AUSTRALIAN UNITY HEALTH LIMITED FUND RULES

All Registered Health Insurers are required to have fund rules under the Private Health Insurance Legislation.

These Fund Rules set out the general principles and rules of membership under which the Company conducts its business.

IMPORTANT NOTES

Before taking out private health insurance with the Company, you and all other persons to be covered on your Membership with the Company must read these Fund Rules. By taking out private health insurance with the Company, you and all the other persons on your Membership become Members of our Fund and agree to our Fund Rules as amended from time to time.

We recommend that these Fund Rules be read together with your product Fact Sheet, member guide, and the terms and conditions. Where terms are capitalised in these Fund Rules, they have the meaning given to them as determined by Section B of these Fund Rules.

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A INTRODUCTION

A1 Rules Arrangement

A.1.1 The Fund Rules

These Fund Rules consist of:

- the General Conditions; and
- the Schedules.

A.1.2 Application of the Fund Rules

These Fund Rules apply to all Products and govern the rights and obligations of Members and the Company in relation to the Fund.

A.1.3 Order of Precedence

In the event of any inconsistency between the General Conditions, any provision in the Schedules and/ or the Constitution, then such inconsistency shall be resolved and prevail in the following order of precedence:

- the Constitution;
- the General Conditions; and
- the Schedules.

A copy of the Fund Rules (General Conditions) and Constitution are available at australianunity.com.au/importantdocuments. A copy of the Schedules can be made available by contacting Australian Unity on 13 29 39.

A2 Health Benefits Fund

A.2.1 Establishment and operation of the Fund

The Company is a for-profit organisation incorporated under the Corporations Act 2001 (Cth) and has established the Fund in accordance with the Private Health Insurance Legislation.

A.2.2 Object of the Fund

The object of the Fund is to provide financial assistance to Members towards the cost of Hospital Treatment and / or Hospital Substitute Treatment and /or General Treatment in accordance with the Private Health Insurance Legislation and these Fund Rules.

A.2.3 Entitlement to Benefits

A Member will be entitled to Benefits and rights provided under the Member's Membership provided that the Membership is not in Arrears.

A.2.4 No entitlement to reserves or surplus of Fund

Subject to Fund Rule A.10 a Member is not entitled to share in any reserves or surplus of the Fund.

A.2.5 Supplementery documents

Where required, the Company will supplement these Fund Rules with the Member Guide and Terms and Conditions (together, the Supplementery Documents), which are available on the Australian Unity website

and will be provided to the Contributor after joining the Fund. All Members are bound by these Supplementary Documents.

A3 Obligations to Insurer

A.3.1 Members bound to Fund Rules

Members of the Fund shall be bound by these Fund Rules and Supplementary Documents, which the Company may amend from time to time in accordance with Fund Rule A7.

A.3.2 Acceptance of Fund Rules

An application to become a Member shall constitute an acceptance by the Member of all terms and conditions in these Fund Rules.

A4 Governing Principles

In addition to these Fund Rules, the rights and obligations of Members and the Company will be governed by:

- the Private Health Insurance Legislation including subordinate legislation;
- the Health Insurance Act and the National Health Act 1953 (Cth);
- the Australian Consumer Law;
- any conditions imposed or any directions made by the Minister for Health under the Private Health Insurance Legislation;
- the rules of the Australian Government's Department of Health and Aged Care or its successor, as they apply to Registered Health Insurers;
- the rules of the Australian Prudential Regulation Authority or its successor; and
- the Constitution.

A5 Use of Funds

A.5.1 Fund assets to be kept distinct and separate

The Company must keep the assets of the Fund distinct and separate from assets of its other health benefits funds (if any) and from all other money, assets or investments of the Company.

A.5.2 Applying or dealing with assets of the Fund

The Company must not apply, or deal with, assets of the Fund, whether directly or indirectly, except in accordance with the Private Health Insurance Legislation. The Company must credit the following amounts in respect of the Fund, to the Fund:

- Contributions payable under policies of insurance that are referable to the Fund;
- income from the investment of assets of the Fund;
- money paid to the Company under a judgment of a court relating to any matter concerning the business of the Fund;

- any other money received by the Company in connection with its conduct of the business of the Fund; and
- any other amounts that the Private Health Insurance Legislation specify.

Payments from the Fund may not be made for any purpose other than to;

- meet the Membership liabilities in accordance with these Fund Rules;
- meet other liabilities or expenses incurred for the purposes of the business of the Fund; and
- make distributions, investments and for any other purpose allowed under the Private Health Insurance Legislation.

A6 No Improper Discrimination

When operating the Fund and making decisions in relation to persons applying for Membership or Members, the Company will not have regard to the following matters, except as permitted by the Private Health Insurance Act or other legislation:

- the suffering by the person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or
- the gender, race, sexual orientation or religious belief of a person; or
- the age of a person; or
- where a person lives; or
- any other characteristic of a person (including, but not just, matters such as occupation or leisure pursuits) that is likely to result in an increased need for Hospital Treatment or General Treatment; or
- the frequency with which the person needs Hospital Treatment or General Treatment; or
- the amount or extent of the Benefit to which the person becomes entitled during a period under his or her Membership; or
- any other matter set out in the Private Health Insurance Legislation as being improper discrimination.

A7 Changes to Rules

A.7.1 The Company may amend these Fund Rules

The Company may amend these Fund Rules or Supplementary Documents by publishing the new or amended version on the Company's website. If the new or amended Fund Rules or Supplementary Documents are or might be detrimental to the interests of Members, the Company will provide reasonable prior written notice to the Contributor (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.

A.7.2 Overriding waiver

The Company may waive the application of a Fund Rule, in its 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 the Company to waive the application of that Fund Rule in any other circumstance.

A8 Dispute Resolution

A.8.1 Internal Dispute Resolution process

A Member may at any time make a complaint to the Company in connection with the Fund or any matter relating to a Contributor's Membership or Product. Such complaints may be made orally or in writing by the Member. The Company will use reasonable endeavours to respond to the complaint quickly and efficiently and in accordance with its internal dispute resolution process.

A.8.2 Private Health Insurance Ombudsman

A Member may contact the Private Health Insurance Ombudsman at any time in relation to any issue with the Fund and nothing in these Fund Rules restricts such contact.

A9 Notices

A.9.1 Service of notices

Any notice required to be provided by the Company to a Contributor or Member under these Fund Rules (Notice), unless otherwise prescribed by the Private Health Insurance Legislation, will be:

- in writing, explaining in plain English;
- delivered to the address (including any electronic address) last nominated by the Member to the Company; and
- an obligation by the Contributor to inform Members within that Membership of change and shall notify any adult insured under that Product of the change within a reasonable period.

A.9.2 Private Health Information Statements

In accordance with the Private Health Insurance Legislation the Company will make available up to date Private Health Information Statements:

- to all persons on request;
- to the Contributor of every Membership that is commenced with the Company, along with details of what the Membership covers and how Benefits under it will be paid, and a statement identifying that the Membership is referable to the Fund operated by the Company;
- to the Contributor of every Membership when a change to the Fund Rules that is or might be detrimental to the interests of a Member requires an update to the Standard Information Statement for that Member's Product;
- to the Contributor of every Membership at least every 12 months; and
- to the Contributor of every Membership that is transferred from another Product or Registered Health Insurer.

A.9.3 Contributor to inform the Company of changes

A Contributor must inform the Company as soon as reasonably possible after a change of address of any Member under the Membership.

A.9.4 Availability of Fund Rules to Members

These Fund Rules (General Conditions), Member Guide , Terms and Conditions are available on the Company's website at australianunity.com.au/importantdocuments. The Schedules can be made available by contacting Australian Unity on 13 29 39.

A10 Winding Up

Where the Fund ceases to be registered under the Private Health Insurance Legislation:

- the Fund will be wound up according to the requirements of the Private Health Insurance Legislation; and
- any credits or outstanding liabilities of the Fund shall be utilised as determined by the Board of Directors of the Company, in accordance with the Constitution and the Private Health Insurance Legislation.

A11 Other

Subject to you meeting the membership eligibility criteria determined by the Board of Australian Unity Limited ('AUL') the Board of AUL may determine that you will become a member of AUL. By becoming a Member of the Fund, you consent on behalf of yourself and the other Members on your Policy, to become a member of AUL and agree to be bound by the Constitution of AUL, in particular, you agree to contribute an amount not exceeding $1 to the property of AUL in the event of AUL being wound up while you are a member of AUL or within 1 year afterwards as set out in the Constitution of AUL. A copy of the AUL Constitution is available on the Company's website at australianunity.com.au/importantdocuments.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

In these Fund Rules, except where the context otherwise requires:

- the singular includes the plural and vice versa, and a gender includes other genders;
- another grammatical form of a defined word or expression has a corresponding meaning;
- a 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;
- 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;
- unless defined in Fund Rule B2, capitalised terms have the understanding to be reasonably understood by the private health insurance industry or Private Health Insurance Legislation as applicable;

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.
- Where there is a reference to surgical prosthesis, surgically implanted prostheses, prostheses list, prosthesis schedule, it means the Medical Device and Human Tissue Products listed on Prescribed List under as defined in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules

These Fund Rules are to be interpreted as far as possible in a manner that is consistent with the Private Health Insurance Legislation.

