Overseas Visitors Rules - (Visiting Cover)

Effective 1 June 2017

A Introduction

A.1 Rules Arrangement

These Overseas Visitors Rules (Visiting Cover) are the Rules under which we agree to provide you with health insurance. Certain words and expressions used in these Rules have particular meanings which, unless defined elsewhere, are defined in Rule B.

A.2 Legislation

We conduct Health Insurance Business and Health Related Business under the *Private Health Insurance Act 2007* (Cth) (**PHI Act**). We provide Overseas Visitors with health insurance to meet the requirements of the Department as specified from time to time.

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:

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 in Australia. If you or anyone on your Policy has been hurt as a result of an Accident, you must obtain medical advice or Treatment from a registered Medical

Practitioner within 72 hours, and if needed, any further Treatment must commence within 180 days of the event.

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

Adult means a person who is neither a Dependent Child nor a Dependent Child Non-Student.

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).

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

AMA Fees means the Australian Medical Association (AMA) fee. The fees are the amount suggested by the AMA as an appropriate fee for each medical and surgical procedures carried out in Australia. AMA fees are usually higher than the MBS fees.

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.

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

Claim means a claim for Benefits.

Commencement Date means the latter 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:

(a) listed in the MBS that:

i. is not clinically necessary; or

ii. does not meet the eligibility conditions for the payment of Medicare benefits; or

(b) not listed in the MBS that is of a plastic or reconstructive nature.

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

(a) aged under 21; or

(b) aged under 25 and receiving a full time education at a school, college or university recognised by Bupa.

Dependent Child Non-Student means a Dependent Child who:

(a) is aged between 18 and 24 (inclusive); and

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

Dependent means a Partner, Dependent Child or Dependent Child Non-Student of the Policy Holder.

DIBP means 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.

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

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

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.

Insurance Business Rules means the *Private Health Insurance (Health Insurance Business) Rules 2015,* as amended, replaced or superseded from time to time.

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 Visitors.

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 insurance 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.

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.

A reference to a **New Policy** means a new Policy with Bupa and a reference to an **Old Policy** means either a previous Policy with either Bupa or another Insurer.

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 the default benefit declared by the Minister from time to time for Nursing Home Type Patients who are Overseas Visitors or, if not so declared, the default benefit declared for Nursing Home Type Patients who are entitled to Medicare benefits.

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 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 Visitor means a person who does not reside in Australia and:

(a) does not hold an Australian passport; and

(b) does not hold Australian citizenship; and

(c) holds an appropriate visa that permits entry into Australia.

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).

Policy means an overseas visitors health insurance policy.

Policy Holder means an Insured Person who is the holder of a Policy.

Pre-existing Condition means where an Insured Person has a 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 day on which Insured Person became insured under the Policy. In forming this opinion, the Medical Practitioner must have regard to any information in relation to

the condition given to him or her by the Medical Practitioner who treated the condition.

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 person registered under Part 4-3 of the PHI 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.

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.

Rules means these Overseas Visitors Rules (Visiting Cover) 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.

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

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

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

Treatment refers to health or medical treatment 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; or

(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:

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

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

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

(d) are not an overseas student or specified temporary visa holder who has insurance provided by a private health insurer in circumstances referred to in rule 18 of the Insurance Business Rules; and

(e) meet the visa requirements we determine.

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

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

C.3.2 Despite Rule C3.1, 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 license or

current passport. We may accept other forms of proof of age at our discretion;

(c) details of any existing condition; and

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

C.4.2 The Policy Holder must advise us as soon as possible 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 17 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 a later date agreed by you and Bupa, provided all required Premiums have been paid and enrolment procedures completed to our satisfaction, and

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

C.6 Transfers and Waiting Periods

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

C.6.2 If you transfer from an Old Policy to a New Policy, Waiting Periods will apply to 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 Minimum Benefits may apply when you acquire a New Policy.

C.6.6 See Rule F for details about Waiting Periods and Minimum Benefits.

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

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

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

(c) if no date of cessation is elected by the Policy Holder, the date on which the next Premium would otherwise be due.

