as a dependant child on another policy (whether with the Company) or another private health insurer’s health benefits fund) provided that the policy holder is the parent of the person and has legal custody of the person. Any benefits paid under the original policy for such dependant child will be taken into account in calculating policy limits applicable to the policy holder’s level of cover.

C4 Membership Applications

C4.1 A policy holder, upon joining, must give complete information as required by the Company on all relevant matters relating to the policy holder and any other adults or dependants covered by the overseas visitor’s health insurance policy, including:

(1) proof of identity;

(2) proof of age such as, original birth certificate, current driver's license or current passport. At the Company's discretion, other forms of proof of age may be accepted;

(3) details of any existing illness, ailment or injury;

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

C4.2 A policy holder must inform the Company as soon as reasonably practical after a change in any information provided at the time of joining.

C4.3 Insured persons agree to be bound by these rules, when they take out an overseas visitor’s health insurance policy with the Company.

C4.4 The Company must not refuse to insure a person under an overseas visitor’s health insurance policy if to do so would result in improper discrimination. An application to be covered under an overseas visitor health insurance product may not be refused, subject to the applicant and all the intended insured persons satisfying all relevant rules.

C4.5 When a policy holder takes out cover with the Company’s health benefits fund the policy holder consents to the collection, use and disclosure by the Company of the personal and health information of all insured persons covered by the policy in accordance with the Company’s privacy policy available online or calling the Company including as described below:

(a) The Company will only collect health and personal information about the policy holder, and other insured persons covered by the overseas visitor’s health insurance policy that is necessary for the purposes of providing the appropriate cover and verifying that it has been provided according to law and with the Company’s overseas visitors health insurance policies. This may include health information collected about a policy holder from health service providers. If the information a policy holder gives to the Company is not complete or accurate, the Company may not be able to provide a policy holder with the cover that they request.

(b) The Company may need to disclose the health or personal information of a policy holder to other parties, such as health care providers and associations, business partners, government authorities, other health funds or other industry bodies. The Company may also use information for internal purposes, such as staff training, claims auditing and compliance monitoring.
(c) The policy holder who arranges and is responsible for payment (as notified to the Company) is responsible for ensuring every insured person covered by the overseas visitors health insurance policy is aware that the Company may collect, use and disclose their personal and health information for the purposes of providing their cover and verifying that appropriate benefits are paid.
C4 Membership Applications – (contd)

(d) An insured person covered by overseas visitors complying health insurance policy aged 17 and over must complete a ‘Keeping it Confidential’ form 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 who arranges and is responsible for payment (as notified to the Company).

(e) Each insured person covered by the overseas visitor’s health insurance policy is entitled to request reasonable access to his or her personal and health information. The Company reserves the right to charge an administration fee for collating such information.

(f) If an insured person covered by the overseas visitors health insurance policy does not consent to the collection or the way the Company uses and discloses their personal and health information, the Company may not be able to provide that person with cover.

(g) The Company may contact any insured person covered by the overseas visitors health insurance policy about new products or services or special offers (including by telephone, email or SMS when these details are provided to the Company as contact details) from any time after the date of joining for an indefinite period. If an insured person does not wish to receive information about new products or services or special offers they may opt out at any time by calling the Company.
C MEMBERSHIP – (contd)

C5 Duration of Membership

C5.1 A person's insurance policy shall commence from the later of:

(1) the date that person applies to take out cover; or

(2) a later selected commencement date as agreed by the insured person and the Company provided that they have paid the first month’s premium and all enrolment procedures are completed to the satisfaction of the Company.

C5.2 An insurance policy continues until the date the policy holder notifies the Company in writing that the policy holder wishes to cease the policy under rule C7, or the Company notifies the policy holder that the policy has ceased under rule C8.

C6 Transfers

C6.1 When a policy holder changes his or her level of cover with the Company, waiting periods apply to any higher benefits not covered on the previous level of cover.

