

**AUSTRALIAN HEALTH MANAGEMENT GROUP PTY LIMITED**  
**(ABN 96 003 683 298)**  
**(“ahm”)**

**HEALTH BENEFITS FUND RULES**

**as at 1 April 2009**

**A PRIVATE HEALTH INSURER REGISTERED UNDER PART 4-3 OF THE**  
***PRIVATE HEALTH INSURANCE ACT 2007***

## **A INTRODUCTION**

### ***A1 Rules Arrangement***

- 1.1 These Rules consist of:
  - (a) The General Conditions;
  - (b) Schedules of Products listing premiums and
  - (c) Schedules listing General Treatment Benefits and Limits and Hospital Treatment Benefits and Limits, and combinations thereof.
- 1.2 These rules apply to all Policy Holders as reported to the Private Health Insurance Administration Council (***PHIAC***).
- 1) Unless the context otherwise requires, any terms used in these Fund Rules that are defined in the *Private Health Insurance Act 2007*, any rules made under that Act or the *Health Insurance Act 1973* have the same meaning in these Fund Rules.
- 2) Part B of these Fund Rules sets out other relevant definitions.
- 3) A reference to the Schedules is a reference to the Schedules attached to these Fund Rules.

### ***A2 Health Benefits Fund***

- 2.1 These are the Rules of the Health Benefits Fund conducted by ahm under the Commonwealth *Private Health Insurance Act 2007* (***Fund***).
- 2.2 These Fund Rules govern the establishment and operation of the Fund and describe the obligations, requirements and entitlements of Policy Holders of the Fund and the obligations, requirements and entitlements of ahm in the operation of the Fund.
- 2.3 The Health Benefits Fund's business consists of
  - a) ahm's health insurance business (***HIB***)
  - b) some or all of ahm's health related businesses that ahm has determined are to be included in the Fund (***HRB***)
  - c) any other business, as allowed under the *Private Health Insurance Act 2007*, as determined by ahm and as allowed under the Constitution.
- 2.4 The registered office of ahm is at Medibank Private Limited, Level 17, 700 Collins St Melbourne VIC 3008.
- 2.5 The chief administration office of the Fund is located at the registered office.
- 2.6 The Fund has been established by ahm.
- 2.7 The Fund shall be conducted and administered by ahm in accordance with these Fund Rules, the Act and the rules. For this purpose, ahm will have all necessary

power to do all acts and things as ahm may consider necessary or expedient for the administration and maintenance of the Fund and the performance of the ahm's obligations under these Fund Rules.

- 2.8 The property of the Fund is vested in ahm to be applied in accordance with the *Private Health Insurance Act 2007*, the rules made under that Act and these Rules. All assets of the Fund not immediately required for the purposes of the Fund may be invested or otherwise applied, in the absolute discretion of ahm, and in accordance with the *Private Health Insurance Act 2007* and the rules,
- 2.9 ahm will participate in the Risk Equalisation Trust Fund in accordance with the provisions of the *Private Health Insurance Act 2007* and the rules.

### **A3 Obligations to Insurer**

- 3.1 A person applying for admission to the Fund as a Policy Holder shall:
  - (a) comply with the requirements of ahm; and
  - (b) give full and complete disclosure of all information as required by ahm.
- 3.2 The Policy Holder shall inform ahm as soon as reasonably possible after a change in any details which are required by ahm to provide the insurance.

### **A4 Governing Principles**

- 4.1 ahm and its Policy Holders are governed by the following documents in order of precedence:
  - (a) *Private Health Insurance Act 2007* and the Private Health Insurance Rules
  - (b) These Fund Rules

### **A5 Use of Funds**

#### **Health Benefits Fund**

ahm's Health Benefits Fund operates HIB and HRB. Money in the Fund is invested in assets and the income arising from those assets is credited to the Health Benefits Fund. As a for profit insurer, the assets of the fund may be applied by ahm for any of the permitted purposes set out in clause 137-10(2) of the *Private Health Insurance Act 2007*.

Commissions received from travel insurance and expatriate insurance agency businesses (net of operating costs) is also credited to the Fund in accordance with Section 137-5 (e) of the *Private Health Insurance Act 2007*.

The details of the debits and credits for the Fund's HIB and HIR are set out below:

## 5.1 Health Insurance Business

ahm provides a range of Complying Health Insurance Products (*CHIPs*) in exchange for premiums. In providing these products it incurs expenditure to facilitate the payment of claims and benefits and associated administration costs. The debits and credits from and to the fund for Health Insurance Business are characterised as follows:

Credits	Debits
Premium Income from CHIPS	Benefits payable to Policy Holders <ul style="list-style-type: none"> <li>- payable to third party providers</li> <li>- payable to ahm for the cost of the provision of HRB within the Fund</li> </ul> Risk Equalisation Pool payments Ambulance levies Administration costs <ul style="list-style-type: none"> <li>- Wages and Salaries</li> <li>- Associated employment oncosts</li> <li>- Advertising and marketing</li> <li>- Health promotions</li> <li>- Business acquisition costs</li> <li>- Provision of staff amenities</li> <li>- Property costs</li> <li>- Advisers, contractors and consultants</li> <li>- Third party service providers               <ul style="list-style-type: none"> <li>o eg member helpline</li> </ul> </li> <li>- Industry fees and levies</li> <li>- Proportion of shared services, shared with HRB, including:               <ul style="list-style-type: none"> <li>- Information technology</li> <li>- Finance</li> <li>- HR</li> <li>- Other corporate administration services</li> </ul> </li> <li>- Dividends</li> </ul>

This is not an exhaustive list.

## 5.2 Health Related Business (HRB)

ahm provides a range of services aimed at Health Management and Chronic Disease Management or otherwise meeting the definition of health related business in the Act as follows:

### 5.2.1 Dental and Optical services

ahm offers a full range of dental at our existing Haymarket, Parramatta and Wagga Wagga clinics including:

- General dentistry (scale and clean, fillings, extractions etc)
- Major dentistry (bridges, crowns, dentures)
- Specialist services (orthodontics, endodontics, periodontics etc)
- Conscious sedation
- Oral Health Educators
- Dental Hygienists

The clinics operate on the concept of “Minimal Intervention Dentistry” which aims to work on prevention rather than cure.

In addition the clinics offer an optical service which includes:

- Visual examinations
- Visual field testing
- Assessments for eye disease
- Vision therapy
- Fitting of contact lenses
- Optical dispensary

The services are available to be used primarily by Policy Holders and their Dependents but also, where capacity exists, the general public and referred patients.

### **5.2.2 Disease Prevention, Health Management and Chronic Disease Management Programs**

ahm operates a number of programs aimed at preventing and managing illness and disease. The range of health management and chronic disease management services are provided to a spectrum of customers as follows:

- Policy Holders of other Private Health Insurers
- Employees of Corporate Entities
- Employees or Customers of Government Entities eg. Department of Veteran’s Affairs

These programs include:

#### *Chronic and Complex Care Program*

A telephonic support program for individuals with a Chronic Disease or with multiple risk factors for chronic disease. The program is conducted across a year and involves outbound calls by a registered nurse providing information on health issues and management of the relevant disease.

#### *Early Discharge and Avoided Admissions Program*

This program coordinates clinical and personal services for participants to allow them to either avoid hospitalisation or leave hospital earlier than would otherwise be possible (and which are not provided by a person authorised by a hospital or under that person’s control, with the direct involvement of the

hospital and so is not “Hospital Treatment”). A care plan is signed off by the admitting doctor and ahm clinical staff, organising for care in the home through a registered third party provider network.

#### *Pregnancy Support Program*

A telephonic support program for new and expectant mothers. The program involves outbound calls by registered midwives both pre and post natal and includes discussions around healthy eating, feeding, and settling. There is an in bound service that continues beyond the outbound phase.

#### *Health Coaching Program*

A telephonic support program for individuals who wish to improve or maintain their health or manage a condition. The program involves outbound calls by qualified clinicians including dietitians, exercise physiologists and occupational therapists over a 6-month period. It utilises motivational interviewing techniques to improve behavioural change in participants. Participants are also provided with information relevant to their health goal.

#### *Health Risk Assessments (HRA)*

The HRA is a questionnaire based assessment of the health risks facing an individual. It is based on a survey developed by the University of Michigan and customised for Australian protocols. Following completion the participant is provided with a health profile which details where they are doing well and where they could improve their health risks. This is often followed by the health coaching program.

#### *Health Promotions*

ahm produces a range of collateral such as fact sheets and flyers that communicate important health information and encourage intervention by individuals in their own health outcomes.

#### *Health Screening and Expos*

ahm organise events aimed at educating and highlighting health risks to populations. These events often include health screens which include blood pressure tests, cholesterol checks, BMI calculations etc. In addition flu vaccinations can be facilitated.

#### *Consulting Services*

ahm offers a population based consulting service aimed at improving the health and well being of a population. This is most often targeting either health and safety outcomes or improvements in productivity for corporate entities.

### 5.2.3 Overseas Students Health Cover

ahm provides private health insurance cover for Overseas Students studying in Australia (*OSHC*) under a deed with the Commonwealth Government through the Department of Health and Ageing. As required by the rules, and that deed, this business forms part of the Fund and is a HRB conducted through the Fund.

The debits and credits of Health Related Business from and to the fund are characterised as follows:

Credits	Debits
Premium Income (OSHC) Payment or reimbursement of treatment costs (through claims made by HIB) for <ul style="list-style-type: none"> <li>- Dental Services</li> <li>- Optical Services</li> <li>- Chronic Disease Management Programs</li> <li>- Health Management Programs</li> <li>- Other (treated as Administration costs in HIB)</li> </ul> External Income <ul style="list-style-type: none"> <li>- Policy Holder co-payments for treatment costs</li> <li>- Private Dental and Optical patients treatment costs</li> <li>- Public sector dental patients treatment costs</li> <li>- Other Health Benefit Funds Chronic Disease Management Programs</li> <li>- Other Health Benefit Funds Health Management Programs</li> <li>- Corporate Health Management Programs</li> <li>- Government Health Management Programs</li> </ul>	Benefits - OSHC Cost of Goods and Services provided <ul style="list-style-type: none"> <li>- Clinical salaries and oncots</li> <li>- Clinical support salaries and oncots</li> <li>- Associated other staff costs</li> <li>- Depreciation of assets used in the provision of goods and services</li> <li>- Stock costs</li> <li>- Third party service providers</li> </ul> Administration costs <ul style="list-style-type: none"> <li>- Wages and Salaries</li> <li>- Associated employment oncots</li> <li>- Information technology</li> <li>- Provision of staff amenities</li> <li>- Property costs</li> <li>- Advisers, contractors and consultants</li> <li>- Proportion of shared services, shared with HRB, including:               <ul style="list-style-type: none"> <li>- Information technology</li> <li>- Finance</li> <li>- HR</li> <li>- Other corporate administration services</li> </ul> </li> <li>- Dividends</li> </ul>

This is not an exhaustive list.

