Fund Rules

Railway and Transport Health Fund

February 2021

rt health

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A INTRODUCTION

A1 Rules Arrangement

A.1.1 The Rules

The rules applicable to all Policies of the Fund consist of:

a) The Fund Rules as set out in this document; and
b) The Product Cover Guides

A.1.2 Application of the Fund Rules

These are the rules of Railway and Transport Health Fund Ltd A.B.N. 93 087 648 744, which is registered as a private health insurer under the *Private Health Insurance Act 2007 (Cth)* (The Act).

The trading name of the Fund shall be "rt health fund". This is the registered business name of Railway and Transport Health Fund Ltd.

A.1.3 Order of precedence

In the event of any inconsistency between the Fund Rules, any provision in the Product Cover Guides and/or the Constitution, then such inconsistency shall be resolved and prevail in the following order of precedence:

a) the Constitution;
b) the Fund Rules; and
c) the Product Cover Guides

A2 Health Benefits Fund

A.2.1 Establishment and operation of the Fund

The Company is a not-for-profit organisation incorporated under the *Corporations Act 2001 (Cth)* and has established the Fund in accordance with the *Private Health Insurance Act 2007 (Cth)*.

A.2.2 Object of the Fund

The object of the Fund is to accept premiums from Members in exchange for providing 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 Policy provided the Member is not in Arrears.

A.2.4 No entitlement to reserve or surplus of the 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 Fund Product Cover Guides

Where required, the Company will supplement these Fund Rules with Product Cover Guides that will not be inconsistent with these Fund Rules. All Members are bound by the Product Cover Guide of their chosen level of cover.

A3 Obligations to Insurer

A.3.1 Members bound to the Fund Rules

All Members are bound by these Fund Rules and Product Cover Guides which the Company may amend from time to time in accordance with the Fund Rule A.7.1

A.3.2 Acceptance of the Fund rules

An application to become a Member and acceptance of the initial Contribution payment by or on behalf of the Member shall constitute an acceptance by the Member of all terms and conditions in these Fund Rules.

A4 Governing Principles

A.4.1 Governing Principles

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

a) the Private Health Insurance Legislation including subordinate legislation;
b) the *Health Insurance Act 1973 (Cth)* and the *National Health Act 1953 (Cth)*;
c) the Australian Consumer Law;
d) any conditions imposed or any directions made by the Minister for Health under the Private Health Insurance Legislation;
e) the rules of the Commonwealth Department of Health or its successor, as they apply to Registered Private Health Insurers; and
f) the rules and standards of the Australian Prudential Regulation Authority or its successor.

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:

a) Contributions payable under policies of insurance that are referable to the Fund;
b) income from the investment of assets of the Fund;
c) money paid to the Company under a judgment of a court relating to any matter concerning the business of the Fund;
d) any other money received by the Company in connection with its conduct of the business of the Fund; and
e) any other amounts that the Private Health Insurance Legislation specifies.

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

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

A6 No Improper Discrimination

A.6.1 The Company may not improperly discriminate

When operating the Fund and making decisions in relation to Members, the Company will not improperly discriminate based on:

a) the suffering by the Member of a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind;
b) the gender, race, sexual orientation or religious belief of a person;
c) the age of a person, except in relation to the calculation of a Lifetime Health Cover Loading or age-based discounts where permitted by the Private Health Insurance Legislation;
d) where a person lives except in relation to different risk equalisation jurisdictions;
e) 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;
f) the frequency with which the person needs Hospital, Medical or General Treatment Services; or
g) the amount, or extent, of the Benefits to which a Member becomes, or has become, entitled during a period; or
h) 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 delete, add to or amend these Fund Rules or the Product Cover Guides at any time in a manner consistent with the Private Health Insurance Legislation and any other law.

A.7.2 Overriding waiver

The Company may under specified circumstances 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 suggest that the Company will, or require the Company to, waive the application of that Fund Rule in any other circumstance including where a circumstance similar to the given circumstance arises again.

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 the Membership or a 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 Commonwealth Ombudsman (Private Health Insurance)

A Member may contact the Commonwealth Ombudsman at any time in relation to any issue with the Fund without reference to the Fund.

A9 Notices

A.9.1 Service of Notice

Any Notices required to be provided to the Principal Member from the Company under these Fund Rules (Notice), unless otherwise prescribed by the Private Health Insurance Legislation, will be

a) in Writing, in English; and
b) delivered to the address (including any electronic address) last nominated by the Principal Member to the Company for the receipt of communications.

A.9.2 Private Health Information Statement (PHIS)

In accordance with the Private Health Insurance Legislation, the Company will make available up-to-date Private Health Information Statements in the format prescribed in the Private Health Insurance Legislation from time to time:

a) to any person on request;
b) in accordance with Rule C.5.1; and;

c) to the Principal Member at least every twelve (12) months.

A.9.3 Principal Member to inform the Company of changes

A Principal Member 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 are available to Members to view on the funds website: www.rthealthfund.com.au

A10 Winding Up

A.10.1 Winding up of the Company

In the event the Company ceases to be registered under the Act, the Fund shall be wound up in accordance with the requirements of the Private Health Insurance Legislation.

In the event of a winding up of the Fund all monies standing to the credit of the Fund and not required for meeting outstanding liabilities, staff allowances, contracted payments and all other expenses of winding up including the requirements of the Act shall be applied by the Board as if it were disposing of assets of the Company in accordance with the Private Health Insurance Legislation.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

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

a) the singular includes the plural and vice versa, and a gender includes other genders;
b) another grammatical form of a defined word or expression has a corresponding meaning;
c) a reference to A$, $A, dollar or $ is to Australian currency;
d) a reference to a party includes the party's executors, administrators, successors and permitted assigns and substitutes;
e) 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;
f) a reference to a State includes a reference to a Territory;
g) a capitalised or non-capitalised word or expression mentioned in these Fund Rules that is also defined in the Private Health Insurance Legislation has the meaning given to it in the Private Health Insurance Legislation;
h) 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;

i) unless defined in Rule B2, capitalised terms have the meaning to be reasonably understood by the private health insurance industry.
j) words defined in these Fund Rules shall have the same meaning when used in the Product Cover Guides unless expressly stated otherwise.

B2 Definitions

In these Rules, unless the contrary intention appears:

Accident means an unforeseen and unintentional event, occurring by chance and resulting from an external force or object causing an involuntary injury to the body requiring immediate medical treatment.

Accredited Private Hospital means a Private Hospital or Private Day Hospital Facility that is accredited with an Accreditation Agency and includes private facilities that are not accredited but will in the opinion of the Company become accredited within twelve months.

Act means the *Private Health Insurance Act 2007 (Cth)* and, where the context requires, includes regulations, rules and other subordinate legislation passed pursuant to that Act as amended or superseded from time to time.

