

MBF Overseas Visitors' Cover Policy Terms & Conditions

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A. GENERAL CONDITIONS

1. About the Policy Terms

The information contained in these Policy Terms provides details about your Policy including who can be on the Policy, Contribution Rates and entitlement to Benefits. These Policy Terms together with the application form and brochure constitute the agreement between MBF and the Policyholder and include the obligations of the Policyholder and Insured Persons (but do not include the Policy Terms that relate to Resident's Cover). Many of the words/terms used in these Policy Terms have a specific meaning. Except as otherwise stated, these meanings are explained in the Definitions section.

2. Insured Persons' Obligations

When you apply to become a Policyholder with MBF you must provide full and complete disclosure on all matters that MBF requests and comply with all reasonable requirements of MBF.

3. Changes to Policy Terms

Policyholders are bound by any changes in the Policy Terms. You are bound by the new Policy Terms from the date MBF determines they are effective, whether or not you are Financial at that date. MBF may make any variation or cancellation of any of the Policy Terms at its discretion, subject to any relevant regulatory approval.

Where practical, MBF will give you at least 14 days' notice of a Contribution Rate change and notice of other changes that significantly reduce Benefits will be notified in accordance with the relevant provisions of the Private Health Insurance Code of Conduct. In the instance where those provisions are not clear, MBF will provide at least 30 days' notice.

Notice of a change is effective if given by any of the following means:

- i. letter sent to the Policyholder at the most recently advised postal address, fax number or email address;
- ii. by inclusion in any MBF publication generally made available to Policyholders;
- iii. publication on MBF's website;
- iv. any electronic transmission; or
- v. any other reasonable means.

Where posted, the notice is deemed received on the day following posting.

4. Dispute Resolution

If you have any complaints or problems concerning your Policy, in the first instance contact MBF on 131 137. If you are not satisfied with the outcome, your concerns will be passed on to the MBF Customer Services Team. If you are not satisfied with the response from MBF, you can contact the Private Health Insurance Ombudsman on 1800 640 695. This is an independent, free service to address the concerns of all members of Australian health funds. It is funded by a levy paid by private health insurers.

B. GENERAL CONDITIONS OF POLICY

1. Eligibility to hold a Policy

Any natural person living in Australia but is not a resident of Australia, and who is not entitled to Medicare benefits (as defined under the Health Insurance Act 1973), is eligible to apply to be a Policyholder or apply to be registered as an Insured Person under a Policy on any Level of Cover, provided they are aged 17 or over.

2. One Person, One Policy

A person is not permitted to:

- i. be admitted as a Policyholder; or
- ii. continue as a Policyholder;

if they have a Policy in relation to an Equivalent Cover with another Fund. If MBF becomes aware a person has an Equivalent Cover with another Fund, MBF may terminate the Policy or elect to void the Policy from the date the Equivalent Cover became effective.

3. Levels of Cover

Unless otherwise indicated in a Level of Cover, MBF may admit a person as a Policyholder in one of the Insured Groups in respect of only one of the following categories:

- i. any one level of Hospital Cover set out in Appendix 6 to the Product Rules;
- ii. any one level of General Treatment Cover set out in Appendix 3 to the Product Rules;
- iii. any combination of one level of Hospital Cover set out in Appendix 6A to the Product Rules and one level of General Treatment Cover set out in Appendix 3 to the Product Rules;

4. Policy Commencement Date

Provided Contribution Rates are paid in accordance with paragraph B.6, below, the Policy commences on the latest of:

- i. the day (24 hours) after the day the application is accepted by MBF; or
- ii. the Policyholder's date of arrival in Australia.

5. Registration of Insured Persons on a Policy

A Policyholder may register his or her Spouse on selected Couple or Family Policies only.

A Policyholder may register a Dependant Child on a Family Policy or a Single Parent Family Policy only.

If a new-born child is added at least 2 months prior to its birth to a Single Parent, Family, Couple or Family Policy then no additional Waiting Periods will be applied, to benefits payable for services to the new-born except for congenital conditions where considered pre-existing (see Waiting Periods below).

6. Payment of Contribution Rates

The Policyholder is responsible for ensuring that the Contribution Rates are paid and that the Policy remains Financial at all times.

7. Policyholder's Authority

Subject to Partner Authority, the Policyholder is the only Insured Person authorised to:

- i. change any of the details of the Policy;
- ii. change the Level of Cover or Level of Covers;
- iii. apply to register a person as an Insured Person;
- iv. remove an Insured Person from the Policy;
- v. make a claim or receive a Benefit for an Insured Person;
- vi. terminate the Policy;
- vii. access the personal information of all Insured Persons on the Policy.

8. Partner Authority

The Policyholder has the option to give their Spouse, as nominated on the application form, permission to have the same authority as the Policyholder in relation to the Policy (see 'Policyholder's Authority').

To do so, the Policyholder must tick the box on the application form at the time of joining or complete the relevant MBF form.

Without Partner Authority, a partner is only permitted to sign for and receive benefits for themselves and request information about their own personal details and claims history.

The Policyholder can revoke the Partner Authority at any time by notifying MBF in writing.

9. Transfers from another fund or MBF Policy

If you become eligible for full Medicare benefits and, if you transfer from another Australian registered health fund or are covered by another MBF Policy, you will have continuity across Policies at the same level of Benefit entitlement for services provided by and common to both Levels of Cover. This is provided that you have already served the relevant Waiting Periods and transferred within two months of ceasing your Policy with the previous fund or rejoined MBF within two months of cancelling your previous MBF Policy. Please note that Overseas Visitors' Policies do not enable Insured Persons to avoid Lifetime Health Cover (LHC) penalties that may apply (for more information about LHC, please visit mbf.com.au).

