nib health funds limited
ABN 83 000 124 381
Fund Rules

Overseas Visitors Health Cover
1 July 2019
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### SCHEDULE K

| K1 | Base Premium Rate |

### SCHEDULE M

Dental
Optical Services
Non Surgically Implanted Prostheses and Appliances
L SCHEDULE

L1 Overseas

The L Schedule Overseas includes the following Schedules:

(a) LV - Overseas Visitors Health Cover

LV1 Table Name or Group of Table Names

This table includes the following Products:

LV10. Executive Top Visitor Cover Singles
LV11. Executive Top Visitor Cover Couples and Families
LV12. Top Visitor Cover Singles
LV13. Top Visitor Cover Couples and Families
LV14. Mid Visitor Cover
LV15. Basic Visitor Cover
LV16. Budget Visitor Cover
LV17. Value Plus
LV20. nib United Gold Visitor Cover
LV22. Visitor Cover
LV23. nib Basic Visitor Cover
LV24. nib Budget Visitor Cover

LV2 General Conditions

LV2.1 Interpretation and Definitions

In this Schedule:

1. Words and phrases commencing with capital letters are defined in Rule LV2.1 (Interpretation and Definitions).

2. Unless otherwise specified, the definitions in Rule LV2.1 (Interpretation and Definitions) apply throughout the Schedule.

3. The definitions in Rule LV2.1 (Interpretation and Definitions) apply only to Schedules:
   LV10 (Executive Top Visitor Cover Singles),
   LV11 (Executive Top Visitor Cover Couples and Families), LV12 (Top Visitor Cover Singles),
   LV13 (Top Visitor Cover Couples and Families),
   LV14 (Mid Visitor Cover),
   LV15 (Basic Visitor Cover),
   LV16 (Budget Visitor Cover),
   LV17 (Value Plus),
   LV20 (nib United Gold Visitor Cover),
   LV22 (Visitor Cover).
   LV23. nib Basic Visitor Cover
   LV24. nib Budget Visitor Cover

4. Where a word or phrase is defined, its other grammatical forms have a corresponding meaning.

5. Where not defined, words and expressions are intended to have their ordinary meaning.

6. Headings are for convenience only and do not affect interpretation.

7. The singular includes the plural and vice versa.

8. A reference to any legislation or a provision of legislation includes all amendments,
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consolidations or replacements and all regulations or instruments issued under it.

9. A reference to the word ‘include’ in any form is not a word of limitation.

Definitions

“Accident” means an event leading to bodily injury caused solely and directly by violent, accidental, external and visible means and resulting solely, directly and independently of any other cause, unless otherwise defined in the Schedules.

“Act” means the Private Health Insurance Act 2007 and any regulations or rules made pursuant to that Act.

"Acupuncture" means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN as an acupuncturist.

“Administration Fee” means a fee charged by nib/IMAN for the cancellation of a Policy that has not been in place for a minimum period. The fee is deducted from the refund amount of any Excess Premiums on the Policy at the date of cancellation.

“Admitted Patient” or “In-Patient” means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment. Treatment received in an Emergency Room of a Hospital without a formal admission does not qualify the patient as an Admitted Patient.

“Adult” has the meaning given in the Act and means a person who is not a Dependant Child.

“Ambulance Services” means the charge for transport provided by or under an arrangement with an approved State or territory ambulance service when determined by a treating doctor as Medically Necessary for admission to Hospital or for Emergency Treatment as outlined within the Schedules.

“Annual Limits” means the maximum amount of Benefits payable for a specific good or service, or category of good or service, in a Policy Year, as set out in the Schedules.

“Antenatal Services” means Benefits are paid on Antenatal classes provided by a Hospital, registered midwife or physiotherapist in a private practice. Antenatal and postnatal services do not have a Medicare Benefits Schedule (MBS) item number. They are payable under the Extras component where applicable.

Treatment for Antenatal and Postnatal services must be:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN as either a Hospital, registered midwife, lactation consultant or physiotherapist in a private practice.

“Assisted Reproductive Services” means services provided by an infertility specialist and include but are not limited to In Vitro Fertilisation (IVF), Zygote Intrafallopian Transfer (ZIFT), Gamete Intrafallopian Transfer (GIFT), Cryopreserved Embryo Transfer, Intracytoplasmic Sperm Injection (ICSI) and Ovum Microsurgery.

“Australian Resident Health Insurance (ARHI)” means Health Insurance for permanent residents of Australia that also have full cover with Medicare. These products offer additional services not covered with Medicare such as treatment in a Private or Public Hospital, dental and physiotherapy. Public Hospitals have long waiting lists if requiring non-emergency treatment.

“Benefits” means an amount of money payable from the Fund to or on behalf of an OVHC Insured Person, in respect of approved expenses incurred by an Insured Person for Treatment, in accordance with the Schedule.
“Calendar Year” means the period from 1 January to 31 December.

“Chiropractic” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation by a Provider who is recognised by nib/IMAN as a chiropractor.

“Claim” means a claim for the payment of Benefits which complies with these Rules.

“Claimable Hospital Expenses” means expenses incurred for Hospital Treatment in respect of which a Benefit is payable.

“Compensation” means an entitlement or a potential entitlement to receive compensation or damages (including a payment in settlement of the claim for compensation or damages) in respect of any Condition.

“Condition” includes any illness, injury, ailment, disease or disorder for which Treatment is sought.

“Consultation” means an attendance on an Insured Person by a Provider in a manner approved by nib/IMAN.

“Continuous Hospitalisation” has the meaning given to it in Rule LV2.16.10 (Continuous Hospitalisation).

“Contracted rate” means the rate negotiated by nib/IMAN with Private Hospitals which have agreements with us. There will be minimum out-of-pocket expenses for customers attending nib/IMAN agreement Private Hospitals.

“Contribution Group” means a group of Policy Holders approved by nib/IMAN for the purposes of Rule LV2.11.3 (Contribution Groups).

“Cosmetic Surgery” means surgery performed to improve the appearance, rather than for medical reasons.

“Couples Policy” means a Policy where the Insured Persons are:
(a) the Policy Holder and their Partner (both Adults), or
(b) the Policy Holder (an Adult) and one of their Dependent Children; or
(c) for LV20 (nib United Gold Visitor Cover) the Policy Holder and their Partner (both Adults).

“Default Benefits” means, in relation to Hospital Treatment, the minimum amount of Benefits that a private health insurer would have been required to pay under the Act (Cth) and associated Rules, if that Hospital Treatment was received by a person covered under a complying health insurance policy, and in a Hospital that does not have an agreement with the insurer.

“Dental Practitioner” means a person registered or licensed to practice as a dental practitioner under a law of a State or Territory that provides for the registration or licensing of dental practitioners or dentists.

“Dental Treatment” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation by a Provider who is recognised by nib/IMAN as a Dental Practitioner.

“Dependant” means a person who is not a Policy Holder and who:
(a) is accompanying the Policy Holder on the same visa; and
(b) living at home with the Policy Holder; and
(c) is a Partner of a Policy Holder; or
(d) is a Dependant Child of a Policy Holder; or
(e) is a Student Dependent of a Policy Holder.
“Dependant Child” (unless otherwise stated in the individual product schedule) means a person who is not a Policy Holder or their Partner and who:
(a) is accompanying the Policy Holder on the same visa; and
(b) is living at home with the Policy Holder; and
(c) is a natural, step, foster or adopted child of the Policy Holder and/or their Partner; and
(d) is aged under 21 years.

“DHA” means the Department of Home Affairs who is responsible for policing Visa Condition 8501.

“Dietary advice” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation by a Provider who is recognised by nib/IMAN as a dietician or nutritionist.

“Eligible Medical Providers” means:
(a) A recognised specialist, consultant physician or general practitioner; or
(b) Being in an approved placement under Section 3GA of the Health Insurance Act 1973; or
(c) A temporary resident doctor with an exemption under s19AB of the Health Insurance Act 1973 who is working in accord with that exemption.

“Eligible Non Medical Providers” means allied health professionals, dentists and dental specialists who:
(a) are registered or hold a licence under relevant State or Territory legislation to provide the General Treatment sought;
(b) are professionally qualified, or a member of a professional body recognised by nib/IMAN;
(c) are in private practice; and
(d) satisfy any other criteria reasonably required by nib/IMAN for nib/IMAN to pay Benefits for General Treatment provided by the Provider.

“Emergency Room” means a department in a medical treatment facility, specialising in acute care of patients who present without prior appointment, either by their own means or by ambulance. It is also known as emergency department (ED), accident & emergency (A&E) or casualty department. An Emergency Room is usually found in a Hospital or other primary care centre.

“Emergency Treatment” means treatment provided for a Life Threatening Illness or Injury, which requires immediate medical attention, action or remedy.

“Excess Premiums” means any Premiums paid beyond the date of cancellation or termination of the Policy and referred to in Rule LV2.8 (Termination of OVHC Policy)

“Exercise Physiology” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN as an exercise physiologist.

“Ex-gratia Payment” means an amount of money payable from the Fund to or on behalf of an OVHC Insured Person, out of goodwill as a discretionary payment in respect of expenses incurred by an Insured Person for Treatment that is not in accordance with the Rules.

“Family Policy” means a Policy where the Insured Persons are:
(a) the Policy Holder and their Partner (both Adults) and one or more of their Dependents listed in the visa; or
(b) the Policy Holder (an Adult) and one or more of their dependents listed in the visa; or
(c) for LV20 (nib United Gold Visitor Cover) the Policy Holder and their Partner (both Adults) and one or more Dependent Children listed in the visa; or
(d) for LV22 (Visitor Cover), the Policy Holder and their Partner (both Adults) and one or more Dependent Children listed in the visa but excluding Student Dependents).

“Fund” means the health Benefits fund established by nib, of which nib/IMAN is a part.
“Gazetted Rates” means, in relation to Hospital Treatment, the rates for treatment provided in a Public Hospital to an ineligible patient as determined or recommended by the Department of Health in the State or Territory in which the treatment is provided.

“General Product” means a Product for General Treatment (Extras).

“General Treatment” means Treatment (including the provision of goods or services) that is intended to manage or prevent a Condition and is not Hospital Treatment.

“Holder” has the meaning given under the Act.

“Hospital” means a facility for which a declaration under section 121-5(6) of the Act is in force.

“Hospital Product” means a Product which includes Benefits for fees and charges for:
(a) some or all Hospital Treatment; and
(b) some or all associated professional services rendered to a Patient receiving Hospital Treatment and include Combined Products.

“Hospital Treatment” means hospital treatment as defined in Section 121-5 of the Act.

“Immunisations” means vaccines that are listed on the National Immunisation Schedule.

“Ineligible Patient” means a person who is:
(a) not an Australian resident; and
(b) not eligible for Medicare Benefits.

“In-Patient” has the same meaning as “Admitted Patient”.

“Insured Person” means the Policy Holder and any person who is insured under the Policy (including Adults and Dependant Children).

“International Workers Health Insurance” (iwhi) means Health Insurance for Overseas Visitors who are not covered by Medicare or have limited coverage with Medicare through a Reciprocal arrangement.

“Life Threatening Illness or Injury” means
(a) a risk of serious sickness, disability or death requiring urgent assessment and/or resuscitation;
(b) suspected acute organ or system failure;
(c) an illness or injury where the function of a body part is acutely threatened;
(d) psychiatric incident whereby the health of the patient or other people is at immediate risk;
(e) severe pain where the function of a body part or organ is suspected to be acutely threatened;
(f) acute haemorrhaging requiring urgent assessment and treatment; or
(g) a condition that requires immediate admission to avoid imminent morbidity or mortality.

“Lower Benefits” means that benefits on applicable Products are reduced for the following services
(a) Gastric banding & obesity surgery
(b) Psychiatric treatments if admitted to Hospital
(c) Palliative care
(d) Pregnancy and birth related services.

For Hospital In-Patient Treatment, benefits are reduced to the rate determined by the relevant State and Territory Health Authority, and In- and Out-Patient medical expenses are reduced to the Medicare Benefits Schedule Fee.

“Medically Necessary” means Treatment that an Eligible Medical Provider or Eligible Non Medical Provider, exercising prudent clinical judgment, would provide to an Insured Person for the purpose of evaluating, diagnosing or treating a Condition and that are:
(a) in accordance with the generally accepted standards of medical practice;
(b) clinically appropriate in terms of type, frequency, extent, site and duration, and considered
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effective for the Insured Person’s Condition;
(c) not primarily for the convenience of the Insured Person or the Eligible Medical Provider or Eligible Non Medical Provider and
(d) not more costly than an alternative service at least as likely to produce equivalent therapeutic or diagnostic results.

“Medicare Benefits Schedule” (MBS) means the schedule set by the Commonwealth Government for the purpose of paying Medicare Benefits.

“Medicare Benefits Schedule Fee” means the amount set under the Medicare Benefits Schedule.

“Membership Year” means a period of twelve months starting from the start date of cover with nib/IMAN, or from the anniversary of that date.

“MIMS” is information on Australian prescription medicines that is used by health care providers.

“Natural Therapies” means General Treatment that is:
(a) approved by nib/IMAN;
(b) listed as a Natural Therapy treatment in the Schedules; and
(c) provided during a Consultation with a Provider who is recognised by nib/IMAN as to provide natural therapy treatment.

“Naturopathy” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN as a naturopath.

“nib/IMAN Agreement Private Hospital” means a Hospital which nib has entered into a Hospital Purchaser Provider Agreement. This agreement covers all nib subsidiaries including nib/IMAN.

“nib First Choice” is the name and branding of the nib Preferred Provider network.

“nib Preferred Provider” means a Provider who has entered an agreement with nib to be part of its Preferred Provider network, nib First Choice

“Occupational Therapy” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN to provide occupational therapy treatment.

“Optometrist” means a person registered or licensed as an optometrist or optician under relevant State or Territory laws.

“Osteopathy” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation by a Provider who is recognised by nib/IMAN as an osteopath.

“Out of Pockets” are charges and fees not covered by nib under a Policy, as determined by these Rules. For example, Out of Pocket Expenses may be incurred when there is a gap between the Benefit that nib will pay and amount charged by the Provider. Also, nib will not pay some personal and take home items like toiletries, newspapers and long-distance and mobile phone calls provided in Hospital. These are billed to Patients by the Hospital. Insured Persons are advised to ask the Hospital and their doctors what their potential out-of-pocket expenses will be.

“Out-Patient” means a person who receives treatment outside of an admission to a Hospital, including treatment at Hospital premises, in a Medical Practitioner’s consulting rooms or at another designated health facility such as a community health centre or polyclinic.

“OVHC” means Overseas Visitor Health Cover under which nib/IMAN offers to an Overseas Visitor, their Partner and Dependents the Benefits set out in these Fund Rules.
“Overseas Visitor” means a Specified Temporary Visa Holder, whose visa is not for the purposes of study. This includes accompanying Dependents on the same visa. “Partner” means a person who lives with another person in a marital or de-facto relationship.

“Patient” means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment. This definition:
(a) includes a new born child who:
   (i) occupies a bed in a Special Care Unit; or
   (ii) is the second or subsequent child of a multiple birth;
(b) and excludes:
   (i) any other new born child whose mother also occupies a bed in the Hospital; and
   (ii) a member of the staff of the Hospital who is receiving treatment in his or her own quarters.

“PBS” means the Pharmaceutical Benefits Scheme.

“PBS pharmaceuticals” means prescription only items listed on the PBS prescribed in line with PBS–approved indications and dispensed by a registered practitioner recognised by nib/IMAN. The amount customers will be paid will depend on their cover.

“Non-PBS pharmaceuticals” are prescription only items not covered by the PBS.
(a) Where PBS pharmaceuticals are covered on a Product, Benefits are payable when:
   (i) dispensed by a registered pharmacy in private practice or a doctor
   (ii) only available on prescription, and
   (iii) listed on the Australian Register of Therapeutic Goods (ARTG), and
   (iv) published within the MIMS Schedule as S4 or S8, and
   (v) listed in the Schedule of Pharmaceutical Benefits Scheme (PBS).
(b) Where Non-PBS pharmaceuticals are covered on a Product, Benefits are payable when:
   (i) dispensed by a registered pharmacy in private practice or a doctor
   (ii) only available on prescription, and
   (iii) listed on the Australian Register of Therapeutic Goods (ARTG), and
   (iv) published within the MIMS Schedule as S4 or S8, and
   (v) not listed in the Schedule of Pharmaceutical Benefits Scheme (PBS)
(c) Benefits are not payable for:
   (i) Non PBS contraceptives; except where deemed Medically Necessary by a General Practitioner

“Physiotherapy” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN as a physiotherapist.

“Plan” means a policy of overseas visitors’ health cover between a Policy Holder and nib/IMAN in accordance with these Rules. The terms “Policy” and “Plan” are interchangeable.

“Podiatric Surgeon” means a holder of a registration in the specialty of podiatric surgery under the State or Territory that provides for the registration or licensing of Podiatric Surgeons.

“Podiatry” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN as a podiatrist.

“Policy” means a policy of overseas visitors’ health cover between a Policy Holder and nib/IMAN in accordance with these Rules. The terms “Policy” and “Plan” are interchangeable.

“Policy Anniversary” means each anniversary of the date when the Policy commenced as detailed on the Membership Certificate

“Policy Holder” means a person in whose name an application for a Policy with nib/IMAN has been
“Policy Category” means Single Policy, Couples Policy or Family Policy.

“Postnatal services” means Benefits are payable for home visits provided by either a registered business, nurse, midwife or lactation consultants in private practice.

“Pre-existing Condition” means a condition, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by nib/IMAN and who has examined relevant information (including information supplied by the Insured Person’s Medical Practitioner), were exhibited by the Insured Person at any time during the 6 months prior to:
(a) the commencement of the Insured Person’s Policy; or
(b) in the case of upgrading from one Hospital Product to another Hospital Product providing higher Benefits for Hospital Treatment (other than a Hospital Product created or revised in response to an increase in hospital charges), at the time the Policyholder for the Policy commenced paying Premiums for the upgraded Hospital Product.

“Premium” means an amount of money determined by nib/IMAN as the premium payable by a Policy Holder for a Policy under a Product in respect of a specified period of cover in accordance with LV2.4.2.

“Premium Rate” means the rate of Premiums for a Product set out in the Schedules as amended from time to time in accordance with these Rules.

“Previous Cover” means:
(a) in respect of an Insured Person who transfers Products, the previous Product in respect of which Premiums were paid by or on behalf of the Insured Person; and
(b) in respect of an Insured Person who transfers from another provider of overseas’ visitors health cover, the previous cover in respect of which Premiums were paid by or on behalf of the Insured Person to the other insurer.

“Private Hospital” means a Hospital which is not administered by the State or Territory Government.

“Private Patient” means a Patient classified as such in accordance with Rule LV2.16 (Hospital Treatment).

“Product” means a defined group of Benefits which are payable to an Insured Person, subject to relevant Rules, for approved expenses incurred by an Insured Person as set out in the Schedules and in respect of which Premiums are payable at the Premium Rates.

“Provider” means:
(a) Hospitals;
(b) Eligible Medical Providers; and
(c) Eligible Non Medical Providers.

“Psychiatric Care Patient” means a Patient classified as such and admitted in a Public or Private Hospital.

“Psychology and Counselling” means General Treatment that is provided by registered psychologists and counsellors. See also LV2.22.7 Medicare Entitlement and Payment of Claims.

“Public Hospital” means a Hospital administered by a State or Territory Government.

“Rehabilitation Patient” means a Patient classified as such in accordance with Rule LV2.16.4 (Rehabilitation Patients).

“Restricted Benefits” means the lower level of Benefits payable for some services under a Product as set out in the Schedules.

“Risk Rating” has the meaning set out in LV2.4.2.
“Risk Assessing” means undertaking a review of a Policy Holder’s or new applicant’s Pre-Existing Conditions to determine likely high claims risk exposure and to then decide whether or not to insure the individual.

“Rules” means these rules as altered or varied from time to time.

“Single Policy” means a Policy where the only Insured Person is the Policy Holder.

“Special Care Unit” means a unit of a Hospital approved by nib/IMAN for the purpose of providing special care, and includes facilities such as intensive care units, critical care units, coronary care units and high dependency nursing care units.

“Specified Temporary Visa Holder” has the meaning conferred under the Private Health Insurance (Health Insurance Business) Rules 2015.

“Speech Therapy” means General Treatment that is:
(a) approved by nib/IMAN; and
(b) provided during a Consultation with a Provider who is recognised by nib/IMAN as a speech therapist.

“Start Date” means the date the Plan comes into effect as shown on the Membership Certificate. This date cannot be prior to arrival in Australia.

“Student Dependant” means a person who is not a Policy Holder or Partner and who:
(a) is accompanying the Policy Holder on the same visa; and
(b) is living at home with, and financially dependent on, the Policy Holder; and
(c) are aged 21 up to age 25 and engaged in full-time or part-time study at an approved school, college, institute or university and not working full time.

“Treatment” means:
(a) in respect of Hospital Products: Hospital Treatment, professional attention and any other item in respect of which Benefits are payable from a Hospital Product; and
(b) in respect of General Products (Extras): services and items for General Treatment for which Benefits are payable under these Rules.

“Visa condition 8501” as per the Department of Home Affairs (DHA) means the condition where a working visa holder must maintain adequate arrangements for health insurance while in Australia as a requirement of their working visa.

“Waiting Period” means a period of time during which a Policy Holder and each Insured Person must continuously hold a Policy for a particular Product before an Insured Person under that Policy has an entitlement to receive a Benefit under that Product.

LV2.2 Eligibility for Overseas Visitors Health Cover

LV2.2.1 Generally

Any Overseas Visitor working in Australia, their Partner and/or Dependants (as listed on the visa), who

(a) is in reasonable health at time of application, and does not have any Pre-Existing Condition of such severity that their health is considered to be in danger; and

(b) holds a temporary resident visa sub-class to visit Australia,

are eligible to be an Insured Person unless nib/IMAN have determined under LV2.3.3 to refuse an application.
An Overseas Visitor on a working visa must take out an OVHC policy in the following manner:

(a) If an OVHC visa has been granted for the Overseas Visitor only then the Overseas Visitor must take out a single OVHC policy.