## **A6 No Improper Discrimination**

6.1 When conducting the Fund and making decisions in relation to prospective Policy Holders and Policy Holders, ahm does not have regard to any of the following matters:

- (a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or
- (b) the gender, race, sexual orientation or religious belief of a person; or
- (c) the age of a person, except to the extent allowed under Part 2-3 of the Act (lifetime health cover); or
- (d) where a person lives, except to the extent allowed under subsection 66-10(2) or section 66-20 of the Act; or
- (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; or
- (f) the frequency with which a person needs Hospital Treatment or General Treatment; or
- (g) the amount or extent of the benefits to which a person becomes entitled during a period under a complying health insurance policy, except to the extent allowed under section 66-15 of the Act; or
- (h) any matter set out in the *Private Health Insurance (Complying Product) Rules* for the purposes of this paragraph

## **A7 Changes to Rules**

- 7.1 ahm has the power to amend, alter, rescind, override and add to these Fund Rules at any time with the exception of those Fund Rules which are required to be changed by direction by the Commonwealth Department of Health and Ageing. Any changes required by the Department must be implemented by the Executive Group Manager in accordance with such direction.
- 7.2 Amendments to these Fund Rules will be implemented from a date approved by ahm.
- 7.3 The Fund Rules that are in force at the date of the provision of a service or good for which a Fund Benefit under these Fund Rules is provided, are the Rules which shall govern the provision of that Fund Benefit.
- 7.4 Any premiums paid in advance on any product that is removed or altered by any change to these Fund Rules will be re-directed to any new product that the Policy Holder chooses to transfer to or is required to transfer to by ahm.
- 7.5 If a Policy Holder chooses to transfer or is required by ahm to transfer to a new product, the new rules and benefits applying to that product will immediately apply to the Policy Holder and any other Policy Holder or Dependent covered under that policy (subject to waiting periods for benefits on services not covered previously). ahm will ensure that adequate notice and transitional arrangements as per its obligations under the Private Health Insurance Code of Conduct are fulfilled.
- 7.7 ahm will notify Policy Holders of any change to the Rules:

- (a) which makes a detrimental change including to the scope, level or amount of benefits payable or treatments offered with regard to its obligations under the Private Health Insurance Code of Conduct; or
  - (b) where the premiums are increased (excluding rounding adjustments).
- 7.8 ahm may notify affected Policy Holders of any change to the Rules:
- (a) which makes a positive change to the scope, level or amount of benefits payable or treatments offered;
  - (b) where the premiums are decreased or there are rounding adjustments to those rates; or
  - (c) any other rule changes
- 7.9 To give effect to Rule 7.7, ahm will take all reasonable steps to directly notify affected Policy Holders in writing, explaining (in plain English) the change before the change takes effect, with regard to its obligations under the *Private Health Insurance Act 2007* and the Private Health Insurance Code of Conduct. ahm will satisfy its obligations under this Rule and Rule 7.7 by giving notice of the change to the Principal Policy Holder only.
- 1) Notifications of the kind detailed in 7.8 will be satisfied by ahm explaining (in plain English) the details of the change in any publication made by ahm generally available to Policy Holders.
  - 2) ahm will provide an up to date Standard Information Statement (SIS) to every Policy Holder at least once every 12 months. ahm will satisfy its obligations under this Rule by sending the SIS to the Principal Policy Holder only.
  - 3) ahm will provide a Standard Information Statement (SIS) to a Policy Holder on joining or a change of cover under the policy held by the Policy Holder. ahm will satisfy its obligations under this Rule by giving notice to the Principal Policy Holder only.
  - 4) ahm will provide a Standard Information Statement to a Policy Holder whenever a Policy Holder requests ahm to provide one in respect of the product held by the Policy Holder.
  - 5) As per section 93-5 of the Act, ahm will provide a Standard Information Statement to any person who requests one and will inform any person about a relevant Standard Information Statement as a result of the person asking for information about a complying health insurance product.

## ***A8 Dispute Resolution***

- 8.1 ahm has obligations to its Policy Holders with regard to Dispute Resolution under the provisions of the Private Health Insurance Code of Conduct. Policy Holders can make a complaint to ahm by phone, over the counter, by e-mail or by letter. The matter will be investigated, the Policy Holder will be kept informed of the progress of the matter and a response will be provided within 21 days

- 8.2 Should the Policy Holder remain dissatisfied with ahm's response, they can contact the Private Health Insurance Ombudsman for free independent advice.

## **A9 Notices**

- 9.1 Policy Holders will be advised in writing for changes to premiums, benefits, legislative changes as well as the Taxation, Lifetime Health Cover Statements or Transfer Certificates as required by the *Private Health Insurance Act 2007* or with regard to ahm's obligations under the Private Health Insurance Code of Conduct. ahm will satisfy its obligations under this Rule by giving notice of the change to the Principal Policy Holder only.
- 9.2 Copies of the Fund Rules will be available to Policy Holders via ahm's website or if requested by the Policy Holder.
- 9.3 Policy Holders must inform ahm as soon as possible of any changes to their personal details or those of any Dependents, including their address and of any change to their Medicare eligibility status.
- 9.4 Any Fund Rules requiring written notice to Policy Holders will be satisfied by sending the notice to the address last supplied by the Principal Policy Holder.

## **A10 Winding Up**

- 10.1 In the event of ahm ceasing to be registered under the Act, the Fund shall be terminated in accordance with the requirements of the *Private Health Insurance Act 2007* and these Fund Rules.
- 10.2 In the event of termination of the Fund all monies standing to the credit of the Fund and not required for meeting outstanding liabilities of the Fund, including Benefits, staff entitlements or allowances, contracted payments and all other expenses of termination including the requirements of the *Private Health Insurance Act 2007* shall be utilized in such manner as may be determined by the Board in accordance with the constitution of ahm.

# **B INTERPRETATION AND DEFINITIONS**

## **B1 Interpretation**

- 1.1 The following shall apply to the interpretation of these Fund Rules:
- (a) these Fund Rules shall be interpreted so as not to conflict with the Constitution of ahm;
  - (b) words in the singular number include the plural and words in the plural include the singular.

## **B2 Definitions**

“Access Gap Cover Scheme” means an agreement between ahm and a medical practitioner or hospital to cover insured persons for all but a specified amount or percentage of the full cost of the medical and associated professional services provided as part of the insured person’s Hospital Treatment or Hospital-Substitute Treatment.

“Accident” means an unplanned or unforeseen event resulting in bodily injury that requires immediate medical treatment in a Hospital.

“Act” means the *Private Health Insurance Act 2007* as amended.

“Active” means that the person is a financial Policy Holder of any Private Health Insurer including ahm, and has not suspended their policy for any reason.

“ADA Schedule” means the Schedule of Dental Services published by the Australian Dental Association Incorporated.

“Agreement” means an agreement entered into between a Hospital or a Medical Practitioner, and ahm under which the Hospital or Medical Practitioner agrees to accept payment by ahm in satisfaction of the amount that would, apart from the agreement, be owed to the Hospital or Medical Practitioner in relation to the treatment provided by the Hospital or Medical Practitioner to an insured person.

“ahm” means Australian Health Management Group Pty Limited ABN 96003683298

“Associated Professional Services” means professional services rendered to a Policy Holder by a medical practitioner while undergoing Hospital Treatment or Hospital Substitute Treatment.

“Allied Health Service” means a health service provided by an allied health professional who is eligible, at the time the service is provided, to claim a Medicare rebate for a service of that type.

“Ambulance cover” means insurance cover for the cost of Emergency Ambulance Transportation or ambulance services associated with the provision of treatment intended to manage or prevent a disease, injury or condition and that is Medically Necessary, and does not include the cost of ambulance subscriptions.

“Audiology Service” means a service or treatment provided by a recognised audiologist.

“Benefit Requirements” means a policy covering Hospital Treatment meets the requirements under Division 72 of the Act.

“Board” means the board of directors of ahm.

“Child” means a natural, step, foster or adopted child of the Policy Holder, a child of whom the Policy Holder has legal custody, or child of a child (grandchild) of the Policy Holder whilst the grandchild’s parent is a Dependent Child.

“Chiropractic Service” means a service or treatment provided by a registered chiropractor.

“Chronic Disease” means a disease that has been, or is likely to be, present for at least six months, including, but not limited to asthma, cancer, cardiovascular illness, diabetes, a mental health condition, arthritis and a musculoskeletal condition.

“Chronic Disease Management Program” as per Rule 12 of the *Private Health Insurance (Health Insurance Business) Rules* means a program that is intended to:

- a) Either:
  - (i) Reduce complications in a person with a diagnosed chronic disease; or
  - (ii) Prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease; and
- b) Requires the development of a written plan that:
  - (i) Specifies the allied health service or services any other goods and services to be provided; and
  - (ii) Specifies the frequency and duration of the provision of those goods and services; and
  - (iii) Specifies the date for review of the plan; and
  - (iv) Has been provided to the patient for consent, and consent is given to the program, before any services under the program are provided; and
- c) Is coordinated by a person who has accepted responsibility for:
  - (i) Ensuring the services are provided according to the plan; and
  - (ii) Monitoring the patient’s compliance with the agreed goals and activities specified in the plan.

“Community Rating Requirements” means the policy has no terms or conditions that would allow ahm to improperly discriminate against a person insured under the policy as set out in Rule A6.1 of these Rules; and the only discounts available under the policy are discounts allowed under Section 66-5 (2) of the Act; and the premiums payable under the policy meet the premium requirements in Section 66-5 of the Act.

“Complex Dentistry” means all services provided by a general dental or specialist practitioner that include periodontics (213-282), oral surgery (331-395), and endodontics (411-458).

“Complying Health Insurance Product” means a product made up of Complying Health Insurance Policies.

