Australian Unity Health Limited Fund Rules

Effective 28 January 2025

A copy of the Fund Rules (General Conditions) is available at australianunity.com.au/importantdocuments. A copy of the Constitution is available online. Before taking out private health insurance with AUHL, please ensure that you and all other persons covered on your Membership with AUHL read these Fund Rules, Fact Sheets and Member Guide which are available on the website.

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Interpretation

- Where terms are capitalised in these Fund Rules, they have the meaning given to them as determined by
- Unless defined in Appendix 1, capitalised terms have the meaning that is reasonably understood by the private health insurance industry or as defined in Private Health Insurance Legislation as applicable;
- another grammatical form of a defined word or expression has a corresponding meaning;
- the words “we”, “us”, “our” refer to Australian Unity Health Limited (AUHL);
- the singular includes the plural and vice versa, and a gender includes other genders;
- these Fund Rules are to be interpreted as far as possible in a manner that is consistent with the Private Health Insurance Legislation;
- any reference to A$, $A, dollar or $ is to Australian currency;
- a reference to a party includes the party's executors, administrators, successors and permitted assigns and substitutes;
- a reference to a statute, ordinance, code, or other law includes regulations and other instruments under it and consolidations, amendments, re-enactments, or replacements of any of them;
- a reference to a State includes a reference to a Territory, including the Territory of Cocos (Keeling) Islands, Christmas Island and Norfolk Island, but excludes other Australian external territories;
- any part of these Fund Rules that may become illegal or unenforceable will be severed and interpreted in order to maintain the integrity of the Fund Rules as a whole;
- A reference to medical devices and / or human tissue products refers to what was previously called surgical prostheses or surgically implanted prostheses;
- Unless otherwise specified in these Fund Rules, a reference to a “Policy Holder” can be read as a reference to any person authorised to take actions on behalf of a Policy Holder;
- A reference to the ‘family’ in A-G means Single Parent Family and Family scales (including Plus scales).

A Introduction

A1 Australian Unity Health Limited (AUHL)

Who are we	• We are a for-profit organisation under the Corporations Act 2001 and operate as a Health Benefits Fund for the purposes of our Health Insurance Business and any Health-Related Business in accordance with the Private Health Insurance Legislation and these Fund Rules. We operate the Health Benefits Fund in accordance with the PHI Act 2007.
AUHL Members	• AUHL Members may be eligible to become a member of Australian Unity Limited (AUL) once they meet eligibility criteria determined by the board of AUL. By becoming a Member of the Fund, Members consent on behalf of themselves and the other Members on their Policy, to become a member of AUL and agree to be bound by the Constitution. In particular, they agree to contribute an amount not exceeding $1 to the property of AUL in the event of AUL being wound up while they are a member of AUL or within 1 year afterwards as set out in the constitution of AUL.
Governing Principles	• The operation of the Fund and the relationship between us and our Members is governed by the Private Health Insurance Legislation including subordinate legislation; the Health Insurance Act and the National Health Act; the Australian Consumer Law; the rules of the Australian Prudential Regulation Authority or its successor; the Fund Rules, Fact Sheets, the Supplementary Documents, and the Constitution. In the event of any inconsistency between the General Conditions and the Constitution, this will be resolved and prevail in the following order of precedence: o the Constitution; o the General Conditions.
Community Rating and Improper Discrimination	• When making decisions in relation to allowing a person to become a Member, we comply with the principle of community rating as determined in the PHI Act 2007, or other legislation.
Dispute resolution	• A Member may at any time make a complaint to AUHL or to the Private Health Insurance Ombudsman in connection with the Fund or any matter relating to their Membership or Product. Details on the complaints management process can be found on australianunity.com.au/health-insurance/legals/complaint-resolution.
Winding Up	• In the event that AUHL is wound up, it will be wound up according to the requirements of the Private Health Insurance Legislation and the Constitution. Subject to those requirements, a Member is not entitled to share in any reserves or surplus of the Fund.

A2 The Fund Rules

Content and purpose	These Fund Rules consist of the General Conditions ***A-G*** and: • apply to all Products offered by Australian Unity Health Limited (AUHL), with the exception of the Overseas Visitor Products; • govern the rights and obligations of Members and AUHL in relation to the Fund.
Obligations and Responsibilities of the Members	• By becoming a Member of AUHL each person automatically accepts all the terms and conditions in the Fund Rules and is bound by them. • Where required, we will supplement these Fund Rules with the Member Guide and Terms and Conditions (together, the Supplementary Documents), which are available on the Australian Unity website and will be provided to the Policy Holder after joining the Fund. All Members are bound by these Supplementary Documents. • All Members must make full and true disclosure in forms submitted to process a claim, change a Membership or other forms, as to all matters referred to in that form. • The Policy Holder must inform us as soon as reasonably possible of any changes to the circumstances of any Member covered under the Membership that may affect the Membership. • It is the Policy Holder's responsibility to inform Members covered on the same Membership of their entitlements as Members, as well as their Benefit entitlements, changes to the Membership and Product changes, and to do so within a reasonable period.
Changes to the Rules	• We may amend these Fund Rules or Supplementary Documents by publishing the new or amended version on our website. If the new or amended Fund Rules or Supplementary Documents are or might be detrimental to the interests of Members, we will provide reasonable prior written notice to the Policy Holder (and other Members, if required under the Fund Rules) on the affected Policies. For the avoidance of doubt, any such notice must comply with any relevant requirements of the Private Health Insurance Legislation, the Australian Consumer Law, and the Code. • Where a Member became entitled to receive a Benefit at a time when a previous Fund Rule or Supplementary Documents applied, the Benefit specified in that earlier version will be payable.
Waivers of the Rules	• We may waive the application of a Fund Rule, at our discretion, provided that such a waiver does not reduce a Member's entitlement to Benefits. The waiver of a particular Fund Rule in a given circumstance does not require AUHL to waive the application of that Fund Rule in any other circumstance.
Notice to Members	• Any notice required to be provided by AUHL to a Member under these Fund Rules, unless otherwise prescribed by the Private Health Insurance Legislation, will be delivered to the address last nominated as preferred method of contact by the Member to AUHL.

B Definitions

For definitions of these Fund Rules, see *Appendix 1* at the end of these Rules.

C Membership

C1 General Conditions of Membership

C.1.1 Application to become a Member

Subject to these Fund Rules:

Who can become a Member	• Unless AUHL otherwise determines, all natural persons are eligible to become Members at any age and they are only eligible to receive Benefits if they are covered under that Membership. • Those under the age of 16 years can only become Policy Holders if the application for their Membership is submitted by their legal parent/guardian who accepts all terms and conditions of Membership, including these Fund Rules, on behalf of the Policy Holder.

Hospital Cover with another fund	• Unless otherwise expressly permitted by the Private Health Insurance Legislation, a person cannot purchase a Hospital Treatment Product or Combined Hospital and General Treatment Product with AUHL if they are covered concurrently with a Hospital Treatment product provided by another Registered Health Insurer.
Dual Membership with Australian Unity	At the absolute discretion of AUHL: • a Member insured under a General Treatment Product with AUHL may be insured under a concurrent General Treatment Product with us. Where this dual Membership exists, portability (as defined by the PHI Act 2007) does not apply between either Membership; • where a Dependant of the Policy Holder needs to be covered under both their Membership and the Membership of the Policy Holder's estranged Partner, dual Memberships of Hospital Treatment Products, Combined Hospital and General Treatment Products and General Treatment Products may be accepted, for an agreed period of time, by AUHL, and all applicable Waiting Periods will apply
Rejection of Application	Subject to Fund Rule ***A1-Community Rating and Improper Discrimination***, we reserve the right to reject an application for admission to AUHL. If an application is refused by us then any Premiums paid at the time of application will be refunded in full.

C.1.2 Types of Members

A Membership will cover the Policy Holder and, depending on the Membership category and scale as listed in ***C.1.3 Membership Categories*** below, can also cover the:

- Policy Holder's Partner; *and/or*
- Dependants – There are three types of Dependants: Child Dependant, Student Dependant, Non-Student Dependant.

C.1.3 Membership Categories

AUHL may offer the following Membership categories to the specified types of Members:

Type of Membership	Scale	Consists of	Cannot Cover
Single Membership	Single	One Member only – the Policy Holder	Policy Holder's Partner, Dependants
Couple Membership	Couple	Two Members only – the Policy Holder and their Partner	Dependants
Single Parent Membership	Single Parent Family	Two or more Members – the Policy Holder and at least one Child Dependant and/or Student Dependant only	Policy Holder's Partner, Non-Student Dependants
	Single Parent Family Plus	Two or more Members – the Policy Holder and at least one Non-Student Dependant. Can additionally include Child Dependants and/or Student Dependants	Policy Holder's Partner
Family Membership	Family	Three or more Members – the Policy Holder, their Partner and at least one Child Dependant and/or Student Dependant only	Non-Student Dependants
	Family Plus	Three or more Members – the Policy Holder, their Partner and at least one Non-Student Dependants. Can additionally include Child Dependants and/or Student Dependants	

C.1.4 Types of Products and Availability

Types of Products	AUHL offers Membership for the version of the Product(s) applicable to the Policy Holder's state of residence registered with AUHL for: • Hospital Treatment Product, • General Treatment Product, • Combined Hospital and General Treatment Products
Concurrent Products	A Member can hold concurrently on a Membership a Hospital Treatment Product and General Treatment Product, unless one of the Products is not available for purchase with the other one.

Limitations	From time-to-time AUHL may offer Products that are only available to purchase: • by one or more selected Membership categories as outlined in Fund Rule ***C.1.3 Membership Categories*** • in the case of a General Treatment Product, with a particular Hospital Treatment Product. • by Members of a Contribution Group, Community or as otherwise allowed by AUHL under these Fund Rules.
Closed and Terminated Products	AUHL may close or terminate a product in accordance with the PHI Act 2007.