(b) If an OVHC visa has been granted for the Overseas Visitor and a Partner then the Overseas Visitor must take out a couples’ OVHC policy listing the Partner as per the visa granted.

(c) If an OVHC visa has been granted for the Overseas Visitor, a Partner and any Dependents then the Overseas Visitor must take out a family OVHC policy listing the Partner and all Dependents as per the visa granted.

(d) If an OVHC visa has been granted for the Overseas Visitor and any Dependents then the Overseas Visitor must take out a family OVHC policy listing all Dependents as per the visa granted.

**LV2.2.2 Minimum Age of Policyholders**

Unless otherwise approved by nib/IMAN, a person aged less than 16 years is not eligible to be a Policyholder.

**LV2.2.3 Dual Policies**

A person who is an Insured Person under an overseas visitors’ health cover Product offered by an insurer other than nib/IMAN is not eligible to contribute to, or Claim under, an equivalent Product offered by nib/IMAN.

Where an nib/IMAN Insured Person holds a Complying Health Insurance Product (CHIP) under the Act and an OVHC Product, benefits are only claimable on one or the other product.

**LV2.2.4 Dependants**

(a) An application as per LV2.3.1 (Form of Application) is necessary to add a Dependant to a Policy.

(b) The following provisions apply to adding Dependents:
   (i) where the Policy is a Single Plan, an upgrade to a Couple plan is necessary to add a Dependent; and
   (ii) where the Policy is a Couple Policy, an upgrade to a Family plan is necessary to add a Dependent.

**Adding Newborns**

A newborn must be added within 60 days from date of birth. The policy will also be backdated and upgraded from Single to a Couple policy or Couple to a Family policy. If the newborn is added to the policy from their date of birth they are considered to have served all of the same waiting periods as the longest serving member. If the newborn is added after 60 days, or the birth occurs outside of Australia or you choose not to backdate the policy, the baby would be added from Date of Notification and normal waiting periods, risk assessing and Pre-Existing Conditions would apply.

**Ceasing to be a Dependant**

A person, who is an Overseas Visitor, who ceases to be eligible to be a Dependent Child or a dependant student under a policy of overseas visitors’ health cover with an insurer other than nib/IMAN, may join nib/IMAN without serving any Waiting Periods (other than the balance of the unexpired waiting period for that benefit under the policy of private health insurance with the other private health insurer) if:

(a) the Benefits provided under the new Product are no higher than the Benefits provided under the Previous Cover; and

(b) the person applies for a Policy within 30 days of ceasing to be a Dependent Child or a dependant student under a policy of overseas visitors’ health cover with another insurer.
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(c) the person is a Specified Temporary Visa Holder working in Australia.

Refer to LV2.5 (Transfers).

LV2.3 OVHC Policy Applications

LV2.3.1 Form of Application

(a) Applications for OVHC Policies will be in the format required by nib/IMAN from time to time.

(b) Applications for OVHC Policies must be accompanied by any proof of details reasonably required by nib/IMAN from time to time.

LV2.3.2 Payment of Premium with Application

An application for an OVHC Policy will be accepted by nib/IMAN only where the Premiums for the minimum period relevant to the applicant have been paid. nib/IMAN may waive this Rule in its discretion.

LV2.3.3 Refusal of Applications

Subject to these Rules, nib/IMAN may in its discretion refuse an application to join nib/IMAN as an Insured Person.

If nib/IMAN refuses an application, nib/IMAN will provide a reason for the refusal to the applicant.

LV2.3.4 Consent of Insured Persons

Each Policy Holder:

(a) authorises nib/IMAN to request and receive Personal Information from a Provider or any other person in respect of a Claim made under a Policy held by that Policy Holder; and

(b) warrants that in relation to their Policy, s/he has obtained the consent of all Insured Persons under that Policy to the authority provided in Rule LV2.3.4(a); and

(c) warrants that s/he has obtained the consent of all Insured Persons under their Policy to provide Personal Information about the Insured Person to nib/IMAN.

LV2.4 Commencement of Policy

Subject to nib/IMAN’s acceptance of an application for a Policy, a Policy commences:

(a) on the date that nib/IMAN confirms that the policy has been accepted;

(b) when the start date of the Policy has passed;

(c) the status is active; and

(d) the Policy is financial.

The application may be received and confirmed prior to the Policy becoming active. This can be no more than 24 months from date of notification.

A minimum payment equal to one month of premium for the Policy joined is required prior to the Policy start date. Corporate customers may be considered financial prior to an invoice being raised.

nib/IMAN may in its discretion organise special arrangements with sponsors and agents where payment is delayed.

The start date of a Policy may be adjusted to align with:

(a) the date the applicant arrives in Australia (this is applicable to visas that are approved
(b) the visa start date (this is applicable to visas that are approved onshore).

If an application for a policy is withdrawn prior to arrival in Australia or prior to start date if the applicant is onshore an administration fee may apply.

**LV2.4.1 Risk Assessing**

Categorised as health related business, nib/IMAN is not subject to community rating and can therefore choose not to underwrite individuals determined to have a high likelihood to incur high claims costs.

nib/IMAN will undertake a Risk Assessing process by examining Pre-Existing Conditions of new applicants, Policy Holders who reactivate their Policies after a suspension of 6 months or more, or Policy Holders who change Products or Policies. nib/IMAN will also undertake a Risk Assessing process in reviewing claims from current Policy Holders and determining whether those claims are a result of an undisclosed Pre-Existing Condition at the date of join.

nib/IMAN can choose not to insure (and in appropriate cases reject claims) based on the Risk Assessing Process.

The applicant or Policy Holder has an obligation or duty to disclose to nib/IMAN any information that is requested by nib/IMAN which it needs to decide whether and on what terms an application for cover is accepted and to assess the Premium payable for the Policy. The applicant or Policy Holder must provide honest and complete answers, and must tell nib/IMAN everything that they know or that a reasonable person in the circumstances could be expected to know. If the Policy Holder does not comply with this duty of disclosure, nib/IMAN may cancel the Policy or reduce the amount that it pays for a claim. If fraud is involved, nib/IMAN may treat the Policy as if it never existed and pay nothing.

**LV2.4.2 Risk Rating**

Risk Rating is different from Risk Assessing in that Risk Assessing is a review process for Pre-existing Conditions to determine whether to accept or reject the applicant (or a claim), whereas Risk Rating is a process for setting Premiums for an applicant or Policy Holder according to their wider claims risk profile.

Risk Rating means undertaking a review of an applicant or a Policy Holder that proposes to be covered under a Policy, to determine the likelihood of a medical event occurring and the likely claims impact.

nib/IMAN determines the Premium payable by that applicant or Policy Holder by starting with the base rate for the relevant Product and scale in accordance with Schedule K1. The base rate is adjusted upwards or downwards depending on the customer's risk profile. This is determined by considering several factors such as Pre-existing Conditions, age, gender and family size.

Risk Rating enables nib/IMAN to accept high risk customers and price the policy accordingly, instead of outright rejecting the application for cover. This will enable nib/IMAN to also price more competitively for low risk customers.

Risk Rating complements Risk Assessment to enhance risk management within nib/IMAN and applies to both new and existing customers.

nib/IMAN may determine that employees, officers or contractors of a particular business will be risk rated by considering the risk profile of the group and Premiums for each Product may be set to apply only to that group.

**LV2.5 Transfers**

**LV2.5.1 Transfers from Another Insurer**
Where a person who was insured under a policy of overseas visitors' health cover with another Australian insurer transfers to nib/IMAN with a break in coverage of 30 days or less and whose Product meets the DHA minimum requirements:

(a) nib/IMAN may apply all relevant Waiting Periods to any Benefits under the new Product that were not provided under the Previous Cover; and

(b) nib/IMAN may apply all relevant Waiting Periods to the unexpired portions of any Waiting Periods not fully served under the Previous Cover.

Where a person who was insured under a policy of overseas visitors' health cover with another Australian insurer transfers to nib/IMAN with a break in coverage of more than 30 days the person will be treated as a new Insured Person for all purposes.

nib/IMAN may also accept transfers from other insurers on a case by case basis in its discretion.

**LV2.5.2 Benefits Paid Under Previous Cover may be Taken into Account**

Where an Insured Person:

(a) transfers from an OVHC policy with another Australian insurer to nib/IMAN; or

(b) transfers to a different nib/IMAN Product,

Any Benefits that have been paid in the current Calendar or Membership Year under the Previous Cover may be taken into account in calculating Annual Limits in determining the Benefits payable under the new Product for the remainder of the Calendar or Membership Year.

If an Insured Person has not finished serving the 12 month waiting period for Pre-Existing Conditions with the previous Insurer then it will continue to be served with nib/IMAN until the full duration of 12 months has been served.

An Insured Person who transfers from one product (previous Cover) to another product (new Cover) or transfers from an OVHC policy with another Australian insurer to nib/IMAN must serve all Waiting Periods which apply to the new Cover and did not apply to the previous Cover, together with the balance of any Waiting Periods which apply to both the previous Cover and the new Cover but were not served under the previous Cover.

During any Waiting Period applicable to the New Product, Benefits are payable at the lower of:

(a) the level of Benefits payable under the Previous Product; or

(b) the level of Benefits payable under the New Product.

**LV2.5.3 Transfers to Another Private Health Insurer**

If an Insured Person transfers to a policy of health insurance with another insurer, nib/IMAN will provide the Insured Person with a transfer certificate.

**LV2.6 Cancellations**

**LV2.6.1 Cancellation of Policies**

Unless otherwise permitted by nib/IMAN any cancellation of an OVHC Policy:

(a) must be authorised by the Policy Holder;

(b) may not have retrospective effect; and

(c) must be in accordance with other arrangements specified by nib/IMAN.

**LV2.6.2 Cancellation Options**

(a) A Policy Holder may cancel their Policy entirely;

(b) A Policy Holder may remove any Insured Persons from their Policy;

(c) Any Insured Person aged at least 16 years of age may leave the Policy; and

(d) A Dependent Child under the age of 16 years may leave the Policy with the agreement of the Policy Holder.
LV2.6.3 Administration Fees

(a) An Administration Fee may be charged and deducted from an Insured Person’s refund if the Insured Person cancels their Policy between the date the application is submitted and up to 30 days from the commencement of their Policy. Refer to LV2.7

(b) An Administration Fee shall be defined from time to time.

(c) If, at the time of cancellation, there is insufficient Excess Premiums to cover the Administration Fee, nib/IMAN may at its discretion waive part of the applicable Administration Fee.

LV2.6.4 Circumstances in which Policies must be Cancelled

A Policy Holder must cancel their Policy on attaining permanent residency.

LV2.6.5 Reinstatement of Cancelled Policies

A Policy must be continuous. If a lapse in cover is greater than 2 months, the Policy Holder must reapply and be subject to all terms and conditions of the application process.

LV2.7 Refund of Premiums

(a) nib/IMAN may in its discretion refund any Excess Premiums when a Policy is terminated if requested to do so by the Policy Holder. Refunds are calculated on a daily pro-rata basis with no minimum period.

(b) nib/IMAN may refund any Excess Premium to a nominated bank account at an Australian financial institution or credit card if the following is supplied by the Policy Holder:
   (i) Full name and address of the Financial Institution;
   (ii) Full name of Account Holder
   (iii) BSB Number; and
   (iv) Account Number

(c) nib/IMAN may refund any Excess Premium to an overseas bank account in Australian Dollars if the following is supplied by the policy Holder;
   (i) Full name and address of the Financial Institution
   (ii) Full name of the Account Holder
   (iii) SWIFT Code; and
   (iv) Account Number

(d) Any bank or transfer costs associated with the refund of premium to an overseas institution will be borne by the Policy Holder and deducted from the premium refund.

(e) An Administration Fee may be charged and deducted from an Insured Person’s refund if the Insured Person cancels their Policy between the date the application is submitted and up to 30 days from the commencement of their Policy.

LV2.8 Termination of OVHC Policy

A Policy terminates on the date a request to cancel is received from the Policy Holder or sponsor which explains the reason for cancellation and upon confirmation with all interested parties, as outlined in the terms and conditions acknowledged at the point of application.

nib/IMAN may terminate a Policy:

(a) if Premiums have not been paid for 2 months;

(b) if a Policy Holder made a false declaration during the application, Risk Assessing or Risk Rating process or made a false claim for Benefits;
(c) if individuals covered on the policy have left or intend to leave Australia for a period of more than 24 months;

(d) if an Insured Person has obtained permanent residency;

(e) nib/IMAN may choose to close Products. This may result in the termination of the Insured Person's Product which means the Insured Person will be offered an alternative Product;

(g) if an Insured Person has engaged in inappropriate behaviour including abuse of staff members at nib/IMAN;

(h) if an Insured Person has attempted to obtain an advantage, monetary or otherwise which the Insured Person is not entitled to.

Upon termination nib/IMAN may inform the DHA and the employer, sponsor or agent.

**LV2.9 Improper Advantage or Unacceptable Behaviour**

nib/IMAN may, by notice in writing to the Policy Holder, terminate a Policy where, in the opinion of nib/IMAN:

(a) an Insured Person covered by the Policy has obtained or attempted to obtain an advantage, monetary or otherwise, and whether for the Insured Person or for any other person, to which the Insured Person is not entitled under these Rules; or

(b) an Insured Person has engaged in inappropriate behaviour including abuse of staff members of nib/IMAN.

**LV2.9.1 Customer Card**

An Insured Person must not knowingly allow any person who is not covered under their Policy, to use their nib/IMAN Customer card to obtain any Treatment or Benefit to which that other person is not entitled under these rules.

nib/IMAN may terminate a Policy, in the event of any fraudulent misuse of the nib/IMAN Customer card which may result in notification to the DHA, employer sponsor and/or agent.

nib/IMAN will not be responsible for any loss suffered or incurred by an Insured Person arising from misuse of their Customer card.

All Insured Persons must keep their nib/IMAN Customer card secure and notify nib immediately if it is lost or stolen.

**LV2.10 Temporary Suspension of OVHC Policy**

**LV2.10.1 Suspension of a policy**

nib/IMAN may approve an application for Suspension of a policy if:

(a) the Insured Person and all insured members on the Policy travel outside of Australia for a period of time as specified below in paragraph (b);

(b) all Insured Persons are away for a period of not less than 4 weeks and not more than 24 months. If all insured members are away for a period greater than 24 months the policy may be cancelled;

(c) the Insured Person notifies nib/IMAN in writing, producing the relevant proof of travel, prior to travel; and
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LV2.10.2 nib/IMAN's Discretion

nib/IMAN may accept or refuse an application for suspension of a Policy in its absolute discretion.

LV2.10.3 Premiums Must be Paid up to Date of Suspension

A Policy may not be suspended unless all Premiums have been paid up to the date of the start of the suspension.

A Policy Holder who applies to suspend or reactivate a Policy must provide all relevant documentation in support of their application reasonably required by nib/IMAN.

LV2.10.4 Effect of Suspension

During the suspension of a Policy:
(a) the Policy Holder is not required to pay Premiums in respect of the Policy; and
(b) any Insured Person covered by the Policy is not entitled to payment of Benefits for services provided during the suspension. In relation to the Premium attributable to the period of the suspension, that amount will be credited to the policy from the date the policy resumes. This will result in the date the policy is paid to being recalculated and advanced.

LV2.10.5 Effect of Suspension on Waiting Periods

A period during which a Policy is suspended is not included for the purposes of completing any Waiting Periods that are to be served by a Policy Holder before an Insured Person is eligible to receive Benefits.

LV2.10.6 Effect of Suspension on Risk Assessment

Where a policy is suspended for a period greater than 6 months the re-activation of that policy will be subject to the completion of a new Pre-existing Condition declaration and the outcomes of the Risk Assessing process.

LV2.11 Payment of Premiums

LV2.11.1 Premium Frequencies

All Premiums must be paid in advance unless otherwise specified. The available payment periods are:

(a) where Premiums are paid to nib/IMAN by direct debit from a financial institution account automatically – monthly, quarterly, half-yearly and yearly.

(b) where Premiums are automatically charged to a credit card – monthly, quarterly, half-yearly or yearly.

(c) where Premiums are paid to nib/IMAN by payroll deduction – weekly, fortnightly, and monthly; or

(d) where Premiums are paid to nib/IMAN by companies via invoice – monthly, quarterly, half-yearly and yearly.

LV2.11.2 Premiums Paid in Advance

Premiums cannot be paid:
(a) more than 12 months in advance of the date joined; or
(b) more than 12 months in advance of the date of payment if the Policy is active, unless approved by nib/IMAN in its discretion.
LV2.11.3 Contribution Groups

nib/IMAN may in its discretion approve any group of Policy Holders as a Contribution Group. A Contribution Group may include:
(a) employees of a particular enterprise or group of enterprises;
(b) members of any organisation; or
(c) Policy Holders who apply for a Policy during a marketing or advertising promotion conducted by nib/IMAN.

LV2.12 Premium Changes

nib/IMAN may change the Premium for a Policy Holder from time to time by way of 14 days’ notice.

Premiums may change as a result of:
(a) a change in operating expenses or market conditions; or
(b) a change in Product; or
(c) a change in Policy Type; or
(d) a change in a Policy Holder's individual circumstances.

Where Premiums are paid by or on behalf of a Policy Holder in advance, a Premium change that takes effect during the period in which that Policy Holder’s Premiums have been paid in advance will not take effect until the Policy Holder’s next Premium falls due.

LV2.13 Premium Discounts

nib/IMAN may discount a Policy Holder’s Premium for any Product in its absolute discretion.

LV2.14 Arrears in Premiums

LV2.14.1 When an OVHC Policy is in Arrears

(a) A Policy paid in advance is in arrears whenever:
   (i) the date to which Premiums have been paid is earlier than the current date; or
   (ii) a scheduled payment has been missed; and
   (iii) the Policy is not suspended.

(b) A Policy paid in arrears under a Contribution Group arrangement as per LV2.11.3(b) (Premium Frequencies) is in arrears whenever:
   (i) the scheduled payment has been missed; and
   (ii) the Policy is not suspended.

LV2.14.2 Termination after 60 Days

A Policy which is in arrears for more than 60 days may be automatically terminated. nib/IMAN may waive this Rule in its discretion.

LV2.14.3 When an OVHC Policy is Less than 60 Days in Arrears

The Policy Holder will be given continuity of coverage under the Policy, and an Insured Person covered by the policy will be entitled to payment of Benefits for services provided during the arrears period where:
(a) a Policy is in arrears for less than 60 days; and
(b) the Policy Holder pays the amount in arrears within the 60 day period.

No Benefits will be paid for services rendered to an Insured Person during the period in which the Policy is in arrears until all Premiums in arrears are paid.

LV2.15 Benefits
LV2.15.1 Approved Goods and Services

Benefits are only payable for goods and services described in the related Schedules to this document, as amended from time to time.

LV2.15.2 Treatment by Providers

Benefits are only payable where Treatment is provided by a nib/IMAN Provider. Where specified in the Schedule, Benefits may vary depending on whether Treatment is provided by a nib Preferred Provider or other Provider.

LV2.15.3 Ambulance Services

Ambulance Benefits are only payable for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

LV2.15.4 Services Provided by Family Members

Benefits are not payable for services rendered by a Provider to:

(a) the Provider’s Partner, dependents, family members or business partner; or
(b) the Partner, dependents or family members of the Provider’s business partner.

LV2.15.5 False or Misleading Claims

Benefits are not payable if any application or claim submitted to nib/IMAN contains false or misleading information.

LV2.15.6 Benefits in Excess of Charges

nib/IMAN will not pay Benefits which exceed the actual charge for the goods or services received by an Insured Person.

LV2.15.7 Total Benefits Payable

As per the DHA requirements, the maximum total payable per person per annum on all nib/IMAN policies is $1 million dollars.

LV2.16 Hospital Treatment

LV2.16.1 Patient Classifications

Benefits for accommodation in Private Hospitals are payable according to the classification of the patient.

Patients are classified in accordance with the guidelines issued by the Minister. The classifications are:

(a) Surgical (as per LV2.16.2 Surgical and Advanced Surgical Patients);
(b) Advanced Surgical (as per LV2.16.2 Surgical and Advanced Surgical Patients);
(c) Obstetric (as per LV2.16.3 Obstetric Patients);
(d) Other (Medical);
(e) Psychiatric Care (as per LV2.16.5 Psychiatric Care Patients), and
(f) Rehabilitation (as per LV2.16.4 Rehabilitation Patients).

nib/IMAN may permit further sub-classifications of patients where not inconsistent with the Minister’s
Guidelines.

**LV2.16.2 Surgical and Advanced Surgical Patients**

Benefits are payable for admissions to Private and Public Hospital as follows:

(a) expenses incurred and paid by or on behalf of an Insured Person, to a Provider for medical, surgical, x-ray, Hospital, nursing or other medical treatment including prescribed medicines, drugs and medical supplies within Australia.

Subject to this Rule, the Benefits payable for Surgical and Advanced Surgical classifications apply:

(a) from the date of admission, where the operative procedure is performed on the first or second day of admission; or

(b) from the date of the procedure, where the operative procedure is performed on the third day of admission or later.

**LV2.16.3 Obstetric Patients**

(a) The Obstetric classification applies only where childbirth occurs following the mother’s admission to a Hospital.

(b) Where labour resulting in childbirth commenced before admission, the Obstetric classification applies from the date of admission.

(c) Where labour commenced after admission, the Obstetric classification applies from the earliest of:

(i) the date on which labour commenced, or

(ii) the date on which an obstetric procedure took place, or

(iii) any other date that nib/IMAN may in its absolute discretion specify.

