Summary of our Fund Rules

A. Terms used

The following terms in this document have the meanings set out below:

Agreement Hospital means a hospital or facility with which we have an agreement, including hospitals referred to as 'Members First', and 'Network Hospitals'.

Bupa, we, us , our means Bupa Australia Pty Ltd.

Benefit limitation period means a fixed period during which a reduced level of benefit applies and is served concurrently with waiting periods.

Our Fund Rules means the Fund Rules of Bupa Australia Pty Ltd, available at bupa.com.au or by contacting us.

General treatment has the meaning set out in section 121-10 of the PHI Act (and is provided under your Extras Cover (including Ambulance only Cover)).

Hospital substitute treatment has the meaning set out in section 69-10 of the PHI Act (and is provided under your Hospital Cover).

Hospital treatment has the meaning set out in section 121-5 of the PHI Act.

Minimum benefits are the reduced benefits that apply for a service once the relevant waiting periods have been served, being the minimum benefits specified under the PHI Act for that service.

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

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

Policy means a complying health insurance policy, as defined by the PHI Act.

Primary Policy holder means the person undertaking the application process who is registered by us as the primary policy holder who is to transact on the Policy.

You, your means a person taking out a Policy with us.

B. Introduction

The PHI Act provides for a private health insurer to have a body of rules that relate to the day-to-day operation of its health insurance business, including Policy terms. These rules are known as Fund Rules. This document is a summary of our Fund Rules as they relate to the terms of your Policy. You can view a copy of our Fund Rules at bupa.com.au or request a copy by contacting us.

1. What are the Fund Rules?

1.1 When you take out a Policy with us, you become a Policy holder with us and agree to be bound by our Fund Rules, copies of which are available upon request or can be accessed at bupa.com.au.

1.2 Our Fund Rules are the terms of your Policy with us for the provision of Hospital Cover and/or Extras Cover (including Ambulance only Cover). Our Fund Rules consist of:

(a) the general conditions that relate to all Policies; and

(b) Schedules that describe Policy specific terms and pricing.

2. What is the Community Rating principle?

The PHI Act provides that when we make decisions in relation to any person insured under a Policy, we must disregard the following matters:

(a) that the person suffers from a chronic disease, illness or other medical condition;

(b) the person's age (except to calculate a Lifetime Health Cover loading);

(c) how often a person needs to claim under their Policy;

(d) the amount of benefits, or how often, a person may claim under their Policy (except in the context of annual limits, as permitted by the PHI Act);

(e) a person's gender, race, religious beliefs or sexual orientation;

(f) where a person lives (except that we are able to charge different premiums and pay different benefits based on a person's State of residence, as permitted by the PHI Act);

(g) any other characteristic of a person (including, but not limited to their occupation or leisure pursuits) that are likely to result in an increased need claim under their Policy; or

(h) any matter set out in the Private Health Insurance (Complying Product) Rules 2007.

3. When and how can We change Our Fund Rules?

3.1 We may change Our Fund Rules at any time by giving you notice (provided that the changes are made in accordance with the PHI Act). Changes to our Fund Rules come into effect as set out in that notice, whether or not you have paid your premiums in advance. When we give you notice, it may be in the form of a generally available publication.

3.2 When we change our Fund Rules, we can change Rules that change the premiums payable for your Policy, the treatments covered by your Policy and/or the benefits payable for treatment covered by your Policy:

3.3 If a change we make to Our Fund Rules is detrimental to you and you are an adult covered by a Policy, we must give you reasonable notice in advance of the change. If your Policy covers more than one adult, we need only notify one of the adults on that Policy.

C. When you join

This section outlines who is eligible to join, the requirements of the application process, when your cover commences, who is authorised to transact on your Policy and how we will deal with you, including the handling of your personal information and any feedback or complaints you have.

4. Who is eligible to join as a Policy holder of Our Fund?

4.1 You must be an Australian resident aged 17 or over to apply to take out a Policy with us (persons under 17 years of age may be registered on a Family or Single Parent Policy as a dependant).

4.2 You may not take out a Policy with us, if you have the same type of Policy with another private health insurer.

4.3 You must be insured under a Policy which accords with your State of residence.

4.4 If you are the parent of a dependent child with legal custody of that dependent child you can register that dependent child on your Family or Single Parent Policy. Where that dependent child is already

registered on another Policy (with us or with another private health insurer) we will take into account any benefits paid in respect of that dependent child under any Policy.