C.7.2 If you cancel the Policy before the date on which the next Premium is due, Bupa will reimburse any Premiums paid in advance except for the first calendar month's Premium which is non-refundable. We may also charge an administration fee for processing the refund

C.7.3 Subject to Rule C7.4, you may not retrospectively cancel a Policy.

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

C.7.5 If a Policy is cancelled within the first 30 days of its commencement, we will refund Premiums paid in advance except for an amount equal to the first calendar month's Premium. Where there has been a Claim made under the Policy within this first 30 days, the

date of cessation will be the date of the most recent Claim made under the Policy.

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

C.8 Termination of Membership

C.8.1 Subject to these Rules, we may, by written notice, terminate part or all of your Policy, giving you our reason(s) for the termination. We may terminate the Policy for any reason including, without limitation, if, in our reasonable opinion:

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

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

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

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

(b) an Insured Person under the Policy is repatriated (including repatriation of mortal remains) to his or her country of origin or is terminally ill and has returned to his or her country of origin.

C.8.3 If we terminate your Policy before the date on which the next Premium is due, we will reimburse any Premiums paid in advance except for the first calendar month's Premium, which is non-refundable. We may also charge you an administration fee in relation to the refund.

C.8.4 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).

C.9 Temporary Suspension of Membership

C.9.1 Subject to this Rule C9, we may suspend your Cover whilst you travel overseas in the following circumstances:

(a) you have had your Cover for two (2) months or more;

(b) you apply to us to suspend your Cover using the form we prescribe from time to time; and

(c) you provide us with documentation (to our reasonable satisfaction) verifying your departure and arrival dates.

C.9.2 We will allow up to three (3) suspensions for overseas travel per calendar year and there must be a period of at least one month of resuming your Cover and paying the applicable Premiums between any two suspensions.

C.9.3 A suspension allowed under this Rule will begin on the later of the date of departure and the date you apply for the suspension.

C.9.4 If your application for suspension doesn't specify an end date, the end date will be the earlier of:

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

(b) 9 months from the start of the suspension.

D Premiums

D.1 Premium Payments

D.1.1 The Premiums for your Product are determined by us from time to time.

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

D.1.3 You must pay all Premiums at least one calendar month in advance (unless Premiums are paid by payroll deduction, in which case the minimum payment period may be one week in advance).

D.1.4 If and when your State of Residence changes, your Premiums will become those applicable in the new State of Residence.

D.2 Premium Rate Changes

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

D.3 Overdue Premiums

D.3.1 Your Premiums are overdue if you do not pay the last due Premium by the due date.

D.3.2 Subject to Rule D.3.3, if your Premiums were overdue but you pay the overdue amount, we will continue pay Benefits for Treatment for which you are Covered.

D.3.3 No Benefits are payable and we may terminate your Policy if your Premiums become overdue by two (2) months or more.

E Benefits

E.1 General conditions

E.1.1 The Rules 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 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; or

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

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

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

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

E.1.6 We will not pay Benefits:

(a) 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; or

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

E.2 Hospital Treatment

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

E.2.2 Benefits for Hospital Treatment are not payable in any of the circumstances outlined in Rule E4.

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

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

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

E.2.6 We will pay Benefits for PBS listed drugs that are prescribed according to PBS approved indications and administered during and forming part of an episode of Hospital Treatment. The Benefit payable will be equal to the PBS listed price in excess of your contribution to the fee for such drug.

E.2.7 For Policies covering Hospital Treatment, we will pay Benefits for pharmaceutical items that are not covered by the PBS that you receive while admitted to an Agreement Hospital. For the purposes of this Rule, 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. Further, to be eligible for the benefit, the pharmaceutical item must be:

(a) intrinsic to the Hospital Treatment;

(b) clinically indicated;

(c) essential to meet satisfactory health outcomes;

(d) directly related to the Treatment for which you are admitted to Hospital;

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

(f) provided by the Hospital during your Hospital admission and not upon or after discharge from the Hospital; and

(g) prescribed as part of but not as the sole reason for the reason for admission to Hospital.

E.2.8 For surgically implanted prostheses – "no gap prostheses" and "gap permitted prostheses as listed in the Prostheses List – we will pay a Benefit that is at least equal to 100% of the minimum benefit listed.