“Complying Health Insurance Policy” means an insurance policy that meets:

- a) Community Rating Requirements; and
- b) Coverage Requirements; and
- c) If the policy covers Hospital Treatment, Benefit Requirements; and
- d) Waiting Period Requirements; and
- e) Portability Requirements; and
- f) Quality Assurance Requirements; and
- g) Any other requirements as set out in the *Private Health Insurance (Complying Product) Rules*.

“Contracted Hospital” means a hospital with which ahm has an Agreement.

“Co-payment” is the daily amount paid by a patient, determined by the relevant policy, if receiving Hospital Treatment at any Hospital or Day Facility.

“Coverage Requirements” means

- a) the only treatments the policy covers are:
  - (i) specified treatments that are Hospital Treatment; or
  - (ii) specified treatments that are Hospital Treatment and specified treatments that are General Treatment; or
  - (iii) specified treatments that are General Treatment but not that are Hospital Substitute Treatment; and
- b) if the policy provides a benefit for anything else, the provision of the benefit is authorised by the *Private Health Insurance (Complying Product) Rules*.

“Day Facility” or “Day Surgery” as defined by ahm means a facility where admission, treatment and discharge are on the same day.

“Day Only Admission” as defined by ahm means admission to and discharge from a Hospital or Day Facility on the same day.

“Dental Service” means a service, treatment, item or appliance provided by or under supervision of a registered general or specialist dentist and included in the ADA Schedule.

“DEP Co-payment” is the amount of out of pocket expense that the insured pays when there is a difference between the fee charged and the Fund benefit for services provided at any ahm Dental and Eyecare Practice for dental services.

“Dependent” as referred to in these rules or in any material produced by ahm will be taken to mean either or all of Dependent Child, Dependent Adult Child and Dependent Student as defined in (a), (b) and (c) below:

- (a) “Dependent Child” of the Principal Policy Holder means a person who is:
  - (i) a Child of the Principal Policy Holder or the Principal Policy Holder’s Partner; and
  - (ii) aged under 18; and
  - (iii) who does not have a Partner;
- (b) “Dependent Adult Child” of a Principal Policy Holder means a person who is:
  - (i) a Child of the Principal Policy Holder or Principal Policy Holder’s Partner; and
  - (ii) aged 18 or over and under 21; and
  - (iii) who does not have a Partner; and
  - (iv) is not a Full Time Employee; and
  - (v) lives with the Principal Policy Holder
- (c) “Dependent Student” of a Principal Policy Holder means a person who is:
  - (i) a Child of the Principal Policy Holder or that Principal Policy Holder’s Partner; and
  - (ii) aged 21 or over and under 25; and
  - (iii) who does not have a Partner; and
  - (iv) is a Full Time Student at a school, university or college; and
  - (v) is not a Full Time Employee.

“Emergency Ambulance Transportation” means a sudden or unexpected need to be transported to Hospital where the only practical method of transportation is by ambulance.

“Eye Therapy Service” means a service or treatment provided by a recognised eye therapist or orthoptist.

“Ex Gratia” means providing a Benefit for a service or good that is not covered by the relevant level of cover under a policy or an extension of a Benefit or limit to that entitled under the relevant level of cover.

“Family Policy” means a policy that includes the Principal Policy Holder, their Partner, and any Dependents of the Principal Policy Holder or their Partner.

“Financial Year” means a period of one year from 1 July to 30 June.

“Full Time Employee” means:

- (1) is not a probationary employee
- (2) someone working at least 30 hours per week minimum or in the past 6 months has earned an amount which on a pro-rata basis is at least equal to the National Training Wage Award Rate.

“Fund” means the Health Benefits Fund conducted by ahm.

“Fund Benefit” or “Benefit” means a benefit payable under these Fund Rules.

“Gap Permitted Prosthesis” means a prosthesis listed in the Protheses Schedule of the *Private Health Insurance (Protheses) Rules* where an amount is specified for that prosthesis in the column under the heading of “minimum benefit” and a different amount is specified in the column under the heading “maximum benefit”.

“General Treatment” as per Section 121-10 of the Act means

- (1) Treatment (including provision of goods and services) that:
  - (a) is intended to manage or prevent a disease, injury or condition; and
  - (b) is not Hospital Treatment
- (2) Without limiting subsection (1) of this definition, General Treatment includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance (Health Insurance Business) rules for the purposes of this subsection.
- (3) Despite subsections (1) and (2) of this definition, neither of the following is General Treatment:
  - (a) the rendering in Australia of a service for which a Medicare benefit is payable, unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise;
  - (b) any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance (Health Insurance Business) Rules for the purposes of this paragraph.

“Gold Card” means a card that evidences a person’s entitlement to be provided with treatment:

- a) in accordance with the Treatment Principles prepared under section 90 of the *Veterans' Entitlements Act 1986*; or
- (a) in accordance with a determination made under section 286 of the *Military Rehabilitation and Compensation Act 2004* in respect of the provision of treatment

“Health Benefits Fund” has the meaning as set out in the Private Health Insurance Act 2007

“Health Insurance Business” as per Section 121-1 of the Act:

- (1) is:
  - (a) the business of undertaking liability, by way of insurance; or
  - (b) an employee health benefits scheme; that relates, in a way referred to in subsection (2) of this definition, to Hospital Treatment or General Treatment.

Note: The following kinds of insurance business are not health insurance business:

- (a) accident and sickness insurance business (see section 121-20 of the Act);
  - (b) liability insurance business (see section 121-25 of the Act);
  - (c) insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules (see section 121-30 of the Act).
- (2) The liability by way of insurance, or the arrangement to make payments under the employee health benefits scheme, must relate to:
    - (a) loss arising out of a liability to pay fees or charges relating to provision in Australia of such treatment; or
    - (b) provision in Australia of such treatment; or
    - (c) the happening of an occurrence connected with the provision in Australia of such treatment; or
    - (d) the happening of an occurrence in Australia that ordinarily requires the provision of such treatment.
  - (3) It does not matter for the purposes of paragraph (2) (d) of this definition whether payment of Benefits to the insured is dependent upon one or more of the following:
    - (a) such treatment or benefit being provided to the insured;
    - (b) the insured requiring such treatment or Benefit;
    - (c) fees or charges being payable by the insured in relation to the provision of such treatment or Benefit.

“Health Management Program” as per Rule 11 (2) of the *Private Health Insurance (Health Insurance Business) Rules* means a program that is intended to manage or ameliorate a person’s specific health condition or conditions and is not a Chronic Disease Management Program.

“Health-Related Business” as per Section 131-15 of the Act means

- (1) a business that is any one or more of the following:
  - (a) a business of providing goods or services (or both) in order to manage or prevent diseases, injuries or conditions;

- (b) a business of undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare for costs associated with providing treatment, goods or services that:
    - (i) are provided to those people in Australia; and
    - (ii) are provided to manage or prevent diseases, injuries or conditions;
  - (c) a business of providing a financial service to assist people insured under complying health insurance products to meet the costs associated with treatment, goods or services that are provided to manage or prevent diseases, injuries or conditions;
  - (d) any other business, or business included in a class of businesses, specified in the *Private Health Insurance (Health Benefits Fund Policy) Rules* for the purposes of this paragraph.
- (2) Despite subsection (1) of this definition, neither of the following is *health-related business*:
- (a) business that is health insurance business; or
  - (b) any other business, or business included in a class of businesses, specified in the *Private Health Insurance (Health Benefits Fund Policy) Rules* for the purposes of this definition.

“Hearing Aids” means a device that assists with a person hearing that is of any of the following types – behind the ear, spectacle type and must be worn on the person and not attached to anything else.

“HICAPS” means Health Insurance Claiming and Processing System. It is an electronic claims processing system accessible to Policy Holders and their Dependents at the provider’s premises.

“Holder” of an insurance policy means a person who is insured under the policy and is not a Dependent.

“Home Nursing” means services provided under a Hospital Substitute program by a registered Nursing Practitioner for the purposes of domiciliary nursing care at a location other than a Hospital or Nursing Home.

“Hospital” means a facility for which a declaration under subsection (6) of Section 121-5 of the Act is in force. This includes Day Surgeries or Day Hospitals.

“Hospital-Substitute Treatment” as per Section 69-10 of the Act means General Treatment that:

- (a) substitutes for an episode of Hospital Treatment; and
- (b) 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; and
- (c) is not specified in the *Private Health Insurance (Complying Product) Rules* as a treatment that is excluded from this definition.

“Hospital Treatment” as per Section 121-10 of the Act means

- (1) 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:
    - (i) by a person who is authorised by a hospital to provide the treatment; or
    - (ii) under the management or control of such a person; and
  - (c) either:
    - (i) is provided at a hospital; or
    - (ii) is provided, or arranged, with the direct involvement of a hospital.
- (2) Without limiting subsection (1) of this definition, Hospital Treatment includes any other treatment, or treatment included in a class of treatments, specified in the *Private Health Insurance (Health Insurance Business) Rules* for the purposes of this subsection.
- (3) Without limiting subsection (1) or (2) of this definition, the reference to treatment in those subsections includes a reference to any of, or any combination of, accommodation, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition.
- (4) Despite subsections (1) and (2) of this definition, treatment is not Hospital Treatment if it is specified in, or is included in a class of treatments specified in, the *Private Health Insurance (Health Insurance Business) Rules* for the purposes of this subsection.

“Major Dental” includes indirect restorative services (541-555, 576, 582-597); prosthodontic services for crowns, bridges and implants (611-691), and dentures and denture components (711-779) regardless of who provides them.

“Medically Necessary” in relation to ambulance transport, means transportation by ambulance that is necessary as, due to the patient’s condition, the patient could not be transported by any other means. It includes transportation by road and air and between hospitals. It does not include transportation for outpatient services.

"Medical Practitioner" means Medical Practitioner as defined in the Act.

“Medicare Levy Surcharge” means the additional surcharge of taxable income imposed by the Australian Taxation Office on high income earners who are eligible for Medicare but who do not have private health insurance for Hospital Treatment with a registered private health insurer. The Medicare levy surcharge is in addition to the normal 1.5% Medicare levy. “High income earners” are those as defined by the Australian Taxation Office.

"Membership Year" means the annual period commencing on the date that the Policy Holder joins a policy with ahm or changes to a new policy of covering hospital treatment and renews every year on that date.

“Minister” means the Commonwealth Minister of State with responsibility for the Act.