C6.2 If a person transfers to an overseas visitors health insurance policy (the new policy) from another overseas visitors health insurance policy (the old policy) with the Company or with another insurer, the waiting period that applies to that person will be no longer than:

(1) for a benefit for hospital treatment or hospital-substitute treatment that was not covered under the old policy - the period allowed under section 75-1 of the PHI Act; and

(2) for a benefit for hospital treatment or hospital-substitute treatment that was covered under the old policy - the balance of any unexpired waiting period for that benefit that applied to the person under the old policy.

If a higher excess or higher co-payment applied under the old policy than applies under the new policy, for a benefit for hospital treatment or hospital-substitute treatment, any period during which the higher excess or higher co-payment continues to apply but will be no longer than the waiting period allowed under section 75-1 of the PHI Act.

C6.3 If a policy holder takes out another overseas visitor health insurance policy with the Company’s health benefits fund, the Company may apply Restricted Benefits to any hospital treatment or hospital-substitute treatment.

C6.4 The Company will take into account any benefits paid by a policy holder in respect of any previous overseas visitor health insurance policy held with the Company or any other private health insurer.

C6.5 For the purposes of this rule C6, a person transfers to a policy (the new policy) from another policy (the old policy) if:

(1) either:

   (a) the person is covered under the old policy at the time the person becomes covered under the new policy; or

   (b) the person ceased to be covered under the old policy no more than 7 days, or a longer number of days allowed by the new policy’s private health insurer for this purpose, before becoming insured under the new policy; and

(2) the old policy is an overseas visitor health policy; and

(3) the person’s premium payments under the old policy were up to date at the time the person became covered under the new policy.
C MEMBERSHIP – (contd)

C7 Cancellation of Membership

C7.1 Subject to Rules C7.4 and C7.4A, a policy holder may cancel his or her policy by advising the Company in writing or as otherwise agreed by the Company. The date of cessation of the policy will be the later of:

(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 no date of cessation is elected by the policy holder, the date of cancellation will be the date to which the policy is paid.

C7.2 Where a policy holder wishes to cancel their policy before the paid to date, subject to Rules C7.4 and D1.2A, the Company will reimburse the policy holder premiums paid in advance, except for the first calendar month’s premium, which is non-refundable.

C7.3 Refunds under Rule C7.2 may incur an administration fee determined by the Company from time to time.

C7.4 A policy holder may not retrospectively cancel their policy.

C7.4A In the case of cancellation of a policy as the result of the death of an insured person (affected person), the Company will terminate the policy and refund any premiums paid, from the day after the affected person’s death.

C7.5 A policy holder may elect to cancel their policy within the first 30 days of commencement of their policy, and the Company will refund premiums paid in advance, except for the first calendar month of premiums in accordance with rule D1.2A. Where there has been a claim made under the policy within the first 30 days of commencement of the policy, the date of cessation will be the date of the most recent claim made under the policy.

C7.6 A dependant child, who has reached the age of 18, may remove themselves from a policy by advising the Company in writing. The date of cessation of the dependant child from the Policy will be the later of the date requested by the dependant child or the date of receipt by the Company of the relevant correspondence.

C8 Termination of Membership

C8.1 The Company may elect to terminate a policy, in whole or in part, on notice to the policy holder or an insured person, provided that in the case of an overseas visitor health insurance policy the grounds for such cessation do not contravene rule A6.

C8.2 The Company will give written notification of the reason for cessation to the policy holder.

C8.3 The Company will, if a person ceases to be an insured person under an overseas visitor’s health insurance policy and does not become insured under another policy of the Company, give the person a certificate under section 99-1 of the PHI Act within 14 days.

C8.4 The Company may terminate an insurance policy immediately in the following circumstances:

(a) If a policy is in arrears of two months or more in accordance with Rule D5.3; or

(b) if an insured person under a policy is repatriated (including repatriation of mortal remains) to his or her country of origin or is terminally ill and has returned to their country of origin, or

Or for any reason, at the discretion of the Company and in accordance with the PHI Act.

C9 Temporary Suspension of Membership

C10 Other

C9.1 A policy holder who has been covered under an overseas visitors health insurance policy with the Company Australia for at least two months may apply to the Company to suspend the policy in cases of overseas travel.
C9.2 The policy holder must provide overseas travel documents to verify departure and return dates.

