

# **BUPA AUSTRALIA PTY LTD**

## **FUND RULES**

### **GENERAL CONDITIONS**

**Effective from 1 July 2010**

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## **A INTRODUCTION**

### ***A1 Rules Arrangement***

A1.1 These rules consist of the:

- (a) General Conditions; and
- (b) Schedule of Tables.

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 ABN 81 000 057 590, conducts *health insurance business* and *health related business* under the *PHI Act*, trading under the brands HBA, Mutual Community, ANZ Health Insurance, MBF, SGIO Health Insurance, SGIC Health Insurance and NRMA Health Insurance.

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 a *complying 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 age of the person, except in relation to the calculation of a Lifetime Health Cover loading (refer Rule D4);
- (3) the frequency with which the person needs *hospital treatment* or *general treatment*;
- (4) the amount, or extent, of the benefits to which the person becomes, or has become, entitled during a period under a *complying health insurance policy* (except to the extent allowed under section 66-15 of the *PHI Act*);
- (5) the gender, race, religious beliefs or sexual orientation of the person;
- (6) where a person lives, except to the extent allowed under the *PHI Act*;
- (7) 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*; or
- (8) any matter set out in the Private Health Insurance (Complying Product) Rules 2007.

## A INTRODUCTION – (contd)

### 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 a *Standard Information Statement* to each *adult* insured every year in accordance with the *PHI Act*;
  - (2) give reasonable advanced notice of any change to the *rules* that would be detrimental to the *adult* insured whether or not a *Standard Information Statement* is required in accordance with the *PHI Act*; and
  - (3) give a newly insured person an up to date copy of the relevant *Standard Information Statement*, details about what the policy covers and how benefits are provided, and a statement identifying the referable *health benefits fund* when they join.
  - (4) if a person asks about a *complying health insurance product*, tell the person that a *Standard Information Statement* is available and, if they ask for a copy, give that person an up to date copy of that *Standard Information Statement*.

A change to the *rules* means a change to the amount of premiums payable in respect of a *complying 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 *complying health insurance policy* the *Company* need only provide this information to one of the *adults* on the *complying health insurance policy*.

### A7.3 Notification in Publications

Subject to the *PHI Act*, 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 a *complying 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 *complying 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) "***Associated Professional Services***" means professional services rendered to a *policy holder* by a *medical practitioner* while undergoing *hospital treatment*.
- (5) "***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;
- (6) "***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 asylum seekers, refugees, relatives of permanent entry permit holders, people authorised to work in *Australia*, or compassionate, humanitarian grounds.
- (7) “**Base rate**” has the meaning set out in subsection 34-1(2) of the *PHI Act*.
- (8) “**Company**” means BUPA Australia Pty Ltd.

## **B INTERPRETATION AND DEFINITIONS – (contd)**

### ***B2 Definitions – (contd)***

- (9) "***complying health insurance policy***" or "***policy***" means an *insurance* policy that meets:
- (a) the community rating requirements in Division 66 of the *PHI Act*;
  - (b) the coverage requirements in Division 69 of the *PHI Act*; and
  - (c) if the policy covers hospital treatment, the benefit requirements in Division 72 of the *PHI Act*; and
  - (d) the waiting period requirements in Division 75 of the *PHI Act*; and
  - (e) the portability requirements in Division 78 of the *PHI Act*; and
  - (f) the quality assurance requirements in Division 81 of the *PHI Act*; and
  - (g) any requirements set out in the Private Health Insurance (Complying Products) Rules for the purposes of this paragraph.
- (10) "***complying health insurance product***" is a product made up of *complying health insurance policies*.
- (11) "***Cosmetic Surgery***" means surgical procedures and any follow up care associated with cosmetic procedures:
- (a) listed in the Plastic and Reconstructive Section (Subgroup 13) 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.
- (12) "***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*;
- (13) "***cover***" in relation to an *insurance* policy has the meaning set out in section 69-5 of the *PHI Act*.
- (14) "***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
- (15) "***dependant child non-student***" has the meaning given to it in the Private Health Insurance (Complying Product) Rules 2007.(No 3)
- (16) "***dependant***" means – *dependant child* and *dependant non student*.
- (17) "***Direct Debit Policyholder***" means a *policy holder* whose premiums are automatically paid to the *Company* using an approved credit facility or from a financial institution account.