Acute Care means the provision of treatment for an ailment or disability which cannot be provided by a nursing home.

Acute Care Certificate means a form required to be completed by a doctor for a Hospital stay over thirty-five (35) continuous days to verify the type of patient as needing Acute Care.

ADA Schedule means the Schedule of Dental Services published by the Australian Dental Association (ADA).

Admitted Patient means a person who meets a certain medical criterion 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.

Adult means a person who is neither a Dependent Child nor a Dependent Child Non-Student.

Adult Dependant is a person who is related to the Principal Member or of the Principal Member's Partner in the same manner as required for a Child Dependant and:

a) is not a Policyholder;
b) is aged 21 to 24 years;
c) is not in Full-Time Study;
d) is not married or in a De Facto Relationship; and
e) who the Policyholder has nominated to stay on the Policy; and

is financially dependent on the Principal Member or the Principal Member's Partner.

Agreement Hospital means a Private Hospital that has entered into a Hospital Purchaser Provider Agreement **(HPPA)** with the Company.

Ancillary Health Benefit means any Benefit in respect of dental, medical and other ancillary services.

Associated Professional Services means Professional Services provided by a Medical Practitioner to, or in respect of, an inpatient of a Hospital.

Approved – see Recognised.

Arrears – see Unfinancial.

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

Australia for the purposes of these Rules includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling) Islands, the Territory of Christmas Island and Norfolk Island but excludes other Australian external territories.

Australian Resident is a person who resides in **Australia** and has permission to remain permanently—either because they are: an **Australian citizen**; the holder of a permanent visa; or the holder of a protected Special Category Visa.

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, prior to application Rule D4 and any other change to a particular Member's Base Rate in accordance with the Private Health Insurance Legislation and these Fund Rules.

Benefit means an amount of money paid or payable to a Member or to a Recognised Provider by the Fund in accordance with the terms and conditions of a Product and these Fund Rules.

Benefit Year for the purpose of the calculation of Benefits and other entitlements payable shall be deemed to commence on 1 January each year to the 31 December.

Benefit Replacement Period means a continuous period that must occur between any two purchases of the same type of Artificial Aid or Appliance item before Benefits are payable.

Calendar Year means the twelve-month period commencing 1 January and finishing 31 December of the same year and has the same meaning as Benefit Year.

Child Dependant means a natural child; legally adopted child; foster child, step-child; or child to whom the Policyholder is appointed as legal guardian and as approved by the Fund from time to time of the Principal Member or of the Principal Member's Partner who has not attained the age of twenty-one (21) years and is not married or living in a De Facto Relationship and is financially dependent on the Principal Member or the Principal Member's Partner.

Clinically Relevant means an appropriate course of treatment such as a procedure or service that is performed or rendered by a Medical Practitioner, Dental Practitioner, Optometrist, or other Recognised Practitioner that is generally accepted within the relevant Profession.

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 C.5.1.

Company means Railway and Transport Health Fund Ltd ABN 93 087 648 744, the registered office of which is 1 Buckingham Street Surry Hills NSW 2010.

Compensation means any of the following:

a) a payment of Compensation or damages pursuant to a judgment, award or settlement;
b) a payment in accordance with a scheme of insurance or Compensation provided for by Commonwealth or State law (for example, Workers Compensation insurance);
c) settlement of a claim for damages (with or without admission of liability);
d) a payment for negligence; or
e) any other payment that, in the opinion of the Company, is a payment in the nature of Compensation or damages.

Complying Health Insurance Product (CHIP) means an insurance Product issued by the Company that takes the form of Hospital Treatment Product, General Treatment Product or Combined Hospital and General Treatment Product in accordance with the Private Health Insurance Legislation.

Constitution means the Constitution of the Company.

Contribution means the amount payable by an individual Member in respect of the Product referable to his or her Membership due to the application.

Contribution Group means a group of Members approved under these Fund Rules.

Continuous Hospitalisation means where an Admitted Patient stays overnight in Hospital is then discharged and within seven (7) days is admitted to the same or different Hospital for the same or related condition.

Co-payment or Daily Excess means a daily amount of money the Member agrees to pay the Hospital for a Hospital stay before Benefits are payable under the relevant Hospital Treatment Product.

Cosmetic Procedure means any surgery, treatment or other procedures which are not allocated an item number within the Medicare Benefits Schedule (MBS) issued by the Medical Services Advisory Committee (MSAC).

CPAP Machine means a Continuous Positive Airway Pressure machine.

Day Hospital Facility means a Registered Hospital and/or Day Facility.

De Facto Relationship means a relationship between two (2) people who are:

a) not legally married, but live together as a couple in a marriage type relationship
b) otherwise, as determined by relevant laws, to be living in a De Facto Relationship.

Default Benefit means the minimum Benefits prescribed by the Minister pursuant to Private Health Insurance (Benefit Requirement) Rules 2011 (Cth).

Dependant means a person who is one of the following a Child Dependant; a Student Dependant; or an Adult Dependant.

Emergency Ambulance means an ambulance service provided by a State Government ambulance service (or a private ambulance service substituted for a State Government ambulance service) or a private ambulance service recognised by rt health fund. Benefits are payable where the Insured Member is transported directly to a Hospital or treated at the scene due to a medical emergency and excludes transportation to hospital for the routine management of an ongoing medical condition or inter Hospital transfers (other than emergency transfers).**Emergency** means a situation where the patient presenting at a Hospital or other medical facility is assessed as Category 1, 2 or 3 on the Australasian Triage Scale.

Episode means the period of Admitted Patient care between an admission and separation such as discharge, characterised by only one (1) care type.

Excess is an amount of money the Member 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.

Excluded refers to treatment under a Hospital Treatment Product for which Benefits are not payable.

Extras Product means a Product that covers General Treatment under these Fund Rules. **Full Time Study** means a course of education at a secondary school or tertiary institution, trade, which is accredited by a State or Federal Government, at least three (3) quarters of the normal fulltime workload or otherwise deemed by the Company as being Full-Time Study, and 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 Principal Member for personal care, domestic or social support after having attended the course of study.

Fund means the Registered Health Benefits Fund conducted 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 Cover means an arrangement where a Medical Practitioner agrees to participate in a scheme with the Company that covers Members in excess of the Medicare Benefits Schedule (MBS) for:

a) all but a specified amount of the full cost of inpatient medical treatments; or

b) the full cost of inpatient medical treatments.

General Treatment has the same meaning ascribed to that term in the Private Health Insurance Legislation. If the term is not defined in the Private Health Insurance Legislation, then the term means Ancillary Health Benefit – see Extras.

Health Insurance Act means the *Health Insurance Act 1973*.

Health Benefits Fund – See Fund.

Health Aids means those that are ordinarily claimable under an eligible Extras Cover as meeting all the following criteria: (a) intended for repeated use; (b) used primarily to alleviate or address

a medical condition; (c) not useful to a person in the absence of an illness, injury or disability; (d) supplied by a reputable supplier listed on rt's list of approved artificial aid.