“Multiple Risk Factors” means for the purposes of these Rules, two or more risk factors relating to Chronic Disease.

“No Gap Prosthesis” means prosthesis listed in the Prostheses Schedule of the *Private Health Insurance (Prostheses) Rules* where an amount is specified for that prosthesis in the column under the heading “minimum benefit” and no amount is specified in the column under the heading “maximum benefit”.

“Non-Agreement Hospital” means a Hospital with which the Fund does not have an Agreement.

“Nursing Home Type Patient” means a patient in a Hospital who has been provided with accommodation and nursing care, for a continuous period exceeding 35 days as per subsection 3(1) of the *Health Insurance Act 1973*.

“Obstetrics” means services or treatment relating to pregnancy, pre or post conception and delivery of a baby.

“Occupational Therapy Service” means a service provided by a recognised occupational therapist.

"Optical Service" means the provision of optical goods or services including frames, lenses, contact lenses and repairs provided by a registered optical dispenser, ophthalmologist or optometrist and excludes non-sight correcting lenses.

“Orthodontics” includes all orthodontic services (811-878) provided by a registered dentist or orthodontist.

“OSHC” means Overseas Student Health Cover, which is not a Complying Health Insurance Product. OSHC is not Health Insurance Business and is not a “policy” under these Fund Rules and a person covered by OSHC is not a Policy Holder under these Fund Rules.

“Osteopathy Service” means a service or treatment provided by a registered osteopath.

“Overseas Student” has the same meaning as in Rule 18 of the *Private Health Insurance (Health Insurance Business) Rules*, that is:

- a) a person who is the holder of a student visa; or
- b) a person who:
  - i) is an applicant for a student visa; and
  - ii) is the holder of a bridging visa; and
  - iii) was, immediately before being granted the bridging visa, the holder of a student visa

“Palliative care” means a type of health care that provides support to people with a life-limiting illness.

"Partner" of a person means the person’s husband or wife or a person who, although not married to the person, lives with that person on a bona fide domestic basis and includes a same-sex partner.

“Patient”

- (a) in relation to a Day Facility, means:
  - (i) a person who attends the Day Facility for the purpose of permitting the provision of professional attention to the person at the Day Facility; or
  - (ii) a person who receives an Outreach Service provided by, or on behalf of, the Day Facility; and
- (b) in relation to a hospital, does not include:
  - (i) a member of the staff of the hospital who is receiving treatment in his or her own quarters; or
  - (ii) except as provided by subsection 3(2) of the *Health Insurance Act 1973*, a newly-born child whose mother also occupies a bed in the hospital.

“PBS” means the Pharmaceutical Benefit Scheme;

“PBS Item” means any drug listed in the Pharmaceutical Benefits Schedule.

“Pharmaceutical Benefits Schedule” means the Schedule of Pharmaceutical Benefits as determined by the Commonwealth Department of Health and Ageing.

"Physiotherapy Service" means a service or treatment provided by a registered physiotherapist.

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

“Policy Holder” means a Holder of a policy that is referable to the Fund. This will include the Principal Policy Holder and their Partner.

“Portability Requirements” means the policy meets the portability requirements as detailed in Section 78-1 of the Act relating to the application of Waiting Periods to new Policy Holders and their Dependents who transferred from a policy provided by another private health insurer or a policy provided by ahm to ensure that Waiting Periods are applied as detailed in F3 of these Rules and no additional Waiting Periods are applied..

"Pre-existing Condition" is an ailment, illness or condition that in the opinion of a Medical Practitioner appointed by ahm, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy or changed their cover. The appointed Medical Practitioner must have regard to any information in relation to the ailment, illness or condition that the Medical Practitioner who treated the ailment, illness or condition provides or that ahm provides.

“Principal Policy Holder” is the first named Policy Holder of a Complying Health Insurance Policy. This person is responsible for the payment of premiums under a Complying Health Insurance Policy issued by the Fund. This person has the authority to terminate the policy and add or delete other persons on the policy. For the avoidance of doubt, OSHC is not Health Insurance Business and is not a Complying Health Insurance Policy and the holders of those policies are not Principal Policy Holders.

“Private health insurance arrangement” means any of the following:

- (a) a private health insurance policy or a product;
- (b) an agreement or arrangement between a private health insurer and a health care provider;
- (c) an agreement or arrangement between a private health insurer and another person (other than a health care provider) that relates to insurance in relation to Hospital Treatment or General Treatment;
- (d) an agreement or arrangement between two or more health care providers that relates to insurance in relation to Hospital Treatment or General Treatment;
- (e) *Private Health Insurance (Complying Product) Rules* made for the purposes of item 1 or 5 of the table in subsection 72-1(2);
- (f) *Private Health Insurance (Prostheses) Rules* made for the purposes of item 4 of the table in subsection 72-1 (2);
- (g) an arrangement between a private health insurer and a private health insurance broker;
- (h) an arrangement between a private health insurance broker and a person seeking to become insured under a private health insurance policy.

“Private hospital” means a Hospital in respect of which there is in force a statement under subsection 121-5 (8) of the Act that the Hospital is a private hospital.

"Product" means a Complying Health Insurance Product comprising of a group of policies or subgroup of policies for which persons insured under the policy are entitled to specific Benefits for the costs of Hospital Treatment or General Treatment.

“Prostheses” means surgically implanted items such as stents, grommets, artificial hips and knees, titanium plates and screws.

"Psychiatric Patient" means a patient undergoing treatment in a Private or Public hospital under the supervision of a psychiatrist, and the treatment program has been approved by ahm.

“Psychology Service” means a service or treatment including hypnotherapy and counselling provided by a registered clinical psychologist.

“Public Hospital” means a Hospital in respect of which there is in force a statement under subsection 121-5 (8) of the Act that the Hospital is a public hospital.

“Quality Assurance Requirements” means the policy meets the quality assurance requirements if the policy prohibits the payment of Benefits for a treatment that does not meet the standards in the *Private Health Insurance (Accreditation) Rules*.

"Recognised Provider" means a person who is recognised by ahm for Benefits and is registered with ahm as a qualified professional provider of services in accordance with the *Private Health Insurance (Accreditation) Rules*.

"Rehabilitation Patient" means a patient undergoing treatment in a Private Hospital under the supervision of a specialist in rehabilitation medicine and the treatment program has been approved by ahm.

“Risk Factors for Chronic Disease” means

- a) lifestyle risk factors including but not limited to smoking, physical inactivity, poor nutrition or alcohol misuse; and
- b) biomedical risk factors including but not limited to high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; and
- c) family history of a Chronic Disease.

“Routine Dental” means services provided by a general dental or specialist practitioner that are of a routine nature and include: all diagnostic services (000s), all preventive services (100s), minor oral surgery services (311-314, 322-324, 399), direct restorative services (511-535) and other restorative services (572-575, 577-578), general services (911-982).

"Single Policy" means a policy that covers only one person.

“Single Parent Policy” means a policy that includes two or more persons of whom one is the Principal Policy Holder and all of the other insured persons are Dependents.

"State" means the state or territory of Australia where a Policy Holder normally resides.

“Travel and Accommodation” means a benefit for travel and accommodation in relation to a hospitalisation or specialist medical appointment where the insured person has to travel more than 200 kms return to access these services or where the patient is a Dependent Child and requires a parent to accompany. The term also includes travel and accommodation for a Partner or next of kin of a patient to attend a hospital to accompany and support a patient in a life or death situation.

"Waiting Period" means the period of time from the date a policy commences, to the date that certain services or items or goods provided to the Policy Holder or other insured persons attract Fund Benefits under these Fund Rules and are detailed in Rule F3.

“Waiting Period Requirements” means the requirements as set out in F3 of these Rules.

### ***B3 Other***

- 3.1 For all amounts to which a Policy Holder is entitled but has not been paid, ahm will make reasonable efforts to contact the person who according to ahm's records is entitled to any refund of premiums or payment of claims. If the refund is not claimed or paid within 3 years from the date of entitlement, the Policy Holder will lose the right to seek payment of the monies. This Fund Rule does not override the claims payment rules contained in E1.
- 3.2 Fund Rule 3.1 applies on and from 1 July 2007, to all persons who are Policy Holders as at and from that date.

## **C MEMBERSHIP**

### ***C1 General Conditions of Membership***

#### Categories

1.1 Categories of the Fund are as follows:

- (1) Single Policy
- (2) Single Parent Policy
- (3) Family Policy

Each category is further defined in B2.

#### Levels of Cover

1.2 A person may be insured for Benefits payable by the Fund in one of the categories listed in Fund Rule C1.1 in respect of any one of the following products that cover:

- (1) specified treatments that are Hospital Treatment as set out in the Schedules; or
- (2) specified treatments that are Hospital Treatment and specified treatments that are General Treatment (that may include hospital-substitute treatment) as set out in the Schedules; or
- (3) specified treatments that are General Treatment but none that are hospital-substitute treatment as set out in the Schedules.

- 1) A person may be admitted to the levels of cover set out in the Schedules.
- 2) A product that includes cover for Hospital-Substitute Treatment covers Hospital Treatment for the same types of treatment covered by the product for Hospital-Substitute Treatment.
- 3) Ambulance services associated with the provision of treatment intended to manage or prevent a disease, injury or condition to an insured person is General Treatment.
- 4) A product that provides a Benefit for anything else other than Hospital Treatment, Hospital-Substitute Treatment or General Treatment must only include a Benefit that is authorised by the *Private Health Insurance (Complying Product) Rules*.
- 5) A policy that covers Hospital Treatment does not include treatments:
- 6) that do not normally require Hospital Treatment (Type C Procedures) unless a certificate by a Medical Practitioner is provided stating that the person insured required Hospital Treatment for that procedure; or
- 7) provided to a person at an emergency department of a Hospital; or
- 8) provided to a newly-born child whose mother also occupies a bed in the Hospital unless the baby is part of a multiple birth or the baby is admitted as a patient due to requiring medical attention.
- 9) A policy that covers General Treatment excludes Benefits for treatment that primarily takes the form of sport, recreation or entertainment except where the treatment is part of a Chronic Disease Management Program or a Health Management Program.
- 10) The Principal Policy Holder can give authority to another person to act on their behalf. Authority can be given to another person aged over 16 covered by the

policy, or to any other person aged over 16 by using the ahm Third Party Authority form.