**LV2.16.4 Rehabilitation Patients**

Benefits for Rehabilitation patients are payable subject to the following conditions:

(a) treatment must be supported by a Rehabilitation Certificate

(b) a further Rehabilitation Certificate is required:

(i) for each period specified in any certificate where Treatment as a Rehabilitation patient beyond 30 days is provided, and

(ii) for any subsequent readmission as a Rehabilitation patient that does not constitute Continuous Hospitalisation.

For the purposes of this Rule, a Rehabilitation Certificate means a certificate in a form approved by nib/IMAN that the patient is in need of a special rehabilitation program to recover from an Acute Catastrophic Illness or Injury.

**LV2.16.5 Psychiatric Care Patients**

Benefits for Psychiatric Care Patients are payable subject to the following conditions:

(a) treatment must be supported by a Psychiatric Care Certificate

(b) a further Psychiatric Care Certificate is required:

(i) for each period specified in any certificate where Treatment as a Psychiatric Care Patient beyond 30 days is provided, and

(ii) for any subsequent readmission as a Psychiatric Care Patient that does not constitute Continuous Hospitalisation.

For the purposes of this Rule, a Psychiatric Care Certificate means a certificate in a form approved by nib/IMAN that the Patient is in need of a special program of acute Psychiatric Care.
LV2.16.6 Counting of Days

The day on which a person became an Admitted Patient and the day of discharge are counted as one day for the purpose of assessing Benefits payable.

After 35 days of continuous hospitalisation (readmission within 7 days or less to the same or another hospital, is also classed as continuous), a certificate from the doctor is required to confirm the need for continued acute hospital care. If this certificate is not issued, benefits payable will be reduced to the Nursing Home Type Patient Benefit and Out-of-Pocket Expenses will apply.

LV2.16.7 Multiple Treatments

Subject to these Rules and the payment of benefits for associated treatments for complications, associated unplanned treatments and common and support treatments (as these terms are defined in the Private Health Insurance Act 2007), where a patient undergoes more than one type of Hospital Treatment during a Hospital Admission, nib will only cover accommodation, theatre fees and procedures related to the covered Treatment performed as part of that Admission. If one or some Hospital Treatments are covered as a Lower Benefit, nib will pay Lower Benefits toward any part of the costs associated with that Treatment. If one or some Hospital Treatments are excluded, no Benefits will be paid toward any part of the costs associated with the excluded Treatment.

LV2.16.8 Subsequent Procedures

Where a patient undergoes a subsequent operative procedure during the same period of hospitalisation:
(a) where the procedure results in the patient having a higher classification, the patient’s classification increases from the date of the procedure, and
(b) where the procedure would otherwise have resulted in the patient moving to a lower classification, the patient’s classification is unchanged until day 15 from the original procedure.

LV2.16.9 Special Care Units

The Benefits payable for Patients of Special Care Units are payable only for periods during which the Patient occupies a bed in a facility approved by nib/IMAN for this purpose.

LV2.16.10 Continuous Hospitalisation

Where a Patient is discharged, and within 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.

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.

LV2.16.11 Medical Purchaser Provider Agreements and Hospital Purchaser Provider Agreements

nib (on behalf of nib/IMAN) may enter into an agreement with:
(a) a Medical Practitioner or group of Medical Practitioners; or
(b) a Hospital or group of Hospitals.

Under which any of the following items, or any combination of the following items, are to remain fixed throughout the term of the agreement in respect of all Insured Persons under a particular Product:
(a) the total charge for any Treatment (excluding paramedical services);
(b) the Benefit payable by nib/IMAN; and
(c) any out-of-pocket expenses payable by the Insured Person.

LV2.16.12 Pharmaceuticals provided in Hospital
Unless otherwise stipulated in these rules Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:
(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:
(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

Any agreement under a Hospital purchaser provider agreement may override this Rule (LV2.16.12).

**LV2.17 Out-Patient Continuing Treatment Following Hospitalisation**

Benefits will be paid for Out-Patient continuing treatment following hospitalisation for services that are:
(a) covered by the Medicare Benefit Schedule (MBS)
(b) home nursing such as wound care or intravenous antibiotics
(c) may include early discharge

Benefits are not payable for:
(a) personal care such as bathing and housekeeping
(b) services provided by Allied health providers such as physiotherapy

All treatment must be documented and approved by the treating doctor prior to discharge. This must be reviewed and approved by the Clinical team prior to Benefits being paid.

**LV2.18 General and Extras Treatment**

**LV2.18.1 General**

The Benefits payable in respect of General Treatment and the conditions relevant to those Benefits are set out in Schedules:
LV10 (Executive Top Visitor Singles);
LV11 (Executive Top Visitor Couples and Families);
LV12 (Top Visitor Singles);
LV13 (Top Visitor Couples and Families);
LV14 (Mid Visitor);
LV15 (Basic Visitor);
LV16 (Budget Visitor);
LV17 (Value Plus);
LV20 (nib United Gold Visitor Cover
LV22 (Visitor Cover).
LV23 nib Basic Visitor Cover
LV24 nib Budget visitor Cover

**LV2.18.2 Conditions**

The following conditions apply to all Benefits
(a) all Benefits are limited to one visit per day per Insured Person to the Provider of the treatment;
(b) unless otherwise stated, Annual Limits are calculated on a Membership Year basis for each Insured Person on the Policy.

**LV2.19 Other**

**LV2.19.1 Ex Gratia Payments**

nib/IMAN may pay Benefits on an ex gratia basis in its discretion.
LV2.19.2 Treatment Outside Australia

No Benefits are payable for treatment (including goods) provided outside Australia.

LV2.20 Waiting Periods

Waiting periods apply to Hospital services, Medical services and General Treatment (Extras) services.

LV2.20.1 Independence of Waiting Periods

Where more than one Waiting Period applies to a Benefit, each Waiting Period is served independently of and concurrently with any other.

LV2.20.2 Pre-existing Conditions

nib/IMAN may refuse to pay or reduce Benefits in respect of a Pre-Existing Condition that is the subject of Treatment within the first 12 months of a Policy for any Product.

If the Hospital Product that the Policy Holder is upgrading to has higher Benefits or includes services that were not previously covered in the previous Hospital Product, then the relevant Waiting Periods will apply to those services or to the higher Benefits. If a Product is changed because of increased Hospital costs the customer does not need to re-serve Waiting Periods. Upgrades from one Hospital Product to another Hospital Product will also be subject to Risk Assessment (see LV2.4.1).

This Exclusion does not apply where a Medical Practitioner certifies, and it is agreed by nib/IMAN, that the Insured Person requires Emergency Treatment, or treatment for a Life Threatening Illness or Injury in Australia.

If the Insured Person transfers from another overseas health insurer to the same level of cover with nib/IMAN, nib/IMAN may recognise the Waiting Periods already served with the other insurer and waive the Waiting Period at nib/IMAN’s discretion. Refer to LV2.5.1 (Transfers).

LV2.20.3 Waiting Periods – Upgrades to a higher level of cover

(a) The 12 month Waiting Period for Pre-Existing Conditions will apply from the Insured Person’s date of joining for the first 12 months. When an Insured Person upgrades their policy during this time they will continue to serve the Pre-Existing Condition Waiting Period until 12 months has been served.

(b) When an Insured Person upgrades their Policy they will also have to serve Waiting Periods to the services that were not previously included from the date of the upgrade. If an Insured Person has upgraded within 12 months of joining nib/IMAN the Waiting Period for the upgrade will be served at the same time as the initial 12 month Waiting Period for Pre-Existing Conditions until both Waiting Periods have been served.

(c) Dependent upon Pre-Existing Conditions an upgrade may be refused.

(d) Where a policy is suspended for a period greater than 6 months the re-activation of that policy will be subject to the completion of a new Pre-existing Condition declaration and the outcomes of the Risk Assessing process.

(e) When upgrading to a higher level of Cover Waiting Periods will apply to services that were not previously included and for services that have a higher benefit. When upgrading to a Product that receives a higher benefit the Insured Person will receive the previous Product’s benefit until the appropriate Waiting Period has been served.

LV2.20.4 Waiting Periods – Hospital Products

For Products LV10 (Executive Top Visitor Singles), LV11 (Executive Top Visitor Couples and Families), LV12 (Top Visitor Singles), LV13 (Top Visitor Couples and Families), LV14 (Mid Visitor),
LV15 (Basic Visitor), LV16 (Budget Visitor), LV17 (Value Plus), LV20 (United Gold Visitor Cover), LV22 (Visitor Cover), LV23 (nib Basic Visitor), LV24 (nib Budget Visitor).

The Waiting Periods for Hospital are:
(a) 12 months for Pre-Existing Conditions
(b) 12 months for pregnancy and birth related services
(c) 2 months for psychiatric,
(d) 2 months rehabilitation and palliative care
(e) no waiting period for ambulance.

When upgrading to a higher level of cover the Pre-existing Condition rule applies. If a member has a Pre-Existing Condition for which the current level of cover does not pay Benefits, a 12 month waiting period will apply.

**LV2.20.5 Waiting Periods – General (Extras) Products**

For Products LV10 (Executive Top Visitor Singles), LV11 (Executive Top Visitor Couples and Families), LV12 (Top Visitor Singles), LV13 (Top Visitor Couples and Families), LV14 (Mid Visitor), LV15 (Basic Visitor), LV16 (Budget Visitor), LV17 (Value Plus), LV20 (United Gold Visitor Cover), LV22 (Visitor Cover), LV23 (nib Basic Visitor), LV24 (nib Budget Visitor).

The Waiting Periods for Extras are:

- General Extras including general dental, acupuncture and optical and other ancillary services.
- Physiotherapy, Osteopathy and Chiropractic Services: 2 months
- Out-Patient prescribed PBS pharmaceuticals: 2 months
- Major Dental and Orthodontics: 6 months
- Laser Eye Surgery: 12 months
- Antenatal and Postnatal Services: 12 months
- Funeral and Repatriation: 12 months for pre-existing
- CPAP Machine: 2 months
- Wheelchairs and crutches: 2 months

For Products LV10 (Executive Top Visitor Singles), LV11 (Executive Top Visitor Couples and Families), LV12 (Top Visitor Singles) the Waiting Period for Hearing Aids is 6 months.

**LV2.20.6 Payment of Benefits**

Benefits are only payable for Treatment provided after the expiration of the relevant Waiting Period.

**LV2.21 Exclusions**

**Exclusions and Limitations – All Products**

Unless expressly provided for in these Rules, Benefits are not payable under Products:
(a) for Claims which relate to services rendered while a Policy is in arrears or suspended;
(b) for Claims which relate to services rendered outside Australia, en route to or from Australia or for items purchased or hired from overseas
(c) where the Insured Person is entitled or may be entitled to Compensation;
(d) for In-Patient and Out-Patient medical services where the Insured Person is entitled to a benefit from Medicare;
(e) for Claims which relate to Treatment rendered by a provider who has not supplied a provider number on their receipt;

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(f) for expenses relating to proprietary (over the counter) medicines or drugs, purchased without a prescription, issued by a Medical Practitioner and not on the PBS and medicines, purchased in bulk lasting beyond the period of insurance (stockpiling). (Must be on general or restricted schedule – not on repatriation schedule);

(g) where an application form or a claim form submitted to nib/IMAN contains fraudulent, false, or misleading information;

(h) for services rendered in a nursing home;

(i) where moneys are payable from another source;

(j) where the Treatment is otherwise excluded by the operation of a Rule;

(k) for luxury room charges;

(l) for respite care as an Out-Patient;

(m) for take home items;

(n) for experimental and/or treatment not covered by Medicare;

(o) for autologous blood collection and storage and egg storage;

(p) for expenses relating to a Pre-Existing Condition;

(q) for expenses incurred within Waiting Periods;

(r) for expenses recoverable from another insurer, including but not limited to claims under motor insurance, sport insurance or public liability policies or under a compulsory workers compensation policy;

(s) for expenses for medical examinations, x-rays, inoculations or vaccinations and other treatments required for the purpose of:
   (i) obtaining, renewing or extending a visa for entry into Australia;
   (ii) obtaining permanent residency status in Australia;
   (iii) travelling outside Australia; or
   (iv) an examination for pre-employment purposes

(t) for expenses relating to any experimental surgical procedures;

(u) For any expense, or that part of an expense, exceeding the Annual Limits specified in the Membership Certificate and Schedule of Benefits,

(v) For elective cosmetic expenses relating to elective cosmetic treatments deemed not Medically Necessary;

(w) For treatment referred by or provided by a spouse or family member of the Insured;

(x) For In–Hospital services, drugs or disposable items not recognised by Medicare (for example, some items associated with robotic surgery may not be covered);

(y) for treatment not considered to be Medically Necessary and where the treatment does not have a Medicare Benefits Schedule item number; does not meet Medicare eligibility criteria, or has not been approved by the Medical services Advisory Committee; or

(z) for same day services.

LV2.22 Compensation Damages and Provisional Payment of Claims
LV2.22.1 Interpretation

In this section:

(a) a reference to a claim (other than a Claim for Benefits) includes a reference to a demand or action;
(b) a reference to an injury includes a Condition (including an Ailment or Injury) for which Benefits would or may otherwise be payable by nib/IMAN for Expenses incurred in its Treatment; and
(c) a reference to an Insured Person receiving Compensation includes:
   (i) Compensation paid to another person at the direction of the Insured Person; and
   (ii) Compensation paid to another Insured Person on the same Policy in connection with an injury suffered by the Insured Person.

LV2.22.2 Insured Person’s Obligations if Entitled to Compensation

Subject to the following, an Insured Person who has, or may have, a right to receive Compensation in relation to an injury, must:

(a) inform nib/IMAN as soon as the Insured Person knows or suspects that such a right exists;
(b) inform nib/IMAN of any decision of the Insured Person to claim for Compensation;
(c) include in any claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable;
(d) take all reasonable steps to pursue the claim for Compensation to nib/IMAN’s reasonable satisfaction;
(e) keep nib/IMAN informed of updates or progress of the claim for Compensation;
(f) inform nib/IMAN immediately upon the determination or settlement of the claim for Compensation; and
(g) repay nib/IMAN any Benefits paid in respect of the injury.

Subject to these Rules, Benefits are not payable for expenses incurred (including after the Insured Person has received any Compensation) in relation to an injury where the Insured Person has received, or may be entitled to receive, Compensation in respect of that injury.

Where nib/IMAN reasonably forms the view that an Insured Person has or may have a right to make a claim for Compensation in respect of an injury, but that right has not been established, nib/IMAN may withhold payment of Benefits for expenses incurred in relation to that injury.

LV2.22.3 Entitlement to Benefits

Subject to these Rules, Benefits are not payable for Expenses incurred (including after the Insured Person has received any Compensation) in relation to an injury where the Insured Person has received, or may be entitled to receive, Compensation in respect of that injury.

Benefits are not payable if the OVHC Insured Person is already covered by a third party, including but not limited to:
(a) Workers Compensation;
(b) Public Liability Insurance;
(c) General Insurance;
(d) Other Health Insurance

LV2.22.4 nib/IMAN’s Rights to Withhold Payment of Benefits

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Where nib/IMAN reasonably forms the view that an Insured Person has or may have a right to make a claim for Compensation in respect of an Injury, but that right has not been established, nib/IMAN may withhold payment of Benefits for expenses incurred in relation to that Injury.

**LV2.22.5 Provisional Payment of Benefits**

Where a claim for Compensation in respect of an injury is in the process of being made, or has been made and remains not finalised, nib/IMAN may in its absolute discretion make a provisional payment of Benefits in respect of expenses incurred in relation to the injury.

In exercising its discretion, nib/IMAN will consider factors such as unemployment or financial hardship and other factors that it considers relevant.

**LV2.22.6 Payment of Benefits**

nib/IMAN may, in its absolute discretion, pay Benefits where:

(a) expenses have been incurred as a result of:
   (i) a complication arising from an injury that was the subject of a claim for Compensation; or
   (ii) the provision of service or item for Treatment of an injury that was the subject of a claim for Compensation; and

(b) that claim has been the subject of a determination or settlement; and

(c) there is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

**LV2.22.7 Medicare Entitlement and Payment of Claims**

In this section a reference to Medicare eligibility includes:

(a) reciprocal Medicare rights under a Reciprocal Health Care Agreement; and

(b) interim Medicare rights associated with the type of visa held.

Sometimes psychology can have a Medicare Benefit Schedule (MBS) item number. This is through the Australian Government’s Better Access to Mental Health Care initiative where a general practitioner refers a patient to a psychologist who is registered under this initiative. Working visitors who are on a reciprocal Medicare card have access to this scheme. They can claim this through their Medicare card. Psychology and Counselling are not claimable under medical Out-Patient services on the Products.

**LV2.22.8 Insured Person’s Obligations if Entitled to Medicare**

Subject to the following, an Insured Person who has, or may have, a right to receive Medicare Benefits, must:

(a) inform nib/IMAN as soon as the Insured Person knows such a right exists;

(b) provide nib/IMAN with Medicare details as soon as the Insured Person has them; and

(c) advise nib/IMAN if this eligibility ceases or changes.

**LV2.22.9 Entitlement to Benefits**

Subject to these Rules, Benefits are not payable for that portion of Expenses where the Insured Person has received, or may be entitled to receive, Medicare Benefits in respect of any Treatment obtained or Expenses incurred.

**LV2.22.10 Insured Persons Claims Process**

Where an Insured Person who has Medicare eligibility incurs Expenses that have an associated Medicare Benefit the Insured Person is to:

(a) make a claim with Medicare for any Treatment associated with Medicare entitlements, first;

(b) then submit the Claim to nib/IMAN accompanied by the Medicare receipt in accordance with LV2.23.1 (Requirements for claims).
LV2.22.11 nib/IMAN’s Rights to Withhold Payment of Benefits

Where nib/IMAN reasonably forms the view that an Insured Person has or may have access to Medicare Benefits, but that right has not been established, nib/IMAN may withhold payment of that portion of Benefit for which Medicare pays a Benefit.

LV2.23 Claims

LV2.23.1 Requirements for Claims

Claims for Benefits must:

(a) be made in the manner approved by nib/IMAN; and

(b) be supported by accounts and/or receipts on the Provider’s letterhead or showing the Provider’s official stamp, and showing the following information:
   (i) the Provider’s name, provider number and address;
   (ii) the Patient’s full name and address;
   (iii) the date of service;
   (iv) the item number/numbers where applicable and description of the service;
   (v) the amount(s) charged; and
   (vi) any other information that nib/IMAN may reasonably request.

Claims can be submitted by fax, email or electronically.

LV2.23.2 Time Limits on Claims

(a) Benefits are not payable where a Claim is lodged more than 2 years after the date on which the service is provided.

(b) nib/IMAN may waive this rule in its discretion.

LV2.23.3 GST Declaration

nib/IMAN requires members making a claim to complete and sign:
Declaration 1 – Goods and Services Tax Declaration
Declaration 2 – Third Party Declaration
Declaration 3 – Claims Declaration

LV2.23.4 Claims become property of nib/IMAN

Unless otherwise agreed by nib/IMAN, all documents submitted in connection with a Claim become the property of nib/IMAN.

LV2.23.5 Agents

nib/IMAN may authorise an Insured Person to delegate to another person the right to Claim or assign Benefits to which the Insured Person may be entitled.

LV2.23.6 Method of Payment of Benefits

(a) nib/IMAN may pay Benefits by electronic funds transfer in accordance with arrangements it determines from time to time.

(b) In the event that a Policy Holder is departing Australia permanently, nib/IMAN may agree to reimburse a claim by electronic funds transfer provided:
   (i) The Policy Holder has requested this in writing; and
   (ii) The Policy Holder has provided the required details of the bank account.

(c) By agreement, nib/IMAN may refund Benefits to an Australian nominated bank account if the
following is supplied by the Policy Holder:
(i) Full name and address of the financial institution;
(ii) Full name of account holder;
(iii) BSB Code; and
(iv) Account Number

(d) By agreement, nib/IMAN may refund a claim to an overseas bank account in Australian Dollars if the following is supplied by the Policy Holder:
(i) Full name and address of the overseas financial institution;
(ii) Full name of account holder;
(iii) SWIFT code; and
(iv) Account Number.

(e) Any bank or transfer costs associated with the refund of claims to an overseas institution will be borne by the Policy Holder and deducted from the claims refund.

**LV2.24 Excesses**

(a) An Excess is the amount of a Benefit that a Policy Holder agrees to pay towards Claimable Hospital Expenses in return for a lower Premium rate than would otherwise apply to the Policy Holder.

(b) If an Excess applies to a Policy and unless otherwise specified in the Schedules, the Excess is only payable if an Insured Person covered by the Policy claims a Benefit for the Claimable Hospital Expense.

(c) The amount of the Excess and relevant limits and conditions which apply to each Product are specified in the Schedule relevant to that Product.

**LV2.25 Product Combinations**

nib/IMAN has discretion to place limitations on Product combinations between the Australian Residents Health Insurance Products and the overseas visitors' health cover Products.

Where an nib/IMAN Insured Person holds a Complying Health Insurance Product (CHIP) under the Act and an overseas visitors' health cover Product, benefits are only claimable on one or the other Product.

**LV3 Premium**

Premium for OVHC Products are as set out in Schedule K
LV10 Executive Top Visitor Cover – Single

LV10.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy

LV10.2 General Conditions

The following conditions apply to all Benefits for this Table:

(a) Benefits for Treatments for General Dental, Major Dental, Optical, Dietary, Home Nursing, Home Care, Immunisations, Allergy Vaccines, Occupational Therapy, Podiatry, Speech Therapy, Natural Therapies, Preventative Care, CPAP Machine, Wheelchairs and Crutches, Hearing Aids, Laser Eye Surgery are subject to a combined Annual Benefits Limit of $1000 per Membership Year for a Single Policy.

(b) Benefits for Treatments for Physiotherapy, Chiropractic and Osteopathy are subject to a combined Annual Benefits Limit of $1000 per Membership Year for a Single Policy.