5. Applying to join

5.1 When you apply for a Policy, you may be required to provide us with any information we request about you or those to be covered by the Policy. This may include:

(a) proof of identity;

(b) proof of age;

(c) details of any existing illnesses, ailments or injuries; and

(d) details of any existing or potential claims against any third party in relation to any illness, ailment or injury.

5.2 If any of the information you provide to us changes, you must notify us as soon as reasonably practicable of such changes.

5.3 We must not refuse to insure a person under a Policy if to do so would be in breach of the Community Rating Principle in clause 2.

5.4 We must accept your application for a Policy, if you and those on your Policy satisfy all of the requirements of our Fund Rules.

6. When your Policy commences

6.1 Provided that you have paid the first month's premium in advance and complied with all enrolment procedures required by us, your Policy will commence the later of:

(a) the date that you apply for the Policy; or

(b) a later date that you have agreed with us.

6.2 Your Policy will continue until:

(a) you notify us that you wish to cancel your policy in accordance with the procedure set out in our Fund Rules; or

(b) we notify you that the Policy has ceased in accordance with our Fund Rules

7. How we handle your personal information

When you take out cover with us, you consent to us collecting, using and disclosing you personal information (and that of all insured persons covered by their Policy) in accordance with our Information Handling Policy (as amended from time to time). Our Information Handling Policy is available on our website, or by contacting us.

8. How we will keep you updated

8.1 We will send all correspondence relating to your Policy to the last address you have provided to us.

8.2 We will update you by providing you with Standard Information Statements relating to your Policy, as required by the PHI Act. We must give an up to date copy of the relevant Standard Information Statement:

(a) to each adult insured every year; and

(b) to each newly insured person when they join.

8.3 You can request a Standard Information Statement at any time by contacting us.

9. How we handle complaints

9.1 If you have any queries about your Policy or Our Fund Rules, please contact us on 134 135. Our Customer Service consultants will endeavour to resolve any issues, or to refer your query to the person within our organisation best placed to resolve it.

9.2 If you have a complaint you can submit it through our complaints resolution process, or by contacting our Customer Relations Manager by calling 1800 802 386, or by sending an email to customerrelations@bupa.com.au. We will address all such complaints and will always endeavour to operate in your best interests, after taking into account our Fund Rules, any relevant laws and the best interests of all policy holders.

9.3 At any time, you may contact the Private Health Insurance Ombudsman (PHIO) in relation to a complaint, or if you are unhappy with the outcome reached through our dispute resolution process. PHIO may be contacted by calling 1800 640 695, or by visiting www.phio.gov.au.

10. Who can transact on a Policy?

10.1 Subject to clause 10.2, the Primary Policy holder is the only person who is authorised to:

(a) change any details of the Policy;

(b) change the level of cover(s);

(c) apply to add or remove persons from a Policy;

(d) receive a benefit for an insured person; and

(e) cancel the Policy;

The Primary Policy holder remains responsible for the payment of premiums on a Policy.

10.2 A Primary Policy holder may nominate any person (**nominated person**) to be authorised to transact on the Policy in the same manner as the Primary Policy holder, except that a nominated person will not be able to cancel the Policy. This authority will remain in place until the Primary Policy holder contacts us to revoke it.

10.3 Any person insured under a Policy aged 18 years or older may request that we remove them from a Policy, notwithstanding that they are not the Primary Policy holder or the nominated person.

D. Policy types

This section outlines the types of policies we offer and who can be covered under your Policy. You should consider all Policy information and Standard Information Statements available to you on request or on our web site before you join to ensure that you take out a Policy that is best suited to your circumstances (noting that your circumstances may change over time).

11. How many persons does a Policy cover?

11.1 You may take out a Policy that covers:

(a) only one person (Single Policy);

(b) 2 adults (and no one else) (Couples Policy);

(c) 2 or more people, only one of whom is an adult (Single Parent Policy);

(d) 3 or more people, only 2 of whom are adults (Family Policy);

(e) 3 or more people, at least 3 of whom are adults; or

(f) such other categories of insured groups as are permitted under the Private Health Insurance (Complying Product) Rules.