Giving another party authority means that the nominee can do anything the Principal Policy Holder can do. This includes (but is not limited to) terminating the policy, changing the cover, removing the Partner and Dependents from the policy or adding themselves to the policy (if they are eligible to do so under the definitions of family or single parent policies) including adding themselves as the new Principal Policy Holder, changing bank account details for payment of benefits or ceasing the payment of premiums.

By giving the authority, the Principal Policy Holder agrees that personal and sensitive information about them may be disclosed to their nominee in the general course of business or in response to requests for information. The authority will remain in place until it is changed or cancelled by the person who is the Principal Policy Holder at that time. “

## ***C2 Eligibility for Membership***

- 2.1 Subject to these Fund Rules, any person is entitled to apply as a Policy Holder. Policy Holders who are not entitled to full and unrestricted Medicare benefits may not be covered for all stated Benefits should they join a Hospital Treatment product, and ahm’s recommendation is that they also join an overseas visitors health cover from another insurer to ensure they are fully covered.
- 2.2 Overseas Students can apply for OSHC which is offered under a deed between the Commonwealth of Australia, as represented by the Department of Health and Ageing and ahm.  
Only this clause C2.3 applies to these persons. OSHC is not a policy under these Fund Rules.  
Persons insured under an OSHC policy are not Policy Holders and are not eligible to the rights conferred on Policy Holders by these Fund Rules, except where the Act or the Commonwealth Deed requires or the Board permits.  
  
OSHC arrangements, terms and conditions and rules are covered under the Commonwealth Deed.
- 2.4 Acceptance of an application and continued eligibility as an insured for Benefits payable by the Fund is conditional on the requirement that the insured does not have a current Active Complying Health Insurance Policy that provides the same type and level (or better) of Benefits with any other Private Health Insurer.

## ***C3 Dependants***

See B2 “Definitions”

## ***C4 Membership Applications***

- 4.1 Applications to become a Policy Holder must be in the form required by ahm.
- 4.2 All relevant information requested by ahm in order to establish and maintain a policy must be supplied by the applicant.
- 4.3 Before an application may be accepted by ahm it must be accompanied by at least one payment frequency's premium payment for the product nominated and at the premium applicable to the State of residence of the applicant unless the applicant intends to pay premiums through a payroll deduction scheme, or any other payment method approved by ahm.
- 4.4 ahm must not refuse to accept any application having regard to the conditions outlined in Fund Rule A6
  - 1) ahm has the right to refuse to accept an application from a person who was a former Policy Holder of ahm whose policy was cancelled through application of Fund Rule C7 or Fund Rule C8.
  - 2) ahm does not have the right to refuse to accept an application for OSHC from an Overseas Students studying in Australia as detailed in Fund Rule C2.3.
  - 3) ahm does not have the right to refuse to accept an application for a Complying Health Insurance Product (CHIP) from anyone who wants to purchase a CHIP irrespective of where the person lives and irrespective of whether they are a resident of Australia, and regardless of whether they have any eligibility for Medicare.
  - 4) All persons included in the application are subject to the same rules and conditions as the Principal Policy Holder.
  - 5) The Principal Policy Holder is required to acknowledge and make the declaration as required by ahm (whether on the paper application, online application or over the telephone) for all new policy applications and changes of cover. By doing so, the Principal Policy Holder and each other Policy Holder agrees to abide by the Fund Rules and also verifies that all the information given to the Fund in the application is true and correct.

## ***C5 Duration of Membership***

- 5.1 The commencement date of an accepted policy application is the day the application is accepted by ahm or some other date as mutually agreed by the Policy Holder and ahm.
- 5.2 If a Policy Holder is more than two months in arrears with payment of premiums then the policy will be terminated by notice in writing from ahm to the Principal Policy Holder, effective from the last financial date of the policy.

## **C6 Transfers**

- 6.1 If a person who is a Policy Holder of a health benefits fund of another Private Health Insurer applies for a policy with ahm and that person is eligible under these Fund Rules, then that person shall be accepted as a Policy Holder. Any period of cover with the previous Private Health Insurer immediately prior to taking out a Complying Health Insurance Product with ahm providing comparable Benefits will count towards any Waiting Period for the ahm Complying Health Insurance Product.
- 6.2 In accepting a transfer of a person from another Private Health Insurer, ahm has the right to include Waiting Period conditions for such portions of any Benefit payable under the Complying Health Insurance Product that are in excess of those Benefits that would have been payable under the Complying Health Insurance Product of the previous Private Health Insurer. Holders of a Gold Card will be treated as if they transferred from another Private Health Insurer.
- 6.3 In accepting a transfer of a person from another Private Health Insurer, ahm has the right to regard any Benefits paid by the previous Private Health Insurer in the current financial or membership year (whatever is applicable to the new product) as being paid by ahm when assessing Benefit entitlements.
- 6.4 If the Policy Holder has a gap in cover from the date of termination from the previous Private Health Insurer to the date of joining ahm all Waiting Periods must be served on the new product.
- 6.5 A transfer initiated by a Policy Holder from one ahm Complying Health Insurance Product to another Complying Health Insurance Product providing similar Benefits, or from one ahm Complying Health Insurance Product option to a different option of the same Complying Health Insurance Product, is treated under these Fund Rules as a transfer from another Private Health Insurer.
- 6.6 A transfer initiated by ahm from one Complying Health Insurance Product to another Complying Health Insurance Product providing similar Benefits or from one ahm Complying Health Insurance Product option to a different option of the same Complying Health Insurance Product, does not require any extra Waiting Periods to be served for additional Benefits that may be provided other than those Waiting Periods that would otherwise have been required under these Fund Rules.
- 6.7 ahm must provide a transfer certificate within 14 days to a Policy Holder who ceases to be a Policy Holder of the Fund. ahm will satisfy its obligations under this Fund Rule by providing the certificate to the Principal Policy Holder only.
- 6.8 ahm will request a transfer certificate within 14 days from the previous private health insurer if the new Policy Holder does not provide the Fund with a transfer certificate within 7 days of joining. Each Policy Holder gives the Fund authorisation to contact the previous private health insurer for that purpose.
- 6.9 For detailed information on waiting periods, refer to F3.

## ***C7 Cancellation of Membership***

- 7.1 ahm must not cancel or vary the policy of any Policy Holder on the grounds of the health of that Policy Holder or of a Dependent.
- 7.2 ahm has the right to immediately cancel a policy from the date of notification to the Principal Policy Holder, if any Policy Holder covered by that policy has committed or attempted to commit, in the opinion of ahm, fraud upon ahm or the Fund or has undertaken, in the opinion of ahm, any illegal action. Any premiums paid in advance of the date of cancellation may be first applied by ahm to offset the cost of the fraud, attempted fraud or illegal action, with ahm being only liable to the Principal Policy Holder for any balance remaining.
- 7.3 Recognised Providers are not able to pay premiums on behalf of any Policy Holder other than for themselves, the Recognised Provider's Partner or Dependents or their employees as part of an Employee Health Benefit Scheme as defined under the Act.
- 7.4 ahm has the right to immediately cancel a policy if the application contained inaccurate or incomplete material information, or if the Principal Policy Holder falsely agreed to any statement contained in the declaration. Cancellation may be effected from the date the policy commenced. The refunded premiums paid will be less any Benefits paid.
- 7.5 ahm has the right to immediately cancel a policy if any person covered by that policy holds an equivalent Active cover with another Private Health Insurer. Cancellation may be effected from the date the policy commenced. The refunded premiums paid will be less any Benefits paid.
- 7.6 Without limiting the powers in Rules C7.1 to C7.5, ahm may terminate a policy provided that the grounds for termination do not contravene any part of the Act and in particular do not relate to any of the items in Rule C2 (Eligibility) or C4 (Application).
- ahm has the power to cancel a policy in writing.
- (1) immediately – for any reason for Policy Holders of OSHC
- (2) in all other cases (other than those already covered by other provisions in Rule C7), with two months' notice.
- 7.7 Where ahm has exercised its rights to cancel a policy, ahm has the right to refuse a future application from any Policy Holder or Dependent insured under that policy.

## ***C8 Termination of Membership***

- 8.1 Only the Principal Policy Holder has the right to terminate the policy by giving notice in writing to ahm in writing and signed by the Principal Policy Holder, effective from the date specified in the notice (being a date no earlier than the date of the notice). Subject to Fund Rule C8.3, on termination, the Principal Policy Holder is entitled to receive a refund of any premiums paid in advance of the date of termination.
- 8.2 Any Policy Holder or Dependent over the age of 16 covered by a policy may give notice in writing to ahm in writing and signed by the Policy Holder or Dependent over the age of 16 (as the case may be), effective from the date specified in the notice (being a date no earlier than the date of the notice) terminating that individual's insurance cover under that policy (but not terminating the policy). Where the termination results in the policy no longer meeting the requirements of the policy category, the policy must be transferred in accordance with rule C6.6 or C6.7.
- 8.3 A Principal Policy Holder who has not yet made any claim for Benefits under the policy and who terminates that policy (in accordance with Fund Rule C8.1) within a period of 30 days from the start date of the policy is entitled to receive a full refund of any premiums paid.
- 8.4 Any notice given under Rule 8.1, 8.2 or 8.3 must be sent to ahm's registered office by delivery, pre-paid post or facsimile transmission only. Email communications are not an acceptable form of notice.

## ***C9 Temporary Suspension of Membership***

- 9.1 ahm may suspend a policy, subject to Fund Rule C9, upon prior written application by the Principal Policy Holder if the reason for suspension is:
- (1) The upcoming temporary absence of the Policy Holders from Australia for more than one month.
  - (2) The inability of any of the Policy Holders to meet the premiums because all of the Policy Holders are in receipt of Job Search Allowance, New Start Allowance or Sickness Allowance or any similar allowance under the *Social Security Act*.
- 9.2 A suspension application will only be considered if the Principal Policy Holder has paid at least one payment frequency's premiums in accordance with Fund Rule C4.3.
- 9.3 There will be no Benefits paid, nor any access to services granted by ahm under its Health Insurance Business or Health Related Business, to any Policy Holder or Dependent covered under a policy that is suspended during the time it is suspended.