C9.3 The Company will consider an application for a suspension to an overseas visitors health insurance policy where the application is made in the form prescribed by the Company from time to time and is submitted before the date of departure. The Company may also, acting in its complete discretion, consider an application made after the date of departure.

C9.4 If granted, the suspension of an overseas visitors health insurance policy will take effect from the day after departure or, if the Company, acting in its discretion, accepts an application made after the date of departure, from the date the policy holder contacted the Company to apply for the suspension.

C9.5 Suspension for overseas travel must be for a period of between one month and a maximum of nine months. A maximum of three overseas suspensions are allowed each calendar year and there must be a period of at least one month premium payments between suspensions.

C9.6 If no return date is stipulated by the policyholder, the maximum suspension period is nine months to retain continuity of cover.
D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Premiums are as set in the Schedule of Contribution Rates.

D1.2 A policy holder, shall at the time the policy holder first becomes insured under an overseas visitors health insurance policy, pay at least one calendar month's premiums in advance. For any subsequent payment, premiums are payable by the date they are due and must be paid for at least one calendar month in advance (unless premiums are paid by payroll deduction, in which case the minimum payment period is one week).

D1.2A The first calendar month of premium paid under an overseas visitors health insurance policy will not be refunded by the Company.

D1.3 A premium is paid to the Company only once it has been received by the Company from the policy holder.

D1.4 Where a policy holder’s State of Residence changes, the premiums payable to the Company will be adjusted so that the policy holder who arranges and is responsible for payment pays the premium for an overseas visitors health insurance policy applicable in the new State of Residence.

D2 Contribution Rate Changes

D2.1 The Company may adjust the premiums that apply to an overseas visitor’s health insurance policy.

D2.2 Policy holders that have paid any premiums for a period that ends after the date that a change in premiums becomes effective, may be adjusted to reflect the change in those premiums.

D3 Contribution Discounts

D3.1 The Company may only offer a discount to its policyholders from time to time.
D4 Arrears in Contributions

D4.1 A policy holder will be in arrears if premiums are not paid by the due date.

D4.2 If a policy holder is in arrears in respect of an overseas visitor’s health insurance policy, then benefits will be paid as if the policy holder is not in arrears for two months; provided a payment is made to cover the amount in arrears. The policy holder will not be entitled to receive any benefits after this two month has elapsed.

D4.3 The Company may cease a policy under a complying health insurance policy if the period of arrears exceeds two months.

D5 Other

D6.1 If a policy holder ceases to be covered by an overseas visitors health insurance policy, he or she will be entitled to receive a refund of any premiums paid in respect of the complying health insurance policy for the period after the date on which the policy holder ceases to be covered by that an overseas visitors health insurance policy (calculated on a pro rata basis) except for:

(a) any administration costs incurred by the Company; and
(b) the first calendar month of premium paid under the policy which is non-refundable.
E BENEFITS

E1 General Conditions

E1.1 The rules in force on the date a treatment is rendered to an insured person will determine whether the person is eligible for and the amount of benefits payable.

E1.2 Benefits for goods and services cannot exceed the actual charge for the goods and services received.

E1.3 Where the Company has paid an amount to a policy holder which was not then lawfully due to the policy holder as the result of an error, and the Company has informed the policy holder within 2 years of the date of payment, the Company shall be entitled to recover the amount from the policy holder.

E1.4 The Company may recover from the policy holder any benefit given where it is found that the information supplied on the enrolment form, claim form or any other official Company form is in error in any matter that may have affected the decision of the Company to pay benefits.

E1.5 The Company may offset any amounts recoverable under these rules against any benefits that would otherwise be payable.

E1.6 The Company may, in its sole discretion make ex-gratia payments in respect of claims that would not otherwise attract benefits under these rules.

E1.7 The Company shall not be liable to a policy holder for any losses, costs, damages, suits or actions arising through the provision of services to an insured person by any recognised practitioner.

E1.8 No insured person may receive benefits in respect of the same treatment from more than one policy of the Company.

