Fund Rules.

Effective November 2023.

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Live Better

These Fund Rules apply to Medibank Private health insurance Covers other than Overseas Student Health Covers.

You should read these Fund Rules in conjunction with the Cover Summary that you would have received when you joined or changed your Cover. If you did not receive, or no longer have, your Cover Summary please contact Medibank on **132 331** or visit **medibank.com.au** for more information.

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A | Introduction.

A1 Rules Arrangement.

A1.1 Application of the Fund Rules

Medibank Private Limited issues private health insurance *Covers* under two different brands, 'Medibank Private' and 'ahm Health Insurance'.

These Fund Rules apply to all Medibank Private and ahm Health Insurance private health insurance *Covers*, other than Overseas Student Health Covers (OSHC).

A1.2 Contents of the Fund Rules

These Fund Rules consist of:

1. the 'Main Rules' (Fund Rules A to G), and
2. the '*Schedules*' (Fund Rules H to J, and L).

Cover Summaries an *Information Statement* are provided to the *Member* on joining, reflecting the *Member's* specific *Cover* and which summarise the *Schedules*. Copies of the *Schedules* can be provided on request via phone.

A2 Health Benefits Fund.

A2.1 Establishment and Administration of the Fund

1. Medibank Private Limited (ABN 47 080 890 259) is a *Private Health Insurer* trading as 'Medibank Private' and 'ahm Health Insurance'.
2. A *Health Benefits Fund* is established in accordance with the Constitution of Medibank Private Limited in order to carry on health insurance business and health-related business as defined under, and in accordance with, the *Private Health Insurance Act*.
3. Medibank Private Limited administers the *Health Benefits Fund* referred to in (2).

A2.2 Purpose of the Fund

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

A2.3 Purpose of the Fund Rules

These Fund Rules set out the arrangements for *Membership* of, and the payment of *Benefits* by, the *Fund*.

A2.4 Members Bound by Fund Rules and Policies

All *Members* of the *Fund* are bound by the *Fund* rules as amended from time to time. The *Fund* will notify *Members* of changes to any applicable Fund Rules in accordance with clause A7.3.

A3 Obligations to Insurer.

A3.1 Applicants and Members to Provide Requested Information

An applicant for *Membership* of the *Fund* shall provide any information that is reasonably requested and relevant to their *Membership* application.

Existing *Members* shall notify the *Fund* of any changes to information required by the *Fund* for example, a *Member's State of Residence* or, in the case of *Visitor Cover*, evidence of visa status, which may affect their *Cover* including eligibility to be insured under their *Cover*, the *Cover Premium*, or *Benefits* payable as soon as reasonably possible after the change.

A4 Governing Principles.

A4.1 Governance of the Fund

The operation of the *Health Benefits Fund* and the relationship between Medibank Private, ahm Health Insurance and each *Member* is governed by:

1. the *Private Health Insurance Act 2007*
2. the *National Health Act 1953*
3. the *Health Insurance Act 1973*
4. these Fund Rules; and
5. the Constitution of Medibank Private Limited.

A5 Use of Funds

A5.1 Financial Control

Medibank Private Limited shall:

1. keep proper accounts and records of the transactions and affairs of the *Health Benefits Fund*
2. ensure that all payments from the *Health Benefits Fund* are correctly made and properly authorised, and
3. maintain adequate control over:
   (a) the assets in its custody, and
   (b) the incurring of liabilities by the *Health Benefits Fund*.

A5.2 Income to be Credited to the Fund

Medibank Private Limited shall credit to the *Health Benefits Fund*:

1. all *Premiums* paid, and
2. such other moneys or income as are required by the *Private Health Insurance Act* to be credited to a *Health Benefits Fund*.

A5.3 Drawings on the Fund

Medibank Private Limited may use the assets of the *Health Benefits Fund* only:

1. for meeting liabilities to pay *Benefits* in accordance with these Fund Rules;
2. for meeting other liabilities and expenses incurred for the purposes of the business of the *Fund*;
3. for making investments of *Fund* assets; and
4. for making such other distributions, payments and transfers as may, from time to time, be permitted under the *Private Health Insurance Act* or which may from time to time be required to be paid under that *Act*.

A | Introduction.

A6 No Improper Discrimination.

A6.1 Community Rating

When making decisions in relation to any person who is, or seeks to become, a *Member*, the *Fund* will not improperly discriminate on the basis:

1. that a person suffers from a *Chronic Disease*, illness or other medical *Condition* or from a particular kind of disease, illness or medical *Condition*;
2. of a person's gender, race, sexual orientation or religious belief;
3. of the age of a person, except to the extent that the *Fund* is required or permitted to do so by the *Private Health Insurance Act* in relation to matters dealt with under Part 2-3 of that Act;
4. of where a person lives, except as permitted by the *Private Health Insurance Act*;
5. of any other characteristic of a person (including his or her occupation or leisure pursuits) that is likely to increase his or her need for *Treatments*;
6. of the frequency with which a person needs *Treatment*;
7. 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
8. of matters which are, from time to time, prohibited by the *Private Health Insurance Act* for these purposes.

A6.2 Exceptions to Community Rating

The restrictions in Fund Rule A6.1 do not apply where:

1. The *Private Health Insurance Act* otherwise permits; or
2. These Fund Rules otherwise permit.

A7 Changes to Rules.

A7.1 Amendments to the Fund Rules

The *Fund* may amend the Fund Rules at any time, in a manner consistent with the *Private Health Insurance Act*.

A7.2 Overriding Waiver

1. The *Fund* may waive the application of a Fund Rule at its discretion, provided that the waiver does not reduce any *Member's* entitlement to *Benefits*.
2. The waiver of a particular Fund Rule in a given circumstance does not require the *Fund* to waive the application of that Fund Rule in any other circumstance.

A7.3 Notification to Policy Holders or Principal Members

1. Where the *Fund* amends (or proposes to amend) a Fund Rule and this amendment is or might be detrimental to the interests of a *Member*, Medibank Private or ahm Health Insurance will inform the *Policy Holder* or *Principal Member* of an affected *Cover* about the change a reasonable time before the change comes into effect (unless the changes are required by law, in which case we will endeavour to provide notice as soon as reasonably possible).
2. Where an amendment to the Fund Rules requires a change to the *Information Statements* for a *Cover*, Medibank Private or ahm Health Insurance will also give the *Policy Holder* or *Principal Member* of an affected *Cover* an updated *Information Statement* for that *Cover* as soon as reasonably practicable after it has been updated.
3. If the *Policy Holder* or *Principal Member* does not agree to the changes to the Fund Rules or *Information Statement*, the *Policy Holder* or *Principal Member* may cancel their *Cover* and Medibank will refund on a pro rata basis the proportion of higher *Premiums* paid. However, if they continue to remain a *Policy Holder* or *Principal Member* after notice has been given by any of these methods, they will be taken to have accepted the change.

A8 Dispute Resolution.

A8.1 Member Complaints

1. A *Member* may make a complaint to Medibank Private or ahm Health Insurance about any aspect of their *Membership* at any time.
2. Medibank Private or ahm Health Insurance will make reasonable endeavours to respond to complaints quickly and efficiently.

A8.2 Private Health Insurance Ombudsman

1. The Private Health Insurance Ombudsman (the Ombudsman) is available to assist health fund *Members* who have been unable to resolve issues with their *Fund*.
2. Nothing in these Fund Rules prevents a *Member* from approaching the Ombudsman at any time.

A9 Notices.

A9.1 Correspondence

Medibank Private or ahm Health Insurance shall send any correspondence to the most recently advised postal address, phone number, fax number or email address of the relevant *Member*.

A9.2 Availability of Fund Rules to Members

The 'Main Rules' are available for *Members* to view at any Medibank store or online at medibank.com.au or ahm.com.au.

Copies of the *Schedules* can be provided on request via phone.

A10 Winding Up.

A10.1

In the event of Medibank Private Limited ceasing to be registered under the *Private Health Insurance Act*, the *Health Benefits Fund* shall be terminated in accordance with the requirements of the *Private Health Insurance Act* and these Fund Rules.

A10.2

In the event of termination of the *Fund* all monies standing to the credit of the *Health Benefits 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* shall be utilised in such manner as may be determined by the board of directors of Medibank Private Limited in accordance with the constitution of Medibank Private Limited.

B | Interpretation and Definitions.

B1 Interpretation.

B1.1 Interpretation of the Fund Rules

1. The Fund Rules are written using 'plain English'.
2. The names of individual *Covers* are referred to in italics, and are not intended to be interpreted more generally.
3. Words or expressions in *Initial Capital Italic* are defined in Fund Rule B2.1 and are intended to be interpreted accordingly.
4. Unless otherwise specified, the definitions and sub-definitions in Fund Rule B2.1 apply throughout the Fund Rules.
5. A sub-definition is a part of the definition to which it belongs, and is not meant to be read in isolation.
6. Where not defined, words and expressions are intended to have their ordinary meaning.
7. A reference to any legislation shall be taken as a reference to that legislation as amended from time to time.
8. These Fund Rules are to be interpreted, so far as possible, in a manner that is consistent with the *Private Health Insurance Act*.
9. Unless the context requires otherwise, a term that is not defined in these Fund Rules but is defined in the *Private Health Insurance Act* will be interpreted with the meaning that it is given in *Private Health Insurance Act*.

B2 Definitions.

B2.1 In these Fund Rules

Accident for Medibank Private means an unforeseen event, occurring by chance and caused by an external force or object, which results in involuntary injury to the body requiring immediate *Treatment*. This definition excludes unforeseen *Conditions* attributable to medical causes.

