Private Health Insurance Fund Rules

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health.com.au

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Important Notes

1) All registered health *Funds* are required to have *Fund* Rules under the Private Health Insurance Legislation.

2) These *Fund* Rules set out the general principles and rules of Membership under which health.com.au conducts its business.

3) By taking out private health insurance with health.com.au, you and all the other persons on your Membership become Members and agree to our *Fund* Rules as amended from time to time.

4) health.com.au recommend that these *Fund* Rules be read together with the policy guide relevant to your Cover.

A INTRODUCTION

A1 Rules Arrangement

A1.1 Contents of the Fund Rules

The health.com.au *Fund* Rules consist of:

a) The General Conditions (Rules A to G); and
b) The *Schedules*

A1.2 Application of the Fund Rules

The *Fund* Rules apply to all health.com.au private health insurance *Products* excluding health.com.au Overseas Visitors Health Cover.

A1.3 Interaction with legislation

Where these rules are inconsistent with any legislation, the relevant legislation will prevail.

A2 Health Benefits Fund

A2.1 Establishment and Administration of the Fund

health.com.au (ACN 152 479 975) is a *Private Health Insurer* which has established a *Health Benefits Fund*. The *Fund* will undertake health insurance business and health insurance related business as defined in the *Private Health Insurance Act.*

A2.2 Purpose of the Fund

The purpose of the *Fund* is to provide *Benefits* to, or on behalf of, *Policy Holders* in accordance with the terms of these *Fund* Rules.

A2.3 Purpose of the Fund Rules

The purpose of the *Fund* Rules is to outline the arrangements for *Policy Holders* of, and the payment of *Benefits* by, health.com.au.

A2.4 Fund Policies

health.com.au may supplement the *Fund* Rules with *Fund* Policies which will be consistent with the *Fund* Rules.

A2.5 Policy Holders Bound by Fund Rules and Policies

Policy Holders of health.com.au are bound by the *Fund* Rules and *Fund* Policies.

A3 Obligations to Insurer

a) health.com.au *Insurance Policy* applicants shall provide any reasonable and relevant information to health.com.au;
b) The *Policy Holder* shall inform the *Fund* of Insurance *Policy* details in the stated time and manner prescribed in these rules;
c) All *Insured Persons* are bound by health.com.au *Fund* Rules and Policies.

A4 Governing Principles

The operation of the *Fund* and the relationship between health.com.au and each *Policy Holder* is governed by:

a) The *Private Health Insurance Act;*
b) The *National Health Act;*
c) The *Health Insurance Act;*
d) health.com.au *Fund* Rules;
e) health.com.au *Fund* Policies, and
f) The health.com.au Constitution.
g) Other applicable laws of the Commonwealth and the *State/ Territory* in which the person resides

A5 Use of Funds

A5.1 Financial Control

health.com.au shall:

a) Keep proper accounts and records of the transactions and affairs of the *Fund*;
b) Ensure all payments from the *Fund* are correctly made and properly authorised; and
c) Maintain adequate control over:
   i. The assets in the custody of the *Fund*; and
   ii. The incurring of liabilities by the *Fund*.

A5.2 Audit

health.com.au accounts and records shall be audited in accordance with legislative requirements.

A5.3 Income to be Credited to the Fund

health.com.au shall credit to the *Fund*:

a) All *Premiums* paid by *Policy Holders*; and
b) Any other moneys or income as outlined in the *Private Health Insurance Act.*

A5.4 Drawings on the Fund

health.com.au may use the assets of the *Fund* only:

a) To pay *Benefits* in accordance with the *Fund* Rules;
b) To pay for other liabilities and expenses incurred for the *Fund* business operations;

c) For making investments; and

d) For making other distributions, payments and transfers permitted or required under the *Private Health Insurance Act.*

A6 No Improper Discrimination

A6.1 Community Rating

health.com.au shall not improperly discriminate on the basis:

a) That a person suffers from any particular disease, illness or other medical *condition*;

b) Of a person's gender, race, sexual orientation or religious belief;

c) Of the age of a person, unless required or permitted to do so by the *Private Health Insurance Act,* Part 2-3;

d) Of where a person lives, except as permitted by the *Private Health Insurance Act;*

e) Of any other characteristics of a person, such as occupation or leisure pursuits, that may increase their need for *Treatments*;

f) Of the frequency of *Treatment* required;

g) Of the amount or extent of the *Benefits* to which a person becomes entitled during a period, other than as permitted by the *Private Health Insurance Act;* or

h) Of any matters prohibited by the *Private Health Insurance Act*, including, but not limited to, Section 55-5 (2)

A7 Changes to Rules

A7.1 Amendments to the Fund Rules

health.com.au may amend the *Fund* Rules at any time consistent with the *Private Health Insurance Act*.

A7.2 Overriding Waiver

a) health.com.au may waive the application of a *Fund* Rule at its discretion and subject to the *Private Health Insurance Act;*

b) Waivers shall not reduce any entitlement to *Benefits*;

c) A waiver is made on a case-by-case basis.

A7.3 Notification to Policy Holders

a) *Policy Holders* shall be notified of *Fund* Rule amendments before the changes come into effect;

b) Updated *Product* information statements shall be supplied to *Policy Holders* and are available upon request.

c) *Policy Holders* shall be notified of all relevant matters in accordance with Section 93-20 and 93-25 of the *Private Health Insurance Act.*

A8 Dispute Resolution

A8.1 Policy Holder Complaints

a) A *Policy Holder* may make a complaint to health.com.au regarding their *Insurance Policy* at any time;

b) health.com.au shall respond to complaints quickly and efficiently.

A8.2 Private Health Insurance Ombudsman

a) The Private Health Insurance Ombudsman (“Ombudsman”) is available to assist *Policy Holders* with unresolved *Fund* issues;

b) A *Policy Holder* may approach the Ombudsman at any time.

A9 Notices

A9.1 Correspondence

health.com.au shall use the most recently advised postal address, fax number or e-mail address of the *Policy Holder.*

A9.2 Availability of Fund Rules to Policy Holders

Fund Rules are available at the registered office of health.com.au or from www.health.com.au.

A10 Winding Up

Upon winding–up or dissolution of the *Fund* any assets remaining after all *Fund* debts and liabilities have been paid shall be distributed in accordance with the *Private Health Insurance Act.*

A11 Other

This Rule is left intentionally blank.

B: Interpretation and Definitions

B1 Interpretation

B1.1 Interpretation of the Fund Rules

The *Fund* Rules shall be interpreted as follows:

a) The *Fund* Rules shall not conflict with the *Fund's* Constitution;
b) Gender references include both male and female (where applicable)
c) Singular and plural words as interchangeable as applicable
d) References to a *State* includes a *Territory*;
e) The names of specific *Products* are italicised
f) Words or expressions in *Initial Capital Bold Italic* are defined in *Fund* Rule B2;
g) *Fund* Rule B2 definitions and sub-definitions apply to all *Fund* Rules and *Policies* unless otherwise stated;
h) A sub-definition shall not be read in isolation;
i) Where no specific definition is supplied words and expressions shall have their ordinary meaning;
j) Legislation references include any amendments to those documents;
k) These *Fund* Rules are to be interpreted with consistency to the *Private Health Insurance Act*;
l) Any undefined terms shall use *Private Health Insurance Act* definitions unless the context requires otherwise.