## **B INTERPRETATION AND DEFINITIONS – (contd)**

### ***B2 Definitions – (contd)***

- (18) **“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.
- (19) **“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.
- (20) **“gold card”** has the meaning set out in subsection 34-15(3) of the *PHI Act*.
- (21) **“health benefits fund”** has the meaning set out in section 131-10 of the *PHI Act*.
- (22) **“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*.
- (23) **“Health Insurance Act”** means the Health Insurance Act 1973 (Cth) as amended from time to time.
- (24) **“health insurance business”** has the meaning set out in Division 121 of the *PHI Act*.
- (25) **“health related business”** has the meaning set out in section 131-15 of the *PHI Act*.
- (26) **“hospital”** has the meaning set out in subsection 121-5(5) of the *PHI Act*.
- (27) **“hospital cover”** has the meaning set out in section 34-15 of the *PHI Act*.
- (28) **“hospital-substitute treatment”** has the meaning set out in section 69-10 of the *PHI Act*.
- (29) **“hospital treatment”** has the meaning set out in section 121-5 of the *PHI Act*.
- (30) **“improper discrimination”** has the meaning set out in section 55-5 of the *PHI Act*.
- (31) **“Insured Person”** means:
- (a) a *policyholder*;
- (b) a *partner* named on a *policy*;

(c) a *dependant* named on a *policy*;

(32) “*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)***

- (33) ***"lifetime health cover age"***, in relation to an *adult* who takes out *hospital cover* after his or her *lifetime health cover base day*, means the *adult's* age on the 1<sup>st</sup> July before the day on which the *adult* took out the *hospital cover*.
- (34) ***"lifetime health cover base day"*** has the meaning set out in section 34-25 of the *PHI Act*.
- (35) ***"Living Well Programs"*** means those programs approved by the *Company* for this purpose, together with such rules and guidelines as the *Company* deems appropriate in relation to the payment of benefits for such programs
- (36) ***"medical practitioner"*** means a medical practitioner within the meaning of the *Health Insurance Act*.
- (37) ***"medicare benefit"*** means a medicare benefit under Part II of the *Health Insurance Act*.
- (38) ***"medicare eligibility day"*** has the meaning set out in subsection 34-25(3) of the *PHI Act*.
- (39) ***"Medication Assistance Service"*** means a one-on-one consultation with a pharmacist approved by the company for the purpose of reviewing the medications being taken by the *insured person*, and is to be provided in accordance with these rules.
- (40) ***"Minister"*** means the Federal Minister or his or her delegate with the powers vested in the Minister by the *PHI Act*.
- (41) ***"Nursing Home Type Patient"*** has the meaning set out in the Private Health Insurance (Benefit Requirements) Rules
- (42) ***"Nursing Home Type Patient's Benefit"*** means the default benefit declared by the *Minister* for *Nursing Home Type Patients* from time to time.
- (43) ***"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
- (44) ***"overseas"*** has the meaning given to it in section 34-30 of the *PHI Act*.
- (45) ***"participant"***, in relation to the *premiums reduction scheme*, means:
- (a) a person who is registered as a participant in the scheme under subsection 23-15(3) of the *PHI Act*; or
  - (b) a person who has applied to be registered as a participant in the scheme under subsection 23-15 (1) of the *PHI Act* and whose application has not been refused.
- (46) ***"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 and *has* the meaning given to it in section 34-30 of the *PHI Act*.
- (47) ***"permitted days without hospital cover"*** has the meaning set out in section 34-20 of the *PHI Act*.
- (48) ***"premiums reduction scheme"*** means the scheme provided for by Division 23 of the *PHI Act*.
- (49) ***"premium group"*** means
- (i) employees of a particular business enterprise or group of enterprises; or
  - (ii) members of a professional association; or

- (iii) any other group deemed by the *Company* to be a premium group, or
  - (iv) a group of *policy holders* approved for the purposes of Fund Rule D1.5
- (50) **"Pharmaceutical Benefits Schedule"** means the Schedule of Pharmaceutical Benefits as published by the Commonwealth Department of Health and Ageing.
- (51) **"PHI Act"** means the Private Health Insurance Act 2007 (Cth).
- (52) **"Private Health Insurance Ombudsman"** means the Private Health Insurance Ombudsman appointed for the purposes of Part 6-2 of the *PHI Act*.
- (53) **"policy holder"**, of a health benefits fund means a holder of a *policy* that is referable to the Company.
- (54) **"pre-existing condition"** has the meaning set out in section 75-15 of the *PHI Act*.