C.1.5 Commencement Date and Duration of the Membership

Commencement of Membership	**The Membership commences for the Policy Holder,** provided all required Premiums have been paid and enrolment procedures completed to our satisfaction**,** on**:**	• the date and time at which the application form is accepted by AUHL; *or* • another date as mutually agreed between the applicant and AUHL
	The Membership commences for the Policy Holder's Partner or **Dependant:**	• The Commencement Date requested by the Policy Holder and approved by AUHL
Commencement Date on Product	Where a Member changes to a different Product, cover for the Member commences on that new Product: • on the date the change takes effect; *or* • another date as mutually agreed between the applicant and AUHL	
Duration of Membership	Coverage under the Membership will continue until cancelled or terminated or during a suspension period, and in accordance with Fund Rule ***C.1.11 Cancellation and Termination of Membership*** and ***C.1.10 Temporary suspension of Membership***	

C.1.6 Rights of Members and Delegated Authority

Different types of Members and Delegated Authorities have different levels of authority to access or make changes to the Membership as permitted and on terms determined by AUHL. They may be granted authority to access or make changes to the Membership, or otherwise act on behalf of the Policy Holder.

C.1.7 Registration of Dependants and Policy Holder's Partner

Subject to the Fund Rules, the Policy Holder can add their Partner and/or a Dependant at any time by providing the personal details of the person in the form and in the manner reasonably required by AUHL.

If Partner or Dependant were	they can be added to the Membership from
not previously covered on the Membership	the day the application is received by AUHL, or a later date. For newborns or newly adopted or foster children, refer to ***C.1.8 Adding a new Child***
previously covered on the Membership and were removed	the day following their removal from the Membership, subject to the following: • For Dependants, an application for cover must be received by the Fund within 3 months of the Dependant ceasing to be covered under the family Membership held with AUHL. The Dependant type as per ***C.1.2 Types of Members,*** will be subject to their eligibility on the commencement date of their registration to the Membership. • For Policy Holder's Partner, an application for cover must be received by the Fund within 30 days of the Partner ceasing to be covered under the couple or family Membership held with AUHL. If they contact us outside these timeframes, they will be added from the date we receive the request to add them or a later day.

Where the addition of a person to a Membership results in a scale change (as required by Fund Rule ***C.1.3 Membership Categories***) or results in other premium adjustments due to Lifetime Health Cover (LHC) and/or adjustment of the Federal Government Rebate, the Membership will be amended from the date the person is added. Premiums for the Membership will be adjusted accordingly from the date the change takes effect.

Ex-Members transferring to a different Membership:

A Dependant 16 years old or older or a Policy Holder's Partner who ceased to be covered on a Membership, may Transfer from that Membership to their own Product, becoming a Policy Holder and Member on their 'own Product', if they contact us and apply for a new Membership within:

- 3 months of the Dependant ceasing to be covered under the family Membership held with us; or
- 30 days of the Policy Holder's Partner ceasing to be covered under the family or couple Membership.

We will allow the commencement of their Own Product from a date within 30 days following the Dependant's or Policy Holder's Partner's removal from the family or couple Membership provided that Premiums are paid back to the date their new Membership commences. If they contact us outside these timeframes, or if they want to commence their Own Policy on another day in the past other than a day within 30 days of ceasing to be covered, the Commencement Date will be the date we receive the request, or a later day agreed between AUHL and Policy Holder.

C.1.8 Adding a new Child

A Child may be added to the Membership from the date of birth (DOB) of a newborn or the adoption / fostering date if:

Membership Category at DOB of newborn, adoption / fostering date was:	And the Policy Holder contacts us to add them	and
Single Parent Family or Family	within 12 months of the DOB or adoption / fostering date	
Couple	within 12 months of the DOB or adoption / fostering date	• Membership is changed to a Single Parent Family/Family Membership, effective from the birth date or adoption / fostering date (as relevant). • Where this change requires a change in Product because there is no Single Parent Family/Family Membership category available, then the change must be to a Product that offers the most equivalent level of Benefits, as determined by AUHL, and any difference in Premiums must be backpaid by the Policy Holder.
Single	within 30 days of the DOB or adoption / fostering date	• Membership is changed to a Single Parent Family/Family Membership (which may require a change in Product), effective from the birth date or adoption / fostering date (as relevant), and any difference in Premiums is backpaid by the Policy Holder.

A Dependant who is added to a Membership outside of the timeframes listed in this Rule ***C.1.8*** can only be added from the date the application to add the Child is made, or a later date.

C.1.9 Registering a Student Dependant

If the Policy Holder notifies us within 3 months of the day the Dependant / Child becomes a Student Dependant, we will allow the change to be backdated to the day the Dependant / Child became a Student Dependant and any Premiums paid in advance will be adjusted on the Membership. If we are notified more than 3 months after the Dependant/ Child becomes a Student Dependant, the change will be effective on the day the Policy Holder notifies AUHL of the change.

C.1.10 Temporary suspension of Membership

The Policy Holder can apply to AUHL to suspend their Membership due to overseas travel or financial hardship, upon the terms and conditions set out under this Fund Rule ***C.1.10***.

- The suspension must apply to all registered Members.
- For overseas travel, the suspension must apply to all Products held by the Members. For financial hardship, the suspension must apply to all Products held by the Member in the Membership.
- For overseas suspension, it is a condition of application for suspension that Members produce evidence as reasonably required by us, including documentation evidencing dates of departure and return to Australia.

Eligibility Rules	Overseas Travel Suspension	Financial Hardship
The Membership must have at least	• Hospital Treatment Product or Combination Hospital Treatment and General Treatment Products. • Memberships with a General Treatment Product only are not eligible for suspension of Membership.	
Prior to the application for suspension, the Membership must have been active for at least a continuous period of	1 month	12 months
Minimum period allowed for the suspension	2 months	N/A
Maximum period allowed for the suspension	24 months	3 months
Minimum period required before applying a new suspension	• A minimum period of 12 months must have elapsed since the Member's last suspension ended, regardless of whether it was for overseas travel or financial. • Members who travel frequently overseas may make application to AUHL to allow overseas travel suspension for a lesser period or on more frequent occasions than these Rules otherwise allow and AUHL may agree in its absolute discretion.	
The Membership must be paid	• up to or in advance of the proposed effective date of suspension	• up to the effective date of suspension
Maximum suspensions in a lifetime of a Membership	Unlimited	3

If the suspension is accepted by AUHL:

	Overseas Travel Suspension	Financial Hardship
The Membership will be suspended effective from the day	• after the date of departure of the Member from Australia or from the date of receipt of the application for suspension, whichever is later	• after the application has been approved for financial hardship
The Membership will resume	at the earlier of: • the day after the Last Day of the Suspension Period as approved by AUHL; or • The date the Member returns to Australia from overseas travel	• the day after the Last Day of the Suspension Period as approved by AUHL
Effects of suspension	• Benefits are not payable for any services rendered to any Member of the Membership whilst the Membership is suspended. • The period of suspension does not count towards the serving of Waiting Periods, Benefit Replacement Periods, or the length of Membership. • The Membership will not be entitled to the Australian Government Rebate on Private Health Insurance and may not be exempt from the Medicare Levy Surcharge during this period. • For the purposes of the Lifetime Health Cover (LHC) the period of suspension does not count towards the maximum permitted days without hospital cover allowed by the Private Health Insurance Legislation, however the 10-year anniversary end date will be delayed by the period the Membership was suspended. • Pre-paid Premiums in respect of any part of the period of suspension are not refundable and will be held to the credit of the Membership pending resumption of Membership. If the Membership is subsequently cancelled, refunds of pre-paid Premiums will be dealt with by AUHL pursuant to Fund Rule ***C.1.11*** and ***Cancellation by the Policy Holder.***	
Resumption of Membership	• Any outstanding Waiting Periods must be served upon resumption of the Membership and subject to this, the Membership will be deemed to resume on the same Product with full continuity of Benefits at the end of the suspension period.	

	• Where the Member was covered under a Product that is no longer available at the time of resumption, the Company will offer a Product that is the closest equivalent and waive any Waiting Periods for increased Benefits. • All pre-paid Premiums held in credit will be applied to the Membership from the day after the Last Day of the Suspension Period.

C.1.11 Cancellation and Termination of Membership

A Membership may be ceased by the Policy Holder or AUHL in the following circumstances:

Cancellation by the Policy Holder	• Within 30 days from the Commencement Date of their Membership, we will allow any new Member who has not yet made a claim to cancel their Membership from the date they joined and receive a full refund of any Premiums paid. • The Policy Holder can cancel their Membership, remove themselves or remove their Partner or Dependants at any time with prior notice to AUHL. Their Partner or Dependants 16 years and over may remove themselves from a Membership at their own request at any time. Unless otherwise permitted by AUHL, a Dependant who is under the age of 16 years may leave the Membership only with the Policy Holder's written consent. • The cancellation, including those requests sent from Registered Health Insurers or intermediaries, will take effect on the day such notice is received by us or such later date as set out in the notice. • Once a Membership (or Member) is cancelled and there is a gap in cover of greater than 1 day, all Members with a gap in cover will cease to have any entitlements to all Benefits. • Retrospective cancellation of a Membership from the day after the date of a Policy Holder's death will be accepted by AUHL subject to, if reasonably required, receipt of official documentation issued by the relevant State agency providing confirmation of their date of death. • The Policy Holder will be entitled to a refund of premiums paid in advance and any refund will be calculated from the date of cancellation of the Membership. • If a person ceases to be insured under a Product and does not become insured under another Product of the Fund, we will give the person a Transfer Certificate within the period required by the Private Health Insurance Legislation. • The cancellation of a Membership will not affect the right of AUHL to recover from a former Member any monies payable or otherwise owing by that person to the Fund.
Termination by AUHL	• Subject to Rule ***D Premiums - Arrears in Premiums*** we may terminate a Membership that is in Arrears for a period of two months or longer. • Where in the opinion of AUHL a Member may have engaged in fraudulent activity, misleads, or deceives the Fund, materially or repeatedly breaches any of these Fund Rules or any other term or condition of Membership with the Fund, we may terminate or suspend a Membership at any time by giving reasonable notice, describing the reason for the termination or suspension to the Policy Holder concerned and providing a refund of any Premiums paid in advance. Neither the Fund nor AUHL shall be under any liability on account of such termination or suspension of Membership. Where a Membership is terminated under this Fund Rule by AUHL, we may reinstate it in our absolute discretion, upon application by the Policy Holder, stating valid reason why the Membership should be accepted and reinstated by AUHL. • The termination will not affect the right of AUHL to recover from a former Member any monies payable or otherwise owing by that person to the Fund.
Refund of Premiums	• Where a Member is entitled for Refund of Premiums paid in advance, we will refund these to their nominated financial institution account.
Reinstatement of Membership terminated due to Arrears	• For Memberships terminated due to Arrears as described above, AUHL has the discretion to reinstate the Membership under a request for Special Consideration from the Policy Holder. Continuity of Benefits will be subject to the back-payment of all outstanding Premiums by the Policy Holder.