11.2 We may elect not to make a Policy available to a category of insured group in clause 11.1.

12. Choosing your Policy

12.1 We offer the following types of Policy:

(a) Hospital Cover– you can view details of our Hospital Covers at http://www.bupa.com.au/health-insurance/cover/hospital

(b) Extras Cover (which does not include hospital-substitute treatment) – you can view details of our Extras Covers at http://www.bupa.com.au/health-insurance/cover/extras-cover

(c) Packaged Cover which is a combination of both Hospital Cover and Extras Cover - you can view details of our Packaged Covers at http://www.bupa.com.au/health-insurance/all-in-one-package

12.2 You may choose your own combination of Hospital Cover and Extras Cover. However, you may not take out more than one Hospital Cover Policy and/or one Extras Cover Policy with us, except that you may choose to take out "Ambulance only Cover" with any other Extras Cover offered by Us

E. Transferring your Policy

When you transfer to us from another private health insurer, or transfer to a different level of cover with us, waiting periods or other restrictions may apply (although we may take into account waiting periods that you have already served if you have held continuous private health insurance cover). This section outlines how we may apply waiting periods and what factors we will take into consideration in such a transfer.

13. Transferring from another Policy

13.1 Your Policy is treated as a new Policy subject to all waiting periods and minimum benefits unless, before you became insured under the Policy with us:

(a) you were covered on an existing Policy with us or with another insurer (**old Policy**) within the last 60 days; and

(b) the premiums on your old Policy were up to date;

If you meet the above requirements, this will be deemed a "**Transfer**".

13.2 If you Transfer from an old Policy to a new Policy with us, then we will apply waiting periods and limits in the following manner:

(a) waiting periods will apply to any benefits, limits or higher benefits on your new Policy if a benefit for hospital treatment, hospital-substitute treatment or general treatment was not covered under your old Policy and, the waiting period that we apply to that benefit will be

no longer than the period allowed under section 75-1 of the PHI Act* or, in the case of general treatment, the period set out in Section H;

(b) we will take in account waiting periods you have served on your old Policy for hospital treatment or hospital-substitute covered under your old Policy, when calculating the waiting periods that apply under your new Policy;

(c) if a benefit for hospital treatment or hospital-substitute treatment was subject to an excess or co-payment that was higher under your old Policy, that higher excess or co-payment will continue to apply for a period that is no longer than the waiting period allowed under section 75-1 of the PHI Act*;

(d) we may apply minimum benefits to any hospital treatment or hospital-substitute treatment;

(e) we will take into account any benefits that you received under your old Policy (including for a particular period of your cover) when determining your benefit entitlements under the new Policy; and

(f). we will take into account purchases made of health appliances and prosthesis under Extras Cover under your old Policy, in calculating the replacement limit that applies upon transfer to the new Policy.

Waiting periods and other limitations on benefits are described in Section H below.

* Section 75-1 of the PHI Act provides that the maximum waiting periods are 12 months for obstetrics and pre-existing conditions, 2 months for psychiatric care, rehabilitation and palliative care and 2 months for any other hospital treatment or hospital substitute treatment.

F. Paying your premiums

The premiums that you pay for your cover is determined by a range of factors including the product you have selected, your State of residence, Lifetime Health Cover and premium changes. This section outlines the requirements for paying your premiums, the circumstances in which your premiums may change, as well as what happens if you fall behind in payment.

14. When you must pay your premiums

14.1 If you are the Primary Policy holder, you are responsible for paying us the premiums applicable to your Policy in the following manner:

(a) when you first become insured under the Policy, you must pay at least one month's premiums in advance; and

(b) for all subsequent payments, you must pay by the date payment is due and in all cases premiums must remain one month in advance (except in the case of payroll deduction payments, in which case the minimum payment is one week).

14.2 We may refuse to accept a payment that would result in your Policy being paid more than 12 months in advance. If you pay your premiums more than 12 months in advance, we may refund the additional portion of premiums.

14.3 A premium is considered to have been paid only when we have received payment in full as cleared funds.

14.4 Under the PHI Act we may be required to apply a Lifetime Health Cover loading to the premiums applicable to your Policy. For more information about when this may occur, see: http://www.bupa.com.au/health-insurance/common-questions/rebates-and-savings/How-to-lock-in-your-Lifetime-Health-Cover

14.5 We may at our discretion approve any group of Policy holders as a contribution group.

14.6 We may only offer a discount in circumstances permitted by the PHI Act.

14.7 If your Policy is cancelled, we will refund to the Primary Policy holder premiums paid in advance of the cancellation date, less any administration costs incurred by us.