## B INTERPRETATION AND DEFINITIONS – (contd)

### B2 Definitions – (contd)

- (55) **"private health insurer"** means a person registered under Part 4-3 of the *PHI Act*.
- (56) **"private health insurance arrangement"** has the meaning set out in Schedule 1 of the *PHI Act*.
- (57) **"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).
- (58) **"private practice"** means a practice operating on an independent and self supporting 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*.
- (59) **"product"** has the meaning set out in subsection 63-5(2) of the *PHI Act*.
- (60) **"product rules"** means rules applying to a *complying health insurance product* that are not inconsistent with the *fund rules*.
- (61) **"product subgroup"** has the meaning set out in subsection 63-5(2A) of the *PHI Act*.
- (62) **"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* prosthesis is an external appliance or device approved by the *Company*, normally associated with a physical replacement of some part of the human body.
- (63) **"PBS"** means the Pharmaceutical Benefits Scheme.
- (64) **"PBS item"** means any drug used for the indication it is listed for in the Pharmaceutical Benefits Schedule.
- (65) **"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*.
- (66) **"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.
- (67) **"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*.
- (68) **"Standard Information Statement"** has the meaning set out in section 93-5 of the *PHI Act*.
- (69) **"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.
- (70) **"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;

- (71) **“TGA Approved”** means an item that has been ‘registered’ on the Australian Register of Therapeutic Goods
- (72) **"transfer"**, in relation to a person, has the meaning set out in section 75-10 of the *PHI Act*.
- (73) **"transfer certificate"** has the meaning set out in section 99-1 of the *PHI Act*.
- (74) **"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) 3 or more people, at least 3 of whom are *adults*;
- (6) 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 a *complying 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* (except to cancel 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 *complying health insurance products*:

- (1) stand-alone *products* that only cover *hospital treatment* as set out in Schedule H;
- (2) stand-alone *products* that only cover *general treatment* (other than *hospital-substitute treatment*) as set out in Schedule I;
- (3) 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.

*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*.

*Policy holders* can choose to take out “Ambo Cover” as set out in Schedule I, Rule I12 with another *complying health insurance product* only in the following circumstances;

1. in the case of a *product* that covers *hospital treatment*, the *product* is the *Company's* “Basic Hospital Cover” as outlined in Schedule H, Rule H8; and
2. in the case of a *product* that covers *general treatment*, any *product* from Schedule I.

C1.3 The *Company* offers *products* for persons who are ineligible for full Medicare benefits as set out in Schedule.

## **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 health benefits fund*.

C2.2 A person may not be *covered* by a *complying health insurance policy* with the *Company* if that person has an equivalent or corresponding *complying health insurance policy* with another *private health insurer*.

### **C2.3 Eligibility to hold a Policy**

Subject to these *rules*, the *Company* will treat any natural person currently legally residing in *Australia* as eligible to be a *policy holder*; or registered as an *insured person* under a *policy* on any level of cover, Where an *insured person* is officially advised that their permanent Australian residency has been granted from a date prior to the date of the advice, for the purposes of these *rules*, the permanent residency is taken to be effective only from the date of the official advice.

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

## **C MEMBERSHIP – (contd)**

### ***C3 Dependants***

- C3.1 The *Company* may elect not to make a *complying health insurance product* available to a category of insured group that includes *dependant 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 *complying 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 a *complying health insurance policy* with the *Company*.
- C4.4 The *Company* must not refuse to *insure* a person under a *complying health insurance policy* if to do so would result in *improper discrimination*. An *application to be covered under a complying health insurance product may not be refused, subject to the applicant and all the intended insured persons satisfying all relevant rules*.
- C4.5 The *Company* will maintain up to date *Standard Information Statements* at all times for each *product subgroup* of each *complying health insurance product* that it makes available and under which it provides cover.
- C4.6 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* policy, titled "Bupa Australia Information Handling Policy", available online or calling the *Company*.