If you transfer to MBF or rejoin MBF more than two months after your previous Policy has ceased, you will have to serve all the Waiting Periods applicable to your new Level of Cover.

If you transfer to a level of MBF cover that provides benefits not covered by your previous fund's Policy, you must serve the relevant Waiting Periods for the additional benefits.

Where Limits apply, including lifetime limits, any benefits paid under your previous Policy are treated as if MBF had paid them under the new Policy.

10. Termination

10.1 MBF may terminate a Policy immediately if:

- i. in the reasonable opinion of MBF the Insured Person has deliberately given false information or has falsely obtained or attempted to obtain a Benefit to which they are not entitled;
- ii. the provision, 'Termination of a Policy in Arrears' apply; or
- iii. MBF gives one month's notice in writing and refunds any Contribution Rates paid by the member for the period after the effective date of termination of the Policy.

10.2 A Policyholder can terminate their Policy at any time or remove any Insured Person from their Policy by notice in writing to MBF

10.3 A Policy will terminate immediately without notice if:

- i. any Insured Person becomes eligible for full Medicare benefits (as defined under the Health Insurance Act 1973);
- ii. the Repatriation Benefit, where applicable, has been paid, in which case the date of termination will be the date the Policyholder leaves Australia.
- iii. your visa entitling you to be in Australia expires or becomes invalid; or
- iv. you leave Australia (including PNG and Norfolk Island) unless MBF, before you departed, agreed to suspend your Policy.

11. Temporary Suspension of Policy

If the Policyholder is covered under Corporate Overseas Visitors' Cover and will be overseas for two or more calendar months, MBF may agree to suspend a Policy. The Policyholder must make an application to MBF in writing prior to the departure date and Date Paid Through together with proof of the date of departure.

MBF may agree in its absolute discretion to suspend a Policy for:

- i. a minimum of two (2) months and a maximum of two (2) years for overseas travel where an Insured Person is (or Insured Persons are) overseas; or
- ii. a minimum of two (2) months and a maximum of three (3) years where an Insured Person (or Insured Persons) are overseas as a direct result of the Policyholder's employment.

12. Reactivation of a Suspended Policy

- i. If the Policyholder has identified his or her proposed date of return on or prior to the date of departure, then the Policy will automatically recommence from the identified date of return. The Policyholder must pay the relevant Contribution Rates for the Date Paid Through period to confirm the recommencement of the Policy.
- ii. If there is no nominated date of return, a suspended Policy must be recommenced within one (1) month of:
 - the date on which the reason for suspension ceases to apply; or
 - the date on which the maximum suspension period has been reached, whichever is earlier.
- iii. The Policyholder must recommence his or her Policy by the time specified in (ii), by:
 - notifying MBF in writing; and
 - paying the relevant Contribution Rates to MBF; and
 - in relation to suspension due to overseas travel, the Policyholder must show proof of date of return as required by MBF; and
 - providing all relevant documentation requested by MBF.
- iv. Where the Policy is not reactivated by the relevant date in accordance with (iii), MBF may terminate the Policy subject to the provision below, 'Termination of Policy in Arrears'.
- v. Where the suspended Policy relates to a Level of Cover that is no longer available, the Policyholder will be required to recommence at a Level of Cover currently available for new Policyholders to MBF.

C. CONTRIBUTIONS

1. Payment of Contribution Rates

Contribution Rates must be paid in advance and payments must be for the entire Date Paid Through Period. An adjustment to your payment and/or Date Paid Through Period may be required following a Contribution Rates increase, change to your level or scale of cover, change to your Policy Terms or change to Legislation.

2. No Entitlement to Claim

You will not be entitled to make a claim for any services provided after the date to which your Policy has been paid. If you make a payment that is less than the full amount due for the Date Paid Through Period, Benefits will not be payable until the entire amount for the Date Paid Through Period have been received by MBF. If, for any reason, payments fall into Arrears, MBF may terminate the Policy with immediate effect by written notice to the Policyholder and subject to 'Termination of a Policy in Arrears'.

3. Treatment During Arrears

- i. Benefits are not payable for Treatment provided to an Insured Person during a period of Arrears.
- ii. Subject to the provisions, 'Termination of a Policy in Arrears', MBF will permit a Policyholder to regain an entitlement to Benefits for such Treatment by paying all outstanding Contribution Rates for the period of Arrears and provided the Contribution Rates are paid in advance for the entire Date Paid Through Period applicable at the time.

4. Termination of a Policy in Arrears

- i. In relation to all Policyholders who are not part of a Contribution Group, when a period of Arrears exceeds sixty (60) days, MBF may terminate the affected Policy with immediate effect by written notice to the Policyholder.
- ii. In relation to Direct Debit Policyholders who are part of a Contribution Group when a period of Arrears exceeds sixty (60) days, MBF may terminate the affected Policy with immediate effect by written notice to the Policyholder.
- iii. In relation to Group Policyholders who are not Direct Debit Policyholders or Invoiced Group Policyholders, when a period of Arrears exceed ninety (90) days, MBF may terminate the affected Policy with immediate effect by written notice to the Policyholder.
- iv. In relation to Invoiced Group Policyholders, when a period of Arrears exceeds one hundred and eighty (180) days, MBF may terminate the affected Policy with immediate effect by written notice to the Policyholder.
- v. Where a Policy has been terminated in accordance with these provisions, MBF has the discretion to reinstate the Policy at the request of the Policyholder, provided that the Policyholder:
 - pays all Contribution Rates as required by MBF; and
 - is subject to Waiting Periods as though the Policyholder and all Insured Persons under the Policy are new Insured Persons; and
 - the duration of the Policy prior to the date of termination shall not be included for the purposes of calculating tenure of the Policy with the Fund.