Reinstatement of Membership terminated by the Member	• Unless otherwise prescribed by the Private Health Insurance Legislation, if a Membership (old Membership) has been cancelled by the Member under the conditions outlined in this rule, the Policy Holder of that old Membership may reinstate the old Membership from the day after it was terminated if:
	  ○ The application for the reinstatement is received by the Fund within 30 days of the old Membership being cancelled; and
	  ○ Contributions are paid back to the date the new Membership commences or is reinstated; and

- The applicant must retain the Product (old Product) they had on the last day of the old Membership, or if permitted by AUHL, they may change to a different Product and will be subject to applicable Waiting Periods.

C.1.12 Changes in Policy Holder due to death

Where the Policy Holder passes away, the Member who is registered under the Membership as their Partner may continue that Membership as the Policy Holder from the day of the Policy Holder's passing.

D Premiums

Calculation of Premiums and payments in advance	• Subject to the Fund Rules, the Base Rate in relation to a Product is calculated with reference to the:
	  ○ applicable Membership category;
	  ○ Product; and
	  ○ state of residence of the Policy Holder (as applicable).
	• Unless otherwise offered or agreed by AUHL, Premiums are payable monthly in advance. AUHL at its discretion may not accept Premiums for a period exceeding 12 months from the date the payment is made, and if a payment is made exceeding 12 months from the date the payment is made and AUHL does not accept this payment, we will refund the portion of Premiums exceeding 12 months.

Premium and Base Rate Changes	• AUHL may amend the Base Rates that apply to its Products and will provide the Policy Holder with reasonable prior written notice of such amendments (and any other Member if required by Private Health Insurance Legislation) in the manner set out in these Fund Rules. • Subject to Rule ***D*** and section ***Calculation of Premiums and payments in advance***, Premiums which have been paid in advance prior to the date the change takes effect may not be affected by the Base Rate changes until the next due date of the Premiums for that Membership. • Where AUHL receives a request to change the Product or make other changes to the Membership that may impact the Premium, the Premium rate will be amended from the date of receipt of that request or a future date as requested by the Policy Holder, or other date as agreed by AUHL. Premiums paid in advance will automatically be adjusted to the new Premium rate which may adjust the current financial date of the Membership.
Premiums Discounts	• AUHL may from time to time apply a discount up to the maximum discount, and for the reasons, allowed under the Private Health Insurance Legislation.
Lifetime Health Cover (LHC)	• AUHL will increase Premiums and apply other Lifetime Health Cover criteria as required, in accordance with the Private Health Insurance Legislation.
Arrears in Premiums	• Where a Membership is in Arrears for a period not exceeding two months and a Member pays such Arrears before the two-month period expires, the Membership will retain uninterrupted Benefit and Membership entitlements. • Where the period of Arrears exceeds 2 months, Fund Rule ***C.1.11*** and section ***Termination by AUHL*** will be applied and a Transfer Certificate will be issued to the Policy Holder. • For the period the Membership is in Arrears and subject to eligibility for receiving Benefits, AUHL will not pay Benefits towards any treatment received by the Members during that period, until the Arrears are paid to us.

Contribution Groups	• AUHL may, at its discretion, approve any group of Policy Holders as a Contribution Group to be eligible for Premium Discounts.
	• A Contribution Group includes but is not restricted to:
	  ○ employees of, or service providers to, a body corporate, partnership, unincorporated body, or other type of enterprise (either for profit or not for profit);
	  ○ members of a professional, industry or trade association;
	  ○ members of a Community; or
	  ○ eligible members who apply for a Policy during a marketing or advertising promotion conducted by AUHL, subject to the terms and conditions of the promotion.

E Waiting Periods, Continuity and Transfers

E1 Waiting Periods

E.1.1 Waiting periods to apply

Unless otherwise permitted by AUHL, subject to Rule *E2 Transfers and Continuity of cover* and *E.1.2 Waiting Periods – Additional Rules*, a Member must serve the Waiting Periods set out in this Rule *E1* before receiving Benefits available under a Product. When more than one Waiting Period applies to Benefits, each Waiting Period must be served independently of any others. At its discretion and subject to these Rules and the Private Health Insurance Legislation, AUHL reserves the right to waive or reduce any Waiting Period, however this waiver or reduction will not affect any other Waiting Periods, Restricted Benefits or other Fund Rule that applies to the same Benefit.

A Waiting Period starts from:

- the Commencement Date of the Membership or Product; or
- the date of Transfer from another Registered Health Insurer in respect of the Member; or
- the registration date of the Member on the Membership,

whichever date is the later.

The following Waiting Periods apply to a Benefit for Hospital, Hospital Substitute and General Treatment subject to the Members chosen new Product.

	Hospital Treatment or Hospital Substitute Treatment	General Treatment
12 Months	• Hospital Benefits for the Clinical Category Pregnancy and Birth • Pre-Existing Conditions except for the Clinical Category Psychiatric, Rehabilitation and Palliative Care services	• Major dental – including Dentures and Prosthodontics (crowns, bridges, and implants); Orthodontics; Surgical extraction(s); Endodontic; Periodontics; Orthotics; • Hearing Aids; Non-Surgical Prosthesis; Braces; Splints; Artificial Aid/Appliances such as: Asthma Pumps/Nebulisers, Blood Glucose Monitors, T.E.N.S. pain management machines, Blood Pressure Monitors, Peak Flow Meters, Oral Device for Sleep Apnoea and C.P.A.P. airway pumps; • Midwifery; Homebirth; • BumptoBaby; Health Support Programs; • All other Preventative Health Services not listed in this table.
6 Months	• Not Applicable	• Optical Services; • Health Management Services • Gym Membership • Nicotine Replacement Therapy • Skin Checks

2 Months	• The following treatments/Clinical Categories, regardless of it being due to a Pre-existing condition:
	  ○ Psychiatric (Unless an eligible Member is making use of the Mental Health Waiver);
	  ○ Rehabilitation;
	  ○ Palliative Care
	• All other treatments not listed in this table.
		• All other services and treatments not listed in this table for General Treatment.

0 Months	• Hospital Treatment or Hospital Substitute Treatment that is required as a result of an Accident that took place after a Member's Commencement Date.	• Preventative Dental (including scale and clean); • Travel Vaccinations; • Cervical Cancer Vaccines, Doctor Health Checks; Quit Smoking; Personal Health Coaching, Weight loss Programs; • Dental Diagnostic Services;

	• Home Nursing; • School Accident Top-Up Benefit; • On-Site Accommodation; • Emergency Ambulance Transportation, Ambulance Attendance.

E.1.2 Waiting Periods – Additional Rules

Gold Card holders	• Where a person joins the Fund within 2 months of ceasing entitlements to a Gold Card under the Veterans' Entitlements Act 1986; the Member will not be subject to any Waiting Periods or Restricted Benefits as described in this Rule ***E1 Waiting Periods*** in respect of Hospital Treatment or General Treatment.
New Dependants	• If a new Dependant is added to a Membership and the conditions set out in ***C.1.8 Adding a new Child*** are met, the new Dependant will have no Waiting Periods. If they are added to a Membership and the conditions set out in ***C.1.8*** are not met, any Waiting Periods that apply to that Product will apply to the Dependant.

E2 Transfers and Continuity of Cover

E.2.1 Continuity of cover – former Australian Unity Members

The following categories of Members will not have to serve any Waiting Periods previously served with Australian Unity if:

- they take out a Product with an equivalent or lower level of Benefits to that offered on their previous Product; *and*
- the Member has served all Waiting Periods that apply prior to the registration. Where they have not served all applicable Waiting Periods or Benefit Replacement Periods, then the balance of any unexpired Waiting Period or Benefit Replacement Period for those Benefits must be served before the new Benefits are available.

This ***E.2.1*** rule applies to Members who have not transferred from another Registered Health Insurer but have either:

- re-joined a previous Membership as a Dependant or Policy Holder's Partner with no gap in cover, as described in ***C.1.7 Registration of Dependants and Policy Holder's Partner***; *or*
- re-instated their Policy subject to ***C.1.11*** and ***Reinstatement of Membership terminated by the Member;*** *or*
- become the Policy Holder or a Member on another Australian Unity Membership with a Commencement Date within 30 days after they ceased to be covered on the previous AUHL Membership.

Where, the Member does not meet the above criteria they may have to serve the Waiting Periods as listed in ***E.1.1 waiting periods*** table above.

