

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

HEALTH BENEFITS FUND RULES

as at 1 April 2012

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 Members as reported to the Private Health Insurance Administration Council (PHIAC), excluding Overseas Student Health Cover (OSHC).
 - 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 (Rules) 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 Members 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 to join the Fund as a Member 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 Member 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 Members are governed by:
- (a) *Private Health Insurance Act 2007* and the *Private Health Insurance Rules*
 - (b) These Fund Rules
 - (c) *National Health Act*
 - (d) *Health Insurance Act*
 - (e) The constitution

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

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:

These services are available to Members on eligible Products

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 Members on eligible Products. 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.

Debits and Credits to the Fund

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

Credits	Debits
Premium Income (OSHC)	Benefits - OSHC
Payment or reimbursement of treatment costs (through claims made by HIB) for	Cost of Goods and Services provided
- Dental Services	- Clinical salaries and oncots
- Optical Services	- Clinical support salaries and oncots
- Chronic Disease Management Programs	- Associated other staff costs
- Health Management Programs	- Depreciation of assets used in the provision of goods and services

<ul style="list-style-type: none"> - Other (treated as Administration costs in HIB) <p>External Income</p> <ul style="list-style-type: none"> - Member co-payments for treatment costs - Private Dental and Optical patients treatment costs - Public sector dental patients treatment costs - Other Health Benefit Funds Chronic Disease Management Programs - Other Health Benefit Funds Health Management Programs - Corporate Health Management Programs - Government Health Management Programs 	<ul style="list-style-type: none"> - Stock costs - Third party service providers <p>Administration costs</p> <ul style="list-style-type: none"> - Wages and Salaries - Associated employment oncosts - Information technology - Provision of staff amenities - Property costs - Advisers, contractors and consultants - Proportion of shared services, shared with HRB, including: - Information technology - Finance - HR - Other corporate administration services - Dividends
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This is not an exhaustive list.

A6 No Improper Discrimination

- 6.1 When conducting the Fund and making decisions in relation to prospective Members and Members, 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 Member chooses to transfer to or is required to transfer to by ahm.
- 7.5 If a Member 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 Members 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 Act 2007* and the Private Health Insurance Code of Conduct are fulfilled.
- 7.7 ahm will notify Members 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 Act 2007* and the Private Health Insurance Code of Conduct; or
 - (b) where the Premiums are increased (excluding rounding adjustments).
- 7.8 ahm may notify affected Members 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 Members 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 Member 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 Members.
- 2) ahm will provide an up to date Standard Information Statement (SIS) to every Member at least once every 12 months. ahm will satisfy its obligations under this Rule by sending the SIS to the Principal Member only.
- 3) ahm will provide a Standard Information Statement (SIS) to a Member on joining ahm or a change of cover under the Policy held by the Member. ahm will satisfy its obligations under this Rule by giving notice to the Principal Member only.
- 4) ahm will provide a Standard Information Statement to a Member whenever a Member requests ahm to provide one in respect of the Product held by the Member.
- 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 Members with regard to Dispute Resolution under the provisions of the Private Health Insurance Code of Conduct. Members can make a complaint to ahm by phone, over the counter, by e-mail or by letter. The matter will be investigated, the Member will be kept informed of the progress of the matter and a response will be provided within 21 days
- 8.2 Should the Member remain dissatisfied with ahm's response, they can contact the Private Health Insurance Ombudsman for free independent advice.

A9 Notices

- 9.1 Members 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 Member only.
- 9.2 Copies of the Fund Rules will be available to Members via ahm's website or if requested by the Member.

- 9.3 Members 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 Members will be satisfied by sending the notice to the address last supplied by the Principal Member.

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

“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 Member 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 a Member.

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

“Associated Professional Services” means professional services rendered to a Member 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

- a) natural, step, foster or adopted child of the Principal Member or their Partner
- b) a child of whom the Principal Member or their Partner has legal custody or
- c) from 1 April 2012, for new policies entered into on or after that date the rule will no longer include a grandchild of the Principal Member or their Partner whilst the grandchild’s parent is a Dependent Child.