D. BENEFITS

1. Entitlement to Benefits

MBF will pay Benefits to a Policyholder in accordance the Policy Terms. In addition, Benefits will only be payable where:

- i. the Treatment is provided by a MBF Recognised Provider* or a Hospital; and
- ii. the service, appliance or Treatment is provided in Australia; and
- iii. the Treatment is Clinically Relevant; and
- iv. in the case of Hospital Treatment, the Insured Person is an admitted patient**; and
- v. the service is a medical service, the Treatment must be provided by a Medical Practitioner for a service in respect of which a Medicare Benefit is payable and in respect of Hospital Treatment for which the Insured Person is entitled to receive Benefits under the Policy; and
- vi. in the case of General Treatment, a service or appliance is provided once per attendance and subject to the General Treatment Benefit Guidelines; and
- vii. the Treatment relates to services or appliances that were provided where the Insured Person and provider were in the physical presence of each other; and
- viii. the Treatment meets the Patient Classification Requirements set out in the Fund Rules.
- ix. the Treatment was provided to Insured Persons properly registered on the Policy.

*provided that (but subject to the discretion of MBF) the Treatment is not rendered by a provider to the provider's spouse, de facto partner, dependants or business partner or the spouse, de facto partner or dependants of the provider's business partner.

**except as provided by the Act or where provided under a HPPA.

2. Reduction in Benefits

- i. Where the amount paid by an Insured Person for a service is lower than the Benefit that would otherwise have been payable, the Benefit shall be reduced to the amount paid.
- ii. Where moneys are payable from more than one source for the same service, MBF may reduce its Benefit by the amount payable from the other source(s).
- iii. Where, in the opinion of MBF, the charge is higher than the provider's usual charge for the service, MBF may assess the claim as if the provider's usual charge had applied.

3. MBF Network Hospitals

In a MBF Network Hospital, the Policyholder's entitlement to Benefits for Hospital Treatment will be satisfied by MBF complying with the terms of the relevant HPPA. MBF will make available to a Policyholder on request a list of the MBF Network Hospitals in each State or Territory.

4. Non-Agreement Hospitals

In a Non-Agreement Hospital, the Policyholder must pay the difference between the amount the Hospital charges and the Benefit paid by MBF, which could be substantial.

5. No Benefits for Hospital Treatment

Benefits are not payable under any Hospital Cover where:

- i. the treatment is not covered by Medicare (unless specifically covered by a HPPA) – examples include, without limitation, cosmetic surgery that is not clinically necessary and reversal of sterilisation;
- ii. the Benefit exceeds the Minimum Benefit for services, tests or procedures which are deemed to be experimental or not in accordance with accepted medical practices and standards, unless those services are provided through a program endorsed by the State Government health authorities and where the program or Treatment has been approved by MBF for the payment of Benefits prior to the Treatment being undertaken;
- iii. the Treatment or accommodation is in premises that are used, or are to be used, exclusively or principally for the care or Treatment of mentally ill or mentally defective persons, other than in a Hospital or where provided under a HPPA;
- iv. services relate to respite care or social hospital admissions;
- v. one or more of the provisions under 'Limitation of Benefits' below apply; or
- vi. if you hold Corporate Overseas Visitors Cover, the Treatment is for a Pre-existing Condition (including congenital Conditions, where considered Pre-existing).

6. Medical Benefits for Admitted Patients

Benefits are payable for medical services provided to an Insured Person by a Medical Practitioner only:

- i. where the service is a professional service in respect of which a Medicare Benefit is payable; and
- ii. while the Insured Person is an Admitted Patient; and
- iii. provided it is related to the Hospital Treatment for which the Insured Person is entitled to receive Benefits under the Policy.

7. Medical Benefits and Gap Cover Arrangements

- i. MBF may implement a Gap Cover Scheme.
- ii. Whether the Gap Cover Scheme applies to a Level of Cover is set out in the Product Rules.
- iii. The Gap Cover Scheme will only apply to an Insured Person for a Treatment where each Medical Practitioner involved in the Treatment agrees to opt in to the Gap Cover Scheme for the Treatment.
- iv. Benefits payable under Gap Cover arrangements are payable subject to the Medical Practitioner who provides Hospital Services under a No Gap Policy giving the Insured Person (or Policyholder where appropriate) written advice of any financial interest the practitioner may have in products or services recommended or provided to the Insured Person.
- v. The Insured Person's entitlement to Benefits for medical services is satisfied by MBF complying with the terms of the Gap Cover Scheme which in addition includes paying 100% of the CMBS Fee.

8. Medical Benefits Where There is no MPPA, PA or Gap Cover Scheme

Where there is no MPPA, PA or Gap Cover Scheme in place for the Treatment, the Policyholder's entitlement to Benefits for medical services

and doctor's charges is satisfied by MBF paying 100% of the CMBS Fee. The Insured Person is responsible for any charges above the CMBS Fee.

9. Medical Benefits Out Of Hospital

Where the Insured Person receives Treatment from a Medical Practitioner out of Hospital, the Insured Person's entitlement to Benefits for medical services and doctor's charges is satisfied by MBF paying 100% of the CMBS Fee. These Benefits are not part of the Gap Cover Scheme. The Insured Person is responsible for any charges above the CMBS Fee.

10. Requirements for Benefits for General Treatment

Benefits for General Treatment are only payable where the service or appliance is:

- i. necessary for the reasonable treatment of the Insured Person in the opinion of a Medical Referee, a Dental Referee or other person nominated by MBF; and
- ii. provided by a MBF Recognised Provider in the presence of the Insured Person.

11. General Treatment Program Agreements

MBF may enter into a special arrangement or agreement with a General Treatment provider or group of such providers to provide General Treatment services and other goods and services to Insured Persons under Approved General Treatment Programs. Approved General Treatment Programs are available on those Levels of Cover where indicated in the Product Rules.