Accident for ahm Health Insurance means an unplanned or unforeseen event resulting in bodily injuries that requires immediate medical *Treatment* in a *Hospital*.

Act means the *Private Health Insurance Act 2007* (Cth) and, where the context requires, includes any Private Health Insurance Rules made by the *Minister* under section 333-20, or by the Australian Prudential Regulation Authority under section 333-25, of that *Act*.

Acute Care Certificate is a certificate in a form approved by Medibank Private or ahm Health Insurance to the effect that an *Admitted Patient* is in ongoing need of acute care. An *Acute Care Certificate* is valid for a period of 30 days and is required to support any period of continuous hospitalisation exceeding 35 days.

Acute Catastrophic Illness or Injury means a *Condition* that has severe symptoms of immediate onset requiring admission to a rehabilitation *Program*.

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

Admitted Patient means a person who is formally admitted to a *Hospital* for the purposes of *Hospital Treatment*. This definition:

1. includes a newborn *Child* who:
   (a) occupies a bed in a *Special Care Unit*, or
   (b) is the second or subsequent *Child* of a multiple birth, but
2. excludes:
   (a) any other newborn *Child* whose mother also occupies a bed in the *Hospital*, and
   (b) an employee of a *Hospital* receiving *Treatment* in their own quarters.

Aged-based Discount means a discount that may be applied to *Hospital Cover Premiums* for *Members* aged between 18 and 29 at the time of purchasing *Hospital Cover*. *Aged-based Discount* may also be referred to as *Youth Discount* or *Young Adult Discount*.

Agreement means an agreement entered into between a *Hospital* or group of *Hospitals*, or a *Medical Practitioner* or group of *Medical Practitioners*, and the *Fund* under which the *Hospital* or *Medical Practitioner* providing the service/s agrees to accept payment by Medibank Private or ahm Health Insurance 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*.

Ambulance means a road vehicle, boat or aircraft operated by a service approved by Medibank Private and ahm Health Insurance and equipped for the transport and/or paramedical *Treatment* of persons requiring medical attention.

Arrears means payment of *Premiums* is not up to date for a *Membership*.

Australia for the purposes of these Fund Rules:

1. includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling) Islands, the Territory of Christmas Island and Norfolk Island, but
2. excludes other Australian external territories.

Benefit (or *Fund Benefit*) means an amount of money payable by the *Fund* in accordance with the terms of these Fund Rules.

Benefit Requirements means that a *Policy* covering *Hospital Treatment* meets the requirements under Division 72 of the *Act*.

Benefit Replacement Period means a continuous period of time that must elapse between any two purchases of the same type of item before *Benefits* are payable in respect of the later purchase. Applicable *Benefit Replacement Periods* are described in the associated *Schedules*.

Board means the board of directors of Medibank Private Limited.

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

Child means one of the following:

1. a natural child (including a newborn child)
2. an adopted child
3. a foster child
4. a step-child (that is, a natural, adopted or foster child of the person's *Partner*), or
5. a child being cared for under guardianship arrangements approved by Medibank or ahm Health Insurance from time to time.

B | Interpretation and Definitions.

Chronic Disease for ahm Health Insurance 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*.

Clinically relevant in relation to a procedure or service means one that is:

1. performed or rendered by a *Medical Practitioner*, *Dental Practitioner* or *Optometrist*; and
2. generally accepted in the relevant profession as being necessary for the appropriate *Treatment* of the *Patient*.

Commonwealth Medicare Benefits Schedule (CMBS): see *Medicare Benefits Schedule*.

Compensation means:

1. a payment of compensation or damages pursuant to a judgment, award or settlement;
2. a payment in accordance with a scheme of insurance or compensation provided for by Commonwealth or State law (e.g. workers compensation insurance);
3. settlement of a claim for damages (with or without admission of liability);
4. a payment for negligence; or
5. any other payment that in the *Fund's* opinion is a payment in the nature of compensation or damages.

Complying Health Insurance Policy (CHIP) means an insurance *Policy* that meets:

1. Community Rating Requirements; and
2. Coverage Requirements; and
3. if the *Policy* covers *Hospital Treatment*, Benefit Requirements; and
4. Waiting Period Requirements; and
5. Portability Requirements; and
6. Quality Assurance Requirements; and
7. any other requirements as set out in the Private Health Insurance (Complying Product) Rules.

Condition means a state of health for which *Treatment* is sought, and includes but is not limited to states variously described as: abnormality, ailment, disability, disease, disorder, health problem, illness, impairment, impediment, infirmity, injury, malady, sickness or unwellness.

Consultation means an attendance by a relevant provider, on and in the physical presence of, a *Patient*, or as otherwise approved by Medibank Private or ahm Health Insurance.

Contracted Hospital means a *Hospital* with which there is an *Agreement* in place.

Co-payment means a daily amount that a *Member* may be required to contribute towards the costs of *Treatment* at any *Hospital*, separate and in addition to any *Excess* applicable. The requirement for, and the amount of, the contribution is determined by reference to the *Cover* held. *Co-payment* may also be referred to as a *Daily Charge* or *Per-Day Payment*.

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

Contributions: see *Premiums*.

Cosmetic Treatment means any *Treatment* which is not medically necessary and aims to revise or change the appearance, colour, texture, structure or position of normal bodily features.

Couple (membership): see *Membership Category*.

Cover (also referred to as *Policy*) means a defined group of *Benefits* payable, subject to relevant Fund Rules, in respect of approved expenses incurred by a *Member*.

Cover Summary means a summary of the services and treatments provided by the *Cover*.

Coverage Requirements means that:

1. the only *Treatments* the *Policy* covers are:
   (a) specified *Treatments* that are *Hospital Treatment*; or
   (b) specified *Treatments* that are *Hospital Treatment* and specified *Treatments* that are *General Treatment*; or
   (c) specified *Treatments* that are *General Treatment* but not that are *Hospital Substitute Treatment*; and
2. if the *Policy* provides a *Benefit* for anything else, the provision of the *Benefit* is authorised by the Private Health Insurance (Complying Product) Rules.

CPAP-type device means an external device used to increase the flow or pressure of air that is available for respiration. These devices include Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (BiPAP) or similar devices, as approved by Medibank from time to time.

Daily Charge: see *Co-payment*.

Day Facility or Day Surgery means a facility where admission, *Treatment* and discharge are on the same day.

Default Benefit (or *Default (Minimum) Benefit*): see *Minimum Benefit*.

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

Dental Treatment means professional *Treatment* that is:

1. approved by Medibank Private; and
2. provided during a *Consultation* with a person who is recognised by Medibank Private as a *Dental Practitioner*.

Dependant means a person who is not married or living in a de facto relationship and is one of the following:

1. a *Child Dependant* being a *Child* of the *Policy Holder* or *Principal Member* who is under the age of 21.
2. a *non-classified Dependant* being a *Child* of the *Policy Holder* or *Principal Member* who has reached the age of 18 but is under the age of 21. For the purposes of these Fund Rules references to *Child Dependant* include *non-classified Dependant*.
3. a *Student Dependant* being a *Child* of the *Policy Holder* or *Principal Member* who:
   (a) has reached the age of 21 but is under the age of 31, and
   (b) is undertaking *Full-Time Education*.
4. an *Adult Dependant* being a *Child* of the *Policy Holder* or *Principal Member* who:
   (a) has reached the age of 21 but is under the age of 31, and
   (b) is not a *Student Dependant;* and
   (c) is a *Member* of an eligible *Cover* or combination of eligible *Covers*.

B | Interpretation and Definitions.

Equity for Medibank Private means an increase in the annual limit applying to a *Benefit*, that depends on the length of continuous *Membership* of the *Cover*.

Equivalent Cover means a *Cover* offered by Medibank Private, ahm Health Insurance or another *Complying Health Insurance Policy* offered by a *Private Health Insurer* which Medibank Private or ahm Health Insurance considers to be equivalent to a *Cover*.

Excess for Medibank Private means an amount that a *Member* must contribute towards his or her *Hospital Treatment*.

Excess for ahm Health Insurance 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*.

Excluded Service means services for which *Benefits* are not payable.

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 Membership: see *Membership Category*.

Financial Date of a *Policy* for ahm Health Insurance 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 Education means a course of study:

1. being undertaken at an Australian Educational Institution; and
2. requiring a full-time study workload as determined by Medibank Private or ahm Health Insurance.

Fund means Medibank Private Limited as the insurer that issues *Covers* under both Medibank Private and ahm Health Insurance brands and this term is used in these Fund Rules to refer to something that is common to both brands or to *Covers* irrespective of which of these brands they are associated with.

Fund Benefit: see *Benefit*.

GapCover means an arrangement or scheme adopted by the *Fund* where a *Medical Practitioner*, if they agree to participate in the arrangement or scheme, may raise charges for *Hospital 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* where Medicare benefits are payable.

General Treatment means *General Treatment* as defined in the *Act*.

Health Benefits Fund means the *Health Benefit Fund* established and maintained by Medibank Private Limited in compliance with Division 131 of the *Act*.

Higher Hospital Cover means any *Hospital Cover* that includes *Benefits* additional to those payable under a *Public Hospital Cover*.

Hospital means a facility declared by the *Minister* to be a *Hospital*.

Hospital Cover means a *Cover* which includes, but is not necessarily restricted to, *Benefits* for fees and charges for:

1. some or all *Hospital Treatment*, and
2. some or all associated professional services rendered to a *Patient* receiving *Hospital Treatment*.