B2 Definitions

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 (defined here as a medical doctor 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 the Company;
- 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 the Company;

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 the Company, 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 the Company for the purpose only of payment of Benefits and includes a Recognised Provider;

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

Artificial Aids/Appliances means any health aid or device designed to assist a Member's medical condition as Approved by the Company, excluding Prostheses;

Banding System means the methodology used to categorise Hospital procedures including for the application of accommodation and theatre charges;

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

- the Contribution amount were not increased under Fund Rule D4; and
- there was no discount of the kind allowed under subsection 66-5(2) of the Private Health Insurance Act 2007;

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;

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 Contributor and/or Contributor'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 2017 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 referred to in the Schedules 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 C5.1;

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

Community Arrangement means an arrangement between the Company 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 set out in Schedules J.44–47 and I.35–38;

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 the Company, is a payment in the nature of compensation or damages;

Constitution means the constitution of the Company;

Continuous Hospitalisation means where an Admitted Patient has an Overnight Stay, is then discharged and within seven (7) days is admitted to the same or different Hospital for the same or related condition;

Contribution means the amount payable by an individual Contributor in respect of the Product referable to his or her Membership;

Contribution Group means a group of Contributors Approved by the Company for the purpose set out in Fund Rule D.3.3;

Contributor means the person in whose name an application for Membership has been accepted and who is responsible for Contribution payments;

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

Convalescent Care refers to a short period of non-acute care provided to assist in a person's recovery from a serious illness, injury or surgery immediately following an acute hospital admission and includes (but is not limited to) non-weight bearing period, awaiting services to be put in place and maintenance care;

Co-payment means a daily amount of money the Contributor 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. This includes Hospital In The Home and Rehabilitation In The Home when Benefits are payable for these services as part of an Agreement Hospital contract;

Cosmetic Procedures means any surgery, treatment or other procedures which are not allocated an item within the Medicare Benefits Schedule issued by the Medical Services Advisory Committee;

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;

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

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

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 Contributor 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 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 the Company 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 Contributor 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 the Company as being fulltime study;

Fund means the health benefits fund established and operated by the Company in accordance with the Private Health Insurance Legislation;

Fund Rules means these rules relating to the operation of the Fund by the Company;

Gap Benefits 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 the Company 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 Fund Rules A to G of these Fund Rules;

General Treatment means treatment (including the provision of goods and services) that is intended to manage or prevent a disease, injury or condition that is not Hospital Treatment. General Treatment includes Hospital Substitute Treatment;

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

Health Insurance Business means the business of providing insurance that relates to Hospital Treatment or General Treatment;

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 the Company 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 as set out in the relevant Schedule;

Hospital Care At 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 Schedules;

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

Hospital Substitute Treatment is treatment that substitutes for an Episode of Hospital Treatment and is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition;

Hospital Treatment is treatment (including the provision of goods and services) that:

- is intended to manage a disease, injury or condition; and
- is provided to a person:
- by a person who is authorised by a Hospital to provide the treatment; or
- under the management or control of such a person; and

either:

- is provided at a Hospital; or
- is provided, or arranged, with the direct involvement of a Hospital,
- Hospital Treatment includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance Legislation as "hospital treatment";

Hospital Treatment Product means a Product referred to in the Schedules 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 Contribution owing;

Lifetime Health Cover Age means, in relation to an adult who takes out hospital cover after his or her Lifetime Health Cover Base Day, the adult's age on the 1 July before the day on which the adult took out the hospital cover;

Lifetime Health Cover Base Day has the same meaning as set out in the Private Health Insurance Legislation;

Loyalty Limit means a yearly Benefit amount for a service that may increase in a Calendar Year with continuous Membership as set out in the relevant Product Schedule for an eligible General Treatment Product, and is not transferrable between Products;

Medical Practitioner means a person as defined in section 3 (1) of the Health Insurance Act and as amended from time to time;

Medical Purchaser-Provider Agreement (MPPA) means an agreement entered into, between the Company and a Medical Practitioner, as described under section 172-5 (1) of the Private Health Insurance Act 2007 and as amended from time to time;

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

Member means a Contributor, Contributor'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 Legislation;

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

New Product has the meaning given to that term in Fund Rule C.6.1;

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

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 the Company 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**") a patient becomes a NHTP after they have received Hospital Treatment at a hospital for a continuous period of hospitalisation exceeding 35 days and are then receiving accommodation and nursing care as an end in itself;

Old Product has the meaning given to that term in Fund Rule C.6.1;

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;

Palliative Care in respect of Hospital Treatment means Hospital care provided to a patient where the patient's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the patient chooses not to pursue curative treatment. Palliative care provides relief of suffering and enhancement of quality of life. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative care if they are undertaken specifically to provide symptomatic relief;

Permitted Days refers to time where a person does not incur any lifetime health cover penalty due to not being covered by a Policy that covers Hospital Treatment;

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);

Pre-existing Condition (PEC) means an ailment, illness or condition that in the opinion of a Medical Practitioner appointed by the Company, 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
- the Company,

gives him or her;

Private Health Information Statement means a brief summary of the key features of a Product that contains the information, and is in the applicable form, set out in the Private Health Insurance Legislation;

Private Health Insurance Legislation means the Private Health Insurance Act 2007 (Cth), Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and their regulations, rules and other instruments under them and consolidations, amendments, re-enactments 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 the Company:

- 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;

Proper Officer means a senior manager of the Fund authorised to make operational decisions on behalf of the Company and in line with these Fund Rules who is appointed by the Company from time to time and includes any delegate appointed by the Proper Officer to act on his or her behalf under these Fund Rules;

Prosthesis means a Surgical Prosthesis or a Non-Surgical Prosthesis;

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

- is Approved and registered by the Company as a provider of relevant treatment, goods or services;
- holds all necessary registrations, licences 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 respite due to carer unavailability;
- short term closure of 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);

Schedules mean Fund Rules I to M of these Fund Rules;

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

Special Consideration means the process specified in Fund Rule C8.4;

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;

Surgical Prosthesis in respect of Hospital Treatment Benefits is any implanted item that is listed on the Australian Government's Prosthesis schedule, as Approved by the Minister under the Private Health Insurance Legislation by which the minimum payable Benefit is determined;

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;

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;

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

Weight Loss Goal is the amount of weight loss that the Member has agreed with the program consultant that they will endeavour to lose as a result of a Company Approved weight loss program that forms part of a Benefit under a Preventative Health Service;

Year of Entitlement means the number of Calendar Years of Membership with the Fund, less any applicable 12 month qualifying period.

C MEMBERSHIP

C1 General Conditions of Membership

C.1.1 Membership Categories

The Company may offer the following Memberships categories to the specified categories of Members

- Singles Membership which consists of:
    - Singles scale: the Contributor only;
- Single Parent Family Membership which consists of:
    - Single Parent Family scale: The Contributor and at least one Child Dependant and/or Student Dependant, but no Non-Student Dependant(s); or
    - Single Parent Family Plus scale: The Contributor and at least one Non-Student Dependant and can additionally include one or more Child Dependants and/or Student Dependants;
- Couples Membership which consists of:
    - Couples scale - the Contributor and the Contributor's Partner only;
- Family Membership which consists of:
    - Family scale: The Contributor, the Contributor's Partner and at least one Child Dependant or Student Dependant, but no Non-Student Dependant(s); or
    - Family Plus scale: The Contributor, the Contributor's Partner and at least one Non-Student Dependant and can additionally include one or more Child Dependants and/or Student Dependants.

C.1.2 Types of Products

A person may be admitted to the Fund as a Member following the purchase of one of these Products and otherwise complying with the applicable Fund Rules:

- a Hospital Treatment Product;
- a General Treatment Product;
- any combination of a Hospital Treatment Product and General Treatment Product allowed to be purchased concurrently in the Schedules; or
- a Combined Hospital and General Treatment Product.

C.1.3 Product availability

The Company may from time to time offer a Product that is only available to purchase:

- by only one or more selected Membership categories as outlined in Fund Rule C.1.1;
- in the case of a General Treatment Product, where a particular Hospital Treatment Product must be purchased along with the General Treatment Product;
- in the case of a Community Product, on its own or with another Community Product.