12. MBF MemberCare Providers

MBF may enter into a special arrangement or agreement with a General Treatment provider or group of such providers in relation to particular General Treatment services or appliances. These providers are known as MBF MemberCare Providers.

13. Benefits for MBF MemberCare Providers

- i. MBF may pay Policyholders different Benefits for General Treatments provided by MBF MemberCare Providers than the Benefits payable for other MBF Recognised Providers for the same General Treatment services.
- ii. Details of the Set Benefits payable by MBF, Benefit conditions and dates of effect for agreements or arrangements made with MBF MemberCare Providers are contained in separate schedules maintained by MBF.

14. Limitation on Benefits for General Treatment

- i. Unless MBF considers there are justifiable circumstances, a Policyholder may only receive Benefits for one service or appliance per day per MBF Recognised Provider.
- ii. Except where agreed by MBF, in its absolute discretion, Benefits for General Treatment are not payable for services or appliances provided to an Insured Person as part of Hospital Treatment.
- iii. MBF may pay different levels of Benefits to different types of MBF Recognised Providers providing similar General Treatment services.
- iv. Benefits for General Treatment services will be provided in accordance with MBF's General Treatment Benefit Guidelines, as amended from time to time.

15. Derecognition of General Treatment Recognised Providers

MBF may at any time declare that a provider is no longer a General Treatment Recognised Provider in the event that the provider:

- i. fails to adhere to any requirements set down by MBF in relation to MBF Recognised Providers; or
- ii. fails to comply with any standards relevant to the MBF Recognised Provider and any Treatment they provide set out in the Private Health Insurance (Accreditation) Rules.

E. LIMITATION OF BENEFITS

The payment of Benefits will be restricted in accordance with the application of any of the following to your Policy:

- i. where the Policy is subject to an overall Limit either in terms of an overall dollar Limit or a maximum number of days for Hospital Treatment Limit whether per person or per Policy, then no Benefits are payable above the overall Limit stated in the Product Rules;
- ii. where you hold Corporate Overseas Visitors Cover and a doctor decides that you need long-term hospital care then, at MBF's election, MBF may pay a Repatriation Benefit.
- iii. where a Waiting Period applies to a Treatment covered under the Policy, no Benefits will be payable for any service, appliance or Treatment received before the relevant Waiting Period has been served. The relevant Waiting Periods are:
 - Pre-existing Condition*** – 12 months (except for Corporate Overseas Visitors Cover which does not pay any Benefit where Treatment is for a Pre-existing Condition)
 - Pregnancy and Birth Related Services – 12 months
 - congenital conditions where considered pre-existing – 12 months (except for Corporate Overseas Visitors Cover which does not pay any Benefit where Treatment is for a Pre-existing Condition)
 - major dental – 12 months
 - health management aids and appliances – 12 months (except for fully handcrafted surgical shoes – 5 years)
 - Optical Appliances – 6 months
 - MBF Living Well Program – 6 months
 - hearing aids – 3 years
 - other conditions – 2 months
 - Treatment for Accidents which occur after joining and would normally have a 2 month waiting period, will have no waiting period.

***except for psychiatric, palliative or rehabilitation services for which a two month Waiting Period applies.

- iv. If you have an Accident or are injured (eg in a motor vehicle accident or as a result of your employment) and have a right to receive Compensation or damages from a third party, you are not eligible for Benefits (includes future cost of treatment). This applies whether or not you pursue the claim and whether or not MBF has made any payment. You may apply for provisional benefits, but these must be paid back if you receive Compensation.

F. PAYMENT OF CLAIMS

1. Form of Claim

Claims for Benefits must be made in a manner approved by MBF and

supported by accounts and/or receipts and other information determined by MBF from time to time.

2. Claims to be Lodged Within Two Years

Benefits are not payable where a claim is lodged more than two (2) years after the date of service.

3. Claims to be Paid Within Two Months

Subject to the conditions of the Policy and all other reasonable conditions of MBF being met, (including the provision of an Acute Care Certificate), MBF will pay a valid claim for Benefits within two (2) months of receipt of all the required documentation. However, MBF may delay payment of a claim in the event of an audit or provider investigation.

4. Medical Examination

Where Benefits are claimed for services, items or appliances which in the opinion of a Medical Referee (or where MBF considers it appropriate, a dental or optical referee appointed by MBF):

- i. may not have been provided to or used by the Insured Person; or
- ii. on the basis of information supplied with the claim are not appropriate to the Treatment of the illness or injury;

a medical examination, by a person nominated by MBF at the expense of MBF, may be requested to determine the validity of any claim.

5. Fraudulent or Incorrect Claims

MBF will not pay any fraudulent or incorrect claim and reserves the right to seek recovery of any amounts wrongfully paid.

6. Policyholders May Delegate

MBF may authorise a Policyholder to delegate to another person the right to claim or assign Benefits to which the Policyholder may be entitled to under the Policy.

7. Manner of Benefit Payment

MBF may pay Benefits by cash, cheque or electronic funds transfer in accordance with arrangements it determines from time to time.

8. Treatment Information

MBF may ask you to provide information about your Treatment, including confirmation that it relates to a diagnosed medical condition and that it is a course of Treatment recognised by MBF. The Policyholder authorises MBF to obtain any information about any Treatment received by any Insured Person under the Policy directly from the provider, including copies of clinical records.

9. Online Claiming

Where a claim is made via online claiming, the benefits payable on any one day will be capped at a dollar amount determined by MBF and notified to Insured Persons from time to time.

G. DEFINITIONS

Unless these Policy Terms specify otherwise, any words and expressions used in these Policy Terms and which are defined in the Private Health Insurance Act 2007 and the Health Insurance Act 1973 shall have the same meanings given to those words and expressions as defined in those Acts.