E.2.2 Transfers between Products within AUHL or from other Australian Registered Health Insurers

Transfer between Products within AUHL	• Subject to Rule ***C.1.6 Rights of Members and Delegated Authority*** a Member may Transfer from a Product (old Product) to another Product (new Product). • Unless otherwise required by the Private Health Insurance Legislation where a Member Transfers to the new Product more than one day after the Member ceased to be covered under the old Product, Waiting Periods will apply as listed in ***E.1.1 – waiting periods*** table
Transfers from other Registered Health Insurers	• An applicant for Membership may Transfer from a product issued by another Registered Health Insurer (old product) to a Product provided by AUHL (new Product) and be accepted as a Member of the Fund subject to this Fund Rule ***E2 Transfers and Continuity of Cover***. • The Member or the previous Registered Health Insurer, are required to provide a Transfer Certificate. Where AUHL has not received a Transfer Certificate we will request one from the Registered Health Insurer in accordance with the Private Health Insurance Legislation and the Code. • AUHL will not apply portability of Benefits or take into consideration Waiting Periods served with the previous Health Insurer if the applicant Transfers to the new Product more than 30 days after the applicant ceased to be covered under the old Product. • When an applicant Transfers from an old product to a new Product within 30 days of them ceasing to be covered under the old product, AUHL will use the information provided by the

	previous Registered Health Insurer and the Transfer Certificate to select an equivalent AUHL product to use for the purposes of continuity of cover. Benefits on our equivalent Product may be different to the benefits on the product with the previous Registered Health Insurer.
Benefits paid under old Product to be taken into account:	• Benefits paid under an old Product in the same Calendar Year that the Member transfers to a new Product referred to in this Fund Rule ***E2 Transfers and Continuity of Cover*** will be deemed to be Benefits paid out of the Calendar Year Benefits limits or lifetime Benefit limits to which a Member or Membership may be entitled under the new Products. • Any unexpired portions of a Benefit Replacement Period or Benefit limit will be considered and that govern the supply or replacement of an Artificial Aid/Appliance or Non-Surgical Prosthesis will be transferred to the new Product.; • Recognition by AUHL of a period of coverage under the old Product in determining yearly Benefit limits under the new Product.

Subject to this Rule ***E.2.2*** and where a Member Transfers to the new Product:

- **for Transfers between Products within AUHL** - with no gap in cover (unless otherwise permitted by the Private Health Insurance Legislation); or
- **for Members who are new to AUHL** - within 30 days of the applicant ceasing to be covered under the old product from another Registered Health Insurer,

the following will apply (as relevant) for services/procedures after the change of cover:

If	And	Then
Old Product and new Product offer comparable/equivalent Benefits	the applicant has not served the applicable Waiting Period and/or Benefit Replacement Period for the Benefit under the old Product	• the balance of any unexpired Waiting Period and/or Benefit Replacement Periods for those Benefits must be served before the new Benefits are available.
	the applicant has served the applicable Waiting Period and/or Benefit Replacement Period for the Benefit under the old Product	• will be able to claim Benefits immediately from the new Product.
Old Product offers lower Benefits compared to the new Product	the applicant has not served the applicable Waiting Period and/or Benefit Replacement Period for the Benefit under the old Product	• the balance of any unexpired Waiting Period and/or Benefit Replacement Period must be served on old Product before the Member is able to claim benefits under that old Product. • Waiting Periods for the higher Benefits will commence when the Member changed to the new Product, and until these are served, Member will receive Benefits under the old Product.
	the applicant has served the applicable Waiting Period and/or Benefit Replacement Period for the Benefit under the old Product	• Waiting Periods for the higher Benefits will commence when the Member changed to the new Product, and until these are served, Member will receive Benefits under the old Product.
New Product has lower Benefits compared to the Benefits of the old Product	the applicant has not served the applicable Waiting Period and/or Benefit Replacement Period for the Benefit under the old Product	• No Benefits are payable prior to the Waiting Periods being served. • the Member will not receive Benefits under the old Product and will receive the lower Benefit under the new Product once Waiting Periods for the service (combined from both Products) have been served.
	the applicant has served the applicable Waiting Period and/or Benefit Replacement Period for the Benefit under the old Product	• the Member will receive Benefits as per the new Product.

Hospital Treatment is required for a Pre-Existing Condition	the Excess or Co-Payment applied under the old Product is different than that which applies under the new Product	• Benefits will be applied with the higher Excess or Co-payment for a period no longer than allowed under the Private Health Insurance Legislation;
The Excess or Co-Payment is different between old and new Products	the Excess or Co-Payment applied under the old Product is higher than that which applies under the new Product	• the Waiting Period must be served before the new Excess or Co-payment is payable

E.2.3 Transfers from Overseas Visitor Products

When a person Transfers from an Overseas Visitor Product offered by another Registered Health Insurer or AUHL to any Product offered by the Fund, we will apply all Waiting Periods as listed in ***E1 Waiting Periods*** to the Benefits available under the new Product with Commencement Date the date the Member joined the new Product. We may apply an exemption to this for AUHL Members with an Overseas Visitor Cover (old Product) who Transfer to an AUHL Product (new Product) with no gap in cover and:

If	and	then
old Product and new Product offer comparable/equivalent Benefits	the applicant has served the applicable Waiting Period for the Benefit under the old Product	may be able to claim Benefits immediately from the new Product
new Product has lower Benefits compared to the old Product		

F Benefits

F1 General Conditions

F.1.1 Payment of Benefits

Details of Benefits available under each Product are set out in the relevant Product Fact Sheet. AUHL will pay Benefits to Members in accordance with the terms and conditions of the Product referable to the Member's Membership and these Fund Rules which are applicable at the date a service is received by a Member.

Where we pay the Benefits	• Where a Member submits a claim for Benefits and the Member has paid the invoice of the provider, we will make the Benefit payment directly into the financial institution account nominated by the Member. • Where a provider's invoice is submitted with the claim and is unpaid, we will pay the applicable Benefit into the provider's nominated financial institution account, or where the provider has not provided such an account to AUHL, we may, at our discretion, issue a cheque made payable to the provider and posted to the Member's address, or make the Benefit payment directly into the financial institution account nominated by the Member.
Maximum Benefit	• Any Benefits available under a Product will not exceed the charge(s) raised for any treatment or services rendered and will be limited to 100% of the amount charged for the service or the amount of the Benefit provided for the service under these Fund Rules and the relevant Product Fact Sheet, whichever is the lesser amount.
Dual Memberships	• In the occurrence of Fund Rule ***C.1.1*** and section ***Dual Membership***, where Benefits are payable from more than one source for the same treatment or service we may amend the Benefit so that the total amount payable from all sources does not exceed the amount charged.

F.1.2 When Benefits are not payable and limitation on Benefits

Notwithstanding any other provision of these Rules,

AUHL will have no liability in respect of a Member:	Reason
• for outpatient (non-Admitted Patient) consultations or treatments, including treatment in Hospital emergency department/room, outpatient consultations in a doctor's room or consultations with a nurse	**Outpatient service**
• for any aspect of a claim or higher Benefit in respect of services or treatment rendered during a Waiting Period;	**Waiting Periods**

• for any claim in respect of services or treatment rendered on or after the date on which a Membership is in Arrears;	**Arrears Policy**
• for any claim in respect of services or treatment rendered to a Member as a patient of a Hospital associated with the Department of Defence or Veterans' Affairs, or by any practitioner acting on behalf of any Naval, Military, Veterans' Affairs or Air Service Authority, unless the patient is a civilian and not entitled to treatment without charge; • for treatment or services or an item where the expense was incurred by the employer of that Member or if the Member was required by a third party (such as a potential employer or life insurer) to obtain that treatment, goods, or services; • where the Member has received, or established a right to receive, Compensation for treatment, goods, or services; • for any claim in respect of services or treatment rendered that primarily takes the form of sport, recreation, or entertainment; • where the Member has received, or has the right to receive, payment for the treatment, goods, or services from a third party including another Registered Health Insurer; • for Benefits for a treatment or service provided to a Member by, or on behalf of, or under an agreement with one of the following; o the Commonwealth; o a State; o a local government; or o an authority established by a law of the Commonwealth or a State, unless under special agreement between AUHL and the provider;	**3rd Party**
• for any claim for professional services rendered by a practitioner in the treatment of themselves as an individual (or Member) or to the practitioner's partner/spouse or Dependants, or business partner, or the spouse/partner or Dependants of the practitioner's business partner, provided that, where the service includes a cost for materials, we may consider payment of Benefits toward the cost of purchase and supply of those materials; • where the provider: o is not a Hospital, Medical Practitioner or Recognised Provider at the time the treatment, goods or services were provided to the Member; or o not working in Private Practice; • for any claim for General Treatment Benefits in respect of services rendered at a public Hospital by one of its salaried employees, where such employee has established a practice within or directly associated with that Hospital and raises charges in his or her own name;	**Provider**
• where the Member has: o failed to make full and complete disclosure as to all matters relied upon in support of, or relevant to, a claim for Benefits; or o provided in support of any claim for Benefits information which is false, inaccurate, or misleading, whether or not such information is contained in a claim form, given orally, or provided in any other manner whatsoever; or o failed to provide such information or medical evidence in respect of a claim as may be required by AUHL; or o failed to provide a signed authority authorising the obtaining of medical evidence concerning the Member from a Medical Practitioner or Recognised Provider of the Member as required by AUHL;	**Member**
• for any claim in excess of fees charged or where no charge is made; • for any claim where a service was rendered outside of Australia; • if the Member does not have an Acute Care Certificate after 35 days of hospitalisation. AUHL has the right to seek the validity of an Acute Care Certificate when required; • for Respite Care; • for personal in-Hospital expenses such as pay TV, nurse not employed by the Hospital; • where Hospital Treatments are experimental or involve a clinical pharmaceutical trial; • for Medical Devices and Human Tissue Products that are not listed on the Prescribed List as defined in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules, unless the Medical Device or Human Tissue Product is evidenced to be Clinically Relevant and then may be Approved by AUHL for Benefit payment;	**Benefits**

• for any claim where the service is not considered Health Insurance Business as prescribed under the Private Health Insurance Legislation; • for treatment or a person supplying treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules.	**Legislation**

F.1.3 Recovery of Benefits

For the purposes of this Rule ***F.1.3***:

'Error' includes	• any mistake of fact or of law or of mixed fact or law; • an error of omission or calculation; and • an error of an administrative or clerical nature.
'Error' may be caused by	• AUHL (including employees or agents of AUHL); and/or • Member; and/or • Other person (was not in whole or in part lawfully due to the Member)
Member includes	• Member and/or their agents, executors, administrators, assigns.