Hearing Aids means a hearing appliance when recommended by a Medical Practitioner.

Health Management Program has the same meaning ascribed to that term in the Health Insurance Legislation.

Hospital Benefit means any Benefit in respect of any Hospital as set out in the relevant Product Cover Guide.

Home Nursing – see Hospital Substitute Treatment.

Hospital has the same meaning ascribed to that term under the Private Health Insurance Legislation and includes a Day Hospital Facility, and any similar facility in which Hospital Treatment is provided.

Hospital Purchaser-Provider Agreement (HPPA) means an agreement entered between the Company and a Hospital or Day Hospital Facility.

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 Product means a Product that covers Hospital Treatment under these Fund Rules.

Hospital Treatment, unless otherwise defined in the Private Health Insurance Legislation, is treatment (including the provision of goods and services) that:

a) is intended to manage a disease, injury or condition; and
b) is provided to a person:
c) by a person who is authorised by a Hospital to provide the treatment; or
d) under the management or control of such a person; and either:
    a. is provided at a Hospital; or
    b. is provided, or arranged, with the direct involvement of a Hospital; and
    c. Includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance Legislation.

Last Day of the Suspension Period or Last Day of Suspension means the day on which a suspended Membership shall cease to be suspended for the purposes of calculating the 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 meaning ascribed to it under section 34-25 of the *Private Health Insurance Act 2007 (Cth)*.

Medical Practitioner means a person as defined in section 3(1) of the *Health Insurance Act 1973* 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 (Cth)* and as amended from time to time.

Medical Treatment means Treatment provided by a Medical Practitioner.

Medicare means Australia's public health insurance system available to eligible persons, such as Australian Residents.

Medicare Benefit means a Medicare Benefit under Part II of the *Health Insurance Act 1973*.

Medicare Benefits Schedule (MBS) means the schedule of items for which Medicare Benefits are payable.

MLS means Medicare Levy Surcharge.

MBS Fee means the fee specified for a given item in the Medicare Benefits Schedule (MBS).

Member means a Principal Member 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.

Minimum Default Benefit – see Default Benefit.

MOVE means MOVE Bank, a member-owned credit union that was established in 1968 as the Railways Credit Union and renamed in 2016.

National Health Act means the *National Health Act 1953 (Cth).*

Non-Agreement Hospital means a Private Hospital or Day Hospital Facility that does not have a Hospital Purchaser Provider Agreement (HPPA) with the Company.

Obstetric Patient in respect of Hospital Treatment Benefits means Hospital care provided to a patient in the management of pregnancy, labour/childbirth including ante and post-natal care.

Overnight Stay means a period in a Hospital that spans both daylight hours and Midnight.

Palliative Care in respect of Hospital Treatment Benefits 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 Palliative Care if they are undertaken specifically to provide symptomatic relief.

Partner of a person means the partner recognised by law (including common law) of that person and/or a person living in a bonafide domestic relationship.

Permitted Days of Absence refers to time when a person does not incur any Lifetime Health Cover penalty due to not being covered by a Hospital Product.

PBS means the Pharmaceutical Benefits Scheme.

Podiatry Service means a service or treatment provided by a registered podiatrist.

Policy means a complying health insurance Policy that covers Hospital Treatment, General Treatment, Ambulance Services or any combination (whether or not it also covers any other treatment or provides a Benefit for anything else) and is referable to the Fund.

Policyholder – see Principal Member.

Pre-Existing Ailment/Condition is any ailment, illness or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of six (6) months ending on the day which the person became insured under the Policy. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition; not on a diagnosis. It is not necessary for the member or their doctor to know what their condition is, or for it to be diagnosed. In forming an opinion about whether an illness is a Pre-Existing Ailment/Condition, the health insurer-appointed Medical Practitioner who makes the decision must consider information provided by the Member's treating doctor.

Principal Member or Policyholder means the person in whose name the Membership is registered to the Fund in accordance with these Fund Rules and who is responsible for Contribution payments and is, by reason of those Contributions, entitled under these Fund Rules to Benefits from the Fund.

Private Health Insurance Business has the meaning set out in the Private Health Insurance Legislation.

Private Health Insurance Legislation means the *Private Health Insurance Act 2007 (Cth)* and its regulations, rules and other instruments under it and consolidations, amendments, re-enactments or replacements of any of them, and other related laws.

Private Health Information Statement (PHIS) means an information statement for a Product subgroup of a Complying Health Insurance Product and is in a form set out in the Act.

Private Hospital means:

- a Private Hospital which is a Recognised Hospital; or
- such other private health facility as approved by the Company in Writing from time to time as a Private Hospital.

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.

Product means a Hospital, Extras or Ambulance Product, or combination provided by the Fund.

Product Cover Guide means a summary of material information applicable to a particular Product issued by the Fund to Members but is not an exhaustive statement of the Product's terms and conditions.

Provider Benefit Schedule refers to either the Dental Schedule as updated in the Fund's database or a set agreement with a provider to pay benefits as per an agreed schedule, as updated from time to time.

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.

Recognised or Approved in respect of a person, 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.

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.

Rehabilitation Patient means any person who is a patient of a Rehabilitation Hospital or facility Approved by the Company and undergoing a Rehabilitation treatment program Approved by the Company.

Restricted Cover means cover where the Company pays only Minimum Benefits for the relevant types of Treatment.

State means the State or Territory of Australia where a Member normally resides.

Student Dependant means a person who is related to the Principal Member or of the Principal Member's Partner in the same manner as required for a Child Dependant who is financially dependent on the Principal Member or the Principal Member's Partner; aged 21 to 24 years; not married or living in a De Facto Relationship; and who is enrolled full-time and attending an approved school, college or university.

TGA means the Therapeutic Goods Administration, an authority that is part of the Australian Department of Health.

TGA Approved means an item that the TGA has registered on the Australian Register of Therapeutic Goods for the condition to be treated.

Transfer Certificate means a certificate issued by a Registered Health Insurer, in a form approved under the Private Health Insurance Legislation, detailing full health insurance cover details and claims histories of a person transferring from the Fund operated by that insurer.

Transfer Date means the date on which a person joins a Product from another Product of the Fund or joins a Product offered by the Fund from another Registered Health Insurer.

Unfinancial in respect of a Membership is where the Principal Member fails to pay in full all Contributions due to be paid by him or her on or before the due date in respect of the Membership.

Veterans' Entitlement Act means the *Veterans' Entitlement Act 1986 (Cth)***.**

Waiting Period means the period from the date a Policy commences to the date that certain services or items provided to the Member may attract Fund Benefits under these Fund Rules (refer sections 75-1 and 75-5 of the *Private Health Insurance Act 2007 (Cth)).*

Writing includes any mode of representing or reproducing words in a visible form, including electronic forms.