(c) no Benefits for Ancillary Services are payable for group or class based treatment.

(d) unless otherwise stated Benefits are only paid for consultations or treatment.

(e) any unused combined annual benefit ($1,000 for a Single Policy) for General Dental, Major Dental, Optical, Dietetics, Home nursing, Home Care, Immunisations, Allergy Vaccines, Occupational Therapy, Podiatry, Speech Therapy, Natural Therapies, Preventative Care, CPAP Machine, Wheelchairs and crutches, Hearing Aids, Laser Eye Surgery is rolled over to the next Membership Year.

LV10.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If an Insured Person goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. Lower Benefits are payable for the following services:

(i) Gastric banding and obesity surgery;

(ii) Psychiatric treatment;

(iii) Palliative Care;
(iv) Pregnancy and birth related services.

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:
- Bone Marrow and Organ Transplants
- Assisted Reproductive Services
- Infertility Investigations
- Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

**LV10.4 Surgically Implanted Prostheses**

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

**LV10.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer while admitted as a patient in Hospital shall be as follows:

(a) for services included – 100% of the cost for that medical service with no out of pockets.

(b) for services listed as Lower Benefits – 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   - Gastric banding and obesity surgery
   - Psychiatric treatment
   - Palliative Care
   - Pregnancy and birth related services

(c) for services listed as excluded no benefit is payable. Excluded services are:
   - Assisted Reproductive Service
   - Infertility Investigations
   - Bone Marrow and Organ Transplants
   - Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for medical services provided to the customer as an outpatient shall be as follows:

(a) 100% of the cost for that medical service. Benefits and limitations are as follows:
   - an annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2000 per Policy per Membership Year.

(b) Out-Patient Exclusions apply to:
   - expenses for counselling and psychological testing;
   - any Services provided by a registered psychologist or providers who are not a psychiatrist;
   - group therapy or counselling sessions, including where the service is provided by a psychiatrist;
   - Assisted reproductive Services;
   - Infertility Investigations.

(c) for services listed as lower Benefits – 100% of the Medicare Benefits Schedule Fee for that medical service.

(d) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital. Provided all documentation from the treating doctor is received and approved prior to discharge this is paid at 100% of the cost.
LV10.6 Pharmaceutical Benefits

In-Hospital

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:
(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:
(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

Out-of Hospital

Pharmaceutical Benefits are payable at 100% of cost with a Membership Year annual limit of $1,000 on a single plan.

Benefits are payable for drugs when the drug is
(a) prescribed by a Medical Practitioner
(b) listed on the Australian Government's Pharmaceutical Benefits Scheme (PBS)
(c) prescribed according to PBS-approved indications

Benefits are not payable for:
(a) non-PBS pharmaceuticals.
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical.

The waiting period for Out-of-Hospital pharmacy is 2 months.

LV10.7 Nursing Home Type Patients

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

LV10.8 Ambulance

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:
(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.
LV10.9 Non Surgically Implanted Prostheses and Appliances

Benefits for Non Surgically Implanted Prostheses and Appliances, known as Artificial Aids, are payable at 100% of cost subject to the following conditions:

(a) a letter of recommendation from a Medical Practitioner or Specialist is required for all artificial aids claims.

Refer to Schedule M table for list of prostheses and appliances and service limits applied.

There is no waiting period for Non Surgically Implanted Prostheses and Appliances.

LV10.10 Physiotherapy

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for each Physiotherapy visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy

(b) No Benefits are payable for group sessions.

There is a 2 month waiting period for Physiotherapy.

LV10.11 Chiropractic

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for each Chiropractic visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy. This includes Benefits for X-rays.

There is a 2 month waiting period for Chiropractic.

LV10.12 Osteopathy

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for each Osteopathy visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy.

There is a 2 month waiting period for Osteopathy.

LV10.13 Dental

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for Dental are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 Single Policy.

(b) no Benefits are payable for teeth whitening or bleaching.

The waiting periods for Dental are as follows:

(a) 2 months for General Dental

(b) 6 months for Major Dental.
**LV10.14 Optical**

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for Optical are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 Single Policy.

(b) Benefits are payable for lenses and contact lenses.

(c) No Benefits are payable for frames.

(d) No Benefits are payable for tinting, coating or hardening of lenses.

Refer to Schedule M table for the list of items that can be paid.

The waiting period for Optical is 2 months.

**LV10.15 Dietary**

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for Dietary are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Dietary is 2 months.

**LV10.16 Home Nursing and Home Care**

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for Home Nursing and Home Care are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

(b) Services must be provided by a Registered Nurse and include changing bandages and respite assistance.

The waiting period for Home Nursing and Home Care is 2 months.

**LV10.17 Immunisations and Allergy Vaccines**

Subject to the limits contained in Schedule LV10.2 (General Conditions) and below, the Benefits for Immunisations and Allergy Vaccines are:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 for a Single Policy.

(b) If the immunisation is listed on the National Immunisation Program Schedule a benefit is payable for the immunization. These include:

(i) Diphtheria, Haemophilus influenza type B (Hib), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Influenza (Flu), Measles, Meningococcal Disease, Mumps, Pertussis (Whooping Cough), Pneumococcal Disease, Poliomyelitis (Polio), Rotavirus, Rubella (German Measles), Tetanus (Lockjaw), Varicella (Chickenpox).

The waiting period for Immunisations and Allergy Vaccines is 2 months.
**LV10.18 Occupational Therapy**

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for Occupational Therapy are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Occupational Therapy is 2 months.

**LV10.19 Podiatry**

Subject to the limits contained in Schedule LV10.2 (General Conditions), Benefits for Podiatry are as follows:

(a) 100% of cost provided by a registered podiatrist up to a maximum Membership Year limit of $1,000 for a Single Policy.

No benefits are payable:

(a) for casts or mouldings associated with the building of an orthotic appliance;

(b) for aids or assisted devices;

(c) where the treatment is provided as part of an inpatient or outpatient treatment to an Insured Person at a Public Hospital or Private Hospital.

The waiting period for Podiatry is 2 months.

**LV10.20 Speech Therapy**

Subject to the limits contained in Schedule LV10.2 (General Conditions), Benefits for Speech Therapy are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Speech Therapy is 2 months.

**LV10.21 Natural Therapies**

Subject to the limits contained in Schedule LV10.2 (General Conditions) and below, the Benefits for Natural Therapies are 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

Natural Therapy Benefits are subject to the following conditions:

(a) Natural Therapy Benefits are only payable for consultations for Acupuncture, Myotherapy, Chinese Herbalism, Naturopathy, Western Herbalism, Homeopathy, Nutrition, Remedial Massage, Bowen Therapy and Shiatsu;

(b) no Benefits are payable for ointment, medications or herbs required as part of the Treatment; and

(c) treatment for trigger point massage is payable only as part of a Remedial Massage consultation.

The waiting period for Natural Therapies is 2 months.
**LV10.22 Preventative Care Benefit**

Subject to the limits contained in Schedule LV10.2 (General Conditions) and below, the Benefits for Preventative Care are 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

<table>
<thead>
<tr>
<th>Preventative Care Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Screening</td>
<td>Includes mammograms and / or ultrasounds. No Benefits if itemised with 59300 or 59303. State Governments run screening programs for women aged 40-70. nib/IMAN will only pay a benefit for screening programs with or without ultrasound for adult women aged under 40 and over 70. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
</tr>
<tr>
<td>Bone Density Testing</td>
<td>Bone mineral density tests are performed by X-Ray or CT scan. Benefits payable for screening tests only. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
</tr>
<tr>
<td>Bowel Cancer Tests (faecal occult blood tests)</td>
<td>Faecal occult blood tests are a screening test for the early detection of bowel cancer. The charge raised is for the &quot;kit&quot; which includes the pathology charge. Benefit payable when billed by a Chemist, a Rotary Club or Enterix only. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
</tr>
<tr>
<td>Thin Prep Tests</td>
<td>Thin Prep is a modified pap test with an increased rate of detection of abnormal cells. Payable when performed with a pap smear on same DOS. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
</tr>
</tbody>
</table>

The waiting period for Preventative Care Benefit is 2 months.

**LV10.23 CPAP Machines, Wheelchairs and Crutches**

Subject to the limits contained in Schedule LV10.2 (General Conditions), and the conditions set out below the Benefits for CPAP Machines, Wheelchairs and Crutches are 100% of cost up to a maximum Membership Year limit of $1000 Single Policy.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rule</th>
<th>Item limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP Machine (for sleep disorders).</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per Policy every 2 years</td>
</tr>
<tr>
<td>Wheelchair / power wheelchair (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>Wheelchairs - Not mobility scooters. Payable when required as a primary means of mobility. 1 per person every 2 years</td>
</tr>
<tr>
<td>Crutches (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per person every 2 years</td>
</tr>
</tbody>
</table>
Overseas Visitors Health Cover Fund Rules

The waiting period for CPAP Machine, Wheelchairs and Crutches is 2 months.

LV10.24 Hearing Aids

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for Hearing Aids are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy when accompanied by a letter from a specialist.

(b) A service limit of 2 per person per 5 years applies.

The waiting period for Hearing Aids is 6 months.

LV10.25 Laser Eye Surgery

Subject to the limits contained in Schedule LV10.2 (General Conditions), the Benefits for Laser Eye Surgery are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Laser Eye Surgery is 12 months.

LV10.26 Antenatal and Postnatal Services

No Benefits for this service.

LV10.27 Other

LV10.27.1 Funeral Expenses

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

LV10.27.2 Medical Repatriation Expenses

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV11 Executive Top Visitor Cover – Couple/family

LV11.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Couple policy;

2) Family policy

LV11.2 General Conditions

The following conditions apply to all Benefits for this Table:

(a) Benefits for Treatments for General Dental, Major Dental, Optical, Dietetics, Home Nursing, Home Care, Immunisations, Allergy Vaccines, Occupational Therapy, Podiatry, Speech Therapy, Natural Therapies, Preventative Care, CPAP Machine, Wheelchairs and Crutches, Hearing Aids, Laser Eye Surgery are subject to a combined Annual Limit of $2,000 per Membership Year for a couple/family policy.

(b) Benefits for Treatments for Physiotherapy, Chiropractic and Osteopathy are subject to a combined Annual Limit of $2,000 per Membership Year for a couple/family policy.

(c) no Benefits for Ancillary Services are payable for group or class based treatment except for Antenatal and Postnatal classes.

(d) unless otherwise stated Benefits are only paid for consultations or treatment.

(e) any unused combined annual benefit ($2000 for a couple/family policy) for General Dental, Major Dental, Optical, Dietetics, Home nursing, Home Care, Immunisations, Allergy Vaccines, Occupational Therapy, Podiatry, Speech Therapy, Natural Therapies, Preventative Care, CPAP Machine, Wheelchairs and crutches, Hearing Aids, Laser Eye Surgery is rolled over to the next Membership Year.

LV11.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.
If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

i. Gastric banding and obesity surgery
ii. Psychiatric treatment
iii. Palliative Care

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

i. Bone Marrow and Organ Transplants
ii. Assisted Reproductive Services
iii. Infertility Investigations
iv. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

LV11.4 Surgically Implanted Prostheses

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

LV11.5 Medical Services Payments

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer as a patient in Hospital shall be as follows:

(a) for services included – 100% of the cost for that medical service with no out of pockets

(b) for services listed as lower Benefits – 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   i. Gastric banding and obesity surgery
   ii. Psychiatric treatment
   iii. Palliative Care

(c) for services listed as excluded no benefit is payable. Excluded services are:
   i. Assisted Reproductive Services
   ii. Infertility Investigations
   iii. Bone Marrow and Organ Transplants
   iv. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery

Benefits for medical services provided to the customer as an outpatient shall be as follows:

(a) 100% of the cost for that medical service. Benefits and limitations are as follows:
   i. an annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2,000 per Policy per Membership Year.

(b) Out-Patient Exclusions apply to:
   i. expenses for counselling and psychological testing, and
   ii. any Services provided by a registered psychologist or providers who are not a psychiatrist, and
   iii. group therapy or counselling sessions, including where the service is provided by a psychiatrist.
   iv. Assisted Reproductive Services
   v. Infertility Investigations

(c) for services listed as lower Benefits – 100% of the Medicare Benefits Schedule Fee for that medical service.

(d) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital Provided all documentation from the treating doctor is received and approved prior to discharge this is
paid at 100% of the cost.

**LV11.6 Pharmaceutical Benefits**

**In-Hospital**

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:

(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

**Out-of Hospital**

Pharmaceutical Benefits are payable at 100% with a Membership Year annual limit of $2000 for a couple/family policy.

Benefits are payable for drugs when the drug is

(a) prescribed by a Medical Practitioner;
(b) listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS);
(c) prescribed according to PBS-approved indications.

Benefits are not payable for:

(a) non-PBS pharmaceuticals;
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical.

The waiting period for Out-of-Hospital pharmacy is 2 months.

**LV11.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV11.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

**LV11.9 Non Surgically Implanted Prostheses and Appliances**

Benefits for Non Surgically Implanted Prostheses and Appliances, known as Artificial Aids, are payable at 100% of cost subject to the following conditions:
Overseas Visitors Health Cover Fund Rules

(a) a letter of recommendation from a Medical Practitioner or Specialist is required for all artificial aids claims.

Refer to Schedule M table for list of prostheses and appliances and service limits applied.

There is no waiting period for Non Surgically Implanted Prostheses and Appliances.

**LV11.10 Physiotherapy**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for each Physiotherapy and Exercise Physiology visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy.

(b) Benefits are payable for Pilates and exercise physiology when provided by either a registered physiotherapist or exercise physiologist.

(c) no Benefits are payable for group sessions.

There is a 2 month waiting period for Physiotherapy.

**LV11.11 Chiropractic**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for each Chiropractic visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy. This includes Benefits for x-rays.

There is a 2 month waiting period for Chiropractic.

**LV11.12 Osteopathy**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for each Osteopathy visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy.

There is a 2 month waiting period for Osteopathy.

**LV11.13 Dental**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for Dental are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy.

(b) no Benefits are payable for teeth whitening or bleaching.

The waiting periods for Dental are as follows:

(a) 2 months for General Dental

(b) 6 months for Major Dental.

**LV11.14 Optical**
Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for Optical are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 For a couple/family policy.

(b) Benefits are payable for lenses and contact lenses.

(c) no Benefits are payable for frames.

(d) No Benefits are payable for tinting, coating or hardening of lenses

Refer to Schedule M table for the list of items that can be paid.

The waiting period for Optical is 2 months.

**LV11.15 Dietary**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for Dietary are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

The waiting period for Dietary is 2 months.

**LV11.16 Home Nursing and Home Care**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for Home Nursing and Home Care are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

(b) services must be provided by a Registered Nurse and include changing bandages and respite assistance.

The waiting period for Home Nursing and Home Care is 2 months.

**LV11.17 Immunisations and Allergy Vaccines**

Subject to the limits contained in Schedule LV11.2 (General Conditions) and below, the Benefits for Immunisations and Allergy Vaccines are 100% of cost up to a maximum Membership Year limit of $2000 for a couples/family policy.

(a) If the immunisation is listed on the National Immunisation Program Schedule a benefit is payable for the immunisation

(b) These include:

i Diphtheria, Haemophilus influenza type B (Hob), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Influenza (Flu), Measles, Meningococcal Disease, Mumps, Pertussis (Whooping Cough), Pneumococcal Disease, Poliomyelitis (Polio), Rotavirus, Rubella (German Measles), Tetanus (Lockjaw), Varicella (Chickenpox).

The waiting period for Immunisations and Allergy Vaccines is 2 months.

**LV11.18 Occupational Therapy**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for Occupational Therapy are as follows:
Overseas Visitors Health Cover Fund Rules

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

The waiting period for Occupational Therapy is 2 months.

**LV11.19 Podiatry**

Subject to the limits contained in Schedule LV11.2 (General Conditions), Benefits for Podiatry are as follows:

(a) 100% of cost provided by a registered podiatrist up to a maximum Membership Year limit of $2000 for a couple/family policy.

No benefits are payable:

(a) for casts or mouldings associated with the building of an orthotic appliance
(b) for aids or assisted devices
(c) where the treatment is provided as part of an inpatient or outpatient treatment to an Insured Person at a Public Hospital or Private Hospital.

The waiting period for Podiatry is 2 months.

**LV11.20 Speech Therapy**

Subject to the limits contained in Schedule LV11.2 (General Conditions), Benefits for Speech Therapy are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2000 for a couple/family policy.

The waiting period for Speech Therapy is 2 months.

**LV11.21 Natural Therapies**

Subject to the limits contained in Schedule LV11.2 (General Conditions) and below, the Benefits for Natural Therapies are 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

Natural Therapy Benefits are subject to the following conditions:

(a) Natural Therapy Benefits are only payable for consultations for Acupuncture, Myotherapy, Chinese Herbalism, Naturopathy, Western Herbalism, Homeopathy, Nutrition, Remedial Massage, Bowen Therapy and Shiatsu
(b) no Benefits are payable for ointment, medications or herbs required as part of the Treatment; and
(c) treatment for trigger point massage is payable only as part of a Remedial Massage consultation.

The waiting period for Natural Therapies is 2 months.

**LV11.22 Preventative Care Benefit**

Subject to the limits contained in Schedule LV11.2 (General Conditions) and below, the Benefits for Preventative Care are 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.
Breast Screening
- Includes mammograms and/or ultrasounds
- No Benefits if itemised with 59300 or 59303
- State Governments run screening programs for women aged 40-70. nib/IMAN will only pay a benefit for screening programs with or without ultrasound for adult women aged under 40 and over 70.
- Benefit payable where the service is not recognized for Medicare Benefit Purposes.

Bone Density Testing
- Bone mineral density tests are performed by X-Ray or CT scan.
- Benefits payable for screening tests only.
- Benefit payable where the service is not recognized for Medicare Benefit Purposes.

Bowel Cancer Tests (faecal occult blood tests)
- Faecal occult blood tests are a screening test for the early detection of bowel cancer.
- The charge raised is for the "kit" which includes the pathology charge.
- Benefit payable when billed by a Chemist, a Rotary Club or Enterix only.
- Benefit payable where the service is not recognized for Medicare Benefit Purposes.

Thin Prep Tests
- Thin Prep is a modified pap test with an increased rate of detection of abnormal cells.
- Payable when performed with a pap smear on same DOS.
- Benefit payable where the service is not recognized for Medicare Benefit Purposes.

The waiting period for Preventative Care Benefit is 2 months.

**LV11.23 CPAP Machines, Wheelchairs and Crutches**

Subject to the limits contained in Schedule LV11.2, and the conditions set out below the Benefits for CPAP Machines, Wheelchairs and Crutches are 100% of cost up to a maximum Membership Year limit of $2,000 couple/family policy.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rule</th>
<th>Item limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP Machine (for sleep disorders).</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per Policy every 2 years</td>
</tr>
<tr>
<td>Wheelchair / power wheelchair (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>Wheelchairs - Not mobility scooters. Payable when required as a primary means of mobility. 1 per person every 2 years</td>
</tr>
<tr>
<td>Crutches (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per person every 2 years</td>
</tr>
</tbody>
</table>

The waiting period for CPAP Machine, Wheelchairs and Crutches is 2 months.

**LV11.24 Hearing Aids**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for Hearing Aids are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy when accompanied by a letter from a specialist.
Overseas Visitors Health Cover Fund Rules

(b) A service limit of 2 per person per 5 years applies.

The waiting period for Hearing Aids is 6 months.

**LV11.25 Laser Eye Surgery**

Subject to the limits contained in Schedule LV11.2 (General Conditions), the Benefits for Laser Eye Surgery are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2000 for a couple/family policy.

The waiting period for Laser Eye Surgery is 12 months.

**LV11.26 Antenatal and Postnatal Services**

The Benefits for antenatal and postnatal classes/services are payable at 100% of cost.

Services must be provided by a registered provider and include, sleep and settle classes, lactation and antenatal classes. 12 month waiting periods apply.

**LV11.27 Other**

**LV11.27.1 Funeral Expenses**

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

**LV11.27.2 Medical Repatriation Expenses**

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV12 Top Visitor Cover – Single

LV12.1 Eligibility
This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy

LV12.2 General Conditions
The following conditions apply to all Benefits for this Table:

(a) Benefits for Treatments for General Dental, Major Dental, Optical, Dietetics, Home Nursing, Home Care, Immunisations, Allergy Vaccines, Occupational Therapy, Podiatry, Speech Therapy, Natural Therapies, Preventative Care, CPAP Machine, Wheelchairs and Crutches, Hearing Aids, Laser Eye Surgery are subject to a combined Annual Benefits Limit of $1000 per Membership Year for a Single Policy.

(b) Benefits for Treatments for Physiotherapy, Chiropractic and Osteopathy are subject to a combined Annual Benefits Limit of $1000 per Membership Year for a Single Policy.

(c) no Benefits for Ancillary Services are payable for group or class based treatment.

(d) unless otherwise stated Benefits are only paid for consultations or treatment.

LV12.3 Hospital Treatment Benefits
Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

i Gastric banding and obesity surgery

ii Psychiatric treatment

iii Palliative Care

iv Pregnancy and birth related services

For services listed as Excluded no Hospital Treatment Benefit shall be payable.
Overseas Visitors Health Cover Fund Rules

Excluded services are:
i  Bone marrow and organ transplants
ii  Assisted Reproductive Services
iii  Infertility Investigations
iv  Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

**LV12.4 Surgically Implanted Prostheses**

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

**LV12.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer admitted as a patient in Hospital shall be as follows:

(a) for services included - 100% of the cost for that medical service with no out of pockets.