E1.9 The Company will not pay any benefits where the product rules determine no payment is payable.

E1.10 Benefits in respect of a treatment will be determined on the basis of the residence of the insured person, who received the treatment.

E1.11 Benefits are not payable in respect of any services that are provided to an insured person during a period where the insured person does not hold an appropriate visa that permits them to enter or to remain in Australia.
E BENEFITS – (contd)

E2 Hospital Treatment

E2.1 Hospital benefits are only payable for hospital treatment provided by a person authorised by a hospital to provide hospital treatment.

E2.2 Hospital benefits for hospital treatment are not payable for any of the circumstances outlined in Rule E 4.

E2.3 The length of stay in hospital is calculated with reference to the date of admission to and the date of discharge from hospital.

E2.4 Medical benefits are payable by the Company for hospital treatment or hospital-substitute treatment covered by the overseas visitors health insurance policy where a Medicare benefit is payable for that treatment.

The Company may, from time to time, for the benefit of policy holders enter into agreements with hospitals (referred to as Members First/Network Agreement and Participating Hospitals) and medical practitioners (referred to as Medical Gap Scheme). The benefits that apply within these agreements may differ from those shown in these rules. Lists of such hospitals are available to policy holders upon request.

E2.6 For all overseas visitors’ health insurance policies that cover hospital treatment, the Company will pay the costs that a policy holder incurs for a PBS item received by an insured person under the policy while admitted to a hospital with which the Company has an agreement as outlined in rule E2.4. No benefits are payable by the Company for:

(1) PBS items received while admitted to a non-agreement hospital;

(2) pharmaceuticals supplied on discharge from hospital; or

(3) where the cost to a policy holder for a PBS item is less than the pharmaceutical benefit co-payment (as determined by the Commonwealth Department of Health and Ageing). In some instances, the Company may cover the co-payment fee.

E2.7 For all overseas visitors’ health insurance policies that cover hospital treatment, the Company will pay costs that a policy holder incurs for each pharmaceutical item that is not covered by the PBS received while admitted to an agreement hospital. For the purposes of this rule E2.7, a course of treatment of the same pharmaceutical item is regarded as one pharmaceutical item. No benefits are payable for non-PBS items received while admitted to a non-agreement hospital. To be eligible for the benefit, the pharmaceutical item must be:

(1) intrinsic to the hospital treatment;

(2) clinically indicated;

(3) essential for the meeting of satisfactory health outcomes for the policy holder;

(4) directly related to treatment of the condition or ailment for which the policy holder was admitted;

(5) a non-experimental drug or compound item;

(6) provided by the hospital during your hospital admission and not provided upon discharge; and

(7) the reason for admission to hospital was not solely for the administration of the pharmaceutical item.
E2 Hospital Treatment – (contd)

E2.8 The Company will pay benefits for a prosthesis item where that prosthesis item is implanted as part of hospital treatment under an overseas visitor’s health insurance policy. In the case of a no-gap prosthesis item the benefits will fully cover the cost of that item. For a gap permitted prosthesis item, the benefits will not fully cover that item, but will cover the amount set out as the minimum benefit in section 72-1 of the PHI Act.

E2.9 All overseas visitors health insurance policies cover hospital-substitute treatment provided by a general or specialist nurse recognised by the Company in the course of private practice provided that:

(1) a medical practitioner has certified that the care is instead of hospitalisation; and

(2) the certification is assessed by a medical practitioner appointed by the Company to be medically reasonable and appropriate.

E2.10 Once a policy holder is a Nursing Home Type Patient, the Company will pay Nursing Home Type Patient’s Benefits for the duration of their classification as a Nursing Home Type Patient. Nursing Home Type Patient must make a contribution to their care as declared by the Minister from time to time.
E BENEFITS – (contd)

E3 General Treatment

E3.1 The Company may determine an insured persons entitlement to a benefit for general treatment (other than hospital-substitute treatment) under an overseas visitors health insurance policy in respect of a period by having regard to the amount of benefits for that kind of treatment already claimed for the person in respect of the period. The Company may not apply this rule across more than one period.