**C MEMBERSHIP – (contd)**

***C4 Membership Applications – (contd)***

## 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* or from another *private health insurer*, *waiting periods* apply to any higher benefits not *covered* on the previous level of *cover*.

C6.2 If a person *transfers* to a *complying health insurance policy* (the **new policy**) from another *complying health insurance policy* (the **old policy**) either within the *Company* or from another *private health 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 *complying health insurance policy* either within the *Company* or from another *private health insurer*, 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 *complying health insurance policy* held with the *Company* or any other *private health insurer*.

When a *policy holder* on a *policy* with another *private health insurer* transfers to the *Company* with a break in coverage of two (2) months or more, the *Company* may apply all relevant *waiting periods* as set out in Fund Rules C.6.

Where a *policy holder* on a *policy* with another *private health insurer* transfers to the *Company* or recommences their *policy* on any level of cover with the *Company* with a break in coverage of greater than two (2) months, the *Company* will treat that person as a new *policy holder* for all purposes except those relating to Lifetime Health Cover as specified at Fund Rule D4.

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 a *complying health insurance 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.

C6.6 The *Company* may apply all relevant *waiting periods* in accordance with Fund Rule C6.4 in relation to *general treatment* benefits (excluding *hospital-substitute treatment*), to the unexpired portion of a benefit replacement period or limit governing the supply or replacement of an appliance or *prosthesis*. A benefit replacement period is a continuous period of time that must pass between any two purchases of the same type of item before benefits are payable in respect of the later purchase.

C6.7 Subject to other Fund Rules, where a *policy holder* transfers from another *private health insurer* or to a different level of cover within the *Company*, any relevant benefits that have been paid in a specified time period under the previous cover may be taken into account in determining the benefits payable under the new level of cover. Any relevant benefits include, but are not limited to, benefits that are subject to an annual or other limits or a maximum number of times a benefit may be payable. Where a *policy holder* has transferred to the *Company* from another *private health insurer*, the *Company* may at its discretion recognise a period of coverage with the previous *private health insurers* in determining annual limits for benefits under the new level of cover.

## C MEMBERSHIP – (contd)

### *C7 Cancellation of Membership*

- C7.1 Subject to Rules C7.4, C7.5 and C7.5A, 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 the date requested by the *policy holder*, which may not be more than 30 days after receipt of the request for cancellation or 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 of receipt of the request for cancellation.
- C7.2 Subject to Rule C7.4 and C7.5, the *Company* will reimburse the *policy holder* any premiums paid in advance where a *policy holder* wishes to cease the policy before the paid to date.
- C7.3 Refunds under Rule C7.2 and C7.4 may incur an administration fee determined by the *Company* from time to time.
- C7.4 On the basis that no claim has been made under their policy and subject to Rule C7.3, a *policy holder* may cancel their *policy* in accordance with Rule C7.1, within 30 days of commencement of their *policy* and the *Company* will reimburse the *policy holder* any premiums paid in respect of their *policy*.
- C7.5 The *Company* may allow a *policy holder* to retrospectively cancel their *policy*, and receive a refund of premiums paid where the request to cancel is within 30 days of the cancellation date or in other cases determined by the *Company*, at its discretion. In the case that a *policy holder* has elected to retrospectively cancel their *policy*, in accordance with this rule (C7.5) and a claim has been paid within 30 days from the relevant request the cancellation will apply from the date of payment of that claim.
- C7.5A In the case of cancellation of a *policy* as the result of the death of an *insured person* (**affected person**), the *Company* will refund any premiums paid, from the date of the affected person's death,
- 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 on notice to the *policy holder* provided that in the case of a *complying 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 a *complying 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) After an *insured person* has reached the maximum suspensions for overseas travel, in accordance with Rule C9.4
  - (b) If a *policy* is in arrears of two months or more in accordance with Rule D5.3; or
  - (c) Or for any reason, at the discretion of the *Company* and in accordance with the *PHI Act*.