C MEMBERSHIP

C1 General Conditions of Membership

C.1.1 Membership Categories

The Company has the following categories of Policy as set out in these Fund Rules:

a) Single Membership – Being a Membership that consists of the Principal Member only;
b) Couples Membership – Being a Membership that consists only of the Principal Member and the Principal Member's Partner;
c) Single Parent Membership – being a Membership that consists of the Principal Member and one (1) or more Child Dependants or Student Dependants only;
d) Family Membership – being a Membership that consists of the Principal Member and the Principal Member's Partner and may include one (1) or more Child Dependants or Student Dependants only.
e) Single Parent Family Extension membership – being a Membership that consists of the Principal Member and may include one or more Child Dependants, Student Dependants or one or more young adults aged 21 to 24 years not registered as a Student Dependant.
f) Family Extension Membership – being a Membership that consists of the Principal Member, the Principal Member's Partner and may include one or more Child Dependants, Student Dependants or one or more young adults aged 21 to 24 years not registered as a Student Dependant.

In the event that the Company does not offer a Single Parent Membership or a Couples Membership in relation to a Product, the Member may apply to join the Single Membership or Family Membership Category.

C.1.2 Types of Products

A person may be admitted to the Fund as a Member in one of the Membership Categories following the purchase of one (1) of these Products and otherwise complying with the applicable Fund Rules:

a) a Hospital Product;

b) a General Treatment Product;
c) any combination of Hospital Product and General Treatment Product allowed to be purchased concurrently in the Product Cover Guides;
d) a Combined Hospital and General Treatment Product;
e) an Ambulance only Product; or
f) a combined Ambulance 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:

a) as a Singles only or Single and Couples Membership;
b) in the case of a Hospital Product, available only where a General Treatment Product must be purchased along with the Hospital Product;
c) in the case of a General Treatment Product, available only where a particular Hospital Product must be purchased along with the General Treatment Product.

C.1.4 Rights of Principal Member

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

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

C.1.5 Rights of the Principal Member's Partner and Dependants

In relation to a Membership, the Principal Member's Partner (if named on the Membership) or a Dependant aged 18 years and older may:

a) pay Contributions;
b) de-register themselves from the Membership (permanently – not by suspension) without the approval of the Principal Member.

A Child Dependant cannot make any administrative decisions, including in relation to claims, with respect to the Membership or his or her registration under the Membership.

C.1.6 Delegated Authority

The Company may permit a Principal Member to authorise, either orally or in Writing, a nominated representative to access or make changes to the Membership on behalf of the Principal Member until further notice is given. This authority will not provide the nominated representative with the authority to nominate further delegated authorities, suspend or cancel the Membership on behalf of the Principal Member.

C.1.7 Eligibility for Benefits

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

1. The Fund is a restricted access insurer under the Act.
2. The following persons are eligible to be insured persons of the Fund:
    a. A person who is, or was, an employee of:
        i. Government or privately-operated land, sea or air transport companies or associated Government entities charged with administering the land, sea or air transport industries;
        ii. Government or privately-operated energy generation and delivery entities; including supply of electricity, gas, oil, petrol, coal, nuclear or renewable energy;
        iii. a contract company, where those employees or former employees were employed to provide services under a contract to an organisation described in paragraphs 2(a)(i), 2(a)(ii), or item (b) (or successors of those organisations).
    b. A person who is, or was, a member of the MOVE Bank.
    c. Is an eligible family member of a person described in clause C.2.1 (2) (a) and (b). Eligible family members include:
        i. Parent
        ii. Brother or sister
        iii. Brother or sister-in-law
        iv. Partner/former Partner (spouse or De Facto)

v. Child (natural, adopted, stepchild, foster child)
vi. Son or daughter-in-law
vii. Grandchild

3. The Fund is prohibited from issuing a Complying Health Insurance Product to a person who does not belong to the group of persons described at clause C.2.1 (2).
4. The Fund is prohibited from ceasing to insure a person because the person has ceased to belong to the group of persons described at clause C.2.1 (2).

C.2.2 Minimum Age of Principal Member

Unless the Company otherwise determines, a person may be a Principal Member at any age. In the case where the Principal Member is under the age of 18 years , the submission of an application for Membership must be made by the legal parent/guardian who accepts all terms and conditions of Membership, including these Fund Rules, on behalf of the Principal Member.

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

C.3.1 Types of Dependants

The three types of Dependants are:

a) Child Dependant;
b) Student Dependant;
a) Adult Dependant.

C.3.2 Registration of Dependants and Principal Member's Partner

Subject to the eligibility requirements in Fund Rule C.2, a Principal Member may register a person as their Dependant or Partner on a Membership by providing the personal details of the person in the form and in the manner reasonably required by the Company.

Where the Membership was a Single Membership prior to their Dependant or Partner being added, the Membership category (as described in Fund Rule C.1.1) will be amended from the date the Dependant or Partner is added. Contributions for the Membership will be adjusted accordingly.

C.3.3 Rights of Dependants and the Principal Member's Partner

In relation to a Membership, the rights of Dependants and the Member's Partner are set out in Fund Rule C.1.5.

C.3.4 Continuity of Cover – Former Partner, Former Student, Child Dependant or Adult Dependant

A Principal Member's Partner, Child Dependant over the age of 18, Student or Adult Dependant may transfer from a Family Membership to his or her own Product, becoming a Member in his or her own right **(Own Product)** with no Waiting Periods applying to the Product, subject to the following:

a) an application for cover must be received by the Fund within two months of the Dependant ceasing to be covered under their previous Membership held with the Company;
b) the applicant must transfer to an Own Product that offers an equivalent or lower level of benefits to that offered under the previous Membership;
c) the applicant must have served all Waiting Periods that apply to the previous Membership;
d) Contributions are paid back to the date at which the previous Membership ceased.

C4 Membership Applications

C.4.1 Application for Membership

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

a) 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
b) 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:

a) make full, true and proper disclosure in the application form as to all matters referred to therein;
b) provide such evidence in support of any statement made in the application form as the Proper Officer may require; and
c) 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 Newborn Child

Provided a newborn's parents have held a Single Parent Family, Couple or Family Membership for at least 2 months, a newborn can be added from date of birth provided the application is received by the Fund within 12 Months of the date of birth. Newborns added after 12 months from date of birth may be subject to waiting periods.

C.4.4 Right to Reject an Application

Subject to Fund Rule A.6, 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

a) Without prejudice to the Member's right to cancel his or her Membership under Fund Rule C.7, the Company may permit the Member to cancel his or her Membership at any time within 30 days of the Commencement Date with prior written notice to, or as otherwise agreed by the Company.

b) If the Company permits a cancellation of the Membership in accordance with Fund Rule C.4.5(a), then the Member may seek a refund of Contributions paid towards the Membership, provided no event has occurred for which a claim is payable under the Membership.