In these Policy Terms, unless the context otherwise requires, the following terms have the following meanings:

'Accident' means an unforeseen event, occurring by chance and:

- i. caused by violent, accidental, external and visible means; and
- ii. which solely, directly and independently of all other causes, results in involuntary bodily injury, which requires immediate treatment.

For the avoidance of doubt it does not include unforeseen Conditions attributable to medical causes;

'Accident Benefit' means Benefits in relation to any Accident occurring after commencement of the Policy resulting in urgent hospital attention as soon as practicable after the Accident:

- i. on any service, item or appliance recognised by MBF for the payment of Benefits under the relevant General Treatment Cover; and
- ii. for those Policyholders who also contribute to a level of MBF Hospital Cover, contributions towards any Excess or Co-Payment.

'Act' means the Private Health Insurance Act 2007 and all related Private Health Insurance Rules.

'Acute Care Certificate' means a certificate set out in Fund Rule E2.28.

'Admitted Patient' means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment and;

- i. includes a new-born child who occupies a bed in a Special Care Unit; or is the second or subsequent child of a multiple birth. This definition excludes:
- ii. any other new-born child whose mother also occupies a bed in the Hospital; and an employee of a Hospital receiving Treatment in their own quarters.

'Ambulance' means a road vehicle, boat or aircraft operated by a service approved by MBF and equipped for the transport and paramedical Treatment of persons requiring medical attention.

'Approved General Treatment Program' means a program of General Treatment services and other goods and services including Chronic Disease Management Programs which MBF has approved for the payment of Benefits.

'Arrears' or **'Period of Arrears'** means where the date to which Contribution Rates have been paid is earlier than the Date Paid Through, other than in relation to a suspended Policy.

'Australia' for the purposes of these Policy Terms:

- i. 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
- ii. excludes Norfolk Island and other Australian external territories.

'Benefit' means an amount of money payable by the Fund in accordance with the Policy Terms.

'Benefit Replacement Period' means in relation to General Treatment Benefits (excluding Hospital-Substitute Treatment), a continuous period of time that must elapse between any two purchases of the same type of item before Benefits are payable in respect of that later purchase. Applicable Benefit Replacement Periods for each Level of Cover which provides Benefits for General Treatment are described in the Product Rules.

'Calendar Year' means the period from 1 January to 31 December.

'Chiropractic and Osteopathy' means professional Treatment that is:

- i. approved by MBF; and
- ii. provided during a Consultation with a practitioner who is recognised by MBF as a chiropractor or an osteopath.

'Chronic Disease Management Program' has the meaning set out in the Private Health Insurance (Health Insurance Business) Rules.

'Clinically Relevant' in relation to a procedure or service means one that is:

- i. performed or rendered by a Medical Practitioner, Dental Practitioner or Optometrist; and
- ii. generally accepted in the relevant profession or specialty group as being clinically appropriate Treatment of the Insured Person receiving the Treatment and not considered to be experimental (not subject to ongoing assessment and research to validate initial safety and efficacy in the relevant clinical circumstance).

'CMBS Fee' means the scheduled fee set out in the Commonwealth Medicare Benefits Schedule as published from time to time.

'Commonwealth Medicare Benefits Schedule (CMBS)' means the 'Medicare Benefits Schedule Book' published by the Department of Health and Ageing, and includes any updates and supplements to the CMBS published from time to time.

'Compensation' means:

- i. a payment by way of damages;
- ii. a payment (other than a payment of Benefits) under a scheme of insurance or compensation provided for by law of the Commonwealth, a State or Territory;
- iii. a payment, whether with or without admission of liability, in settlement of a claim for damages or of a claim under a scheme referred to in (ii);
- iv. a payment by way of damages (or, whether with or without admission of liability, in settlement of a claim for damages) for professional negligence in relation to a claim for payment referred to in (i), (ii) or (iii); or
- v. a right to claim compensation, damages or other payments under the Veteran's Affairs system, but not in relation to any beneficiary of the Commonwealth Department of Veteran's Affairs who elects to be treated for any condition or injury outside the Veteran's Affairs system; or
- vi. any other payment that, in the opinion of MBF, is a payment in the nature of compensation or damages.

'Condition' means any actual or perceived state of health for which Treatment is sought and includes but is not limited to states variously described as: abnormality, ailment, disability, disease, disorder, health problem, illness, impairment, impediment, infirmity, injury, malady, sickness or unwellness.

'Consultation' means an attendance by a relevant provider on, and in the physical presence of, a patient, or as otherwise approved by MBF.

'Continuous Hospitalisation' means where an Admitted Patient is discharged and, within seven (7) days is admitted to the same or a different Hospital for the same or a related Condition, the two admissions are regarded as forming one period of Continuous Hospitalisation.

In the case where the Hospitals are different, Benefits at the Advanced Surgical, Surgical or Obstetric levels are payable in respect of the later admission only if an appropriate procedure is rendered following that

admission.

'Contribution Group' means a group of Policyholders recognised by MBF as a Contribution Group. A Contribution Group may include, but is not restricted to:

- i. employees of a particular business enterprise or group of enterprises;
or
- ii. members of a professional association.

'Contribution Rates' means the premium or fees payable, plus any additional government charges such as GST, under a Policy in relation to the Levels of Cover held as set out in Appendix 7 of the Product Rules.

'Co-Payment' means an amount payable by a Policyholder towards the cost of services provided under an HPPA and is payable in addition to, and before, any Excess.

'Cosmetic Surgery' means surgical procedures:

- i. listed in the Plastic and Reconstructive Section (Subgroup 13) of the Commonwealth Medicare Benefits Schedule that:
 - are not Clinically Relevant;
 - do not meet the eligibility conditions for the payment of Medicare benefits; or
- ii. of a plastic or reconstructive nature that are not listed in the Commonwealth Medicare Benefits Schedule.