B2 Definitions

Access Gap Cover Scheme is the *Fund's* approved medical *benefits* scheme that provides a 'no gap' or 'known gap' *benefit* for the payment of medical *benefits* in excess of the *Medicare Benefits Schedule*.

Accident means an unforeseen, co-incidental event caused by an unintentional external source that results in a physical injury that requires immediate *Treatment*. This definition excludes unforeseen *Conditions* attributable to medical causes.

Active means *Policy Holder* of any *Private Health Insurer* whose *Policy* is financially current and not lapsed or suspended.

Acute Care Certificate is a health.com.au approved form certifying that an *Admitted Patient* is in need of ongoing acute care. This certificate is valid for 30 days and is required for any period of continuous hospitalisation exceeding 35 days.

Admitted Patient means a person admitted to a *Hospital* for *Hospital Treatment*. This definition:

a) Includes a newborn child who:
   i. Occupies a bed in a *Special Care Unit*, or
   ii. Is the second or subsequent child of a multiple birth, but
b) Excludes:
   i. Any other new-born child whose mother occupies a bed in the *Hospital*

Age Based Discount: a premium discount on eligible *hospital* covers of two per cent for each year that a person is aged under 30 when they first purchase *hospital* insurance, to a maximum of 10 per cent for 18 to 25 year olds. The discount then reduces by two per cent each year from age 41.

Agreement means an understanding between a *Hospital* or a *Medical Practitioner* and health.com.au in which the *Hospital* or *Medical Practitioner* agree to an accepted payment by health.com.au for monies owed for *Treatment* to an *Insured Person*.

Ambulance means medical transportation, professionally equipped for transport and/or paramedic *Treatment* of persons requiring attention.

Approved Credit Facility means a health.com.au approved credit card or similar credit arrangement by which *Policy Holders* can pay their *Premiums* automatically.

Approved Credit Facility Policy Holder means a *Policy Holder* whose *Premiums* are automatically paid to health.com.au using an *Approved Credit Facility* in accordance with *Fund* rule D1.3.

Arrears has the meaning set out in rule D5.1.

Australia means the *States* and Territories.

Benefit means the amount of money payable by the *Fund* in accordance with the terms of these *Fund* rules.

Benefit Replacement Period means the continuous time period that must elapse between any two same item purchases before *Benefits* for the later purchase are payable (or before the later purchase becomes eligible for *Benefits*).

Calendar Year means the period from 1 January to 31 December.

Clinical Categories means a standard way of describing *Treatments* as developed by the Department of Health.

Clinically Relevant means a procedure or service delivered by a *Medical Practitioner, Dental Practitioner* or *Optometrist* which is an industry accepted and appropriate *Treatment* for the patient.

Compensation means:

a) A payment for damages;
b) An insurance or *Compensation* payment (other than a payment of *Fund Benefits*) provided for by a Commonwealth, *State* or *Territory* law
c) A payment in settlement of a damages claim or a claim under any scheme referred to in (b) regardless of liability
d) A payment in settlement of a professional negligence damages claim in relation to payment claims in (a), (b) or (c), regardless of liability
e) Any other payment that, in the opinion of health.com.au, is a payment in the nature of *Compensation* or damages.

Complying Health Insurance Product means a health insurance *Product* that complies with the *Private Health Insurance Act.*

Condition means any actual or perceived state of health for which *Treatment* is sought and includes conditions described as: abnormality, ailment, disability, disease, disorder, health problem, illness, impairment, impediment, infirmity, injury, malady, sickness or unwellness.

Contracted Hospital means a *Hospital* with which health.com.au has an *Agreement* under *Fund* rule E2.1.

Contribution Group means a group of *Policy Holders* which may include employees of a particular business or group of businesses or members of a professional association or customers of a specific channel.

Cosmetic Surgery means surgical procedures:

a) Listed in the Plastic and Reconstructive Section (Subgroup 13) of the *Medicare Benefits Schedule* but are not *Clinically Relevant* or do not meet the eligibility conditions for payment of *Medicare Benefits*, or
b) Of a plastic or reconstructive nature but are not listed in the *Medicare Benefits Schedule.*

Couple (Policy) is a *Complying Health Insurance Product* that insures the *Policy Holder* and another person who is not a *Dependant Child*.

Default Benefit means an amount determined by the *Minister* to be the minimum *Benefit* payable under a *Hospital Product* for a particular type of *Hospital Treatment.*

Dental Practitioner means a person registered or licensed, under a *State* or *Territory* law, as a dental practitioner, dentist, dental surgeon, specialist dentist, advanced dental technician, clinical dental technician or dental prosthetist.

Dependant Child means a person:

a) Who is aged under 21; or
b) Who is not aged 25 or over and who does not have a Spouse/Partner and who is a *Dependant child non-student* or a *Dependant Student*.

Dependant child non-student is a *Dependant Child* who:

a) Who is aged between 21 and 24 (inclusive); and
b) Is not receiving *Full-time Education*.

Dependant Student is a *Dependant Child* who is receiving *Full-time Education*.

Direct Debit Policy Holder means a *Policy Holder* whose *Premiums* are automatically paid to health.com.au from a financial institution account, in accordance with *Fund* rule D1.3.

Direct Policy Holder means a *Policy Holder* who is not an *Approved Credit Facility Policy Holder*, a *Direct Debit Policy Holder* or a *Group Policy Holder*.

Excess means the amount that a *Policy Holder* must contribute towards *Hospital Treatment* under the terms of the relevant *Product*.

Extras means a *Product* that provides *Benefits* for services and *Treatments* other than eligible **Hospital Treatments.**

Family (Policy) is a *Complying Health Insurance Product* that insures the *Policy Holder*, another person who is not a *Dependant Child* and at least one other person who is a *Dependant Child*.

Full-time Education means a course of study undertaken at any secondary school, secondary college, post-secondary institution, publicly funded tertiary institution or private sector tertiary institution, which is accredited by a relevant *State* government authority as a higher education or technical or further education institution in *Australia* which requires a **Full-time Study Workload.**

Full-time Study Workload means a person is enrolled in and undertaking:

a) At least three-quarters of the normal full-time workload. Optional subjects can be included but not subjects credited because of recognised prior learning; or
b) At least two-thirds of a normal full-time workload where:
    i. There is no choice because of course requirements;
    ii. The Academic Registrar of the institution has directed, in writing, that a lighter load must be taken; or
    iii. The Academic Registrar of the institution has recommended that a lighter load be taken for specific academic or vocational reasons. This applies for half a year only, the remainder of the year must be at the normal 'full-time' rate; or
c) At least one-quarter of a normal full-time workload where there is medical evidence that the student suffers from a substantial disability.

A course of study will not be considered full time if there is a break of more than 8 weeks due to illness or injury, unless:

a) The student remains enrolled in the course for period of absence; and
b) A *Medical Practitioner* provides a certificate stating the nature of the illness or injury, affirms that the student cannot study because of this *condition* and confirms that the student should be able to resume study within 16 weeks; and
c) The Academic Registrar of the institution or an equivalent officer states, in writing, that the student can resume full-time study when deemed medically fit by the *Medical Practitioner*.