C.4.6 Reinstatement of a Terminated Membership

If a Membership has been terminated under the conditions outlined in Fund Rule C.8 the Company has the discretion to reinstate the Membership under a request for Special Consideration (see C.8.4) from the Principal Member. Continuity of Benefits will be subject to the back-payment of all outstanding Contributions.

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:

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

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

a) a Private Health Information Statement (PHIS); and
b) a Product Cover Guide in relation to the Member's selected Product which provides the details of what the Product covers, how Benefits are calculated and a statement identifying that the Membership is referrable 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 C.7 or Fund Rule C.8 (as applicable) and subject to the Membership not being Unfinancial.

C.5.3 Change of Policy

A Principal Member 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 Transfer – Australian Registered Health Insurer

An applicant for Membership may transfer from a Product issued by another Registered Health Insurer **(Old Product)** to a 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:

a) the transfer must take place within two (2) months of the applicant ceasing to be covered under the Old Product;
b) the applicant must transfer to a New Product that offers an equivalent or lower level of Benefits to that offered under the Old Product;
c) the applicant must have served all applicable Waiting Periods that apply to the Old Product; and
d) the receipt by the Company of the applicant's Transfer Certificate from his or her 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:

a) where the applicant transfers to the New Product more than two (2) months after the applicant ceased to be covered under the Old Product;
b) 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;
c) where an Excess 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 is payable;

d) where Hospital Treatment is deemed Pre-Existing, Benefits will be applied with the higher Excess for a period no longer than allowed under the Private Health Insurance Legislation;
e) 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.

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.

Any Benefits payable for a major dental item, or under a MPPA or Gap Cover service in respect of any Pre-Existing Ailment/Conditions will, for a period of twelve months from the date of commencement of the New Product, be equal to those payable by the previous Registered Health Insurer or those set out in the New Product, whichever is the lesser amount.

C.6.4 Transfers Between Products Within the Fund

Where a Member transfers to a New Product, the following day after the Member ceased to be covered under the Old Product the following will apply:

a) 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;
b) where the New Product has lower Benefits compared to the Benefits of the Old Product, the Member shall receive the lower level of Benefits available under the New Product;
c) where Hospital Treatment is deemed Pre-Existing, Benefits will be applied with the higher Excess or Co-payment/Daily Excess for a period no longer than allowed under the Private Health Insurance Legislation;
d) where the Old Product and New Product offer comparable Benefits, but the applicant has not served all applicable Waiting Periods under the Old Product, the balance of any unexpired Waiting Period or Benefit Replacement Period for those Benefits must be served before the new Benefits are available.

C.6.5 Benefits Paid Under Old Product to be Taken into Account

Benefits paid under an Old Product referred to in this Fund Rule C.6 shall be deemed to be Benefits paid from the Calendar Year Benefit limits or lifetime Benefit limits to which a Member or Membership may be entitled under the New Product.

C.6.6 Changes in Principal Member

Where the Principal Member dies, the Member who is registered under the Membership as the Principal Member's Partner may continue that Membership (either at the Single Rate or Family Rate) in his or her own name as a Principal Member with full continuity of Benefits, provided all applicable Waiting Periods have been served by the Principal Member's Partner at such time.

C7 Cancellation of Membership

C.7.1 Cancellation by Principal Member

a) The Principal Member 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.
b) Retrospective cancellation of a Membership from the day after the date of a Principal Member's death will be accepted by the Company subject to receipt of official documentation issued by the relevant State agency providing confirmation of the Principal Member's date of death.
c) A Principal Member may remove a Partner or any Dependants from his or her Membership at any time.
d) A Principal Member's Partner or Dependant aged at least 18 years may remove themselves from a Membership at their own request at any time.
e) Unless otherwise permitted by the Company, a Dependant who is under the age of 18 years may leave the Membership only with the Principal Member's written consent.

C.7.2 Refund of Contributions Paid in Advance

The Principal Member is entitled to a refund of Contributions paid in advance on cancellation of a Membership. Any refund will be calculated from the date of cancellation of the Membership.

C.7.3 Issue of Transfer Certificate

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 90 days 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 Company; materially or repeatedly breaches any of these Fund Rules or any other term or condition of Membership, the Company may terminate or suspend a Member's Membership at any time by giving reasonable notice in Writing, describing the reason for the cancellation or suspension and, in the event of cancellation, refund any Contributions paid in advance.

C.8.3 Retained Rights

The termination or cancellation of a Membership under Fund Rules C.7 or C.8 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 C.8 the Company may reinstate the Membership at its absolute discretion, upon written application by the Principal Member in a form prescribed by the Company, stating the valid reason why the Membership should be accepted and reinstated by the Fund. If a membership is reinstated by the Company, Continuity of all applicable Benefit entitlements will apply subject to back-payment of all outstanding Contributions by the Member.

C9 Temporary Suspension of Membership

C.9.1 Application for Suspension

A Principal Member may apply to the Company to suspend his or her Membership under the terms and conditions set out under this Fund Rule C.9. 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 Principal Member plans to travel overseas:

a) the Principal Member will depart Australia for a period of no less than 28 days but no more than two (2) years;
b) the Principal Member must have held their Membership for a minimum of 12 months before it can be suspended;
c) there is a minimum period of six months between the end of one period of suspension and the beginning of another period of suspension;
d) the Membership is paid up to the date of departure before it can be suspended;
e) the suspension applies to the all Products and Members on the Membership;
f) in order to reactivate the Membership, a Principal Member must provide proof of travel for each person covered by the Membership within 30 days of returning to Australia.

C.9.3 Financial Hardship Suspension of Membership

The Company may offer a suspension for financial hardship. Suspensions will be considered on a case by case basis at the discretion of the Fund.

C.9.4 Member to Provide Information

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

In the case of suspension for financial hardship, it is a condition that the Principal Member provides to the Company any documentation the Company reasonably requests to substantiate any application due to financial hardship.

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 Principal Member. The suspension, once accepted by the Company, is effective from:

a) 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
b) the day after the application has been approved for financial hardship.

C.9.6 Effect of Suspension

a) Benefits are not payable for any services rendered to any Member of the Membership while the Membership is suspended.

b) The period of suspension does not count towards the serving of Waiting Periods, Benefit Replacement Periods or the length of Membership.

c) 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 (MLS) during this period.

d) 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) A suspended Membership resumes on the earlier of:

i. the day after the Last Day of the Suspension Period as approved by the Company; or

ii. the day the Principal Member requests the Company to resume the Membership.

b) Where the Member complies in full with the terms and conditions of the suspension, subject to Fund Rule C.9.6(b), the Membership shall be deemed to resume on the same Product with full continuity of Benefits at the end of the suspension period.

c) All Contributions held in credit under Fund Rule C.9.6 (d) shall be applied to the Membership from the day after the Last Day of the Suspension Period. If the Membership is in Arrears due to the Member's failure to make a further Contribution payment, the Membership and all Benefit entitlements shall cease.

d) 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 D.4, 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 Principal Member (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 weekly (or in weekly multiples) in advance.