(b) for services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:

i  Gastric banding and obesity surgery
ii  Psychiatric treatment
iii  Palliative care
iv  Pregnancy and birth related services

(c) for services that are excluded no benefit is payable. Excluded services are:

i  Assisted Reproductive Services
ii  Infertility Investigations
iii  Bone Marrow and Organ Transplants
iv  Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for medical services provided to the customer as an outpatient shall be as follows:

(a) 100% of the cost for that medical service. Benefits and limitations are as follows:

i  An annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2000 per Policy per Membership Year.

(b) Out-Patient Exclusions apply to:

i  Expenses for counselling and psychological testing, and
ii  Any Services provided by a registered psychologist or providers who are not a psychiatrist, and
iii  Group therapy or counselling sessions, including where the service is provided by a psychiatrist.
iv  Assisted Reproductive Services
v  Infertility Investigations

(c) for services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service.

(d) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital. Provided all documentation is received and approved prior to discharge this is paid at 100% of the cost.
**LV12.6 Pharmaceutical Benefits**

**In-Hospital**

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:

(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

**Out-of Hospital**

Pharmaceutical Benefits are payable at 100% with a Membership Year annual limit of $1000 on a single plan.

Benefits are payable for drugs when the drug is:

(a) Prescribed by a Medical Practitioner
(b) Listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS)
(c) prescribed according to PBS-approved indications

Benefits are not payable for:

(a) non-PBS pharmaceuticals
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical.

The waiting period for Out-of-Hospital pharmacy is 2 months.

**LV12.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV12.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

**LV12.9 Non Surgically Implanted Prostheses and Appliances**

Benefits for Non Surgically Implanted Prostheses and Appliances, known as Artificial Aids, are payable at 100% of cost subject to the following conditions:

(a) a letter of recommendation from a Medical Practitioner or Specialist is required for all artificial
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aids claims.

Refer to Schedule M table for list of prostheses and appliances and service limits applied.

There is no waiting period for Non Surgically Implanted Prostheses and Appliances.

LV12.10 Physiotherapy

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for each Physiotherapy and Exercise Physiology visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy.

(b) Benefits are payable for Pilates and exercise physiology when provided by either a registered physiotherapist or exercise physiologist.

(c) No Benefits are payable for group sessions.

There is a 2 month waiting period for Physiotherapy.

LV12.11 Chiropractic

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for each Chiropractic visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy. This includes Benefits for x-rays.

There is a 2 month waiting period for Chiropractic.

LV12.12 Osteopathy

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for each Osteopathy visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy.

There is a 2 month waiting period for Osteopathy.

LV12.13 Dental

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for Dental are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 Single Policy.

(b) no Benefits are payable for teeth whitening or bleaching.

The waiting periods for Dental are as follows:

(a) 2 months for General Dental

(b) 6 months for Major Dental.

LV12.14 Optical

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for Optical are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 Single Policy.
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(b) Benefits are payable for lenses and contact lenses.

(c) No Benefits are payable for frames.

(d) No Benefits are payable for tinting, coating or hardening of lenses.

Refer to Schedule M table for the list of items that can be paid.

The waiting period for Optical is 2 months.

**LV12.15 Dietary**

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for Dietary are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Dietary is 2 months.

**LV12.16 Home Nursing and Home Care**

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for Home Nursing and Home Care are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

(b) Services must be provided by a Registered Nurse and include changing bandages and respite assistance.

The waiting period for Home Nursing and Home Care is 2 months.

**LV12.17 Immunisations and Allergy Vaccines**

Subject to the limits contained in Schedule LV12.2 (General Conditions) and below, the Benefits for Immunisations and Allergy Vaccines are 100% of cost up to a maximum membership year limit of $1,000 for a Single Policy:

(a) If the immunisation is listed on the National Immunisation Program Schedule a benefit is payable for the immunisation.

(b) These include:

(i) Diphtheria, Haemophilus influenzae type B (Hib), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Influenza (Flu), Measles, Meningococcal Disease, Mumps, Pertussis (Whooping Cough), Pneumococcal Disease, Poliomyelitis (Polio), Rotavirus, Rubella (German Measles), Tetanus (Lockjaw), Varicella (Chickenpox).

The waiting period for Immunisations and Allergy Vaccines is 2 months.

**LV12.18 Occupational Therapy**

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for Occupational Therapy are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Occupational Therapy is 2 months.

**LV12.19 Podiatry**

Subject to the limits contained in Schedule LV12.2 (General Conditions), Benefits for Podiatry are as
Overseas Visitors Health Cover Fund Rules

follows:

(a) 100% of cost provided by a registered podiatrist up to a maximum Membership Year limit of $1,000 for a Single Policy.

No benefits are payable:

(a) for casts or mouldings associated with the building of an orthotic appliance

(b) for aids or assisted devices

(c) where the treatment is provided as part of an inpatient or outpatient treatment to an Insured Person at a Public Hospital or Private Hospital.

The waiting period for Podiatry is 2 months.

**LV12.20 Speech Therapy**

Subject to the limits contained in Schedule LV12.2 (General Conditions), Benefits for Speech Therapy are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Speech Therapy is 2 months.

**LV12.21 Natural Therapies**

Subject to the limits contained in Schedule LV12.2 (General Conditions) and below, the Benefits for Natural Therapies are 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

Natural Therapy Benefits are subject to the following conditions:

(a) Natural Therapy Benefits are only payable for consultations for Acupuncture, Myotherapy, Chinese Herbalism, Naturopathy, Western Herbalism, Homeopathy, Nutrition, Remedial Massage, Bowen Therapy and Shiatsu

(b) no Benefits are payable for ointment, medications or herbs required as part of the Treatment; and

(c) treatment for trigger point massage is payable only as part of a Remedial Massage consultation.

The waiting period for Natural Therapies is 2 months.
LV12.22 Preventative Care Benefit

Subject to the limits contained in Schedule LV12.2 (General Conditions) and below, the Benefits for Preventative Care are 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

<table>
<thead>
<tr>
<th>Breast Screening</th>
<th>Includes mammograms and / or ultrasounds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Benefits if itemised with 59300 or 59303</td>
</tr>
<tr>
<td></td>
<td>State Governments run screening programs for women aged 40-70. nib/IMAN will only pay a benefit for screening programs with or without ultrasound for adult women aged under 40 and over 70.</td>
</tr>
<tr>
<td></td>
<td>Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone Density Testing</th>
<th>Bone mineral density tests are performed by X-Ray or CT scan.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits payable for screening tests only.</td>
</tr>
<tr>
<td></td>
<td>Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Bowel Cancer Tests (faecal occult blood tests)</th>
<th>Faecal occult blood tests are a screening test for the early detection of bowel cancer.</th>
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<td></td>
<td>The charge raised is for the &quot;kit&quot; which includes the pathology charge.</td>
</tr>
<tr>
<td></td>
<td>Benefit payable when billed by a Chemist, a Rotary Club or Enterix only.</td>
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<th>Thin Prep Tests</th>
<th>Thin Prep is a modified pap test with an increased rate of detection of abnormal cells.</th>
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<tr>
<td></td>
<td>Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
</tr>
</tbody>
</table>

The waiting period for Preventative Care Benefit is 2 months.

LV12.23 CPAP Machines, Wheelchairs and Crutches

Subject to the limits contained in Schedule LV12.2, and the conditions set out below the Benefits for CPAP Machines, Wheelchairs and Crutches are 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rule</th>
<th>Item limit</th>
</tr>
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<tbody>
<tr>
<td>CPAP Machine (for sleep disorders).</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per Policy every 2 years</td>
</tr>
<tr>
<td>Wheelchair / power wheelchair (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>Wheelchairs - Not mobility scooters. Payable when required as a primary means of mobility.</td>
</tr>
<tr>
<td>Crutches (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per person every 2 years</td>
</tr>
</tbody>
</table>
The waiting period for CPAP Machine, Wheelchairs and Crutches is 2 months.

**LV12.24 Hearing Aids**

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for Hearing Aids are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy when a letter of recommendation is provided by specialist.

(b) A service limit of 2 per person per 5 years applies.

The waiting period for Hearing Aids is 6 months.

**LV12.25 Laser Eye Surgery**

Subject to the limits contained in Schedule LV12.2 (General Conditions), the Benefits for Laser Eye Surgery are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $1,000 Single Policy.

The waiting period for Laser Eye Surgery is 12 months.

**LV12.26 Antenatal and Postnatal Services**

No Benefits for this service.

**LV12.27 Other**

**LV12.27.1 Funeral Expenses**

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

**LV12.27.2 Medical Repatriation Expenses**

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV13 Top Visitor Cover – Couple/Family

LV13.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Couple Policy  
2) Family Policy

LV13.2 General Conditions

The following conditions apply to all Benefits for this Table:

(a) Benefits for Treatments for General Dental, Major Dental, Optical, Dietetics, Home nursing, Home Care, Immunisations, Allergy Vaccines, Occupational Therapy, Podiatry, Speech Therapy, Natural Therapies, Preventative Care, CPAP Machine, Wheelchairs and crutches, Hearing Aids, Laser Eye Surgery are subject to a combined Annual Benefits Limit of $2,000 per Membership Year for a couple/family policy.

(b) Benefits for Treatments for Physiotherapy, Chiropractic and Osteopathy are subject to a combined Annual Benefits Limit of $2,000 per Membership Year for a couple/family policy.

(c) No Benefits for Ancillary Services are payable for group or class based treatment except for Antenatal and Postnatal services.

(d) Unless otherwise stated Benefits are only paid for consultations or treatment.

LV13.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care;

(b) the cost of paramedical services such as physiotherapy.

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.
Lower Benefits are payable for the following services:

i. Gastric banding and obesity surgery
ii. Psychiatric treatment
iii. Palliative Care

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

i. Bone Marrow and Organ Transplants
ii. Assisted reproductive Services
iii. Infertility Investigations
iv. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

**LV13.4 Surgically Implanted Prostheses**

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

**LV13.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer as a patient in Hospital shall be as follows:

(a) for services included – 100% of the cost for that medical service with no out of pockets.

(b) for services listed as lower Benefits – 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   i. Gastric banding and obesity surgery
   ii. Psychiatric treatment
   iii. Palliative care

(c) for In-Patient and Out-Patient pregnancy and birth related medical services the benefit paid is 100% of the Medicare Benefits Schedule fee.

(d) for services that are excluded no benefit is payable. Excluded services are:
   i. Assisted Reproductive Services
   ii. Infertility Investigations
   iii. Bone Marrow and Organ Transplants
   iv. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for medical services provided to the customer as an outpatient shall be as follows:

(a) 100% of the cost for that medical service. Benefits and limitations are as follows:
   i. an annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2,000 per Policy per Membership Year.

(b) Out-Patient Exclusions apply to:
   i. expenses for counselling and psychological testing; and
   ii. any Services provided by a registered psychologist or providers who are not a psychiatrist; and
   iii. group therapy or counselling sessions, including where the service is provided by a psychiatrist.
   iv. Assisted Reproductive Services
   v. Infertility Investigations

(c) for services listed as lower Benefits – 100% of the Medicare Benefits Schedule Fee for that service.

(d) Out-Patient continuing treatment following hospitalisation due to early discharge from
Hospital. Provided all documentation from the treating doctor is received and approved prior to discharge this is paid at 100% of cost.

**LV13.6 Pharmaceutical Benefits**

**In-Hospital**

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:

(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

**Out-of-Hospital**

Pharmaceutical Benefits are payable at 100% with a Membership Year annual limit of $2000 for a couple/family policy.

Benefits are payable for drugs when the drug is:

(a) prescribed by a Medical Practitioner
(b) listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS)
(c) prescribed according to PBS-approved indications

Benefits are not payable for:

(a) non-PBS pharmaceuticals.
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical.

The waiting period for Out-of-Hospital pharmacy is 2 months.

**LV13.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV13.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

**LV13.9 Non Surgically Implanted Prostheses and Appliances**

Benefits for Non Surgically Implanted Prostheses and Appliances, known as Artificial Aids, are payable at 100% of cost subject to the following conditions:
a letter of recommendation from a Medical Practitioner or Specialist is required for all artificial aids claims.

Refer to Schedule M table for list of prostheses and appliances and service limits applied.

There is no waiting period for Non Surgically Implanted Prostheses and Appliances.

LV13.10 Physiotherapy

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for each Physiotherapy and Exercise Physiology visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy.

(b) Benefits are payable for Pilates and exercise physiology when provided by either a registered physiotherapist or exercise physiologist

(c) no Benefits are payable for group sessions.

There is a 2 month waiting period for Physiotherapy.

LV13.11 Chiropractic

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for each Chiropractic visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy. This includes Benefits for x-rays.

There is a 2 month waiting period for Chiropractic.

LV13.12 Osteopathy

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for each Osteopathy visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy.

There is a 2 month waiting period for Osteopathy.

LV13.13 Dental

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for Dental are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy.

(b) no Benefits are payable for teeth whitening or bleaching.

The waiting periods for Dental are as follows:

(a) 2 months for General Dental
(b) 6 months for Major Dental.

LV13.14 Optical

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for Optical are
Overseas Visitors Health Cover Fund Rules

as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $2,000 for a couple/family policy.

(b) Benefits are payable for lenses and contact lenses.

(c) no Benefits are payable for frames.

(d) No Benefits are payable for tinting, coating or hardening of lenses

Refer to Schedule M table for the list of items that can be paid.

The waiting period for Optical is 2 months.

**LV13.15 Dietary**

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for Dietary are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

The waiting period for Dietary is 2 months.

**LV13.16 Home Nursing and Home Care**

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for Home Nursing and Home Care are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

(b) services must be provided by a Registered Nurse and include changing bandages and respite assistance.

The waiting period for Home Nursing and Home Care is 2 months.

**LV13.17 Immunisations and Allergy Vaccines**

Subject to the limits contained in Schedule LV13.2 (General Conditions) and below, the Benefits for Immunisations and Allergy Vaccines are 100% of cost up to a maximum Membership Year limit of $1,000 for a Single Policy:

(a) If the immunisation is listed on the National Immunisation Program Schedule a benefit is payable for the immunization

(b) These include:

(i) Diphtheria, Haemophilus influenzae type B (Hib), Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Influenza (Flu), Measles, Meningococcal Disease, Mumps, Pertussis (Whooping Cough), Pneumococcal Disease, Poliomyelitis (Polio), Rotavirus, Rubella (German Measles), Tetanus (Lockjaw), Varicella (Chickenpox).

The waiting period for Immunisations and Allergy Vaccines is 2 months.

**LV13.18 Occupational Therapy**

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for Occupational Therapy are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.
Overseas Visitors Health Cover Fund Rules

The waiting period for Occupational Therapy is 2 months.

**LV13.19 Podiatry**

Subject to the limits contained in Schedule LV13.2 (General Conditions), Benefits for Podiatry are as follows:

(a) 100% of cost provided by a registered podiatrist up to a maximum Membership Year limit of $2,000 for a couple/family policy.

No benefits are payable:

(a) for casts or mouldings associated with the building of an orthotic appliance
(b) for aids or assisted devices
(c) where the treatment is provided as part of an inpatient or outpatient treatment to an Insured Person at a Public Hospital or Private Hospital.

The waiting period for Podiatry is 2 months.

**LV13.20 Speech Therapy**

Subject to the limits contained in Schedule LV13.2 (General Conditions), Benefits for Speech Therapy are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

The waiting period for Speech Therapy is 2 months.

**LV13.21 Natural Therapies**

Subject to the limits contained in Schedule LV13.2 (General Conditions) and below, the Benefits for Natural Therapies are 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

Natural Therapy Benefits are subject to the following conditions:

(a) Natural Therapy Benefits are only payable for consultations for Acupuncture, Myotherapy, Chinese Herbalism, Naturopathy, Western Herbalism, Homeopathy, Nutrition, Remedial Massage, Bowen Therapy and Shiatsu
(b) no Benefits are payable for ointment, medications or herbs required as part of the Treatment; and
(c) treatment for trigger point massage is payable only as part of a Remedial Massage consultation.

The waiting period for Natural Therapies is 2 months.

**LV13.22 Preventative Care Benefit**

Subject to the limits contained in Schedule LV13.2 (General Conditions) and below, the Benefits for Preventative Care are 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.
<table>
<thead>
<tr>
<th>Preventive Care Benefit</th>
<th>Description</th>
<th>Item limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Screening</td>
<td>Includes mammograms and / or ultrasounds. No Benefits if itemised with 59300 or 59303. State Governments run screening programs for women aged 40-70. nib/IMAN will only pay a benefit for screening programs with or without ultrasound for adult women aged under 40 and over 70. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
<td></td>
</tr>
<tr>
<td>Bone Density Testing</td>
<td>Bone mineral density tests are performed by X-Ray or CT scan. Benefits payable for screening tests only. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
<td></td>
</tr>
<tr>
<td>Bowel Cancer Tests (faecal occult blood tests)</td>
<td>Faecal occult blood tests are a screening test for the early detection of bowel cancer. The charge raised is for the &quot;kit&quot; which includes the pathology charge. Benefit payable when billed by a Chemist, a Rotary Club or Enterix only. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
<td></td>
</tr>
<tr>
<td>Thin Prep Tests</td>
<td>Thin Prep is a modified pap test with an increased rate of detection of abnormal cells. Payable when performed with a pap smear on same DOS. Benefit payable where the service is not recognized for Medicare Benefit Purposes.</td>
<td></td>
</tr>
</tbody>
</table>

The waiting period for Preventative Care Benefit is 2 months.

**LV13.23 CPAP Machines, Wheelchairs and Crutches**

Subject to the limits contained in Schedule LV13.2, and the conditions set out below the Benefits for CPAP Machines, Wheelchairs and Crutches are 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

<table>
<thead>
<tr>
<th>Item</th>
<th>Rule</th>
<th>Item limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP Machine (for sleep disorders)</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per Policy every 2 years</td>
</tr>
<tr>
<td>Wheelchair / power wheelchair (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per person every 2 years</td>
</tr>
<tr>
<td>Crutches (including hire)</td>
<td>Letter of recommendation required from a specialist</td>
<td>1 per person every 2 years</td>
</tr>
</tbody>
</table>

The waiting period for CPAP Machine, Wheelchairs and Crutches is 2 months.

**LV13.24 Hearing Aids**
Overseas Visitors Health Cover Fund Rules

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for Hearing Aids are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy when a letter of recommendation is provided by specialist.

(b) A service limit of 2 per person per 5 years applies.

The waiting period for Hearing Aids is 6 months.

LV13.25 Laser Eye Surgery

Subject to the limits contained in Schedule LV13.2 (General Conditions), the Benefits for Laser Eye Surgery are as follows:

(a) 100% of cost up to a maximum Membership Year limit of $2,000 for a couple/family policy.

The waiting period for Laser Eye Surgery is 12 months.

LV13.26 Antenatal and Postnatal Services

The Benefits for antenatal and postnatal classes/services are payable at 100% of cost.

Services must be provided by a registered provider and include, sleep and settle classes, lactation and antenatal classes. 12 month waiting periods apply.

LV13.27 Other

LV13.27.1 Funeral Expenses

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

LV13.27.2 Medical Repatriation Expenses

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV14 Mid Visitor Cover

LV14.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy; and
2) Couples Policy; and
3) Family Policy

LV14.2 General Conditions

The following conditions apply to all Benefits for this Table:

(a) Benefits for Treatments for Physiotherapy, Chiropractic and Osteopathy are subject to a combined Annual Benefits Limit of $1000 for a Single Policy per Membership Year and $2,000 per Membership Year for a couple/family policy.

(b) No Benefits for Ancillary Services are payable for group or class based treatment.

(c) Unless otherwise stated Benefits are only paid for consultations or treatment.

LV14.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care;

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

i Gastric banding and obesity surgery
ii Psychiatric treatment
iii Palliative Care
iv Pregnancy and birth related services

For services listed as Excluded no Hospital Treatment Benefit shall be payable.
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Excluded services are:

i. Bone Marrow and Organ Transplants
ii. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery
iii. Assisted Reproductive Services
iv. Infertility Investigations.

**LV14.4 Surgically Implanted Prostheses**

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

**LV14.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer while admitted as a patient in Hospital shall be as follows:

(a) for services included - 100% of the cost for that medical service with no out of pockets.

(b) for services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   i. Gastric banding and obesity surgery
   ii. Psychiatric treatment
   iii. Palliative Care
   iv. Pregnancy and birth related services

(c) for services that are excluded no benefit is payable. Excluded services are:
   i. Bone Marrow and Organ Transplants
   ii. Assisted Reproductive Services
   iii. Infertility Investigations
   iv. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for medical services provided to the customer while as an outpatient shall be as follows:

(a) 100% of the cost for that medical service. Benefits and limitations are as follows:
   i. An annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2,000 per Policy per Membership Year.

(b) Out-Patient Exclusions apply to:
   i. Expenses for counselling and psychological testing, and
   ii. Any Services provided by a registered psychologist or providers who are not a psychiatrist, and
   iii. Group therapy or counselling sessions, including where the service is provided by a psychiatrist.

(c) for services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service.

(d) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital. Provided all documentation from the treating doctor is received and approved prior to discharge this is paid at 100% of the cost.

**LV14.6 Pharmaceutical Benefits**

In-Hospital

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and
Overseas Visitors Health Cover Fund Rules

(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:
(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

Out-of-Hospital

Pharmaceutical Benefits are payable at 100% with a Membership Year annual limit of $1,000 on a single plan and $2,000 on a couple or family plan.

Benefits are payable for drugs when the drug is
(a) prescribed by a Medical Practitioner
(b) listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS)
(c) prescribed according to PBS-approved indications

Benefits are not payable for:
(a) non-PBS pharmaceuticals.
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical.

The waiting period for Out-of-Hospital pharmacy is 2 months.

LV14.7 Nursing Home Type Patients

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

LV14.8 Ambulance

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

LV14.9 Non Surgically Implanted Prostheses and Appliances

Benefits for Non Surgically Implanted Prostheses and Appliances, known as Artificial Aids, are payable at 100% of cost subject to the following conditions:

(a) a letter of recommendation from a Medical Practitioner or Specialist is required for all artificial aids claims.