15. When your premiums may change

15.1 We may adjust the premiums that apply to your Policy in accordance with section 66-10 of the PHI Act (including where you have paid in advance).

15.2 We may charge different premiums in different States and Territories in Australia. Where your State of residence changes, your premiums will be adjusted to reflect your new State of residence.

16. If your premium payments fall into arrears

16.1 If you do not pay your premiums by the due date, your Policy will be considered to be in arrears.

16.2 If the period of arrears on your Policy exceeds 2 months, we may cancel your Policy.

G. Making claims and receiving benefits

This section sets out what you may claim under your Policy. Before you commence treatment, it is important that you contact us to ascertain your eligibility for benefits for that particular treatment.

17. Making a claim

17.1 You must submit a claim within 2 years of receiving the relevant treatment; otherwise we will not pay a benefit. Benefits will be paid in accordance with our Fund Rules in force at the time you make your claim.

17.2 Any claim you submit must be submitted in a form approved by us. For information on your claiming options, see: http://www.bupa.com.au/health-insurance/common-questions/i-am-a-member/how-to-make-a-claim. Your claim must be supported by any information we request to substantiate the claim.

17.3 The benefits we pay for goods and services cannot exceed the actual charge for the goods and services received.

17.4 Where we have paid you any amount in error we are entitled to recover that amount from you.

17.5 We may refuse to pay, or may recover from you, any benefits where it is found that the information supplied to us in any approved form was in error in relation to any matter that may have affected the payment of benefits.

17.6 We may offset any amounts that we are entitled to recover from you against any benefits that would otherwise be payable to you.

17.7 We may in our sole discretion make ex-gratia payments in respect of claims you make that would not otherwise attract any benefits under your Policy.

17.8 We will not be liable to you for any losses, costs, damages, suits or actions arising through the provision of services to you or any person insured under your Policy by any recognised practitioner.

17.9 Benefits are payable on the basis of the State of residence of the Primary Policy holder, rather than the State or Territory in which the treatment was provided.

17.10 We may enter into agreements with hospitals for services covered by Hospital Cover or providers of services or items covered by Extras Cover. The benefits that apply within these agreements may differ from benefits payable for non-network providers. You can locate providers that we have agreements with at http://www.bupa.com.au/find-a-provider.

18. What is covered during Hospital treatment

18.1 If you have Hospital Cover and are admitted to hospital as a private patient, we will pay:

(a) medical benefits where a Medicare benefit is payable for that treatment, in accordance with section 72-1 of the PHI Act.

(b) where hospital treatment has been provided by a person authorised to provide hospital treatment.

(c) from the date of your admission to hospital, until discharge but not inclusive of the date of discharge.

(d) for a prosthesis item implanted as part of hospital treatment under your Policy as follows:

(i) for a non-gap prosthesis item, the benefits payable will cover the full cost of the item; and

(ii) for a gap permitted prosthesis item, the benefits payable will not cover the full cost of the item, but will cover the amount set out as the minimum benefit in section 72-1 of the PHI Act.

(e) when a person is classified as a Nursing Home Type Patient, Nursing Home Type Patient Benefits whilst they are classified as such. Nursing Home Type Patients are required to make a contribution to the cost of their care and we may request an Acute Care Certificate and any additional information from the medical record.

18.2 If you are admitted to an Agreement Hospital, we will pay benefits for pharmaceutical items covered by the Pharmaceutical Benefits Scheme (**PBS**) that are supplied during your admission (but not upon discharge) unless the cost of the item is less than the relevant PBS co-payment determined by the Department of Health and Ageing.

18.3 If you are admitted to an Agreement Hospital, we will pay benefits for pharmaceutical items not covered by the PBS, that are supplied during your admission (but not upon discharge), provided that the pharmaceutical item is:

(a) intrinsic to the hospital treatment, clinically indicated, and essential for you as the patient to meet satisfactory health outcomes;

(b) directly related to treatment of the condition or ailment for which you were admitted;

(c) not an experimental drug or compound item; and

(d) not the sole reason for the admission.