“Chiropractic Service” means a service or treatment provided by a recognised 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 Member 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.

“Compensation” means:

- a) a payment by way of damages
- b) a payment under a scheme of insurance or compensation provided for by Commonwealth or State law (for example, workers compensation insurance)
- c) settlement of a claim for damages (with or without admission of liability)
- d) a payment for negligence;
- e) any other payment that in ahm's opinion is a payment in the nature of compensation or damages.

“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.

“Couple Policy” means a Policy that includes the Principal Member and their Partner.

“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 Out-of-pocket” is the amount of out of pocket expense that the Member 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, and eyecare services and products.

“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, Dependent Student and Dependent Adult as defined in (a), (b) (c) and (d) below:

- (a) “Dependent Child” of the Principal Member means a person who is:
 - (i) a Child of the Principal Member or the Principal Member’s Partner; and
 - (ii) aged under 18; and
 - (iii) who does not have a Partner;

- (b) “Dependent Adult Child” of a Principal Member means a person who is:
 - (i) a Child of the Principal Member or Principal Member’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 Member

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

- (d) “Dependent Adult” of a Principal Member means a person who is:
 - (i) a Child of the Principal Member or that Principal Member’s Partner; and
 - (ii) aged 18 or over and under 25; and
 - (iii) who does not have a Partner; and
 - (iv) is not a Full Time Student at a school, university or college

“Disease Prevention Programs” means ahm’s Health Risk Assessment and Health Coaching Program (and as described in Fund Rule A5.2.2) which are intended to ameliorate a person's specific health condition or conditions.

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

“Excluded Service” means a service for which no Benefit of any kind is payable

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

“Excess” means an amount paid by a Patient towards the cost of Hospital Treatment received at any Hospital or Day Facility before any Benefits are payable. An Excess is payable per Hospital admission each Membership Year, determined by the relevant Policy.

“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 Member, their Partner, and any Dependents.

“Financial Date” of a Policy means the date to which the Principal Member has fully paid the Premiums in respect of the Policy.

“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.

“Full Time Student” means a person who is enrolled in and undertaking full time study workload at a school, university or college. Full time study workload means:

- (1) at least $\frac{3}{4}$ of the normal full time workload for the particular course; or
- (2) a workload assessed at 0.375 or more per semester for the purposes of the Higher Education Contribution Scheme; or
- (3) a workload assessed by the Academic Registrar of the school, university or college as the maximum workload a person should undertake as a result of that person suffering a substantial disability or medical condition.

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

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

“GapCover Scheme” means an arrangement adopted by ahm and pursuant to which a Medical Practitioner if they agree to participate in the scheme may raise charges for Hospital Treatment or Hospital-Substitute Treatment in accordance with the permitted charges under that scheme and the Fund will cover Members for all or all but a specified amount or percentage of that charge for the medical and associated professional services provided as part of the Member’s Hospital Treatment or Hospital-Substitute Treatment where Medicare benefits are payable.

“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
- b) 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 Members at the provider’s premises.

“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 121-5 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.

"Member" means a person who is insured under a Complying Health Insurance Product that is referable to the Fund.

"Membership Year" means the annual period commencing on the date that the Member joins a Policy with ahm or changes to a new Policy 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.

"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 Member under these Fund Rules.

"Osteopathy Service" means a service or treatment provided by a recognised osteopath.

"Outpatient" means a patient of a Hospital who is not an admitted patient

“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 recognised physiotherapist.

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

“Policy” means a Complying Health Insurance Policy held by a Member that provides coverage for a defined group of Benefits payable, subject to these Fund Rules, in respect of approved expenses incurred by a Member.

“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

Members 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.

“Premium” means the amount of money payable in respect of each Product or Product component as determined by ahm from time to time (and as may be increased in accordance with Fund Rule D2).