Hospital Service means *Professional Attention* or any other item in respect of which *Benefits* are payable from a *Hospital Cover*.

Hospital Substitute Treatment means *Hospital Substitute Treatment* as defined in the *Act*.

Hospital Treatment means *Hospital Treatment* as defined in the *Act*.

Included Services for Medibank Private means services for which *Benefits* are payable.

Independent Private Practice means a professional practice (whether sole, partnership or group) that is self-supporting. This means that its accommodation, facilities and services are not provided or subsidised by another party such as a *Public Hospital* or publicly funded facility.

Information Statement means a Private Health Information Statement.

Medical Devices and Human Tissue Products:

1. in relation to a *Hospital Cover:* any item on the *Federal Government's Medical Devices and Human Tissue Schedule,* which for the purpose of these Fund Rules, is the schedule approved by the Minister under the Private Health Insurance (Medical Devices and Human Tissue) Rules, and
2. in relation to *General Treatment Cover:* an external appliance or device approved by the *Fund* normally associated with a physical replacement of some part of the human body.

Medically Necessary for ahm Health Insurance 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 Benefits Schedule (MBS; or Commonwealth Medicare Benefits Schedule (CMBS)) means the 'Medicare Benefits Schedule Book' published by the Commonwealth Department of Health, and includes any updates and Supplements to the Schedule published from time to time.

Member means a person who holds *Membership* of a *Cover* with the *Fund* or another Health Insurer.

Membership means *Membership* of the *Fund* through the payment of *Premiums* in accordance with these Fund Rules.

Members' Choice Provider means one of the following:

1. *Members' Choice General Treatment Provider* is a provider of a *General Treatment Service* with whom the *Fund* has entered into an arrangement under these Fund Rules which appoints the provider as a *Members' Choice Provider.*
2. *Members' Choice Advantage Provider* is a *Members' Choice General Treatment Provider* of a *General Treatment Service* with whom the *Fund* has entered into an arrangement under these Fund Rules which appoints the provider as a *Members' Choice Advantage Provider.*
3. *Members' Choice Hospital* is a *Contracted Hospital* that forms part of the *Fund's Members' Choice* network.

Membership Bonus for Medibank Private means a component of certain combined *Covers* which provides *Benefits* for approved *Membership* and health related expenses. These *Benefits* are additional to those available under the *Hospital* and *General Treatment* components of these *Covers*.

Membership Category means one of the following:

1. *Single Membership*, which includes one *Member*
2. *Couple Membership*, which includes the *Policy Holder* or *Principal Member* and their *Partner*
3. *Family Membership*, which includes the *Policy Holder* or *Principal Member*, their *Partner*, and one or more other *Dependants*
4. *Single Parent Family Membership*, which includes the *Policy Holder* or *Principal Member* and one or more *Dependants*.

B | Interpretation and Definitions.

Membership Year for ahm Health Insurance means the annual period commencing on the date that the *Member* joins a *Policy* or changes to a new *Policy* covering *Hospital Treatment* and renews every year on that date.

Mental Health Waiver means a waiver of the two *Month Waiting Period* for an upgrade from *Restricted Services to Included Services* for hospital psychiatric services in accordance with Division 78 of the *Act* for an eligible *Member*. The *Mental Health Waiver* can only be used once in a *Member's* lifetime across any *Private Health Insurer*.

Minimum (Default) Benefit means an amount determined by the *Minister* to be the *Minimum Benefit* payable under a *Hospital Cover* for a particular type of *Treatment* in a *Hospital*.

Minister means the *Minister* administering the *Act* or his or her delegate.

Month means a period of time from a date in a *Month*:

- up to, but not including, the corresponding date in the following *Month*; or, where there is no corresponding date,
- to the end of the following *Month*.

Multiple Risk Factors for ahm Health Insurance means for the purposes of these Rules, two or more risk factors relating to *Chronic Disease*.

Nursing Home Type Patient means a person who has been an *Admitted Patient* for a period of continuous hospitalisation exceeding 35 days and for whom an *Acute Care Certificate* is currently not in force.

Obstetrics-related Service for Medibank Private means a service that is listed under Group T4 (Obstetrics) of the *Medicare Benefits Schedule*, including any other services that are approved by the Commonwealth Department of Health and from time to time.

Obstetrics-related Service for ahm Health Insurance means services or *Treatment* relating to pregnancy and delivery of a baby, including complications and associated care provided whilst admitted to *Hospital* for pregnancy or birth related *Treatment*.

Outpatient means a *Patient* of a *Hospital* who is not an *Admitted Patient*.

PackageBonus for Medibank Private means a component of PackagePlus *Covers* which provides *Benefits* for approved *Membership* and health related expenses. These *Benefits* are additional to those available under the *Hospital* and *General Treatment* components of these *Covers*.

Partner means a person who lives with the *Policy Holder* or *Principal Member* in a marital or de facto relationship.

Patient: see *Private Patient* or *Public Patient*

PBS: see *Pharmaceutical Benefits Scheme*

PBS Medication means any pharmaceutical listed in the *Schedule of Pharmaceutical Benefits* and prescribed in accordance with the provisions of the *Pharmaceutical Benefits Scheme*.

PEC: see *Pre-Existing Condition*.

Per-Day Payment: see *Co-payment*.

Pharmaceutical Benefits Scheme (PBS) means the Commonwealth Scheme for the payment of pharmaceutical *Benefits* detailed in Part VII of the *National Health Act 1953*.

Policy: see definition of *Cover*.

Policy Holder for Medibank Private means a person in whose name an application for *Membership* of Medibank Private has been accepted, or any other person whom Medibank Private may, from time to time, treat as the *Policy Holder*.

Pre-existing Condition (PEC) is an ailment, illness or *Condition* that in the opinion of a *Medical Practitioner* appointed by the *Fund*, the signs or symptoms of that ailment, illness or *Condition* existed at any time in the period of six *Months* ending on the day on which the 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 the *Fund* provides.

Premiums means an amount of money a *Policy Holder* or *Principal Member* is required to pay in respect of a specified period of *Cover*.

Principal Member for ahm Health Insurance is the first named *Member* of an ahm Health Insurance *Complying Health Insurance Policy*.

Private Health Insurance Act means the *Private Health Insurance Act 2007* (Cth) and, where the context requires, includes any Private Health Insurance Rules made by the *Minister* under section 333-20, or by the Australian Prudential Regulation Authority under section 333-25, of that Act.

Private Health Insurer means an organisation registered, or taken to be registered as such under the *Act*.

Private Hospital means a *Hospital* that has been declared by the *Minister* to be a *Private Hospital*.

Private Patient means an *Admitted Patient* who is not a *Public Patient*.

Product: see *Cover*.

Professional Attention for Medibank Private means:

1. medical or surgical *Treatment* by or under the supervision of a *Medical Practitioner*,
2. obstetric *Treatment* by or under the supervision of a *Medical Practitioner* or a *Registered Nurse* with obstetric qualifications,
3. *Dental Treatment* by or under the supervision of a *Dental Practitioner*, or
4. podiatric *Treatment* by or under the supervision of a *Registered Podiatric Surgeon*.

Program for Medibank Private means a specified group of services or *Treatments* (including, but not limited to, those referred to in these Fund Rules) that is:

1. provided at a *Hospital*, and
2. recognised by Medibank Private for the purpose of paying *Benefits*.

Prosthesis means, in relation to *General Treatment Cover*, an external appliance or device approved by the *Fund* normally associated with a physical replacement of some part of the human body.

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 Medibank Private or ahm Health Insurance.

Public Hospital means a *Hospital* that has been declared by the *Minister* to be a *Public Hospital*.

Public Hospital Cover means Medibank Private *Basic Public Hospital Cover* offered in Queensland, and Medibank Private *Public Hospital Cover* offered in all other *States*.

Public Patient (or *Medicare Patient*) means an *Admitted Patient* of a *Public Hospital* who receives *Treatment* without charge.

B | Interpretation and Definitions.

Qualifying Period, for Medibank Private in relation to a *Member* transferring from a *Visitors Cover* to another Medibank Private *Cover*, includes:

1. any *Waiting Period* applicable to both *Covers*, either in general terms or to a specific *Benefit*, and
2. a *Benefit Replacement Period*.

Recognised Provider means:

1. a *Hospital*; or
2. a *General Treatment* provider in *Australia* who:
   (a) is in *Independent Private Practice*, and
   (b) for each relevant class of service or *Treatment*, satisfies all *Recognition Criteria*; or
3. any other provider recognised by Medibank Private or ahm Health Insurance.

Recognition Criteria means the following conditions applying to *Recognised Providers*:

1. the provider is registered, or holds a licence, under any relevant *State* or *Territory* legislation to render *Treatment* for which recognition is sought;
2. the provider is professionally qualified, or a member of a professional body recognised by Medibank Private or ahm Health Insurance;
3. the provider maintains comprehensive and accurate *Patient* records, that are made at the time or as soon after the service as practicable, that clearly identify the *Patient* and the *Treatment* provided, and are written in English and understandable by a third party;
4. the provider provides facilities that meet the standards determined or recognised by Medibank Private or ahm Health Insurance; and
5. any other criteria that Medibank Private or ahm Health Insurance consider reasonably suitable.

Registered Podiatric Surgeon means a podiatric surgeon as defined under the Private Health Insurance (Medical Devices and Human Tissue Products) Rules.

