nib health funds limited ABN 83 000 124 381 Fund Rules

Overseas Visitors Health Cover

1 September 2026

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L SCHEDULE

L1 Overseas

The L Schedule Overseas includes the following Schedules:

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. Advantage Visitor Cover
LV16. Budget Visitor Cover
LV17. Value Plus
LV20. nib United Gold Visitor Cover
LV23. nib Advantage Visitor Cover
LV24. nib Budget Visitor Cover
LV25. nib Core Extras Visitor Cover
LV26. nib Standard Visitor Cover
LV27. nib Visitor Care

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 (Advantage Visitor Cover),
   LV16 (Budget Visitor Cover),
   LV17 (Value Plus),
   LV20 (nib United Gold Visitor Cover),
   LV23. (nib Advantage Visitor Cover)
   LV24. (nib Budget Visitor Cover)
   LV25. (nib Core Extras Visitor Cover)
   LV26. (nib Standard Visitor Cover)
   LV27. (nib Visitor Care)

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, 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.

"ADA Schedule" means the Schedule of Dental Services published by the Australian Dental Association Incorporated, as updated from time to time.

"Acupuncture" means General Treatment that is:
approved by nib/IMAN; and
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; or
(c) provided by an online antenatal course Provider recognised by nib/IMAN

"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 and Dental Service" 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)
(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**" means the amount a Policy Holder elects to pay for Claimable Hospital Expenses before a Benefit is paid unless otherwise specified in the Schedules. An Excess is payable in each Calendar Year.

"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 Dependants listed in the visa; or
(b) the Policy Holder (an Adult) and two 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.

"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 Program 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 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.

"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 or when an Excess applies. 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 Dependants 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.

(a) Where PBS pharmaceuticals are covered on a Product, Benefits are payable when:
  i. dispensed by a registered practitioner recognised by nib/IMAN, and
  ii. only available on prescription, and
  iii. listed on the Australian Register of Therapeutic Goods (ARTG), and
  iv. published within the Poisons Standard as S4 or S8, and
  v. listed in the Schedule of Pharmaceutical Benefits Scheme (PBS).

"Non-PBS pharmaceuticals" are prescription only items not covered by the PBS.

(a) Where Non-PBS pharmaceuticals are covered on a Product, Benefits are payable when:
  i. dispensed by a registered practitioner recognised by nib/IMAN, and
  ii. only available on prescription, and
  iii. listed on the Australian Register of Therapeutic Goods (ARTG), and
  iv. published within the Poisons Standard as S4 or S8, and
  v. not listed in the Schedule of Pharmaceutical Benefits Scheme (PBS)

Benefits are not payable for:
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.

"Poisons Standard" means the Poisons Standard as published on the Federal Register of Legislation from time to time (also known as the Standard for the Uniform Scheduling of Medicines and Poisons).

"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 accepted.

"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 (a change to a lower Excess constitutes an upgrade).

"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 LV2.4.1.

"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 LV2.4.1.

"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 Consent to disclose personal information

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.

LV2.2.2 Generally

LV2.2.2 is not applicable for Schedule LV27:

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 Dependants then the Overseas Visitor must take out a family OVHC policy listing the Partner and all Dependants as per the visa granted

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

LV2.2.3 Minimum Age of Policyholders

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

LV2.2.4 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.

LV2.2.5 Dependants

An application as per LV2.3.1 (Form of Application) is necessary to add a Dependant to a Policy. The following provisions apply to adding Dependants:

(a) where the Policy is a Single Plan, an upgrade to a Couple plan is necessary to add a Dependent; and

(b) 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 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 dependent student under a policy of overseas visitors' health cover with another insurer.

(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.

LV2.4 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 offshore), or

(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 Rating

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.

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 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.

(c) where the Excess on the new Cover is lower than the Excess on the Previous Cover, the Excess on the Previous Cover will apply for the first two months (regardless of whether the admission is related to a Pre-existing Condition). For the following 10 months, if the admission relates to a Pre-existing Condition or pregnancy and birth related services, the previous excess will apply.

Where a person who was insured 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 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 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

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

An Administration Fee shall be defined from time to time.

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;
   (a) Full name and address of the Financial Institution
   (b) Full name of the Account Holder
   (c) SWIFT Code; and
   (d) 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, 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) if nib/IMAN chooses to close a Product. This will result in the termination of the Insured Person's Product, in which case the Insured Person will be offered an alternative Product;

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

(g) 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) 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;

(d) the Insured Person has completed 1 months membership; and

(e) the Insured Person is not classified under Schedule LV27. Policies on ScheduleLV27 are not eligible for suspension.

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.

LV2.11 Payment of Premiums

LV2.11.1 Premium Frequencies

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

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

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

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

(e) 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) A Contribution Group may include:

(b) employees of a particular enterprise or group of enterprises;

(c) members of any organisation; or

(d) 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;

(e) a change in Excess level.

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 Policy paid in advance is in arrears whenever:

(a) the date to which Premiums have been paid is earlier than the current date; or

(b) a scheduled payment has been missed; and

(c) the Policy is not suspended.

A Policy paid in arrears under a Contribution Group arrangement as per LV2.11.3

(a) (Premium Frequencies) is in arrears whenever:

(b) the scheduled payment has been missed; and

(c) 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

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

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

(b) Where labour commenced after admission, the Obstetric classification applies from the earliest of:
(c) the date on which labour commenced, or

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

(e) 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:
treatment must be supported by a Rehabilitation Certificate

(a) a further Rehabilitation Certificate is required:

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

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

(a) a further Psychiatric Care Certificate is required:

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

(c) 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,

(a) are to remain fixed throughout the term of the agreement in respect of all Insured Persons under a particular Product:

(b) the total charge for any Treatment (excluding paramedical services);

the Benefit payable by nib/IMAN; and

(a) 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 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 nib's 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 (Advantage Visitor);
LV16 (Budget Visitor);
LV17 (Value Plus);
LV20 (nib United Gold Visitor Cover);
LV23 (nib Advantage Visitor Cover)
LV24 (nib Budget visitor Cover)
LV25 (nib Core Extras Visitor Cover)
LV26 (nib Standard 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.

LV2.18.3 General Treatments for Dental Service

General Treatments benefits for Dental Services will be provided only in respect of procedures or services set out in the ADA Schedule. Benefits are payable only in respect of approved procedures or services performed by a registered dentist or dental technician in private practice or employed by a registered health insurer.

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.

Where an Excess applies and the Excess on the new Cover is lower than the Excess on the Previous Cover, this constitutes an upgrade and the Excess on the Previous Cover will apply for the first two months (regardless of whether the admission is related to a Pre-existing Condition). For the following 10 months, if the admission relates to a Pre-existing Condition or pregnancy and birth related services, the previous excess will apply.

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.

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) 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 (Advantage Visitor), LV16 (Budget Visitor), LV17 (Value Plus), LV20 (United Gold Visitor Cover), LV23 (nib Advantage 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.

For Product LV27 (nib Visitor Care) the Waiting Periods for Hospital are:

(a) 2 months for rehabilitation and palliative care

(b) 1 day for ambulance

(c) 1 day for all other services

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 (Advantage Visitor), LV16 (Budget Visitor), LV17 (Value Plus), LV20 (United Gold Visitor Cover), LV23 (nib Advantage Visitor), LV24 (nib Budget Visitor), LV25 (nib Core Extras Visitor Cover), LV26 (nib Standard Visitor Cover)

The Waiting Periods for Extras are:

General Extras including general dental, acupuncture and optical and other ancillary services.	2 months
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
Medical Repatriation	12 months for Pre-Existing Conditions
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. For Product LV25 (nib Core Extras Visitor Cover) the Waiting Period for Major Dental is 12 months and for Optical, 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;

(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 information submitted by or on behalf of a member to nib/IMAN in respect of an application or claim, 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:

(d) Compensation paid to another person at the direction of the Insured Person; and

(e) 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;

(a) inform nib/IMAN of any decision of the Insured Person to claim for Compensation;

(b) include in any claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable;

(c) take all reasonable steps to pursue the claim for Compensation to nib/IMAN's reasonable satisfaction;

(d) keep nib/IMAN informed of updates or progress of the claim for Compensation;

(e) inform nib/IMAN immediately upon the determination or settlement of the claim for Compensation; and

(f) repay nib/IMAN any Benefits paid in respect of the injury.

(g) 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

.

(h) 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

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:

(b) a complication arising from an injury that was the subject of a claim for Compensation; or

(c) the provision of service or item for Treatment of an injury that was the subject of a claim for Compensation; and

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

(e) 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.

LV 2.22.8 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.

LV 2.22.9 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:

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

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

(b) the Provider's name, provider number and address;

(c) the Patient's full name and address;

(d) the date of service;

(e) the item number/numbers where applicable and description of the service;

(f) the amount(s) charged; and

(g) any other information that nib/IMAN may reasonably request.

(h) 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

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

(a) In the event that a Policy Holder is departing Australia permanently, nib/IMAN may agree to reimburse a claim by electronic funds transfer provided:

(b) The Policy Holder has requested this in writing; and

(c) The Policy Holder has provided the required details of the bank account.

By agreement, nib/IMAN may refund Benefits to an Australian nominated bank account if the following is supplied by the Policy Holder:

(a) Full name and address of the financial institution;

(b) Full name of account holder;

(c) BSB Code; and

(d) Account Number

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:

(a) Full name and address of the overseas financial institution;

(b) Full name of account holder;

(c) SWIFT code; and

(d) Account Number.

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

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. The Excess is payable to the Hospital prior to receiving Treatment from the Hospital.

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.