Fund means the 'health.com.au' *Health Benefits Fund*, unless the context refers to another *Benefits Fund*.

General Treatment means a *Product* that pays *Benefits* for *Extras*.

Group Policy Holder means a *Policy Holder* who is a part of a *Contribution Group*.

Health Insurance Act means the *Health Insurance Act 1973* (Cth) including amendments.

Hearing Aid means a health.com.au approved appliance designed to improve a person's hearing.

Hospital means a facility as defined in the *Private Health Insurance Act.*

Hospital Product means a *Product* which includes *Benefits* for fees and charges for some or all *Hospital Treatment*.

Hospital Service means *Treatment* for which *Benefits* are payable from a *Hospital Product*.

Hospital Treatment means *Hospital Treatment* as defined in section 121-5 of the *Private Health Insurance Act* and includes:

a) *Hospital* accommodation and nursing care; and
b) The provision of a *Prosthesis* listed in the schedule of the Private Health Insurance (Prostheses) Rules.

Independent Private Practice means a practice that provides *Treatment*, including accommodation, facilities and services, that is self-supporting and not provided or subsidised by another party such as a *Public Hospital* or publicly funded facility.

Insured Person means a person who is covered under a *Policy* and includes the *Policy Holder*.

Lifetime Health Cover means the scheme under Part 2-3 of the *Private Health Insurance Act.*

Major Dental Treatment includes, but is not limited to, orthodontic *Treatment*, crowns, bridgework, complete dentures, partial dentures, prosthodontics services, implant procedures, periodontics, oral surgery and oral appliances for sleep apnoea.

Medical Practitioner means a person who is registered or licensed as a *Medical Practitioner* under a *State* or *Territory* law.

Medicare Benefit means a *benefit* paid by Medicare under the *Medicare Benefits Schedule*.

Medicare Benefits Schedule means all the regulations and determinations that create or contain items in tables, or rules of interpretation for those items, that describe services for which *Medicare benefits* are payable. These include Health Insurance (General Medical Service Table) Regulations, the Health Insurance (Pathology Services Table) Regulations and the Health Insurance (Diagnostic Imaging Services Table) Regulations.

Minister means the Minister, or delegate, administering the *Private Health Insurance Act.*

Month means a period of time from a particular date up to, but not including, the corresponding date in the following month, or, if there is no corresponding date, to the end of the following month.

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

Nursing Home Type Patient (NHTP) means a nursing-home type patient as defined in Schedule 4 of the Private Health Insurance (Benefit Requirements) Rules.

Obstetrics-related Service means a service that is listed under Group T4 (Obstetrics) or Group M13 in the *Medicare Benefits Schedule.*

Optometrist means a person registered or licensed as an optometrist or optician under a *State* or *Territory* law.

Pharmaceutical Benefits Scheme (PBS) means the Commonwealth Scheme for the payment of pharmaceutical *Benefits* detailed in Part VII of the *National Health Act*.

Policy means a *Complying Health Insurance Product* of the *Fund* through the payment of *Premiums* in accordance with these *Fund* rules.

Policy Category means one of the following:

a) *Single Policy;*
b) *Couple Policy;*
c) *Family Policy;*
d) *Single Parent Family Policy*.

Policy Holder means the named principal *Insured Person* on a *Policy*, who is responsible for the payment of *Premiums* and to whom *Benefits* will be paid, unless health.com.au is otherwise notified. If the named principal *Insured Person* dies or becomes legally incapacitated, in the absence of any written notice from the legal personal representative or lawful attorney of that person, the next named *Insured Person* is taken to be the *Policy Holder*.

Pre-Existing Ailment (PEA) means*:*

a) Where:
    i. The person has an ailment, illness or *condition*; and

ii. In the opinion of a *Medical Practitioner* appointed by health.com.au 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*.

b) In forming an opinion for the purposes of paragraph (l)(b), the *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* gives him or her.

c) If:

i. health.com.au replaces a *Complying Health Insurance Product* with another *Complying Health Insurance Product*; and

ii. A person who was insured under a *Policy* that was in the replaced *Product* is transferred by health.com.au to a *Policy* that is in the replacement *Product*;

Pregnancy-related Service means any type of *Treatment* related to the management of pregnancy, labour and childbirth, ante and post natal care, sterility reversal and *Obstetrics-related Services*.

Premiums means the money a *Policy Holder* pays to health.com.au in exchange for a specified period of coverage for a *Product*.

Private Health Insurance Act means the Private Health Insurance Act 2007 (Cth) and includes any Private Health Insurance Rules made by the *Minister* under section 333-20, or by the Private Health Insurance Council under section 333-25, of that Act.

Private Health Insurer means an organisation registered as such under the *Private Health Insurance Act.*

Private Hospital means a *Hospital* that has been declared as such by the *Minister* under the *Private Health Insurance Act.*

Private Patient means *Insured Person* who has been admitted to a *Private Hospital* for *Treatment* and who is not a *Public Patient*.

Product means a defined group of *Benefits* payable for approved expenses incurred by a *Policy Holder*, subject to *Fund* rules.

Product tier: There are four tiers of *Hospital Products:* Gold, Silver, Bronze and Basic. Each product tier has a minimum standard of service that must be covered in accordance with Private Health Legislation Amendment Act 2018. Insurers will be able to offer additional coverage in Basic, Bronze and Silver tiers, allowing for Basic plus, Bronze plus and Silver plus products.

Prosthesis means a prosthesis listed in the schedule of the Private Health Insurance (Prostheses) Rules.

Public Hospital means a *Hospital* that has been declared as such by the *Minister* under the *Private Health Insurance Act*.

Public Patient means an *Insured Person* who has been admitted to a *Public Hospital* for *Treatment* without charge.

Recognised Provider means a *Hospital*, or a provider of *Extras* who is in *Independent Private Practice* and satisfies *Recognition Criteria*, or any other health.com.au recognised provider.

Recognition Criteria means the conditions set by health.com.au which apply to *Recognised Providers*. They include appropriate registration or licenses under relevant *State* or *Territory* legislation, professional qualifications or membership of a health.com.au recognised professional body, the provision of health.com.au approved facilities and any other criteria that health.com.au considers reasonable.

Restricted Service means the *Default Benefit* is the *Benefit* payable for a service or *Treatment* under a specified *Hospital Product*.

Schedule means a 'Schedule of Contribution Rates, Benefits and Specific Conditions' referred to at rule A1.1.

Single (Policy) is a *Complying Health Insurance Product* that insures only one *Insured Person*, being the *Policy Holder*.

Single Parent Family (Policy) is a *Complying Health Insurance Product* that insures the *Policy Holder* and at least one other *Insured Person* who is a *Dependant Child* of the *Policy Holder*.

Special Care Unit means a health.com.au approved unit of a *Hospital* used for providing special care and includes intensive care, critical care, coronary care and high dependency nursing care units.

State means each of New South Wales, Queensland, South Australia, Tasmania, Victoria and Western Australia.

State of Residence means, subject to the following, the *State* or *Territory* in which the *Policy Holder* resides. A *Policy Holder* living in the Australian Capital Territory is considered a resident of New South Wales and a *Policy Holder* living in the Territory of Cocos (Keeling) Islands or the Territory of Christmas Island is considered a resident of the Northern Territory.