“Principal Member” is the first named Member 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. To avoid doubt, OSHC is not Health Insurance Business and is not a Complying Health Insurance Policy and the holders of those policies are not Principal Members.

“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

- (a) in relation to Hospital Treatment: any item on the Prostheses Schedule of the Private Health Insurance (Prostheses) Rules (for example surgically implanted items such as stents, grommets, artificial hips and knees, titanium plates and screws): and
- (b) in relation to General Treatment: an external appliance or device approved by ahm, normally associated with a physical replacement of some part of the human body (for example artificial limb, glass eye).

"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 recognised 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*.

"Restricted Service" means a service identified in the Schedules for the applicable Policy for which only a default benefit (as described in Rule E 2.2) is paid

"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 Member and all of the other insured persons are Dependents.

"State" means the state or territory of Australia.

“State of Residence” means the State in which the Principal Member currently resides. For the purposes of these Fund Rules:

- (a) unless otherwise specified, a Principal Member living in the Australian Capital Territory (ACT) is taken to be a resident of New South Wales (NSW); and
- (b) a Principal Member living in the Territory of Cocos (Keeling) Islands or the Territory of Christmas Island is taken to be a resident of the Northern Territory (NT).

“Travel and Accommodation” means a Benefit for travel and accommodation in relation to a hospitalisation or specialist medical appointment where the Member 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 Member 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 Member 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 15 months from the date of entitlement, the amount will become unclaimed money.

This Fund Rule does not override the claims payment rules contained in E1.

3.2 Any unclaimed amounts less than \$20 (or such higher amount as may be prescribed by the *Unclaimed Money Act (VIC) 2008* will be forfeited by the

Member if it cannot be paid within 15 months from the date of entitlement. Such amounts will become part of the assets of the Fund.

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
- (4) Couple Policy

Each category is further defined in B2.

Levels of Cover

1.2 Subject to these Fund Rules 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.

1.3 A person may be admitted to the levels of cover set out in the Schedules.

1.4 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.

1.5 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.

1.6 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.

1.7 A Policy that covers Hospital Treatment does not include treatments:

- 1) that do not normally require Hospital Treatment (Type C Procedures) unless a certificate by a Medical Practitioner is provided stating that the Member required Hospital Treatment for that procedure; or
 - 2) provided to a person at an emergency department of a Hospital; or
 - 3) 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.
- 1.8 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
- 1.9 The Principal Member 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.
- 1.10 Giving another party authority means that the nominee can do anything the Principal Member 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 Member, changing bank account details for payment of benefits or ceasing the payment of Premiums.
- 1.11 By giving the authority, the Principal Member 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 Member at that time. “
- 1.12 ahm may from time to time declare that the Dependent Adult Policy component is only available on certain Products.
- 1.13 ahm may from time to time declare that the Couple Policy Fund category is only available for certain Products.
- 1.14 Subject to these Fund Rules, the Principal Member must inform ahm of changes to Member details within 2 months of the change. Such changes include:
- (1) change of address or contact details of a Member;
 - (2) change of the Partner status of a Dependent;
 - (3) a Dependent is no longer eligible to be a Dependent;
 - (4) a Dependent Student ceases or defers study;
 - (5) a Dependent Adult Child or a Dependent Student commences Full Time Employment

- (6) A change to the Medicare details or status of any member

C2 Eligibility for Membership

- 2.1 Subject to these Fund Rules, any person is entitled to apply as a Member. Members 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 C2.2 applies to these persons. OSHC is not a Policy under these Fund Rules.
ahm has the power to cancel a Policy in writing immediately – for any reason for holders of OSHC
Persons insured under an OSHC policy are not Members and are not eligible to the rights conferred on Members 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 and in the policy document.
- 2.3 A member may hold a Policy only in respect of the Principal Member's State of Residence.