'Date Paid Through' means the end of the Date Paid Through Period in respect of which the Policyholder is required to pay Contribution Rates.

'Date Paid Through Period' means the entire period corresponding with the Payment Frequency chosen by the Policyholder.

'Day Hospital' means a day hospital facility as declared by the Minister under the Act.

'Dental Practitioner' means a person registered or licensed under a law of a State or Territory as a dental practitioner, dentist, dental surgeon, specialist dentist, advanced dental technician, clinical dental technician or dental prosthesisist.

'Dental Referee' means a dental practitioner appointed by MBF from time to time to act as a Dental Referee.

'Dental Treatment' means professional Treatment that is:

- i. approved by MBF; and
- ii. provided during a Consultation with a person who is recognised by MBF as a Dental Practitioner.

'Dependant' means Dependant Child and Student Dependant.

'Dependant Child' means:

- i. a child of the Policyholder or his or her Spouse under 21 years who does not have a Spouse, including a legally adopted child, a step-child or a foster child, and who is dependant on the Policyholder or his or her Spouse;
- ii. such other person under 21 years that MBF may, in its absolute discretion, accept from time to time; and
- iii. a child of the Policyholder or his or her Spouse who does not have a Spouse, including a legally adopted child, a step-child or foster child, who is over 21 years but under 25 years and who is a Student Dependant.

'Direct Debit Policyholder' means a Policyholder whose Contribution Rates are automatically paid to MBF using an approved credit facility or

from a financial institution account, in accordance with Fund Rule D1.3.

'Emergency Ambulance Transport' means where MBF pays a benefit for ambulance services where the services are provided by a State or Territory government service or an organisation recognised by MBF. Benefits are only available for emergency or casualty transportation where, in the opinion of a medical officer, an Insured Person requires immediate treatment in circumstances where there is serious threat to the Insured Person's life or health. Benefits are not payable for transportation from a hospital to your home, nursing home or other hospital, for transportation for ongoing medical treatment, or where your State government provides an ambulance benefit (eg Queensland and Tasmania). There is no ambulance benefit for MBF Public Hospital cover.

'Equivalent Cover' means a Level of Cover offered by MBF or another Fund which MBF considers to be equivalent to a Level of Cover offered by MBF.

'Excess' is a per year amount of Benefit a Policyholder agrees to forego in exchange for a lower Contribution Rate.

'Extras Cover' has the same meaning as General Treatment.

'Financial' means all Contribution Rates have been paid in full to the Date Paid Through.

'Fund' means the health benefits fund conducted by MBF and a reference to admission to the Fund and like terms refers to the issue of a Policy of insurance referable to MBF in relation to one or more Levels of Cover.

'Gap Cover Scheme' means the Medical Practitioner Gap Cover Scheme operated and offered by the Fund.

'General Treatment' has the same meaning as set out in section 121-10 of the Act.

'General Treatment Benefit Guidelines' means the Therapy Guidelines and Dental Guidelines.

'General Treatment Cover' means cover that only provides Benefits for General Treatment, excluding Hospital-Substitute Treatment.

'Goods and Services Tax' or **'GST'** means the broad-based tax on most supplies of goods and services consumed in Australia.

'Group Policyholder' means a Policyholder who is a member of a Contribution Group.

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

'Hospital' means:

- i. a Day Hospital, Private Hospital or Public Hospital; or
- ii. any other premises declared by the Minister to be a hospital in accordance with the Act.

'Hospital Cover' means a Level of Cover which includes Benefits for fees and charges for:

- i. some or all Hospital Treatment; and
- ii. some or all associated professional services rendered to a patient receiving Hospital Treatment.

'Hospital Service' means Professional Attention or any other item in respect of which Benefits are payable from a Hospital Cover.

'Hospital-Substitute Treatment' has the same meaning as set out in section 69-10 of the Act.

'Hospital Treatment' has the same meaning as set out in section 121-5 of the Act but excluding sub-section (4) and does not include treatment for

any pre-existing conditions, ailments or illnesses.

'HPPA' means a Hospital Purchaser Provider Agreement entered into between MBF and the proprietor of a Hospital.

'Insured Group' means one of the following:

- i. For a Single Policy, either
 - the Policyholder; or
 - where approved by MBF, a person other than the Policyholder;
- ii. For a Couple Policy, the Policyholder and their Spouse;
- iii. For a Family Policy, the Policyholder, their Spouse, and one or more Dependant Children; and
- iv. For a Single Parent Family Policy, the Policyholder and one or more Dependant Children.

'Insured Person' means:

- i. a Policyholder;
- ii. a Spouse registered on a Policy; and
- iii. a Dependant Child registered on a Policy.

'Invoiced Group Policyholder' means a Policyholder who is a member of a Contribution Group which is invoiced by MBF for the Contribution Rates payable by all members of the Contribution Group.

'Level of Cover' means one or more of the Levels of Cover as referred to in the section dealing with Level of Cover in these Policy Terms.

'Limits' means the maximum Benefit in a service category per Insured Person per calendar year except in the case of life-time limits (as referred to in the Product Rules) and periodic limits (as referred to in the General Treatment Benefit Guidelines).

'MBF AutoPay' means an arrangement approved by MBF to enable Policyholders to pay their Contribution Rates automatically from their credit card, bank account or other credit facility.

'MBF' means MBF Australia Limited ACN 000 057 590, ABN 81 000 057 590.

'MBF MemberCare Provider' means a provider of a General Treatment with whom MBF has entered into an arrangement.

'MBF Network Hospital' means a Hospital with which MBF has a HPPA.

'MBF Network Hospital Payment' means the amount that MBF agrees to pay a provider as set out in a HPPA, provided that the HPPA will specify that the Insured Person will be required to pay the fixed dollar contribution specified in the HPPA and any non-agreement out-of-pocket expenses.