AUHL is entitled to recover from a Member the whole or part of a Benefit amount paid to them, as the case may be, if:

- the payment was made due to an 'error'; and
- AUHL notified the Member about this 'error', within 24 months from the date of the payment of the Benefit.

Without prejudice to any remedy otherwise available, any amount that is recoverable by AUHL under these Fund Rules may be set off against Benefits otherwise payable then or thereafter to the Member after providing 30 days' prior written notice to the Member. Some exceptions to this Rule apply if the claim is related to Compensation, as detailed in Rule ***F4 Compensation, Damages and Provisional Payment of Claims***

F2 Hospital Treatment

F.2.1 Hospital Treatment Benefits

Subject to the terms of a Product and the Fund Rules, Hospital Benefits will only be available in respect of the cost of Hospital Treatment in a Hospital or other facilities as permitted by the Private Health Insurance Legislation:

Where Benefits are payable for	those Benefits will be paid according to
Overnight Stay **Same Day procedure** **Multiple procedures** **Nursing Home Type Patients**	• the Private Health Insurance Legislation, including guidelines and rules as set out by the Department of Health and Aged Care; and • where applicable, agreed terms (Hospital Purchaser-Provider Agreement) with the Private Hospitals.
Medical Devices and Human Tissue Products (where the Clinical Category is covered)	• the Prescribed List as defined in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules. These need to be provided as part of Hospital Treatment (or Hospital Substitute Treatment as applicable) where a Medicare benefit is payable for the associated professional service for the Member

Podiatric Surgery (Provided by a Registered Podiatric Surgeon)	• If a Product provides a Benefit for the Clinical Category Podiatric Surgery (Provided by a Registered Podiatric Surgeon), the only Benefits payable will be for:
	  ○ Hospital accommodation (bed fees) at the medical/other rate as listed on the Product' Fact Sheet; and
	  ○ the cost of the Medical Device or Human Tissue Product listed on Prescribed List as defined in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules.
	• For admissions payable under Accident Cover as described in ***F.2.6 Accident Cover,*** Benefits will be payable but limited to the accommodation fees and Medical Device and Human Tissue Products.
	• No Benefits are payable for doctor's services / fees, theatre fees or other charges.

F.2.2 Agreements with Private Hospitals and Medical Practitioners

AUHL may from time to time enter into a Hospital Purchaser-Provider Agreement (HPPA) with a Hospital, or Medical Purchaser-Provider Agreement (MPPA) with a Medical Practitioner and may, as a result of such agreements, provide Benefits, unless otherwise stated in these Fund Rules, that vary from those listed on the Product's Fact Sheet.

F.2.3 In-Hospital pharmacy Benefits

A pharmaceutical Benefit referred to in this Rule *F.2.3* must be:

- intrinsic to the Hospital Treatment provided
- clinically indicated and essential for meeting satisfactory health outcomes for the Member
- non-experimental
- in the PBS list
- TGA approved for the treatment of the condition or ailment for which the Member has been admitted

Subject to this Rule, for the Hospital Treatment described in the Product's Fact Sheet and only where Benefits are payable by AUHL for the Clinical Category:

For admissions in Private Agreement Hospital	• We will cover the costs for Pharmaceutical Benefits dispensed to the Member while the Member is an Admitted Patient at an Agreement (HPPA) Hospital and as per the agreement with that Hospital • For Restricted or Excluded Clinical Categories, no Benefits are payable for pharmaceutical charges
For admissions in Public Hospital	• No benefits are payable for pharmaceutical charges in a Public Hospital for Emergency or non-Emergency Hospitalisation.
For admissions in Second Tier Private Hospitals	• For non-Emergency Hospitalisation and Covered Clinical Categories, we will cover the costs for Pharmaceutical Benefits dispensed to the Member while the Member is an Admitted Patient as set out under the schedules supplied by the Australian Health Service Alliance (AHSA) as at the date of service. • For Emergency Hospitalisation and Covered Clinical Categories only, we will cover up to but not exceeding the rate specified and normally charged by the Hospital to patients who do not have cover with a Registered Health Insurer • No Benefits are payable for Restricted or Excluded Clinical Categories
For admissions in Non-Agreement Private Hospitals (non-Second Tier)	• No Benefits are payable for non-Emergency Hospitalisations • No Benefits are payable for Restricted or Excluded Clinical Categories • For Emergency Hospitalisation and Covered Clinical Categories only, we will cover up to but not exceeding the rate specified and normally charged by the Hospital to patients who do not have cover with a Registered Health Insurer
Maximum Quantity dispensed	• we will cover the cost for pharmaceutical benefits up to a maximum quantity dispensed as listed in the Schedule of Pharmaceutical Benefits (Department of Health and Aged Care), or as recorded on PBS Authorities

Pharmaceutical Benefits are not payable:

- Where the cost to a Member for a drug or medicinal preparation listed in the Schedule of Pharmaceutical Benefits is less than the benefit co-payment (as determined by the Department of Health and Aged Care)
- for High Cost or experimental drugs that are not listed on the Pharmaceutical Benefits Schedule or are not approved by the Therapeutic Goods Administration (TGA) for the use in the specific condition
- if the Member is treated for an illness, ailment or condition that is subject to exclusion, Waiting Period, or the Minimum (default) Benefit as described in these Rules or the relevant Product's Fact Sheet
- for pharmacy items dispensed upon leaving the Hospital

F.2.4 Non-Agreement Hospitals

Public Hospital - Emergency or non-Emergency Hospitalisation	
Overnight or same day	The Benefits payable towards the cost of treatment and overnight accommodation or same day accommodation in a shared or private room of a public Hospital will be

	equivalent to the minimum benefit for overnight or same day admissions as set out in the Private Health Insurance (Benefit Requirements) Rules 2011 as at the date of service.
Non—agreement private Hospital - Non-Emergency Hospitalisations	
Second-Tier Private Hospitals	The Benefits payable towards the cost of treatment and accommodation in a Non-Agreement Hospital that is included in the list of second-tier eligible hospitals will be the minimum Benefits referred to in Schedule 5 of the Private Health Insurance (Benefit Requirements) Rules 2011 and as set out under the schedules supplied by the Australian Health Service Alliance (AHSA) as at the date of service, and payable as per rules within the Product's Fact Sheet.
Non-Agreement Private Hospitals (non-Second Tier)	Where a private Hospital that is a Non-Agreement Hospital and is not a Second Tier Hospital, the Benefits payable for treatment and accommodation in that Hospital are referred to in the ***Non-Agreement (Private) Hospital Benefits*** table below and section ***Non-Emergency Hospitalisation*** and payable as per the rules within the Product's Fact Sheet.
Non—agreement private Hospital - Emergency Hospitalisations	
Second Tier and Non-Agreement Private Hospitals (non-Second Tier)	Where a Member makes a claim for Benefits for Emergency Hospitalisation in a Second Tier Hospital or Non-Agreement private Hospital that is not a Second Tier Hospital within Australia and the claim is accepted by AUHL as Emergency Hospitalisation, the maximum Benefit payable for treatment and accommodation in that Hospital in the ***Non-Agreement (Private) Hospital Benefits*** table below and section ***Emergency Hospitalisation*** and payable as per the rules within the Product's Fact Sheet.

Non-Agreement (Private) Hospital Benefits:

Non-Emergency Hospitalisation
• Where a Non-Agreement private Hospital in Australia is not approved for entitlement to Second Tier Hospital benefits, the Benefits payable for non-Emergency Hospitalisation are:
• The accommodation Benefits referred in Schedule 1 or Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules 2011.
• The maximum benefit for theatre fees, labour ward, intensive care and coronary care are determined by AUHL.
Emergency Hospitalisation
• For all Non-Agreement private Hospitals, including Second Tier Hospitals in Australia and for Emergency Hospitalisation:
• For Covered clinical categories as listed in the relevant Fact Sheet, up to but not exceeding the rate specified and normally charged by the Hospital to patients who do not have cover with a Registered Health Insurer.
• For Restricted clinical categories, the minimum Benefits referred to in Schedule 1 or Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules 2011.

F.2.5 Excluded Treatment and Restricted Benefits Exclusions

As determined by AUHL, selected Products will have Clinical Categories / treatments that are listed as 'covered', 'not covered', 'excluded' or 'restricted':

Where the Clinical Category is	Then
Covered	Benefits are payable according to the terms of the Products and the Fund Rules.
Excluded / Not Covered	Subject to ***F.2.6 Accident Cover*** and unless the Fund is otherwise required to pay these as 'Covered', no Benefits will be payable by AUHL towards any costs incurred by a Member for those treatments and associated services.
Restricted	Subject to ***F.2.6 Accident Cover*** and unless the Fund is otherwise required to pay these as 'Covered', Hospital Treatments are limited to the Minimum (default) Benefit for the duration of a Product's cover.

F.2.6 Accident Cover

Subject to the Fund Rules and terms of the Product, including ***F4 Compensation, Damages and Provisional Payment of Claims***, AUHL will provide Benefits for a Clinical Category that is Restricted, Not Covered or Excluded as if it was Covered, only where the Fact Sheet for the relevant Product at the date of the service states that it includes 'Accident Cover' and only where, based on relevant evidence, AUHL is satisfied:

- the Member requires Hospital Treatment due to injuries sustained in an Accident; and
- the Accident occurred on or after the Commencement Date on the relevant Product; and
- the procedure for the treatment due to this Accident is Excluded or Restricted; and
- the benefit for the treatment is payable by Medicare.