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

If a Policy Holder makes a change to their Policy and the new Policy has a higher Excess than the previous Policy, the higher Excess will be payable immediately. If the Excess on the new Policy is lower than the previous Policy, the Excess on the Previous Policy will apply for the first two months (regardless of whether the admission is related to a Pre-existing Condition). For the following 10 months, if the admission relates to a Pre-existing Condition or pregnancy and birth related services, the previous excess will apply.

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 LV2.2.2 (General):

(a) 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:

(a) Gastric banding and obesity surgery;

(b) Psychiatric treatment;

(c) Palliative Care;

(d) Pregnancy and birth related services.

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

Excluded services are:

(a) Bone Marrow and Organ Transplants

(b) Assisted Reproductive Services

(c) Infertility Investigations

(d) 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.

for services listed as Lower Benefits – 100% of the Medicare Benefits Schedule Fee for that medical service. Lower Benefits are payable for the following:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

for services listed as excluded no benefit is payable. Excluded services are:

(a) Assisted Reproductive Service

(b) Infertility Investigations

(c) Bone Marrow and Organ Transplants

(d) 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:

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

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

Out-Patient Exclusions apply to:

(a) expenses for counselling and psychological testing;

(b) any Services provided by a registered psychologist or providers who are not a psychiatrist;

(c) group therapy or counselling sessions, including where the service is provided by a psychiatrist;

(d) Assisted reproductive Services;

(e) Infertility Investigations.

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

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

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

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:

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

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

(b) The waiting periods for Dental are as follows:

(c) 2 months for General Dental

(d) 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
:

(c) 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

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.

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.

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

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 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 $100,000. 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 LV2.2.2 (General):

(a) Couple policy;

(b) 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

(c) For services listed as Lower Benefits, Hospital Treatment Benefits shall be payable equivalent to the

(d) “Gazetted Rate” determined by the State and Territory Health Authorities for:

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

(f) emergency department fees that leads to an admission

(g) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

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

Excluded services are:

(a) Bone Marrow and Organ Transplants

(b) Assisted Reproductive Services

(c) Infertility Investigations

(d) 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:

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

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

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

for services listed as excluded no benefit is payable. Excluded services are:

(a) Assisted Reproductive Services

(b) Infertility Investigations

(c) Bone Marrow and Organ Transplants

(d) 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:

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

(a) an annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2,000 per Policy per Membership Year.

Out-Patient Exclusions apply to:

(a) expenses for counselling and psychological testing, and

(b) any Services provided by a registered psychologist or providers who are not a psychiatrist, and

(c) group therapy or counselling sessions, including where the service is provided by a psychiatrist.

(d) Assisted Reproductive Services

(e) Infertility Investigations

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

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

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:

(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.

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

These include:

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:

(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

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.

(a) Natural Therapy Benefits are subject to the following conditions:

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

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

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

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.

(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 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 $100,000. 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 LV2.2.2 (General):

(a) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(a) Bone marrow and organ transplants

(a) Assisted Reproductive Services

(b) Infertility Investigations

(c) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative care

(d) Pregnancy and birth related services

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

(a) Assisted Reproductive Services

(b) Infertility Investigations

(c) Bone Marrow and Organ Transplants

(d) 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:

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

Out-Patient Exclusions apply to:

(a) Expenses for counselling and psychological testing, and

(b) Any Services provided by a registered psychologist or providers who are not a psychiatrist, and

(c) Group therapy or counselling sessions, including where the service is provided by a psychiatrist.

(d) Assisted Reproductive Services

(e) Infertility Investigations

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

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 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 for PBS Pharmaceuticals are payable at 100% with a Membership Year annual limit of $1000 on a single plan.

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 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.

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:

2 months for General Dental

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.

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

no Benefits are payable for frames.

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:

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

These include:

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 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.

(a) Natural Therapy Benefits are subject to the following conditions:

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

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

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.

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.

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.

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

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 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 $100,000. 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 LV2.2.2 (General):

(a) Couple Policy

(b) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

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

Excluded services are:

(a) Bone Marrow and Organ Transplants

(b) Assisted reproductive Services

(c) Infertility Investigations

(d) 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.

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

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative care

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

for services that are excluded no benefit is payable. Excluded services are:
Assisted Reproductive Services

(a) Infertility Investigations

(b) Bone Marrow and Organ Transplants

(c) 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:

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

(a) an annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2,000 per Policy per Membership Year.

Out-Patient Exclusions apply to:

(a) expenses for counselling and psychological testing; and

(b) any Services provided by a registered psychologist or providers who are not a psychiatrist; and

(c) group therapy or counselling sessions, including where the service is provided by a psychiatrist.

(d) Assisted Reproductive Services

(e) Infertility Investigations

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

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

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) 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

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.

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 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.

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

These include:

(a) 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.

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.

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.

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.

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

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

LV13.24 Hearing Aids

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 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 $100,000. 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 LV2.2.2 (General):

(a) Single Policy; and

(b) Couples Policy; and

(c) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(c) Assisted Reproductive Services iv

(d) 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.

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

(b) Gastric banding and obesity surgery

(c) Psychiatric treatment

(d) Palliative Care

(e) Pregnancy and birth related services

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

(a) Bone Marrow and Organ Transplants

(b) Assisted Reproductive Services

(c) Infertility Investigations

(d) 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:

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

(a) An annual limit applies to Out-Patient psychiatric services where provided by a psychiatrist only, of $2,000 per Policy per Membership Year.

Out-Patient Exclusions apply to:

(a) Expenses for counselling and psychological testing, and

(b) Any Services provided by a registered psychologist or providers who are not a psychiatrist, and

(c) Group therapy or counselling sessions, including where the service is provided by a psychiatrist.

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

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

(a) administered to the patient during their stay in Hospital; or

(b) provided to the Insured Person on discharge from Hospital.

No Benefits are payable for 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 for PBS Pharmaceuticals 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 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:

(b) 100% of cost of each visit up to a maximum Membership Year limit of $1,000 for a Single Policy and $2000 for a couple / family policy (combined limit with Chiropractic and Osteopathy)

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 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 $100,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.

LV15 Advantage Visitor Cover

LV15.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.2 (General):

(a) Single Policy; and

(b) Couples Policy; and

(c) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(c) Assisted Reproductive Services

(d) 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

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

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(a) Bone Marrow and Organ Transplants

(b) Assisted Reproductive Services

(c) Infertility Investigations

(d) 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:

(a) Psychiatric

(b) Expenses for counselling and psychological testing, and

(c) Any Services provided by a registered psychologist or providers who are not a psychiatrist, and

(d) Group therapy or counselling sessions, including where the service is provided by a psychiatrist.

(e) Bone Marrow and Organ Transplants

(f) Assisted Reproductive Services

(g) Infertility Investigations

Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for Emergency Facilities shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities.

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 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 for PBS Pharmaceuticals are payable at 100% of cost with a Membership Year annual limit of $500 per person.

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 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 $100,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.

LV15.28 Excess

The amount of the Excess and relevant limits and conditions which apply to the Product are as follows:

(a) The Policy Holder may choose their Excess on the Product;

(b) The Excess amount options are $0 and $500;

(c) Subject to the paragraphs below, the maximum Excess payable per admission for each person under the Product will be the Excess amount option;

(d) The Excess payable for Singles will be capped to the chosen level of Excess in any Calendar Year;

(e) The Excess payable for Couples and Family Group Policies will be capped to an amount that is twice the chosen level of Excess in any Calendar Year;

(f) With the exception of Dependent Children, the Excess applies to all Insured Persons covered by the Policy;

(g) No Excess is payable for the Hospital admission of a Dependent Child covered under a Family Policy.

LV16 Budget Visitor Cover

LV16.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.2 (General):

(a) Single Policy; and

(b) Couples Policy; and

(c) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(c) Assisted Reproductive Services iv

(d) 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:

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

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

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

For services that are excluded no Benefit is 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.

(c) Assisted Reproductive Services

(d) Infertility Investigations

Benefits for medical services provided to the customer while not in a Hospital shall be as follows:

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.

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 outof 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 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 $100,000. The expenses for the cost of ambulance transport in Australia and in your home country are also claimable under this Plan.

LV16.28 Excess

The amount of the Excess and relevant limits and conditions which apply to the Product are as follows:

(a) The Policy Holder may choose their Excess on the Product;

(b) The Excess amount options are $0 and $500;

(c) Subject to the paragraphs below, the maximum Excess payable per admission for each person under the Product will be the Excess amount option;

(d) The Excess payable for Singles will be capped to the chosen level of Excess in any Calendar Year;

(e) The Excess payable for Couples and Family Group Policies will be capped to an amount that is twice the chosen level of Excess in any Calendar Year;

(f) With the exception of Dependent Children, the Excess applies to all Insured Persons covered by the Policy;

(g) No Excess is payable for the Hospital admission of a Dependent Child covered under a Family Policy.

LV17 Value Plus

LV17.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.2 (General):

(a) Single Policy; and

(b) Couples Policy; and

(c) 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

(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:

(b) for services included 100% of the Medicare Benefit Schedule (MBS) for that medical service.

(c) 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:

Out-Patient Exclusions apply to:

(a) Expenses for counselling and psychological testing, and

(b) Any Services provided by a registered psychologist or providers who are not a psychiatrist, and

(c) Group therapy or counselling sessions, including where the service is provided by a psychiatrist.

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 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 for PBS Pharmaceuticals are payable at 100% of cost with a Membership Year annual limit of $500 per person.

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 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 $100,000. 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 LV2.2.2 (Generally):

(a) Single Policy; and

(b) Couples Policy; and

(c) 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:

(a) the cost of charges for Hospital accommodation, theatre fees, labour ward, intensive care, coronary care the cost of paramedical services such as physiotherapy

(a) The cost of dressings, sutures, needles and other disposable items

(b) 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 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 for PBS Pharmaceuticals 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 Program Schedule

(d) 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

(d) 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

(c) 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.