Suspendable Product means a *Product,* the terms of which allow the *Policy Holder* to request that the term of the *Policy* is suspended in accordance with the terms of a written notice by the *Policy Holder* to health.com.au.

Suspension means the temporary discontinuation of a *Policy* in accordance with these *Fund* rules. (Subject to rule C9).

Territory means each of the Australian Capital Territory, Northern Territory, the Territory of Cocos (Keeling) Islands and the Territory of Christmas Island.

Transfer means a transfer from another *Private Health Insurer*'s *Fund* to health.com.au with a break in coverage no longer than that specified in rule C6.1; or a change of *Product* within health.com.au's *Fund*.

Treatment means services and items for which *Benefits* are payable under these *Fund* rules and applies to *Hospital Products, Hospital Services* and *Hospital Treatment*. *Treatment* means services and consultations for which *Benefits* are payable under these *Fund* rules and applies to *Extras*. It excludes any treatment or services which are not provided either personally or under the direct supervision of the provider.

Waiting Period means the continuous period of time that applies to an *Insured Person* for a *Benefit* under a *Policy*:

a) starting at the time the *Insured Person* becomes insured under the *Policy*; and
b) ending at the time specified in the *Policy*; during which the *Insured Person* is not entitled to the *Benefits* under the *Policy*.

C MEMBERSHIP

C1 General Conditions of Membership

C1.1 Same Policy Category and Products

a) All *Insured Persons* under the same *Policy* belong to the same *Policy Category* and have the same *Product* and *Benefits*.

b) Subject to rule C1.2, only the *Policy Holder* is authorised to request changes to the *Policy*. Any *Insured Person* may receive a *Benefit* to which they are entitled under the *Policy*.

C1.2 Termination of Membership

A *Policy Holder* (including the *Policy Holder's* legal personal representative or duly authorized attorney) may request, in writing, for another person to gain authorisation to request changes to the *Policy*, except for *Policy* termination, which may only be made by the *Policy Holder* (including the *Policy Holder's* legal personal representative or duly authorised attorney). This authority maybe withdrawn by the *Policy Holder* at any time by written notification to the *Fund*. Nothing in this rule or rule C1.1 restricts the right of an *Insured Person* to make a request to be removed from a *Policy* pursuant to rule C7.1

C1.3 The *Policy Holder* is responsible for ensuring that the *Premiums* are paid, and that the *Policy* remains financial at all times.

C1.4 Eligibility of Policy

The *Fund* offers *Complying Health Insurance Products* as set out in *Schedules* H, I and J.

C1.5 Change of Policy Details

A *Policy Holder* must inform health.com.au within two (2) months of any relevant changes to a *Policy*. These changes may include change of name, address, contact details and *Dependant* eligibility.

C2 Eligibility for Membership

C2.1 Policy Eligibility: General

Subject to these *Fund* rules, any person is eligible to be a *Policy Holder* of any health.com.au *Product*.

C2.2 Minimum Age of Policy Holders

Unless otherwise approved by health.com.au, a person aged under 16 is not eligible to be a *Policy Holder*.

C3 Dependants

C3.1 Dependants Ceasing Eligibility

A person who ceases to be eligible to be a *Dependant* may become a *Policy Holder* in their own right. If the application is made within two (2) months of ceasing to be a *Dependant*, no *Waiting Periods* will be applied except:

a) the balance of a *Waiting Period* not served under the previous *Policy*:

b) the difference in coverage of *Treatment* between the two policies.

C4 Membership Applications

C4.1 Premiums Payable with Application

A *Fund* application will only be accepted when the relevant *Premium* has been paid, as specified in rule D1.3.

C4.2 Form of Application

health.com.au may specify the application form to be submitted to join the *Fund*.

C4.3 Refusal of Applications for Policy

health.com.au may refuse an application to join an *Insured Person* including a *Policy Holder* or as a *Dependant*. Refusals will be subject to compliance to rule A6.1 and applicants will be notified of the reasons for refusal.

C4.4 Reinstatement of Cancelled Policy

If a *Policy* has been cancelled (see rule C7.1) health.com.au has the discretion to reinstate the *Policy* at the request of the *Policy Holder*.

Continuity of entitlements will be subject to the payment of all outstanding *Premiums* (see rule D5.2).

C4.5 Information in Support of an Application for Policy

A person seeking to become a *Policy Holder* of health.com.au is required to provide any relevant information requested by health.com.au.

C5 Duration of Membership

C5.1 Policy Commencement Date

A *Policy* commences on the date on which the application is lodged or, when approved, at a later date nominated by the applicant. A new born child may be added to an existing *Policy* (other than a *Single Policy*), from the date of birth, without additional *Waiting Periods* provided that the request for the change is received by health.com.au within two (2) months of the date of birth. When the *Policy Holder* of a *Single Policy* wishes to add a newborn child the *Policy Category* must be amended to reflect the change and additional *Waiting Periods* for *Product* changes, in accordance with these rules, will apply.

C5.2 Policy End dates

A *Policy* ends on the cancellation or termination dates determined under rule C7 or C8.

C6 Transfers

C6.1 Transfers from Other Funds within Two (2) Months – Waiting Periods

When a *Policy Holder* of another *Fund Transfers* to health.com.au with a break in coverage of two (2) months or less, relevant *Waiting Periods* will apply in the following circumstances:

a) to any *Benefits* that were not provided under the previous *Product*
b) to any difference between the level of coverage of *Treatment* between the *Product* offered by health.com.au and the previous *Product* as at the date of the service
c) to any unexpired portion of any *Waiting Periods* under the previous *Product*, and
d) to any unexpired portion of a *Benefit Replacement Period* or limit governing the supply or replacement of an appliance or *Prosthesis*.

C6.2 Joining health.com.au from Another Fund with a Break of More Than Two (2) Months

Where a former *Policy Holder* of another *Fund* joins health.com.au with a break in coverage of greater than two (2) months, the person will be treated as a new *Policy Holder* for all purposes.

C6.3 Product changes within health.com.au

When an existing *Policy Holder Transfers* to a new health.com.au *Product* that is deemed by health.com.au to be at a lower level, any *Benefits* are payable at the level of the new *Product*. When an existing *Policy Holder Transfers* to a new health.com.au *Product* that is deemed to be at a higher level, any *Benefits* will be paid at the level of the previous *Product* until the relevant *Waiting Periods* applicable to the new *Product* have been served.

C6.4 Previous Benefits May be Taken into Account

When a *Policy Holder Transfers* from another *Fund* or to a different health.com.au *Product* any *Benefits* already paid under the previous *Product* maybe taken into account in determining *General Treatment Benefits* payable under the new *Product*. These may include annual or other limits.

C6.5 Equity Transfers

When a *Policy Holder Transfers* from another *Fund*, health.com.au may consider previous coverage when determining annual limits for *Benefits* under the new *Product*.