Contributions will not be accepted for a period exceeding 12 months in advance. Where Contributions have been paid for a period exceeding 12 months in advance, the Fund at its discretion may refund the portion of Contribution exceeding 12 months.

D.1.3 Group Deductions

Where Contributions are made through a group deduction scheme as referred to in Fund Rule D3.3, Contributions may be paid in Arrears for a period determined by the Company. The Company may revoke this decision at any time with 30 days' notice to the relevant Members. If this occurs, Members will be liable to make a payment to catch up any Arrears and bring their Membership Contributions to a minimum of one week in advance.

D2 Contribution Rate Changes

a) Contribution rates may be changed in accordance with these Fund Rules and any requirements set out in the Private Health Insurance Legislation.
b) 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 notice of such amendments as set out in these Fund Rules and as required by the Private Health Insurance Legislation.
c) If, on the date the Company sends a notice under Fund Rule D.2(b), the 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.
d) The Company may, at its discretion offer Members rate protection for a period not exceeding 31 March the following Calendar Year.
e) Where the Company receives a request from the Principal Member 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 Principal Member. 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 Discount Not to Exceed Prescribed Maximum

Contributions paid by Policyholders belonging to a Contribution Group may be discounted up to the maximum amount permissible under the Act.

D.3.2 Contribution Groups

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

a) employees of a body corporate, partnership, unincorporated body or other type of enterprise (either for profit or not for profit);
b) members of a professional, industry or trade association; or
c) members of a community.

D4 Lifetime Health Cover

D.4.1 Application of Lifetime Health Cover Provisions

a) 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.

b) The amount of Contributions payable for Hospital Treatment Product in respect to an Adult who did not have Hospital cover on his or her 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 Ten 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 of Absence 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 90 days and the Member pays such Arrears before the 90-day period expires, the Membership will retain uninterrupted Benefit and Membership entitlements, provided the Member also complies with Fund Rule D.1.2.

D.5.2 Termination of a Membership in Arrears

Where the period of Arrears exceeds 90 days, Fund Rule C.8.1 will be applied and a Transfer Certificate will be issued to the Principal Member on termination of the Membership.

D.5.3 Treatment Where Contributions are in Arrears

Subject to Fund Rule D.5.1, if the Member 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 until the Arrears are paid to the Company by the Member.

E BENEFITS

E1 General Conditions

E.1.1 Payment of Benefits

a) Details of Benefits available under each Product are set out in the relevant Product Cover Guide.
b) The Company will pay Benefits to Members in accordance with the terms and conditions of the Product referable to the Member's Membership and these Fund Rules. All Benefits and conditions of Benefits are those which are applicable at the date a service is received by a Member.
c) 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 Principal Member in accordance with Fund Rule G.1.7.
d) Where a Recognised Provider's invoice is submitted with the claim and is unpaid, the Fund will pay the applicable Benefit into that Recognised Provider's nominated financial institution account, or where the provider has not provided such an account to the Company, issue a cheque made payable to the Recognised Provider and posted to the Member's address or to the provider as the Company sees fit.

E.1.2 Benefits Not to Exceed Charges

a) 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 set out in the relevant Product Cover Guide for the service, whichever is the lesser amount.
b) 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.
c) Where a Benefit is calculated in reference to a percentage of a charge, if evidenced by the Company that a treatment or service charge is higher than the provider's usual charge for the service, the Proper Officer may assess the claim as if the provider's usual charge had applied.

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:

a) for any aspect of a claim or higher Benefit in respect of services or treatment rendered during a Waiting Period;
b) for any claim where the Membership remains in Arrears for the relevant time the services or treatment was rendered;
c) 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;
d) 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;
e) for any claim in excess of fees charged or where no charge is made;
f) 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;
g) for any claim where a service or transaction was rendered outside of Australia;
h) for any claim where the service is not considered Private Health Insurance Business as prescribed under the Private Health Insurance Legislation;
i) for treatment or services or an item where the expense was incurred by the employer of that Member or if the Member obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at the Company's discretion;
j) where the provider is not:
    i. a Hospital, Medical Practitioner or Recognised Provider at the time the treatment, goods or services were provided to the Member; or
    ii. working in Private Practice;
k) where the Member has received, or established a right to receive, Compensation for treatment, goods or services;
l) if the Member does not have an Acute Care Certificate after 35 days of hospitalisation;
m) 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;
n) where the Member has:
    i. failed to make full and complete disclosure as to all matters relied upon in support of, or relevant to, a claim for Benefits; or

ii. provided in support of any claim for Benefits information which is false, inaccurate or misleading, whether such information is contained in a claim form, given orally or provided in any other manner whatsoever; or
iii. failed to provide such information or medical evidence in respect of a claim as may be required by the Proper Officer; or
iv. 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:

a) 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
b) 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 the Member the whole or that part of the said amount, as the case may be.
c) For the purposes of this Fund Rule, the expression 'error' includes:
   i. any mistake of fact or of law or of mixed fact or law;
   ii. an error of omission or calculation; and
   iii. an error of an administrative or clerical nature.

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

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.

E.1.5 Waiver and Ex-Gratia Benefits

The Company shall have the right to review any particular term or condition of these Fund Rules in specific instances and shall also have the right to provide, without prejudice, an ex gratia payment of Benefit under such terms and conditions as defined in the Company's ex-gratia policy. The Company reserves the right to vary this policy from time to time.

E.1.6 Treatment Standard Requirements

Notwithstanding anything to the contrary in these Fund Rules, in respect of any Product, the Company will not pay Benefits towards treatment or a person supplying treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules 2011.

E2 Hospital Treatment

E.2.1 Hospital Treatment Benefits

a) 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.

b) 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 Commonwealth Department of Health. The classifications are:

- Surgical
- Advanced Surgical
- Obstetric
- Other (Medical)
- Psychiatric Care
- Rehabilitation

c) A procedure is identified by reference to the relevant item number within the Medicare Benefits Schedule (MBS) or by reference to the Private Health Insurance Legislation.

d) 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 Commonwealth Department of Health from time to time plus (where relevant) any Benefits payable in respect of theatre fees, as listed in the Provider Benefit Schedule.

e) The Company will pay the minimum Benefit as listed in the Private Health Insurance (Prostheses) Rules 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 Hospital Purchaser Provider Agreement (HPPA), the following Fund Rules will apply in calculating Benefits:

a) The day of admission and the day of discharge shall be counted together as one day.
b) 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.
c) 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

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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.

d) 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.
e) 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.
f) 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.
g) 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 (MBS) shall be used for patient classification purposes.
h) 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.
i) 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.
j) Where a Member's hospitalisation bridges the end of a Benefit Year and part of the next year the Excess amount for the New Year will apply to the first subsequent admission in the new Benefit Year.