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 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.
Doctor Health Checks	Where there is no MBS Item, or claimable through employee or another party)

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

LV20.27.1 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

Fitness Centre fees or Personal Training services where:

(a) 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

(b) 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

(c) 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.

LV23 nib Advantage Visitor Cover

LV23.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.2 (General):

(a) Single Policy; and

(b) Couples Policy; and

(c) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(c) Assisted Reproductive Services

(d) 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

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

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(a) Bone Marrow and Organ Transplants

(b) Assisted Reproductive Services

(c) Infertility Investigations

(d) 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:

(b) Psychiatric

(c) Expenses for counselling and psychological testing, and

(d) Any Services provided by a registered psychologist or providers who are not a psychiatrist, and

(e) Group therapy or counselling sessions, including where the service is provided by a psychiatrist.

(f) Bone Marrow and Organ Transplants

(g) Assisted Reproductive Services

(h) Infertility Investigations

(i) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for Emergency Facilities shall be payable equivalent to the “Gazetted Rate” determined by the State and Territory Health Authorities.

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 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 for PBS Pharmaceuticals are payable at 100% of cost with a Membership Year annual limit of $500 per person.

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

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 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 $100,000. The expenses for the cost of ambulance transport in Australia and in your home, country are also claimable under this Plan.

LV23.28 Excess

The amount of the Excess and relevant limits and conditions which apply to the Product are as follows:

(a) The Policy Holder may choose their Excess on the Product;

(b) The Excess amount options are $0 and $500;

(c) Subject to the paragraphs below, the maximum Excess payable per admission for each person under the Product will be the Excess amount option;

(d) The Excess payable for Singles will be capped to the chosen level of Excess in any Calendar Year;

(e) The Excess payable for Couples and Family Group Policies will be capped to an amount that is twice the chosen level of Excess in any Calendar Year;

(f) With the exception of Dependent Children, the Excess applies to all Insured Persons covered by the Policy;

(g) No Excess is payable for the Hospital admission of a Dependent Child covered under a Family Policy.

LV24 nib Budget Visitor Cover

LV24.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.2 (General):

(a) Single Policy; and

(b) Couples Policy; and

(c) 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:

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

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

(c) Assisted Reproductive Services

(d) 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.

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

(a) Gastric banding and obesity surgery

(b) Psychiatric treatment

(c) Palliative Care

(d) Pregnancy and birth related services

For services that are excluded no Benefit is 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.

(c) Assisted Reproductive Services

(d) Infertility Investigations

Benefits for medical services provided to the customer while not in a Hospital shall be as follows:

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.

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

(a)

Out-of-Hospital

No 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

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 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 $100,000. The expenses for the cost of ambulance transport in Australia and in your home, country are also claimable under this Plan

LV24.28 Excess

The amount of the Excess and relevant limits and conditions which apply to the Product are as follows:

(a) The Policy Holder may choose their Excess on the Product;

(b) The Excess amount options are $0 and $500;

(c) Subject to the paragraphs below, the maximum Excess payable per admission for each person under the Product will be the Excess amount option;

(d) The Excess payable for Singles will be capped to the chosen level of Excess in any Calendar Year;

(e) The Excess payable for Couples and Family Group Policies will be capped to an amount that is twice the chosen level of Excess in any Calendar Year;

(f) With the exception of Dependent Children, the Excess applies to all Insured Persons covered by the Policy;

(g) No Excess is payable for the Hospital admission of a Dependent Child covered under a Family Policy.

LV25 nib Core Extras Visitor Cover

LV25.1 Eligibility

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

(a) Single Policy; and

(b) Couples Policy; and

(c) Family Policy

LV25.2 General Conditions

The following conditions apply to all Benefits for this Table:

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

LV25.3 Hospital Treatment Benefits

No Benefits for Hospital Benefits are payable.

LV25.4 Surgically Implanted Prostheses

No Benefits for Surgically Implanted Prostheses are payable.

LV25.5 Medical Services Payments

No Benefits for Medical Services are payable.

LV25.6 Pharmaceutical Benefits

No Benefits for Pharmaceutical Benefits are payable.

LV25.7 Nursing Home Type Patients

No Benefits for Nursing Home Services are payable.

LV25.8 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.

LV25.9 Non Surgically Implanted Prostheses and Appliances

No Benefits for Non Surgically Implanted Prostheses are payable.

LV25.10 Physiotherapy

Subject to the limits contained in Schedule LV25.2 (General Conditions), the Benefits for Physiotherapy are as follows:

(a) Up to 60% of cost per visit with a limit of $400 per Insured Person, per Calendar Year

There is a 2 month waiting period for Physiotherapy.

LV25.11 Chiropractic

No Benefits for Chiropractic services Prostheses are payable.

LV25.12 Osteopathy

No Benefits for Osteopathy Services are payable.

LV25.13 Dental

Subject to the limits contained in Schedule LV25.2 (General Conditions), the Benefits for Dental are as follows:

Preventative Dental:

(a) Up to 60% of cost of each service with no limit per Insured Person, per Calendar Year

General Dental:

(a) Up to 60% of cost of each service with a limit of $600 per Insured Person, per Calendar Year.

Major Dental:

(a) Up to 60% of cost of each service with a limit of $600 per Insured Person, per Calendar Year.

The waiting periods for Dental are as follows:

2 months for Preventative Dental

2 months for General Dental

12 months for Major Dental

LV25.14 Optical

Subject to the limits contained in Schedule LV25.2 (General Conditions), the Benefits for Optical are as follows:

Optical appliances

(a) Up to 60% of cost per appliance with a limit of $250 per Insured Person, per Calendar Year

There is a 6 month waiting period for Optical.

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

LV25.15 Dietetics

No Benefits for Dietetics are payable.

LV25.16 Home nursing and home care

No Benefits for Home nursing and home care are payable.

LV25.17 Immunisations and Allergy Vaccines

No Benefits for Immunisations and Allergy Vaccines are payable.

LV25.18 Occupational Therapy

No Benefits for Occupational Therapy are payable.

LV25.19 Podiatry

No Benefits for Podiatry are payable.

LV25.20 Speech Therapy

No Benefits for Speech Therapy are payable.

LV25.21 Natural Therapies

No Benefits for Natural Therapies are payable.

LV25.22 Preventative Care Benefit

No Benefits for Preventative Care are payable.

LV25.23 CPAP Machines, Wheelchairs and Crutches

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

LV25.24 Hearing Aids

No Benefits for Hearing Aids are payable.

LV25.25 Laser Eye Surgery

No Benefits for Laser Eye Surgery are payable.

LV25.26 Antenatal and Postnatal Services

No Benefits for Antenatal and Postnatal Services are payable.

LV25.27 Other

LV25.27.1 Medical Repatriation Expenses

No Benefits for Medical Repatriation Expenses are payable

LV26 nib Standard Visitor Cover

LV26.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in LV2.2.2 (General):

(a) Single Policy; and

(b) Couples Policy; and

(c) Family Policy.

LV26.2 General Conditions

No General conditions apply

LV26.3 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; and

(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; and

(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. This is to avoid a surplus payment of Benefits.

Lower Benefits are payable for the following services:

(a) Gastric banding and obesity surgery;

(b) Psychiatric treatment;

(c) Palliative Care; and

(d) Pregnancy and birth related services.

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;

(c) Assisted Reproductive Services; and

(d) Infertility Investigations.

LV26.4 Surgically Implanted Prostheses

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

LV26.5 Medical Services Payments

Other than as expressly provided in these Rules, Benefits for Medical Services provided to an Insured Person 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.

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

(a) Gastric banding and obesity surgery;

(b) Psychiatric treatment;

(c) Palliative Care; and

(d) Pregnancy and birth related services.

For services that are excluded no benefit is payable. Excluded services are:

(a) Bone Marrow and Organ Transplants;

(b) Assisted Reproductive Services;

(c) Infertility Investigations; and

(d) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

Benefits for medical services provided to an Insured Person as an Out-Patient shall be as follows:

(a) 100% of the Medicare Benefits Schedule Fee for that medical service for General Practitioner consultations.

(b) 85% of the Medicare Benefit Schedule Fee for Out-patient specialist services including pathology, radiology, specialists and specialist services.

Out-Patient Exclusions apply to:

(a) Psychiatric;

(b) Expenses for counselling and psychological testing;

(c) Any Services provided by a registered psychologist or providers who are not a psychiatrist;

(d) Group therapy or counselling sessions, including where the service is provided by a psychiatrist;

(e) Bone Marrow and Organ Transplants;

(f) Assisted Reproductive Services;

(g) Infertility Investigations;

(h) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery; and

(i) Pregnancy and birth related services, including but not limited to obstetrician and midwife consultations, general practitioner consultations, pathology, radiology and ultrasounds related to a pregnancy.

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.

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.

LV26.6 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 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 for PBS Pharmaceuticals for expenses exceeding the equivalent of the current Pharmaceutical Benefits Scheme patient contribution for general beneficiaries are payable up to $50 per pharmaceutical item with a maximum benefit of $500 per Membership Year per Single Policy and $1,000 per Couples and Family Policy.

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.

LV26.7 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).

LV26.8 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.

LV26.9 Non Surgically Implanted Prostheses and Appliances

No Benefits are payable for Non Surgically Implanted Prostheses and Appliances.

LV26.10 Physiotherapy

No Benefits for Physiotherapy are payable.

LV26.11 Chiropractic

No Benefits for Chiropractic are payable.

LV26.12 Osteopathy

No Benefits for Osteopathy are payable.

LV26.13 Dental

No Benefits for Dental are payable.

LV26.14 Optical

No Benefits for Optical are payable.

LV26.15 Dietetics

No Benefits for Dietetics are payable.

LV26.16 Home Nursing and Home Care

No Benefits for Home nursing and home care are payable.