E.2.9 We will only cover Hospital-Substitute Treatment that is provided by a Recognised Practitioner who is a general or specialist nurse where:

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

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

E.2.10 If you become a Nursing Home Type Patient, we will pay Nursing Home Type Patient Benefits for the duration of your classification as a Nursing Home Type Patient. You must make a contribution to the cost of your care as declared by the Minister from time to time.

E.3 General Treatment

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

E.3.2 We will only pay Benefits for General Treatment (but not where provided as part of Hospital Treatment) where it is provided:

(a) by or on behalf of a Recognised Practitioner in Private Practice; and

(b) on premises registered with us, unless we otherwise approve.

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

E.3.4 We will pay Benefits for:

(a) dental Treatment (including routine post-operative care) in accordance with our schedule of dental Benefits;

(b) major dental services including crowns, bridgework, partial dentures and repairs, prosthodontic services, implant prostheses, periodontics, oral surgery, endodontics, oral appliances for sleep apnoea and complete dentures;

(c) complete dentures, limited to one set of complete dentures per Insured Person every three years;

(d) prescriptions supplied by a pharmacist in Private Practice and prescribed by a registered Medical Practitioner. We will pay Benefits for PBS and Non-PBS prescription items which are TGA Approved and where such approval is for the condition for which the items have been prescribed. Benefits are subject to any co-payment for Outpatient pharmacy Benefits applying under your Policy;

(e) asthma pumps that are approved by us;

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

(g) the following appliances where prescribed by a Recognised Practitioner and custom made:

i. pressure garments;

ii. callipers, short or long;

iii. artificial limbs;

iv. mammary prostheses following mastectomy;

v. corrective footwear as determined by Bupa;

vi. orthopaedic footwear as determined by Bupa;

vii. braces, all types;

viii. knee braces;

ix. footdrop splints, all types;

x. special splints for children under 5 years of age;

xi. impotency pumps;

xii. TENS machines;

xiii. artificial eyes, ears or noses; and

xiv. wigs from an outlet approved by Bupa and only for patients who suffer loss of hair following chemotherapy or similar medical Treatment as determined by Bupa.

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

E.3.6 Bupa may, from time to time, for the Benefit of its Policy Holders enter into agreements with providers of General Treatment. The Benefits that apply under these agreements may differ from, and will take precedence over, those shown in these Rules. Lists of agreements with providers of General Treatment are available on request.

E.3.7 We will only pay Benefits for:

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

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

E.3.8 To the extent the cost is not otherwise covered by a third party arrangement, Bupa will pay a Benefit equal to the cost of transport by an ambulance provided by, or under an arrangement with, a government approved ambulance service when medically necessary for:

(a) admission to Hospital;

(b) Emergency Treatment on-site; or

(c) inter-Hospital transfer for Emergency Treatment.

Inter-Hospital transfers for Emergency Treatment include transfers that are necessary because the original admitting Hospital does not have the required clinical facilities but do not include transfers due to patient preferences.

E.3.9 No benefit is payable in relation to non-emergency ambulance unless otherwise specified in the Product Schedule.

E.3.10 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 or the applicable State or Territory definition (the latter to prevail over the former to the extent of any inconsistency).

E.4 Where Benefits are Not Payable

E.4.1 We will not pay Benefits for:

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

(b) Treatment rendered by a suspended practitioner;

(c) Treatment (including Hospital Treatment) rendered in connection with your or a Dependent's employment;

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

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

(f) Treatment rendered by an Insured Person to:

i. that Insured Person or anyone else Covered by the same Policy; or

ii. that Insured Person's business associate, the business associate's Partner or the business associate's Dependent where they are Covered by a Bupa Policy,

unless otherwise approved by us in our sole discretion;

(g) any Treatment rendered contrary to the law of the Commonwealth, State or Territory jurisdiction in which the Treatment was rendered;

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

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

(j) any Treatment:

i. provided overseas including Treatment necessary en route to or from Australia; or

ii. arranged in advance of the Insured Person's arrival in Australia.