Refer to Schedule M table for list of prostheses and appliances and service limits applied.

There is no waiting period for Non Surgically Implanted Prostheses and Appliances.
LV14.10 Physiotherapy

Subject to the limits contained in Schedule LV14.2 (General Conditions), the Benefits for each Physiotherapy visit are as follows:

(a) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy and $2,000 for a couple / family policy (combined limit with Chiropractic and Osteopathy)

(b) no Benefits are payable for group sessions.

There is a 2 month waiting period for Physiotherapy.

LV14.11 Chiropractic

Subject to the limits contained in Schedule LV14.2 (General Conditions), the Benefits for each Chiropractic visit are as follows:

(a) 100% of costs of each visit up to a maximum Membership Year limit of $1000 for a Single Policy and $2,000 for a couple / family policy (combined limit with Physiotherapy and Osteopathy). This includes Benefits for x-rays.

There is a 2 month waiting period for Chiropractic.

LV14.12 Osteopathy

Subject to the limits contained in Schedule LV14.2 (General Conditions), the Benefits for each Osteopathy visit are as follows:

(a) 100% of costs of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy and $2,000 for a couple / family policy (combined limit with Chiropractic and Physiotherapy).

There is a 2 month waiting period for Osteopathy.

LV14.13 Dental

No Benefits for Dental are payable.

LV14.14 Optical

No Benefits for Optical are payable.

LV14.15 Dietetics

No Benefits for Dietetics are payable.

LV14.16 Home nursing and home care

No Benefits for Home nursing and home care are payable.

LV14.17 Immunisations and Allergy Vaccines

No Benefits for Immunisations and Allergy Vaccines are payable.

LV14.18 Occupational Therapy

No Benefits for Occupational Therapy are payable.

LV14.19 Podiatry
No Benefits for Podiatry are payable.

**LV14.20 Speech Therapy**

No Benefits for Speech Therapy are payable.

**LV14.21 Natural Therapies**

No Benefits for Natural Therapies are payable.

**LV14.22 Preventative Care Benefit**

No Benefits for Preventative Care are payable.

**LV14.23 CPAP Machines, Wheelchairs and Crutches**

No Benefits for CPAP Machines, Wheelchairs and Crutches are payable.

**LV14.24 Hearing Aids**

No Benefits for Hearing Aids are payable.

**LV14.25 Laser Eye Surgery**

No Benefits for Laser Eye Surgery are payable.

**LV14.26 Antenatal and Postnatal Services**

No Benefits are payable.

**LV14.27 Other**

**LV14.27.1 Funeral Expenses**

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

**LV14.27.2 Medical Repatriation Expenses**

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV15 Basic Visitor Cover

LV15.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy; and
2) Couples Policy; and
3) Family Policy.

LV15.2 General Conditions

No General conditions apply

LV15.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

i Gastric banding and obesity surgery
ii Psychiatric treatment
iii Palliative Care
iv Pregnancy and birth related services

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

i Bone Marrow and Organ Transplants
ii Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery
iii Assisted Reproductive Services
iv Infertility Investigations
LV15.4 Surgically Implanted Prostheses

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

LV15.5 Medical Services Payments

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer while admitted as a patient in Hospital shall be as follows:

(a) for services included - 100% of the cost for that medical service with not out of pockets

(b) for services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   i   Gastric banding and obesity surgery
   ii  Psychiatric treatment
   iii  Palliative Care
   iv  Pregnancy and birth related services

(c) for services that are excluded no benefit is payable. Excluded services are:
   i   Bone Marrow and Organ Transplants
   ii  Assisted Reproductive Services
   iii  Infertility Investigations
   iv  Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for medical services provided to the customer while as an outpatient shall be as follows:

(a) 100% of the Medicare Benefit Schedule Fee for that medical service.

Out-Patient Exclusions apply to:
   i   Psychiatric
   ii  Expenses for counselling and psychological testing, and
   iii  Any Services provided by a registered psychologist or providers who are not a psychiatrist, and
   iv  Group therapy or counselling sessions, including where the service is provided by a psychiatrist.
   v  Bone Marrow and Organ Transplants
   vi  Assisted Reproductive Services
   vii  Infertility Investigations
   viii Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

(a) Benefits for Emergency Facilities shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities.

(b) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital. Provided all documentation from the treating doctor is received and approved prior to discharge. This is payable at 100% of cost.

LV15.6 Pharmaceutical Benefits

In-Hospital

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:
(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.
No Benefits are payable for:
(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

**Out-of Hospital**

Pharmaceutical Benefits are payable at 100% of cost with a Membership Year annual limit of $500 per person.

Benefits are payable for drugs when the drug is
(a) prescribed by a Medical Practitioner
(b) listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS)
(c) prescribed according to PBS-approved indications

Benefits are not payable for:
(a) non-PBS pharmaceuticals
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical

The waiting period for Out-of-Hospital pharmacy is 2 months.

**LV15.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV15.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:
(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

**LV15.9 Non Surgically Implanted Prostheses and Appliances**

No Benefits are payable for Non Surgically Implanted Prostheses and Appliances.

**LV15.10 Physiotherapy**

No Benefits for Physiotherapy are payable.

**LV15.11 Chiropractic**

No Benefits for Chiropractic are payable.

**LV15.12 Osteopathy**

No Benefits for Osteopathy are payable.
LV15.13 Dental  
No Benefits for Dental are payable.

LV15.14 Optical  
No Benefits for Optical are payable.

LV15.15 Dietetics  
No Benefits for Dietetics are payable.

LV15.16 Home Nursing and Home Care  
No Benefits for Home nursing and home care are payable.

LV15.17 Immunisations and Allergy Vaccines  
No Benefits for Immunisations and Allergy Vaccines are payable.

LV15.18 Occupational Therapy  
No Benefits for Occupational Therapy are payable.

LV15.19 Podiatry  
No Benefits for Podiatry are payable.

LV15.20 Speech Therapy  
No Benefits for Speech Therapy are payable.

LV15.21 Natural Therapies  
No Benefits for Natural Therapies are payable.

LV15.22 Preventative Care Benefit  
No Benefits for Preventative Care are payable.

LV15.23 CPAP Machines, Wheelchairs and Crutches  
No Benefits for CPAP Machines, Wheelchairs and Crutches are payable.

LV15.24 Hearing Aids  
No Benefits for Hearing Aids are payable.

LV15.25 Laser Eye Surgery  
No Benefits for Laser Eye Surgery are payable.

LV15.26 Antenatal and Postnatal Services  
No Benefits for this service are payable.

LV15.27 Other  

LV15.27.1 Funeral Expenses
Overseas Visitors Health Cover Fund Rules

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

LV15.27.2 Medical Repatriation Expenses

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV16 Budget Visitor Cover

LV16.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy; and
2) Couples Policy; and
3) Family Policy

LV16.2 General Conditions

No General conditions apply.

LV16.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

i  Gastric banding and obesity surgery
ii  Psychiatric treatment
iii  Palliative Care
iv  Pregnancy and birth related services

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

i  Bone Marrow and Organ Transplants
ii  Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery
iii  Assisted Reproductive Services
iv  Infertility Investigations
**LV16.4 Surgically Implanted Prostheses**

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

**LV16.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer while in Hospital shall be as follows:

(a) For services included - 100% of the cost for that medical service with no out of pockets.

(b) For services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   i. Gastric banding and obesity surgery
   ii. Psychiatric treatment
   iii. Palliative Care
   iv. Pregnancy and birth related services

(c) For services that are excluded no Benefit is payable. Excluded services are:
   i. Bone Marrow and Organ Transplants
   ii. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.
   iii. Assisted Reproductive Services
iv. Infertility Investigations

Benefits for medical services provided to the customer while not in a Hospital shall be as follows:

(a) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital. Provided all documentation from the treating doctor is received and approved prior to discharge this is paid at 100% of the cost.

(b) Emergency Facility- Only covered if the treatment leads to an admission as an In-Patient or is certified by the treating doctor as Emergency Treatment. Paid at 100% of cost.

No other Benefits payable for medical services provided to the customer while not in a Hospital.

**LV16.6 Pharmaceutical Benefits**

**In-Hospital**

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and

(b) administered to the patient during their stay in Hospital; or

(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:

(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of Hospital pharmaceutical.

**Out-of Hospital**

No Benefits for out-of Hospital Pharmaceutical Benefits are payable.

**LV16.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a
daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV16.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and

(b) defined by the relevant service provider as emergency ambulance transport; or

(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or

(d) defined by a treating doctor as Medically Necessary transport.

**LV16.9 Non Surgically Implanted Prostheses and Appliances**

No Benefits are payable for Non Surgically Implanted Prostheses and Appliances.

**LV16.10 Physiotherapy**

No Benefits for Physiotherapy are payable.

**LV16.11 Chiropractic**

No Benefits for Chiropractic are payable.

**LV16.12 Osteopathy**

No Benefits for Osteopathy are payable.

**LV16.13 Dental**

No Benefits for Dental are payable.

**LV16.14 Optical**

No Benefits for Optical are payable.

**LV16.15 Dietetics**

No Benefits for Dietetics are payable.

**LV16.16 Home Nursing and Home Care**

No Benefits for Home nursing and home care are payable.

**LV16.17 Immunisations and Allergy Vaccines**

No Benefits for Immunisations and Allergy Vaccines are payable.

**LV16.18 Occupational Therapy**

No Benefits for Occupational Therapy are payable.

**LV16.19 Podiatry**

No Benefits for Podiatry are payable.
LV16.20 **Speech Therapy**

No Benefits for Speech Therapy are payable.

LV16.21 **Natural Therapies**

No Benefits for Natural Therapies are payable.

LV16.22 **Preventative Care Benefit**

No Benefits for Preventative Care are payable.

LV16.23 **CPAP Machines, Wheelchairs and Crutches**

No Benefits for CPAP Machines, Wheelchairs and Crutches are payable.

LV16.24 **Hearing Aids**

No Benefits for Hearing Aids are payable.

LV16.25 **Laser Eye Surgery**

No Benefits for Laser Eye Surgery are payable.

LV16.26 **Antenatal and Postnatal Services**

No Benefits for this service are payable.

LV16.27 **Other**

LV16.27.1 **Funeral Expenses**

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

LV16.27.2 **Medical Repatriation Expenses**

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV17 Value Plus

LV17.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy; and
2) Couples Policy; and
3) Family Policy

LV17.2 General Conditions

The following conditions apply to all Benefits for this Table:

(a) Benefits for outpatient Pharmaceutical Benefits are payable up to the annual limit of $500 per person per Membership Year.

LV17.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital 100% of:

(a) the contract rate for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the contract rate of paramedical services for physiotherapy, exceptional drugs and prescriptions per the individual nib Agreement Private Hospital contract

In a Public Hospital, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

In a Private Hospital that has not entered into a provider agreement with nib/IMAN:

(a) not less than the basic default Benefits for Hospital accommodation, theatre fees, labour ward, intensive care and coronary care

No Benefits are payable for disposables.

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

(a) Bone Marrow and Organ Transplants

(b) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery
Overseas Visitors Health Cover Fund Rules

(c) Assisted Reproductive Services
(d) Infertility Investigations

**LV17.4 Surgically Implanted Prostheses**

100% of the Benefit covered for approved surgically implanted prosthetic devices as determined by the Federal Government.

**LV17.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer while in Hospital shall be as follows:

(a) for services included - 100% of the Medicare Benefit Schedule (MBS) fee for that medical service.

Benefits for medical services provided to the customer while not in a Hospital shall be as follows:

(a) for services included 100% of the Medicare Benefit Schedule (MBS) for that medical service.
(b) Benefits for Emergency Facilities shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities.

Benefits and limitations are as follows:

(a) Out-Patient Exclusions apply to:
   i Expenses for counselling and psychological testing, and
   ii Any Services provided by a registered psychologist or providers who are not a psychiatrist, and
   iii Group therapy or counselling sessions, including where the service is provided by a psychiatrist.
(b) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital. Provided all documentation from the treating doctor is received and approved prior to discharge this is payable at 100% of the MBS.

**LV17.6 Pharmaceutical Benefits**

**In-Hospital**

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:

(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of Hospital pharmaceutical.

**Out-of Hospital**

Pharmaceutical Benefits are payable at 100% of cost with a Membership Year annual limit of $500 per person.

Benefits are payable for drugs when the drug is
(a) prescribed by a Medical Practitioner;
(b) listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS).
Overseas Visitors Health Cover Fund Rules

(c) prescribed according to PBS-approved indications

Benefits are not payable for:
(a) non-PBS pharmaceuticals;
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical.

The waiting period for Out-of-Hospital pharmacy is 2 months.

**LV17.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV17.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:
(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

**LV17.9 Non surgically implanted prostheses and appliances**

No Benefits are payable for non-surgically implanted prostheses and appliances.

**LV17.10 Physiotherapy**

No Benefits for physiotherapy are payable.

**LV17.11 Chiropractic**

No Benefits for chiropractic are payable.

**LV17.12 Osteopathy**

No Benefits for Osteopathy are payable.

**LV17.13 Dental**

No Benefits for Dental are payable.

**LV17.14 Optical**

No Benefits for Optical are payable.

**LV17.15 Dietetics**

No Benefits for Dietetics are payable.
**LV17.16 Home Nursing and Home Care**
No Benefits for Home Nursing are payable.

**LV17.17 Immunisations and Allergy Vaccines**
No Benefits for Immunisations and Allergy Vaccines are payable.

**LV17.18 Occupational Therapy**
No Benefits for Occupational Therapy are payable.

**LV17.19 Podiatry**
No Benefits for Podiatry are payable.

**LV17.20 Speech Therapy**
No Benefits for Speech Therapy are payable.

**LV17.21 Natural Therapies**
No Benefits for Natural Therapies are payable.

**LV17.22 Preventative Care Benefit**
No Benefits for Preventative Care Benefits are payable.

**LV17.23 CPAP Machines, Wheelchairs and Crutches**
No Benefit for CPAP Machines, Wheelchairs and Crutches are payable.

**LV17.24 Hearing Aids**
No Benefit for hearings aids are payable.

**LV17.25 Laser Eye Surgery**
No Benefit for Laser Eye Surgery is payable.

**LV17.26 Antenatal and Postnatal Services**
No Benefit for Antenatal and postnatal services is payable.

**LV17.27 Other**

**LV17.27.1 Funeral Expenses**
The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

**LV17.27.2 Medical Repatriation Expenses**
The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.
LV20 nib United Gold Visitor Cover

LV20.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (Generally):

1) Single Policy; and
2) Couples Policy; and
3) Family Policy

This Product is only available to customers that are Overseas Visitors and are eligible, in accordance with their employer’s criteria, to take out a corporate plan with United Gold Visitor Cover that includes the provision of health insurance in Australia.

This Product allows dependents up to the age of 26 to remain on a family policy at no extra cost.

LV20.2 General Conditions

The following conditions apply to all Benefits for this Table:

(a) all Benefits for General Treatment are limited to one visit per day per Insured Person to the Provider of the treatment;
(b) where a Provider provides different treatments during the one visit, the Benefit for the General Treatment is paid for the treatment that attracts the highest benefit;
(c) no Benefits for General Treatment are payable for group or class based services except for Healthier Lifestyle treatments, antenatal classes; group physiotherapy and group exercise physiology;
(d) unless otherwise stated Annual Limits are calculated on a Calendar Year basis for each Insured Person in the Policy under this Table;
(e) Benefits for Treatments for General Dental, Major Dental and Orthodontia are subject to a combined Annual Limits of $2,500 per Insured Person per Calendar Year;
(f) Benefits for Physiotherapy and Exercise Physiology are subject to a combined annual benefit of 40 visits per Calendar Year per Insured Person;
(g) Benefits for Treatments for Chiropractic and Osteopathy are subject to a combined annual benefit of 40 visits per Calendar Year per Insured Person;
(h) No Benefits or part thereof is payable for a service where a Medicare benefit is payable;
(i) No waiting periods apply for any services.

LV20.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib 100% of:
Overseas Visitors Health Cover Fund Rules

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

(c) The cost of dressings, sutures, needles and other disposable items

(d) Pharmaceuticals to the extent set out in LV20.6 (Pharmaceutical Benefits).

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

(a) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

**LV20.3.1 Psychiatric Treatment**

Hospital Treatment Benefits for Psychiatric Treatment shall be payable as follows:

(a) Public Hospital – 100% of the rate charged

(b) Private Hospital – 100% of the rate charged

**LV20.3.2 Palliative Care**

Hospital Treatment Benefits for Palliative Care shall be payable as follows:

(a) Public Hospital – 100% of the rate charged

(b) Private Hospital – 100% of the rate charged

**LV20.3.3 Pregnancy & Birth Related Services**

Hospital Treatment Benefits for Pregnancy and birth related services shall be payable as follows:

(a) Public Hospital – 100% of the rate charged

(b) Private Hospital – 100% of the rate charged

**LV20.3.4 Assisted Reproductive Services**

Hospital Treatment Benefits for Assisted Reproductive Services shall be payable as follows:

(a) Public Hospital – 100% of the rate charged

(b) Private Hospital – 100% of the rate charged

**LV20.3.5 Gastric Banding & Obesity Surgery**

Hospital Treatment Benefits for Gastric Banding & Obesity Surgery shall be payable as follows:

(a) Public Hospital – 100% of the rate charged

(b) Private Hospital – 100% of the rate charged
LV20.3.6 Podiatric Surgery

Hospital Treatment Benefits for Podiatric Surgery shall be payable as follows:

(a) Public Hospital – 100% of the rate charged
(b) Private Hospital – 100% of the rate charged

LV20.4 Surgically Implanted Prostheses

100% of the cost covered for approved surgically implanted prosthetic devices as determined by the Federal Government.

LV20.5 Medical Services Payments

Other than as expressly provided in these Rules, benefits for Medical Services provided to a customer while admitted as a patient in Hospital or as an outpatient shall be as follows:

(a) For services included - 100% of the cost for that medical service with no out of pockets.
(b) For services listed as excluded no benefit is payable. Excluded services are:
   (i) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

LV20.5.1 Podiatric Surgery

For Podiatric Surgery no Medical Services are payable for:
   (a) Podiatric Surgeon fees for services performed in Hospital.
   (b) Benefits for theatre fees and services performed by the Podiatric Surgeon.
   (c) Any medical practitioner, specialist, radiologist, radiographer, sonographer, or pathologist that may be provided during or associated with Podiatric Surgery (provided by a registered Podiatric Surgeon).

LV20.6 Pharmaceutical Benefits

In-Hospital

Pharmaceutical benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:
(a) It is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) Provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:
(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

Out-of Hospital

Pharmaceutical benefits are payable at 100% of cost of the prescription over and above the maximum PBS charge with no annual limit.

Benefits are payable for drugs when the drug is:
(a) prescribed by a Medical Practitioner
(b) listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS)
(c) listed on the National Immunisation register
(d) listed on MIMS
Overseas Visitors Health Cover Fund Rules

(e) prescribed according to PBS-approved indications

**LV20.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV20.8 Ambulance**

Ambulance Benefits are payable in accordance with LV2.15.3 (Ambulance Services).

**LV20.9 Non Surgically Implanted Prostheses and Appliances**

Benefits for Non Surgically Implanted Prostheses and Appliances, known as Artificial Aids, are payable at:

(a) 100% of cost up to an annual limit of $5000 per Insured Person per Calendar Year.

Refer to Schedule M table for list of prostheses and appliances and service limits applied.

**LV20.10 Physiotherapy**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for each Physiotherapy and Exercise Physiotherapy visit are as follows:

(a) 100% of cost of each visit up to a maximum of 40 visits per Calendar Year per person.

(b) Benefits are payable for pilates and exercise physiology when provided by a registered physiotherapist.

(c) Group Physiotherapy and Exercise Physiology are covered.

**LV20.11 Chiropractic**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for each Chiropractic visit are as follows:

(a) 100% of cost of each visit up to a maximum of 40 visits per Calendar Year per person. This includes benefits for x-rays.

**LV20.12 Osteopathy**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for each Osteopathy visit are as follows:

(a) 100% of cost of each visit up to a maximum of 40 visits per Calendar Year per person.

**LV20.13 Dental**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for Dental are as follows:

(a) General Dental 100% of cost

(b) Major Dental 80% of cost

(c) Orthodontia of 60% cost
General Dental, Major Dental and Orthodontia has a combined annual limit of $2,500 per Insured Person per Calendar Year.

No benefits are payable for teeth whitening or bleaching.

**LV20.14 Optical**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for Optical are as follows:

(a) 100% of cost up to a maximum limit of $350 per Insured Person per Calendar Year.

Optical Benefits are not payable:

(a) For sunglasses or for tinting, coating or hardening of lenses

**LV20.15 Dietary**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for Dietary are as follows:

(a) 100% of cost. No annual limit.

**LV20.16 Home Nursing and Home Care**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for Home Nursing and Home Care are as follows:

(a) 100% of cost. No annual limit.

(b) Services must be provided by a Registered Nurse and include changing bandages and respite assistance.

Home Nursing Benefits are not payable for Mothercraft nursing, Tresillian nursing or Karitane nursing at home.

Home nursing to be provided by a registered general trained nurse in private practice, for the treatment of an Insured Person’s illness, disease, incapacity or disability when the Insured Person is totally dependent on nursing care.

**LV20.17 Immunisations and Allergy Vaccines**

Benefits for Immunisations and Allergy Vaccines are paid under LV19.6 Pharmaceutical Benefits.

**LV20.18 Occupational Therapy**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for Occupational Therapy are as follows:

(a) 100% of cost up to a maximum of 20 visits per Calendar Year per Insured Person.

**LV20.19 Podiatry**

Subject to the limits contained in Schedule LV20.2, benefits for Podiatry are as follows:

(a) 100% of cost. No annual limit.