F.2.7 Co-Payments and Excesses

Excesses and Co-payments are amounts of money the Policy Holder agrees to pay the Hospital towards the accommodation costs of a Hospital Same Day or Overnight admission, including Hospital In the Home, before Benefits are payable under the terms of a Hospital Treatment Product or Combined Hospital and General Treatment Product. Where the Member selects a Product with an Excess and/or Co-payments, subject to the relevant limits and conditions as specified in the relevant Product Fact Sheet, the Member will be liable in respect of the following charges raised for the Hospital accommodation:

	Membership Category	Rules	Waivers for Accidents
Excess	Single	• for one Excess each Calendar Year.	If the Excess and/or Co-payment was waived for an admission due to an Accident, the Member may be liable for the Excess and/or Co-payment for any subsequent admission not related to an Accident.
	Couple Single Parent Family Family	• for one Excess per person each Calendar Year with a maximum 2 Excesses per Policy per Calendar Year.	
Co-payment	All Membership Categories	• for the Co-payment amount for each day for day or overnight admissions.	

F.2.8 Medical Benefits

Medical minimum Benefit	Medical Benefits can include fees raised by medical specialists, surgeons, assistant surgeons, anesthetists, physiotherapists, pathologists, and radiologists and are separate to the fees the Hospital may charge for accommodation, time in theatre and other Hospital services. For these medical fees, the Australian Government sets the Medicare Benefits Schedule (MBS). For Admitted Patients in a public or private Hospital and for eligible services, Medicare pays up to 75% of the MBS fee. Where the Member is entitled to receive Benefits for inpatient services from Australian Unity, we will pay the remaining 25%.
Gap Cover	Under eligible Products where the service for the Member is rendered by or on behalf of a Medical Practitioner under the Gap Cover scheme, we will pay up to the agreed amount. The Gap Cover scheme does not extend to costs such as Hospital Excess or medical services listed under the Pathology or Radiology category.

F.2.9 Hospital substitution programs, Chronic Disease Programs and Preventative Health Services

All Hospital and Combined Hospital and General Treatment Products provide Benefits for Hospital Substitute Treatment (Healthcare in the Home) provided by an Approved provider in Private Practice. Healthcare in the Home services can be provided in substitution for days spent in Hospital on the condition:

- the cost of Hospital Substitute Treatment is less than or equal to the equivalent costs of these Hospital-based services; and
- a Medical Practitioner has certified the care can be a substitute for hospitalisation and that AUHL certifies the service to be reasonable and clinically appropriate. At our discretion we may extend the payment of Hospital Benefits beyond the maximum periods specified in this Fund Rule in individual cases.

AUHL may also provide other benefits as described in *F.3.3 Chronic Disease Management, Preventative Health Services, and other programs.*

F.2.10 Ambulance

Emergency Ambulance Transportation and Ambulance Attendance are General Treatment Benefits. See *F.3.2 – Determination of Benefits under General Treatment for Dental, Pharmacy, Ambulance)* for details.

F3 General Treatment

F.3.1 General Treatment Benefits

The below rules apply for General Treatment:

When Benefits are Payable	
Included services	• General Treatment Products and the General Treatment component of a Combined Hospital and General Treatment Product will detail the included services only.
Purchaser Provider Agreements	• AUHL may from time to time for the Benefit of its Members enter into purchaser provider agreements with General Treatment providers and may as a result of these agreements provide Benefits which vary from those listed in the Product's Fact Sheet and Benefit Schedules.
Recognised Providers	• Benefits will only be payable in respect of charges made for services rendered by General Treatment providers who are Recognised Providers or who are members of organisations who are Recognised associations and satisfy the requirements of the Private Health Insurance (Accreditation) Rules. • AUHL may at its discretion require a General Treatment provider to complete a declaration concerning their or its Private Practice status, in the form prescribed by AUHL from time to time, prior to payment of Benefits.
Schedules	• Benefits for General Treatment consultations will only be payable as described in the Product's Fact Sheet and Benefit Schedules, and only for the time during which a Member is receiving direct or active attention. It does not include preliminary or subsequent attendances such as making of appointments and writing reports, and these cannot be treated as separate consultations. • The Benefits payable and the conditions associated for General Treatment services by Recognised Providers are listed within the relevant Product's Fact Sheet and Benefit Schedules.
When Benefits are not Payable	
Excluded	• Subject to the Fund Rules, services not detailed in the Product's Fact Sheet will be deemed excluded which means no Benefits will be payable by AUHL towards any costs incurred by a Member for those services.
Limitations	
Maximum services per day	• Benefits for General Treatment consultations will only be payable on the basis of one consultation per patient, per practitioner, per day.
Other service limitations	• As determined from time to time by AUHL, the General Treatment Benefits specified in the Product's Fact Sheet and Benefit Schedules are subject to limitations of frequency of treatment for particular items and/or combinations of items, which may be provided at the same time or within particular periods. • Unless otherwise stated, limitations apply to each Member covered by a Membership.
Lifetime Benefit limits	• Lifetime Benefit limits or 'lifetime limits' apply for the lifetime of the individual Member and apply equally to Members for particular General Treatments and are not tied to the duration of Products. The amount of Benefits that count towards a lifetime limit can be accumulated over 2 or more Products that may cover a Member. Benefits received by Members for similar services and treatments from other General Treatment Products provided by Registered Health Insurers will be included in the calculation of a Member's total lifetime limit for a treatment or service.

F.3.2 Determination of Benefits under General Treatment for Dental, Pharmacy, Ambulance

Benefits for Dental, Pharmacy and Ambulance services under General Treatment are paid up to the terms of the Product set out in the relevant Fact Sheet and Benefit Schedules, which are determined as follows:

Dental services	• Benefits will be provided only for dental item numbers and procedures published by the Australian Dental Association. • Benefits are payable only in respect of Approved procedures or services performed by a dental practitioner with general and/or specialist registration under the Health Practitioner Regulation National Law, as in force in each state and territory who is a Recognised Provider in Private Practice or employed by a Registered Health Insurer.

Out of Hospital Pharmacy		• Benefits are payable after deduction of the current PBS co-payment at the date of service, on private prescription items listed as a Schedule 4 or Schedule 8 pharmaceutical on the Australian Register of Therapeutic Goods, which are: ○ prescribed by a Medical Practitioner for the Member; ○ supplied by a registered pharmacist in Private Practice; ○ Approved by the Therapeutic Goods Administration for the indication for which they have been prescribed; ○ not otherwise supplied or Funded by a public arrangement scheme, including the Pharmaceutical Benefits Scheme; ○ not otherwise excluded by AUHL under the Fund Rules or the Member Guide
Ambulance	**General Rules**	• There will be no entitlement to Benefits for Emergency Ambulance Transportation or Ambulance Attendance: ○ where coverage is included via a State levy included within the Premiums referable to a Hospital Treatment Product or Combined Hospital and General Treatment Product; ○ where the Member is a resident of a State that provides a free Ambulance transportation scheme; ○ where the Member is covered under an ambulance subscription scheme, or the transportation is claimable from another source.
	Emergency Transportation	• Benefits will be payable where it is coded or invoiced by the relevant State Ambulance authority as an Emergency Ambulance Transportation. • There will be no entitlement to Benefits: ○ for non-emergency transportation provided by the Ambulance service that may be clinically necessary; ○ for transportation (emergency or non-emergency) provided after Hospital discharge to home including aged care facility or nursing home; ○ for non-emergency transfers between Hospitals or from medical facilities.

F.3.3 Chronic Disease Management, Preventative Health Services, and other programs

AUHL may from time to time, cover on eligible Products as referred to in the Product's Fact Sheet and Benefit Schedules, a Chronic Disease Management Program and/or Hospital Substitute Treatment program or other programs for Members. The program/s must be provided by a Recognised Provider in Private Practice.

F4 Compensation, Damages and Provisional Payment of Claims

F.4.1 Where Benefits shall not be payable

Benefits will not be payable for a claim in respect of expenses incurred for any ailment, illness, or injury:

- where a Member has an entitlement under a statutory compensation scheme to Compensation in respect of that ailment, illness, or injury; or
- where the Member has received in respect of that ailment, illness or injury, any payment of any Compensation pursuant to any judgment, award, settlement, or agreement to the extent that the Compensation includes those expenses. If we have paid Benefits for those expenses, AUHL may pursue the Member for repayment of those Benefits.

Where AUHL reasonably forms the view that a Member is likely to have a right to make a claim for Compensation under a statutory compensation scheme in respect of an ailment, illness or injury, but the Member has not yet established that right, we may, acting reasonably and upon providing reasonable notice to the Member, withhold payment of Benefits for expenses incurred in relation to that ailment, illness or injury until the Member has taken reasonable steps to pursue enquiries in relation to the claim for Compensation to AUHL's reasonable satisfaction.

If it is established that the Member has no right to Compensation, or where the Member elects not to pursue their right to claim for Compensation (acting reasonably), then Benefits will be payable in accordance with these Fund Rules.

F.4.2 Where Benefits may be available

Where the amount of entitlement of a Member for Compensation is in the reasonable opinion of AUHL less than the Benefits which would otherwise be payable under these Fund Rules, we may in our absolute discretion determine to pay Benefits for the Member concerned in such amount as we may decide, but not in any event exceeding the difference between the amount of the Benefits otherwise payable and the amount of the entitlement for Compensation.

F.4.3 Assumption of Members' legal rights

If the Member notifies us that they will not be making a claim for Compensation under Rule ***F.4.4***, then we may assume the legal rights of the Member in respect of all or any parts of the claim.