LV26.17 Immunisations and Allergy Vaccines

No Benefits for Immunisations and Allergy Vaccines are payable.

LV26.18 Occupational Therapy

No Benefits for Occupational Therapy are payable.

LV26.19 Podiatry

No Benefits for Podiatry are payable.

LV26.20 Speech Therapy

No Benefits for Speech Therapy are payable.

LV26.21 Natural Therapies

No Benefits for Natural Therapies are payable.

LV26.22 Preventative Care Benefit

No Benefits for Preventative Care are payable.

LV26.23 CPAP Machines, Wheelchairs and Crutches

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

LV26.24 Hearing Aids

No Benefits for Hearing Aids are payable.

LV26.25 Laser Eye Surgery

No Benefits for Laser Eye Surgery are payable.

LV26.26 Antenatal and Postnatal Services

No Benefits for this service are payable.

LV26.27 Other

LV26.27.1 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 $100,000. The expenses for the cost of ambulance transport in Australia and in your home, country are also claimable under this Plan.

LV26.28 Excess

The amount of the Excess and relevant limits and conditions which apply to the Product are as follows:

(a) The Excess amount is $500;

(b) Subject to the paragraphs below, the maximum Excess payable per admission for each person under the Product will be the Excess amount;

(c) The Excess payable for Singles will be capped to the level of Excess in any Calendar Year;

(d) The Excess payable for Couples and Family Group Policies will be capped to an amount that is twice the level of Excess in any Calendar Year;

(e) With the exception of Dependent Children, the Excess applies to all Insured Persons covered by the Policy;

(f) No Excess is payable for the Hospital admission of a Dependent Child covered under a Family Policy.

LV27 nib Visitor Care

LV27.1 Eligibility

This Table is Open to the following Policy Categories subject to the conditions contained in this Table:

(a) Single Policy; and

(b) Couples Policy.

LV27.2 General Conditions

Visas and Premiums

This Table does not satisfy Visa Condition 8501 requirement as set out by the DHA.

LV2.2.2 does not apply to this Table and is replaced with the following rule.

(a) Any Overseas Visitor in Australia, and their Partner (as listed on the visa), who holds a temporary resident visa sub-class 600, 601, 651 to visit Australia; is eligible to be an Insured Person unless nib has determined under LV2.3.3 to refuse an application.

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.

Benefits are not payable for any expenses relating to any Pre Existing Conditions for the duration of the Policy.

LV27.3 Hospital Treatment Benefits

Other than as expressly provided in these Rules, Benefits for Hospital Treatment 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 lead to an admission

In a Private Hospital that has not entered into a provider agreement with nib:

(a) not less than the basic default Benefits for Hospital accommodation, theatre fees, labour ward, intensive care and coronary care.

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

Excluded services are:

1. Accidental Injury Benefit
2. Assisted Reproductive Services
3. Bone Marrow and Organ Transplants
4. Cataracts
5. Cosmetic Surgery
6. Dialysis for Chronic Kidney Failure
7. Heart and Vascular System
8. Hospital Psychiatric Services
9. Implantation of Hearing Devices
10. Insulin Pumps
11. Joint Replacements
12. Pain Management with Device
13. Podiatric Surgery
14. Pregnancy and Birth
15. Sleep Studies
16. Weight Loss Surgery
17. Services Not Covered by Medicare

LV27.4 Surgically Implanted Prostheses

Benefits are payable at 100% of the cost for approved surgically implanted prosthetic devices as determined by the Federal Government.

LV27.5 Medical Services Payments

Other than as expressly provided in these Rules, Benefits for Medical Services provided to an Insured Person while admitted as a Patient in Hospital shall be as follows:

(a) for services included - 100% of the Medicare Benefit Schedule Fee for that medical service.

The following Medical Services are excluded and no Benefits are payable:

1. Accidental Injury Benefit
2. Assisted Reproductive Services
3. Bone Marrow and Organ Transplants
4. Cataracts
5. Cosmetic Surgery
6. Dialysis for Chronic Kidney Failure
7. Heart and Vascular System
8. Hospital Psychiatric Services
9. Implantation of Hearing Devices
10. Insulin Pumps
11. Joint Replacements
12. Pain Management with Device
13. Podiatric Surgery
14. Pregnancy and Birth
15. Sleep Studies
16. Weight Loss Surgery
17. Services Not Covered by Medicare

Benefits for medical services provided to the Insured Person as an Out-Patient shall be as follows:

(a) 100% of the Medicare Benefit Scheme Fee for that medical service for General Practitioner consultations.

(b) 100% of the Medicare Benefit Scheme Fee for Out-Patient specialist services including pathology, radiology, specialists and specialist services.

Out-Patient Exclusions apply to:

(a) Psychiatric

(b) Expenses for counselling and psychological testing, and

(c) Any Services provided by a registered psychologist or providers who are not a psychiatrist, and

(d) Group therapy or counselling sessions, including where the service is provided by a psychiatrist.

(e) Bone Marrow and Organ Transplants

(f) Assisted Reproductive Services

(g) Services not covered by Medicare such as Cosmetic Surgery (to enhance appearance) or experimental surgery.

(h) Pregnancy and birth related services, including but not limited to obstetrician and midwife consultations, general practitioner consultations, pathology, radiology and ultrasounds related to a pregnancy.

Emergency Facility – Only covered if the treatment leads to an admission as an In-Patient. Paid at 100% of the Gazetted Rate.

LV27.6 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 in 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 drugs issued for the sole purpose of use at home. These drugs are to be assessed under Out-of-Hospital pharmaceuticals

Out-of-Hospital

Pharmaceutical Benefits for PBS Pharmaceuticals for expenses exceeding the equivalent of the current Pharmaceutical Benefits Scheme patient contribution for general beneficiaries are payable up to $50 per pharmaceutical item with a maximum benefit of $300 per Membership Year per Single Policy and $600 per Couples Policy.

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.

No waiting period applies for Out-of-Hospital pharmacy.

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).

LV27.8 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.

LV27.9 Non Surgically Implanted Prostheses and Appliances

No Benefits are payable for Non Surgically Implanted Prostheses and Appliances.

LV27.10 Physiotherapy

No Benefits for Physiotherapy are payable.

LV27.11 Chiropractic

No Benefits for Chiropractic are payable.

LV27.12 Osteopathy

No Benefits for Osteopathy are payable.

LV27.13 Dental

No Benefits for Dental are payable.

LV27.14 Optical

No Benefits for Optical are payable.

LV27.15 Dietetics

No Benefits for Dietetics are payable.

LV27.16 Home Nursing and Home Care

No Benefits for Home nursing and home care are payable.

LV27.17 Immunisation and Allergy Vaccines

No Benefits for Immunisation and Allergy Vaccines are payable.

LV27.18 Occupational Therapy

No Benefits for Occupational Therapy are payable.

LV27.19 Podiatry

No Benefits for Podiatry are payable.

LV27.20 Speech Therapy

No Benefits for Speech Therapy are payable.

LV27.21 Natural Therapies

No Benefits for Natural Therapies are payable.

LV27.22 Preventative Care Benefit

No Benefits for Preventative Care are payable.

LV27.23 CPAP Machines, Wheelchairs and Crutches

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

LV27.24 Hearing Aids

No Benefits for Hearing Aids are payable.

LV27.25 Laser Eye Surgery

No Benefits for Laser Eye Surgery are payable.

LV27.26 Antenatal and Postnatal Services

No Benefits for this service are payable.

LV27.27 Other

LV27.27.1 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 $20,000. The expenses for the cost of ambulance transport in Australia and in your home, country are also claimable under this Plan.

LV27.28 Excess

The amount of the Excess and relevant limits and conditions which apply to the Product are as follows:

(a) The Excess amount is $750;

(b) Subject to the paragraphs below, the maximum Excess payable per admission for each person under the Product will be the Excess amount;

(c) The Excess payable for Singles will be capped to the level of Excess in any Calendar Year;

(d) The Excess payable for Couples Policies will be capped to an amount that is twice the level of Excess in any Calendar Year;

SCHEDULE K BASE PREMIUM RATE

Effective 1 September 2026

Schedule	Product	Scale	Yearly Base Rate
LV10, LV11	Executive Top Visitor Cover	Single	$8,617.19
		Couple	$25,578.41
		Family	$31,564.77
LV12, LV13	Top Visitor Cover	Single	$7,720.13
		Couple	$15,438.71
		Family	$19,584.42
LV14	Mid Visitor Cover	Single	$7,395.02
		Couple	$14,791.53
		Family	$19,374.96
LV15	Advantage Visitor Cover	Single	$5,137.39
		Couple	$10,270.16
		Family	$13,403.46
LV15	Advantage Visitor Cover ($500 Excess)	Single	$3,750.24
		Couple	$8,437.29
		Family	$10,611.30
LV16	Budget Visitor Cover	Single	$1,786.48
		Couple	$3,574.57
		Family	$5,191.69
LV16	Budget Visitor Cover ($500 Excess)	Single	$1,082.32
		Couple	$2,164.10
		Family	$3,142.63
LV17	Value Plus	Single	$2,707.74
		Couple	$6,101.36
		Family	$7,651.54
LV20	nib United Gold Visitor Cover	Single	$5,029.93
		Couple	$9,506.06
		Family	$16,942.81
LV23	nib Advantage Visitor Cover	Single	$5,137.39

		Couple	$10,270.16
		Family	$13,403.46
LV23	nib Advantage Visitor Cover ($500 Excess)	Single	$3,750.24
		Couple	$8,437.29
		Family	$10,611.30
LV24	nib Budget Visitor Cover	Single	$1,786.48
		Couple	$3,574.57
		Family	$5,191.69
LV24	nib Budget Visitor Cover ($500 Excess)	Single	$1,082.32
		Couple	$2,164.10
		Family	$3,142.63
LV25	nib Core Extras Visitor Cover	Single	$881.89
		Couple	$1,763.78
		Family	$1,852.14
LV26	nib Standard Visitor Cover ($500 excess)	Single	$1,775.47
		Couple	$3,905.32
		Family	$5,396.89
LV27	nib Visitor Care	Single	$797.89
		Couple	$1,994.72