E.2.3 Benefits for Surgical Podiatry Procedures

If a Product provides a Benefit for procedures provide by an Accredited Specialist Podiatrist, the only Benefit payable as per the minimum requirement set out in the Private Health Insurance Accreditation Rules 2011 and the *Private Health Insurance Act 2007 (Cth).*

E.2.4 Purchaser Provider Agreements

a) The Company may from time to time enter into a Hospital Purchaser Provider Agreement **(HPPA)** with a Hospital or Medical-Purchaser Provider Agreement **(MPPA)** with a Medical Practitioner and may, as a result of such agreements, provide Benefits that vary from those listed in the Product Cover Guide.

b) Where a Member is charged for Hospital Treatment or a professional Medical Treatment where a HPPA or MPPA applies, the Benefits will, unless otherwise stated in these Fund Rules, be as specified in the HPPA or MPPA (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, Benefits will be payable as per the Private Health Insurance Legislation.

E.2.6 In-Hospital Pharmaceutical Benefits

a) Subject to this Rule E.2.6, for Hospital Treatment and combined Hospital and General Treatment Products 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.

b) The Fund covers costs for Pharmaceutical Benefits up to a maximum quantity dispensed as listed under the PBS or as recorded on an Authority Prescription Form.

c) A Pharmaceutical Benefit referred to in this Rule E.2.6 must be: (i) intrinsic to the Hospital Treatment provided, (ii) clinically indicated, (iii) essential for meeting satisfactory health outcomes for the Member and (iv) non-experimental drugs. This does not include Pharmaceutical Benefits that are listed under the 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.

d) Benefits will not be payable for high cost or experimental drugs that are not listed under the PBS or are not Approved by the Therapeutic Goods Administration (TGA) for the use in the specific condition.

e) Where the cost to a Member for a drug or medicinal preparation listed under the PBS is less than the PBS co-payment, these drugs are not considered to be Pharmaceutical Benefits and are not covered by the Fund.

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 Benefit is payable the following shall apply:

a) the difference between the Benefit paid by Medicare and the Medicare Benefits Schedule (MBS) fee for eligible services - 25%; or

b) 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 Informed 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

a) All Hospital Products and Combined Hospital and General Treatment Products offered by the Company will provide Benefits for Hospital Substitute Treatment provided by a Recognised provider in Private Practice. Services can be provided in substitution for days spent in Hospital on the condition that:
    i. the cost of Hospital Substitute Treatment is less than or equal to the equivalent costs of these Hospital-based services; and
    ii. 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.
b) 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.
c) Hospital Treatment Benefits that will not be payable:
    i. where Hospital Treatments are experimental or involve a clinical pharmaceutical trial;
    ii. for a Surgical Prosthesis that has not been Approved and listed on the Private Health Insurance (Prostheses) Rules, unless it is evidenced to be Clinically Relevant and then may be Approved by the Proper Officer for Benefit payment;
    iii. the Company shall have the right to seek an Acute Care Certificate.

E3 General Treatment

E.3.1 When Benefits are Payable

a) 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 that are Recognised Associations and satisfy the requirements of the Private Health Insurance (Accreditation) Rules 2011.
b) 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.
c) Benefits for General Treatment consultations will only be payable based on one consultation per patient, per practitioner, per day.
d) Benefits for General Treatment consultations will only be payable as described in the Product Cover Guides 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.

e) The Benefits payable and the conditions associated with General Treatment services by Recognised Providers are listed within the Product Cover Guides.

E.3.2 Determination of Benefits

a) General Treatment Benefits for Dental Services will be provided only in respect of procedures or services recommended by the Australian Dental Association (ADA) and which are itemised under the headings General Dental or Major Dental or Orthodontics as set out in a relevant Product Cover Guides (the item numbers used therein being those provided by the ADA). Benefits are payable only in respect of Approved procedures or services performed by a dentist or dental technician who is a Recognised Provider in Private Practice or employed by a Registered Health Insurer.

b) General Treatment Benefits towards pharmacy are payable after deduction of the current PBS contribution, on private prescription items (S4 and S8) which are:
   i. prescribed by a Medical Practitioner;
   ii. supplied by a registered pharmacist in Private Practice;
   iii. Approved by the Therapeutic Goods Administration (TGA) for the indication for which they have been prescribed;
   iv. not otherwise supplied or funded by a public arrangement scheme, including the PBS;
   v. not otherwise Excluded by the Company.

E.3.3 Emergency Ambulance

a) Where a Hospital Product or Combined Hospital and General Treatment Product provides Benefits towards Emergency Ambulance Services, Benefits will be payable in accordance with the Product Cover Guide for Emergency Ambulance Transportation or an Emergency Ambulance Attendance where it is coded or invoiced by the relevant State Ambulance authority as an Emergency Ambulance Transportation or Emergency Ambulance Attendance.

b) There shall be no entitlement to Benefits where:
   i. coverage is included via a State levy included within the Contribution referable to a Hospital Product or Combined Hospital and General Treatment Product;
   ii. non-emergency transportation provided by the Ambulance service that is not clinically necessary;
   iii. transportation provided after Hospital discharge to a home or nursing home;
   iv. for transfers between Hospitals or from medical facilities;
   v. the Member holds a State based ambulance membership subscription; or
   vi. the Member is a resident of a State that provides a free Ambulance transportation scheme.

c) Benefits are paid at the maximum as outlined in the relevant Product Cover Guide.

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 Provider Benefit Schedule.

E4 Other

E.4.1

Health Management Programs and Hospital Substitute Treatment

The Company may from time to time, at its discretion on eligible Products as referred to in the Product Cover Guides, make available a Health Management Program and/or Hospital Substitute Treatment program. The program (s) must be provided by a Recognised provider in Private Practice.

F LIMITATION OF BENEFITS

F1 Excesses

F.1.1 Products with Excesses

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

F2 Waiting Periods

F.2.1 Waiting Periods to Apply

a) Unless otherwise permitted by the Company, subject to Rule C.6, a Member must serve the Waiting Periods set out in this Rule F.3 before receiving Benefits available under a Product and no Benefits are payable in relation to treatments received during an applicable Waiting Period.
b) 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 or the registration date of the Member on the Membership (whichever date is the later) as listed in this Rule F.2.
c) 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.2.2 Hospital Treatment Waiting Periods

The following Waiting Periods apply to a Benefit for Hospital Treatment or Hospital Substitute Treatment subject to the Member's chosen New Product:

a) For a Benefit for Hospital Treatment or Hospital Substitute Treatment:

i. Obstetric treatment or treatment for a Pre-Existing Ailment/Condition (other than treatment covered by paragraph (ii))—12 months;
Note: in cases of premature births a Benefit will be applicable where the Member giving birth would have completed twelve months of Membership at the date the birth was due to occur.
ii. Psychiatric care, Rehabilitation or Palliative Care (whether or not for a Pre-Existing Ailment/Condition)—2 months;
iii. any other benefit—2 months.

b) In the case of Hospital services required resulting from an Accident, the Waiting Period shall be reduced to one (1) day.