## **C9 Temporary Suspension of Membership**

- C9.1 A *policy holder* who has been *covered* under a *complying health insurance policy* for at least twelve months may apply to the *Company* to suspend the *policy* in cases of overseas travel, financial hardship or as a result of imprisonment.
- C9.1A A *policy holder* who has been *covered* under a *complying health insurance policy* for at least twelve months may apply to the *Company* to suspend the *cover* under a *policy* in respect of any *insured person* in cases of overseas travel or as a result of imprisonment.
- C9.2 The *policy holder* must provide overseas travel documents to verify departure and return dates. Any documentation reasonably requested by the *Company* must be provided by a *policy holder* to substantiate a case of financial hardship.
- C9.3 The *policy holder* must make an application for suspension for overseas travel prior to the date of departure. Suspension for overseas travel takes effect from the day after departure. Suspension for financial hardship takes effect from the day after application is approved by the *Company*.
- C9.4 Suspension for overseas travel must be for a period of between two months and two years. A maximum of three periods of suspension for overseas travel are permitted and there must be a period of at least one month with premium payments between each such suspension. Suspension for financial hardship may be for an individual period of no less than 3 months, with the total of all periods of suspension for financial hardship under this rule (C9.4) not able to exceed 12 months during the time a person is covered by a *complying health insurance policy* with the *Company*. Suspension as a result of imprisonment applies for a maximum of 4 continuous years.
- C9.5 If the *policy* has not been terminated, the *policy* will recommence, with the applicable premium payments due and payable;
- (1) In the case of suspension for overseas travel, upon the return date of overseas travel;
  - (2) In the case of suspension due to financial hardship, upon the return date following the cessation of financial hardship; and
  - (3) In the case of suspension as a result of imprisonment, upon the date the *policy holder* is released, as evidenced by a release form issued by the Department of Correctional Services.
- C9.6 If the *policy holder's* level of cover is no longer available on return from suspension, the *policy holder* may choose another level of cover. Rule C6 will apply to that transfer.
- C9.7 No benefits are payable for treatment during a period of suspension. *Waiting periods* and *Restricted Benefits* that were applicable to the *policy holder* at the start of suspension continue to apply on resumption of the *policy holder*.
- C9.8 Periods of suspension do not count towards the serving of *waiting periods* or periods of *Restricted Benefits*.
- C9.10 (a) If the *policy holder* has identified their proposed date of return on or before the date of departure, then the *Company* will require that the *policy holder* notify the *Company* of this date and the *policy* will automatically recommence from the identified date of return. The *policy holder* must pay the relevant premium to confirm the recommencement of the *policy*
- (b) If (a) does not apply, a suspended *policy* must be recommenced within one month of the earlier of the date of which the reason for suspension ceases to apply, or the date on which the maximum suspension period has been reached.

## **C10 Other**

## **D CONTRIBUTIONS**

### ***D1 Payment of Contributions***

- D1.1 Premiums are as set in Schedule K. These premiums do not include the increased premiums described in rule D4.
- D1.2 A *policy holder*, shall at the time the *policy holder* first becomes insured under a *complying 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).
- D1.3 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 the *complying health insurance policy* applicable in the new *State of Residence*.
- D1.5 The *Company* will require that a *policy holder* pay contributions at the premium for the chosen insured groups and level of cover.
- D1.6 The *Company* may at its discretion approve any group of *policy holders* as a *premium group*.
- D1.7 Unless otherwise specified or agreed by the *Company*, the *Company* may refuse to accept a payment of premiums, that would cause a *policy* to be paid up to a date which exceeds 12 months in advance of the date of payment. Where through any other circumstance the period in which the *policy* is financial exceeds 12 months from the current date, the *Company* may refund the portion of the premiums in excess of 12 months.

### ***D2 Contribution Rate Changes***

- D2.1 The *Company* may adjust the premiums that apply to a *complying health insurance policy* in accordance with section 66-10 of the *PHI Act*.
- 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 if to do so will comply with section 66-5 of the *PHI Act*.

### ***D4 Lifetime Health Cover***

- D4.1 The *Company* must increase the amount of premiums payable for *hospital cover* in respect of an *adult* if:
- (1) the *adult* did not have *hospital cover* on his or her *lifetime health cover base day*;
  - (2) the *adult* ceases to have *hospital cover* after his or her *lifetime health cover base day*.

The amount by which the premium will be increased is set out in Division 34 of the *PHI Act* and is calculated by reference to a *policy holder's lifetime health cover age*. An *adult* is taken to have *hospital cover* at any time during which the *adult* holds a *gold card*.