18.4 If you are admitted to a hospital that is not an Agreement Hospital , we will not pay benefits for pharmaceutical items that are supplied during your admission (whether covered by the PBS or otherwise).

18.5 We will pay for hospital-substitute treatment provided by a general or specialist nurse recognised by us in the course of private practice, provided that:

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

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

19. Extras treatment

19.1 We may apply limits to the amount you can claim for a service under Extras Cover during a specified period of time.

19.2 We will pay benefits under Extras Cover where the treatment has been provided by a provider recognised by us in private practice on premises registered with us, provided that the services or appliances provided as part of that treatment have not been provided as part of hospital treatment.

19.3 We will pay benefits under Extras Cover in accordance with the terms of your Policy and as follows:

(a) we will pay benefits for dental treatments including post-operative care and benefits for major dental services cover crowns, bridgework, complete dentures, partial dentures and denture repairs, prosthodontic services, implant procedures, periodontics, oral surgery, endodontics and oral appliances for sleep apnoea;

(c) we will pay benefits for Pharmacy prescriptions that are:

(i) a Schedule 4 or Schedule 8 substance;

(i) supplied by a pharmacist in private practice;

(i) prescribed by a registered medical practitioner;

(iii) prescription items which are not supplied under the PBS;

(iv) approved by the Therapeutic Goods Administration for the condition for which they have been prescribed; and

(v) not specifically excluded from benefits by us.

(d) we will pay benefits for Asthma Foundation approved asthma pumps and for Diabetes Australia approved blood glucose monitors;

(e) we will pay benefits for certain appliances that are fully custom-made and provided by a provider recognised by us;

(f) we will pay for your local and interstate travelling expenses when your expenses are associated with essential medical or hospital treatment and you travel more than 300 kilometres return distance;

(g) we will pay for your overnight non-hospital accommodation as a patient and for your attendant, when you travel away from home for treatment that cannot be provided by your own doctor;

(h) if your Policy covers Medication Assistance Services, we will pay benefits in accordance with our agreement with the relevant recognised provider;

19.4 We will only pay benefits under Extras Cover for:

(a) a single service provided by a recognised practitioner in private practice on a given day; and

(b) for more than one service provided by a recognised practitioner in registered premises in private practice, where that provider is recognised by us in more than one profession.

H. Limitation of benefits

In some circumstances, the amount of benefits you receive may be reduced or withheld. This may be due to a specific feature of your cover (such as a waiting period, minimum benefits or an exclusion), or because you may be entitled to a payment from a third party for the same thing. This section outlines those circumstances.

20. Excesses and co-payments

On some Hospital Covers, when you or a person on your Policy is admitted to hospital as a private patient, you may be required to pay:

(a) a co-payment, which is applicable for any same-day or overnight hospital admissions; or

(b) an excess, which is an amount deducted from the benefits that we would have otherwise paid towards hospital treatment.

21. Waiting periods

21.1 We may apply waiting periods in the following circumstances:

(a) when you join for the first time;

(b) when you transfer from another private health insurer (see clause 13 above);

(c) when you change your cover with us (see clause 13 above); and

(d) when you add a new dependant to your Policy (except in the case of newborns on an existing Policy) in which case any waiting periods and minimum benefits will apply to the new dependant.

21.2 When you add a newborn child to a Family or Single Parent Policy waiting periods will not apply to the newborn child, provided that:

(a) the Policy was in existence prior to the birth of the child; or

(b) if the Policy was not in existence prior to the birth of the child, that the child is added to the Policy within 2 months of their date of birth.

A newborn child is deemed to have served the same waiting periods and periods of minimum benefits as the Policy holder.

21.3 When you rejoin your child dependant to your Policy, the child dependent will be deemed to have served the same waiting periods and periods of minimum benefits as you.

21.4 Waiting periods will not apply for a treatment under a Policy in respect of a person who:

(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 2 months after they ceased to hold, or to be entitled to treatment under a gold card.

21.5 The waiting periods applicable for Hospital Cover are as follows:

Treatment type	Waiting period
Pre-existing conditions	1 year
Obstetric patients	1 year
Laser eye correction surgery	3 years
Psychiatric*	2 months
Rehabilitation*	2 months
Palliative care*	2 months
All other treatment#	2 month

* This waiting period applies whether or not the conditions is pre-existing.