Unless otherwise approved by ahm, from 1 April 2012, for new policies entered into on or after that date a person aged under 16 is not eligible to be a Principal Member

C3 Dependents

- 1) See B2 "Definitions"
- 2) Subject to these Fund Rules, a Child who ceases to be a Dependent may become a Principal Member by choosing a currently available ahm Product. No additional Waiting Periods will apply provided that:
- 3) The level of cover remains the same as what was previously held as a Dependent; and
- 4) The Child applies to be a Principal Member within 30 days of ceasing to be a Dependent and commences cover from the date immediately after ceasing to be a Dependent

C4 Membership Applications

- 4.1 Applications to become a Member 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 (subject to Fund Rule D1.3 (1) 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 Member 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 unless the student was a previous applicant whose policy was cancelled for reasons other than arrears in premiums.
 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 Member.
 5. The Principal Member 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 Member and each other Member 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 Member and ahm.
- 5.2 If a Member 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 Member, 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 Member. 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 Member 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 Member 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 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 Member on the grounds of the health of that Member.
- 7.2 ahm has the right to immediately cancel a Policy from the date of notification to the Principal Member, if any Member 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 Member for any balance remaining.
- 7.3 Recognised Providers are not able to pay Premiums on behalf of any Member 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 Member 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).
- (1) ahm has the power to cancel a Policy in writing 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 Member insured under that Policy.

- 7.8 Where ahm has exercised its right to cancel a Policy, ahm may at its discretion reinstate the Policy at the Principal Member's request with continuity of entitlements, subject to payment of all premiums as required under D1.

C8 Termination of Membership

- 8.1 Only the Principal Member has the right to terminate the Policy by
- 1) giving notice in writing to ahm and signed by the Principal Member, effective from the date specified in the notice (being a date no earlier than the date of the notice) or
 - 2) giving notice over the telephone by the Principal Member provided that the Principal Member agrees to have the telephone conversation recorded, effective from the date notified by the Principal Member (being a date no earlier than the date of the telephone conversation).

Subject to Fund Rules C7, C8.3 and F7 on termination, the Principal Member is entitled to receive a refund of any Premiums paid in advance of the date of termination.

- 8.2 Any Member over the age of 16 covered by a Policy may give notice terminating that individual's insurance cover under that Policy (but not terminating the Policy):
- (1) in writing to ahm in writing and signed by that Member, effective from the date specified in the notice (being a date no earlier than the date of the notice)
 - (2) over the telephone provided that the Member agrees to have the telephone conversation recorded, effective from the date notified by the Member (being a date no earlier than the date of the telephone conversation)

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 Member 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 in writing given under Rule 8.1(1), 8.2(1) or 8.3 must be sent to ahm's business address (as nominated by ahm) by delivery, pre-paid post or facsimile transmission only. E-mail requests to terminate a Policy will not be accepted unless

the email attaches a scanned copy of a request to terminate a Policy that has been signed by the Principal Member.

C9 Temporary Suspension of Membership

- 9.1 ahm may suspend a Policy, subject to this Fund Rule C9, upon prior written application by the Principal Member if the reason for suspension is:
- (1) The upcoming temporary absence of the Members from Australia for more than one month.
 - (2) The inability of any of the Members to meet the Premiums because all of the Members are in receipt of New Start Allowance or Sickness Allowance or any similar allowance (relating to unemployment) under the *Social Security Act*.
- 9.2 A suspension application will only be considered if the Principal Member 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 Member 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 Members 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) The Principal Member shall apply for a suspension of the Policy prior to leaving Australia by providing ahm with a copy of their itinerary or e-ticket or some other proof of date of departure and return that is in a form acceptable to ahm
 - (2) The maximum period of suspension permitted is two years.
 - (3) The Policy must be resumed on the earlier of:
 - i. a date nominated by the Principal Member (which date is prior to any Members returning to Australia); or
 - ii. the actual date of return of at least one Member to Australia; or
 - iii. two years from the date the suspension commenced.
 - (4) The Principal Member must, within 30 days of the return to Australia, advise ahm of any changes to the date of resumption of the Policy. The Principal Member must provide a further copy of the itinerary, e-ticket or some other proof as acceptable to ahm as evidence of actual return to Australia..
 - (5) Failure to advise ahm of the return to Australia of any Member within 30 days of return (pursuant to Fund Rule C9.5 (4)) 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.