- D4.2 The *Company* must stop increasing the amount of premiums payable by a *policy holder* for *hospital cover* where required, in accordance with the requirements, under Division 34 of the *PHI Act*

## **D CONTRIBUTIONS – (contd)**

### ***D4 Lifetime Health Cover – (contd)***

D4.3 The premiums will not be increased for a *policy holder* under this rule D4 where:

- (1) at the time the *policy holder* first took out *hospital cover* with a *private health insurer*, the 1 July following the *policy holder's* 31st birthday had not arrived; or
- (2) the *policy holder* had *hospital cover* at 1 July 2000 and has maintained it since then; or
- (3) the *policy holder* was born on or before 1 July 1934; or
- (4) a *policy holder* who turned 31 on or before 1 July 2000 was *overseas* on 1 July 2000; or
- (5) the *policy holder* is the subject of a determination (with effect immediately before 1 April 2007) under clause 10 of Schedule 2 of the *National Health Act 1953 (Cth)*.

D4.4 The premium payable by a *policy holder* for *hospital cover*:

- (1) under rule D4.1 (1) increases by 2% of the *base rate* for each year a *policy holder's lifetime health cover age* is above 30. The maximum amount of any premium increase under this rule is an amount equal to 70% of the *base rate*; and
- (2) under rule D4.1 (2) increases by 2% for each year the *policy holder* is without *hospital cover* (calculated in accordance with section 34-5 of the *PHI Act*).

D4.5 The amount of increased premiums for a membership with more than one *adult* is calculated by averaging the increased premiums applicable to each *adult* in accordance with section 37-20 of the *PHI Act*.

D4.6 The Private Health Insurance (Lifetime Health Cover) Rules 2007 contain special provisions for certain groups of people including the following:

- (1) people who have health services provided by the Australian Antarctic Division of the Department of the Environment and Heritage;
- (2) members of the Australian Defence Forces (and their *adult* dependants) on continuous full time service and whose health services are provided by or through the Australian Defence Force.

### ***D5 Arrears in Contributions***

D5.1 A *policy holder* will be in arrears if premiums are not paid by the due date.

D5.2 If a *policy holder* is in arrears in respect of a *complying 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.

D5.3 The *Company* may cease a *policy* under a *complying health insurance policy* if the period of arrears exceeds two months.

### ***D6 Other***

D6.1 If a *policy holder* ceases to be covered by a *complying 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 *complying health insurance policy* (calculated on a pro rata basis) less any administration costs incurred by the *Company*.

## **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 or refuse to pay any benefit 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 state of residence of the *insured person*, who received the treatment and is not payable based on the state in which the treatment was received by the *insured person*.
- E1.11 In lieu of monetary benefits payable to a *policy holder* the *Company* may in its absolute discretion apply services or appliances to an insured person.

## **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 but not inclusive of the date of discharge from *hospital*.
- E2.4 The *Company* must ensure that *complying health insurance policies* that cover *hospital treatment* meet the benefit requirements set out in section 72-1 of the *PHI Act* and the Private Health Insurance (Benefits Requirements) Rules 2007. Medical benefits are payable by the *Company* in accordance with section 72-1 of the *PHI Act* for *hospital treatment* or *hospital-substitute treatment* covered by the *complying health insurance policy* where a Medicare benefit is payable for that treatment.
- E2.5 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 and medical practitioners are available to *policy holders* upon request.
- E2.6 For all *complying 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).
- E2.7 For all *complying 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.

## **E BENEFITS – (contd)**

### ***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 a *complying 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 *complying 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.
- E2.11 Where a *policy holder* is classified as a *Nursing Home Type Patient*, the *Company* can request an Acute Care Certificate and any additional supporting information from the medical record.

## **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 a *complying 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 a *complying 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 non-*PBS* prescription items which are *TGA Approved* and where such approval is for that condition. Pharmacy benefits are not payable if they are excluded by the *Company*. Benefits are not payable for *PBS items*.
  - (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*.
  - (7) Local and interstate travelling benefits are payable for expenses associated with essential medical or hospital treatment where the total return distance travelled is at least 300 kilometres.