- 9.4 Any period of suspension does not count in calculating any Waiting Periods. On reactivation of the policy, the Policy Holders and Dependents must serve the balance of any Waiting Periods.
- 9.5 This Fund Rule applies to suspension in accordance with Fund Rule C9.1 (1) - Overseas Suspension.
- (1) Policy entitlements shall be made available immediately upon resumption of payment of premiums provided that the payment of premiums is resumed within thirty days of any Policy Holder returning to Australia. Proof of date of re-entry is required.
  - (2) Resumption of the policy is not permitted until at least one Policy Holder covered by the policy returns to Australia and will commence as at the date of return to Australia, provided that ahm receives written notice of that return within 30 days of the date of return to Australia.
  - (3) Failure to advise ahm of the return to Australia of any Policy Holder within 30 days of return (pursuant to Fund Rule C9.5 (2)) means that the policy will be re-activated only from the date of notification, with a gap in the period of cover and all persons insured under the policy will need to re-serve any relevant Waiting Periods.
- 9.6 This Fund Rule applies to suspension in accordance with Fund Rule C9.1 (2) - Unemployment Suspension.
- (1) Two years continuous holding of a Complying Health Insurance Product with ahm is required.
  - (2) Proof of receipt of the relevant Allowance must be provided.
  - (3) Policy entitlements shall be made available immediately upon resumption of payment of premiums provided that payment of premiums is resumed within thirty days of any Policy Holder resuming employment. Proof of the date employment recommenced is required and must be provided within 30 days of resuming employment.
  - (4) Failure to advise ahm of recommencement of employment of any Policy Holder's return to work within 30 days (pursuant to Fund Rule C9.6(3)) means that the policy will be activated only from the date of notification with a gap in cover and all persons insured under the policy will need to re-serve any relevant Waiting Periods.

## **D CONTRIBUTIONS**

### ***D1 Payment of Contributions***

- 1.1 Premiums may be paid by a Policy Holder in advance or through a payroll deduction scheme or by such other arrangements as are authorised by ahm from time to time.
- 1.2 The premium rates for a Single Policy shall be half of the premium for a Family Policy and based on the definition in B2 of “Single Policy”.
- 1.3 Policy Holders whose premiums are not paid through a payroll deduction arrangement shall be required to make premium payments in advance.
- 1.4 The Principal Policy Holder is required to pay the rate applicable to the State in which the Principal Policy Holder resides.
- 1.5 The premium applied to a Single Parent Policy will be a reduced amount of the Family Policy premium for the same level of cover, as determined by ahm.

### ***D2 Contribution Rate Changes***

- 2.1 ahm has the right to change premium rates if an application to alter rates is approved by the Minister.
- 2.2 Once the Minister approves an application by ahm to change its premium rates, ahm reserves the right to apply the new premium rate to any premiums received after the date of the announcement taking into account the effective date of the change. Any Policy Holders whose financial date is in advance of the Minister’s approval will not be exempt from such changes.

### ***D3 Contribution Discounts***

- 3.1 Discounts may apply up to 12% per annum in accordance with the Act and the Rules.

#### ***D4 Lifetime Health Cover***

- 4.1 If a person does not have Hospital cover on 1 July following their 31st birthday and decide to take out hospital cover later in life, that person will pay a 2% loading (Lifetime Health Cover Loading) on top of their premium for every year they are aged over 30. Some exemptions are applicable. The onus is on the Policy Holder to advise details to claim an exemption.
- 4.2 People who were born on or before 1 July 1934 are exempt from the Lifetime Health Cover Loading and are able to join ahm at any time and pay the same premium as someone who takes out coverage at age 30.
- 4.3 Other limited exemptions to the Lifetime Health Cover Loading apply under the Act. The onus is on the Policy Holder to advise details to claim an exemption.
- 4.4 The Lifetime Health Cover Loading requirement ceases for each Policy Holder after 10 years of continuous coverage.

#### ***D5 Arrears in Contributions***

- 5.1 No Benefits shall be paid for services rendered to a Policy Holder or their Dependents during the period in which the policy is in arrears until the premium arrears are paid and accepted by ahm.
- 5.2 No Benefits will be paid for claims where the date of service is later than the financial date of the policy.
- 5.3 ahm has the right to refuse to accept premium arrears if these premiums are tendered later than two months after the financial date of the policy.

#### ***D6 Other***

- 6.1 ahm established the Health and Medical Research Fund in 1986 to support medical research. Any Policy Holder can make a voluntary contribution to the Health and Medical Research Fund. Members of the general public can also make donations to the Health and Medical Research Fund. That fund is operated and accounted for separately from the Health Benefits Fund, and in accordance with the Health and Medical Research Fund Trust Deed. ahm provides administrative support and services to the Health and Medical Research Fund.

## **E BENEFITS**

### ***E1 General Conditions***

- 1.1 Benefits are limited up to 100% of the documented cost to the insured person for any service or good for which Benefits are payable as determined by the policy.
- 1.2 Benefits will be in the form of undertaking the liability for some or all of the loss arising out of payment of fees or charges for the provision of goods and services for Hospital Treatment or General Treatment rendered in Australia as determined by the level of cover of the policy.
- 1.3 Benefits are not payable in respect of relevant services or goods provided during any relevant Waiting Period.
- 1.4 Benefits are not payable in respect of services or goods that have been provided to a person insured during a period for which the premiums have not been paid.
- 1.5 Benefits are not payable in respect of a service or good that has been rendered to a person insured if the expenses in respect of that service or good were incurred by the employer of a Policy Holder or if the person to whom that service or good was rendered obtained that service in connection with, or in conjunction with; employment, or application for employment, an industrial undertaking or profession, or a life insurance examination or the like.
- 1.6 Benefits are not payable in respect of services or goods unless the provider is a Recognised Provider.
- 1.7 Irrespective of the financial date of the policy, or whether the policy is paid in advance, Benefits may be varied during the year on a date of ahm's choosing, subject to adequate notice being provided in accordance with the obligations under the Act and the Private Health Insurance Code of Conduct.
- 1.8 If a Benefit has been erroneously paid then ahm is entitled to recover any such amount that should not have been paid under these Fund Rules in any period within 2 years of making the erroneous payment.
- 1.9 The Benefit for a particular service is the Benefit that is applicable to that service on the date the service or principal component of the service was provided, and in the case of dental orthodontic, prosthodontic, crown and bridge services, the date of service is the date the appliance or prosthesis was fitted.
- 1.10 Notwithstanding these Fund Rules, but subject to the Act and the rules, ahm has the right to review the operation or effect of any particular Fund Rule in specific instances and also has the right to provide, without prejudice, an Ex Gratia payment, provided at the absolute discretion of ahm and subject to any conditions ahm sees fit to impose (that are not inconsistent with the Act), for the cost of goods and services that the Policy Holders or Dependents are not entitled to under their level of cover, as long as those goods or services fall within the

definition of Hospital Treatment or General Treatment and are offered by ahm. Requests for Ex-Gratia benefits will be determined based on the requirements of the Act and the rules, the expected health outcome of the person and the financial viability of the Fund. Where a request is for a service or good not covered by the Policy Holder's level of cover but is covered under another ahm product a change of cover will be recommended.

- 1.11 Benefits will not be payable for services performed by a provider to the provider, the provider's Partner, Dependents, any business partner or business partner's Partner or Dependents.
- 1.12 Benefits will only be paid for one service per provider per date of service. Multiple services provided by the same provider on the same day will be treated as one service.
- 1.13 Benefits are not payable on consultations provided over the telephone or Internet unless express prior approval has been provided by ahm.
- 1.14 Benefits are not payable in respect of services or goods provided to an insured person for which Benefits are payable or subsidised by another entity including government departments or agencies, insurance companies, an employer or other such party where not a compensable claim as described in F7.
- 1.15 Benefits will not be paid unless a valid receipt or invoice is provided unless the claim is made through HICAPS.
- 1.16 Benefits will not be paid where the service date on the receipt or invoice is more than 2 years from the date of lodgement of the receipt or invoice with ahm.
- 1.17 Benefits are only payable for the cost of goods and services purchased or provided within Australia. Hospital Treatment and General Treatment received or goods purchased overseas (including Norfolk Island) are not eligible for Benefits.
- 1.18 Benefits for pharmacy item paid under General Treatment will only be paid for non-PBS items that are supplied on a valid prescription and are not available over the counter or off the shelf. Benefits will not be paid for herbal medicines or vitamins.

## ***E2 Hospital Treatment***

- 2.1 A policy that covers Hospital Treatment must meet the Benefit Requirements of Division 72 of the Act by providing a Benefit for:
  - (i) any part of Hospital Treatment that is one or more of the following:
    - (a) psychiatric care;
    - (b) rehabilitation;
    - (c) palliative care;if the treatment is provided in a hospital and no Medicare benefit is payable for that part of the treatment.

- (ii) Hospital Treatment covered under the policy for which a Medicare benefit is payable
- (iii) if the policy covers Hospital-Substitute Treatment—Hospital-Substitute Treatment covered under the policy for which a Medicare benefit is payable.
- (iv) (a) Hospital Treatment covered under the policy; and
  - (b) if the policy covers Hospital-Substitute Treatment, Hospital-Substitute Treatment covered under the policy; that is the provision of a prosthesis of a kind listed in the *Private Health Insurance (Prostheses) Rules* in circumstances:
  - (c) in which a Medicare benefit is payable; or
  - (d) set out in the *Private Health Insurance (Prostheses) Rules* for the purposes of this table item.
- (v) any treatment for which the *Private Health Insurance (Benefit Requirements) Rules* specify there must be a Benefit.

## 2.2 Default Benefit

2.2.1 The minimum benefit (default benefit) for the accommodation cost of an episode of Hospital Treatment that must be covered under Division 72 of the Act and where a Restricted Benefit is paid is the amount specified in Schedules 1-3 of the *Private Health Insurance (Benefit Requirements) Rules*.

2.2.2 The default benefit for restricted services covers the cost of:

- (i) Shared accommodation at a Public hospital;
- (ii) The Commonwealth Government prescribed rate (as above) for accommodation in a Private hospital;
- (iii) Medical gap benefits
- (iv) Surgically implanted prosthesis listed in the Prostheses Schedule and determined in the *Private Health Insurance (Prostheses) Rules* as no gap prosthesis.

2.2.3 No Benefit is paid for costs associated with theatre or intensive care.

## 2.3 Second-Tier Default Benefit

2.3.1 The minimum benefit (second-tier default benefit) for an episode of Hospital Treatment at a facility that does not have an Agreement is the amount specified in Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules*.