- (6) Any period of return to Australia must be advised no matter the length of time and Premiums must be paid for any period of time any Member is in Australia.

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 Member resuming employment. Proof of the date employment recommenced is required and must be provided within 30 days of resuming employment.
- (4) The Policy must be resumed on the earlier of:
 - i. a date nominated by the Principal Member (which date is prior to any Members resuming employment); or
 - ii. the actual date of resumption of employment; or
 - iii. two years from the date the suspension commenced.
- (5) Failure to advise ahm of recommencement of employment of any Member'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 Members insured under the Policy will need to re-serve any relevant Waiting Periods.
- (6) The maximum period of suspension permitted is two years

9.7 If, by the second anniversary of a suspension, the Policy has not been resumed by the Principal Member, the Policy will be automatically reinstated and any arrears in Premiums will be dealt with in accordance with Fund Rule C5.

9.8 Partial suspensions are not permitted.

9.9 Where ahm agrees to suspend a Policy, all Policies and Policy components held by the Principal Member must be suspended together.

D CONTRIBUTIONS

D1 Payment of Contributions

- 1.1 Premiums may be paid by a Member in advance or through a payroll deduction scheme or by such other arrangements as are authorised by ahm from time to time.
- 1.2 Members whose Premiums are not paid through a payroll deduction arrangement shall be required to make Premium payments at least one payment frequency in advance.
- 1.3 The Principal Member is required to pay the Premium rate applicable to the the Principal Member's State of Residence.
 - 1) At any given time, payment of Premiums in advance must not exceed 12 months in advance of the payment date. Where Premiums have been paid in excess of 12 months in advance, ahm may refund the portion of the amount paid which exceeds 12 months.
 - 2) ahm may at its discretion approve any group of Member as a contribution group in accordance with the Act and the Rules.

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 Members 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 Member 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 Member to advise details to claim an exemption.
- 4.4 The Lifetime Health Cover Loading requirement ceases for each Member after 10 years of continuous coverage for so long as each Member holds hospital cover. The Member may be required to provide proof of payment of the Loading for the previous 10 years.

D5 Arrears in Contributions

- 5.1 No Benefits shall be paid for services rendered to a Member 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

- 1) ahm established the Health and Medical Research Fund in 1986 to support medical research. Any Member can make a voluntary contribution to the Health and Medical Research Fund. 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 Member 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 Member 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 Member if the expenses in respect of that service or good were incurred by the employer of a Member 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 ahm may, at its discretion, pay Benefits on an ex-gratia basis .
- 1.10 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.
- 1.11 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.

- 1.12 Benefits are not payable on consultations provided over the telephone or Internet unless express prior approval has been provided by ahm.
- 1.13 Benefits are not payable in respect of services or goods provided to a Member 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.
- 1.14 Benefits will not be paid unless a valid receipt or invoice is provided unless the claim is made through HICAPS.
- 1.15 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.
- 1.16 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.
- 1.17 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.
- 1.18 ahm may
- i) refuse to pay Benefits in respect of any claim and
 - ii) suspend or cancel a provider's recognition for the purpose of paying Benefits where it has reasonable grounds to believe that:
 - (1) a Hospital has ceased to meet the definition under B2 or
 - (2) a Recognised Provider has ceased to practice or has ceased to meet any Recognition criteria set by ahm or
 - (3) a Recognised Provider has in the opinion of ahm, committed or participated in any fraudulent activity in relation to provision of a service to a Member
- 1.19 Benefits will be paid:
- (i) directly into an Australian bank account nominated by the Principal Member (or their authorised third party), or
 - (ii) by cheque payable to the Principal Member (or their authorised third party) or
 - (iii) by cash (to a total of \$300 only) if the claim is made at the Wollongong office of the fund;

and where the cost of service has been paid.