C7 Cancellation of Membership

C7.1 Cancellation of Policy

a) A *Policy Holder* may cancel the *Policy* entirely or, subject to paragraph (b), request health.com.au to remove any *Insured Person* from the *Policy*.
b) health.com.au must not remove an *Insured Person* who is at least 16 years of age at the request of the *Policy Holder* unless health.com.au gives written notice to the *Insured Person* (or where the *Insured Person* is under 16, any other person covered by the *Policy* who is over the age of 16 and who health.com.au reasonably believes is person on whom the *Insured Person* maybe dependent), advising that within 30 days of the date of the notice the *Insured Persons* entitlements to *Benefits* under the *Policy* will

be cancelled and from that date the person will no longer be entitled to *Benefits* and the cancellation may have impacts on the *Insured Person* pursuant to *Lifetime Health Cover* and *Medicare Levy Surcharge* requirements, health.com.au may offer the *Insured Person* a replacement *Policy*.

c) An *Insured Person* who is aged at least 16 years may give notice to health.com.au to leave the *Policy*.
d) Unless otherwise permitted by health.com.au, a *Dependant* who is aged under 16 years may leave the *Policy* only with the *Policy Holder's* written agreement.

Any *Policy* cancellations must be authorised in writing, must not have a retrospective effect and must be in accordance with these rules.

C7.2 Refunds of Premiums

health.com.au will refund pre-paid *Premiums* on a pro rata basis of the remaining term when a *Policy* ceases only when legally required to do so. health.com.au may refund some or all pre-paid *Premiums* upon written request by a former *Policy Holder*, however refunds will be calculated from the date of receipt of the request, health.com.au may deduct a reasonable administrative charge.

C7.3 Reimbursement of Premiums

If a *Policy Holder* chooses to cancel his or her *Policy* within 30 days of commencement of the *Policy*, the *Fund* will refund any *Premiums* paid during that period after deducting from the amount of any refund of *Premiums* the cost of any claims paid during that period.

C8 Termination of Membership

C8.1 Termination of Policy Where a Policy Holder Acts Improperly

Where a *Policy Holder* acts to gain an improper advantage for themselves or any other *Insured Person*, health.com.au may terminate the relevant *Policy* immediately. "Improper advantage" means any advantage, monetary or otherwise, to which a *Policy Holder* is not entitled. *Policy Holders* will be notified of termination in writing.

C8.2 Termination of Policy in Other Circumstances

health.com.au retains the right to terminate a *Policy* for reasons other than those specified in rules C8.1 and D5.3. If health.com.au invokes this right, it must provide the *Policy Holder* with at least two (2) months' notice in writing, including a reason for the termination, health.com.au will refund any *Premiums* paid in advance, as at the date of the termination. If a *Policy* is terminated under this rule, the *Policy* may be reinstated at the request of the *Policy Holder*, with continuity of entitlements, subject to the payment of all *Premiums* as required under rule D5.2 and health.com.au being satisfied that the reasons for termination have been remedied and are not likely to reoccur.

C9 Temporary Suspension of Membership

C9.1 Suspension of Policy

Subject to these rules, health.com.au may permit a *Policy Holder* who holds a *Suspendable Product* to suspend their *Policy* for the period of time set out in the notice of *Suspension*.

C9.2 Policy to be Paid in Advance

A *Policy* may not be *Suspended* unless the *Premiums* have been paid to the date of *Suspension*.

C9.3 Arrangements during Suspension Period

During a period of *Suspension*, no *Premiums* are payable, no *Benefits* are payable, and the period of *Suspension* does not count in relation to *Waiting Periods* and *Benefit Replacement Periods*.

C9.4 Minimum Period Between Suspensions

A *Policy* may be re-suspended for the same reason as previously *Suspended*, only when a minimum time period has elapsed since reactivation. This time period is six (6) months for overseas travel and twelve (12) months for all other allowable circumstances.

C9.5 Documentation to be Provided

A *Policy Holder* who wishes to *Suspend* or reactivate a *Policy* must provide all relevant documentation in support of the application that health.com.au specifies.

C9.6 Reactivation of a Suspended Policy

A *Suspended Policy* must be reactivated within one (l) month of either the date on which the *Suspension* ceases to apply or the date on which the maximum period of *Suspension* has been reached -whichever date is earliest. If the *Policy* is not reactivated by the relevant date and has subsequently fallen into *Arrears*, health.com.au may terminate the *Policy* subject to rule D5.3.

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Premiums Payable for Each Product

Premiums payable for each *Product* are set out in the *Schedules*.

D1.2 Contribution Groups

health.com.au may approve any group of *Policy Holders* as a *Contribution Group*.

D1.3 Premiums Payable in Advance

All *Premiums* are payable in advance. Advance payment periods that are available, subject to approval by health.com.au are as follows:

a) *Direct Debit Policy Holders*: fortnightly, monthly and quarterly;

b) *Approved Credit Facility Policy Holders*: fortnightly, monthly, quarterly, half yearly and yearly or such longer period as health.com.au may approve;

c) *Group Policy Holders*: weekly, fortnightly, half- monthly, four- weekly, monthly, quarterly, half-yearly and yearly, and

d) *Direct Policy Holders*: monthly, quarterly, half- yearly, yearly or such longer period as health.com.au may approve.

D1.4 Premiums Limited to 30 Months in Advance

health.com.au may refuse any payment or portion of payment of *Premiums* which would cause the period of the *Product* to exceed 30 months. In these cases health.com.au may refund the *Excess* payment.

D2 Contribution Rate Changes

D2.1 Premiums May be Changed

health.com.au may change the *Premium* for any *Product* in accordance with the *Private Health Insurance Act* and subject to rules D2.2 and D2.3.

D2.2 Rate Protection

Subject to rule D2.3, *Premiums* which have been paid in advance may not be affected by rate changes until a new payment period commences.

D2.3 Product changes and Reactivated Policies

When a *Product* change occurs, or a *Suspended Policy* is reactivated, the *Premium* which applies at that time will apply. *Product* changes include changes in the type and level of *Benefits* or changes of *Policy Category*.

Changes in a *Policy Holder's State of Residence* may also result in *Premium* changes applicable to the new *State of Residence*.

D3 Contribution Discounts

D3.1 Premium Discounts

health.com.au may only offer discounts on any *Premiums* if to do so will comply with section 66-5 of the *Private Health Insurance Act*.

D3.2: Age Based Discounts

Premium discounts of up to 10% will be available to *Policy Holders* aged 18 to 29 on eligible Hospital *Products*. The eligible *Products* are:

a) Basic Plus Starter ($750 Excess)

b) Classic Bronze Plus ($750 Excess)

D3.3: Age Based Discount Application

a) The *Age Based Discount* will be based on a *Policy Holder's* age when they become insured under an eligible Hospital *Product*.

b) *Age Based Discounts* start at 10% for *Policy Holders* aged 18-25 and decrease by 2% each year to age 29.

c) Where a Hospital *Product* Covers more than one Adult the amount of discounted *Premiums* is calculated by averaging the discounted *Premiums* applicable to each *Insured Person*.

d) An *Insured Person* receiving an *Age Based Discount* will continue to receive the discount until the age of 41 whilst they remain on an eligible *Product*. After age 41, the discount will be removed at a rate of 2% per year until the age of 45.

e) Any *Age Based Discount* that an *Insured Person* was receiving at a previous *Fund* will be carried over when that *Insured Person* joins health.com.au.