## 2.4 Hospital Treatment Products

2.4.1 All Hospital Treatment Products shall provide Benefits as listed in the Schedules.

2.4.2 For residents of New South Wales and the Australian Capital Territory the State and Territory Governments claim a levy from AHM which entitles Policy Holders to ambulance transport free of charge. For residents of Victoria, South Australia, Western Australia or the Northern Territory the Fund pays 100% of

the cost for Medically Necessary ambulance services. Benefits for Ambulance Cover do not apply in Tasmania or Queensland as state schemes are in place.

2.4.3 Benefits are not payable for patients of nursing homes, aged care facilities or for associated respite care.

## 2.5 Hospital Benefits

The Fund has an Agreement with the majority of Private hospitals throughout Australia which include arrangements on how they will charge for Hospital Treatment. At Contracted Hospitals, the Fund will pay 100% of the Benefits for agreed theatre, intensive care and accommodation charges for the Hospital Treatments as specified in the Schedules less any co-payment applicable to the policy.

2.5.1 Unless specified in a product, hospital benefits will only be available for Hospital Treatment in Public or Private hospital or a Day Facility.

2.5.2 AHM will pay Benefits to Contracted Hospitals in accordance with the Agreement.

2.5.3 Where a hospital does not have an Agreement with AHM, Benefits will be payable in accordance with the default benefits under Schedule 1-3 or the second-tier default benefits under Schedule 5 of the *Private Health Insurance (Benefit Requirements) Rules*.

2.5.4 The length of stay in hospital will be calculated by including the first day (date of admission) but excluding the last day (date of discharge).

2.5.5 AHM pays Medical Gap benefits up to 25% of the Commonwealth Medical Benefit Schedule (CMBS) fee. Benefits in excess of the CMBS fee are payable where there is an Access Gap Cover Scheme arrangement in place.

2.5.6 AHM pays Benefits for pharmaceuticals not covered by the Pharmaceutical Benefits Scheme when they are included in the relevant Agreement with the Contracted Hospital.

2.5.7 AHM pays Benefits for surgically implanted prostheses in accordance with the relevant Agreement with the Contracted Hospital and as set out in the *Private Health Insurance (Prostheses) Rules*.

2.5.8 AHM pays Benefits for nursing home type patients (NHTP) in accordance with Schedule 4 of the *Private Health Insurance (Benefits Requirements) Rules*. Where there is a dispute about whether the person insured is a NHTP the matter will be resolved between the hospital and AHM but may be referred to the Private Health Insurance Ombudsman for mediation.

2.5.9 Hospital Benefits will only be available for Hospital Treatment provided by a person who is authorised by a hospital to provide treatment.

## 2.6 Pharmaceutical Benefits for Admitted Patients

2.6.1 For all policies that include a hospital Benefit component, AHM will pay the costs that a patient incurs for a PBS item received while admitted to a Contracted Hospital.

2.6.2 To be eligible for the Benefit, the PBS item must be:

- (1) intrinsic to the Hospital Treatment;
- (2) clinically indicated;
- (3) essential for the meeting of satisfactory health outcomes for the patient;  
and
- (4) directly related to treatment of the condition or ailment for which the patient was admitted.

2.6.3 AHM also covers the costs that the insured incurs for special patient contributions, brand premiums and therapeutic group premiums listed in the Pharmaceutical Benefits Schedule that apply to certain pharmaceutical benefits, regardless of whether the insured has reached the Safety Net Threshold under PBS arrangements.

2.6.4 Payment by AHM is limited to:

- (1) the payment for the maximum quantity as listed in the Pharmaceutical Benefits Schedule; or
- (2) as recorded on an Authority Prescription Form (and authorised by Medicare Australia).

2.6.5 Where the cost to the insured for a PBS item is less than the pharmaceutical benefit co-payment (as determined by the Commonwealth Department of Health and Ageing) these drugs are not covered by AHM.

2.6.6 Nothing in this Fund Rule 2.6 obliges or requires AHM to pay a Benefit for a charge for a pharmaceutical benefit supplied under Part VII of the *National Health Act 1953*, unless the circumstances of the charge are covered by section 92B of *National Health Act 1953*.

## 2.7 Medical Benefits

2.7.1 For medical services provided as part of Hospital Treatment or Hospital-Substitute Treatment for which a Medicare benefit is payable, Medicare pays 75% of the scheduled fee and the Fund pays the remaining 25% of the scheduled fee up to the charge (except where an Access Gap Cover Scheme arrangement is in place). Any charge for services above the scheduled fee or Access Gap Cover Scheme arrangement is payable by the Policy Holder. If the charge is less than the scheduled fee, the Fund pays so much of the charge as exceeds 75% of the scheduled fee.

2.7.2 For medical services provided as part of Hospital Substitute Treatment for which a Medicare benefit is payable, Medicare pays 75% of the scheduled fee and the Fund pays the remaining 25% of the scheduled fee up to the charge

(except where an Access Gap Cover Scheme arrangement is in place). Any charge for services above the scheduled fee or Access Gap Cover Scheme arrangement is payable by the Policy Holder. If the charge is less than the scheduled fee, the Fund pays so much of the charge as exceeds 75% of the scheduled fee. No Benefit is payable if the Medicare benefit payable is at least 85% of the scheduled fee.

2.7.3 Where there is an Access Gap Cover Scheme in place, Medicare pays 75% of the scheduled fee, the Fund pays the remaining 25% of the scheduled fee as well as the amount up to the agreed Access Gap Cover schedule. Any charge for services above the Access Gap Cover schedule fee is payable by the Policy Holder.

2.7.4 Medical Practitioners who opt to take part in this scheme must inform Policy Holders:

- (1) in writing of any amounts the Policy Holder can reasonably be expected to pay for the treatment by the Medical Practitioner and any associated professional services, if possible before the provision of such treatment and services or otherwise, as soon as practical; and
- (2) of any financial interest a person providing the treatment or any associated professional services have in products or services recommended or provided to the Policy Holder.

2.7.5 A cap of \$400 per item above the Access Gap Cover fee or \$800 for obstetrics services is allowed for a Medical Practitioner to participate in the Access Gap Cover Scheme. Charges quoted above these permitted caps means the Medical Practitioner has opted to not participate in the scheme and any additional Benefits above the scheduled fee will not be paid.

2.7.6 If the Fund enters into an Agreement with a Medical Practitioner for the provision of treatment to an insured person, the Agreement will not limit the Medical Practitioner's professional freedom, within the scope of accepted clinical practice, to identify and provide appropriate treatments.

### ***E3 General Treatment***

3.1 All Products including a General Treatment component shall provide Fund Benefits or Fund services in accordance with the Schedules.

3.2 A policy that covers General Treatment must meet the requirements of the Act

3.3 The maximum Benefit and limits for General Treatment for of all ahm products are set out in the Schedules.

3.4 The Fund may pay stated higher Benefits for the cost of services provided by selected General Treatment providers as part of a preferred provider arrangement. A list of these preferred providers will be maintained by ahm and provided to Policy Holders on request.

- 3.5 For Pharmaceutical Benefits paid out of a General Treatment product an amount equal to the current general patient PBS rate will be deducted from all items before a Benefit is paid.
- 3.6 The Fund will not cover as part of General Treatment (including Hospital-Substitute Treatment) professional services for which a Medicare benefit is payable except as detailed below.
- 3.7 The classes of services for which a Medicare benefit is payable and which can be covered as part of a Hospital-Substitute Treatment under General Treatment are:
- (i) the professional medical therapeutic services identified in Groups T1 to T11 of the Medicare Benefits Schedule general medical services table that are:
    - a. items in the table without a 75% benefit; or
    - b. not stated in the item to be services that are to be performed in a hospital for the Medicare benefit to be payable; and
  - (ii) oral and maxillofacial services set out in Groups O1 to O11 of the Medicare Benefits Schedule general medical services table that are:
    - a. items in the table without a 75% benefit; or
    - b. not stated in the item to be services that are to be performed in a hospital for the Medicare benefit to be payable; and
  - (iii) the associated services in the:
    - a. pathology services tables; and
    - b. diagnostic imaging services table,
 that is integral to the provision of the services in Rule E3.6 (i) and (ii) above.
- 3.8 ahm will not cover as part of General Treatment, as per Rule 11 (1) of the Private Health Insurance (Health Insurance Business) Rules, any treatment which primarily takes the form of sport, recreation or entertainment, other than such treatment which is part of a Chronic Disease Management Program or a Health Management Program that has been approved by the ahm.
- 3.9 Loyalty Benefits
- 3.9.1 Loyalty Benefits are based on a Principal Policy Holder maintaining a policy with ahm for a continuous period and apply to a range of General Treatment Benefits payable in any Financial Year. This means the Benefit limit for the claiming period specified will depend on the number of continuous years that the Principal Policy Holder has held a policy.  
The General Treatment benefits table in the Schedules detail limit entitlements.
- 3.9.2 The loyalty date for the whole policy is determined by the length of time that the Principal Policy Holder has held a policy without interruption. If a person insured under that policy is no longer insured under that policy for any reason, including the death or other change in status of the Principal Policy Holder, each person's entitlement to the loyalty benefit will be calculated by reference to the joining date of that person.  
Some examples:

1. Betty (Principal Policy Holder) started an ahm family policy in 1980 and John joined the policy in 1985 when he was born. John left the family policy to start his own single policy with ahm. Because he has been with ahm since 1985, he will start a single policy with 22 (as at 2007) years of loyalty.
2. Tom (ahm policy holder since 2001) married Betty and joined her policy in 2004. The policy stays in Betty's name so their loyalty date remains at 1980 and they are each entitled to 27 years of loyalty. If the policy had transferred into Tom's name (and he becomes the Principal Policy Holder) their loyalty date would be 2001 instead of 1980 and their loyalty years and associated benefits would be less.
3. Betty passed away in 2005. When Betty passed away, the policy transferred into Tom's name. As he is now the Principal Policy Holder, loyalty limits are based on when he joined ahm in 2001.

If a change to a policy is required, Policy Holders must consider who will be the Principal Policy Holder. This determines the loyalty years designated and the limits claimable.

3.9.3 As loyalty limits apply to a Financial Year, the number of years a Principal Policy Holder has been a Policy Holder at 1 July each year, determines the category of loyalty Benefits.

For example, although in December 2006 Tom has been a Policy Holder for 5 years (he joined in 2001), he will not be entitled to his 5 years loyalty limits until 1 July of the following year.