E3.2 The Company will pay a benefit under an overseas visitor’s health insurance policy for general treatment only (and not where services or appliances are provided as part of hospital treatment) where the general treatment has been rendered:

(1) by or on behalf of a recognised practitioner in private practice;
(2) on premises registered with the Company, unless approved otherwise by the Company.

E3.3 General treatment benefits are not payable for any of the circumstances outlined in Rule E4.

E3.4 General treatment benefits are payable in accordance with the schedule of benefits maintained by the Company and subject to the following:

(1) Dental benefits are payable in accordance with the schedule of dental benefits (which follows the "Australian Schedule of Dental Services and Glossary - Australian Dental Association Inc") maintained by the Company. All treatments are inclusive of routine post-operative care.
(2) Major dental services include crowns, bridgework, partial dentures and repairs, prosthodontic services, implant prostheses, periodontics, oral surgery, endodontics, oral appliances for sleep apnoea and complete dentures.
(3) The benefit for complete dentures is limited to one set of complete dentures per insured person every three years.
(4) Pharmacy benefits are payable for prescriptions supplied by a pharmacist in private practice and prescribed by a registered medical practitioner. Benefits are payable for PBS and non-PBS prescription items which are TGA Approved and where such approval is for that condition, and are subject to any co-payment applicable for outpatient pharmacy benefits under an overseas visitors health insurance policy.
(5) Asthma pumps must be approved by the Asthma Foundation and blood glucose monitors must be approved by Diabetes Australia for benefits to be payable by the Company.

(6) Defined Appliances benefits are payable for the following items when prescribed by a recognised practitioner and are custom made:
  - Pressure garments
  - Callipers, short or long
  - Artificial limbs
  - Mammary prostheses following mastectomy
  - Corrective footwear as determined by the Company
  - Orthopaedic footwear as determined by the Company
  - Braces, all types
  - Knee brace
  - Footdrop splint, all types
  - Special splints for children under 5 years of age
  - Impotency pump
  - TENS machines
  - Artificial eye, ear or nose
  - Wigs from an outlet approved by the Company and then only for patients who suffer loss of hair following chemotherapy or similar medical treatment as determined by the Company.
E BENEFITS – (contd)

E3 General Treatment – (contd)

E3.5 The amount of a benefit for a treatment under an overseas visitor health insurance policy may be different from the amount of a benefit for the same treatment under another complying health insurance policy that is in the same product, if the difference is only because the persons insured under the policies live in a different state.

E3.6 The Company may, from time to time, for the benefit of its policy holders enter into agreements with providers of general treatment. The benefits that apply within these agreements may differ from those shown in these rules. Lists of agreements with providers of general treatment are available to policy holders upon request.

E3.7 If a policy holder takes out general treatment cover with the Company, the Company will only pay benefits:

(a) for a single service of general treatment provided to a policy holder by a recognised practitioner in private practice on a given day; and

(b) for more than one service general treatment on a given day provided by a recognised practitioner in registered premises in private practice who is recognised by the Company in more than one profession.
BUPA AUSTRALIA PTY LTD OVERSEAS VISITOR RULES – EFFECTIVE 1 September 2015

E BENEFITS – (contd)

E4 Other
E4.1 Benefits are not payable for:

(2) Any costs incurred as a result or consequence of criminal activity.

(3) Any service rendered by a suspended practitioner.

(4) Professional services or hospitalisation rendered in connection with a *policy holder or dependant child’s* employment.

(5) Services that may be paid or provided by the Commonwealth, the State, a local governing body, or an authority established by any law.

(6) Services rendered more than two years ago (unless the *Company*, in its absolute discretion, chooses to pay benefits in cases of hardship or for claims relating to unsuccessful compensation or damages cases).

(7) Professional services rendered or goods supplied by an *insured person* to:

(a) that *insured person*, their *dependent*, *partner* or other *insured person* on the policy; and

(b) that insured person’s business associate or their *partner* or *dependent*, where the business associate, *partner* or *dependent* is insured under a policy with the *Company*

unless otherwise approved at the discretion of the *Company*.

(8) Any services rendered contrary to a law of the Commonwealth or State in which they were rendered.