D4 Lifetime Health Cover

D4.1 Lifetime Health Cover

Lifetime Health Cover loadings will be applied to *Premiums* in accordance with the *Private Health Insurance Act*.

D5 Arrears in Contributions

D5.1 A Policy in Arrears

Whenever the date to which *Premiums* have been paid passes, other than a *Policy* that has been *Suspended*, the *Policy* will be in *Arrears* and will not be *Active*.

D5.2 Treatment during Arrears

Benefits are not payable for any *Treatment* provided to an *Insured Person* whilst the *Policy* is in *Arrears*. However, subject to rule D5.3, an *Insured Person* may regain entitlement to *Benefits* for *Treatment* by paying, or causing the *Policy Holder* to pay, all outstanding *Premiums* plus the relevant minimum amount of advance *Premiums* specified in rule D1.3.

D5.3 Termination of a Policy in Arrears

When the period of *Arrears* exceeds two (2) months, health.com.au may terminate a *Policy* with immediate effect without written notice to the *Policy Holder.*

E: Benefits

E1 General Conditions

Benefits in this section are payable subject to Section F (Limitation of *Benefits*) of these rules. Details of the *Benefits* available under each *Product* are set out in the relevant *Schedule* which forms part of these rules.

E1.1 Treatment to be Provided by Recognised Providers

Benefits are payable only where *Treatment* is provided by a *Recognised Provider*.

E1.2 Providers who fail to Meet Recognition Criteria

health.com.au may decline to pay *Benefits* if it has reasonable grounds to believe that, at the time the services were provided, the provider, premises or facilities was not a *Recognised Provider*.

E1.3 Recognised Providers Who Cease to Meet Recognition Requirements

health.com.au may decline to pay *Benefits* or suspend or cancel a *Recognised Provider's* status if it has reasonable grounds to believe that, at the time the services were provided, the *Recognised Provider* had ceased to meet the *Recognition Criteria*.

E1.4 Benefit Reductions

health.com.au may reduce the payable *Benefit* in the following circumstances:

1) where the charge for the *Treatment* paid by a *Policy Holder* is lower than the payable *Benefit*;
2) where money is payable from more than one source for the same *Treatment*;
3) where the *Treatment* was provided free of charge to the *Insured Person.*

E1.5 Providers Treating Themselves, Family Members and Business Partners and Family

a) Subject to b), Benefits are not payable for treatment rendered by a provider to:
   i. The provider's Partner, Dependants, or business partner, or
   ii. Family members of the provider and the provider's business partner including: wife/husband, brother/sister, children, parents, grandparents and grandchildren, or
   iii. The provider themselves,
   iv. The Partner or Dependants of the provider's business partner, or
   v. Any other person not independent from the practice.

b) health.com.au may at its discretion pay *Benefits* in these cases:
   i. Where it is satisfied that the charge is a legally enforceable debt, or
   ii. In respect of the invoiced cost of materials required in connection with any treatment.

E1.6 Benefit Liability where Incorrect Information Provided

Benefits are not payable if an application or claim form contains false or misleading information.

E1.7 No Benefit Payable where Provider does not meet Accreditation requirements

health.com.au will not pay any *Benefit* for *Treatment* provided by a person who does not meet the current standards required by the Private Health Insurance (Accreditation) Rules.

E1.8 Benefits paid to be based on the Provider's usual charge

Where a *Benefit* is calculated by reference to a percentage of a charge, health.com.au will only pay the *Benefit* on the basis of the *Recognised Provider's* usual charge. No additional *Benefit* will be paid on the increment charged over the usual charge.

E1.9: Limitations on Consultations provided on the Same Day

health.com.au has limitations on Consultations provided on the same day.

a) More than one consultation and/or *Treatment* type per day has been claimed and performed by the same provider within a group of chiropractors (excluding X-Ray), acupuncturists, homeopaths, osteopaths, physiotherapists, myotherapists and remedial masseuses.

E2 Hospital Treatment

E2.1 Hospital Benefits Payable According to Agreements

The *Benefits* payable will generally be those specified in relevant *Agreements* when an *Insured Person* is charged for *Treatment* provided in a *Contracted Hospital* or when a *Treatment* is provided through an *Access Gap Cover Scheme*.

E2.2 Non Contract Hospitals

For *Treatment* provided at non-*Contracted Hospitals*, health.com.au will pay *Benefits* that are at least the equivalent to the *Default Benefit*.

E2.3 Surgically Implanted Prostheses

The *Fund* will pay *Benefits* for a *Prosthesis* when that *Prosthesis* is implanted as part of a *Treatment* under a *Policy*. In the case of a no-gap *Prosthesis* the *Benefits* will fully cover the cost of that item. In relation to *Access Gap Cover Scheme Prostheses*, the *Benefits* will only cover the amount set out as the minimum *Benefit* in Rule 6 of the Private Health Insurance (Prostheses) Rules.

E2.4 Pharmaceuticals Provided During Hospital Treatment

No *Benefit* is payable for pharmaceuticals (*PBS* or non-*PBS* items) provided as part of a *Hospital Treatment* unless as specified in the relevant *Agreement*.

E2.5 Nursing Home Type Patients

Where an *Insured Person* is classified as a *NHTP*, health.com.au may request an *Acute Care Certificate* and any additional supporting information from the medical record. Once the *Insured Person* is a *NHTP*, health.com.au will pay NHTP *Benefits* for the duration of their classification as a *NHTP*. *NHTPs* must make a contribution to their care as declared by the *Minister*.

E2.6 Hospital Substitute Treatments

All *Complying Health Insurance Products* cover *Hospital Substitute Treatment* and *Benefits* will be paid as specified in the relevant *Agreement*.

E2.7 Medical Services Treatments

All *Complying Health Insurance Products* cover *Treatment* and *Benefits* where applicable will be paid in accordance with the *Private Health Insurance Act* and as specified in the relevant *Access Gap Cover Scheme*.

E3 General Treatment

E3.1 Extras Benefits Payable According to the Schedules

The *Benefits* payable for *Extras*, and the conditions relevant to those *Benefits*, are set out in the *Schedules*. *Benefits* for *Dental Treatment* are payable in accordance with the schedule of dental *benefits* maintained by health.com.au. All *Treatments* are inclusive of routine post-operative care.

E3.2 Network Extras Providers

Subject to rule E4.2, health.com.au may enter into special arrangements with a provider of *Extras*, or group of such providers, to provide *Benefits* for particular *Extras*. These *Benefits* may differ from those shown in these rules and may be determined on the basis of *State of Residence* of the provider. Where such *Agreements* exist, details will be made available to *Policy Holder*s.

E4 Other

E4.1 Ex Gratia Benefits

health.com.au may pay *Benefits* on an ex gratia basis, at its discretion.

E4.2 Interstate Treatment

Subject to rule E1.4 when a *Policy Holder* receives *Treatment* outside their *State of Residence*, *Benefits* applicable to the *State* or *Territory* of Treatment are payable.

E4.3 Treatments not Covered

Benefits are not payable for the following:

a) items not paid by Medicare including any *cosmetic surgery* procedure unless the procedure is *Clinically Relevant*;

b) *Treatments* that are experimental;

c) *Treatments* involving a clinical trial pharmaceutical;

d) services provided overseas;
e) *Treatment* provided by a suspended *Recognised Provider*.