C.1.4 Rights of Contributors

In relation to a Membership, provided the Contributor complies with eligibility criteria in Fund Rule C2, the Contributor may:

- submit claims on behalf of the Contributor, Contributor's Partner and Dependants on the Membership;
- request from the Company a statement of claims made by the Contributor, Contributor's Partner and/or any Dependants under the Membership, (unless the Contributor's Partner and Dependants have requested the Company to not disclose their personal claims history to the Contributor);
- request that their claims history and or any other personal information including address not be disclosed to any person, including the Contributor's Partner or Dependants under the Membership;
- change the contact/notice details on the Membership;
- change the payment method and frequency;
- register or de-register Contributor's Partner and/or Dependants on the Membership;
- change the Product(s) referable to the Membership;
- apply to receive the Federal Government Rebate and nominate a tier in relation to the Membership;
- cease being the Contributor on the Membership by nominating the Contributor's Partner (if named on the membership) as the Contributor;
- cancel and, subject to these Fund Rules, suspend or re-instate the Membership; and
- request Contribution records of the Membership.

C.1.5 Rights of Contributor's Partner and Dependants

Subject to any greater authority granted under rule C.1.6, in relation to a Membership, the Contributor's Partner (if named on the Membership) or a Dependant may:

- pay Contributions;
- request that their claims history not be disclosed to any person, including the Contributor;
- de-register themselves from the Membership (permanently – not by suspension) without the approval of the Contributor;
- make enquiries in relation to their Product specifications; and
- submit claims under the Membership.

A Child Dependant who is under the age of 16 years cannot make any administrative decisions, including in relation to claims, with respect to the Membership or their registration under the Membership.

C.1.6 Delegated Authority

A person may be granted authority to access or make changes to the Membership, or otherwise act on behalf of the Contributor, as permitted and on terms determined by the Company.

C.1.7 Restriction of outside coverage

Unless otherwise expressly permitted by the Private Health Insurance Legislation, a person shall not be admitted as a Contributor, Contributor's Partner or Dependant or continue as a Contributor, Contributor's Partner or Dependant, to a Hospital Treatment Product or Combined Hospital and General Treatment Product if he or she is covered for Hospital Treatment under a private health insurance Policy provided by another Registered Health Insurer.

C.1.8 Dual Membership

- In the Company's discretion, a Member insured under a General Treatment Product of the Fund may be insured under a concurrent General Treatment Product of the Fund. Where this dual Membership exists, portability does not apply between either Membership.
- At the absolute discretion of the Company, where a Dependant of a Contributor needs to be covered under both a Contributor's Membership and the Membership of an estranged Contributor's Partner, dual Memberships of Hospital Treatment Products, Combined Hospital and General Treatment Products and General Treatment Products will be accepted, for an agreed period of time, by the Company.

C.1.9 Eligibility for Benefits

Unless otherwise agreed to by the Company, only persons who are registered as Members on a Membership are eligible to receive Benefits under a Membership.

C2 Eligibility for Membership

C.2.1 Eligibility

Subject to these Fund Rules, all natural persons are eligible to become Members of the Fund. The Fund shall consist of an unlimited number of Members.

C.2.2 Minimum Age of Contributor

Unless the Company otherwise determines, a person may be a Contributor at any age. In the case where the Contributor is under the age of 16 years of age however, the submission of an application for Membership must be by the legal parent/guardian who accepts all terms and conditions of Membership, including these Fund Rules, on behalf of the Contributor.

C.2.3 State of Residence

A Member may hold Membership for the version of the Product applicable to the Member's State of residence.

C3 Dependants and Contributor's Partner

C.3.1 Types of Dependants

The types of Dependants are:

- Child Dependant
- Student Dependant
- Non-Student Dependant

C.3.2 Registration of Dependants and Contributor's Partner

- Subject to the eligibility requirements in Fund Rule C2, a Contributor may register a person as a Dependant or Contributor's Partner on a Membership by providing the personal details of the person in the form and in the manner reasonably required by the Company.
- A Dependant or Contributor's Partner, can only be added from the date the application is made, or a later date, unless otherwise permitted by the Company as per Rule C.3.4 and C.4.3.
- Subject to Rule C.4.3 and C.3.4 and where the addition of a person to a Membership results in a scale change (as required by Fund Rule C.1.1) or results in other premium adjustments due to Lifetime Health Cover and/or adjustment of the Federal Government Rebate, the Membership will be amended from the date the person is added. Contributions for the Membership will be adjusted accordingly.

C.3.3 Continuity of cover with no Waiting Periods- former Dependants or former Contributor's Partner

A former Contributor's Partner or former Dependant over the age of 16 years who is no longer covered on the family or Couples Membership may transfer from that Membership to their own Product, becoming a Contributor and Member on their own right (Own Product) with no Waiting Periods applying to the Product, subject to the following:

- 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 the Company; or
    - within 30 days of the Contributor's Partner ceasing to be covered under the family or Couples Membership; and
    - the applicant must transfer to a Product that offers an equivalent or lower level of Benefits to that offered under the family or Couples Membership; and

- the applicant must have served all Waiting Periods that apply to the family or Couples Membership (where applicant has not served all applicable Waiting Periods or Benefit Replacement Periods under the family or Couples' Membership's Product, then the balance of any unexpired Waiting Period or Benefit Replacement Period for those Benefits must be served before the new Benefits are available); and

the Commencement Date of their Own Product must be the date following the Dependant's or Contributor's Partner's removal from the family or Couples Membership and Contributions are paid back to the date at which the family or Couples Membership ceased. C.3.4 Continuity of cover when no Waiting Periods apply– Re-registration of former Dependant and Contributor's Partner on a family or Couples Membership

A Contributor's Partner or Dependant who is removed from a family or Couples Membership and subject to their eligibility to be covered in the Membership, may be added back to that Membership with no Waiting Periods applying to the Product the Membership had at the day they were ceased to be covered, 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 the Company;
- For Contributor's Partner, an application for cover must be received by the Fund within 30 days of the Contributor's Partner ceasing to be covered under the Couples or family Membership held with the Company; and
- the Commencement Dates of the the Dependant's and Contributor's Partner's on the Membership after the re-registration, must be the date following their removal from the Membership; and
- subject to the Rules, if the re-registration results an increase of the premium, Contributions are paid back to the date at which they were added back to the Membership.

Where the Dependant and Contributor's Partner are added to the Membership with gap in cover (more than one day after they were ceased to be covered under the Membership), Waiting Periods will apply as per Rule F3.

C.3.5 Registering a Student Dependant

A Contributor or anyone on the Membership with Delegated Authority may change the Dependant type to Student Dependant or add a Child as Student Dependant to the Membership. If the Contributor or the Delegated Authority notifies the Company within 3 months of the day the Dependant / Child becomes a Student Dependant, the Company will allow the change to be backdated to the day the Dependant / Child became a Student Dependant and any Contributions paid in advance will be adjusted on the Membership.

If the Company is notified 3 months or more after the Dependant / Child becomes a Student Dependant, the change will be effected on the day the Contributor or Delegated Authority notifies the Company of the change.

C4 Membership Applications

C.4.1 Application for Membership

A person shall apply to be admitted to the Fund as a Contributor:

- by submitting a true and correct completed application form (in paper or electronic form) or verbal application via telephone providing information as required by the Company from time to time; and

- making a valid payment of the minimum required applicable Contribution or by completing the relevant documents or authorities that will facilitate a bank debit of the applicable Contribution.

C.4.2 Obligations of person applying for Membership

The person applying for Membership must:

- make full, true and proper disclosure in the application form as to all matters referred to therein;
- provide such evidence in support of any statement made in the application form as the Proper Officer may require; and
- unless otherwise agreed to by the Company, pay to the Company an amount which is not less than the first Contribution payable if accepted as a Member of the Fund.

C.4.3 Adding a new Dependant

a. A new Dependant may be added to a family or Couples Membership, from the date of birth or date of adoption / fostering (as relevant), provided that:

    i if the Membership was a Single Parent Family/Family/Couple Membership as at the birth date or adoption / fostering date (as relevant):

        A the application to add the Dependant is received by the Fund within 12 months of the birth date or adoption / fostering date (as relevant); and

        B if the Membership was a Couple Membership as at the birth date or adoption date (as relevant), the Membership is changed to a Single Parent Family/Family Membership, effective from the birth date or adoption / fostering date (as relevant); and

        C where the change in B. 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 the Fund, and any difference in Contributions must be back-paid by the Contributor;

    ii if the Membership was a Single Membership as at the birth date or adoption / fostering date (as relevant);

        A the application to add the Dependant is received by the Fund within 30 days of the birth date or adoption / fostering date (as relevant); and

        B the 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 Contributions is back-paid by the Contributor.

b. A new Dependant who is added to a Membership outside of the timeframes in (a)(i) and (a)(ii) above can ony be added from the date the application to add the Dependant is made, or a later date.

Waiting periods may apply to the Dependants set out in F.3.7.

C.4.4 Right to reject application

Subject to Fund Rule A6, the Company reserves the right to reject an application for admission to the Fund. If an application is refused by the Fund then any Contributions paid at the time of application will be refunded in full.