No waiting periods apply for benefits provided in relation to accidents proved to occur after the Policy commences.

21.6 The waiting periods applicable for Extras Cover are as follows:

Treatment type	Waiting period
Pre-existing conditions	1 year
General dental	2 months
Major dental	1 year
Orthodontics	1 year
Appliances	1 year
Heart screening tests	1 year
Living Well Program	6 months
Hire, repair and maintenance of appliances	6 months
All other treatments#	2 months

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.

22. Benefit limitation periods

Some of our Policies have benefit limitation periods for specific services for Policy holders and their dependent children. During a benefit limitation period, we will pay benefits for eligible claims at the minimum benefits specified under the PHI Act for that service.

23. Minimum benefits

23.1 Some of our Policies have minimum benefits for certain services# such that benefits for the relevant service are paid the minimum default benefits specified under the PHI Act for that service. For further details, please contact us or see:

Hospital Covers: http://www.bupa.com.au/health-insurance/cover/hospital

Packaged Covers: http://www.bupa.com.au/health-insurance/all-in-one-package

#The types of services to which minimum benefits may apply depending upon your chosen level of Cover could include 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 and surgery; hospital admissions which result from

cosmetic surgery; renal dialysis or chronic renal failure; or hospital admissions for services that do not attract Medicare benefits.

24. Where you may be entitled to claim from another source

24.1 We will not pay a benefit in respect of a condition, injury or ailment where, in our reasonable opinion, you or a person on your Policy may receive, has claimed and received, or has established a right to receive 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). If it is established that you have no right to compensation or benefits, we will pay benefits.

24.2 We will pay benefits, where in our opinion the amount of a claim for compensation or damages is less than the benefits that we would have otherwise paid. However, the amount that we will pay will not exceed the difference between the compensation you receive and the benefit we would have ordinarily paid.

24.3 We may pay benefits that relate to a condition, injury of ailment that we believe may give rise to a claim for compensation or damages subject to you or a person on your Policy giving an undertaking in writing to us that you or a person on your Policy:

(a) will make a claim for compensation and damages; and

(b) will pursue the claim with all due diligence; and

(c) will include in such a claim all hospital, medical, dental, paramedical and related expenses; and

(d) will reimburse us for any benefits paid from the proceeds from the claim if successful.

24.4 You must immediately notify us, upon settlement of your claim, if you have received compensation in relation to a condition, injury or ailment. We will not pay benefits where the settlement:

(a) includes terms specifying that moneys paid do not relate to past or future expenses in respect of which benefits would not otherwise be payable; or

(b) part of the claim is abandoned or compromised so that such expenses or are excluded or represented by a nominal sum only.

24.5 We may, in our absolute discretion, make a provisional payment of benefits towards expenses incurred in relation to a condition, injury of ailment where you are in the process of making a claim or compensation or damages with respect to that condition, injury or ailment, but the claim is not yet finalised. Such a provisional payment may be subject to you signing an undertaking, or satisfying any other conditions that we reasonably require. If you do not comply with the undertakings or conditions required by us, we may discontinue the provisional payments and require you to re-pay any provisional payments you have already received.

25. Circumstances where no benefits are paid by us

25.1 We will not pay Hospital Cover or Extras Cover benefits for:

(a) services that are provided overseas;

(b) hospital treatment or medical services where the procedure:

(i) is not covered by Medicare benefits;

(ii) is cosmetic surgery (except where the procedure is clinically necessary);

(iii) is experimental; or

(iv) relates to the clinical trial of pharmaceuticals.

We will pay a minimum benefit for hospital admissions which result from cosmetic surgery.

(c) outpatient medical services (services provided to patients who are not admitted to hospital).

(d) costs that are incurred as a result of criminal activity;

(e) treatment rendered by a suspended practitioner;

(f) professional services or hospitalisation rendered in connection with your employment or the employment of an insured person under your Policy;

(g) services that may be funded or provided by the Commonwealth, the State or Territory, a local governing body, or an authority established by any law;

(h) professional services provided or goods supplied by you to your dependent child, business associate or your partners;

(i) services provided contrary to a Commonwealth or State law;

(j) any service not provided as claimed, or insufficiently described in the claim; or

(k) services which we reasonably believe are excessive and not reasonably necessary for the adequate care of you or any other insured on your Policy.