F: Limitation of Benefits

F1 Co-Payments

F1.1 Co Payments

Co-payments may apply to a Cover. Where a Co- payment applies, the amount of the Co-payment and any applicable conditions will be specified in the relevant *Schedule*.

F2 Excesses

F2.1 Excesses

The amount of the *Excess* and relevant limits and conditions are specified in the *Schedule* relevant to the *Policy Holder's Product*.

F3 Waiting Periods

F3.1 Independence of Waiting Periods

Where more than one *Waiting Period* applies to a *Benefit*, each *Waiting Period* is served independently of and concurrently with any other.

F3.2 Waiver of Waiting Periods

The waiver or reduction of a particular *Waiting Period* has no effect on any other *Waiting Period* or any other rule applicable to the same service.

F3.3 Waiver in Case of Accidents

health.com.au may, in its absolute discretion, waive the two (2) month *Waiting Period* for *Treatment* required as the result of an *Accident*.

F3.4 Waiting Periods

Benefits are not payable for *Treatments* during a *Waiting Period*. A *Waiting Period* will not apply to a newborn child of a *Policy Holder* under a *Family Policy* or a *Single Parent Policy* if the *Fund* is notified of the birth within two (2) months of the date of birth.

F3.5 Pre-Existing Ailment: Waiting Period

For any *General Treatment*, or, in accordance with the *Private Health Insurance Act* for *Hospital Treatment*, health.com.au may refuse or reduce *Benefits* in respect of a *Pre-Existing Ailment* within the first twelve (12) months of cover. This also applies when a *Policy Holder* upgrades their *Product*.

F3.6 PEA: Information from Treating Practitioner(s)

health.com.au may appoint a medical or other relevant practitioner to ascertain a *Pre-Existing Ailment*. This person must take into account information provided by the practitioner(s) who treated the *Insured Person* in the six (6) months prior to becoming an *Insured Person* or changing their *Product*, and any other material relevant to the claim. Until any other relevant material is received by health.com.au consideration of the claim for a *Benefit* may be suspended or the application of rule F3.5 may be activated.

F3.7 PEA Waiting Period Not to Apply Where the Fund Alters the Policy

When the terms of an existing *Product* is changed by health.com.au any higher or additional *Benefits* will not be subject to an additional *Pre-Existing Ailment Waiting Period*. This Rule has no effect on any other *Waiting Period* or condition that applies to a newly available *Benefit*.

F3.8 Hospital Treatment: Waiting Period

The following *Waiting Periods* apply to *Benefits* payable under *Hospital Products* for the *Hospital Treatment* listed:

12 Months - *Pregnancy-related Services*

12 Months - *Pre-existing Ailment*

2 Months - All other *Hospital Treatment* (Including psychiatric, rehabilitation and palliative care)

1 Day - *Accidents*

health.com.au may, in its discretion waive the two month *Waiting Period* for *Hospital Treatment* required as a result of an *Accident* occurring during the two month *Waiting Period* if the one (1) day *Accident Waiting Period* has been served.

As health.com.au does not have a *Product* that includes full cover for psychiatric cover, *Insured Persons* will not be able to utilise the one-off

mental health *Waiting Period* waiver if upgrading their cover.

F3.9 General Treatment: Waiting Period

The following *Waiting Periods* apply to *Benefits* payable under *Extras Products* for the *General Treatment* listed:

Major Dental Treatment - 12 months

Non- surgically implanted *Prostheses* and appliances (including *Hearing Aids* and blood glucose monitors) - 12 Months

All other *General Treatment* - two months

A one day *Waiting Period* shall apply for *Accidents* and *Ambulance*.

health.com.au may, in its discretion waive the two month *Waiting Period* for *General Treatment* required as a result of an *Accident* occurring during the two month *Waiting Period*.

F4 Exclusions

Some policies may exclude an *Insured Person* from receiving *Benefits* toward the cost of certain forms of *Hospital Treatment*. Such exclusions are detailed in the *Schedules*.

F5 Benefit Limitation Periods

No *Benefit* limitation periods apply on health.com.au *Products*.

F6 Restricted Benefits

F6.1 Restricted Services

Default Benefits may apply for the following *Restricted Services*:

a) Pregnancy related services (including childbirth);
b) Heart, artery, cardiac related services;
c) Psychiatric services;
d) Assisted reproductive services (including IVF);
e) Male and female sterility reversals;
f) Hip, knee or joint replacement;
g) Rehabilitation services;
h) Cataract and eye lens procedures and surgery;
i) *Cosmetic surgery*;
j) Renal dialysis or chronic renal failure;
k) Palliative care;
l) Bariatric surgery;
m) Podiatric surgery; and
n) *Hospital* admissions for services not eligible for Medicare rebates.

F7: Compensation Damages and Provisional Payment of Claims

F7.1: Definitions

In Fund Rule F7:

a) A reference to a "Claim" includes a claim, demand, action, proceeding, litigation, judgment or award other than a claim for *Benefits*;
b) A reference to an "injury" includes a *Condition*, ailment or injury for which *Benefits* would or may otherwise be, payable by health.com.au for expenses incurred in relation to its *Treatment*; and
c) A reference to an *Insured Person* receiving *Compensation* includes:
    i. *Compensation* paid to another person at the direction of the *Insured Person*, and
    ii. *Compensation* paid to another *Insured Person* on the same *Membership* in connection with an injury suffered by the *Policy Holder*.

F7.2: Obligations of an Insured Person

Subject to Fund Rule F7.8, an **Insured Person** who has, or may have, a right to receive *Compensation* in relation to an injury, must:

a) Inform health.com.au as soon as the *Insured Person* knows or suspects that such a right exists;
b) Inform health.com.au of any decision of the *Insured Person* to Claim for *Compensation*;
c) Include in any Claim for *Compensation* the full amount of all expenses for which *Benefits* are, or would otherwise be payable;
d) Take all reasonable steps to pursue the Claim for *Compensation* to health.com.au's satisfaction;
e) Keep health.com.au informed and updated as to the progress of the Claim for *Compensation*, and

f) Inform health.com.au immediately upon the determination or settlement of the Claim for *Compensation*.

F7.3: Entitlement of Benefits for an Injury

a) Subject to Fund Rule F7.5, and unless otherwise permitted under this Fund Rule, *Benefits* are not payable for expenses incurred in relation to the injury where the *Insured Person* has received, or may be entitled to receive, *Compensation* in respect of that injury.
b) The expenses referred to in Fund Rule F7.3a) include expenses incurred after the *Insured Person* has received any *Compensation*.

F7.4: health.com.au May Provisionally Withhold Payment

Where a *Insured Person* appears to have a right to make a Claim for *Compensation* in respect of an injury but that right has not been established, health.com.au may, at its discretion, elect not to assess a claim for *Benefits* in respect of expenses incurred in relation to that injury until the *Insured Person* has taken all reasonable steps to pursue enquiries in relation to the Claim for *Compensation* to health.com.au's satisfaction.