For unpaid accounts, the benefit cheque will be made payable to the Provider or their authorised representative.

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 surgically implanted prosthesis up to the minimum benefit listed in the *Prostheses Schedule* of the *Private Health Insurance (Prostheses) Rules*
 - (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 up to the minimum benefit listed in the Prostheses Schedule of the *Private Health Insurance (Prostheses) Rules*

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 Members 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 or Excess 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 Medicare Benefit Schedule (MBS) fee where a Medicare benefit is payable for an in-hospital service. Benefits in excess of the MBS fee are payable where there is a GapCover Scheme arrangement in place and a Medical Practitioner agrees to participate in that scheme.

- 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.
- 2.5.10 No benefits will be payable for any service named as an Excluded Benefit on any policy
- 2.5.11 The minimum Default Benefit as described in Rule 2.2 will be paid for any service named as a Restricted Service on any policy

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 Member 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 Member 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 Member 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 E 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 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 a medical practitioner charges in accordance with the GapCover Scheme). Any charge for services above the MBS scheduled fee or charge permitted by the GapCover Scheme is payable by the Member. If the charge is less than the MBS 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 a medical practitioner charges in accordance with a GapCover Scheme). Any charge for services above the MBS scheduled fee or charge permitted by the GapCover Scheme is payable by the Member. If the charge is less than the MBS scheduled fee the Fund pays so much of the charge as exceeds 75% of the scheduled fee. No benefit is payable by ahm if the Medicare benefit payable is at least 85% of the scheduled fee.

2.7.3 Where a GapCover Scheme is available and a Medical Practitioner charges in accordance with that scheme, Medicare pays 75% of the scheduled fee, the Fund pays the remaining 25% of the scheduled fee as well as an additional amount so that the combination of Medicare and the Fund contributions towards the charge for the relevant treatment provided by the Medical Practitioner is equivalent either to (1) the MBS scheduled fee or (2) the charge permitted by the GapCover scheme or (3) if the charge is less than the MBS scheduled fee, so much of the charge that exceeds 75% of the scheduled fee. Any charge for services above the charge permitted by the GapCover scheme is payable by the Member.

- 2.7.4 Medical Practitioners who opt to take part in this scheme must inform a Member:
- (1) in writing of any amounts the Member can reasonably expect to pay for the treatment by the Medical Practitioner and any associated professional services - if possible before the provision of such treatment and services and 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 Member.
- 2.7.5 If a Medical Practitioner levies a charge for a medical treatment that is higher than the charge permitted by the GapCover Scheme for that treatment, this means the Medical Practitioner has opted not to participate in the GapCover Scheme and the amount payable for the treatment by the Fund will be 25% of the MBS scheduled fee. Amounts above the MBS fee will be payable by the Member
- 2.7.6 If the Fund enters into an Agreement with a Medical Practitioner for the provision of treatment to a Member, 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 Members 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 Member 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 Member 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 Member 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 Member, 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 Member) 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 Member 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 Member) 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 Member, loyalty limits are based on when he joined ahm in 2001.

If a change to a Policy is required, Members must consider who will be the Principal Member. 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 Member has been a Member at 1 July each year, determines the category of loyalty Benefits. For example, although in December 2006 Tom has been a Member 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.

3.9.4 A Member may continue to accrue loyalty years for the purposes of calculating a Member's loyalty date even if the Policy held by the Member is not eligible for loyalty limits.

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 Members on eligible Products and the general public. A schedule of fees (DEP Fee Schedule) is available to determine the:

- (i) service fees (DEP Scheduled Fee) and administrative charges;
- (ii) Benefits (if applicable); and
- (iii) out of pocket expenses (DEP Out-of-Pockets)

payable or able to be claimed by Members for services provided to a Member insured under the Policy.

The DEP Fee Schedule can be made available to Members by request at any ahm Dental and Eyecare Practice where DEP management deem provision of the schedule appropriate.