(9) Any service that was not rendered as claimed or is insufficiently described in the claim.

(10) Any services which the *Company* reasonably believes are excessive and not reasonably necessary for the adequate care of the *policy holder* or their *dependant children*.

(11) Any services provided overseas.

(12) If, in the *Company’s* reasonable opinion, the *policy holder* may receive any compensation, damages, or benefits, from another source for a condition, injury or ailment (even if the compensation, damages, or benefits is stated to exclude any medical expenses).

(13) Benefits not payable by Medicare including any *Cosmetic Surgery* procedure unless the procedure is deemed clinically relevant or experimental or clinical trials pharmaceuticals. Any follow up care pertaining to non-Medicare recognised cosmetic surgery is paid at minimum benefits.

(14) Unless otherwise specified the *Company* outpatient services, which are services provided to patients who are not admitted patients.
F LIMITATION OF BENEFITS

F2 Excesses

F2.1 Policy holders may choose overseas visitors health insurance policy that covers hospital treatment tables that include an excess.

F2.2 An excess is deducted from benefits that would otherwise be payable by the Company under these rules for hospital treatment.

F2.3 Any excess that applies to an overseas visitor’s health insurance policy will be outlined in accordance with Schedules H&J.

F3 Waiting Periods

F3.1 Waiting periods apply to policy holders joining a private health insurer for the first time and apply from the date of joining before any benefits can be claimed. Where a policy holder leaves another private health insurer and takes out cover with the Company, the Company may require the policy holder to serve a waiting period for a particular service if he or she takes out a cover which pays a benefit for service for which he or she was not covered for with the other private health insurer.

F3.1A Where a person takes out a policy with the Company on or after 1 September 2015, the waiting periods on that policy commence on the later of:

(a) the policy holder’s date of arrival in Australia; or
(b) the date the policy commenced.

F3.2 Where a policy holder changes cover with the Company to a table of cover which pays a benefit for a service that was not previously covered or for which a higher benefit is payable, the Company may require the policy holder to serve a waiting period in respect of the new benefit from the date of changing cover. No benefits are payable to new policy holders during waiting periods. Policy holders transferring to a higher table of cover with the Company receive benefits at the previous lower level of cover during waiting periods.

F3.2A In the case of a dependant, where they cease to be covered under an overseas visitor health insurance policy (the old policy) as a dependant with the Company and within 60 days become a policy holder of an overseas visitors health insurance policy (the new policy) with the Company with the same and/or lower levels of cover than the old policy they will be deemed to have served the same waiting periods as the old policy. In the case of any changes in levels of cover, waiting periods apply to any higher benefits not covered under the old policy.

F3.3 if a policy holder adds a new dependant to their overseas visitor health insurance policy (other than a newborn), any waiting periods and periods of restricted benefits that apply to that complying health insurance policy must be served in full by the new dependant. A newborn will be deemed to have served the same waiting periods and periods of restricted benefits as the policy holder

F3.4 In the case of a newborn on a family or sole parent cover;

(1) Where the relevant cover was in existence prior to the birth of the newborn, the newborn will not be required to serve waiting periods.

(2) Where the relevant cover was not in existence prior to the birth of the newborn, the newborn will not be required to serve waiting periods where the newborn is added within 2 month of birth

F3.5 In the case of a dependant where they rejoin an overseas visitor health insurance policy where a parent is a policy holder they will be deemed to have served the same waiting periods and periods of restricted benefits as the policy holder.
F LIMITATION OF BENEFITS – (contd)

F3 Waiting Periods – (contd)

F3.4 (a) For all products made available by the Company the waiting periods that apply for hospital treatment benefits are as follows:

<table>
<thead>
<tr>
<th>Type of Case</th>
<th>Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-existing condition§</td>
<td>Twelve Months</td>
</tr>
<tr>
<td>Obstetric Patient§</td>
<td>Twelve Months</td>
</tr>
<tr>
<td>Laser Eye Correction Surgery</td>
<td>Twelve Months</td>
</tr>
<tr>
<td>Psychiatric* +§</td>
<td>Twelve Months for Short Stay, Standard and Mid Visitors’ Cover</td>
</tr>
<tr>
<td></td>
<td>Two Months for all other products</td>
</tr>
<tr>
<td>Rehabilitation* +</td>
<td>Twelve Months for Short Stay, Standard and Mid Visitors’ Cover</td>
</tr>
<tr>
<td></td>
<td>Two Months for all other products</td>
</tr>
<tr>
<td>Palliative Care* +</td>
<td>Twelve Months for Short Stay Visitors’ Cover</td>
</tr>
<tr>
<td></td>
<td>Two Months for all other products</td>
</tr>
<tr>
<td>All Other Cases^</td>
<td>Two Months</td>
</tr>
</tbody>
</table>

§ For Overseas Students Health Cover only, the waiting periods listed do not apply for treatment that, in the Company’s reasonable opinion, is ‘Emergency Treatment’ as that term is defined in the Deed for the Provision of Overseas Student Health Cover between the Company and the Department of Health.

* This waiting period applies whether or not there is a Pre-existing condition.

^ No waiting periods apply for benefits provided in relation to accidents proved to occur after the policy commences or to ambulance services.

+ No waiting period applies for these services on the following tables: Ultimate Corporate Visitors Cover, Gold Visitors Cover, Platinum Visitors Cover (hospital component), Executive Corporate Visitors Cover (hospital component), Gold Visitors Cover with Excess, Platinum Visitors cover with Excess (hospital component), Essential Visitors Cover, Essential Plus Visitors Cover (hospital component), Classic Visitors Cover (off sale), Select Visitors Cover (off-sale), Corporate Overseas Visitors Cover (hospital component, off-sale).
F LIMITATION OF BENEFITS – (contd)

F3 Waiting Periods – (contd)

F3.5 The *waiting periods* that apply to overseas visitor *general treatment* benefits are as follows:

<table>
<thead>
<tr>
<th>Type of Case</th>
<th>Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-existing condition</td>
<td>Twelve Months</td>
</tr>
<tr>
<td>General Dental</td>
<td>Two Months</td>
</tr>
<tr>
<td>Major dental</td>
<td>Twelve Months</td>
</tr>
<tr>
<td>Appliances</td>
<td>Twelve Months</td>
</tr>
<tr>
<td>Hire, Repair and Maintenance of Appliances</td>
<td>Six Months</td>
</tr>
<tr>
<td>All Other Cases</td>
<td>Two Months</td>
</tr>
</tbody>
</table>

F4 Exclusions

F4.1 Services for which exclusions may apply on the *Company’s* overseas visitors health insurance products are as follows and will vary by product:

- Pregnancy related services
- Bone barrow and organ transplants
- Cosmetic surgery
- Renal dialysis
- Services not covered by Medicare
- Pre-existing condition
- Assisted Reproductive Services (including IVF)
- Cosmetic surgery (that is not clinically necessary and where benefits are not payable by Medicare)
- Cataract surgery
- Hip and knee replacement
- Sterilisation reversal

F5 Benefit Limitation Periods

F5.1 The *Company* has benefit limitation periods ("BLPs") for specific types of services. Benefit limitation periods are the reduced benefits that apply for a service for a fixed period of time once the relevant *waiting periods* have been served, being the minimum default benefits determined by the *Minister* from time to time for that service. These periods may range from 1 to 2 years, depending on the service and the product. BLPs apply to new *policy holders* or *dependant children* and may apply to *policy holders* who transfer to this level of cover.

F5.2 During a BLP, eligible claims will be paid by the *Company* at the minimum default benefit levels as determined by the *Minister* from time to time. These benefits are generally not adequate to cover private hospital costs, but fully cover shared ward costs in a public hospital. BLPs apply from the date of joining the applicable Overseas Visitors Hospital Covers.
F5 Benefit Limitation Periods – (contd)

F5.3 Services for which BLPs may apply on the Company’s *overseas visitor health insurance products* are as follows:

- Pregnancy related services (including childbirth)
- Heart or Artery related services
- Psychiatric
- Assisted reproductive services (including IVF)
- Hip or knee replacement
- Rehabilitation services
- Cataract surgery

F5.4 BLPs on the Company’s *overseas visitor health insurance products* are served concurrently with waiting periods.