(k) any Treatment if, in Bupa's reasonable opinion, you may receive

any compensation, damages, or benefits from another source for the relevant condition, (even if the compensation, damages, or benefits are stated to exclude any medical expenses);

(l) Treatment for which no equivalent Medicare Benefits would be payable, including any Cosmetic Surgery or experimental or clinical trials of pharmaceuticals. If, however, your Policy includes Cover for follow-up care associated with Cosmetic Surgery for which no equivalent Medicare Benefits would be payable, we will pay the equivalent of Minimum Benefits that would apply for such Treatment;

(m) Treatment provided to you when you are not admitted to Hospital, unless otherwise specified in the relevant Product Schedule.

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 periods of Minimum Benefits 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 periods of Minimum Benefits;

(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 periods of Minimum Benefits 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 and periods of Minimum Benefits as the Policy Holder.

F.3 Excesses

F.3.1 Your Policy may include Cover for Hospital Treatment that includes an Excess.

F.3.2 If applicable, we will deduct the Excess from the Benefits payable for Hospital Treatment.

F.3.3 Excesses are outlined in the relevant Schedules.

F.4 Minimum Benefits

F.4.1 Subject to these Rules, we may apply Minimum Benefits for specific types of Treatment. Minimum Benefit is a fixed period during which a Minimum Benefits apply in relation to the Treatment. Minimum Benefits may range from two (2) months to two (2) years or for the full duration of the cover, depending on the Treatment and the Product. Minimum Benefits apply when you acquire or transfer to a New Policy.

F.4.2 During the period where Minimum Benefits apply, we will pay only Minimum Benefits for eligible Claims. These Benefits are generally not adequate to cover private Hospital costs, but will fully cover shared ward costs in a public Hospital.

F.4.3 Details of the applicable Minimum Benefits are provided in Product Schedule.

G CLAIMS

G.1 General

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

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

G.1.3 Claims for Benefits must be;

(a) made in a manner we approve; and

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

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

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

iii. the date and description of service;

iv. the amount(s) charged; and

v. any other information that we may reasonably request.

PRODUCTS SCHEDULE

PART 1 – OVERVIEW OF ALL OVERSEAS VISITORS (VISITING COVER) PRODUCTS

1. List of Overseas Visitors (Visiting Cover) Products

The following products are Overseas Visitors (Visiting Cover) products:

Guardian Plus Visitors Cover	
Standard Visitors Cover	
Short Stay Visitors Cover	Advantage Visitors Cover
Mid Visitors Cover	
Standard Plus Visitors 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 facility fees	Fees charged by a private or public hospital emergency department for attending the facility
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.
AMBULANCE BENEFIT	
Ambulance cover	Emergency and non-emergency transportation or on-the-spot treatment provided by a Bupa recognised ambulance provider.

2.2 General Treatment

General Treatment Benefits are covered under an Overseas Visitors (Visiting Cover) products as listed in the relevant Product Specification.

PART 2 – PRODUCT SPECIFICATION

Product 1 – Guardian Plus Visitors Cover

1.1 Eligibility

Offsale

Product closed to new members and existing members changing cover.

1.2 Hospital Treatments and Medical Benefits

1.2.1 Benefit Limit

Covered Item	Benefit Limit
HOSPITAL COSTS – When admitted to a Member Firsts 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 a Minimum Benefit or exclusion applies.
Operating theatre, labour wards and critical care fees	Covered in full, except for services where a Minimum Benefit or exclusion applies.
Emergency department facility fees	Covered in full - only if admitted into that hospital during same episode
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. 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 pay $20 then Bupa will refund 80% of the balance per script items up to a maximum of $500 per person per calendar year. This is provided the item's usage is approved by the TGA
AMBULANCE BENEFIT	
Ambulance cover	Unlimited for emergency transportation 3 times per person per calendar year for non-emergency transportation

1.2.2 Excess

Excess amount of $300 is payable once per person per calendar year, up to a maximum of twice on the membership. Each individual on the membership will never pay their total excess amount more than once per calendar year.