F.4.4 Member Obligations

- Where a Member establishes his or her right to a payment by way of Compensation and accepts a settlement, whether or not such settlement is later Approved by a duly constituted Court or Tribunal, Benefits are not payable where the terms of such settlement can be reasonably attributed to expenses past or future in respect of which Benefits from AUHL are otherwise payable.
- Where, in respect of a claim for Benefits for a condition, injury, or ailment, it appears to AUHL that a Member has, or may have a right to Compensation for that condition, injury, or ailment, we must inform the Member of this. Where the Member has been so informed, or where Benefits have been paid which relate to such a claim, the Member is obliged to:
    - inform AUHL as soon as the Member knows or suspects that such a right exists;
    - inform AUHL of any decision of the Member to claim for Compensation (or, for the avoidance of doubt, not to claim for Compensation);
    - keep us informed of and updated as to the progress of any claim made for Compensation (including by disclosing to AUHL and its legal advisers all matters relevant to the progress of any claim made for Compensation); and
    - inform AUHL promptly upon the determination of settlement of the claim for Compensation or the establishment of a right to receive Compensation; and
    - notify AUHL upon payment of the claim or any part payment and direct that from the proceeds of any such claim there is first deducted and paid to the Fund by way of reimbursement, an amount equal to the amount of Benefits paid by this Fund in respect of such condition, injury, or ailment.

G Claims – General Rules

Rules	
Making a claim	• Claims for Benefits will be made in a form as required by AUHL from time to time • A Member must make full and true disclosure in the claim form as to all matters referred to therein.
Evidence in support of claim	If required by AUHL, the Member must, in support of any claim for Benefits under these Fund Rules: • deliver to AUHL a signed authority authorising us to obtain from any Hospital, Medical Practitioner or Recognised Provider of the Member such medical evidence as we may reasonably require; or • provide such further evidence (Documentation) in support of the Member's claim for Benefits as we may reasonably require. AUHL may retain all such Documentation it receives under this Fund Rule ***G*** and such documents will become the property of AUHL.
Appointment of Medical Practitioner	• AUHL may appoint a suitably qualified Medical Practitioner to advise AUHL on medical and technical aspects of any claim as necessary from time to time.
Assessment of a claim	• AUHL may request and review personal information (including sensitive information) from a Member (or someone acting on their behalf), or their provider, prior to or after the payment of a Benefit for a claim. The information that may be requested is information necessary to assist in reviewing the claim only and will not be used for marketing purposes. By submitting a claim, the Member provides consent for AUHL to obtain such personal information (including sensitive information) from the relevant provider(s), which may include but is not limited to prescriptions, signed receipts, invoices, treatment plans, Medical/Patient records, and Appointment schedule.

	• Where adequate information is not provided and/or AUHL is unable to substantiate the requisite details in relation to a claim, Benefits may not be payable, or if already paid, may be recovered in accordance with Fund Rule ***F.1.3 Recovery of Benefits***.
Claim lodgment within 2 years	• AUHL will not pay Benefits for a claim submitted to the Fund more than two (2) years after the date of hospitalisation or the date services were rendered. • Where, in our opinion, hardship (including but not limited to unsuccessful claims for Compensation) would otherwise be caused to the Member, we may waive this rule and pay Benefits in respect of that claim.

Accident means an unplanned and unforeseen event, occurring by chance, and leading to bodily injuries caused solely and directly by an external force or object requiring treatment from a Medical Practitioner who is not the member or a relative of the Member, within 7 days of the event, but excludes injuries arising out of: surgical procedures; unforeseen illness; pregnancy; drug use; and aggravation of an underlying condition or injury;

Acute Care means the provision of treatment for an ailment or disability which cannot be provided by a nursing home which includes (but is not limited to) care for admitted patients where the principal clinical intent is to do one or more of the following:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of illness or injury;
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions; or
- perform diagnostic or therapeutic procedures;

Acute Care Certificate means a certificate that:

- has been completed by a Medical Practitioner;
- is in a form approved by AUHL;
- is valid for a period of 30 days;
- to the effect that an Admitted Patient is in ongoing need of Acute Care; and
- is required to support any period of continuous hospitalisation exceeding 35 days;

Admitted Patient means a person who meets a certain medical criteria and undergoes a Hospital's formal admission process as either an Overnight Stay patient or a Same Day patient to receive a service under the required Episode of care;

Agreement Hospital means a private Hospital that has entered into a Hospital Purchaser-Provider Agreement (HPPA) with AUHL;

Ambulance Attendance means the arrival of an Ambulance and attendance and treatment of a patient by a paramedic, where the condition is stable enough that transportation to Hospital is not required;

Ancillary Schedule means a General Treatment Policy document, used by AUHL, detailing claims assessment rules, Product benefits and claim eligibility criteria;

Approved in respect of a person, Medical Practitioner, organisation, Hospital, facility, treatment, or procedure, means a person, Medical Practitioner, organisation, Hospital, facility, treatment, or procedure which has been recognised or approved by AUHL for the purpose only of payment of Benefits and includes a Recognised Provider;

Artificial Aid/Appliances means any health aid or device designed to assist a Member's medical condition as Approved by AUHL, excluding Non-Surgical Prostheses and Medical Devices and Human Tissue Products;

Arrears means**,** in respect of a Membership, where the Policy Holder fails to pay in full all Premiums due to be paid by him or her on or before the due date;

Base Rate means the base rate of Premium in relation to a Product set by AUHL that would be payable if:

- the Premium amount was not increased under Fund Rule D; and
- there was no discount of the kind allowed under the Private Health Insurance Legislation

Benefit means an amount of money or service that may be provided to a Member, or on behalf of or for the benefit of a Member to a Recognised Provider, Medical Practitioner or Hospital, by the Fund, in accordance with the terms of a Product and these Fund Rules;

Benefit Replacement Period means one of the following (as determined by the statement of the Benefit in the relevant Fact Sheet for a Product):

- a continuous period of time that must occur between any two purchases of the same type of Artificial Aid/Appliance item before Benefits are payable; or
- a continuous period of time that must occur before the Benefit limit for a type of Artificial Aid/Appliance item resets following the initial purchase of that same type of Artificial Aid/Appliance item;

Benefit Schedule means Ancillary Schedule and Dental Schedules. These are maintained by AUHL outside of these Fund Rules;

Calendar Year means the twelve-month period commencing 1st January and finishing 31st December of the same year;

Child in respect of a Membership means any of the following:

- a natural child (including newborns);
- a legally adopted child;
- a stepchild;
- a foster child;

of the Policy Holder and/or Policy Holder's Partner;

Child Dependant in respect of a Membership means a Child up to the age of 22 years (inclusive) who is not married or living in a De Facto Relationship;

Chronic Disease Management Program has the same meaning within the Private Health Insurance (Health Insurance Business) Rules 2018 contained in the Private Health Insurance Legislation;

Clinically Relevant means an appropriate course of treatment such as a procedure or service that is performed or rendered by a Medical Practitioner or Recognised Provider that is generally accepted within the relevant profession;

Clinical Category has the same meaning as that in the Private Health Insurance Legislation (for ease of reference see rule 4 of the Private Health Insurance (Complying Product) Rules 2015);

Code means the Private Healthcare Australia (PHA) Private Health Insurance Code of Conduct, as amended, or replaced from time to time;

Combined Hospital and General Treatment Product means a Product that provides Benefits towards all, or some services defined as General Treatment and as Hospital Treatment through a single Product;

Commencement Date means the effective date of a Member's coverage under a Product as set out in Fund Rule ***C.1.5 Commencement Date and Duration of the Membership***;

Community means a group of people who meet the relevant criteria set out in a Community Arrangement;

Community Arrangement means an arrangement between AUHL and an organisation regarding the provision of Community Products to persons who are members of, or otherwise associated with, the organisation and meet the criteria described in the arrangement.

Community Product means a Product that is only available to Members of a Community

Company means Australian Unity Health Limited (ACN 078 722 568);

Compensation means any of the following:

- a payment of compensation or damages pursuant to a judgment, award, or settlement;
- a payment in accordance with a scheme of insurance or compensation provided for by Commonwealth or State law (for example, workers compensation insurance);
- settlement of a claim for damages (with or without admission of liability);
- a payment for negligence; or
- any other payment that, in the opinion of AUHL, is a payment in the nature of compensation or damages.

A reference to a Member receiving Compensation includes Compensation paid to another person at the direction of the Member and Compensation paid to another Member on the same Membership in connection with a treatment, good or service received by the Member;

Constitution means the constitution of AUHL;

Co-payment means a daily amount of money the Policy Holder agrees to pay the Hospital for a Hospital stay for a Member before Benefits are payable under the relevant Hospital Treatment Product or Combined Hospital and General Treatment Product for that Hospital stay;

Day Hospital refers to a Hospital that does not provide overnight accommodation;

De Facto Relationship means a relationship between two people who are:

- not legally married, but live together as a couple in a marriage type relationship; and
- are otherwise as determined by relevant laws to be living in a de facto relationship;

Dental Schedule means a General Treatment Policy document, used by AUHL, detailing Australian Dental Association's glossary of treatment codes, the associated Benefit payable and claim eligibility criteria;

Dependant means a Child Dependant, Non-Student Dependant or Student Dependant;

Emergency Ambulance Transportation means ambulance transportation where the ambulance provider codes and invoices the transportation as an 'emergency'. Benefits are not payable for ambulance transportation that is invoiced by the ambulance provider as non-emergency patient transport;

Emergency Hospitalisation means hospitalisation (excluding emergency department) which occurs as a result of a person presenting at a Hospital with or under at least one of the following conditions or circumstances: Significant pain; Shock; Significant infection; Acute trauma; Abuse; Committable mental illness; Significant haemorrhage or threat of haemorrhage; Vital sign or mental status change; Brought to Hospital by police; or Brought to Hospital by ambulance;