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

Members either joining or transferring to any of ahm's eligible 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 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

Members either joining or transferring to any of ahm's eligible 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 and Members who do not hold an eligible Product are eligible to receive treatment at the full DEP Scheduled Fee.

Normal transfer rules apply as detailed in Rule C6.

4.1.2 Benefit Conditions

- 1) Services rendered incur a DEP Out-of-Pocket as set out in the DEP Fee Schedule.
- 2) Where limits on dental service entitlements have been reached, Waiting Periods have not been served, or the Members level of cover does not include the particular item or treatment, the Member will be charged the full DEP Scheduled Fee
- 3) Where it is required that a patient is referred to a private practice provider, normal private practice rules, that provider's fees and normal Policy Benefits and limits apply

4.1.3 Restriction on Treatment

In addition to Fund Rule E4.1.2(2), a Member may be required to pay the full DEP Scheduled Fee for services and treatment where:

- (1) Satisfactory arrangements have not been made for settling accounts for DEP Out-of-Pocket payments or any other charges raised by the Dental and Eyecare Practice.
- (2) 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.

In addition, ahm has the absolute power to restrict any Member from using the services of any ahm Dental and Eyecare Practice at any time and for any length of time it deems appropriate, providing the Principal Member is informed of the reason for such restriction.

4.1.4 Out of Pocket Expenses (DEP Out-of-Pocket)

DEP Out-of-Pocket payments represent the difference between the Benefit payable for a particular service and the DEP scheduled fee for that particular service provided by the Dental & Eyecare Practices. DEP Out-of-Pocket payments are payable at the time the service is provided or as scheduled in the treatment plan.

4.1.5 Limits

Dental and optical limits for Members of all ahm General Treatment products are set out in the policy documents.

Any treatment in excess of the allowable limit must be paid for in full in accordance with the DEP Fee Schedule.

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 Member on the Policy. There are set limits for each Member for each Membership Year or for each Policy as set out in the policy documents.
- 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 Member will have to serve the relevant Waiting Period before the lower Co-payment applies.

F2 Excesses

1. An Excess in relation to Hospital Treatment is an amount paid towards the cost of Hospital Treatment (including Day Only Admissions). The amount of the Excess and relevant limits and conditions are set out in the policy documents.
2. An Excess may apply to each Member on the Policy. Excess limits for each Member or for each Policy are set out in the policy documents.
3. If changing to a level of hospital cover with a lower level of Excess a Member will have to serve the relevant Waiting Period before the lower Excess applies.

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 Members have to wait a set time before claiming for services and Benefits provided to the Member that were not previously covered or for which Waiting Periods have not been served.

During a Waiting Period for a service or treatment a Member 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"> ▪ Ambulance services ▪ Hospital Treatment that is required as a result of an accident ▪ Chronic Disease Management Programs
2 months	<ul style="list-style-type: none"> ▪ Hospital Treatment (where there are no Pre-existing Conditions. ▪ Psychiatric, rehabilitation and palliative care (whether or not a Pre-existing Condition)
12 months	<ul style="list-style-type: none"> ▪ Pre-existing Conditions ▪ Obstetrics, pregnancy and birth related conditions ▪ Speech processors ▪ Insulin pump replacements

General Treatment (that is not Hospital-Substitute Treatment)

1 day	<ul style="list-style-type: none"> ▪ Ambulance services ▪ Travel and Accommodation relating to a hospitalisation ▪ Disease Prevention Programs
12 months	<ul style="list-style-type: none"> ▪ Complex Dental ▪ Major Dental ▪ Orthodontics ▪ Podiatric surgery ▪ Orthotics ▪ Hearing Aids ▪ Pre and post natal services ▪ Medical gases ▪ Joint fluid replacement injections ▪ Disease management appliances
3 years	<ul style="list-style-type: none"> ▪ Laser eye surgery

3.2 Waiting Periods served with a previous Private Health Insurer will be counted towards Waiting Periods served with ahm, provided the Member 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 Member 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 Member 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

Depending on the level of cover chosen by the Member, Benefits may be excluded on particular Hospital Treatments as detailed in the Schedules.