Rehabilitation Patient means a *Patient* undergoing *Treatment* in a *Private Hospital* under the supervision of a specialist in rehabilitation medicine and the *Treatment Program* has been approved by Medibank Private or ahm Health Insurance.

Resident Cover means any *Cover* offered by the *Fund* other than a *Visitors Cover* or Overseas Student Health Cover (OSHC).

Restricted Service means a service or *Treatment* in respect of which the *Benefit* payable under a specified *Hospital Cover* is the relevant *Minimum Benefit*.

Restricted Services Cover for Medibank Private means a *Higher Hospital Cover* containing a *Restricted Service*.

Risk Factors for Chronic Disease for ahm Health Insurance means:

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

Same-Day refers to a period of hospitalisation that commences and finishes on the same date.

Schedule means Fund Rule Schedules H, I, J and L referred to in these Fund Rules, unless otherwise indicated by the context.

Single (membership): see *Membership Category*.

Single Parent Family (membership): see *Membership Category*.

Special Care Unit means a unit of a *Hospital* for the purpose of providing special care, and includes facilities such as intensive care units, critical care units, coronary care units, and high dependency nursing care units.

State of Membership for Medibank Private means the *State* or *Territory* in which the *Policy Holder* currently has *Cover*. To avoid doubt, this definition has relevance only to a *Member* of a *Resident Cover*.

State of Residence means the *State* or *Territory* in which the *Policy Holder* or *Principal Member* currently resides. For the purposes of these Fund Rules:

1. unless otherwise specified, a *Policy Holder* or *Principal Member* living in the Australian Capital Territory (ACT) or Norfolk Island is taken to be a resident of New South Wales (NSW), and
2. a *Policy Holder* or *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).

State means the *State* or *Territory* of *Australia*.

Suspendable Cover means any *Cover* other than Ambulance Cover.

Suspension means the temporary discontinuation of a *Membership* in accordance with these Fund Rules.

Territory: see *State*.

Transfer for Medibank Private means:

1. a *Transfer* from another *Health Benefits Fund* to Medibank Private with a break in coverage no longer than that specified in these Fund Rules; or
2. a change of *Cover* within Medibank Private.

Treatment means:

1. in respect of *Hospital Covers: Hospital Services* and *Hospital Treatment*, and
2. in respect of *General Treatment Covers*: services and items for which *Benefits* are payable under these Fund Rules. To avoid doubt, a 'service' excludes any *Treatment* that is not provided by the provider personally or under the direct supervision of the provider.

Visitors Cover includes Overseas Visitors Health Cover and Overseas Workers Health Cover *Covers* unless expressly stated to exclude them, but does not include Overseas Student Health Cover (OSHC).

Waiting Period is a period of time a *Member* must serve on a *Cover* before *Benefits* are payable. *Benefits* are not payable for goods and services obtained during a *Waiting Period*.

Young Adult Discount: see *Aged-based Discount*.

Youth Discount: see *Aged-based Discount*.

C | Membership.

C1 General Conditions of Membership.

C1.1 Same Membership Category and Covers

All *Members* under the same *Membership* shall:

1. belong to the same *Membership Category*, and
2. have the same *Cover* or *Covers*.

C1.2 GST

Where the *Premium* for a *Visitors Cover* includes an amount in respect of Goods and Services Tax (GST), each *Member* on that *Cover* is taken to have no entitlement to claim back the GST on the *Premium* as an input tax credit and to represent to Medibank Private that he or she has no intention of making a claim for any portion of that GST as an input tax credit, unless and until the *Member* notifies Medibank Private in writing that the *Member* is entitled to do so.

C1.3

Medibank Private or ahm Health Insurance may from time to time declare that, for an additional *Premium*, a *Cover* can include an *Adult Dependant*.

C2 Eligibility for Membership.

C2.1 Membership Eligibility: General

Subject to these Fund Rules, any person is entitled to apply as a *Member*.

C2.2 Membership Eligibility: Medibank Private Visitors Covers

1. *Membership* of a *Visitors Cover* is available only to persons who:
   (a) are not eligible for full or interim Medicare benefits; and
   (b) meet the eligibility requirements for the *Visitors Cover*.
2. To enable Medibank Private to determine eligibility, it may, upon reasonable notice to the *Member*, require reasonable production of proof of eligibility to become, or to continue as, a person insured under a particular *Cover*.
3. If a *Member* fails to provide documentary evidence to the reasonable satisfaction of Medibank Private, Medibank Private may deem that *Member* to be ineligible to be insured under that *Cover*.

C2.3 Ineligible Members: Medibank Private Visitors Cover

Where:

1. a *Member* joins a *Visitors Cover* which the *Member* was ineligible to join; or
2. a *Member* insured under a *Visitors Cover* ceases to be eligible to hold that *Cover* (whether due to any change of visa or residency status or otherwise); or
3. a *Visitors Cover* is issued to a *Policy Holder* and neither that *Policy Holder* nor any *Partner* of that *Policy Holder* who is also insured under the *Cover* meets the visa requirement specified in these Fund Rules at that time or, having met that visa requirement at the time of issue of that *Visitors Cover*, ceases to meet that requirement;

then Medibank Private will notify the *Member* that they are no longer eligible and may, at its discretion and in compliance with laws do all or any combination of the following:

1. terminate the *Membership*;
2. migrate the *Membership* from that *Cover* (the 'ineligible cover') to a different type of *Cover* (the 'substituted cover'), being such other type of *Cover* that Medibank Private reasonably considers, in the circumstances, is the most appropriate substitute for the ineligible *Cover* and that is a type of *Cover* which any affected *Members* are in fact eligible to join;

and Medibank Private may, at its discretion (exercised reasonably and in compliance with laws), do any of these things with retrospective effect from such prior date as the affected *Members* first became ineligible to hold or to continue to hold the relevant *Cover*.

Where Medibank Private terminates *Membership* or migrates *Members* to a substituted *Cover* with retrospective effect under this clause C2.3, it may also (as applicable):

1. reassess *Premiums* payable by or on behalf of the affected *Members* and *Benefits* paid to or in respect of affected *Members*,
2. notify the *Members* of any underpayment of *Premiums* or any overpayment of *Benefits* and require immediate payment or repayment to Medibank Private of the same,
3. notify the *Members* and pay any overpayment of *Premiums* and underpayment of *Benefits*,
4. apply any pre-paid *Premiums* standing to the credit of the *Membership* towards any amount owed to Medibank Private by way of repayment of *Benefits*, and
5. treat any *Membership* as being in *Arrears* until all such underpayments of *Premium* and overpayment of *Benefits* have been made good.

Medibank Private will give *Members* notice when this occurs.

Medibank Private may take such other measures to the extent permitted by law and as are reasonably determined by Medibank Private as appropriate in the circumstances, including, but not limited to, those that are available under any other provisions of these Fund Rules, at law, in Equity or pursuant to statute. Without limiting the foregoing, Medibank Private may also notify any government department or authority (including, but not limited to, the Australian Taxation Office and the Department of Home Affairs) of any circumstances relating to the situation of a *Member* having been insured under a *Visitors Cover* for which the *Member* was ineligible.

C | Membership.

C2.4 Members Granted Retrospective Australian Residency: Medibank Private Visitors Cover

Where a *Member* of a *Visitors Cover* is officially advised that their permanent Australian residency has been granted from a date prior to the date of the advice, for the purposes of these Fund Rules, the permanent residency is taken to be effective only from the date of the advice.

C2.5 State of Residence (Resident Covers)

A *Member* may hold *Membership* only in respect of the *Policy Holder* or *Principal Member's State of Residence*.

C2.6 Minimum Age of Policy Holder or Principal Member

Unless otherwise approved by the *Fund*, a person aged under 16 is not eligible to be a *Policy Holder* or *Principal Member*.

C3 Partner and Dependants.

C3.1 Partner Ceasing Eligibility

The *Policy Holder* or *Principal Member* must advise if their *Partner* ceases to be eligible to be covered as their *Partner* as defined in these Fund Rules.

Subject to these Fund Rules, a person who ceases to be eligible to be a *Partner* may become a *Policy Holder* or *Principal Member* by choosing a currently marketed *Cover*.

C3.2 Dependants Ceasing Eligibility

The *Policy Holder* or *Principal Member* must advise if a *Dependant* ceases to be eligible to be covered as a *Dependant* in accordance with these Fund Rules.

Subject to these Fund Rules, a person who ceases to be eligible to be a *Dependant* may become a *Policy Holder* or *Principal Member* by choosing a currently marketed *Cover*.

C4 Membership Applications.

C4.1 Form of Application

Applications to become a *Member* must be in the form required by Medibank Private or ahm Health Insurance.

C4.2 Refusal of Applications: Medibank Private Visitors Cover

1. Medibank Private may, for legitimate and reasonable reason, refuse an application for a person to join Medibank Private *Visitors Cover* as a *Policy Holder*, a *Policy Holder's Partner*, or as a *Dependant*.
2. Where Medibank Private refuses such an application, it will give the applicant notice of the reason (or reasons, as the case may be) for the refusal.

C4.3 Reinstatement of Cancelled Membership

Where a *Membership* has been cancelled under these Fund Rules, Medibank Private or ahm Health Insurance may, at its discretion, reinstate the *Membership* at the request of the *Policy Holder* or *Principal Member*, with continuity of entitlements, subject to the payment of all *Premiums* as required under these Fund Rules.

C4.4 Information in Support of an Application for Membership

A person seeking to become a *Member* is required to provide such information as set out by Medibank Private in the application form.