C.4.5 Cooling Off Period

- Without prejudice to the Contributor's right to cancel his or her Membership under Fund Rule C7, the Company may permit the Contributor to cancel their Membership at any time within 30 days of the Commencement Date with prior written notice to, or as otherwise agreed by, the Company.
- Should the Company permit a cancellation of the Membership in accordance with Fund Rule C.4.5then the Contributor may seek a refund of Contributions paid towards the Membership, provided no claim has been made under the Membership.

C.4.6 Reinstatement of a terminated Membership

If a Membership has been terminated under the conditions outlined in Fund Rule C8 the Company has the discretion to reinstate the Membership under a request for Special Consideration from the Contributor. Continuity of Benefits will be subject to the back-payment of all outstanding Contributions by the Contributor.

C5 Duration of Membership

C.5.1 Commencement Date

Subject to any applicable Waiting Periods as set out in these Fund Rules and without limiting any other provision of these Fund Rules, a person's cover under a Product commences on:

- in the case of the Contributor, the date and time at which the application form and first Contribution is received and accepted by the Company; or
- in the case of a Contributor's Partner or Dependant, when the Contributor validly registers that Contributor's Partner or Dependant on the Membership;
- where there is a change in Policy under Fund Rule C.5.3, the date such change takes effect in relation to the Member; or
- a date other than the date set out in Fund Rules C.5.1 above and as agreed between the Company and the Contributor.

Where the Contribution is received and accepted by the Company, the Company will provide to the Contributor:

- a Private Health Information Statement; and
- a Fact Sheet in relation to the Member's selected Product which provides the details of what the Product covers and how Benefits are calculated and a statement identifying that the Membership is referable to the Fund operated by the Company.

C.5.2 Duration of Membership

Coverage under the Membership will commence on the Commencement Date and will continue until cancelled or terminated in accordance with Fund Rule C7 or Fund Rule C8 (as applicable).

C.5.3 Change of Product

A Contributor may apply to the Company to change the Product referable to his or her Membership. Such application for change will be made in the manner specified by the Company from time to time.

C6 Transfers

C.6.1 Transfers - Australian Registered Health Insurers

An applicant for Membership may transfer from a Product issued by another Registered Health Insurer (Old Product) to a Product, or another Product, provided by the Company (New Product) and be accepted as a Member of the Fund subject to this Fund Rule C6.

C.6.2 Transfers - Australian Registered Health Insurers when no Waiting Periods apply

An applicant may transfer from an Old Product to a New Product with continuity of Benefits, subject to the following:

- the transfer must take place within thirty days of the applicant ceasing to be covered under the Old Product;
- the applicant must transfer to a New Product that offers an equivalent or lower level of Benefits to that offered under the Old Product; and
- the applicant must have served all applicable Waiting Periods that apply to the Old Product; and

The above are subject to the receipt by the Company of the applicant's Transfer Certificate from the applicant's former Registered Health Insurer.

C.6.3 Transfers - Australian Registered Health Insurers when Waiting Periods apply

If an applicant transfers from an Old Product to a New Product, Waiting Periods apply in the following circumstances:

- where the applicant transfers to the New Product more than thirty days after the applicant ceased to be covered under the Old Product;
- where the New Product offers higher Benefits to that offered by the Old Product, then the Waiting Period for the higher Benefit must be served before Benefits at the higher level are available;
- where an Excess or Co-payment applied under the Old Product is higher than that which applies under the New Product, then the Waiting Period must be served before the new Excess or Co-payment is payable;
- where Hospital Treatment is required for a Pre-existing Condition, Benefits will be applied with the higher Excess or Co-payment for a period no longer than allowed under the Private Health Insurance Legislation; or
- where the Old Product and New Product offer comparable or lower Benefits but the applicant has not served all applicable Waiting Periods under the Old Product, then the balance of any unexpired Waiting Period or Benefit Replacement Period for those Benefits must be served before the new Benefits are available.

The above can be confirmed by the Company on the receipt of the applicant's Transfer Certificate from his or her former Registered Health Insurer.

C.6.4 Requirement of Transfer Certificate

Where the Company has not received a Transfer Certificate as required under Fund Rule C.6.2 or C.6.3, the Company will request one from the Registered Health Insurer in accordance with the Private Health Insurance Legislation and the Code.

C.6.5 Transfers between Products within the Fund

- 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.
- Where a member transfers to the New Product the following day after the Member ceased to be covered under the Old Product the following will apply:
    - a Member transferring from an Old Product offering lower Benefits to a New Product offering higher Benefits shall receive only the lower Benefits available under the Old Product until the Waiting Periods under the New Product have been served;
    - where the New Product has lower Benefits compared to the Benefits of the Old Product, then the Member shall receive the lower level of Benefits available under the New Product for services rendered as from the Transfer Date;
    - where Hospital Treatment is required for a Pre-existing Condition, Benefits will be applied with the higher Excess or Co-payment for a period no longer than allowed under the Private Health Insurance Legislation;
    - where the Old Product and New Product offer comparable Benefits but the applicant has not served all applicable Waiting Periods under the Old Product, then the balance of any unexpired Waiting Period or Benefit Replacement Period for those Benefits must be served before the new Benefits are available.

C.6.6 Benefits paid under Old Product to be taken into account

Benefits paid under an Old Product referred to in this Fund Rule C6 in the same Calendar Year that the Member transfers to a New Product shall 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 including:

- 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 Prosthesis;
- Recognition by the Company of a period of coverage under the Old Product in determining yearly Benefit limits under the New Product.

C.6.7 Transfers under Suspension

Where an applicant transfers from an Old Product and that Product was suspended under a mechanism equivalent to Fund Rule C9, the Fund for the purposes of Lifetime Health Cover (Fund Rule D4) will recognise the person transferring to the New Product as having held the Old Product for the duration of that suspension.

C.6.8 Transfers from Overseas Visitor Products

When a person transfers from an Overseas Visitor Product to any Product offered by the Company, the Company will apply all Waiting Periods as permitted under the Private Health Insurance Legislation to the Benefits available under the new Product. The Company may apply an exemption to the applicable Waiting Periods in this Fund Rule C.6.8 provided that:

- Waiting Periods have been served under a comparable Overseas Visitor Product provided by the Company under comparable fund rules; and

- the applicant's premium payments under the Overseas Visitor Product were up to date at the Commencement Date of the New Product.

C.6.9 Changes in Contributor

Where the Contributor dies, the Member who is registered under the Membership as the Contributor's Partner (if named in the Membership) may continue that Membership in his or her own name as a Contributor.

C7 Cancellation of Membership

C.7.1 Cancellation by Contributor

- The Contributor may cancel a Membership at any time with prior written notice to, or as otherwise agreed by, the Company. The cancellation will take effect on the day such notice is received by the Company or such later date as set out in the notice.
- Once a Membership is cancelled in accordance with Fund Rule C.7.1(a), and there is a gap in cover of greater than 1 day, all Members covered under the applicable Product shall cease to have any entitlements to all Benefits
- Retrospective cancellation of a Membership from the day after the date of a Contributor's death will be accepted by the Company subject to, if reasonably required, receipt of official documentation issued by the relevant State agency providing confirmation of the Contributor's date of death.
- A Contributor may remove any Dependants from his or her Membership at any time.
- A Contributor's Partner or Dependants 16 years and over may remove themselves from a Membership at their own request at any time.
- Unless otherwise permitted by the Company, a Dependant who is under the age of 16 years may leave the Membership only with the Contributor's written consent.

C.7.2 Refund of Contributions paid in advance

If a Contributor desires to cancel a Membership and to seek a refund of any Contributions paid in advance, the Contributor will automatically be entitled to a refund of premiums paid in advance and any refund will be calculated from the date of cancellation of the Membership.

C.7.3 Issue of Transfer Certificates

The Company must, if a person ceases to be insured under a Product and does not become insured under another Product of the Fund, give the person a Transfer Certificate within the period required by the Private Health Insurance Legislation.

C8 Termination of Membership

C.8.1 Termination of Memberships in Arrears

Without limiting Fund Rules C.8.2 or C.8.3, the Company may terminate a Membership that is in Arrears for a period of two months or longer.

C.8.2 Cancellation by the Company

Where in the opinion of the Company 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 of condition of Membership against the Fund, the Company may terminate or suspend a Contributor's Membership at

any time by giving reasonable notice in writing, describing the reason for the cancellation to the Contributor concerned and a refund of any Contributions paid in advance.

Neither the Fund nor the Company shall be under any liability on account of such termination or suspension of Membership.

C.8.3 Retained rights

The termination or cancellation of a Membership under Fund Rules C7 or C8 will not affect the right of the Company to recover from a former Member any monies payable or otherwise owing by that person to the Fund.

C.8.4 Special Consideration

Where a Membership is terminated under this Fund Rule C8 the Company may reinstate the Membership in its absolute discretion, upon written application by the Contributor in a form prescribed by the Company, stating valid reason why the Membership should accepted and reinstated by the Fund. Continuity of all applicable Benefit entitlements will apply subject to back-payment of all outstanding Contributions by the Contributor.