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 Member, Benefits may have restrictions on particular Hospital Treatments as detailed in the Schedules.

F7 Compensation Damages and Provisional Payment of Claims

- 7.1 A Member who has, or may have, a right to receive Compensation in relation to an injury, must:
 - (1) inform ahm as soon as the Member knows or suspects such right exists;
 - (2) inform ahm of any decision to make a claim for Compensation;
 - (3) include in the claim, the full amount of all expenses for which Benefits are, or would otherwise be payable;
 - (4) keep ahm informed of and updated as to progress of the claim;
 - (5) inform ahm immediately upon the determination or settlement of the claim.

7.2 Subject to Fund Rule F7.3, Benefits are not payable for expenses incurred in relation to an injury where the Member has received, or may be entitled to receive, Compensation in respect of that injury.

7.3 Where a claim for Compensation is in the process of being made or has been made and remains unfinalised, ahm may in its absolute discretion make provisional payment of Benefits in respect of expenses incurred in relation to the injury. Any provisional payment will be conditional upon the Member signing a legally binding irrevocable undertaking (in a form required by ahm), that contains an agreement by the Member, in consideration for provisional payment:

- (1) to comply with Fund Rule F7.1
- (2) to be bound by these Fund Rules
- (3) to authorise the Member's legal representative to disclose to ahm all matters relating to the progress of the claim and details of any determination made or settlement reached
- (4) to repay to ahm in accordance with Fund Rule F7.4 all Benefits paid in relation to the injury.

7.4 Where ahm has paid Benefits (whether by way of provisional payment or otherwise) in relation to an injury and the Member has received Compensation in relation to that injury, the Member must repay to ahm the full amount that ahm paid in relation to the injury, upon the determination or settlement of the claim for Compensation. The obligation to repay applies whether or not:

- (1) the determination or settlement includes the full amount that ahm has paid;
- (2) the terms of settlement specify that the sum of money paid under the settlement relates to past or future medical expenses.
- (3) whether the member has signed a legally binding irrevocable order as set out in 7.3 or not

7.5 (1) In addition to the Member's obligations under the preceding Fund Rules, where a determination or settlement of a claim for Compensation includes an allocation for future medical expenses in respect of the injury:

- (a) the Member must use that allocation to pay for treatment in respect of the injury;
- (b) ahm may refuse to pay Benefits for such treatment until the allocation is exhausted;
- (c) the Member must keep and provide to ahm evidence to establish that the allocation has been exhausted and exhausted on treatment for the injury; and
- (d) if the Member cannot provide such evidence or the allocation has been exhausted on expenses other than for treatment of the injury, ahm may refuse to pay benefits for treatment in respect of the injury.

(2) The Member must upon request provide evidence to ahm to establish whether a determination or settlement includes an allocation for future medical expenses.

ii) Where it is anticipated that the Member has future medical needs in respect of the injury, the Member must use reasonable endeavours to procure an award or settlement that includes a specified allocation for future medical expenses.

iii) Where, despite the Member's reasonable endeavours, a determination or settlement does not include a specified allocation for future medical expenses, ahm may in its absolute discretion agree to pay Benefits for treatment in respect of the injury rendered after the determination or settlement.

7.6 ahm may in its absolute discretion and subject to any conditions that it deems appropriate, determine that a Member need not repay any or all of the Benefits paid by ahm in relation to the injury.

7.7 Under no circumstances will Benefits be paid to holders of OSHC, where the Benefit relates to an injury for which the hold has or may have a right to claim Compensation. .

7.8 A Member's obligations under this Fund Rule F7 continue despite any termination of the Member's Policy.

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 Member or Member's authorised agent for payment of Benefits in regard to a service which the Member 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 Member.
- 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 Member, and may use a third party to investigate or validate any claim made.