I. Suspending and cancelling your Policy

This section outlines when you may suspend your Policy, or what happens when you elect to cancel your Policy. In addition, this section outlines in what circumstances we may cancel your Policy.

26. Suspending your Policy

26.1 If you have been covered under a Policy with us for at least 12 months you may apply in the approved form to suspend your Policy, in the event of:

(a) overseas travel; or

(b) financial hardship; or

(c) imprisonment.

We will not pay any benefits during a period of suspension.

26.2 If you apply to suspend your Policy for overseas travel you must make your application prior to your departure from Australia and provide us with travel documents verifying your departure and return dates. We will automatically recommence the Policy from the date of return.

26.3 If approved, suspension will take effect from the day after your departure from Australia and is for a minimum period of 2 months, up to a maximum period of 2 years. We will permit a maximum of 3 periods of suspension for overseas travel over the lifetime of a Policy, provided that you pay at least 1 month of premiums between suspensions

26.4 If you apply to suspend your Policy due to financial hardship, you must provide us with any documentation that we reasonable request to substantiate a case of financial hardship.

26.5 If approved, suspension due to financial hardship will take effect from the day after we approve your application and is for a minimum period of 3 months, up to a maximum of 12 months in the aggregate for all periods of suspension for financial hardship during the period you are covered by a Policy with us.

26.6 We will permit suspension due to imprisonment for a maximum period of 4 continuous years.

26.7 Your Policy will recommence from suspension, and you will need to recommence paying premiums:

(a) in the case of overseas travel, from the date of your return to Australia;

(b) in the case of financial hardship, from the date after the financial hardship suspension ends;

(c) in the case of imprisonment, from the date that you are released from custody, as evidenced by documentation from the Department of Correctional Services in the relevant State or Territory.

26.8 If, at the conclusion of a suspension period, your Policy is no longer offered by us, you may choose another Policy and clause 13 will apply to the transfer. Suspension periods do not count towards waiting periods or periods of minimum benefits.

27. When you may cancel your Policy

27.1 A Primary Policy holder may cancel their Policy by notice in writing to us, (or by any other means approved by us from time to time) with effect from the date which is:

(a) the later of:

(i) the date requested by the Primary Policy holder, which may not be more than 30 days after we receive the cancellation request; and

(ii) the date of the most recent claim paid on the Policy; or

(b) where no cancellation date is requested by the Primary Policy holder, the date we receive the request to cancel.

27.2 We will refund to the Primary Policy holder any premiums paid in advance of the cancellation date, subject to any applicable administration fee.

27.3 If you cancel your Policy during the 30 day cooling off period after purchasing your Policy, we will refund any premiums you have paid, provided that you have not made any claims.

27.4 A Primary Policy holder may retrospectively cancel their Policy, provided that the request to cancel is made within 30 days of the effective cancellation date. Where a claim has been paid within 30 days of the cancellation request, we will cancel the Policy from the date of payment of that claim.

28. When we may cancel your Policy

28.1 We may cancel your Policy by giving you notice (provided that the grounds for cancellation do not contravene the Community Rating Principle outlined in clause 2, above), where in our reasonable opinion we believe you or a person on your Policy:

(a) have been involved in any fraudulent, negligent and/or criminal act against us; or

(b) have acted in a way that can be construed as threatening to any of our employees, or could be viewed as negatively affecting the working environment of any of our employees;

28.2 We may immediately cancel your Policy if:

(a) your Policy has reached the maximum number of permitted suspensions for overseas travel, as outlined in clause 26.3;

(b) your Policy is in arrears by 2 months or more; and

(c) at our discretion for any reason, in accordance with the PHI Act.

28.3 We will give you written notification of the reason(s) for cancellation of your Policy.

28.4 If you cease to be covered by a Policy with us and do not become insured under another Policy with us within 14 days, we will give you a transfer certificate under section 99-1 of the PHI Act.†

† Section 99-1 of the PHI Act requires an insurer to issue a transfer certificate to a person, when they cease to be insured with that insurer. If you are transferring to a new insurer, you may need to provide this certificate to that insurer.

28.5 A Single Policy will be cancelled as a result of the death of the Primary Policy holder (the **deceased person**) and we will refund any premiums paid, from the date of the deceased person's death to the deceased person's estate.