C9 Temporary Suspension of Membership

C.9.1 Application for suspension

A Contributor may apply to the Company to suspend his or her Membership upon the terms and conditions set out under this Fund Rule C9. An application for suspension of Membership must be made in the form prescribed by the Company from time to time. The suspension shall apply to all registered Members and Products held under the Membership.

C.9.2 Overseas suspension of Membership

The following eligibility rules apply to an application to suspend a Membership where the Contributor plans to travel overseas:

- the Membership must have a Hospital Treatment Product referable to it;
- Memberships with a General Treatment Product only shall not be eligible for suspension of Membership under this Fund Rule C.9.2;
- the Member will depart Australia for a period of no less than 2 months but no more than 2 years;
- the Membership must have been active for at least a continuous period of 1 month prior to the application being made;
- a minimum period of 12 months must have elapsed since the Member's last suspension;
- the Membership must be paid up to or in advance of the proposed effective date of suspension; and
- A Member who travels frequently overseas may make application to the Company to allow overseas travel suspension for a lesser period or on more frequent occasions than these Rules otherwise allow.
- A Contributor with two different Products under a Membership may not suspend one Product without also suspending the other Product.
- The Company will assess an application under this Fund Rule C9.2 and Fund Rule C9.4 in its absolute discretion and provide a response.

C.9.3 Financial Hardship suspension of Membership

The following eligibility rules apply to an application for a financial hardship suspension:

- the Membership must have a Hospital Treatment Product referable to it;
- Memberships with a General Treatment Product only shall not be eligible for suspension of Membership under this Fund Rule C.9.3;
- the Membership must have been active for at least a continuous period of 12 months prior to the application being made;
- a minimum period of 12 months must have elapsed since the Member's last suspension;
- the Membership must be paid up to the effective date of suspension; and
- the suspension period may be for a maximum period of three months; and
- a Membership is permitted three periods of financial hardship suspension in a lifetime.
- A Contributor with two different Products may not suspend one Product without also suspending the other Product.
- The Company will assess an application under this Fund Rule C.9.3 in its absolute discretion and provide a response.

C.9.4 Member to provide information

For overseas suspension, it is a condition of application for suspension that Members produce evidence as reasonably required by the Company including documentation evidencing dates of departure and return to Australia.

C.9.5 Acceptance of application at the Company's discretion

If the application for suspension is accepted by the Company, the Company shall confirm in writing the term of the suspension to the Contributor. The suspension, once accepted by the Company, is 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; or
- the day after the application has been Approved for financial hardship.

C.9.6 Effect 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.
- Pre-paid Contributions in respect of any part of the period of suspension are not refundable and shall be held to the credit of the Membership pending resumption of Membership. If the Membership is subsequently cancelled, refunds of pre-paid Contributions will be dealt with by the Company pursuant to Fund Rule C.7.2.

C.9.7 Resumption of Membership

A suspended Membership resumes at the earlier of:

- the day after the Last Day of the Suspension Period as Approved by the Company; or
- for a Membership suspended under C.9.2, the date the Member returns to Australia from overseas travel;
- Where the Member complies in full with the terms and conditions of the suspension, subject to Fund Rule C.9.7 (e), the Membership shall 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 Contributions held in credit under Fund Rule C.9.6 shall be applied to the Membership from the day after the Last Day of the Suspension Period.
- Any outstanding Waiting Periods must be served upon resumption of the Membership.

D CONTRIBUTIONS

D1 Payment of Contributions

D.1.1 Determining Contribution rates

Subject to Fund Rule D4, the Contribution in relation to a Product is to be calculated with reference to the applicable Membership category, Product and state of residence of the applicant or Contributor (as applicable).

D.1.2 Period for which Contributions can be made

Subject to Fund Rule D.1.3, unless otherwise offered or agreed by the Company Contributions shall be payable monthly (or in monthly multiples) in advance. The Company at its discretion may not accept Contributions for a period exceeding 12 months from the date the payment is made.

Where Contributions have been paid for a period exceeding 12 months from the date the payment is made, and the Company does not accept these Contribution, the Fund must refund the portion of Contribution exceeding 12 months.

D.1.3 Group deductions

Where Contributions are made through a group deduction scheme as referred in Fund Rule D.3.3, Contributions shall be payable at least one week in advance.

D2 Contribution Rate Changes

- Contribution rates may be changed in accordance with these Fund Rules and any requirements set out in the Private Health Insurance Legislation.
- The Company may amend the Base Rates referable to a Product in a State as permitted by the Private Health Insurance Legislation and will provide Members with reasonable prior written notice of such amendments as set out in these Fund Rules and required by Private Health Insurance Legislation.

- Whereas at the date on which the Company sends a notice under Fund Rule D.2the Company has received, in respect of a Membership, Contributions paid in advance, the amendment to the Base Rate in relation to that Membership does not take effect until the next due date of the Contributions for that Membership.

- Where the Company receives a request from the Contributor to change to a New Product of the Fund, the Contribution rate will be amended from the date of receipt of that request or future date as requested by the Contributor. Contributions paid in advance will automatically be adjusted to the new Contribution rate which may adjust the current financial date of the Membership.

D3 Contribution Discounts

D.3.1 Contribution Discounts

Unless otherwise prescribed under the Private Health Insurance Legislation, the Contribution rate for Memberships may be discounted as described below, for any of the following reasons:

- because Contributions for Products other than Community Products are paid at least 12 months in advance - 4%;

- because Contributions for Products other than Community Products are paid at least 6 months in advance - 2%;

- because Contributions for Products other than Community Products are paid by payroll (group) deduction - at the Company's discretion;

- because Contributions for Products other than Community Products are paid by pre-arranged automatic transfer from an account at a bank or other financial institution - 4%;

- because Members of the Membership (other than Community Products) have agreed to communicate with the Company, and make claims under the Membership, by electronic means only - 4%;

- because the Members of the Membership are treated under these Fund Rules as belonging to a Contribution Group - at the Company's discretion;

- because the Company is not required to pay a levy in relation to the Membership under a law of a State - at the Company's discretion; or

- for a reason set out in the Private Health Insurance Legislation – at the Company's discretion.

Where such discounts are available, a Membership is only entitled to one discount referred to above up to the maximum 12%. Where under the circumstances a Member shall qualify for more than one discount referred above, the highest discount will take precedence.

D.3.2 Discount not to exceed prescribed maximum

A Contribution rate may not be discounted greater than the maximum percentage allowed under the Private Health Insurance Legislation.

D.3.3 Contribution Groups

The Company may at its discretion approve any group of Contributors as a Contribution Group. A Contribution Group includes, but is not restricted to:

- employees of 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; or
- members of a Community.

D4 Lifetime Health Cover

D.4.1 Application of lifetime health cover provisions

- The Company shall increase the Base Rate for certain Members covered under a Hospital Treatment Product or Combined Hospital and General Treatment Product in the manner and where required under the lifetime health cover provisions of the Private Health Insurance Legislation.
- The amount of Contributions payable for Hospital Treatment Product in respect to an adult who did not have hospital cover on his Lifetime Health Cover Base Day will be increased by an amount worked out as follows:

  (Lifetime Health Cover Age – 30) x 2% x Base Rate

D.4.2 10 years continuous cover

Notwithstanding Fund Rule D.4.1, the Company shall remove any loading on the Base Rate that is payable by a Member who has held a Hospital Treatment Product or Combined Hospital and General Treatment Product where a loading required by Fund Rule D.4.1 has been applied for a continuous period of 10 years, and has only been interrupted by Permitted Days as prescribed by the Private Health Insurance Legislation.

D5 Arrears in Contributions

D.5.1 Continuation of cover following Arrears

Where a Membership is in Arrears for a period not exceeding two months and a Contributor pays such Arrears before the two-month period expires, the Membership will retain uninterrupted Benefit and Membership entitlements, provided the Contributor also complies with Fund Rule D.1.2.

D.5.2 Termination of a Membership in Arrears

Where the period of Arrears exceeds 2 months, Fund Rule C.8.1 will be applied and a Transfer Certificate will be issued to the Contributor.

D.5.3 Treatment where Contributions are in Arrears

Subject to Fund Rule D.5.1, if the Contributor does not pay Contributions due under the Membership by the due date, the Company will not pay Benefits towards any treatment received after the due date unless and until the Arrears are paid to the Company by the Contributor.

E BENEFITS

E1 General Conditions

E.1.1 Payment of Benefits

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

- Where a Member submits a claim for Benefits and the Member has paid the invoice of the provider, the Fund will make the Benefit payment directly into the financial institution account nominated by the Member in accordance with Fund Rule G.1.7.
- Where a provider's invoice is submitted with the claim and is unpaid, the Fund will pay the applicable Benefit into the provider's nominated financial institution account, or where the provider has not provided such an account to the Company, the Fund may, at its 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.