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,
LV25 nib Core Extras 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;

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Comprehensive oral examination	011	100%	100%	100%	100%	100%	60%
Periodic oral examination	012	100%	100%	100%	100%	100%	60%
Oral examination – limited	013	100%	100%	100%	100%	100%	60%
Consultation	014	100%	100%	100%	100%	100%	60%
Consultation – extended (30 minutes or more)	015	100%	100%	100%	100%	100%	60%
Consultation by referral	016	100%	100%	100%	100%	100%	60%
Consultation by referral – extended (30 minutes or more)	017	100%	100%	100%	100%	100%	60%
Written report (not elsewhere included)	018	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Referral	019	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Intraoral radiograph – per exposure	022	100%	100%	100%	100%	100%	60%
Cone Beam Computed Tomography – scan acquisition – per appointment	026	100%	100%	100%	100%	100%	60%
Extraoral radiograph – maxillary, mandibular – per exposure	031	100%	100%	100%	100%	100%	60%
Lateral, antero-posterior, postero-anterior or submento-vertex radiograph of the skull – per exposure	033	100%	100%	100%	100%	100%	60%
Radiograph of temporomandibular joint – per exposure	035	100%	100%	100%	100%	100%	60%
Cephalometric radiograph – lateral, antero-posterior, postero-anterior or submento-vertex – per exposure	036	100%	100%	100%	100%	100%	60%
Panoramic radiograph – per exposure	037	100%	100%	100%	100%	100%	60%
Hand-wrist radiograph for skeletal age assessment	038	100%	100%	100%	100%	100%	60%
Computed Tomography of the skull or parts thereof	039	100%	100%	100%	100%	100%	60%
Bacteriological examination	041	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Culture examination and identification	042	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Antibiotic sensitivity test	043	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Collection of specimen for pathology examination	044	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Saliva screening test	047	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Microbiological screening test	048	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Biopsy of tissue	051	100%	100%	100%	100%	100%	60%
Histopathological examination of tissue	052	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Cytological investigation	053	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Blood collection	055	100%	100%	100%	100%	100%	60%
Haematological examination	056	100%	100%	100%	100%	100%	60%
Procedures to derive biologically active components from a collection of blood	057	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Comprehensive head and neck cancer examination and risk assessment	059	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Pulp testing – per appointment	061	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Diagnostic model – per model	071	100%	100%	100%	100%	100%	60%
Photographic records – intraoral – per appointment	072	100%	100%	100%	100%	100%	60%
Photographic records – extraoral – per appointment	073	100%	100%	100%	100%	100%	60%
Diagnostic modelling – physical – per tooth	074	100%	100%	100%	100%	100%	60%
Diagnostic modelling – digital – per tooth	075	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Intraoral evaluation of diagnostic modelling – per tooth or tooth replacement	076	100%	100%	100%	100%	100%	60%
Cephalometric analysis – excluding radiographs	081	100%	100%	100%	100%	100%	60%
Tooth-jaw size prediction analysis	082	100%	100%	100%	100%	100%	60%
Tomographic analysis	083	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Cone Beam Computed Tomography analysis and/or interpretation – small field of view (less than one complete dental arch)	087	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Cone Beam Computed Tomography analysis and/or interpretation – maxillary or mandibular dentition (single arch)	088	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Cone Beam Computed Tomography analysis and/or interpretation – maxillary and mandibular dentition (both arches)	089	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Cone Beam Computed Tomography analysis and/or interpretation – temporomandibular joints only	090	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Cone Beam Computed Tomography analysis and/or interpretation – orofacial structures	091	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Removal of plaque and/or stain	111	100%	100%	100%	100%	100%	60%
Recontouring and polishing of pre-existing restoration(s) – per tooth	113	100%	100%	100%	100%	100%	60%
Removal of calculus – first appointment	114	100%	100%	100%	100%	100%	60%
Removal of calculus – subsequent appointment	115	100%	100%	100%	100%	100%	60%
Enamel micro-abrasion – per tooth	116	100%	100%	100%	100%	100%	60%
Bleaching, internal – per application	117	100%	100%	100%	100%	100%	60%
Bleaching, external – per tooth	118	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Bleaching, home application	119	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Topical application of remineralisation agents, one treatment	121	100%	100%	100%	100%	100%	60%
Topical remineralisation agents, home application – per arch	122	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Application of a cariostatic agent – per tooth	123	100%	100%	100%	100%	100%	60%
Dietary analysis and advice	131	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Oral hygiene instruction	141	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Tobacco counselling	142	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Provision of a mouthguard – indirect	151	100%	100%	100%	100%	100%	60%
Bi-maxillary mouthguard – indirect	153	100%	100%	100%	100%	100%	60%
Fissure and/or tooth surface sealing – per tooth	161	100%	100%	100%	100%	100%	60%
Resin infiltration – per tooth	163	100%	100%	100%	100%	100%	60%

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Desensitising procedure – per appointment	165	100%	100%	100%	100%	100%	No Benefit
Odontoplasty – per tooth	171	100%	100%	100%	100%	100%	No Benefit
Treatment of acute periodontal infection – per appointment	213	100%	100%	100%	100%	100%	60%
Clinical periodontal analysis and recording	221	100%	100%	100%	100%	100%	60%
Periodontal debridement – per tooth	222	100%	100%	100%	100%	100%	60%
Non-surgical treatment of peri-implant disease – per implant	223	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Gingivectomy – per tooth	231	100%	100%	100%	100%	80%	No Benefit
Periodontal flap surgery – per tooth	232	100%	100%	100%	100%	80%	60%
Surgical treatment of peri-implant disease – per implant	233	100%	100%	100%	100%	80%	60%
Application of biologically active material	234	100%	100%	100%	100%	80%	60%
Gingival graft – per tooth, implant or extraction socket	235	100%	100%	100%	100%	80%	60%
Guided tissue regeneration – per tooth or implant	236	100%	100%	100%	100%	80%	60%
Guided tissue regeneration – membrane removal	237	100%	100%	100%	100%	80%	60%
Periodontal surgery for crown lengthening – per tooth	238	100%	100%	100%	100%	80%	60%
Gingival xenograft – per tooth	239	100%	100%	100%	100%	80%	60%
Root resection – per root	241	100%	100%	100%	100%	80%	60%
Osseous surgery – per tooth or implant	242	100%	100%	100%	100%	80%	60%
Osseous graft – per tooth or implant	243	100%	100%	100%	100%	80%	60%
Osseous graft – block	244	100%	100%	100%	100%	80%	60%
Periodontal surgery involving one tooth	245	100%	100%	100%	100%	80%	60%
Maxillary sinus augmentation – trans-alveolar technique – per sinus	246	100%	100%	100%	100%	100%	60%
Maxillary sinus augmentation – lateral wall approach – per sinus	247	100%	100%	100%	100%	100%	60%
Active non-surgical periodontal therapy – per quadrant	250	100%	100%	100%	100%	100%	60%
Supportive periodontal therapy – per appointment	251	100%	100%	100%	100%	100%	60%
Removal of a tooth or part(s) thereof	311	100%	100%	100%	100%	100%	60%
Sectional removal of a tooth or part(s) thereof	314	100%	100%	100%	100%	100%	60%
Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division	322	100%	100%	100%	100%	80%	60%
Surgical removal of a tooth or tooth fragment requiring bone removal and/or tooth division	324	100%	100%	100%	100%	80%	60%
Alveoloplasty – per segment	331	100%	100%	100%	100%	80%	60%
Ostectomy – per jaw	332	100%	100%	100%	100%	80%	60%
Reduction of fibrous tuberosity	337	100%	100%	100%	100%	80%	60%
Reduction of flabby ridge – per segment	338	100%	100%	100%	100%	80%	60%
Removal of hyperplastic tissue	341	100%	100%	100%	100%	80%	60%
Repositioning of muscle attachment	343	100%	100%	100%	100%	80%	60%
Vestibuloplasty	344	100%	100%	100%	100%	80%	60%