F7.5: Provisional Payments

a) Where a Claim for *Compensation* in respect of an injury is in the process of being made, or has been made and remains unfinalized, health.com.au may in its absolute discretion make a provisional payment of *Benefits* in respect of expenses incurred in relation to the injury.
b) In exercising its discretion, health.com.au may consider factors such as unemployment or financial hardship or any other factors it considers relevant.
c) A provisional payment is conditional upon the *Insured Person* signing a legally binding undertaking and acknowledgement supplied by health.com.au, which contains an agreement by the *Insured Person*, in consideration for the payment:
    i. To comply with Fund Rule F7.2;
    ii. That it is bound by these Fund Rules;
    iii. To disclose to health.com.au on request, all matters pertaining to the progress of the Claim for *Compensation* and details of any determination made or any settlement reached in respect of the Claim for *Compensation* and that the provision of such information to health.com.au does not constitute a waiver of any legal professional privilege or any other forms of privilege;
    iv. To repay to health.com.au the full amount of the provisional payment as a debt immediately repayable upon the award or settlement of the Claim for *Compensation*, whether or not the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future for which Fund *Benefits* are otherwise payable; and
    v. That health.com.au has specified rights of subrogation whereby health.com.au acquires all rights and remedies of the *Insured Person* in relation to the Claim for *Compensation*.

F7.6: Where Benefits have been paid by health.com.au

a) Subject to Fund Rule F7.9, where:
    i. health.com.au has paid *Benefits*, whether by way of provisional payments or otherwise, in relation to an injury; and
    ii. The *Insured Person* has received *Compensation* in respect of that injury,

the *Insured Person* must repay to health.com.au the full amount that health.com.au paid in relation to the injury, upon the determination or settlement of the Claim for *Compensation*.

b) This Fund Rule applies whether or not:
    i. The determination or settlement sum includes the full amount that health.com.au paid; or

ii. The terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future in respect of which *Benefits* are otherwise payable; or
iii. The relevant *Insured Person* complied with their obligations under Fund Rule F7.2.

F7.7: Rights of health.com.au

If an *Insured Person* makes a Claim for *Compensation* in relation to an injury and fails to:

a) Comply with any obligation in Fund Rule F7.2 or F7.6; or
b) Include in their Claim for *Compensation* any payments of *Benefits* by health.com.au in relation to any injury,

health.com.au may, without prejudice to its rights (including its broader subrogation rights) in its absolute discretion take any action permitted by law to:

i. Assume that all expenses in relation to the injury have been met from the *Compensation* payable or received pursuant to the Claim for *Compensation*; and/or
ii. Pursue the *Insured Person* for repayment of all *Benefits* paid by health.com.au in to the injury; and/or
iii. Assume the legal rights of the *Insured Person* in respect of all or any parts of the Claim for *Compensation*.

F7.8: Claim Abandoned

Where:

a) an *Insured Person* has or may have a right to make a Claim for *Compensation* in respect of an injury, and
b) health.com.au reasonably determines that the *Insured Person* has abandoned or chosen not to pursue that Claim,

Benefits are payable (subject to other Fund Rules) if the *Insured Person* signs a legally-binding undertaking supplied by health.com.au by which the *Insured Person* agrees, in consideration for the payment of *Benefits*, not to pursue that Claim.

F7.9: Requirements to Repay Benefits may be Waived

Where, in respect of an *Insured Person*'s Claim for *Compensation* in relation to an injury:

a) The *Insured Person* has complied with Fund Rule F7.2, and
b) health.com.au has given prior consent to the settlement of the Claim for an amount that is less than the total *Benefits* paid or which would otherwise have been payable by health.com.au,

health.com.au may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the *Insured Person* need not repay any part or the full amount of the *Benefits* paid by health.com.au in respect of that injury.

F7.10: Benefits for Expenses Subsequent to *Compensation*

health.com.au may, in its absolute discretion, pay *Benefits* where:

a) Expenses have been incurred as a result of:
   i. A complication arising from an injury that was the subject of a Claim for *Compensation*, or
   ii. The provision of a service or item for *Treatment* of an injury that was the subject of a Claim for *Compensation*, and
b) That Claim has been the subject of a determination or settlement, and
c) There is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

F7.11: Future medical expenses

a) Where it is anticipated that an *Insured Person* has future medical needs in relation to an injury, the *Insured Person* must use reasonable endeavours to procure an award or settlement of a Claim for *Compensation* that includes a specified allocation for future medical expenses.
b) On request by health.com.au, an *Insured Person* must provide evidence to health.com.au to establish whether a determination or settlement of a Claim for

Compensation includes an allocation for future medical expenses.

c) Where a determination or settlement of a Claim for *Compensation* includes an allocation for future medical expenses in relation to an injury:

   i. the *Insured Person* must use that allocation to pay for *Treatment* of that injury;
   ii. the Fund may refuse to pay *Benefits* for *Treatment* relating to that injury until the allocation is exhausted;
   iii. the *Insured Person* must keep and provide to health.com.au evidence to establish that the allocation has been exhausted on expenses for *Treatment* of that injury; and
   iv. if the *Insured Person* cannot provide such evidence, or the allocation has been exhausted on expenses other than for *Treatment* of that injury, health.com.au may refuse to pay *Benefits* for *Treatment* relating to that injury.

d) Where an *Insured Person* has complied with their obligations in Fund Rule F7.11a) but a determination or settlement of a Claim for *Compensation* does not include a specified allocation for future medical expenses, health.com.au may in its absolute discretion agree to pay *Benefits* for *Treatment* rendered after the determination or settlement in relation to the relevant injury.

F7.12: Cancellation/Termination of Membership

A Member's obligations under these Fund Rules continue despite any termination or cancellation of Membership.

G: Claims

G1 General

G1.1 Form of Claim

Claims for *Benefits* must be made in a manner approved by health.com.au and be supported by accounts or receipts on the *Recognised Providers* letterhead or on documents showing the *Recognised Providers* official stamp. These receipts must also include the following information:

a) the *Recognised Provider's* name, provider number and address;
b) the patient's full name and address;
c) the date of *Treatment*;
d) a description of the *Treatment*;
e) the amount(s) charged, and
f) any other information that health.com.au may reasonably request.

G1.2 Documents to Remain Property of health.com.au

All documents submitted in connection with a claim become the property of health.com.au, unless otherwise agreed.

G1.3 Claims to be Lodged Within Two Years

Benefits are not payable where a claim is lodged more than two (2) years after the date of *Treatment.*

G1.4 Claims to be Paid Within Two Months

Subject to rules F3.7 and G1.3, health.com.au will, within two (2) months of receipt of a claim, assess it and pay any eligible *Benefits*.

G1.5: Incorrect or Fraudulent Claims

If a *Claim* is found to be incorrect or fraudulent, health.com.au may at its discretion:

a) Suspend all Claiming;
b) Offset the amount paid against future *Claims* or *Premiums*;
c) Seek repayment of the funds;
d) Notify the appropriate authorities.

G2 Other

G2.1 Policy Holders May Delegate

health.com.au may authorise a *Policy Holder* to delegate to another person the right to claim *Benefits* to which the *Policy Holder* or an *Insured Person* may be entitled.

G2.2 Manner of Benefit Payment

health.com.au may pay *Benefits* by cheque or electronic funds transfer or may prescribe the method of payment of *Benefits* and insist that *Benefits* be paid using that method.