The *Policy Holder* or *Principal Member* is required to acknowledge and make the declaration which is required for all new applications and changes of *Cover*. By doing so, the *Policy Holder* or *Principal Member,* the *Policy Holder* or *Principal Member's Partner* and each *Dependant* agrees to abide by the Fund Rules and also verifies that all the information given in the application is true and correct.

C5 Duration of Membership.

C5.1 Membership Commencement Date: Resident and Visitors Covers

1. *Membership* commences on the latest of:
   (a) the date on which an application is lodged with Medibank Private or ahm Health Insurance, or
   (b) where Medibank Private or ahm Health Insurance agrees, a later date nominated in the application, or
   (c) for ahm Health Insurance, a date mutually agreed between the *Member* and ahm Health Insurance, or
   (d) in the case of a Medibank Private *Visitors Cover*, the *Policy Holders* date of arrival in *Australia*.
2. A newborn *Child* may be added to a *Single Parent Family*, *Couple* or *Family Membership* from its date of birth provided the application is received by the *Fund* within 12 *Months* of the date of birth. Only those *Waiting Periods* applying to the *Policy Holder* or *Principal Member* at that time will apply to the *Child*, provided the *Membership* commenced no later than the *Child's* date of birth.
3. Any *Child* added to a *Single Parent Family*, *Couple* or *Family Membership* more than 12 *Months* after the date of birth will be added from the date of application. Only those *Waiting Periods* applying to *Policy Holder* or *Principal Member* at that time will apply to the *Child*, provided that the *Membership* commenced no later than the *Child's* date of birth.
4. A newborn *Child* may be added to a *Single Membership* from its date of birth and only those *Waiting Periods* applying to the *Policy Holder* or *Principal Member* at that time will apply to the *Child*, provided that:
   (a) the *Membership* commenced no later than the *Child's* date of birth;
   (b) the application is received by the *Fund* within two *Months* of the date of birth; and
   (c) the *Membership Category* is amended to *Family* or *Single Parent Family Membership*, as agreed.

C | Membership.

C6 Transfers.

C6.1 Transfers to Medibank Private from Other Health Insurers within two Months

When a *Member* of another *Private Health Insurer Transfers* to Medibank Private with a gap in *Cover* of two *Months* or less, Medibank Private will apply all relevant *Waiting Periods*:

1. to any *Benefits* under the Medibank Private *Cover* that were not provided under the previous *Cover*
2. to the difference (if any) between the *Benefit* payable by Medibank Private in respect of a service and that payable by the previous *Fund* as at the date of service
3. to the unexpired portion of any *Waiting Periods* not fully served under the previous *Cover*, and
4. to the unexpired portion of a *Benefit Replacement Period* or limit governing the supply or replacement of an appliance or *Prosthesis*.

C6.2 Transfers to Medibank Private from Other Health Insurers after two Months

Where a former *Member* of another *Private Health Insurer* joins Medibank Private with a gap in *Cover* of more than two *Months*, Medibank Private will treat the person as a new *Member* for all purposes.

C6.3 Transfers to ahm Health Insurance from Other Health Insurers within 30 days

When a *Member* of another *Private Health Insurer* transfers to ahm Health Insurance with a gap in *Cover* of 30 days or less, ahm Health Insurance will apply all relevant *Waiting Periods*:

1. to any *Benefits* for services or *Treatment* under the ahm Health Insurance *Cover* that are services or *Treatments* that were not provided under the previous *Cover*
2. to the difference (if any) between a higher *Benefit* payable (or any annual or other limit) by ahm Health Insurance in respect of a service and that payable by the previous *Fund* as at the date of service
3. to the unexpired portion of any *Waiting Periods* not fully served under the previous *Cover*, and
4. to the unexpired portion of a *Benefit Replacement Period* or limit governing the supply or replacement of an appliance or *Prosthesis*.

C6.4 Transfers to ahm Health Insurance from Other Health Insurers after 30 days

When a *Member* of another *Private Health Insurer* transfers to ahm Health Insurance with a gap in *Cover* of more than 30 days, ahm Health Insurance will treat the person as a new *Member* for all purposes.

C6.5 Cover Changes

Where a *Member* transfers to a different *Cover* that is:

1. deemed to be a lower level of *Cover*, *Benefits* (where payable) are payable at the level of the new *Cover* provided that the relevant *Waiting Period* has been served as at the date of *Treatment*.
2. deemed to be a higher level of *Cover*, then during any *Waiting Period* applicable to the new *Cover*, *Benefits* (where payable) are payable at the level of the previous *Cover* provided that the relevant *Waiting Period* has been served as at the date of *Treatment* under the previous *Cover*.

C6.6 Previous Benefits will be Taken into Account

1. Subject to other Fund Rules, where a *Member* transfers from another *Private Health Insurer* or to a different *Cover*, any relevant *Benefits* that have been paid in a specified time period under the previous *Cover* will be taken into account in determining the *Benefits* payable under the new *Cover*.
2. 'Any relevant *Benefits*' include, but are not limited to, *Benefits* that are subject to an annual or other limit or a maximum number of days of hospitalisation.

C6.7 Equity Transfers

1. Where a *Member* has transferred to Medibank Private from another *Private Health Insurer*, Medibank Private may at its discretion recognise a period of *Cover* with the previous organisation in determining annual limits for *Benefits* under the new *Cover*.
2. Where a *Member Transfers* from one Medibank Private *Cover* with *Equity* for a *General Treatment Service* to another Medibank Private *Cover* with *Equity* for that same *General Treatment Service*, the *Member's Equity* entitlements for that *General Treatment Service* will be retained.

C6.8 Visitors Covers: Transfers

Where a Medibank Private *Visitors Cover* includes an *Excess*, and a *Policy Holder Transfers* to any other *Hospital Cover* offered by Medibank Private that includes an *Excess*, and

1. makes a claim for *Benefits* during the first two *Months* of *Membership* of the new *Hospital Cover*, or
2. makes a claim for *Benefits* under the new *Hospital Cover* to which these Fund Rules would otherwise apply. *Benefits* are payable as if the *Policy Holder* were still a *Member* of a *Visitors Cover*.

C6.9 Transfers from Visitors Covers: Qualifying Periods

When a *Member Transfers* from a *Visitors Cover* to any other Medibank Private *Cover*, Medibank Private will apply *Qualifying Periods* to:

1. any additional level of *Benefits* provided under the new *Cover*
2. *Benefits* for any item offered under the new *Cover* but not under the original *Cover*, and
3. any unexpired portions of any *Qualifying Periods* not served under the original *Cover*.

C6.10 Transfers from Visitors Covers: Exemption from Qualifying Periods

Subject to these Fund Rules, a *Member* who *Transfers* from a *Visitors Cover* to another Medibank Private *Cover* is not required to serve any *Qualifying Period*, provided that:

1. the new *Cover* is considered by Medibank Private to be an *Equivalent Cover*, and
2. the *Member* has served all *Qualifying Periods* applicable to the original *Cover*, and
3. the *Premiums* payable under the original *Cover* are paid to a date no earlier than two *Months* before the effective date of the *Transfer*.

C | Membership.

C7 Cancellation of Membership.

C7.1 Cancellation of Membership

1. Subject to (2):
   (a) a *Policy Holder* or *Principal Member* may cancel their *Membership* entirely at any time,
   (b) a *Policy Holder* or *Principal Member* may remove any *Dependants* from their *Membership*,
   (c) the *Policy Holder* or *Principal Member's Partner* or a *Dependant* aged at least 16 years of age may leave the *Membership*, and/or
   (d) a *Dependant* under 16 years of age may leave the *Membership* with the agreement of the *Policy Holder* or *Principal Member*.
2. Unless otherwise permitted by the *Fund*, the above actions:
   (a) may not have retrospective effect from the date of receipt of the request for cancellation, and
   (b) must be in accordance with any other arrangements specified by the *Fund*.

C7.2 Refunds of Premiums

1. the *Fund* has an obligation to refund excess *Premiums* when a *Membership* ceases only where required to do so by a law or where specified in these Fund Rules (including clauses A7, C2, C7, C8 and D1).
2. subject to (1), the *Fund* will refund some or all of the excess *Premiums* after receiving a request from a former *Policy Holder* or *Principal Member*. Such a refund will generally be calculated from the date of receipt of the request.
3. the *Fund* may also deduct a reasonable and proportionate administrative charge (notified in advance) from any refund.

C7.3 Cooling Off Period

A *Policy Holder* or *Principal Member* who has not yet made any claim for *Benefits* under the *Policy* and who terminates that *Policy* within a period of 30 days from the start date of the *Policy* ('cooling off period') is entitled to receive a full refund of any *Premiums* paid.

C8 Termination of Membership.

C8.1 Termination of Membership Where a Member Acts Improperly

1. Where, in the reasonable opinion of Medibank Private or ahm Health Insurance, a *Member's* act or omission has caused the *Member* to obtain or attempt to obtain an improper advantage, for themselves or for any other *Member*, the *Fund* may terminate the relevant *Membership* immediately, by written notice to the *Policy Holder* or *Principal Member*.
2. Where, in the reasonable opinion of Medibank Private or ahm Health Insurance, any action or conduct by a *Member* which threatens the health and safety of Medibank Private or ahm Health Insurance staff, the *Fund* will terminate the relevant *Membership* immediately and provide written confirmation to the *Policy Holder* or *Principal Member*.
3. For the purposes of this Fund Rule, 'improper advantage' means any advantage, monetary or otherwise, to which a *Member* is not entitled under the Fund Rules, except where the advantage was caused or contributed to by the *Fund's* negligence, fraud or willful misconduct. This includes (but is not limited to) any situation where a *Member* has been insured under a *Cover* under which the *Member* was not eligible to be insured.