1.2.3 Minimum Benefits

In accordance with Rule F.4 of this Overseas Visitors Rule, Minimum Benefits apply for:

- the duration of this cover for the following services:
    - Surgical podiatry procedures.
- the first 6 months from the date your cover commences in accordance with Rule C.5(a), for the following services:
    - Cardiac and cardiac related services
    - Hip or knee replacements including arthroplasty, revisions and resurfacing procedures
    - Cataract surgery
    - Renal dialysis

Please Note – For this product only (Guardian Plus Visitors Cover), Minimum Benefits do not apply when admitted to a Public Hospital

1.2.4 Exclusions

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

- IVF and assisted reproductive services
- Cosmetic surgery that is not clinically necessary
- Bone marrow transplants
- Organ transplants

1.2.5 Waiting periods

In accordance with Rules F.1 and F.2 of this Overseas Visitors Rule, the following Waiting Periods apply:

Psychiatric, rehabilitation and palliative care	2 months
Pre-existing Conditions	12 months
Pregnancy (including childbirth)	12 months

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

1.3 General Treatment Benefits

1.3.1 Benefit Limit

60% of cost at all recognised provider	
Services	**Yearly limits**
General Dental	Combined annual maximums apply Year 1 $800 Year 2 $880 Year 3 $960 Year 4 $1,040 Year 5 $1,120 Year 6+ $1,200
Major Dental	
Orthodontics	
Optical	$180
Antenatal and Postnatal	$300
Physiotherapy	Year 1 $350 Year 2 $385 Year 3 $420 Year 4 $455 Year 5 $490 Year 6+ $525
Chiropractic/Osteopathy	Year 1 $350 Year 2 $385 Year 3 $420 Year 4 $455 Year 5 $490 Year 6+ $525
Health Management (prior to 1 June 2017 known as Living Well)	$100
Speech Therapy	Combined annual maximums apply Year 1 $400 Year 2 $440 Year 3 $480 Year 4 $520 Year 5 $560 Year 6 $600 Sublimit of $100 for Hire, Repair and Maintenance of Health Aids and Appliances Other sublimits also apply
Eye Therapy	
Occupational Therapy	
Dietary	
Pharmacy	
Psychology	
Podiatry	
Health Aids and Appliances	
Hire, Repair and Maintenance of Health Aids and Appliances	
Natural Therapies Including: acupuncture, Alexander Technique, Chinese herbalism, Exercise Physiology, Feldenkrais, homeopathy, iridology, massage, naturopathy, western herbalism. **Massage** Includes: aromatherapy, Bowen Technique, kinesiology, reflexology, shiatsu and remedial massage.	
Home Nursing	$350

Travel and Accommodation	Travel - $100 Accommodation- $150 capped at $40 per night

1.3.2 Waiting Periods

Services	Waiting Periods
General Dental	2 months
Major Dental	12 months
Orthodontics	12 months
Optical	2 months
Antenatal and Postnatal	2 months
Physiotherapy	2 months
Chiropractic/Osteopathy	2 months
Health Management **(prior to 1 June 2017 known as Living Well)**	6 months
Speech Therapy	2 months
Eye Therapy	2 months
Occupational Therapy	2 months
Dietary	2 months
Pharmacy	2 months
Psychology	2 months
Podiatry	2 months
Health Aids and Appliances	12 months
Hire, Repair and Maintenance of Health Aids and Appliances	6 months
Natural Therapies Including Massage	2 months
Home Nursing	2 months
Travel and Accommodation	2 months

Product 2 – Standard Visitors 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 a Minimum Benefit or exclusion applies.
Operating theatre, labour wards and critical care fees	Covered in full, except for services where a Minimum Benefit or exclusion applies. No cover for Labour wards.
Emergency department facility fees	Covered in full - only if admitted into that hospital during same episode
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. 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 MEDICIALMEDICAL 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 pay $20 then Bupa will refund 60% of the balance per script items up to a maximum of $300 per person per calendar year. This is provided the item's usage is approved by the TGA
AMBULANCE BENEFIT	
Ambulance cover	Unlimited for emergency transportation 3 times per person per calendar year for non-emergency transportation

2.2.2 Excess

Nil

2.2.3 Minimum Benefits

In accordance with Rule F.4 of this Overseas Visitors Rule, Minimum Benefits apply for the duration of this cover for the following services:

- Cardiac related services
- Surgical podiatry procedures.