Episode is the period of care between an admission and separation such as discharge, characterised by only one care type;

Excess is an amount of money the Policy Holder agrees to pay the Hospital towards the accommodation costs of a Hospital admission before Benefits are payable under the terms of a Hospital Treatment Product or Combined Hospital and General Treatment Product;

Excluded Treatment (Excluded) refers to treatment under a Hospital Treatment Product or Combined Hospital and General Treatment Product for which Benefits are not payable;

Fact Sheet means a summary of material information applicable to a particular Product issued by AUHL to Members, but is not an exhaustive statement of the Product's terms and conditions;

Fulltime Student means a person undertaking:

- a course of education at a secondary school or tertiary institution, a trade apprenticeship or an industry, employer or government training scheme, which is accredited by a State or Federal Government, provided that the course of study results upon completion in the Student Dependant being qualified to seek or maintain gainful employment in the general workforce and that the Dependant is not, or will not remain, dependent upon the Policy Holder for personal care, domestic or social support after having attended the course of study; and
- at least three quarters of the normal fulltime study workload or otherwise deemed by AUHL as being fulltime study;

Fund means the Health Benefits Fund established and operated by AUHL in accordance with the Private Health Insurance Legislation;

Fund Rules means these rules relating to the operation of the Fund by AUHL. 'Rule' refers to a particular rule or rules within this Fund Rules;

Gap refers to the amount of money payable above the Medicare Benefits Schedule payments pursuant to a Medical Purchaser-Provider Agreement (MPPA), Hospital Purchaser-Provider Agreement or Approved scheme;

Gap Cover means an arrangement where a Medical Practitioner agrees to participate in a scheme with AUHL that covers Members on a patient-by-patient basis in excess of the Medicare Benefits Schedule for:
- all but a specified amount of the full cost of inpatient medical treatments; or
- the full cost of inpatient medical treatments;

General Conditions means Rules A to G of these Fund Rules;

General Treatment has the same meaning as described in the PHI Act 2007;

General Treatment Product means a Product which include Benefits towards services that constitute General Treatment and/or Hospital Substitute Treatment;

Health Benefits Fund has the same meaning as described in the PHI Act 2007;

Healthcare in the Home means a Hospital Substitute Treatment program and can include an early discharge or substitution from an acute Hospital care program. Members in consultation with their Medical Practitioner may choose to utilise these services to reduce or avoid acute Hospital accommodation or recovery as described in the Product's Fact Sheet;

Health Insurance Act means the Health Insurance Act 1973 (Cth);

Health Management Program has the same meaning as described in the Private Health Insurance Legislation;

Health Related Business has the same meaning as described in the PHI Act 2007;

High-Cost Drug means medicines which:
- are not listed on the pharmaceutical benefits scheme under the National Health Act;
- incur acquisition cost equivalent to or more than $250 per dose to a Member; and
- are not covered by any other funding source;

Home Nursing means services provided by a Registered General Nurse in Private Practice at the home of the Member. Unless otherwise notified by AUHL from time to time, a registered Medical Practitioner must have certified the Home Nursing services and that those services are/were in lieu of hospitalisation;

Hospital has the same meaning ascribed to that term under the Private Health Insurance Legislation and includes a Day Hospital facility;

Hospital Benefit means any Benefit in respect of any Hospital Treatment as set out in the relevant Fact Sheet;

Hospital Purchaser-Provider Agreement (HPPA) means an agreement entered into between AUHL and a Hospital and as amended from time to time;

Hospital Substitute Treatment has the same meaning as described in the PHI Act 2007;

Hospital Treatment has the same meaning as described in the PHI Act 2007;

Hospital Treatment Product means a Product which include Benefits towards services that constitute Hospital Treatment only;

Last Day of the Suspension Period means the day on which a suspended Membership shall cease to be suspended for the purposes of calculating Premium owing;

Medical Devices and Human Tissue Products means products listed on Prescribed List as defined in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules;

Medical Practitioner means a person as defined in the Health Insurance Act and as amended from time to time;

Medical Purchaser-Provider Agreement (MPPA) means an agreement entered into, between AUHL and a Medical Practitioner, as described in the PHI Act 2007 and as amended from time to time;

Medicare Benefits Schedule means the 'Medicare Benefits Schedule ' published by the Department of Health and Aged Care and includes any updates to the Schedule published from time to time;

Member means a Policy Holder, Policy Holder's Partner, or a Dependant;

Membership means the collection of rights and obligations that apply to Members under these Fund Rules arising out of the purchase of a Product;

Mental Health Waiver means the once-in-a-lifetime waiver of the Waiting Period for an upgrade for in-Hospital psychiatric treatment in accordance with the Private Health Insurance Legislation;

Minimum (default) Benefit means for the purpose of Hospital Treatment the minimum benefits payable by AUHL as required in the Private Health Insurance Legislation;

Non-Agreement Hospital means a Hospital either public or private that does not have a Hospital Purchaser-Provider Agreement with AUHL;

Non-Student Dependant in respect of a Membership means a Child who is:
- between the age of 23 (inclusive) and 30 (inclusive);
- not a Fulltime Student; and
- not married or living in a De Facto Relationship;

Non-Surgical Prosthesis in respect of General Treatment benefits means any external appliance or device Approved by AUHL that is associated with the physical replacement of some part of the human body such as a limb, eye, or wig;

Nursing Home Type Patient (or "NHTP") has the same meaning as described in the Private Health Insurance Legislation;

Overnight Stay means a period of time in a Hospital that spans both daylight hours and midnight;

Overseas Visitor Product means a Product that offers Hospital and medical insurance to people who are not citizens of Australia and/or are not eligible to full Medicare entitlements;

Pharmaceutical means any medicine listed in the Pharmaceutical Benefits Schedule that is dispensed to the Member;

Pharmaceutical Benefits Schedule or **PBS** means the "Schedule of Pharmaceutical Benefits" published by the Department of Health and Aged Care;

Policy means an insurance policy that covers Hospital Treatment or General Treatment or both (whether or not it also covers any other treatment or provides a Benefit for anything else);

Policy Holder means the person in whose name an application for Membership has been accepted and who is responsible for Premium payments;

Policy Holder's Partner means a legally married spouse of, or a person in a De Facto Relationship with, the Policy Holder;

Pre-existing Condition (PEC) means an ailment, illness, or condition that in the opinion of a Medical Practitioner appointed by AUHL, the signs or symptoms of that ailment, illness or condition existed at any time in the period of six months ending on the day on which the Member became insured under the Policy. In forming their opinion, the Medical Practitioner must have regard to any information in relation to the ailment, illness, or condition that:

- the Medical Practitioner who treated the Member for the ailment, illness, or condition; and
- AUHL,

gives them;

Premium means the amount payable by an individual Policy Holder in respect of the Product referable to their Membership;

Private Health Insurance Legislation for the purposes of these Fund Rules means the Private Health Insurance Act 2007 (Cth), Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and any regulations, rules and other instruments under them and consolidations, amendments, reenactments, or replacements of any of them, and other related laws;

Private Practice means a professional practice (whether sole, partnership or group) that operates on an independent and self-supporting basis. This means that its accommodation, facilities and/or services are not provided or subsidised by another party such as a public Hospital or publicly funded facility;

Private Room means in relation to a Hospital patient a room in which a person occupies the sole bed in the room but does not include a room normally fitted and furnished for multiple occupancy but occupied by one person;

Product means a collection of insurance Policies issued by AUHL:

- that cover the same treatments; and
- that provide Benefits that are worked out in the same manner; and
- whose other terms and conditions are the same as each other;

Recognised Provider means a provider of General Treatment (whether the provider is an individual or an organisation) who:

- is Approved and registered by AUHL as a provider of relevant treatment, goods, or services;
- holds all necessary registrations, licenses, or approvals under relevant State legislation to render the relevant treatment, goods or services including in relation to the premises from which the treatment, goods or services are to be, or are being, provided; and
- complies with all other requirements of the Private Health Insurance (Accreditation) Rules;

Registered Health Insurer means an organisation that is permitted to provide, or is registered as a provider of, private health insurance in Australia under the Private Health Insurance Legislation;

Registered Podiatric Surgeon means a podiatric surgeon who holds specialist registration in the specialty of podiatric surgery under the Health Practitioner Regulation National Law Act 2009;

Respite Care means where the primary reason for admission is the short-term unavailability of the patient's usual care. Examples may include:

- admission due to carer illness or fatigue;
- planned respited due to carer unavailability;
- short term closure off care facility;
- short term unavailability of community services

Restricted Benefit means the Minimum (default) Benefit that applies to a service or treatment under a Hospital Treatment Product continuously for the life of the Product;

Same Day means a period of time in a Hospital that is not an Overnight Stay (i.e., that does not span midnight);

Second Tier Hospital has the same meaning as the term; "second-tier eligible hospital", used in the Private Health Insurance Legislation (for ease of reference see the Private Health Insurance (Benefit Requirement) Rules 2011;

Special Consideration means the application for request for reinstatement of a Membership which was terminated due to Arrears, as described in Fund Rule ***C.1.11- Termination by AUHL***;

Student Dependant in respect of a Membership, is a Child who is:

- between the age of 23 (inclusive) and 30 (inclusive);
- not married or living in a De Facto Relationship; and
- a Fulltime Student;

Transfer means the process in which a person joins a Product from another Product or Membership of the Fund or joins a Product offered by the Fund from another Registered Health Insurer;

Transfer Certificate means a certificate issued by a Registered Health Insurer detailing full health insurance cover details and claims histories of a person Transferring from the fund operated by that insurer and meeting the required criteria as detailed in the Private Health Insurance Legislation;

Waiting Period means a period during which a Member must hold continuous Membership under a particular Product or Membership before the Member has an entitlement to receive a Benefit at the level payable on that Product.