'MBF Recognised Provider' means any person who is in Private Practice and who:

- i. is a Medical Practitioner; or
- ii. where professional registration is required, has and maintains the required registration and who meets and continues to meet MBF documented recognition criteria; or
- iii. where there is no registration requirement, meets and continues to meet MBF documented recognition criteria, whose services or appliances attract a Benefit or payment from MBF and in relation to the provision of General Treatment services who is advised by MBF that he or she is a recognised provider for the purposes of providing the particular General Treatment services.

'Medical Practitioner' means a person as defined in section 3(1) of the Health Insurance Act.

'Medication Assistance Service' means a one-on-one consultation with a pharmacist approved by MBF for the purpose of reviewing the medications being taken by the Insured Person, and is to be provided in accordance with the conditions set out in Fund Rule E.3.13(c).

'Medical Referee' means a Medical Practitioner appointed by MBF from time to time to act as a medical referee.

'Minister' means the Federal Minister or his or her delegate with the powers vested in the Minister by the Act.

'MPPA' means a Medical Purchaser Provider Agreement entered into between MBF and a Medical Practitioner.

'MPPA, PA or Gap Cover Scheme Payment' means the amount set out in an MPPA, PA or Gap Cover Scheme (as relevant), provided that MBF may specify that the Policyholder will be required to pay out-of-pocket expenses (if any).

'Non-Agreement Hospital' means a Hospital in relation to which MBF does not have a HPPA.

'Resident Level of Cover' means any health cover offered by MBF except for MBF Overseas Visitors' Cover and MBF Corporate Overseas' Visitors Cover.

'Nursing Home Type Patient' means a person who has been an Admitted Patient for a period of Continuous Hospitalisation exceeding 35 days and in respect of whom an Acute Care Certificate has not been provided to and approved by MBF.

'Nursing Home Type Patient Benefit' means in relation to an Admitted Patient in:

- i. a Public Hospital – the amount set out, or worked out using the method set out, in Schedule 4 to the Private Health Insurance (Benefit Requirements) Rules as the Minimum Benefit, or method for working out the Minimum Benefit, for patients in a Public Hospital; and
- ii. a Private Hospital – the amount set out, or worked out using the method set out, in Schedule 4 to the Private Health Insurance (Benefit Requirements) Rules as the Minimum Benefit, or method for working out the Minimum Benefit, for patients in a Private Hospital.

'Occupational Therapy' means professional Treatment that is:

- i. approved by MBF; and
- ii. provided during a Consultation with a practitioner who is recognised by MBF as an occupational therapist.

'Optical Appliance' means an appliance or a component of an appliance that has been approved by MBF and which:

- i. is prescribed by an optometrist or ophthalmologist; and
- ii. is designed and manufactured with the sole purpose of correcting a refractive error; or
- iii. is designed and manufactured with the sole purpose of causing image enhancement on the retina of the eye due to change of focal length caused by that appliance.

'Optometrist' means a person registered or licensed as an Optometrist or optician under a law of a State or Territory.

'Orthoptics' means professional Treatment that is:

- i. approved by MBF; and
- ii. provided during a Consultation with a practitioner who is recognised by MBF to provide Orthoptics Treatment.

'Out-patient' means a patient of a Hospital who is not an Admitted Patient.

'Out-patient Services' means Treatment for which MBF does not pay a Benefit unless MBF has a specific agreement with the hospital for a service or MBF specifies otherwise under your Level of Cover and we have an agreement with the provider for that treatment. Out-patient treatment includes but is not limited to:

- i. procedures that do not clinically require formal admission to a Hospital, eg procedures performed in a doctor's surgery;
- ii. emergency room treatment;
- iii. consultation with your specialist before a labour admission;
- iv. most fertility treatment; and
- v. services where Medicare doesn't pay your doctor's fee at the in-patient hospital benefit rate, eg a paediatrician check-up of a non-admitted newborn baby in hospital.

'PA' means a Practitioner Agreement entered into between a Medical Practitioner and a Hospital.

'Package Cover' means a Level of Cover that provides Benefits for Hospital Treatment and General Treatment.

'Patient Classification Requirements' means the patient classifications set out in Fund Rules E2.4 - 2.11.

'Payment Frequency' means the payment periods as specified in Fund Rule D1.4 for which the Policyholder chooses to pay his or her Contribution Rates.

'PBS' means the Pharmaceutical Benefits Scheme.

'PBS Item' means any drug listed in the Pharmaceutical Benefits Schedule, regardless of the quantity for which it is prescribed.

'Pharmaceutical Benefits Schedule' means the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing).

'Physiotherapy' means professional Treatment that is:

- i. approved by MBF; and
- ii. provided during a Consultation with a practitioner who is recognised by MBF as a physiotherapist.

'Policy' means a Policy of insurance issued by MBF which is referable to the Fund and which covers one or more Insured Persons.

'Policy Terms' means these Policy Terms & Conditions and includes the Fund Rules and Product Rules as registered with the Department of Health and Ageing and amended from time to time.

'Policyholder' or **'Contributor'** means the person in whose name the Policy is registered and who is responsible for payment of the Contribution Rates for the Policy.

'Pre-existing Condition' means a Condition where the signs or symptoms of which, in the opinion of a practitioner appointed by MBF, existed at any time during the six (6) months preceding the day on which the Insured Person joined MBF or transferred to a higher Level of Cover.

'Pregnancy and Birth Related Service' means any type of Treatment related to the management of pregnancy, labour and childbirth, including ante and post-natal care and includes, but is not restricted to obstetrics-related services.

'Private Health Insurance Code of Conduct' refers to the industry Code of which MBF is a signatory.