No benefits are payable:

(a) for casts or mouldings associated with the building of an orthotic appliance

(b) for aids or assisted devices

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where the treatment is provided as part of an inpatient or outpatient treatment to an Insured Person at a Public or Private Hospital.

**LV20.20 Speech Therapy**

Subject to the limits contained in Schedule LV20.2, benefits for Speech Therapy are as follows:

(a) 100% of cost up to a maximum of 20 visits per Calendar Year per person.

**LV20.21 Natural Therapies**

Subject to the limits contained in Schedule LV20.2 and below, the Benefits for Natural Therapies are:

(a) 100% of cost. No annual limit.

Natural Therapy Benefits are subject to the following conditions:

(a) Natural Therapy benefits are only payable for consultations for Acupuncture, Myotherapy, Chinese Herbalism and Remedial Massage.

(b) No benefits are payable for ointment or medications required as part of the Treatment; and

(c) Treatment for trigger point massage is payable only as part of a Remedial Massage consultation

**LV20.22 Preventative Health Tests**

Subject to the limits contained in Schedule LV20.2 and below, the Benefits for Preventative Health tests are 100% of cost. No annual limit.
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Screening</td>
<td>Includes mammograms and / or ultrasounds</td>
<td>No benefits if itemised with 59300 or 59303</td>
</tr>
<tr>
<td></td>
<td>State Governments run screening programs for women aged 40-70.</td>
<td>nib will only pay a benefit for screening programs with or without</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ultrasound for adult women aged under 40 and over 70.</td>
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<tr>
<td></td>
<td></td>
<td>Benefit payable where the service is not recognized for Medicare</td>
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<tr>
<td></td>
<td></td>
<td>Benefit Purposes.</td>
</tr>
<tr>
<td>Bone Density Testing</td>
<td>Bone mineral density tests are performed by X-Ray or CT scan.</td>
<td>Benefits payable for screening tests only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefit payable where the service is not recognized for Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefit Purposes.</td>
</tr>
<tr>
<td>Bowel Cancer Tests</td>
<td>Faecal occult blood tests are a screening test for the early detection</td>
<td>The charge raised is for the &quot;kit&quot; which includes the pathology</td>
</tr>
<tr>
<td>(faecal occult blood tests)</td>
<td>of bowel cancer.</td>
<td>charge.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefit payable when billed by a Chemist, a Rotary Club or Enterix</td>
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<tr>
<td></td>
<td></td>
<td>only.</td>
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<tr>
<td></td>
<td></td>
<td>Benefit payable where the service is not recognized for Medicare</td>
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<tr>
<td></td>
<td></td>
<td>Benefit Purposes.</td>
</tr>
<tr>
<td>Thin Prep Tests</td>
<td>Thin Prep is a modified pap test with an increased rate of detection</td>
<td>Payable when performed with a pap smear on same DOS.</td>
</tr>
<tr>
<td></td>
<td>of abnormal cells.</td>
<td>Benefit payable where the service is not recognized for Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefit Purposes.</td>
</tr>
<tr>
<td>Doctor Health Checks</td>
<td>Where there is no MBS Item, or claimable through employee or another party</td>
<td></td>
</tr>
</tbody>
</table>

**LV20.23 CPAP Machines, Wheelchairs and Crutches**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for CPAP Machine and Wheelchairs are as follows:

(a) 100% of cost up to a maximum of $5,000 per Insured Person per Calendar Year.

This benefit is included in the Non Surgically Implanted Prostheses and Appliances. Refer to Schedule M for service limits.

No benefits are payable for Crutches.

**LV20.24 Hearing Aids**

Subject to the limits contained in Schedule LV20.2 (General), the Benefits for Hearing Aids are as follows:

(a) 100% of cost up to a maximum of $5,000 per person per Calendar Year.

(b) limited to 2 appliances every 5 years

(c) includes the cost of one repair for each Insured Person in each Calendar Year.
LV20.25 Laser Eye Surgery
No benefit is payable for Laser Eye Surgery.

LV20.26 Antenatal and Postnatal Services
Subject to the limits contained in Schedule LV20.2 (General) the Benefits for antenatal and postnatal classes/services are payable at:

(a) 100% of cost. No annual limit.

(b) Services must be provided by a registered provider and include, sleep and settle classes, lactation and antenatal.

LV20.27 Other
No benefits are payable for Other.

LV20.27.1 Funeral Expenses
No benefits are payable for Funeral Expenses.

LV20.27.2 Medical Repatriation Expenses
No benefits are payable for Medical Repatriation Expenses.

LV20.28 Orthoptics (Eye Therapy)
Subject to the limits contained in Schedule LV20.2 (General) the Benefits for Orthoptics are payable at 100% of cost up to 20 visits per Calendar Year per person.

LV20.29 Psychology
Subject to the limits contained in Schedule LV20.2 (General) the Benefits for Psychology are payable at 100% of cost. No annual limit.

LV20.30 Healthier Lifestyle
Subject to the Annual Limits and other conditions set out below, the benefits for prevention health management, known as nib healthier lifestyle benefits are payable for the following:

(a) nib recognised weight management programs. No benefit is payable for food, books, videos;

(b) nib recognised quit smoking programs and nicotine replacement therapy including nicotine patches, inhalers, lozenges and gum; and

(c) Fitness Centre fees or Personal Training services where:
   i The policy of a fitness centre, visits to a fitness centre or sessions with a personal trainer is required to enable the Insured Person to undertake a health management program for the treatment of a health related condition; and
   ii The health management program has been recommended to an Insured Person by a medical practitioner or provider who has the Insured Person under their care for the treatment of the health related condition; and
   iii All supporting documentation required by nib in relation to the health management program has been completed in the manner required by nib; and

The benefits have a combined annual limit of $250 per Insured Person per Calendar Year.
LV22 Visitor Cover

LV22.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in this Table:

1) Single Policy; and
2) Couples Policy; and
3) Family Policy.

LV22.2 General Conditions

Visas and Premiums

1 This Table does not satisfy Visa Condition 8501 requirement as set out by the DHA.

2 LV2.2.1 does not apply to this Table and is replaced with the following rule.

Any Overseas Visitor in Australia, their Partner and/or Dependents (as listed on the visa), who:

(a) is in reasonable health at time of application, and does not have any Pre-Existing Condition of such severity that their health is considered by a Medical Practitioner to be in danger; and

(b) (i) is yet to enter Australia and holds a temporary resident visa sub-class 600, 601, 651, 417 and 462 to visit Australia; or

(ii) has entered Australia but has not been in Australia for more than 7 days and holds a visa 600, 601 and 651;

is eligible to be an Insured Person unless nib has determined under LV2.3.3 to refuse an application.

An Overseas Visitor on a visa must take out an OVHC policy in the following manner:

(a) if an OVHC visa has been granted for the Overseas Visitor only then the Overseas Visitor must take out a single OVHC policy;

(b) if an OVHC visa has been granted for the Overseas Visitor and a Partner then the Overseas Visitor must take out a couples’ OVHC policy listing the Partner as per the visa granted;

(c) if an OVHC visa has been granted for the Overseas Visitor, a Partner and any Dependents (but excluding Student Dependents) then the Overseas Visitor must take out a Family OVHC policy listing the Partner and all Dependents (but excluding Student Dependents) as per the visa granted;

(d) if an OVHC visa has been granted for the Overseas Visitor and any Dependents (but excluding Student Dependents) then the Overseas Visitor must take out a Family OVHC policy listing all Dependents (but excluding Student Dependents) as per the visa granted.

3 Cover under this Table must be purchased for a minimum length of cover of one (1) month and a maximum length of cover of twelve (12) twelve months.

4 Overseas Visitors holding a temporary resident visa sub-class 600, 601 and 651 must pay the Premium for the length of the Policy. Notwithstanding Rule LV2.11, the Premium for
Overseas Visitors Health Cover Fund Rules

temporary resident visa sub-class 600, 601, 651 must be paid by direct debit from a credit card and may not be paid by direct debit from a financial institution account or payroll deduction.

5 Benefits are not payable for any expenses relating to any Pre Existing Conditions for the duration of the Policy.

Transfers

6 LV2.5 (Transfers) does not apply to this Table.

7 Cover under this Table is not available to Overseas Visitors that hold a temporary resident 600, 601 and 651 visa and transfer from another private health insurer registered under the Act or from a general insurer.

Accident

8 All Hospital Treatment and Medical Services must be related to injuries sustained in an Accident and must be provided in a Hospital (not a Doctor’s surgery) where an inpatient admission has occurred.

9 Benefits for Accidents are only payable if the Insured Person:
   (a) presents to a medical practitioner (e.g. a general practitioner) or Hospital Emergency Department within 72 hours after an Accident (documentation may be required as proof); and
   (b) is first admitted to a Hospital as an inpatient:
      (i) within 90 days after time of presentation to the medical practitioner or Hospital Emergency Department; or
      (ii) at a later date due to medical reasons restricting the initial admission occurring within the time required in paragraph (i).

10 Any Hospital Treatment provided after the first 90 days will be paid at the level of Benefits of the Insured Person’s level of cover.

11 An Insured Person and their Medical Practitioner must contact nib to confirm eligibility of cover and must complete an Accident form if requested by nib before a Benefit is paid.

Accidental Injury Benefit

12 An Accidental Injury Benefit is payable for Hospital Treatment and Medical Services that are otherwise excluded in this Table if:
   (a) the Insured Person suffers an Accident; and
   (b) the Insured Person is admitted as an inpatient for immediate Hospital Treatment; and
   (c) the Insured Person requires Emergency Treatment as a result of the Accident.

Hospital Emergency Department

13 Benefits for Hospital Emergency Department services are only payable if the services relate to Emergency Treatment which leads to the Insured Person being admitted into Hospital.

14 Unless expressly provided in this Table, Benefits are not payable for:
   (a) Hospital Emergency Department attendance which does not result in an admission;
   (b) Treatment and services rendered outside of a Hospital (Out-Patient services).

Excess

15 The amount of the Excess and relevant limits and conditions which apply to are as follows:
   (a) there is only one Excess available;
Overseas Visitors Health Cover Fund Rules

(b) the Excess amount is $250 per admission;
(c) the maximum Excess payable under the Policy in any Policy Year will be $500;
(d) with the exception of Dependent Children, the Excess applies to all Insured Persons covered by the Policy;
(e) no Excess is payable for the Hospital admission of a Dependent Child covered under a Family Policy.

Definitions

16 The following definitions only apply to this Table and override the same definitions set out in Rule LV2.1 (Interpretation and Definitions).

“Accident” means a single physical event that occurs during the Policy Year, which is caused by external force or object, and results solely, directly and independently of any other cause, including illness, which is both unintentional and unsolicited by the Insured Person, resulting in involuntary injury to the body requiring immediate Hospital Treatment.

“Accidental Injury Benefit” means a Benefit payable for any excluded Hospital Treatment or Medical Services if:
(a) the Insured Person suffers an Accident; and
(b) the Insured Person is admitted as an inpatient for immediate Hospital Treatment; and
(c) the Insured Person requires Emergency Treatment as a result of the Accident.

“Emergency Treatment” means Hospital Treatment where an Insured Person is:
(a) at risk of serious morbidity or mortality and requiring urgent assessment and resuscitation; or
(b) in severe pain and suspected to suffer acute organ or system failure;
(c) suffering from the viability of function of a body part or organ that is acutely threatened; or
(d) suffering acute haemorrhaging and requiring urgent assessment and Hospital Treatment; or
(e) suffering a Condition that requires immediate Hospital Treatment to avoid imminent morbidity or mortality and where a transfer to another Hospital is impractical.

“Excess” means an amount that the Policy Holder must contribute towards Hospital Treatment. An Excess is payable in each Policy Year.

“Medical Practitioner” means medical practitioner as defined in the Act.

LV22.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Benefits for Hospital Treatment shall be payable in an nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib at 100% of the cost of:
(a) charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care; and
(b) charges for paramedical services such as physiotherapy; and
(c) where applicable and pre-approved by nib, charges relating to Hospital Treatment received under Accidental Injury Benefit provision.

The following Hospital Treatment is excluded and no Benefits are payable unless an Accidental Injury Benefit applies:
1 Brain Surgery
2 Cancer Treatment
3 Heart Procedures
4 Palliative Care

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Overseas Visitors Health Cover Fund Rules

5 Rehabilitation
6 Stroke Treatment
7 Back Surgery
8 Eye Surgery
9 Joint Replacement
10 Joint Investigation
11 Gastroscopies
12 Renal Dialysis
13 Assisted Reproductive Treatment
14 Infertility Investigation
15 Obesity Surgery
16 Pregnancy and Birth Services
17 Psychiatric Treatment
18 Cosmetic Surgery
19 Oral and Maxillofacial Surgery
20 Podiatric treatment
21 Cochlear implants
22 Bone marrow and organ transplant

**LV22.4 Surgically Implanted Prostheses**

Benefits are payable at 100% of the cost for approved surgically implanted prosthetic devices as determined by the Federal Government.

**LV22.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for approved Medical Services provided to an Insured Person while in Hospital are payable as follows:

(a) 100% of the cost for Medical Services with no out of pocket expenses;

(b) 100% of the cost of Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital;

(c) 100% of the cost of Medical Services relating to Hospital Treatment received under an Accidental Injury Benefit but only where approved by nib in writing.

The following Medical Services are excluded and no Benefits are payable unless an Accidental Injury Benefit applies:

1 Brain Surgery
2 Cancer Treatment
3 Hearth Procedures
4 Palliative Care
5 Rehabilitation
6 Stroke Treatment
7 Back Surgery
8 Eye Surgery
9 Joint Replacement
10 Joint Investigation
11 Gastroscopies
12 Renal Dialysis
13 Assisted Reproductive Treatment
14 Infertility Investigation
15 Obesity Surgery
16 Pregnancy & Birth Services
17 Psychiatric Treatment
18 Cosmetic Surgery
19 Oral and Maxillofacial Surgery
20 Podiatric treatment
LV22.6 Pharmaceutical Benefits

In-Hospital

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where the medication is:
(a) included in the Hospital invoice;
(b) administered to an Insured Person during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:
(a) drugs issued for the sole purpose of use at home;

LV22.7 Ambulance

Benefits are payable at 100% of cost for an ambulance service within Australia that is:
(a) provided by a State or Territory Ambulance Service; and
(b) defined by the relevant service provider as emergency ambulance transport; and
(c) defined by a treating doctor as Medically Necessary transport.

Benefits are also payable where an ambulance is called to attend an emergency but on arriving is no longer required this charge will be covered.

LV22.8 Non Surgically Implanted Prostheses and Appliances

No Benefits are payable for Non Surgically Implanted Prostheses and Appliances.

LV22.9 Physiotherapy

No Benefits for Physiotherapy are payable.

LV22.10 Chiropractic

No Benefits for Chiropractic are payable.

LV22.11 Osteopathy

No Benefits for Osteopathy are payable.

LV22.12 Dental

No Benefits for Dental are payable except as specified in Schedule M for an Accidental Injury Benefit.

LV22.13 Optical

No Benefits for Optical are payable.

LV22.14 Dietetics

No Benefits for Dietetics are payable.

LV22.15 Home Nursing and Home Care
Overseas Visitors Health Cover Fund Rules

No Benefits for Home nursing and home care are payable.

**LV22.16 Immunisation and Allergy Vaccines**

No Benefits for Immunisation and Allergy Vaccines are payable.

**LV22.17 Occupational Therapy**

No Benefits for Occupational Therapy are payable.

**LV22.18 Podiatry**

No Benefits for Podiatry are payable.

**LV22.19 Speech Therapy**

No Benefits for Speech Therapy are payable.

**LV22.20 Natural Therapies**

No Benefits for Natural Therapies are payable.

**LV22.21 Preventative Care Benefit**

No Benefits for Preventative Care are payable.

**LV22.22 CPAP Machines, Wheelchairs and Crutches**

No Benefits for CPAP Machines are payable.

Subject to the following conditions, Wheelchairs and Crutches are covered at 100% up to $1,000 per Insured Person per Membership Year.

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<thead>
<tr>
<th>Item</th>
<th>Rule</th>
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<td>Wheelchair or motorised wheelchair</td>
<td>Following an Accident accompanied by a letter of recommendation from</td>
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<td>(including hire)</td>
<td>the treating Medical Practitioner</td>
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<td></td>
<td>Wheelchairs – not mobility scooters. Payable when required as a primary means of mobility.</td>
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<td>Crutches (including hire)</td>
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<td></td>
<td>the treating Medical Practitioner</td>
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</table>

**LV22.23 Hearing Aids**

No Benefits for Hearing Aids are payable.

**LV22.24 Laser Eye Surgery**

No Benefits for Laser Eye Surgery are payable.

**LV22.25 Antenatal and Postnatal Services**

No Benefits for this service are payable.

**LV22.26 Other**

1 July 2019
**LV22.26.1 Funeral Expenses**

Other than as expressly provided in these Rules, if an Insured Person sustains an Accident resulting in death, nib will reimburse the reasonable expenses incurred up to $20,000 for the cost of returning the Insured Person's mortal remains to their country of origin, or the reasonable cost of funeral, burial or cremation expenses in Australia, subject to nib being notified as soon as possible of the death, and before any repatriation or funeral services have been arranged.

**LV22.26.2 Medical Repatriation Expenses**

Other than as expressly provided in these Rules, if an Insured Person sustains an Accident resulting in life-threatening injury, nib will pay the reasonable expenses incurred up to $1,000,000 for the cost of airfare, on board stretcher, accompanying aero-medical specialists and nursing staff to repatriate the Insured Person to their country of origin, subject to nib being notified as soon as possible, and before any repatriation services have been arranged, and nib's appointed Medical Practitioner certifying that the repatriation is Medically Necessary.
LV23 nib Basic Visitor Cover

LV23.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy; and
2) Couples Policy; and
3) Family Policy.

LV23.2 General Conditions

No General conditions apply

LV23.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

i Gastric banding and obesity surgery
ii Psychiatric treatment
iii Palliative Care
iv Pregnancy and birth related services

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

i Bone Marrow and Organ Transplants
ii Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery
iii Assisted Reproductive Services
iv Infertility Investigations
**LV23.4 Surgically Implanted Prostheses**

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

**LV23.5 Medical Services Payments**

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer while admitted as a patient in Hospital shall be as follows:

(a) for services included - 100% of the cost for that medical service with not out of pockets

(b) for services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   i. Gastric banding and obesity surgery
   ii. Psychiatric treatment
   iii. Palliative Care
   iv. Pregnancy and birth related services

(c) for services that are excluded no benefit is payable. Excluded services are:
   i. Bone Marrow and Organ Transplants
   ii. Assisted Reproductive Services
   iii. Infertility Investigations
   iv. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for medical services provided to the customer while as an outpatient shall be as follows:

(a) 100% of the Medicare Benefit Schedule Fee for that medical service.

Out-Patient Exclusions apply to:
   i. Psychiatric
   ii. Expenses for counselling and psychological testing, and
   iii. Any Services provided by a registered psychologist or providers who are not a psychiatrist, and
   iv. Group therapy or counselling sessions, including where the service is provided by a psychiatrist.
   v. Bone Marrow and Organ Transplants
   vi. Assisted Reproductive Services
   vii. Infertility Investigations
   viii. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

(a) Benefits for Emergency Facilities shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities.

(b) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital is payable at 100% of cost, provided all documentation from the treating doctor is received and approved prior to discharge.

**LV23.6 Pharmaceutical Benefits**

**In-Hospital**

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital; or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:
Overseas Visitors Health Cover Fund Rules

(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of-Hospital pharmaceutical.

**Out-of Hospital**

Pharmaceutical Benefits are payable at 100% of cost with a Membership Year annual limit of $500 per person.

Benefits are payable for drugs when the drug is

(a) prescribed by a Medical Practitioner
(b) listed on the Australian Government’s Pharmaceutical Benefits Scheme (PBS)
(c) prescribed according to PBS-approved indications

Benefits are not payable for:

(a) non-PBS pharmaceuticals
(b) drugs that are listed on both the repatriation and non-repatriation list and the dosage and quantity are identical

The waiting period for Out-of-Hospital pharmacy is 2 months.

**LV23.7 Nursing Home Type Patients**

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.

Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV23.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and
(b) defined by the relevant service provider as emergency ambulance transport; or
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or
(d) defined by a treating doctor as Medically Necessary transport.

**LV23.9 Non Surgically Implanted Prostheses and Appliances**

No Benefits are payable for Non Surgically Implanted Prostheses and Appliances.

**LV23.10 Physiotherapy**

No Benefits for Physiotherapy are payable.

**LV23.11 Chiropractic**

No Benefits for Chiropractic are payable.

**LV23.12 Osteopathy**

No Benefits for Osteopathy are payable.

**LV23.13 Dental**

1 July 2019
No Benefits for Dental are payable.

**LV23.14 Optical**
No Benefits for Optical are payable.

**LV23.15 Dietetics**
No Benefits for Dietetics are payable.

**LV23.16 Home Nursing and Home Care**
No Benefits for Home nursing and home care are payable.

**LV23.17 Immunisations and Allergy Vaccines**
No Benefits for Immunisations and Allergy Vaccines are payable.

**LV23.18 Occupational Therapy**
No Benefits for Occupational Therapy are payable.

**LV23.19 Podiatry**
No Benefits for Podiatry are payable.

**LV23.20 Speech Therapy**
No Benefits for Speech Therapy are payable.

**LV23.21 Natural Therapies**
No Benefits for Natural Therapies are payable.

**LV23.22 Preventative Care Benefit**
No Benefits for Preventative Care are payable.

**LV23.23 CPAP Machines, Wheelchairs and Crutches**
No Benefits for CPAP Machines, Wheelchairs and Crutches are payable.

**LV23.24 Hearing Aids**
No Benefits for Hearing Aids are payable.

**LV23.25 Laser Eye Surgery**
No Benefits for Laser Eye Surgery are payable.

**LV23.26 Antenatal and Postnatal Services**
No Benefits for this service are payable.

**LV23.27 Other**

**LV23.27.1 Funeral Expenses**
The Policy Holder and accompanying family members are eligible to claim for burial expenses or the
cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

**LV23.27.2 Medical Repatriation Expenses**

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home, country are also claimable under this Plan.
LV24 nib Budget Visitor Cover

LV24.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.1 (General):

1) Single Policy; and
2) Couples Policy; and
3) Family Policy

LV24.2 General Conditions

No General conditions apply.