(8) Overnight non-hospital accommodation benefits are payable for the patient and an attendant for travel away from home for treatment unable to be provided by the patient's own doctor.

(9) Where a *complying health insurance policy* states that a benefit is payable for *Medication Assistance Service*, the *Company* will pay a benefit in accordance with its agreement with the relevant *recognised practitioner*.

(10) Where a *complying health insurance policy* states that an *accident benefit* is payable, the *Company* will pay a benefit in provided that proof that the occurrence of the accident and documentary evidence of admission to hospital or to the emergency department of a hospital is provided to the *Company* upon request.

### ***E3 General Treatment – (contd)***

- E3.5 The amount of a benefit for a treatment under a *complying 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*.

## **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 a *policy holder's dependent child* or business associate or their *Partners* or *dependant children* 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 trial 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, that is services provided to patients who are not admitted patients

## F LIMITATION OF BENEFITS

### *F1 Co Payments*

F1.1 The *complying health insurance policy* chosen by a *policyholder* may require that a co-payment be made in respect of an *insured person*. The co-payment will apply for any overnight or same day admissions where an *insured person* is admitted to a *hospital*.

### *F2 Excesses*

F2.1 *Policy holders* may choose a *complying 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 a *complying health insurance policy* will be outlined in accordance with Schedules H and 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*.

F3.2 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 a *complying health insurance policy* (the **old policy**) as a *dependant* with the *Company* and within 60 days become a *policy holder* of a *complying 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 *complying 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 a *complying 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*.

A *waiting period* will not apply to any *hospital treatment* or *general treatment* covered by a *complying health insurance policy* where that person:

- (a) held a *gold card*, or was entitled to treatment under a *gold card*, before applying for the *insurance*; and
- (b) applies for the *insurance* no longer than two months after the person ceased to hold, or be entitled under, the *gold card*.

**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:

<b><i>Type of Case</i></b>	<b><i>Waiting Period</i></b>
<i>Pre-existing condition</i>	Twelve Months
<i>Obstetric Patient</i>	Twelve Months
Laser Eye Correction Surgery	Three Years
Psychiatric*	Two Months
Rehabilitation*	Two Months
Palliative Care*	Two Months
All Other Cases^	Two Months

\* 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

## F LIMITATION OF BENEFITS – (contd)

### F3 Waiting Periods – (contd)

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

<i>Type of Case</i>	<i>Waiting Period</i>
<i>Pre-existing condition</i>	Twelve Months
General Dental	Two Months
Major dental	Twelve Months
Orthodontics	Twelve Months
Appliances	Twelve Months
Heart Screening Tests	Twelve Months
Living Well Program	Six Months
Hire, Repair and Maintenance of Appliances	Six Months
All Other Cases <sup>^</sup>	Two Months

<sup>^</sup>No waiting periods apply for benefits provided in relation to accidents proved to occur after the policy commences or *Accident benefit* included as a benefit for accidents occurring after the policy commences

### F4 Exclusions

F4.1 Unless otherwise stated in these *rules*, there are no total exclusions applicable to any types of *hospital treatment* on any of the *Company's hospital treatment tables*.

### 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. 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 Overseas Visitors Hospital Cover.

## **F LIMITATION OF BENEFITS – (contd)**

### ***F5 Benefit Limitation Periods – (contd)***

F5.3 Services for which BLPs may apply on the Company's products include:

- 
- All Psychiatric services (except eating disorders and post natal depression)
- Assisted reproductive services (including IVF)
- Hip or knee replacement
- Cataract surgery
- Renal dialysis or chronic renal failure
- Bone marrow transplants

F5.4 BLPs on the *Company's* products are served concurrently with *waiting periods*.

### ***F6 Restricted Benefits***

F6.1 *Restricted Benefits* may apply to the following:

- Pregnancy related services (including childbirth)
- Heart, artery, cardiac related services
- Psychiatric services
- Assisted reproductive services (including IVF)
- Hip, knee or joint replacement
- Rehabilitation services
- Cataract and eye lens procedures & surgery
- Cosmetic surgery
- Renal dialysis or chronic renal failure
- Hospital admissions for services not eligible for Medicare rebate

### ***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.

## **F LIMITATION OF BENEFITS – (contd)**

### ***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 a *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 under 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***