C8.2 Termination of Membership in Other Circumstances

1. In any circumstance other than as specified in these Fund Rules, Medibank Private or ahm Health Insurance may terminate a *Membership* by giving the *Member* prior written notice.
2. If the *Fund* invokes the rule in C8.1(1) or C8.2(1), it shall:
   (a) provide the *Policy Holder* or *Principal Member* with notice in writing including a reason for the termination, and
   (b) refund any *Premiums* paid in advance as at the date of the termination above a prescribed minimum refundable amount and/or less any *Benefits* paid, and
   (c) assess claimed *Benefits* that are outstanding. Claims for *Benefits* properly incurred up to the date of termination can be made within two years after the date of service in accordance with G1.2.
3. Where a *Membership* has been terminated under the rule in C8.1(1) or C8.2(1), Medibank Private or ahm Health Insurance has discretion to reinstate the *Membership* at the request of the *Policy Holder* or *Principal Member*, with continuity of entitlements, subject to the payment of all *Premiums* as required under these Fund Rules, or can refuse, acting reasonably, a future application from any *Member* insured under that *Policy*.

C9 Temporary Suspension of Membership.

C9.1 Suspension of Membership Policy

Subject to these Fund Rules, the *Fund* may permit a *Member* who holds a *Suspendable Cover* to suspend their *Membership*.

C9.2 Reasons and Time Limits: Medibank Private Resident Covers

A *Membership* of a *Resident Cover* may be suspended, at the *Policy Holder's* or *Policy Holder's* authorised third party's request, in the following circumstances:

1. *Membership Suspension* for a maximum of two years, while the *Policy Holder* or the *Policy Holder's Partner* continues to receive a form of short-term income maintenance paid by Centrelink (such as Youth Allowance, JobSeeker Payment or Parenting Payment).
2. *Membership Suspension* for a maximum of two years, where the *Policy Holder* is recognised by a government agency or Medibank Private as suffering financial hardship caused by naturally occurring conditions determined from time to time (for example, in circumstances relating to a natural disaster).
3. *Membership Suspension or Partial Suspension* for a minimum of two *Months* and a maximum of four years, where a *Member* is (or *Members* are) overseas.
4. *Membership Suspension* for a maximum of three *Months* where the *Policy Holder* is recognised by Medibank Private as suffering from temporary financial hardship.
5. *Partial Suspension* for a maximum of four years, where a *Member* is in jail.
6. Any other circumstances that Medibank Private may approve from time to time.

C | Membership.

C9.3 Reasons and Time Limits: ahm Health Insurance

A *Membership* of a *Cover* may be suspended, at the *Member's* or *Member's* authorised third party's request, in the following circumstances:

1. *Membership Suspension* for a maximum of two years, where the *Principal Member* is recognised by a government agency or ahm Health Insurance as suffering financial hardship caused by naturally occurring conditions determined from time (for example, in circumstances relating to a natural disaster).
2. *Membership Suspension* for a maximum of two years, while the *Principal Member* or the *Principal Member's Partner* continues to receive a form of short-term income maintenance paid by Centrelink (such as Youth, NewStart or Sickness Allowance).
3. *Membership Suspension* for a maximum of three *Months* where the *Principal Member* is recognised by ahm Health Insurance as suffering from temporary financial hardship.
4. *Membership Suspension* for a minimum of 30 days and a maximum of two years, where all *Members* on the *Cover* are overseas.
5. Any other circumstances that ahm Health Insurance may approve from time to time.

C9.4 Suspension Arrangements: Medibank Private Visitors Cover

1. *Membership Suspension* or *Partial Suspension* for a minimum of two *Months* and a maximum of 12 *Months*, where a *Member* is (or *Members* are) overseas
2. Any other circumstances that Medibank Private may approve from time to time.

C9.5 Memberships to be Paid in Advance

For Medibank Private *Members*, a *Membership* may not be suspended unless the *Premiums* have been paid to a date at least two weeks in advance of the date of *Suspension*.

For ahm Health Insurance *Members*, a *Membership* may not be suspended unless the *Premiums* have been paid up until the date of *Suspension*.

C9.6 All Suspendable Covers to be Suspended

A *Member* with two different types (i.e. *Hospital* and *General Treatment*) of *Suspendable Cover* (including where these are on separate *Memberships*) may not suspend one *Cover* or *Membership* without also suspending the other.

C9.7 Arrangements during Suspension Period

During the period in which a *Member* is suspended:

1. for Medibank Private, the *Membership Category* will be adjusted where appropriate
2. for Medibank Private, the *Member* will not be taken into account for the purposes of calculation of *Premiums*
3. *Benefits* are not payable for *Treatment* received by the *Member*, and
4. the period does not count for any purpose in relation to the *Member*, including *Waiting Periods* and *Benefit Replacement Periods*.

C9.8 Minimum Period Between Suspensions

A *Membership* may be suspended only where the following minimum periods have elapsed since the reactivation from a previous *Suspension* for the same reason:

Medibank Private *Memberships*:

- six *Months* – overseas travel
- 12 *Months* – all other allowable circumstances

ahm Health Insurance *Memberships*:

- 12 Months – temporary financial hardship.
- one day – all allowable circumstances.

A *Membership* may be suspended for financial hardship only where a three *Month* period has elapsed since the reactivation from a short-term income maintenance paid by Centrelink *Suspension*.

C9.9 Documentation to be Provided

A *Member* who wishes to suspend or reactivate a *Membership* must provide all relevant documentation in support of their application that the *Fund* may specify either at the time of application or upon reasonable request of the *Fund*.

C9.10 Reactivation of a Suspended Membership

1. For Medibank Private, a suspended *Membership* must be reactivated by the *Member* within one *Month* of:
   (a) the date on which the reason for *Suspension* ceases to apply, or
   (b) the date on which the maximum *Suspension* period has been reached, whichever is the earlier.
2. For ahm Health Insurance, a suspended *Membership* must be reactivated by the *Member*:
   (a) on the date of return to *Australia*; or
   (b) on the date of resumption of employment; or
   (c) two years from the date of *Suspension*, whichever is the lesser.
3. Where the *Membership* is not reactivated by the relevant date, and has subsequently fallen into *Arrears*, the *Fund* may terminate the *Membership* subject to these Fund Rules. The Fund will provide notice prior to termination in accordance with D5.3.

D | Contributions.

D1 Payment of Contributions.

D1.1 Premiums Payable for Each Cover

Premiums payable for each *Cover* are determined by Medibank Private or ahm Health Insurance (in accordance, where applicable, with the *Act*).

D1.2 Contribution Groups

Medibank Private or ahm Health Insurance may at its discretion approve any group of *Members* as a *Contribution Group*.

D1.3 Premiums Payable in Advance

1. All *Premiums* are payable in advance.
2. For *Members* of ahm Health Insurance whose *Premiums* are not paid through a payroll deduction arrangement, they shall be required to make *Premium* payments at least one payment frequency in advance.

D1.4 Premiums Limited to 12 Months in Advance: Resident Covers

1. The *Fund* may, acting reasonably, refuse to accept a payment of *Premiums*, or any part thereof, that would cause the period of *Cover* to exceed 12 *Months* in advance of the date of payment. 'Refuse to accept' includes the refund of any payment accepted in good faith.
2. Where through any other circumstance the period of *Cover* exceeds 12 *Months* from the current date, the *Fund* may refund the portion of the *Premiums* in excess of 12 *Months*.

D1.5 Premiums from Third Parties May be Refused

The *Fund* may, acting reasonably and in compliance with laws, refuse to accept *Premiums* from a third party.

D1.6 Premium Rates Applicable to State of Residence

Members are required to pay the *Premium* rate applicable to the *Policy Holder* or *Principal Member's State of Residence*.

D2 Contribution Rate Changes.

D2.1 Premiums May be Changed

The *Fund* may change the *Premium* for any *Cover* in accordance with the requirements set out in the *Act* and will provide reasonable notice of any change to *Premiums*. A *Member* that disagrees with the proposed *Premium* increase may terminate its *Membership* in accordance with clause C7.

D2.2 Rate Protection

Subject to these Fund Rules, where *Premiums* have been accepted in respect of an existing *Membership* for a period in advance, a *Premium* change announced by Medibank Private or ahm Health Insurance to take effect during that advance period will not affect the date to which *Premiums* have been paid.

D2.3 Cover Changes and Reactivated Memberships

1. Where a *Cover* change occurs, or a suspended *Membership* is reactivated, the *Premium* current as at the date of the *Cover* change or reactivation applies to the *Membership* from that date. The *Fund* will notify the *Member* of the current *Premium* amount. A *Member* that disagrees with the current *Premium* may terminate its *Membership* in accordance with clause C7.
2. For the purposes of this Fund Rule, '*Cover* change' includes:
   (a) the addition or removal of a *Cover* component
   (b) a change in the level of existing *Cover*
   (c) subject to (3), a change in the *State of Membership*, or
   (d) a change of *Membership Category* resulting in a change in *Premiums*.
3. Where the *State of Membership* is changed but the *Cover* and the *Membership* are otherwise entirely unchanged, the *Fund* may permit rate protection.

D3 Contribution Discounts.