2.2.4 Exclusions

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

- IVF and assisted reproductive services
- Pregnancy (including childbirth)
- Cataract and eye lens procedures
- Hip/Knee join replacement including arthroplasty, revision and resurfacing procedures
- Rental dialysis
- All cosmetic surgery and sterilisation reversal.

2.2.5 Waiting periods

In accordance with Rules F.1 and F.2 of this Overseas Visitors Rule, the following Waiting Periods apply:

Psychiatric and rehabilitation	12 months
Pre-existing Conditions	12 months

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

2.3 General Treatment Benefits

Not covered under this product

Product 3 – Standard Plus Visitors Cover

3.1Eligibility

On sale

3.2 Hospital Treatments and Medical Benefits

3.2.1 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 a Minimum Benefit or exclusion applies.
Operating theatre, labour wards and critical care fees	Covered in full, except for services where a Minimum Benefit or exclusion applies. No cover for Labour wards.
Emergency department facility fees	Covered in full - only if admitted into that hospital during same episode
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. 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 MEDICIALMEDICAL 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 pay $20 then Bupa will refund 60% of the balance per script items up to a maximum of $300 per person per calendar year. This is provided the item's usage is approved by the TGA
AMBULANCE BENEFIT	
Ambulance cover	Unlimited for emergency transportation 3 times per person per calendar year for non-emergency transportation

3.2.2 Excess

Nil

3.2.3 Minimum Benefits

In accordance with Rule F.4 of this Overseas Visitors Rule, Minimum Benefits apply for the duration of this cover for the following services:

- Cardiac related services
- Surgical podiatry procedures.

3.2.4 Exclusions

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

- IVF and assisted reproductive services
- Pregnancy (including childbirth)
- Cataract and eye lens procedures
- Hip/Knee join replacement including arthroplasty, revision and resurfacing procedures
- Rental dialysis
- All cosmetic surgery and sterilisation reversal.

3.2.5Waiting periods

In accordance with Rules F.1 and F.2 of this Overseas Visitors Rule, the following Waiting Periods apply:

Psychiatric and rehabilitation	12 months
Pre-existing Conditions	12 months

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

3.3 General Treatment Benefits

3.3.1 Benefit Limit

50% of cost at all recognised provider	
Services	**Yearly limits**
General Dental	$300
Optical	$150
Physiotherapy	Combined annual maximum of $200 applies for Physiotherapy, Chiropractic and Natural Therapies This maximum includes a $100 sub-limit for massage
Chiropractic	
Natural Therapies including: acupuncture, Alexander Technique, Chinese herbalism, Exercise Physiology, Feldenkrais, homeopathy, iridology, massage naturopathy, western herbalism **Massage** includes: aromatherapy, Bowen Technique, kinesiology, reflexology, shiatsu, and remedial massage	

3.3.2 Waiting Periods

Services	Waiting periods
General Dental	2 months
Optical	2 months
Physiotherapy	2 months
Chiropractic	2 months
Natural Therapies – including Massage	2 months

Product 4 – Short Stay Visitors Cover

4.1Eligibility

On sale
Only available to single or couple under 50 years old.

4.2 Hospital Treatments and Medical Benefits

4.2.1 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 a Minimum Benefit or exclusion applies.
Operating theatre, labour ward and critical care fees	Covered in full, except for services where a Minimum Benefit or exclusion applies. No cover for Labour wards
Emergency department facility fees	Covered in full - only if admitted into that hospital during same episode
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. 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'll receive up to $50 per script item up to a maximum of $300 per person per calendar year after you pay the PBS patient co-payment fee. This is provided the item's usage is approved by the TGA
AMBULANCE BENEFIT	
Ambulance cover	Unlimited for emergency transportation No cover for non-emergency transportation

4.2.2 Excess

Your excess amount of $250 is payable once per person per calendar year, up to a maximum of twice on the membership. Each individual on the membership will never pay their total excess amount more than once per calendar year.