## ***E4 Other***

### **4.1 Fund Dental and Eyecare Services - Benefits & Conditions**

Dental services and Eyecare services may be provided at ahm's Dental and Eyecare Practices to ahm Policy Holders, their Dependants and the general public. A schedule of fees is available to determine the charges, benefits and out of pocket expenses (DEP Co-payments) payable or able to be claimed by Policy Holders for services provided to persons insured under the policy.

Dental Services provided at the ahm Dental and Eyecare Practices are provided under the terms and conditions listed below:

#### **4.1.1 Eligibility for Treatment**

##### **Dental Services**

Policy Holders and their Dependents either joining or transferring to any of ahm's products that include dental Benefits are eligible to receive treatment for:

- (1) Routine Dental services, providing they have been insured under any ahm policy that includes a Routine Dental Benefit for at least two months continuously, or have served an equivalent Waiting Period on a comparable product as at the date of treatment.
- (2) Complex Dental services, providing they have been insured under any ahm policy that includes a Complex Dental Benefit for at least twelve months continuously, or have served an equivalent Waiting Period on a comparable product as at the date of treatment.
- (3) Major Dental services, providing they have been insured under any ahm policy t that includes a Major Dental Benefit for at least twelve months continuously, or have served an equivalent Waiting Period on a comparable product as at the date of the treatment.
- (4) Orthodontic services, providing they have been insured under any ahm policy that includes Orthodontic Benefits for at least twelve months continuously, or have served an equivalent Waiting Period on a comparable product as at the date of commencement of treatment and this level of cover is held for the duration of the treatment.

#### Optical Services

Policy Holders and their Dependants either joining or transferring to any of ahm's products that include Optical Benefits are eligible to receive Optical Services providing:

- (1) They have been insured under any ahm policy that includes an Optical Benefit for at least six months continuously, or have served an equivalent Waiting Period on a comparable product as at the date of the service.

Services at ahm's Dental and Eyecare Practices are subject to the conditions and restrictions as detailed in Fund Rules E4.1.2-5.

The general public are eligible to receive treatment at the full scheduled fee.

Normal transfer rules apply as detailed in Rule C6.

#### 4.1.2 Benefit Conditions

Dental services for diagnostic and preventive items (as specified by the DEP fee schedule) will be provided to a Policy Holder and their Dependents at no additional charge, where they qualify as eligible patients in accordance with Fund Rule E4.1.1 except in the following cases:

- (1) Services rendered incur a DEP Co-payment as set out in the DEP Fee Schedule which is available to Policy Holders at any ahm Dental and Eyecare Practice.

- (2) Where limits on dental service entitlements have been reached, in which case private patient charges will be raised for services rendered.
- (3) Where it is required that a patient is referred to a private practice provider, normal private practice rules, fees and benefits apply.
- (4) Where the level of cover does not include that item or treatment.

#### 4.1.3 Restriction on Treatment

Services will not be provided at no cost or charge to a Policy Holder or Dependent where:

- (1) Waiting Periods have not been served.
- (2) Satisfactory arrangements have not been made for settling accounts for DEP Co-payments or any other charges raised by the Dental and Eyecare Practice.
- (3) Premiums are not paid up to the date of service or group payroll deductions are not in line with the financial date of the group.
- (4) Benefit limits for that category of services have been reached.
- (5) Services are not included under the Policy Holder's level of cover.

In these instances services may be provided at the full scheduled fee.

ahm has the absolute power to restrict any Policy Holder or their Dependents from using the services of any ahm Dental and Eyecare Practice, providing the Principal Policy Holder is informed of the reason for such restriction.

#### 4.1.4 Out of Pocket Expenses (DEP Co-Payments)

DEP Co-payments represent a surcharge whereby the patient shares in the cost of certain services provided by the Dental & Eyecare Practices. A schedule of DEP Co-payments is set out in the DEP Fee Schedule available to Policy Holders at any ahm Dental and Eyecare Practice. DEP Co-payments are payable at the time the service is provided or as scheduled in the treatment plan.

#### 4.1.5 Limits

Dental limits for Policy Holders of all ahm General Treatment products are set out in the Schedules.

Any treatment in excess of the allowable limit must be paid for in accordance with the DEP Fee Schedule available at any ahm Dental and Eyecare Practice.

## 4.2 Funeral Benefits

ahm has previously offered funeral benefits as part of a health insurance policy. Since 1 April 2007, ahm no longer offers that benefit. However, nothing in this rule affects the rights of any person to a funeral benefit, where that entitlement arose prior to 1 April 2007. Any entitlement that is preserved under this rule cannot be altered, redeemed or exchanged for other Benefits or any other entitlement.

## **F LIMITATION OF BENEFITS**

### ***F1 Co Payments***

- 1) A co-payment in relation to Hospital Treatment is the daily amount paid towards the cost of a hospitalisation (including Day Only Admissions). A co-payment may apply to each person covered on the policy. There are set limits for each person insured for each Membership Year or for each policy as set out in the Schedules.
- 2) For Top Hospital products the co-payment is waived for Dependents and for admissions as a result of a non-compensable accident.
- 3) If changing to a level of hospital cover with a lower level of co-payment a person insured will have to serve the relevant Waiting Period before the lower co-payment applies.

### ***F2 Excesses***

No excesses apply to Hospital Treatment products.

### ***F3 Waiting Periods***

- 3.1 When taking out or transferring to a policy for Hospital and/or General Treatment or changing level of cover, the Policy Holders and their Dependents have to wait a set time before claiming for services and benefits provided to the Policy Holder or their Dependents that were not previously covered or for which Waiting Periods have not been served.

During a Waiting Period for a service or treatment a person insured under the policy is not entitled to a Benefit for that service or treatment.

Waiting periods apply as follows:

#### **Hospital and Hospital-Substitute Treatment**

1 day	<ul style="list-style-type: none"><li>▪ Ambulance services</li><li>▪ Hospital Treatment that is required as a result of an accident</li></ul>
2 months	<ul style="list-style-type: none"><li>▪ Hospital Treatment (where there are no Pre-existing Conditions).</li></ul>

	<ul style="list-style-type: none"> <li>▪ Psychiatric, rehabilitation and palliative care (whether or not a Pre-existing Condition)</li> </ul>
12 months	<ul style="list-style-type: none"> <li>▪ Pre-existing Conditions</li> <li>▪ Obstetrics, pregnancy and birth related conditions</li> </ul>

**General Treatment (that is not Hospital-Substitute Treatment)**

1 day	<ul style="list-style-type: none"> <li>▪ Ambulance services</li> <li>▪ Travel and Accommodation relating to a hospitalisation</li> </ul>
2 months	<ul style="list-style-type: none"> <li>▪ General treatment except as specified below</li> <li>▪ Travel and Accommodation relating to specialist medical services or outpatient procedures</li> </ul>
6 months	<ul style="list-style-type: none"> <li>▪ Optical (except for laser eye surgery)</li> <li>▪ Outpatient procedure room fees</li> <li>▪ Post operative and medical aids</li> </ul>
12 months	<ul style="list-style-type: none"> <li>▪ Complex Dental</li> <li>▪ Major Dental</li> <li>▪ Orthodontics</li> <li>▪ Podiatric surgery</li> <li>▪ Orthotics</li> <li>▪ Hearing Aids</li> <li>▪ Pre and post natal services</li> <li>▪ Medical gases</li> <li>▪ Joint fluid replacement injections</li> <li>▪ Disease management appliances</li> </ul>
3 years	<ul style="list-style-type: none"> <li>▪ Laser eye surgery</li> </ul>

- 3.2 Waiting Periods served with a previous Private Health Insurer will be counted towards Waiting Periods served with ahm, provided the person insured has transferred with current continuous comparable coverage.
- 3.3 For Partners and Dependents covered by a policy, other than at birth, all Waiting Periods apply.
- 3.4 A pregnant Policy Holder holding a single policy must upgrade to a family or single parent family policy at least 2 months prior to the birth of the child for the child to be covered without Waiting Periods.
- 3.5 The 12 month Waiting Period applying to obstetrics applies to a premature birth whether or not the Policy Holder is pregnant at the time of joining a relevant policy with ahm or changing cover to include obstetrics.

- 3.6 Subject to the Act and the rules, ahm reserves the right in its absolute discretion to waive any Waiting Period.

#### ***F4 Exclusions***

There are no exclusions on any Hospital Treatment product.

#### ***F5 Benefit Limitation Periods***

There are no Benefit limitation periods on any Hospital Treatment product.

#### ***F6 Restricted Benefits***

Depending on the level of cover chosen by the Policy Holder, Benefits may have restrictions on particular Hospital Treatments as detailed in the Schedules.

#### ***F7 Compensation Damages and Provisional Payment of Claims***

- 7.1 Policy Holders are required to advise ahm if any claim is covered by compensable insurance or a compensable claim of any kind.
- 7.2 ahm agrees to pay Benefits for claims that are covered by other compensable insurance or are the responsibility of another party provided that the Policy Holder agrees to complete an Irrevocable Letter of Undertaking providing for reimbursement to ahm of those Benefits once the compensable claim is paid or an agreement for financial reimbursement is reached.
- 7.3 No compensable claims covered by any form of other insurance or a compensable claim of any kind will be paid to holders of Overseas Student Health Cover or Overseas Visitors Health Cover.

## **G CLAIMS**

### ***G1 General***

#### ***1.1 Claim Form***

- 1.1.1 ahm reserves the right to require that a signed authorised claim form be completed by the Policy Holder or Policy Holder's authorised agent for

payment of Benefits in regard to a service which the Policy Holder or a Dependant has received from a Recognised Provider.

- 1.1.2 Original accounts, receipts or prescriptions containing the itemised details of the services performed, who performed the services, dates of the services and the cost of each item must be attached to the authorised claim form. ahm will not accept a photocopy of any account, receipt or prescription. ahm will retain all original documents submitted in support of a claim.
- 1.1.3 ahm will not accept any account, receipt, prescription or any other document, which has been altered in any way by any person, so as to misrepresent any of the original details contained on those documents.
- 1.1.4 No Benefits will be paid unless the service has actually been rendered or the good supplied to a Policy Holder or Dependent.
- 1.1.5 ahm reserves the right in its complete discretion to validate all claims with the provider of the good or service or with the Policy Holder, and may use a third party to investigate or validate any claim made.