D3.1 Discounts on Premiums

Discounts may apply up to 12% per annum in addition to any *Aged-based Discount* in accordance with the *Act*.

D4 Lifetime Health Cover.

D4.1 Lifetime Health Cover Premiums

Medibank Private and ahm Health Insurance will increase *Premiums* and apply other Lifetime Health Cover criteria as required, in accordance with the *Act*.

D5 Arrears in Contributions.

D5.1 Memberships In Arrears

A *Membership* (other than a suspended *Membership*) is 'in *Arrears*' or in 'a `period of *Arrears*' whenever the date to which *Premiums* have been paid is earlier than the current date.

D5.2 Treatment During Arrears

1. *Benefits* are not payable for *Treatment* provided to a *Member* during a period of *Arrears*.
2. Subject to these Fund Rules, a *Policy Holder* or *Principal Member* may regain an entitlement to *Benefits* for such *Treatment* by paying:
   (a) all outstanding *Premiums* as agreed with the *Fund*, and
   (b) the minimum amount of advance *Premiums* relevant to the *Policy Holder* or *Principal Member*, as specified in these Fund Rules.

D5.3 Termination of a Membership in Arrears

When a period of *Arrears* exceeds two *Months*, the *Fund* may terminate a *Membership* with immediate effect without written notice to the *Policy Holder* or *Principal Member*.

Where a *Membership* has been terminated the *Fund* has the discretion to reinstate the *Membership* at the request of the *Policy Holder* or *Principal Member*, with continuity of entitlements, subject to the payment of all *Premiums* as required under these Fund Rules.

D6 Other.

D6.1 Health and Medical Research Fund

Australian Health Management Group Pty Ltd established the Health and Medical Research Fund in 1986 to support medical research. Any *Member* who holds an ahm Health Insurance *Cover* 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. Australian Health Management Group Pty Ltd provides administrative support and services to the Health and Medical Research Fund. Australian Health Management Group Pty Ltd is a related body corporate of Medibank Private Limited but not part of the *Health Benefits Fund* conducted by Medibank Private Limited.

Members should check their *Cover Summary* and with the *Hospital*, provider or *Fund* to confirm what *Benefits* may be payable.

E | Benefits.

E1 General Conditions.

Members should check their *Cover Summary* and with the *Hospital*, provider or *Fund* to confirm what *Benefits* may be payable.

E1.1 Treatment to be Provided by Recognised Providers

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

E1.2 Recognised Providers Who Cease to Meet Recognition Requirements

The *Fund* may:

1. refuse to pay *Benefits* in respect of any claim, and
2. suspend or cancel the provider's recognition for the purpose of paying *Benefits* where it has reasonable grounds to believe that:
   (a) a *Hospital* has ceased to meet the definition as set out in these Fund Rules, or
   (b) a *Recognised General Treatment Provider* has ceased to be in *Independent Private Practice*, or has ceased to meet any *Recognition Criterion*
   (c) a *Recognised Provider* has, in the opinion of the *Fund*, committed or participated in any fraudulent activity in relation to the provision of a service to a *Member*.

E1.3 Benefit Reductions

Where a *Benefit* is payable, the *Fund* may reduce the *Benefit* in the following circumstances:

1. where the amount paid by a *Member* for a service is lower than the *Benefit* that would otherwise have been payable, the *Fund* shall reduce the *Benefit* to the amount paid,
2. where moneys are payable from more than one source for the same service, the *Fund* may reduce its *Benefit* such that the total amount payable from all sources does not exceed the amount charged, and
3. in determining entitlements to *General Treatment Benefits* in respect of a period, the *Fund* will have regard to the amount of *Benefits* for that kind of *Treatment* already claimed for the *Member* in respect to that period.
4. where in the reasonable opinion of the *Fund* the charge is higher than the provider's usual charge for the service, the *Fund* may assess the claim as if the provider's usual charge had applied.

E1.4 Providers Treating Family Members, and Business Partners and Family

1. Subject to (2), *Benefits* are not payable by the *Fund* for *Treatment* rendered by a provider to:
   (a) the provider's *Partner*, *Dependants*, or business partner, or
   (b) the *Partner* or a *Dependant* of any business partner of the provider.
2. The *Fund* may at its discretion pay *Benefits* in these cases:
   (a) where it is satisfied that the charge is raised as a legally enforceable debt, or
   (b) in respect of the invoiced cost of materials required in connection with any *Treatment*.

E1.5 Benefit Liability where Incorrect Information Provided

Benefits are not payable if, in the application or claim, the *Member* provides false or misleading information.

E1.6 No Benefit Payable where Provider does not meet Accreditation Requirements

The *Fund* will not pay any *Benefit* for *Treatment* or services provided by a person who does not meet the standards required from time to time by any Private Health Insurance (Accreditation) Rules or rules of the *Fund* that may be in force.

E1.7 Fraudulent Behaviour of a Recognised Provider

If in the reasonable opinion of the *Fund*, a *Recognised Provider* has committed or participated in any fraudulent activity in relation to provision of a service to a *Member*, the *Fund* may refuse to pay a *Benefit* or may suspend or cancel the provider's recognition with the *Fund*.

E2 Hospital Treatment.

Members should check their *Cover Summary* and with the *Hospital*, provider and/or doctor or *Fund* to confirm what *Benefits* may be payable.

E2.1 Hospital Benefits Payable According to the Schedules

The *Benefits* payable in respect of *Hospital Treatment* and the conditions relevant to those *Benefits* are set out in the Fund Rules and associated *Schedules*. A *Cover Summary* and an *Information Statement* are provided to the *Member* on joining, reflecting the *Member's* specific policy and which summarise the *Schedules*.

E2.2 Same-Day Patients

Benefits for *Same-Day Hospital* accommodation are payable only where the *Member* is an *Admitted Patient*.

E2.3 Benefits for Hospital Treatment

Benefits are payable according to the *Act* and the Private Health Insurance Rules.

The *Fund* has Hospital Purchaser Provider *Agreements* (HPPAs) with *Private Hospitals*.

Where a *Hospital* does not have an *Agreement* with the *Fund*, *Benefits* will be paid in accordance with the *Act* and the Private Health Insurance Rules.

E | Benefits.

E2.4 Patient Classification: Rehabilitation Patients

Benefits for *Rehabilitation Patients* are payable subject to the following conditions:

1. *Rehabilitation Patient* means an *Admitted Patient* or *Outpatient* receiving *Treatment* for a rehabilitation *Condition* grouped to a Rehabilitation Diagnostic Related Group (DRG) as defined in the Australian Refined Diagnosis Related Groups Definitions Manual, published from time to time by the Commonwealth Department of Health.
2. Approved Rehabilitation *Program* means a *Program* that is approved by the *Fund* for the purpose of paying *Benefits* at the *Rehabilitation Patient* rate.
3. *Benefits* at the *Rehabilitation Patient* rate are payable subject to the following conditions:
   (a) Rehabilitation *Treatment* in a *Private Hospital* must be provided as part of an approved rehabilitation *Program*
   (b) The *Fund* may require the *Treatment* to be supported by a Rehabilitation Care Certificate in a form approved by the *Fund* or some other form of documentation to support the need for the *Patient* to participate in a *Program* to assist in recovery from an *Acute Catastrophic Illness or Injury*.
   (c) The service is not a *Restricted Service* under the *Cover*.
   (d) Subject to the service not being a *Restricted Service* under the *Cover*, *Benefits* for *Rehabilitation Patients* who receive *Treatment* in other than an approved rehabilitation *Program* are payable at the applicable Other (Medical) Patient rate.

E2.5 Patient Classification: Psychiatric Patients

1. *Psychiatric Patient* means an *Admitted Patient* or *Outpatient* receiving *Treatment* for a psychiatric *Condition* that is grouped to a Mental Disorder Diagnostic Related Group (DRG) as defined in the Australian Refined Diagnosis Related Groups Definitions Manual, published from time to time by the Commonwealth Department of Health.
2. *Approved Psychiatric Program* means a *Program* that is approved by the *Fund* for the purpose of paying *Benefits* at the *Psychiatric Patient* rate.
3. *Benefits* at the *Psychiatric Patient* rate are payable subject to the following conditions:
   (a) Psychiatric *Treatment* in a *Private Hospital* must be provided as part of an approved psychiatric *Program*.
   (b) The *Fund* may require the *Treatment* to be supported by a Psychiatric Care Certificate in a form approved by the *Fund* or some other form of documentation to support the need of the *Patient* to participate in a psychiatric *Program*.
   (c) the *Patient* is not under the custodial care of a *State* or *Territory*.
   (d) the service is not a *Restricted Service* under the *Cover*.
4. Subject to the service not being a *Restricted Service* under the *Cover*, *Benefits* for *Psychiatric Patients* who receive *Treatment* in other than an approved psychiatric *Program* are payable at the Other (Medical) Patient rate.

E2.6 Patient Classification: Counting of Days

1. The day on which a person became an *Admitted Patient* and the day of discharge are counted as one day for the purpose of assessing *Benefits* payable.

2. Days spent in a special unit (such as an intensive care, critical care, coronary care, or high dependency nursing care unit) do not interrupt the counting of days in relation to the *Patient* classification on entering the unit. To avoid doubt, *Benefits* payable upon discharge from the special unit will be paid at the classification applicable upon entering the unit, after taking into account any days spent in the unit.

E2.7 Patient Classification: Multiple Procedures

Subject to these Fund Rules, where a *Patient* undergoes more than one operative procedure during the one theatre admission, the procedure with the highest fee in the *Medicare Benefits Schedule* determines the *Patient's* classification.