F6 Restricted Benefits

F6.1 Lifetime *Restricted Benefits* may apply to the following services and will apply to some *overseas visitor health insurance products*:

- Pregnancy related services
- Heart, artery and cardiac related services
- Cosmetic surgery

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Benefits are not payable in respect of a condition, injury or ailment which is the subject of a claim where an *insured person* has claimed and received or established a right to receive a payment by way of compensation or damages from a third party.

F7.2 Where the amount of a claim for compensation or damages is in the opinion of the *Company* less than the benefits that would have otherwise been payable, benefits are payable. The amount of benefits payable shall not exceed the difference between the benefit that would have otherwise been payable and the amount of compensation or damages.

F7.3 Where the *Company* believes that a condition, injury or ailment is one which may give rise to a claim for compensation or damages or benefits have been paid which relate to such a claim, the *Company* may require the *insured person* to sign an undertaking, in a form acceptable to the *Company*, before payment or further payment of benefit occurs. The undertaking will require the *insured person* to make a claim for compensation or damages, to pursue the claim with all diligence, and to include in such claim all hospital, medical, dental, paramedical and related expenses. Proceeds from the claim are to be used to reimburse the *Company* for any benefits that were paid for the condition, injury or ailment.
F7 Compensation Damages and Provisional Payment of Claims – (contd)

F7.4 Benefits are not payable if it appears to the Company that the insured person may be entitled to payment by way of compensation or damages but has not yet established the right to such payment. The insured person will be required to establish such right, and inform the Company of any decision to pursue a claim for compensation. If it is established that there is no right to compensation or damages, then benefits are payable.

F7.5 Where an insured person establishes a right to compensation or damages and accepts a settlement, and 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 part of the claim is abandoned or compromised so that such expenses are excluded or represented by a nominal amount only, then benefits are not payable.

F7.6 Where an insured person has received compensation in relation to the injury they must inform the Company immediately upon determination of the settlement of the claim for Compensation.

F7.7 Where in the Company’s opinion an insured person appears to have a right to make a claim for compensation in respect of an injury but that right has not been established, the Company may withhold payment of benefits in respect of expenses incurred in relation to that injury.

F7.8 Where a claim for compensation in respect of an injury is in the process of being made or has been made and remains unfinalised, the Company may in its absolute discretion make a provisional payment of benefits in respect of expenses incurred in relation to the injury.

F7.9 Any provisional payment may be conditional upon the insured person signing an undertaking or other conditions required by the Company.

F7.10 If the insured person does not comply with the requirements of the undertaking or conditions required by the Company, the Company may discontinue any provisional payments and where required by the Company repays the Company of any provisional payments already paid.

F7.11 Any provisional payments of benefits by the Company may be regarded as a debt payable to the Company.

F7.12 Where the insured person is less than 18 years of age, the policyholder will be principally responsible and must assume any responsibility in signing the undertaking.

F7.13 Where an insured person and a policyholder complete an undertaking, both parties may be liable for any provisional payment.

F7.14 References to an insured person receiving compensation includes;

(i) Compensation paid to another person at the direction of the insured person; and

(ii) Compensation paid to another insured person on the same Policy in connection with an injury suffered by the insured person.

F8 Other
G CLAIMS

G1 General

G1.1 Claims must be submitted within two years of the date of service, otherwise benefits are not payable.

G1.2 The *Company*, in its absolute discretion, may waive rule G1.1 in cases of hardship or for claims relating to unsuccessful compensation or damages cases.

G1.3 Claims for benefits must;

   a. Be made in a manner approved by the company; and
   b. Be supported by accounts and/or receipts on the providers letterhead or showing the providers official stamp and showing the following information:
      i. the providers name, number and address;
      ii. the *insured persons* full name and address;
      iii. date and description of service;
      iv. the amount(s) charged; and
      v. any other information that the *Company* may reasonably request.

G2 Other