4.2.3 Minimum Benefits

In accordance with Rule F.4 of this Overseas Visitors Rule, Minimum Benefits apply for the duration of this cover for the following services:

- Surgical podiatry procedures

4.2.4Exclusions

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

- Pre-existing conditions, ailments or illness
- Pregnancy (including childbirth)
- IVF and assisted reproductive services
- Cataract surgery and eye lens procedures
- Hip/Knee join replacement including arthroplasty, revision and resurfacing procedures
- All cosmetic surgery

4.2.5Waiting periods

In accordance with Rules F.1 and F.2 of this Overseas Visitors Rule, the following Waiting Periods apply:

Psychiatric, rehabilitation and palliative care	12 months

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

4.3 General Treatment Benefits

Not covered under this Product.

Product 4 – Advantage Visitors Cover

5.1 Eligibility

Off sale

Product closed to new members and existing members changing cover.

5.2 Hospital Treatments and Medical Benefits

5.2.1 Benefit Limit

Covered Item	Benefit Limit
HOSPITAL COSTS – When admitted to a Members First or Network private hospital or 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 a Minimum Benefit or exclusion applies.
Operating theatre, labour wards and critical care fees	Covered in full except for services where a Minimum Benefit or exclusion applies.
Emergency department facility 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 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. 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 pay $20 then Bupa will refund 80% of the balance per script items up to a maximum of $500 per person per calendar year. This is provided the item's usage is approved by the TGA
AMBULANCE BENEFIT	
Ambulance cover	Unlimited for emergency transportation 3 times per person per calendar year for non-emergency transportation

5.2.2 Excess

Nil

5.2.3 Minimum Benefits

In accordance with Rule F.4 of this Overseas Visitors Rule, Minimum Benefits apply for:

- the duration of this cover for the following services:
  - Surgical podiatry procedures.
- the first 2 years from the date your Policy commences in accordance with Rule C.5(a), for the following services:
  - Hip or knee replacements including arthroplasty, revisions and resurfacing procedures
  - Cataract surgery

5.2.4 Exclusions

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

- IVF and assisted reproductive services
- Cosmetic surgery that is not clinically necessary.

5.2.5 Waiting periods

In accordance with Rules F.1 and F.2 of this Overseas Visitors Rule, the following Waiting Periods apply:

Pre-existing Conditions, aliments, or illnesses	12 months
Pregnancy (including childbirth)	12 months

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

5.3 General Treatment Benefits

Not covered under this Product.

Product 6 – Mid Visitors Cover

6.1Eligibility

Off sale
Product closed to new members and existing members changing cover.

6.2 Hospital Treatments and Medical Benefits

6.2.1 Benefit Limit

Covered Item	Benefit Limit
HOSPITAL COSTS – No cover for private hospital admissions When admitted 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 a Minimum Benefit or exclusion applies.
Operating theatre, labour wards and critical care fees	Covered in full except for services where a Minimum Benefit or exclusion applies.
Emergency department facility fees	Covered in full - only if admitted into that hospital during same episode.
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. 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 MEDICIALMEDICAL BENEFITS	
In-patient medical expenses	Up to 100% of AMA 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 pay $20 then Bupa will refund 60% of the balance per script items up to a maximum of $500 per person per calendar year. This is provided the item's usage is approved by the TGA
AMBULANCE BENEFIT	
Ambulance cover	Unlimited for emergency transportation 3 times per person per calendar year for non-emergency transportation

6.2.2 Excess

Nil

6.2.3 Minimum Benefits

In accordance with Rule F.4 of this Overseas Visitors Rule, Minimum Benefits apply for the duration of this cover for the following services:

- Surgical podiatry procedures.

6.2.4 Exclusions

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

- IVF and assisted reproductive services
- Cataract and eye lens procedures
- Hip/Knee join replacement including arthroplasty, revision and resurfacing procedures
- All cosmetic surgery and sterilisation reversal.

6.2.5 Waiting periods

In accordance with Rules F.1 and F.2 of this Overseas Visitors Rule, the following waiting periods apply:

Psychiatric and rehabilitation	12 months
Pre-existing Conditions	12 months
Pregnancy (including childbirth)	12 months

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

6.3General Treatment Benefits

Not covered under this product