E.1.2 Benefits not to exceed charges

- Any Benefits available under a Product shall not exceed the charge(s) raised for any treatment or services rendered. Accordingly, Benefits shall be limited to 100% of the amount charged for the service or the amount of the Benefit provided under the relevant Schedules to these Fund Rules for the service, whichever is the lesser amount.

In the occurrence of Fund Rule C.1.8, where Benefits are payable from more than one source for the same treatment or service the Fund may amend the Benefit so that the total amount payable from all sources does not exceed the amount charged.

E.1.3 When Benefits are not payable

Notwithstanding any other provision of these Rules, the Fund shall have no liability in respect of a Member:

- for any aspect of a claim or higher Benefit in respect of services or treatment rendered during a Waiting Period;
- for any claim in respect of services or treatment rendered on or after the date on which a Membership is in Arrears;
- 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 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;
- for any claim in excess of fees charged or where no charge is made;
- 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 partner or Dependants of the practitioner's business partner, provided that, where the service includes a material cost the Fund may consider payment of Benefits toward the cost of purchase and supply of those materials;
- for any claim where a service was rendered outside of Australia;
- for any claim in respect of services or treatment rendered that primarily takes the form of sport, recreation or entertainment;

- for any claim where the service is not considered Health Insurance Business as prescribed under the Private Health Insurance Legislation;
- 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 provider is not:
    - a Hospital, Medical Practitioner or Recognised Provider at the time the treatment, goods or services were provided to the Member;
    - or working in Private Practice;
- where the Member has received, or established a right to receive, Compensation for treatment, goods or services;
- if the Member does not have an Acute Care Certificate after 35 days of hospitalisation;
- 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;
- where the Member has:
    - failed to make full and complete disclosure as to all matters relied upon in support of, or relevant to, a claim for Benefits; or
    - 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
    - failed to provide such information or medical evidence in respect of a claim as may be required by the Proper Officer; or
    - 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 the Proper Officer.

E.1.4 Recovery of Benefits

Where:

- an amount or any part of an amount has been paid to a Member which, by reason of an error, whether on the part of the Company, or any employee or agent of the Company, or the Member or any other person, was not in whole or in part lawfully due to the Member; and
- the Company has within a period of 24 months from the date of the payment, notified the Member of the error then the Company shall be entitled to recover from a Member the whole or that part of the said amount, as the case may be.

For the purposes of this Fund Rule, the expression "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.

For the purposes of this Fund Rule, the expression "Member" where appearing in this Fund Rule includes the Member, his or her agents, executors, administrators and assigns.

This Fund Rule E.1. does not include a claim for compensation or damages where the Company has the right to recover from a Member the whole or part of the benefits paid by the Company for services subject of the Compensation claim without regard to the limitation period of 24 months.

Without prejudice to any remedy otherwise available, the Company shall be entitled to set off against and deduct from monies otherwise payable then, or thereafter, by it to the Member, any amount recoverable by it pursuant to these Fund Rules after providing 30 days' prior written notice to the Members.

E.1.5 Treatment standard requirements

Notwithstanding anything to the contrary in these Rules, in respect of any Product, the Fund will not pay Benefits towards treatment or a person supplying treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules.

E2 Hospital Treatment

E.2.1 Hospital Treatment Benefits

- Subject to the terms of a Product, Hospital Benefits shall 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 in respect of admission for an Overnight Stay in a public or private Hospital, those Benefits will be paid according to patient classification and length of stay. Patients are classified according to the medical procedure they are admitted for and as per the guidelines issued by the Department of Health and Aged Care. The classifications are:
    - Surgical
    - Advanced Surgical
    - Obstetric
    - Other (Medical)
    - Psychiatric Care, and
    - Rehabilitation.
- A procedure is identified by reference to the relevant item number within the Medicare Benefits Schedule or by reference to Private Health Insurance Legislation.
- Where Benefits are payable in respect of admission to Hospital for a Same Day procedure, those Benefits will be paid according to the Banding System as issued by the Department of Health and Aged Care from time to time plus (where relevant) any Benefits payable in respect of theatre fees, as listed in the Schedules.
- The Fund will pay the Benefit as set out in the Australian Government Prostheses List in respect of a surgically implanted prosthesis, human tissue item or other medical device that is provided as part of Hospital Treatment (or Hospital Substitute Treatment as applicable) where a Medicare benefit is payable for the associated professional service.

E.2.2 Calculation of Benefits

In the absence of any term to the contrary appearing in a HPPA, the following Fund Rules will apply in calculating Benefits:

- The day of admission and the day of discharge shall be counted together as one day.
- For a surgical patient, Benefits at the advanced surgical and surgical rates shall be payable commencing from the day prior to the day upon which the surgery was performed provided that the Proper Officer may in his or her absolute discretion approve the payment of additional Benefits at the advanced surgical or surgical rates after consideration of medical evidence and satisfactory proof that a longer pre-operative period was necessary for the particular procedure.
- For an obstetric patient, benefits at the obstetrics rate shall be payable only from the day upon which labour (including induction of labour) commences. Benefits are not payable for admission for bed rest or observation prior to commencement of labour, unless the attending Medical Practitioner certifies that the obstetric patient needs Acute Care in Hospital, in which case Benefits are payable at the medical/other rate provided that the Proper Officer may in his or her absolute discretion approve additional Benefits at the obstetrics rate in respect of other hospitalisation directly relating to obstetrics, after consideration of the medical evidence.
- For rehabilitation patients, Benefits at the rehabilitation rate shall be payable only where the treatment is provided in an Approved facility and is supported by a rehabilitation certificate Approved by the Company that medically evidences the patient's need for a rehabilitation program to recover from an acute illness or injury.
- For psychiatric patients, benefits at the psychiatric rate shall be payable only where the treatment is for a psychiatric condition that is grouped to a mental disorder diagnostic related group (DRG) and is provided in an Approved facility or Approved program and is supported by a psychiatric certificate Approved by the Company. Benefits for treatment in an Approved facility or an Approved program are payable at the other (medical) rate.
- Where a person is discharged from Hospital and readmitted (to the same Hospital or another Hospital) within a period of seven days, both periods of hospitalisation shall be regarded as continuous, unless the re-admitting Hospital establishes to the satisfaction of the Company that the readmission was for a different medical condition from the previous admission.
- Where a patient undergoes more than one operative procedure during one theatre admission, the procedure which attracts the highest fee under the Medicare Benefits Schedule shall be used for patient classification purposes.
- Benefits at the advanced surgical and surgical/obstetrics rates are payable only in respect of the period of hospitalisation at the Hospital where the procedure was performed. Where a Member is subsequently transferred to another Hospital, the medical/other rates of Benefits shall be payable from the date of transfer to that other Hospital.
- If the Member has been in Hospital for 35 days of Continuous Hospitalisation an Acute Care Certificate is required by the attending Medical Practitioner certifying the need for either ongoing Acute Care, psychiatric or rehabilitation treatment, together with any other information requested by the Company. Upon expiry of the certificate the Member will be entitled only to those Benefits detailed in Schedule 4 Part 2 of the Private Health Insurance (Benefit Requirement) Rules as amended or replaced from time to time.

E.2.3 Benefits for Podiatric Surgery (Provided by a Registered Podiatric Surgeon)

If a Product Schedule provides a Benefit for Podiatric Surgery (Provided by a Registered Podiatric Surgeon), the only Benefits payable will be for Hospital accommodation at the medical/other rate and the cost of prostheses as listed in the prostheses list set out in the Private Health Insurance Legislation.

E.2.4 Purchaser Provider Agreements

- The Company may from time to time enter into a Hospital Purchaser Provider Agreement with a Hospital or Medical Purchaser Provider Agreement with a Medical Practitioner and may, as a result of such agreements, provide Benefits that vary from those listed in the Schedules.
- Where a Member is charged for Hospital Treatment or a professional medical treatment where a Hospital Purchaser Provider Agreement or Medical Purchaser Provider Agreement applies, the Benefits will, unless otherwise stated in these Fund Rules, be as specified in the Hospital Purchaser Provider Agreement or Medical Purchaser Provider Agreement (as the case may be).

E.2.5 Non-agreement Hospitals

Where a Member makes a claim for Benefits for hospitalisation in a Non-Agreement Hospital, minimum Benefits will be payable as detailed in Part 2 of the Private Health Insurance (Benefit Requirements) Rules 2011 and Schedule M1.1.