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Skin or mucosal graft	345	100%	100%	100%	100%	80%	60%
Repair of skin and subcutaneous tissue or mucous membrane	351	100%	100%	100%	100%	80%	60%
Fracture of maxilla or mandible – not requiring fixation	352	100%	100%	100%	100%	80%	60%
Fracture of maxilla or mandible – with wiring of teeth or intraoral fixation	353	100%	100%	100%	100%	80%	60%
Fracture of maxilla or mandible – with external fixation	354	100%	100%	100%	100%	80%	60%
Fracture of zygoma	355	100%	100%	100%	100%	80%	60%
Fracture of the maxilla or mandible requiring open reduction	359	100%	100%	100%	100%	80%	60%
Mandible – relocation following dislocation	361	100%	100%	100%	100%	80%	60%
Mandible – relocation requiring open operation	363	100%	100%	100%	100%	80%	60%
Osteotomy – maxilla	365	100%	100%	100%	100%	80%	60%
Osteotomy – mandible	366	100%	100%	100%	100%	80%	60%
Removal of tumour, cyst or scar – cutaneous, subcutaneous or in mucous membrane	371	100%	100%	100%	100%	80%	60%
Removal of tumour, cyst or scar involving muscle, bone or other deep tissue	373	100%	100%	100%	100%	80%	60%
Surgery to salivary duct	375	100%	100%	100%	100%	80%	60%
Surgery to salivary gland	376	100%	100%	100%	100%	80%	60%
Repair of soft tissue	377	100%	100%	100%	100%	80%	60%
Surgical removal of foreign body	378	100%	100%	100%	100%	80%	60%
Marsupialisation of cyst	379	100%	100%	100%	100%	80%	60%
Surgical exposure of an unerupted tooth – per tooth	381	100%	100%	100%	100%	80%	60%
Surgical exposure and attachment of device for orthodontic traction	382	100%	100%	100%	100%	80%	60%
Repositioning of displaced tooth/teeth – per tooth	384	100%	100%	100%	100%	80%	60%
Surgical repositioning of unerupted tooth – per tooth	385	100%	100%	100%	100%	80%	60%
Splinting of displaced tooth/teeth – per displaced tooth	386	100%	100%	100%	100%	80%	60%
Replantation and splinting of a tooth – per avulsed or intentionally removed tooth	387	100%	100%	100%	100%	80%	60%
Transplantation of tooth or tooth bud	388	100%	100%	100%	100%	80%	60%
Surgery to isolate and preserve neurovascular tissue	389	100%	100%	100%	100%	80%	60%
Surgical intervention of a frenum	391	100%	100%	100%	100%	80%	60%
Drainage of abscess	392	100%	100%	100%	100%	80%	60%
Surgery involving the maxillary antrum	393	100%	100%	100%	100%	80%	60%
Surgery for osteomyelitis	394	100%	100%	100%	100%	80%	60%
Repair of nerve trunk	395	100%	100%	100%	100%	80%	60%
Control of reactionary or secondary post-operative haemorrhage	399	100%	100%	100%	100%	80%	60%
Direct pulp capping	411	100%	100%	100%	100%	80%	60%
Incomplete endodontic therapy (tooth not suitable for further treatment)	412	100%	100%	100%	100%	80%	60%

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Pulpotomy	414	100%	100%	100%	100%	80%	60%
Complete chemo-mechanical preparation of root canal – one canal	415	100%	100%	100%	100%	80%	60%
Complete chemo-mechanical preparation of root canal – each additional canal	416	100%	100%	100%	100%	80%	60%
Root canal obturation – one canal	417	100%	100%	100%	100%	80%	60%
Root canal obturation – each additional canal	418	100%	100%	100%	100%	80%	60%
Extirpation of pulp or debridement of root canal(s)	419	100%	100%	100%	100%	80%	60%
Resorbable root canal filling – primary tooth	421	100%	100%	100%	100%	80%	60%
Periapical curettage – per root	431	100%	100%	100%	100%	80%	60%
Apicectomy – per root	432	100%	100%	100%	100%	80%	60%
Exploratory periradicular surgery	433	100%	100%	100%	100%	80%	60%
Apical seal – per canal	434	100%	100%	100%	100%	80%	60%
Sealing of perforation	436	100%	100%	100%	100%	80%	60%
Surgical treatment and repair of external root resorption – per tooth	437	100%	100%	100%	100%	80%	60%
Hemisection	438	100%	100%	100%	100%	80%	60%
Exploration and/or negotiation of a calcified canal – per canal, per appointment	445	100%	100%	100%	100%	80%	60%
Removal of root filling – per canal	451	100%	100%	100%	100%	80%	60%
Removal of a cemented root canal post or post crown	452	100%	100%	100%	100%	80%	60%
Removal or bypassing fractured endodontic instrument	453	100%	100%	100%	100%	80%	60%
Additional appointment for irrigation and/or dressing of the root canal system – per tooth	455	100%	100%	100%	100%	80%	60%
Obturation of resorption defect or perforation (non-surgical)	457	100%	100%	100%	100%	80%	60%
Guided endodontic repair – per tooth	459	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Metallic restoration – one surface – direct	511	100%	100%	100%	100%	100%	60%
Metallic restoration – two surfaces – direct	512	100%	100%	100%	100%	100%	60%
Metallic restoration – three surfaces – direct	513	100%	100%	100%	100%	100%	60%
Metallic restoration – four surfaces – direct	514	100%	100%	100%	100%	100%	60%
Metallic restoration – five surfaces – direct	515	100%	100%	100%	100%	100%	60%
Adhesive restoration – one surface – anterior tooth – direct	521	100%	100%	100%	100%	100%	60%
Adhesive restoration – two surfaces – anterior tooth – direct	522	100%	100%	100%	100%	100%	60%
Adhesive restoration – three surfaces – anterior tooth – direct	523	100%	100%	100%	100%	100%	60%
Adhesive restoration – four surfaces – anterior tooth – direct	524	100%	100%	100%	100%	100%	60%
Adhesive restoration – five surfaces – anterior tooth – direct	525	100%	100%	100%	100%	100%	60%
Adhesive restoration – veneer – anterior tooth – direct	526	100%	100%	100%	100%	100%	60%
Adhesive restoration – one surface – posterior tooth – direct	531	100%	100%	100%	100%	100%	60%
Adhesive restoration – two surfaces – posterior tooth – direct	532	100%	100%	100%	100%	100%	60%

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Adhesive restoration – three surfaces – posterior tooth – direct	533	100%	100%	100%	100%	100%	60%
Adhesive restoration – four surfaces – posterior tooth – direct	534	100%	100%	100%	100%	100%	60%
Adhesive restoration – five surfaces – posterior tooth – direct	535	100%	100%	100%	100%	100%	60%
Adhesive restoration – veneer – posterior tooth – direct	536	100%	100%	100%	100%	100%	60%
Metallic restoration – one surface – indirect	541	100%	100%	100%	100%	80%	60%
Metallic restoration – two surfaces – indirect	542	100%	100%	100%	100%	80%	60%
Metallic restoration – three surfaces – indirect	543	100%	100%	100%	100%	80%	60%
Metallic restoration – four surfaces – indirect	544	100%	100%	100%	100%	80%	60%
Metallic restoration – five surfaces – indirect	545	100%	100%	100%	100%	80%	60%
Tooth-coloured restoration – one surface – indirect	551	100%	100%	100%	100%	80%	60%
Tooth-coloured restoration – two surfaces – indirect	552	100%	100%	100%	100%	80%	60%
Tooth-coloured restoration – three surfaces – indirect	553	100%	100%	100%	100%	80%	60%
Tooth-coloured restoration – four surfaces – indirect	554	100%	100%	100%	100%	80%	60%
Tooth-coloured restoration – five surfaces – indirect	555	100%	100%	100%	100%	80%	60%
Tooth-coloured restoration – veneer – indirect	556	100%	100%	100%	100%	80%	60%
Adaptation of new restoration to existing removable prosthesis – per tooth	571	100%	100%	100%	100%	80%	60%
Provisional/interim restoration – per tooth	572	100%	100%	100%	100%	100%	60%
Metal band	574	100%	100%	100%	100%	100%	60%
Pin retention – per pin	575	100%	100%	100%	100%	100%	60%
Cusp capping – per cusp	577	100%	100%	100%	100%	100%	60%
Restoration of an incisal corner – per corner	578	100%	100%	100%	100%	100%	60%
Bonding of tooth fragment	579	100%	100%	100%	100%	100%	60%
Preformed full crown – metallic – significant tooth preparation	586	100%	100%	100%	100%	80%	60%
Preformed full crown – metallic – minimal tooth preparation	587	100%	100%	100%	100%	80%	60%
Preformed full crown – tooth-coloured	588	100%	100%	100%	100%	80%	60%
Removal of indirect restoration	595	100%	100%	100%	100%	80%	60%
Recementing of indirect restoration	596	100%	100%	100%	100%	80%	60%
Post – direct	597	100%	100%	100%	100%	80%	60%
Restoration root capping – direct	598	100%	100%	100%	100%	100%	60%
Full crown – polymeric material – indirect	611	100%	100%	100%	100%	80%	60%
Full crown – ceramic – indirect	613	100%	100%	100%	100%	80%	60%
Full crown – veneered – indirect	615	100%	100%	100%	100%	80%	60%
Full crown – metallic – indirect	618	100%	100%	100%	100%	80%	60%
Post and core for crown – indirect	625	100%	100%	100%	100%	80%	60%
Preliminary restoration for crown – direct	627	100%	100%	100%	100%	80%	60%
Post and root cap – indirect	629	100%	100%	100%	100%	80%	60%

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Provisional crown – per tooth	631	100%	100%	100%	100%	80%	60%
Provisional bridge pontic – per pontic	632	100%	100%	100%	100%	80%	60%
Provisional implant abutment – per abutment	633	100%	100%	100%	100%	80%	60%
Provisional implant restoration – per implant abutment	634	100%	100%	100%	100%	80%	60%
Bridge pontic – direct – per pontic	642	100%	100%	100%	100%	80%	60%
Bridge pontic – indirect – per pontic	643	100%	100%	100%	100%	80%	60%
Semi-fixed attachment	644	100%	100%	100%	100%	80%	60%
Precision or magnetic attachment	645	100%	100%	100%	100%	80%	60%
Bonded retainer – direct – per tooth	648	100%	100%	100%	100%	80%	60%
Bonded retainer – indirect – per tooth	649	100%	100%	100%	100%	80%	60%
Recementing crown or veneer	651	100%	100%	100%	100%	80%	60%
Recementing bridge or splint – per abutment	652	100%	100%	100%	100%	80%	60%
Rebonding of bridge or splint where retreatment of bridge surface is required	653	100%	100%	100%	100%	80%	60%
Removal of crown	655	100%	100%	100%	100%	80%	60%
Removal of bridge or splint	656	100%	100%	100%	100%	80%	60%
Repair of crown or bridge – indirect – per crown or pontic	658	100%	100%	100%	100%	80%	60%
Repair of crown, bridge or veneer – direct – per crown, pontic or veneer	659	100%	100%	100%	100%	80%	60%
Fitting of implant abutment – per abutment	661	100%	100%	100%	100%	80%	60%
Removal of implant and/or retention device	663	100%	100%	100%	100%	80%	60%
Fitting of bar for denture – per tooth or implant	664	100%	100%	100%	100%	80%	60%
Prosthesis with resin base attached to implants – removable – per arch	665	100%	100%	100%	100%	80%	60%
Prosthesis with metal frame attached to implants – fixed – per arch	666	100%	100%	100%	100%	80%	60%
Prosthesis with metal frame attached to implants – removable – per arch	667	100%	100%	100%	100%	80%	60%
Implant prosthetic screw replacement	668	100%	100%	100%	100%	80%	60%
Removal and reattachment of prosthesis fixed to implant(s) – per implant	669	100%	100%	100%	100%	80%	60%
Full crown attached to osseointegrated implant – non-metallic – indirect	671	100%	100%	100%	100%	80%	60%
Full crown attached to osseointegrated implant – veneered – indirect	672	100%	100%	100%	100%	80%	60%
Full crown attached to osseointegrated implant – metallic – indirect	673	100%	100%	100%	100%	80%	60%
Diagnostic template	678	100%	100%	100%	100%	80%	60%
Surgical implant guide	679	100%	100%	100%	100%	80%	60%
Insertion of the first stage of two-stage endosseous implant – per implant	684	100%	100%	100%	100%	80%	60%
Insertion of the first stage of two-stage maxillofacial endosseous implant – per implant	685	100%	100%	100%	100%	80%	60%
Insertion of a one-stage maxillofacial endosseous implant – per implant	686	100%	100%	100%	100%	80%	60%