'Private Hospital' means:

- i. a Hospital that is approved as such under a law of the Commonwealth, or of a State or Territory; or
- ii. any other Hospital recognised by MBF as a Private Hospital for the purpose of paying Benefits.

'Private Practice' means:

- i. in relation to an individual provider, where the provider is self-employed and solely responsible for his or her own operating costs, sick leave and annual leave and whose income is principally derived from the fees charged to patients or clients for services rendered at that practice; and
- ii. in relation to a group of providers, where the income of that group is principally derived from fees received from patients or clients attending that group practice; provided that the individual or group provider is not funded or contracted to any public or private entity except for the payment of rent to such entity.

'Professional Attention' means:

- i. medical or surgical Treatment by or under the supervision of a Medical Practitioner; or
- ii. obstetric-related Treatment by or under the supervision of a Medical Practitioner or a Registered Nurse with obstetric qualifications; or
- iii. Dental Treatment by or under the supervision of a Dental Practitioner; or
- iv. podiatric Treatment by or under the supervision of an Accredited Podiatrist.

'Program' means a specified group of services or Treatments that is:

- i. provided at a Hospital; and
- ii. recognised by MBF for the purpose of paying Benefits.

'Prosthesis' means:

- i. in relation to a Hospital Cover: any item on the Federal Government's Prosthesis List or any other relevant item approved by MBF; or
- ii. in relation to a General Treatment Cover: an external appliance or device approved by MBF normally associated with a physical replacement of some part of the human body.

'Public Hospital' means a recognised public hospital approved by the Minister for the payment of Benefits.

'Recognition Criteria' are the following conditions that apply to MBF Recognised Providers:

- i. the provider is registered or holds a licence under relevant State or Territory legislation to render Treatment for which recognition is sought; or
- ii. the provider is professionally qualified or a member of a professional body recognised by MBF; or
- iii. the provider meets the standards determined or recognised by MBF and any other criteria that MBF considers reasonable.

'Repatriation Benefit' is available only under MBF Corporate Overseas Visitors' Cover and is payable where a doctor decides that you need long-term hospital care, and, at MBF's election, MBF decides to pay a once only Benefit of up to \$5,000 towards the medical and transportation costs incurred in the repatriation of a chronically ill or injured Insured Person to their country of origin.

'Rules' means the Private Health Insurance Rules made in accordance with sections 333-20 and 333-25 of the Act.

'Same-Day' refers to a period of hospitalisation that commences and finishes on the same date.

'Schedule Fee' means, in relation to a professional service, the fee for that service set out in Part II of the Health Insurance Act 1973.

'Schedule Fee Gap Benefit' means:

- i. the charges payable for a medical service are greater than or equal to the CMBS Fee for that medical service – 25% of that CMBS Fee; or
- ii. if charges payable for a medical service are less than the CMBS Fee – the amount (if any) by which the charge exceeds 75% of that CMBS Fee.

'Set Benefit' means the benefit which is determined by MBF and reviewed periodically, taking into account, as it considers appropriate:

- i. prices raised to Insured Persons of MBF in the relevant State for the service or treatment that attracts a Benefit;
- ii. prices in other States for the service or treatment that attracts a Benefit;
- iii. recommended charges of, and Benefits paid by other Funds;
- iv. recommended charges of professional associations;
- v. survey or other market information;
- vi. any agreements with providers in respect of the provision of the service or treatment that attracts a Benefit to Insured Persons;
- vii. the effect on premiums; and
- viii. overall cost to MBF.

'Settlement' means settlement outside court, a court award or judgment, and includes ex-gratia payments and/or non-disclosed amounts. 'Settled' has a corresponding meaning.

'Special Care Unit' means a unit of a Hospital approved by MBF for the purpose of providing special care and includes facilities such as intensive care units, critical care units, coronary care units, and neonatal special care units.

'Spouse' in relation to a person means a person to whom the first person:

- i. is legally married; or
- ii. is not legally married but with whom the first person is living as a couple as if they were married on a genuine domestic basis irrespective of gender.

'Student Dependant' means a child without a Spouse, including a legally adopted child, a step-child or a foster child, of the Policyholder or his or her Spouse who:

- i. has attained the age of 21 but who is under 25 years of age; and
- ii. who is undertaking full-time or part-time study at a school, college or university; and
- iii. who is fully or partially maintained by the Policyholder or the Policyholder's Spouse and who is not:
 - in receipt of a taxable income from the school, college or university; or
 - in receipt of an invalid pension or a disability allowance, which results in the child's total income exceeding \$14,000 per year.

'Suspension' means the temporary discontinuation of a Policy in accordance with the Policy Terms. Suspension can be one of the following:

- i. Policy Suspension, which applies to all Insured Persons on the Policy; or
- ii. Partial Suspension, which applies to specified Insured Person(s) only (other than in the case of a Single Policy);

'Therapies' means the following services:

- i. physiotherapy;
- ii. chiropractic;
- iii. osteopathic services;
- iv. antenatal;
- v. occupational therapy;
- vi. podiatry;
- vii. psychology;
- viii. dietetics;

and such other services as are specified in the relevant Level of Cover.

'Treatment' means:

- i. in respect of Hospital Cover: Hospital Services and Hospital Treatment;
- ii. in respect of Hospital Cover which includes Hospital-Substitute Treatment: Hospital Services, Hospital Treatment and Hospital-Substitute Treatment;
- iii. in respect of General Treatment Cover: services and items from which Benefits are payable under these Fund Rules. To avoid doubt, a 'service' excludes any treatment that is not provided by the provider personally or under the direct supervision of the provider.

'Waiting Period' means a period of time during which an Insured Person must have been covered under a Policy continuously at a particular Level of Cover at a particular Insured Group and for which all relevant Contribution Rates have been paid, before the Policyholder has an entitlement to receive a Benefit for that Insured Person for a Treatment.



Take a positive step