E.2.6 In-hospital pharmacy Benefits

- Subject to this Rule E.2.6, for the Hospital Treatment and combined Hospital and General Treatment Products described in the Schedules the Fund covers all costs that a Member incurs for pharmaceutical Benefits dispensed to the Member while the Member is an Admitted Patient at an Agreement (HPPA) Hospital.
- The Fund covers costs for pharmaceutical benefits up to a maximum quantity dispensed as listed in the Schedule of Pharmaceutical Benefits (Department of Health of Aged Care), or as recorded on an Authority Prescription Form (and authorised by the Department of Human Services).
- A pharmaceutical Benefit referred to in this Rule E.2.6 must be intrinsic to the Hospital Treatment provided, clinically indicated and essential for meeting satisfactory health outcomes for the Member and are non-experimental drugs. This does not include pharmaceutical Benefits that are Non-PBS or are dispensed to the Member but not directly related to treatment of the condition or ailment for which the Member has been admitted.
- Benefits will not be payable 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;
- Where the cost to a Member for a drug or medicinal preparation listed in the Schedule of Pharmaceutical Benefits Department of Health and Aged Care is less than the pharmaceutical benefit co-payment (as determined by the Department of Health and Aged Care), these drugs are not considered to be 'pharmaceutical benefits' and are not covered by the Fund under this section of the Fund Rules.
- Pharmaceutical benefits are not payable under this Fund Rule E.2.6 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 Schedules.

E.2.7 Accident Cover

- Where a Schedule for a Product states that it includes "Accident Cover", the Company will, subject to the remainder of this section E.2.7, provide Benefits for Hospital Treatment (as relevant to the specific Product) required for injuries sustained in an Accident, including for treatments that are otherwise listed as Excluded Treatment, Restricted Benefits or Not Covered, provided a Medicare benefit is payable.
- Where the relevant Hospital Treatment for the purposes of above clause (a) is the Clinical Category "Podiatric Surgery (provided by a registered podiatric surgeon)", Benefits will be payable for, and limited to, accommodation and prosthesis (even though no Medicare benefit is payable). Theatre fees will not be covered.
- Unless the Schedule for the relevant Product states otherwise, the Excess or Co-payment is payable in respect of the services described in Fund Rule E.2.7 above.
- Out-of-pockets costs will apply for Hospital Treatment required as a result of an Accident if the Member is admitted to a Non-Agreement Hospital.
- A Benefit for treatment required as a result of an Accident will be payable only if the following is provided to the Company to the reasonable satisfaction of the Company:
    - medical evidence to verify the occurrence of the Accident after joining the Product; and
    - for Hospital Treatment, documentary evidence of an admission to Hospital.
    - Benefits payments under this Fund Rule E2.7 are subject to Fund Rule F7.
    - Benefits will not be payable for attendance at a hospital emergency department.

E.2.8 Medical Gap Cover

Where treatment is provided to a Member in a hospital facility and medical services in respect of an Approved medical professional are rendered to which a Medicare Benefits is payable the following shall apply:

- the difference between the Benefit paid by Medicare and the Medicare Benefits Schedule (MBS) fee for eligible services - 25%; or
- Under eligible Products where the service is rendered by or on behalf of a Medical Practitioner under the "Gap Cover" scheme then up to the agreed schedule.

A Medical Practitioner who provides treatment under a Gap Cover arrangement shall give the Member written advice of any amount they can reasonably be expected to pay for those services. This is called financial consent.

The Gap Cover scheme does not extend to costs such as hospital Excess or medical services listed under the Pathology or Radiology category.

E.2.9 Miscellaneous matters

All Hospital Treatment Products and Combined Hospital and General Treatment Products offered by the Company will provide Benefits for Hospital Substitute Treatment provided by an Approved provider in Private Practice. Services can be provided in substitution for days spent in Hospital on the condition that:

- 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 the Proper Officer of the Company certifies the service to be reasonable and clinically appropriate.

The Proper Officer may, after receiving evidence from a Medical Practitioner appointed by it, exercise discretion to extend the payment of Hospital Benefits beyond the maximum periods specified in this Fund Rule in individual cases.

Hospital Treatment Benefits that will not be payable:

- where Hospital Treatments are experimental or involve a clinical pharmaceutical trial;
- for a Surgical Prosthesis that is not listed on the Prostheses List, unless it is evidenced to be Clinically Relevant and then may be Approved by the Proper Officer for Benefit payment;

The Company shall have the right to seek the validity of an Acute Care Certificate.

E3 General Treatment

E.3.1 When Benefits are payable

- 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.
- The Company may at its discretion require a General Treatment provider to complete a declaration concerning his, her or its Private Practice status, in the form prescribed by the Company from time to time, prior to payment of Benefits.
- Benefits for General Treatment consultations will only be payable on the basis of one consultation per patient, per practitioner, per day.
- Benefits for General Treatment consultations will only be payable as described in the 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 Schedules. These Fund Rules are supported by the Ancillary Schedules and Dental Schedules as maintained by the Fund.

E.3.2 Determination of Benefits

- **General Treatment Benefits for dental services** will be provided only in respect of procedures or services published by the Australian Dental Association and as set out in a relevant Product Schedule (the item numbers used therein being those provided 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.
- **General Treatment Benefits towards pharmacy** are payable after deduction of the current PBS contribution, on private prescription items (listed as a Schedule S4 or S8 pharmaceutical on the Australian Register of Therpeutic Goods) which are:
    - prescribed by a Medical Practitioner;
    - 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 the Company under the Fund Rules and Member Guide.

E.3.3 Ambulance Services

- **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 Contribution referable to a Hospital Treatment Product or Combined Hospital and General Treatment Product;
  - the Member is a resident of a State that provides a free Ambulance transportation scheme;
  - the Member holds a State based ambulance membership subscription.
- **Emergency Ambulance 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 provided after hospital discharge to home or nursing home;
  - for non-emergency transfers between Hospitals or from medical facilities;

E.3.4 Purchaser Provider Agreements - General Treatment

The Company 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 Schedules.

E4 Other

E.4.1 Chronic Disease Management and hospital substitution programs

The Company may from time to time, cover on eligible Products as referred to in the Schedules, Chronic Disease Management Program and/or Hospital Substitute Treatment program to Members. The program/s must be provided by a Recognised Provider in Private Practice. Such services include but are not limited to:

- Hospital Substitute Treatment programs (healthcare in the home):
  - Hospital Care at Home
  - Rehabilitation at Home
  - Infusions at Home
- Chronic Disease Management Programs (Health Support Programs):
  - HealthierMe®

- MindStep™ Mental Health Program

E.4.2 Preventative Health Benefits

The Company may cover on eligible Products, as referred to in the Schedules, preventative health programs to Members of the Fund. The program/s must be provided by a Recognised Provider in Private Practice. Such programs include but are not limited to:

- Doctor Health Checks
- Lift for Life
- Cervical Cancer Vaccinations
- Quit Smoking Programs
- Weight loss programs
- Diabetes Australia

E.4.3 Other programs

The Company may from time to time, cover on eligible Products, as referred to in the Schedules, other programs to Members of the Fund. The program/s must be provided by a Recognised Provider in Private Practice. Such programs include but are not limited to:

- BumptoBaby

F LIMITATION OF BENEFITS

F1 Co Payments

A Hospital Treatment Product or Combined Hospital and General Treatment Product chosen by a Member and as referred to in Schedule J will determine whether Co-payments for particular Hospital Treatment will need to be made by the Member towards the accommodation cost for a Hospital admission.

F2 Excesses

F.2.1 Products with Excesses

The Company may offer Hospital Treatment Products or Combined Hospital and General Treatment Products with Excess options. The Excess is deducted from the Hospital Treatment Benefits that would otherwise be payable by the Fund.

F.2.2 Application of Excesses

Where the Member selects a Product with an Excess, the amount of the Excess, relevant limits and conditions are specified in the in the Schedules together with the relevant Product Fact Sheet.

F3 Waiting Periods

F.3.1 Waiting periods to apply

- Unless otherwise permitted by the Company, subject to Rule C6, a Member must serve the Waiting Periods set out in this Rule F3 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.
- A Waiting Period starts from the Commencement Date of the Membership or date of transfer from another Registered Health Insurer in respect of the Member for or the registration date of the Member on the Membership (whichever date is the later) as listed in this Rule F3.
- If during a Waiting Period the Member has upgraded to a New Product from a Product with lower Benefits and the Member would have been entitled to a Benefit under the Old Product, then Member shall be entitled to Benefits at the rate provided in the Old Product.

F.3.2 Hospital Treatment Waiting Periods

The following Waiting Periods apply to a Benefit for Hospital Treatment or Hospital Substitute Treatment subject to the Members chosen New Product;

12 months	Hospital Benefits for Pregnancy and Birth Pre-Existing Conditions except Psychiatric, Rehabilitation and Palliative Care services.
2 months	Psychiatric*, Rehabilitation and Palliative Care (regardless of it being due to a Pre-Existing Condition). All other treatments not listed in this table. *Unless an eligible Member is making use of the Mental Health Waiver.
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.

F.3.3 General Treatment Waiting Period

The following Waiting Periods apply to a Benefit for General Treatment subject to the Members chosen New Product.