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Insertion of a mini-implant – per implant	687	100%	100%	100%	100%	80%	60%
Insertion of a one-stage endosseous implant – per implant	688	100%	100%	100%	100%	80%	60%
Provisional implant	689	100%	100%	100%	100%	80%	60%
Provisional retention or anchorage device	690	100%	100%	100%	100%	80%	60%
Second-stage surgery of two-stage endosseous implant – per implant	691	100%	100%	100%	100%	80%	60%
Closure of screw access chamber	692	100%	100%	100%	100%	80%	60%
Remodelling of a fixed implant prosthesis	693	100%	100%	100%	100%	80%	60%
Repair or replacement of the ceramic component of an implant metal-ceramic or all ceramic crown or bridge – per prosthetic tooth	694	100%	100%	100%	100%	80%	60%
Cleaning and polishing of an implant prosthesis	695	100%	100%	100%	100%	80%	60%
Removal of fractured abutment screw	696	100%	100%	100%	100%	80%	60%
Complete maxillary denture	711	100%	100%	100%	100%	80%	60%
Complete mandibular denture	712	100%	100%	100%	100%	80%	60%
Provisional complete maxillary denture	713	100%	100%	100%	100%	80%	60%
Provisional complete mandibular denture	714	100%	100%	100%	100%	80%	60%
Provisional complete maxillary and mandibular dentures	715	100%	100%	100%	100%	80%	60%
Metal palate or plate	716	100%	100%	100%	100%	80%	60%
Complete maxillary and mandibular dentures	719	100%	100%	100%	100%	80%	60%
Partial maxillary denture – resin base	721	100%	100%	100%	100%	80%	60%
Partial mandibular denture – resin base	722	100%	100%	100%	100%	80%	60%
Provisional partial maxillary denture	723	100%	100%	100%	100%	80%	60%
Provisional partial mandibular denture	724	100%	100%	100%	100%	80%	60%
Partial maxillary denture – custom fabricated metal framework	727	100%	100%	100%	100%	80%	60%
Partial mandibular denture – custom fabricated metal framework	728	100%	100%	100%	100%	80%	60%
Retainer (clasp) – per tooth	731	100%	100%	100%	100%	80%	60%
Occlusal rest – per rest	732	100%	100%	100%	100%	80%	60%
Tooth/teeth (partial denture)	733	100%	100%	100%	100%	80%	60%
Overlays – per tooth	734	100%	100%	100%	100%	80%	60%
Precision or magnetic denture attachment	735	100%	100%	100%	100%	80%	60%
Immediate tooth replacement – per tooth	736	100%	100%	100%	100%	80%	60%
Resilient lining	737	100%	100%	100%	100%	80%	60%
Wrought bar	738	100%	100%	100%	100%	80%	60%
Metal backing of denture teeth – per backing	739	100%	100%	100%	100%	80%	60%
Adjustment of a denture	741	100%	100%	100%	100%	80%	60%
Relining – complete denture – processed	743	100%	100%	100%	100%	80%	60%
Relining – partial denture – processed	744	100%	100%	100%	100%	80%	60%
Remodelling – complete denture	745	100%	100%	100%	100%	80%	60%

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Remodelling – partial denture	746	100%	100%	100%	100%	80%	60%
Relining – complete denture – direct	751	100%	100%	100%	100%	80%	60%
Relining – partial denture – direct	752	100%	100%	100%	100%	80%	60%
Cleaning and polishing of pre-existing denture	753	100%	100%	100%	100%	80%	60%
Denture base modification	754	100%	100%	100%	100%	80%	60%
Maintenance of overdenture attachment – per attachment	755	100%	100%	100%	100%	80%	60%
Reattaching pre-existing retainer (clasp) to denture	761	100%	100%	100%	100%	80%	60%
Replacing/adding retainer (clasp) to denture – per retainer (clasp)	762	100%	100%	100%	100%	80%	60%
Repairing broken base of a complete denture	763	100%	100%	100%	100%	80%	60%
Repairing broken base of a partial denture	764	100%	100%	100%	100%	80%	60%
Replacing and/or adding a new tooth to a denture or implant prosthesis – per tooth	765	100%	100%	100%	100%	80%	60%
Reattaching an existing tooth on denture – per denture tooth	766	100%	100%	100%	100%	80%	60%
Adding a denture tooth to a partial denture to replace an extracted or decoronated tooth – per denture tooth	768	100%	100%	100%	100%	80%	60%
Repair or addition to metal frame	769	100%	100%	100%	100%	80%	60%
Tissue conditioning – per application	771	100%	100%	100%	100%	80%	60%
Splint – resin	772	100%	100%	100%	100%	80%	60%
Splint – metal – indirect	773	100%	100%	100%	100%	80%	60%
Characterisation of denture base	775	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Impression – denture repair/modification	776	100%	100%	100%	100%	80%	60%
Identification	777	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Inlay for denture tooth	778	100%	100%	100%	100%	80%	60%
Surgical guide for an immediate denture	779	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Obturator	781	100%	100%	100%	100%	80%	60%
Surgical/interim obturator	782	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Revision of surgical/interim obturator	783	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
interim or diagnostic Maxillofacial prosthesis	785	100%	100%	100%	100%	80%	60%
Mandibular resection prosthesis	786	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Extraoral prosthesis – ear	787	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Extraoral prosthesis – nose	788	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Extraoral prosthesis – eye	789	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Adjustment of a maxillofacial prosthesis	790	100%	100%	100%	100%	80%	60%
Passive removable appliance – per arch	811	100%	100%	100%	100%	60%	No Benefit
Active removable appliance – per arch	821	100%	100%	100%	100%	60%	No Benefit
Functional orthopaedic appliance – custom fabrication	823	100%	100%	100%	100%	60%	No Benefit
Functional orthopaedic appliance – prefabricated	824	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Sequential plastic aligners – per arch	825	100%	100%	100%	100%	60%	No Benefit
Partial banding – per arch	829	100%	100%	100%	100%	60%	No Benefit
Full arch banding – per arch	831	100%	100%	100%	100%	60%	No Benefit
Removal of banding – per arch	833	100%	100%	100%	100%	60%	No Benefit
Fixed palatal or lingual arch appliance	841	100%	100%	100%	100%	60%	No Benefit
Partial banding for inter-maxillary elastics (vertical and/or cross elastics)	842	100%	100%	100%	100%	60%	No Benefit
Expansion appliance – fixed – per arch	843	100%	100%	100%	100%	60%	No Benefit
Sagittal movement appliance	844	100%	100%	100%	100%	60%	No Benefit
Passive appliance – fixed	845	100%	100%	100%	100%	60%	No Benefit
Minor tooth guidance – fixed	846	100%	100%	100%	100%	60%	No Benefit
Extraoral appliance	851	100%	100%	100%	100%	60%	No Benefit
Bonding of attachment for application of orthodontic force	862	100%	100%	100%	100%	60%	No Benefit
Orthodontic adjustment	871	100%	100%	100%	100%	60%	No Benefit
Reattachment of passive appliance – fixed	872	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Repair of passive appliance – fixed	873	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Removal of passive appliance – fixed	874	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Repair of removable appliance – resin base	875	100%	100%	100%	100%	60%	No Benefit
Repair of removable appliance – clasp, spring or tooth	876	100%	100%	100%	100%	60%	No Benefit
Addition to removable appliance – clasp, spring or tooth	877	100%	100%	100%	100%	60%	No Benefit
Relining – removable appliance – processed	878	100%	100%	100%	100%	60%	No Benefit
Course of orthodontic treatment	881	100%	100%	100%	100%	60%	No Benefit
Course of orthodontic treatment with orthognathic surgery	882	100%	100%	100%	100%	60%	No Benefit
Palliative care – per appointment	911	100%	100%	100%	100%	100%	60%
After-hours callout	915	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Travel to provide services	916	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Teleconsultation	919	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Extended teleconsultation (30 minutes or more)	920	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Teleconsultation by referral	921	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Individually made tray – medicament(s)	926	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Provision of medication/medicament	927	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Intravenous cannulation and establishment of infusion	928	100%	100%	100%	100%	100%	60%
Provision of neuromodulator therapy	929	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Local anaesthesia	941	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Sedation – intravenous – per 30 minutes or part thereof	942	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Relative analgesia – inhalation of nitrous oxide and oxygen mixture – per 30 minutes or part thereof	943	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit

Item Description	Item Number	LV10 Executive Top Single	LV11 Executive Top Couple /Family	LV12 Top Singles	LV13 Top Couple/ Family	LV20 nib United Gold Visitor Cover	LV25 nib Core Extras Visitor Cover
Relaxation therapy	944	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Low level laser therapy – per appointment	945	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Dental acupuncture – per appointment	948	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Treatment under general anaesthesia/sedation	949	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Minor occlusal adjustment – per appointment	961	100%	100%	100%	100%	100%	60%
Clinical occlusal analysis, including muscle and joint palpation	963	100%	100%	100%	100%	100%	60%
Registration and mounting of models for occlusal analysis	964	100%	100%	100%	100%	100%	60%
Occlusal appliance	965	100%	100%	100%	100%	100%	60%
Adjustment of pre-existing occlusal appliance – per appointment	966	100%	100%	100%	100%	100%	60%
Pantographic tracing	967	100%	100%	100%	100%	100%	60%
Occlusal adjustment following occlusal analysis – per appointment	968	100%	100%	100%	100%	100%	60%
Physical therapy for temporomandibular joint and associated structures – per appointment	971	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Repair/addition – occlusal appliance	972	100%	100%	100%	100%	100%	60%
Splinting and stabilisation – direct – per tooth	981	100%	100%	100%	100%	100%	60%
Enamel stripping – per appointment	982	100%	100%	100%	100%	100%	60%
Mandibular advancement appliance for diagnosed snoring and obstructive sleep apnoea	984	100%	100%	100%	100%	100%	60%
Repair/addition – snoring or sleep apnoea device	985	100%	100%	100%	100%	100%	60%
Post-operative care not otherwise included	986	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Recontour tissue – per appointment	987	100%	100%	100%	100%	100%	60%
Treatment not otherwise included (specify)	990	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
GST	999	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit

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
LV25 nib Core Extras 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.

ITEM NUMBER	DESCRIPTION OF SERVICE	LV10	LV11	LV12	LV13	LV20	LV25
		Executive Top Singles	Executive Top Couples /Families	Top Singles	Top Couples / Families	nib United Gold Visitor Cover	nib Core Extras Visitor Cover
9460	Rigid spherical lens - pair	100%	100%	100%	100%	100%	60%
9461	Rigid Toric Lens - pair	100%	100%	100%	100%	100%	60%
9464	Soft spherical lens (non disposable) - pair	100%	100%	100%	100%	100%	60%
9465	Soft toric lens - pair	100%	100%	100%	100%	100%	60%
9466	Rigid spherical lens - single	100%	100%	100%	100%	100%	60%
9467	Rigid Toric lens - single	100%	100%	100%	100%	100%	60%
9468	One only hard (non PMMA)spherical lens	100%	100%	100%	100%	100%	nil
9469	One only hard (non PMMA)Toric lens	100%	100%	100%	100%	100%	nil
9470	Soft spherical lens (non disposable) - single	100%	100%	100%	100%	100%	60%
9471	Soft toric lens	100%	100%	100%	100%	100%	60%
9472	Frames	nil	nil	nil	nil	100%	60%
9475	Bifocal spectacle lens - pair	100%	100%	100%	100%	100%	60%
9476	Multifocal (trifocal or progressive) spectacle lens - pair	100%	100%	100%	100%	100%	60%
9479	Bifocal spectacle lens - single	100%	100%	100%	100%	100%	60%
9480	Multifocal (trifocal or progressive) spectacle lens - single	100%	100%	100%	100%	100%	60%
9481	Extended wear - pair	100%	100%	100%	100%	100%	60%
9482	Other contact lens - single	100%	100%	100%	100%	100%	60%
9483	Repair	100%	100%	100%	100%	100%	60%
9484	Single vision lens - pair	100%	100%	100%	100%	100%	60%
9485	Single vision lens - single	100%	100%	100%	100%	100%	60%
9486	Bifocal contact lens - pair	100%	100%	100%	100%	100%	60%
9487	Bifocal contact lens - single	100%	100%	100%	100%	100%	60%
9489	Frequent replacement/spherical lens – single or pair	100%	100%	100%	100%	100%	60%
9493	Frequent replacement toric lens – single or pair	100%	100%	100%	100%	100%	60%
9873	Orthokeratology contact lens - single	100%	100%	100%	100%	100%	60%
9874	Orthokeratology contact lens - pair	100%	100%	100%	100%	100%	60%
611	High Index Material (single)	nil	nil	nil	nil	nil	nil

ITEM NUMBER	DESCRIPTION OF SERVICE	LV10	LV11	LV12	LV13	LV20	LV25
		Executive Top Singles	Executive Top Couples /Families	Top Singles	Top Couples / Families	nib United Gold Visitor Cover	nib Core Extras Visitor Cover
612	High Index Material (pair)	nil	nil	nil	nil	nil	nil
621	Aspheric Design (single)	nil	nil	nil	nil	nil	nil
622	Aspheric Design (pair)	nil	nil	nil	nil	nil	nil
631	Lens Tinting (single)	nil	nil	nil	nil	nil	nil
632	Lens Tinting (Pair)	nil	nil	nil	nil	nil	nil
641	Photochromatic (Glass) (single)	nil	nil	nil	nil	nil	nil
642	Photochromatic (Glass((pair)	nil	nil	nil	nil	nil	nil
643	Photochromatic (Plastic) (single)	nil	nil	nil	nil	nil	nil
644	Photochromatic (Plastic((pair)	nil	nil	nil	nil	nil	nil
651	Hard Coating (single)	nil	nil	nil	nil	nil	nil
652	Hard Coating (pair)	nil	nil	nil	nil	nil	nil
661	Multi/Anti-reflective Coating (single)	nil	nil	nil	nil	nil	nil
662	Multi/Anti-reflective Caoting (pair)	nil	nil	nil	nil	nil	nil
671	UV Coating (single)	nil	nil	nil	nil	nil	nil
672	UV Coating (pair)	nil	nil	nil	nil	nil	nil
681	Glass Lens hardening (single)	nil	nil	nil	nil	nil	nil
682	Glass lens Hardening (pair)	nil	nil	nil	nil	nil	nil
691	Fresnel Lens/Prism (single)	nil	nil	nil	nil	nil	nil
692	Fresnel Lens/Prism (pair)	nil	nil	nil	nil	nil	nil

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.

Item	Requirements	Additional Points	Item limits (if applicable)
Nebulizer	Letter of recommendation from a Medical Practitioner / Specialist required	n/a	1 per person every 2 years
Ankle-Foot Orthosis (Include Pnuematic Boot)	Only payable pre & post-surgery. Letter of recommendation from specialist required. Braces must have rigid support and must be fitted and assessed by a qualified practitioner	n/a	2 per person per year
Knee Brace		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.	1 per person per year
Back Brace		n/a	1 per person per year
Shoulder Brace		n/a	1 per person per year
Knee-Ankle Foot Orthosis (Include Pneumatic Boot)		n/a	2 per person per year
Rigid Neck Brace		3 types of rigid neck braces have been identified: the aspen collar, OA Plastic Collar and the Royce Philadelphia Collar	1 per person per year
Blood Glucose Monitor (also known as Reflolux or medisense softact machine)	Letter of recommendation from a Medical Practitioner / Specialist required	n/a	2 per policy per year
Surgical Stockings	Letter of recommendation from a Medical Practitioner / Specialist required	n/a	

In the table set out below which sets out Benefits for non-surgically implanted prostheses and appliances:

(a) the Benefits apply to Schedules:
LV20 nib United Gold Visitor Cover .

(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.

Item Number	Description of Service	Service Limit (all service limits are 'per person' unless otherwise specified)
8001	Unilateral external Mammary prosthesis after mastectomy	1 per 3 years
8002	Bilateral external Mammary prosthesis after mastectomy	1 per 3 years
8003	Back Brace	1 per 3 years
8005	Ankle-Foot Orthosis	1 per 3 years
8006	Knee-ankle foot Orthosis	1 per 3 years
8007	Blood glucose monitor	1 per 3 years
8008	Nebulizer	1 per 3 years
8009	Wigs	1 per 3 years
8010	Irlen lenses	1 per 3 years
8011	Surgical stockings	No limit
8012	Peak flow meter	1 per 3 years
8015	CPAP machine (for sleep disorders)	1 per 3 years
8016	TENS machine (pain relieving stimulator)	1 per 3 years
8017	Knee brace	1 per 3 years
8019	Pressure garments	1 per 3 years
8020	Wheelchair/power wheel chair	1 per 3 years
8021	Walking frames	1 per 3 years
8022	Hip Orthosis	1 per 3 years
8023	Blood pressure monitor (sphygmomanometer)	1 per 3 years
8024	Injection delivery device	1 per 3 years
8025	Needle-less injector (diabetic aid)	1 per 3 years
8027	Spacer	1 per 3 years
8029	Abdominal binders/hernia supports	1 per 3 years
8033	Artificial eye	1 per 3 years
8034	Joint fluid replacement	1 per 3 years
8035	Shoulder brace	1 per 3 years
8036	Finger, thumb, hand, wrist, arm & elbow Orthosis & splints	1 per 3 years
8037	CPAP parts	1 per 3 years
8038	CoaguChek	1 per 3 years
8039	Erectile dysfunction pump	1 per 3 years
8053	Post mastectomy bras	1 per 3 years
8054	Rigid neck brace	1 per 3 years
8063	Hip protector	1 per 3 years
8067	Speech processor	1 per 3 years
8068	Macular degeneration aids	1 per 3 years
8109	Orthotic appliance	2 per 3 years
9100	Orthopaedic shoes/boots	2 per 3 years
9299	Hearing aid (monaural)	2 per 5 years
9302	Hearing aid (binaural)	
9300	Hearing aid repair	1 per year