F.2.3 Mental Health Care Exemption

A Member is entitled to once in a lifetime exception to the normal two (2) month Waiting Period for Hospital Psychiatric Care provided the following conditions are met:

a) the Member holds a Hospital Product with any Registered Health Insurer;
b) the Member has not accessed the waiver at any other time with any Registered Health Insurer;
c) the Member is an Admitted Patient of a Hospital; and
d) the Member is under the care of an Addiction Medicine Specialist or Consultant Psychiatrist.

This exception can be backdated by up to five (5) business days.

F.2.4 General Treatment Waiting Periods

a) For a Benefit for Health Aids, including braces and wigs, orthotics and orthopaedic shoes if covered by the Product – 12 months of continuous Membership of the Product. (For CPAP Machine – there is a Waiting Period of three years in respect to a replacement CPAP Machine).
b) For a Benefit for crowns and bridges and other dental prosthetic services including inlays, dentures, denture repairs and implants, orthodontia, endodontia, periodontics, and occlusal adjustments if covered by the Product – 12 months of continuous Membership of the Product.
c) For a Benefit for Hearing Aids, if covered by the Product – 24 months of continuous Membership of the Extras Product.
d) For a Benefit for optical appliances and repairs – 3 months of continuous Membership of any of the Extras Products (Except in the case of Fit & Healthy Extras where the Waiting Period is 6 months).
e) For a Benefit in respect of any other General Treatment – 2 months of continuous Membership of a Product that covers General Treatment.

F.2.5 No Waiting Period Applies to Accident-Related Services and Emergency Ambulance

Where there is a claim for Benefits in respect of:

a) an injury caused by an Accident, that took place after a Member's Commencement Date; or
b) Emergency Ambulance Transportation or Emergency Ambulance Attendance, as described in Rule E.3.3, the two (2) month Waiting Period described in Rule F.3.2 shall not apply to the Member in respect of that Benefit.

F.2.6 No Waiting Period Applies to Gold Card Holders

Where a person joins the Fund within two (2) months of ceasing entitlements to a Gold Card under the *Veterans' Entitlements Act 1986 (Cth)* the Member will not be subject to any Waiting Periods as described in this Rule F2 in respect of Hospital Treatment or General Treatment.

F.2.7 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.2.8 Waiting Periods – Newborns and Dependants

In the case of any newborn(s) added within twelve (12) months of the birth to a Family or Single Parent Membership, the newborn(s) will not be required to serve any Waiting Period.

In the case of a new Dependant (other than a newborn) being added to an existing Family or Single Parent Membership, any Waiting Periods that apply to that Product must be served in full by that new Dependant.

F3 Exclusions

As determined by the Company, selected Hospital Products or Combined Hospital and General Treatment Products detailed in the Product Cover Guides will have specified treatments that are listed as 'Exclusions' or 'Excluded benefits', which means no Benefits will be payable by the Company towards any costs incurred by a Member for those treatments.

F4 Restricted Benefits

Treatments that are limited to the Minimum Default Benefit for the duration of a Product's cover are set out in selected Hospital Product or Combined Hospital and General Treatment Products' Product Cover Guides.

F5 Compensation Damages and Provisional Payment of Claims

1. Benefits are not payable under any of the Company's Products in relation to expenses incurred in respect of any condition, injury or ailment which is the subject of a claim where a Member has received or established a right to receive a payment by way of Compensation or damages from a third party.
2. Where the amount of the entitlement for Compensation or damages is less than the Benefit that would otherwise be payable under the relevant Product, partial Benefits are

payable up to the limit of the difference between the full Benefit payable and the Compensation or damages entitlement.

3. 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 damages payable by a third party, the Company at its absolute discretion may require that before payment of any Benefit the Member in respect of whom Benefits are otherwise payable shall sign an irrevocable undertaking and authority in favour of the Company, in a form acceptable to the Company, pursuant to which the Member undertakes to:
   a) include in any such claim, all Hospital, paramedical and related expenses in respect of which Benefits otherwise are or may be payable by the Company;
   b) not withdraw the claim for such expenses; and
   c) notify the Company forthwith upon payment of the claim or any part thereof and the Member directs that from any such claim there is first deducted and paid to the Company by way of reimbursement, an amount equal to the amount of Benefits paid by the Company in respect of such condition, injury or ailment.
4. Where a Benefit has been paid and the Member receives or establishes the right to receive payment by way of Compensation or damages, the Benefit paid must be repaid to the Company immediately to the quantum of the recovery or right to recovery.

F6 Other

F.6.1 Lifetime Benefit Limits

Lifetime Benefit Limits or 'lifetime limits' 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 two 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. The applicable lifetime limit for a Product is stated in the relevant Product Cover Guide.

G CLAIMS

G1 General

G.1.1 How claims may be made

a) Claims for Benefits shall be made in Writing in a form as required by the Company from time to time 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).

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b) A Member must make full and true disclosure in the claim form as to all matters referred to therein.
c) 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:

a) deliver to a 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 in his or her absolute discretion require; or
b) provide such further evidence in support of the Member's claim for Benefits as the Proper Officer may in his or her absolute discretion 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 information from a Member about their healthcare provider prior to or after the payment of a Benefit for a claim. Information requested by the Company will be directly related to a claim where the Member has acknowledged either verbally or in Writing a declaration requesting Benefit entitlements to be paid to the Member or their healthcare provider. Such information may include but is not limited to:

- Prescriptions
- Signed receipts
- Invoices
- Treatment plans
- Medical/Patient records
- Appointment schedule

G.1.5 Claim Lodgement

a) The Company will not pay Benefits for a claim submitted to the Fund more than two (2) years after the date of Hospital Treatment or the date General Treatment services were rendered.
b) Where, in the opinion of the Proper Officer, hardship would otherwise be caused to the Member, the Company may waive Fund Rule G1.5(a) and pay Benefits in respect of that claim.

G.1.6 Payment of Claims

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 at its absolute discretion determine to pay any such claim by way of a cheque payable to the Member.

The Company may, upon receiving written authority from the Member, together with an unpaid account for Hospital, Medical or General Treatment, make payment of the appropriate Benefit to the Recognised Providers or Medical Practitioners nominated account or by issuing a cheque in the name of the Recognised Provider or Medical Practitioner (as the case may be) who rendered the service.

H SCHEDULE OVERSEAS

H1 Overseas

No Benefits are paid for treatments, services or products rendered or provided to a Member outside Australia.