In line with Rule C.1.8 where a Member has undertaken a second General Treatment Policy to obtain further Benefits for General Treatment the Company will deem this to be a new cover not eligible for portability and all applicable Waiting Periods will apply:

12 months	Major dental – including Dentures and Prosthodontics (crowns, bridges and implants); Orthodontics; Surgical extraction(s); Endodontic; Periodontics; Orthotics; Hearing Aids; Non-Surgical Prosthesis; Braces and 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 and Homebirth; BumptoBaby and Health Support Programs; All other Preventative Health Services not listed in this table.
6 months	Optical Services; Health Management Services.
2 months	All other services and treatments not listed in this table.
0 months	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 On-Site Accommodation Emergency Ambulance Transportation Ambulance Attendance, as described in Rule E.3.3

F.3.4 Not Used

F.3.5 No Waiting Period applies to 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 F3 in respect of Hospital Treatment or General Treatment.

F.3.6 Waiver of Waiting Periods

The Company may, in its absolute discretion, waive or reduce a Waiting Period for Benefits, however, this waiver or reduction will not affect any other Waiting Periods, Restricted Benefits or other Fund Rule that applies to the same Benefit.

F.3.7 Waiting Periods – New Dependant

- If a new Dependant is added to a Membership and the conditions set out in either C.4.3(a)(i) or C.4.3(a)(ii) are met, the new Child Dependant will have no Waiting Periods.
- If a new Dependant is added to a Membership and the conditions set out in either C.4.3(a)(i) or C.4.3(a)(ii) are not met, any Waiting Periods that apply to that Product will apply to the Dependant.

F4 Exclusions

As determined by the Company, selected Hospital Treatment or Combined Hospital and General Treatment Products detailed in the Schedules will have specified treatments that are listed as ‘exclusions’ or ‘excluded

benefits', which means no Benefits will be payable by the Company towards to any costs incurred by a Member for those treatments.

General Treatment Products and the General Treatment component of a Combined Hospital and General Treatment Product will detail the included services only. Services not detailed in the Schedules will be deemed excluded which means no Benefits will be payable by the Company towards any costs incurred by a Member for those services.

~~F5 (Not Used)~~

F6 Restricted Benefits

Hospital Treatments that are limited to the Minimum (default) Benefit for the duration of a Product's cover are set out in selected Hospital Treatment or Combined Hospital and General Treatment Products' Schedules. Restricted Benefits under this Fund Rule F6 may apply to any treatments within aClinical Category, as set out in the Schedules.

F7 Compensation Damages and Provisional Payment of Claims

F.7.1 Where Benefits shall not be payable

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

a. where a Member has made any claim or application or instituted any proceedings under any law of the Commonwealth, State seeking Compensation in respect of that ailment, illness or injury; or

b. where a Member has sustained such ailment, illness or injury in circumstances where the Member is, in the opinion of the Proper Officer, entitled to make a claim or application or institute proceedings under law of the Commonwealth, any State seeking Compensation in respect of that ailment, illness or injury; or

c. 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 whether or not any such judgment, award, settlement or agreement excludes or purports to exclude expenses in respect of any Benefits which may be provided under these Fund Rules.

F.7.2 Where Benefits may be available

Where the amount of entitlement of a Member for Compensation is in the opinion of the Company less than the Benefits which would otherwise be payable under these Fund Rules, the Company may in its absolute discretion determine to pay Benefits for the Member concerned in such amount as the Company 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.7.3 Irrevocable Undertaking

Where the Company is of the opinion that a condition, injury or ailment is one which may give rise to a claim for Compensation, or where Benefits have been paid which relate to such a claim, the Company at its absolute discretion may require that before payment or further payment of Benefits is made, the Member in respect of whom the Benefits are otherwise payable shall sign an Irrevocable Undertaking, or other such document as determined by the Company from time to time, in favour of the Company, in a form acceptable to the Company, pursuant to which the Member undertakes to:

a. comply with the obligations set out in Rule F.7.5;

b. make such a claim for Compensation and to include in any such claim all Hospital; paramedical and related expenses in respect of which Benefits otherwise are or may be payable by the Fund;

c. not to withdraw the claim for such expenses in Rule F.7.3(b);

d. to prosecute the claim with all diligence;

e. to disclose to the Company and its legal advisers all matters relevant to the prosecution of the said claim;

f. to notify the Company upon payment of the claim or any part payment and directs 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.

F.7.4 Non-compliance with Irrevocable Undertaking

If, in the reasonable opinion of the Company, the Member fails to comply with Rule F.7.5, then:

a. the Company may assume that all expenses in relation to the condition, injury or ailment have been met from the Compensation payable or received pursuant to the claim; and

b. the Company may pursue the Member for repayment of Benefits paid by the Company in relation to the condition, injury or ailment; and / or

c. assume the legal rights of the Member in respect of all or any parts of the claim.

F.7.5 Member Obligations

a. Where, in respect of a claim for Benefits, it appears to the Company that a Member may be entitled to receive a payment by way of Compensation, but the Member has not established his or her right to that payment, Benefits are not payable. The Member shall be required to establish his or her right to receive payment by way of Compensation before the claim may be considered by the Company. If it is established that the Member has no right to payment by way of Compensation through another source, then the relevant Benefits shall be payable.

b. 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, and where the terms of such settlement specify that the sum of money paid under the settlement does not relate to expenses past or future in respect of which Benefits from the Company are otherwise payable, or where the Member abandons or compromises any part of the claim so that such expenses are excluded, then Benefits are not payable.

c. For the avoidance of doubt, where, in respect of a claim for Benefits, it appears to the Company that a Member has, or may have a right to Compensation, the Member is obliged to:

    i inform the Company as soon as the Member knows or suspects that such a right exists;

    ii inform the Company of any decision of the Member to claim for Compensation;

    iii include in any claims for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable by the Company;

    iv take all reasonable steps to pursue the claim for Compensation to the Company's reasonable satisfaction;

    v keep the Company informed of and updated as to the progress of the claim for Compensation; and

vi inform the Company immediately upon the determination of settlement of the claim for Compensation or the establishment of a right to receive Compensation.

F8 Other

F.8.1 Lifetime 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 and Benefits received by Members for similar services and treatments from other insurance 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 8.2 Limitations of General Treatment Benefits

As determined from time to time by the Company, the General Treatment Benefits specified in Schedules I and J 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.

F.8.3 Services Rendered by a Government Body

The Company will not pay Benefits for a treatment or service provided to a Member by, or on behalf of, or under an agreement with one of the following;

- the Commonwealth;
- a State;
- a local government; or
- an authority established by a law of the Commonwealth or a State,

unless under special agreement between the Company and the provider.

G CLAIMS

G1 General

G.1.1 How claims may be made

- Claims for Benefits shall be made in writing in a form as required by the Company from time to time (being electronic or in hard copy) and where required by the Company, be accompanied by the account of the Hospital, Medical Practitioner or Recognised Provider for the period of hospitalisation or for the services or treatments rendered or such other evidence as may be considered by the Company to be sufficient proof that the hospitalisation has occurred or the services were rendered (Documentation).
- A Member must make full and true disclosure in the claim form as to all matters referred to therein.
- The Company may retain all such Documentation it receives under this Fund Rule G1 and such documents will become the property of the Company.

G.1.2 Evidence in support of claim

If required by the Proper Officer, a Member shall in support of any claim for Benefits under these Fund Rules:

- deliver to the Proper Officer a signed authority authorising that Officer to obtain from any Hospital, Medical Practitioner or Recognised Provider of the Member such medical evidence as the Proper Officer may reasonably require; or
- provide such further evidence in support of the Member's claim for Benefits as the Proper Officer may reasonably require.

G.1.3 Appointment of Medical Practitioner

The Company may appoint a suitably qualified Medical Practitioner to advise the Company on medical and technical aspects of any claim as necessary from time to time.

G.1.4 Assessment of a claim

The Company 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. By submitting a claim, the Member provides consent for the Company 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 the Company 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 E.1.4

G.1.5 Claim lodgement

- The Company 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 the opinion of the Proper Officer, hardship (including but not limited to unsuccessful claims for Compensation) would otherwise be caused to the Member, the Company may waive Fund Rule G.1.5 and pay Benefits in respect of that claim.

G.1.6 Payment of claims

The Proper Officer may, upon receiving written authority from the Member, together with an unpaid account for hospitalisation, make a payment of the appropriate Benefit direct to the Hospital where the hospitalisation occurred or, in the case of a claim for General Treatment Benefits or Benefits with respect to in-hospital treatment rendered by a Medical Practitioner, make payment of the appropriate Benefit to the Member as per E.1.1.

G.1.7 Member must nominate account for Benefit crediting purposes

In order for the Company to pay Benefits in respect of service accounts paid by the Member, the Member must provide to the Company details of their nominated financial institution account. The Company may determine to pay any such claim by way of a cheque payable to the Contributor, if reasonably required.