LV24.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Hospital Treatment Benefits shall be payable as follows to an admitted Insured Person:

In a nib Agreement Private Hospital, Public Hospital or in a Private Hospital that has not entered into a provider agreement with nib/IMAN 100% of:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care

(b) the cost of paramedical services such as physiotherapy

For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities for:

(a) overnight and day only Hospital accommodation (all costs including: all theatre, intensive care, labour wards, ward drugs)

(b) emergency department fees that leads to an admission

(c) admitted patient care and post-operative services that are a continuation of care associated with an early discharge from Hospital.

If a customer goes to a Private Hospital, and the charge is less than the “Gazetted Rate”, nib/IMAN will pay the rate charged by the Private Hospital. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

i) Gastric banding and obesity surgery
ii) Psychiatric treatment
iii) Palliative Care
iv) Pregnancy and birth related services

For services listed as Excluded no Hospital Treatment Benefit shall be payable.

Excluded services are:

i) Bone Marrow and Organ Transplants
ii) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery
iii) Assisted Reproductive Services
iv) Infertility Investigations
LV24.4 Surgically Implanted Prostheses

The Benefits for Surgically Implanted Prostheses are payable at 100% of cost.

LV24.5 Medical Services Payments

Other than as expressly provided in these Rules, Benefits for Medical Services provided to a customer while in Hospital shall be as follows:

(a) For services included - 100% of the cost for that medical service with no out of pockets.

(b) For services listed as lower Benefits - 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:
   i. Gastric banding and obesity surgery
   ii. Psychiatric treatment
   iii. Palliative Care
   iv. Pregnancy and birth related services

(c) For services that are excluded no Benefit is payable. Excluded services are:
   i. Bone Marrow and Organ Transplants
   ii. Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.
   iii. Assisted Reproductive Services
   iv. Infertility Investigations

Benefits for medical services provided to the customer while not in a Hospital shall be as follows:

(a) Out-Patient continuing treatment following hospitalisation due to early discharge from Hospital is paid at 100% of cost, provided all documentation from the treating doctor is received and approved prior to discharge.

(b) Emergency Facility – paid at 100% of cost but only covered if the treatment leads to an admission as an In-Patient or is certified by the treating doctor as Emergency Treatment.

No other Benefits are payable for medical services provided to the customer while not in a Hospital.

LV24.6 Pharmaceutical Benefits

In-Hospital

Pharmaceutical Benefits for PBS Pharmaceuticals, where prescribed according to PBS-approved indications, and non-PBS Pharmaceuticals are payable at 100% of cost where:

(a) it is included on the Hospital invoice; and
(b) administered to the patient during their stay in Hospital or
(c) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for:

(a) drugs issued for the sole purpose of use at home. These drugs are to be assessed under out-of Hospital pharmaceutical.

Out-of Hospital

No Benefits for out-of Hospital Pharmaceutical Benefits are payable.

LV24.7 Nursing Home Type Patients

A Nursing Home Type Benefit is a benefit set by the Federal Government for a Patient who is in Hospital, but not in need of acute Hospital care, while awaiting a nursing home placement.
Where a customer is classified as a Nursing Home Type Patient they will be required to contribute a daily co-payment towards the cost of their Hospital stay (co-payments are also determined by the Federal Government).

**LV24.8 Ambulance**

Ambulance Benefits are payable at 100% of cost for an ambulance service within Australia that is:

(a) provided by a State or Territory Ambulance Service where the OVHC Insured Person is not covered by a State Government Ambulance Scheme; and  
(b) defined by the relevant service provider as emergency ambulance transport; or  
(c) where an ambulance is called to attend an emergency but on arriving is no longer required this charge will also be covered; or  
(d) defined by a treating doctor as Medically Necessary transport.

**LV24.9 Non Surgically Implanted Prostheses and Appliances**

No Benefits are payable for Non Surgically Implanted Prostheses and Appliances.

**LV24.10 Physiotherapy**

No Benefits for Physiotherapy are payable.

**LV24.11 Chiropractic**

No Benefits for Chiropractic are payable.

**LV24.12 Osteopathy**

No Benefits for Osteopathy are payable.

**LV24.13 Dental**

No Benefits for Dental are payable.

**LV24.14 Optical**

No Benefits for Optical are payable.

**LV24.15 Dietetics**

No Benefits for Dietetics are payable.

**LV24.16 Home Nursing and Home Care**

No Benefits for Home nursing and home care are payable.

**LV24.17 Immunisations and Allergy Vaccines**

No Benefits for Immunisations and Allergy Vaccines are payable.

**LV24.18 Occupational Therapy**

No Benefits for Occupational Therapy are payable.

**LV24.19 Podiatry**
Overseas Visitors Health Cover Fund Rules

No Benefits for Podiatry are payable.

**LV24.20 Speech Therapy**

No Benefits for Speech Therapy are payable.

**LV24.21 Natural Therapies**

No Benefits for Natural Therapies are payable.

**LV24.22 Preventative Care Benefit**

No Benefits for Preventative Care are payable.

**LV24.23 CPAP Machines, Wheelchairs and Crutches**

No Benefits for CPAP Machines, Wheelchairs and Crutches are payable.

**LV24.24 Hearing Aids**

No Benefits for Hearing Aids are payable.

**LV24.25 Laser Eye Surgery**

No Benefits for Laser Eye Surgery are payable.

**LV24.26 Antenatal and Postnatal Services**

No Benefits for this service are payable.

**LV24.27 Other**

**LV24.27.1 Funeral Expenses**

The Policy Holder and accompanying family members are eligible to claim for burial expenses or the cost of returning the body or ashes to the home country up to $20,000 per Insured Person. Food catering is not covered under this benefit.

**LV24.27.2 Medical Repatriation Expenses**

The Policy Holder and accompanying family members have Benefits for 100% of the cost of medical repatriation to their home country when this is deemed Medically Necessary by a Medical Practitioner appointed by nib/IMAN. The Expenses for the cost of air fares, on board stretcher, accompanying aero-medical specialists and nursing staff are covered up to $1,000,000. The expenses for the cost of ambulance transport in Australia and in your home, country are also claimable under this Plan.
<table>
<thead>
<tr>
<th>Schedule</th>
<th>Product</th>
<th>Scale</th>
<th>Yearly Base Rate (Includes GST) 2019</th>
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<tbody>
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SCHEDULE M

Dental

In the table set out below:

(a) the Benefits apply to Schedules:
   LV10 Executive Top Visitors Singles,
   LV11 Executive Top Visitors Couples & Families,
   LV12 Top Visitors Singles,
   LV13 Top Visitors Couples & Families,
   LV20 nib United Gold Visitor Cover,
   LV22 Visitor Cover
   LV23 nib Basic Visitor Cover
   LV24 nib Budget Visitor Cover

(b) the Benefits payable for the Services for each Schedule shall be no greater than:
   (i) those Benefit amounts set out below. Where no Benefit for a Service is specified for a
       Schedule, no Benefit for that Service is payable;
   (ii) subject to the Annual Limits and conditions set out in that Schedule; and
   (iii) subject to Treatment by a nib Preferred Provider or as otherwise set out;

(c) Benefits in Schedule M are payable according to whether Treatment is provided by a nib
    Preferred Provider or other Provider. Where the Insured Person is resident more than 20
    kilometres from a nib Preferred Provider, the same Benefit will apply as if Treated by a nib
    Preferred Provider;

(d) the Benefits for LV22 are only Accident Injury Benefits.
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## Overseas Visitors Health Cover Fund Rules

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<td>Photographic records – extraoral</td>
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1 July 2019
## Overseas Visitors Health Cover Fund Rules

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<td>Guided tissue regeneration – per tooth or implant</td>
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## Overseas Visitors Health Cover Fund Rules

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<td>Item Description</td>
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<td>Transplantation of tooth or tooth bud</td>
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1 July 2019

117
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## Overseas Visitors Health Cover Fund Rules

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<th>Item Description</th>
<th>LV11 Executive Top Single</th>
<th>LV12 Top Singles</th>
<th>LV13 Top Couple/Family</th>
<th>LV20 nib United Visitor Cover</th>
<th>LV22 Visitor Cover</th>
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1 July 2019
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## Overseas Visitors Health Cover Fund Rules

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<td>Dental acupuncture – per appointment</td>
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</table>

1 July 2019
<table>
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<tr>
<th>Item Description</th>
<th>Item Number</th>
<th>LV10 Executive Top Single</th>
<th>LV11 Executive Top Couple/Family</th>
<th>LV12 Top Singles</th>
<th>LV13 Top Couple/Family</th>
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<th>LV22 Visitor Cover</th>
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<td>Treatment under general anaesthesia/sedation</td>
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<td>Clinical occlusal analysis including muscle and joint palpation</td>
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<td>Registration and mounting of models for occlusal analysis</td>
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<td>Occlusal splint</td>
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<td>Adjustment of pre-existing occlusal splint – per appointment</td>
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<td>Pantographic tracing</td>
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<td>Adjunctive physical therapy for temporomandibular joint and associated structures</td>
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<td>Repair/addition – occlusal splint</td>
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<td>Splinting and stabilisation – direct – per tooth</td>
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<td>Single arch oral appliance for diagnosed snoring and obstructive snoring and sleep apnoea</td>
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<td>Bi-maxillary oral appliance for diagnosed snoring and obstructive snoring and sleep apnoea</td>
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<tr>
<td>Repair/addition – snoring or sleep apnoea device</td>
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<td>100%</td>
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<tr>
<td>Post-operative care not otherwise included</td>
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<td>Re-contour tissue – per appointment</td>
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</table>
**Optical Services**

In the table set out below which sets out Benefits for Optical services:

(a) the Benefits apply to Schedules:
    LV10 Executive Top Visitors Singles,
    LV11 Executive Top Visitors Couples & Families,
    LV12 Top Visitors Singles,
    LV13 Top Visitors Couples & Families,
    LV20 nib United Gold Visitor Cover
    LV23 nib Basic Visitor Cover
    LV24 nib Budget Visitor Cover

(b) the Benefits payable for the Services for each Schedule shall be:

(i) those Benefit amounts set out below. Where no Benefit for a Service is specified for a Schedule, no Benefit for that Service is payable;

(ii) subject to the Annual Limits and conditions set out in that Schedule.
## Overseas Visitors Health Cover Fund Rules

### Item Number vs. Description of Service

<table>
<thead>
<tr>
<th>ITEM NUMBER</th>
<th>DESCRIPTION OF SERVICE</th>
<th>LV10</th>
<th>LV11</th>
<th>LV12</th>
<th>LV13</th>
<th>LV20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Executive Top Singles</td>
<td>Executive Top Couples/Families</td>
<td>Top Singles</td>
<td>Top Couples/Families</td>
<td>nib United Gold Visitor Cover</td>
</tr>
<tr>
<td>9460</td>
<td>Rigid spherical lens - pair</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>9461</td>
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<td>100%</td>
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<tr>
<td>9464</td>
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<tr>
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<td>LV12</td>
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<td>Executive Top Singles</td>
<td>Executive Top Couples/Families</td>
<td>Top Singles</td>
<td>Top Couples/Families</td>
<td>nib United Gold Visitor Cover</td>
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<td>9489</td>
<td>Frequent replacement/spherical lens – single or pair</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>643</td>
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<td>Hard Coating (single)</td>
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<td>Multi/Anti-reflective Coating (single)</td>
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<td>Multi/Anti-reflective Coating (pair)</td>
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<td>UV Coating (pair)</td>
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</table>
Non Surgically Implanted Prostheses and Appliances

In the table set out below which sets out Benefits for non surgically implanted prostheses and appliances:

(a) the Benefits apply to Schedules:
LV10 Executive Top Visitors Singles,
LV11 Executive Top Visitors Couples & Families,
LV12 Top Visitors Singles,
LV13 Top Visitors Couples & Families and
LV14 Mid Visitors

(b) the Benefits payable for the Services for each Schedule shall be subject to the Annual Limits, service limits and conditions set out in that Schedule.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description of Service</th>
<th>Service Limit (all service limits are ‘per person’ unless otherwise specified)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td>Requirements</td>
<td>Additional Points</td>
</tr>
<tr>
<td>Nebulizer</td>
<td>Letter of recommendation from a Medical Practitioner / Specialist required</td>
<td>n/a</td>
</tr>
<tr>
<td>Ankle-Foot Orthosis (Include Pneumatic Boot)</td>
<td>n/a</td>
<td>2 per person per year</td>
</tr>
<tr>
<td>Knee Brace</td>
<td>Only payable pre &amp; post-surgery; Letter of recommendation from specialist required. Braces must have rigid support and must be fitted and assessed by a qualified practitioner</td>
<td>The brace should extend from the groin to the ankle and have a hinged rigid support. No Benefits payable for soft knee braces for sporting purposes.</td>
</tr>
<tr>
<td>Back Brace</td>
<td>n/a</td>
<td>1 per person per year</td>
</tr>
<tr>
<td>Shoulder Brace</td>
<td>n/a</td>
<td>1 per person per year</td>
</tr>
<tr>
<td>Knee-Ankle Foot Orthosis (Include Pneumatic Boot)</td>
<td>n/a</td>
<td>2 per person per year</td>
</tr>
<tr>
<td>Rigid Neck Brace</td>
<td>3 types of rigid neck braces have been identified: the aspen collar, OA Plastic Collar and the Royce Philadelphia Collar</td>
<td>n/a</td>
</tr>
<tr>
<td>Blood Glucose Monitor (also known as Reflux or medisense softact machine)</td>
<td>Letter of recommendation from a Medical Practitioner / Specialist required</td>
<td>n/a</td>
</tr>
<tr>
<td>Surgical Stockings</td>
<td>Letter of recommendation from a Medical Practitioner / Specialist required</td>
<td>n/a</td>
</tr>
<tr>
<td>Item Number</td>
<td>Description of Service</td>
<td>Service Limit</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>8001</td>
<td>Unilateral external Mammary prosthesis after mastectomy</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8002</td>
<td>Bilateral external Mammary prosthesis after mastectomy</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8003</td>
<td>Back Brace</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8005</td>
<td>Ankle-Foot Orthosis</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8006</td>
<td>Knee-ankle foot Orthosis</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8007</td>
<td>Blood glucose monitor</td>
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<td>8008</td>
<td>Nebulizer</td>
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<td>Wigs</td>
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<td>Irlen lenses</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8011</td>
<td>Surgical stockings</td>
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</tr>
<tr>
<td>8012</td>
<td>Peak flow meter</td>
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</tr>
<tr>
<td>8015</td>
<td>CPAP machine (for sleep disorders)</td>
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</tr>
<tr>
<td>8016</td>
<td>TENS machine (pain relieving stimulator)</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8017</td>
<td>Knee brace</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8019</td>
<td>Pressure garments</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8020</td>
<td>Wheelchair/power wheel chair</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8021</td>
<td>Walking frames</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8022</td>
<td>Hip Orthosis</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8023</td>
<td>Blood pressure monitor (sphygmomanometer)</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8024</td>
<td>Injection delivery device</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8025</td>
<td>Needle-less injector (diabetic aid)</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8027</td>
<td>Spacer</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8029</td>
<td>Abdominal binders/hernia supports</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8033</td>
<td>Artificial eye</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8034</td>
<td>Joint fluid replacement</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8035</td>
<td>Shoulder brace</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8036</td>
<td>Finger, thumb, hand, wrist, arm &amp; elbow Orthosis &amp; splints</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8037</td>
<td>CPAP parts</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8038</td>
<td>CoaguChek</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8039</td>
<td>Erectile dysfunction pump</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8053</td>
<td>Post mastectomy bras</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8054</td>
<td>Rigid neck brace</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8063</td>
<td>Hip protector</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8067</td>
<td>Speech processor</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8068</td>
<td>Macular degeneration aids</td>
<td>1 per 3 years</td>
</tr>
<tr>
<td>8109</td>
<td>Orthotic appliance</td>
<td>2 per 3 years</td>
</tr>
<tr>
<td>9100</td>
<td>Orthopaedic shoes/boots</td>
<td>2 per 3 years</td>
</tr>
<tr>
<td>9299</td>
<td>Hearing aid (monaural)</td>
<td>2 per 5 years</td>
</tr>
<tr>
<td>9302</td>
<td>Hearing aid (binaural)</td>
<td></td>
</tr>
<tr>
<td>9300</td>
<td>Hearing aid repair</td>
<td>1 per year</td>
</tr>
</tbody>
</table>
Non Surgically Implanted Prostheses and Appliances

In the table set out below which sets out Benefits for Non Surgically Implanted Prostheses and Appliances (Artificial Aids):

(a) the Benefits apply to Schedules:
LV22 IMAN Visitor Cover

(b) The Benefits payable for the Services for each Schedule shall be:
(i) Those Benefit amounts set out below;
(ii) Subject to the service limits and conditions set out in that Schedule;

(c) “service limits” shall mean the number of times during any Calendar Year that a Benefit will be paid for a particular service. All service limits are per person unless otherwise specified below.

<table>
<thead>
<tr>
<th>Description of aid</th>
<th>Item number</th>
<th>Service limits that apply</th>
<th>LV22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Binders / Hernia Supports</td>
<td>8029</td>
<td>2 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Ankle-Foot Orthosis (includes Pneumatic Boot)</td>
<td>8005</td>
<td>2 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Artificial Eye</td>
<td>8033</td>
<td>1 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Back Brace</td>
<td>8003</td>
<td>1 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Bilateral external mammary prosthesis after mastectomy</td>
<td>8002</td>
<td>4 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Blood Glucose Monitor</td>
<td>8007</td>
<td>2 per Policy per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Blood Pressure Monitor (sphygmomanometer)</td>
<td>8023</td>
<td>1 per policy every 2 Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>CoaguChek</td>
<td>8038</td>
<td>1 per policy every 2 Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>CPAP machine (for sleep disorders)</td>
<td>8015</td>
<td>1 per policy every 2 Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>CPAP Parts</td>
<td>8037</td>
<td>2 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Erectile Dysfunction Pump</td>
<td>8039</td>
<td>1 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Finger, Hand, Wrist, Arm &amp; Elbow Orthoses and Splints</td>
<td>8036</td>
<td>1 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Hearing aid (monaural)</td>
<td>9299</td>
<td>2 per person per 5 years</td>
<td>Nil</td>
</tr>
<tr>
<td>Hearing aid (binaural)</td>
<td>9302</td>
<td>2 per person per 5 years</td>
<td>Nil</td>
</tr>
<tr>
<td>Hearing aid repair</td>
<td>9300</td>
<td>1 per person per year</td>
<td>Nil</td>
</tr>
<tr>
<td>Hip Orthosis</td>
<td>8022</td>
<td>1 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Hip Protector</td>
<td>8063</td>
<td>1 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Injection Delivery Device</td>
<td>8024</td>
<td>1 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Irlen Lenses</td>
<td>8010</td>
<td>1 pair per person per Calendar Year</td>
<td>Nil</td>
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<tr>
<td>Joint Fluid Replacement</td>
<td>8004</td>
<td>-</td>
<td>Nil</td>
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<tr>
<td>Knee Brace</td>
<td>8017</td>
<td>1 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Knee-Ankle Foot Orthosis</td>
<td>8006</td>
<td>2 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Macular degeneration aids</td>
<td>8068</td>
<td>1 per person per 3 years</td>
<td>Nil</td>
</tr>
<tr>
<td>Nebuliser</td>
<td>8008</td>
<td>1 per every 2 Calendar Years</td>
<td>Nil</td>
</tr>
<tr>
<td>Needle-less injector (diabetic aid)</td>
<td>8025</td>
<td>1 per policy per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Orthotic appliance</td>
<td>8109</td>
<td>2 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Orthopaedic shoes</td>
<td>9100</td>
<td>2 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Peak Flow Meter</td>
<td>8012</td>
<td>1 per policy</td>
<td>Nil</td>
</tr>
<tr>
<td>Post mastectomy bras</td>
<td>8053</td>
<td>2 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Pressure Garments</td>
<td>8019</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>Rigid neck brace</td>
<td>8054</td>
<td>1 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Shoulder Brace</td>
<td>8035</td>
<td>1 per person per Calendar Year</td>
<td>100%</td>
</tr>
<tr>
<td>Spacer</td>
<td>8027</td>
<td>2 per policy per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Speech processor</td>
<td>8067</td>
<td>1 per person per 3 years</td>
<td>Nil</td>
</tr>
<tr>
<td>Surgical Stockings</td>
<td>8011</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>Tens Machine (pain relieving stimulator)</td>
<td>8016</td>
<td>1 Tens Machine OR 1 Magic Hand per policy every 2 Calendar Years</td>
<td>Nil</td>
</tr>
<tr>
<td>Unilateral external mammary prosthesis after mastectomy</td>
<td>8001</td>
<td>2 per person per Calendar Year</td>
<td>Nil</td>
</tr>
<tr>
<td>Walking Frames</td>
<td>8021</td>
<td>1 per person every 3 Calendar Years</td>
<td>Nil</td>
</tr>
<tr>
<td>Wheelchair / Power Wheelchair</td>
<td>8020</td>
<td>1 per person every 2 Calendar Years</td>
<td>100%</td>
</tr>
<tr>
<td>Description of aid</td>
<td>Item number</td>
<td>Service limits that apply</td>
<td>LV22</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Wigs</td>
<td>8009</td>
<td>2 per person per Calendar Year (due to treatment of a medical condition)</td>
<td>nil</td>
</tr>
</tbody>
</table>