E2.8 Patient Classification: Subsequent Procedures

Where a *Patient* undergoes a subsequent operative procedure during the same period of hospitalisation:

1. where the procedure results in the *Patient* having a higher classification, the *Patient's* classification increases from the date of the procedure, and

2. where the procedure would otherwise have resulted in the *Patient* moving to a lower classification, the *Patient's* classification is unchanged.

E2.9 Special Care Unit Patients

The higher *Benefits* for *Patients* of *Special Care Units* are payable only for periods during which the *Patient* occupies a bed in a facility approved by the *Fund* for this purpose, such approval not to be unreasonably withheld.

E2.10 Continuous Hospitalisation

1. Where an overnight *Admitted Patient* is discharged, and within seven days is admitted to the same or a different *Hospital* for the same or a related *Condition*, the two admissions are regarded as forming one period of continuous hospitalisation.

2. In the case where the *Hospitals* are different, *Benefits* at the Advanced Surgical, Surgical or Obstetric levels are payable in respect of the later admission only if an appropriate procedure is rendered following that admission.

E2.11 Agreements with Doctors and Hospitals

1. Subject to these Fund Rules, the *Fund* may enter into an *Agreement* with a *Medical Practitioner* or a group of *Medical Practitioners*, or a *Hospital* or a group of *Hospitals*, specifying the total charge for any *Treatment* and the *Benefits* payable by the *Fund*.

2. Any amendments to the *Agreement* that take effect during the period of the *Agreement* may not increase any out-of-pocket expenses payable by *Members*.

3. Where an *Agreement* of the type referred to in paragraph (1) establishes a charge that may be made by a provider of *Hospital Services* or *Hospital Treatment*, the amount of these charges over and above the *Benefit* (if any) must (subject to any restriction in the payment of *Benefits* because of applicable *Excesses* and *Waiting Periods*) be the same as that payable by any other *Member* who has the same *Resident Cover*.

E | Benefits.

E2.12 GapCover

The *Schedules* referred to in these Fund Rules shall provide that the *Benefits* under *GapCover* arrangements are payable subject to the following conditions:

1. A *Medical Practitioner* who provides *Hospital Services* under *GapCover* shall give the *Member* written advice of any amount the *Member* can reasonably be expected to pay for those services.
   (a) if possible the advice shall be given before such services are provided, or otherwise as soon as reasonably practical, and
   (b) the recipient of the advice shall acknowledge receipt of the advice, and
2. A *Medical Practitioner* who provides *Hospital Services* under *GapCover* shall give the *Member* written advice of any financial interest the practitioner may have in products or services recommended or provided to the *Member*.

E2.13 Pharmaceuticals in Agreement Hospitals

1. Where a *Hospital Cover* includes *Benefits* for *PBS Medications* supplied to an *Admitted Patient* of a *Contracted Hospital*, the *Benefit* will meet the full cost of the pharmaceutical if:
   (a) it is directly related to the *Treatment* of the *Condition* for which the *Member* was admitted, and
   (b) in the case of a *Restricted or Excluded Services Cover*, the *Hospital Treatment* is not in respect of a *Restricted or Excluded Service*.
2. The 'full cost' referred to in (1)(a) includes the *Patient Co-payment*, and any special or *Patient* contribution, brand premium or therapeutic group premium otherwise payable by the *Patient* under the *Pharmaceutical Benefits Scheme*.
3. *Benefits* for non-*PBS* medications supplied to an *Admitted Patient* of a *Contracted Hospital* are payable where:
   (a) the *Benefit* is specifically included in the *Agreement* with the *Hospital*; or
   (b) the *Fund* agrees to pay some or all of the cost of the medication at its discretion.
4. Payment of a *Benefit* under sub-rule 3(b) is subject to the following conditions:
   (a) the non-*PBS* medication must be directly related to the *Treatment* of the *Condition* for which the *Member* is admitted;
   (b) the non-*PBS* medication must not be experimental or provided as part of a clinical trial; and
   (c) in the case of a *Restricted* or *Excluded Services Cover*, the *Treatment* for which the *Member* is admitted must not be in respect of a *Restricted* or *Excluded Service*.

E3 General Treatment.

Members should check their *Cover Summary* and with the provider or *Fund* to confirm what *Benefits* may be payable.

E3.1 General Treatment Benefits Payable According to the Schedules

The *Benefits* payable in respect of *General Treatment Services*, and the conditions relevant to those *Benefits*, are set out in the associated *Schedules*.

E3.2 Arrangements with General Treatment Providers

Subject to these Fund Rules, the *Fund* may enter into a special arrangement with a *General Treatment* provider, or group of such providers, to provide *Benefits* for particular *General Treatment Services*. An arrangement may appoint the provider as a *Members' Choice Provider*, or such other category of provider as Medibank may establish from time to time. Any special arrangement with a *General Treatment* provider, or group of such providers, may not increase any out-of-pocket expenses payable by *Members*.

E3.3 Loyalty Benefits: ahm Health Insurance

1. Loyalty *Benefits* are based on a *Principal Member* maintaining a *Policy* with ahm Health Insurance for a continuous period as set out in the *Cover Summary*. As loyalty limits apply to a *Financial Year*, the number of years a *Principal Member* has held an ahm Health Insurance *Policy* at 1 July each year determines the category of loyalty *Benefits*.
2. The loyalty date for the whole *Policy* is determined by the length of time that the *Principal Member* has held an ahm Health Insurance *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.

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.

E4 Other.

E4.1 Ex-Gratia Benefits

The *Fund* may pay *Benefits* on an *Ex-Gratia* basis, at its discretion.

E4.2 Members' Choice Providers

1. Subject to these Fund Rules, details of *Benefits* payable by the *Fund*, *Benefit* conditions, and dates of effect for agreements or arrangements made under this Fund Rule for each *Members' Choice Provider* are contained in separate *Schedules* maintained by Medibank Private. A *Cover Summary* and an *Information Statement* are provided to the *Member* on joining, reflecting the *Member's* specific policy and which summarise the *Schedules*.
2. Subject to (3), and unless otherwise specified in these Fund Rules, the payment of *Benefits* for *Treatment* provided by *Members' Choice Providers* is subject to all relevant Fund Rules.
3. the *Fund* may pay a lower *Benefit* than as set out in a *Schedule* if:
   (a) the *Benefit* is payable for *Treatment* provided under an *Agreement* referred to in these Fund Rules; and
   (b) the *Member* is not subject to any increase in their out-of-pocket expenses for that *Treatment*.

E | Benefits.

E4.3 Interstate Treatment: Members' Choice Providers

Where a *Member* of a Medibank Private *Resident Cover* receives *Treatment* outside their *State of Membership* from a *Members' Choice Provider*:

1. *Benefits* for *Hospital Treatment* are payable in accordance with the *Fund's Agreement* with the provider
2. *Benefits* for *General Treatment Services* are payable in accordance with the appropriate *Members' Choice* schedule in the *State* or *Territory* in which the service is provided, and
3. in the case of *General Treatment Services*, *Benefits* are payable only if the *Member's Cover* provides *Benefits* for the *Treatment* in the *State of Membership*.

E4.4 Interstate Treatment: non Members' Choice Providers

Subject to these Fund Rules, where a *Member* of a Medibank Private *Resident Cover* receives *Treatment* outside their *State of Membership* from a non *Members' Choice Provider*:

1. in the case of *Hospital Treatment*, *Benefits* applicable to the *State* or *Territory* of *Treatment* are payable, and
2. in the case of *General Treatment Services or Treatment*:
   (a) where the *Member's Cover* includes *Benefits* for the *Service* or *Treatment* in the *State of Membership*, the *Benefits* applicable to that *State* or *Territory* are payable, but
   (b) where the *Member's Cover* does not include *Benefits* for the *Service or Treatment* in the *State of Membership*, no *Benefits* are payable.

E4.5 Funeral Benefits: ahm Health Insurance

ahm Health Insurance has previously offered funeral *Benefits* as part of a health insurance *Policy*. Since 1 April 2007, ahm Health Insurance no longer offers that *Benefit*. However, nothing in this rule affects the entitlement 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.

E4.6 Disease Management and other Health Management Programs

The *Fund* may make disease management and other health management programs available under one or more of its *Covers* from time to time. Where the *Fund* offers such a program, participation will be subject to a *Member* meeting any applicable participation criteria which will be made available to the *Member* in advance.

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* and *Cover Summary*.

F2 Excesses.

F2.1 Excesses

The amount of the *Excess* and relevant limits and conditions are specified in the *Schedule* and *Cover Summary*.

F3 Waiting Periods.

F3.1 Waiver of Waiting Periods

Subject to the *Act* and the rules, the *Fund* reserves the right in its absolute discretion to waive any *Waiting Period*.

F3.2 Waiver in Case of Accidents: Medibank Private Hospital Covers

Medibank Private may at its discretion waive the one day and two *Month Waiting Period* for *Treatment* required as the result of an *Accident* occurring within that *Waiting Period*.

F3.3 Pre-Existing Conditions (PEC): Waiting Period

1. The *Fund* may refuse or reduce *Benefits* in respect of a *Pre-Existing Condition* that is the subject of *Treatment* within the first 12 *Months* of *Membership* of any *Cover*.
2. To avoid doubt, this Fund Rule also applies where a *Member* transfers to another *Cover* which provides higher *Benefits* for the relevant *Treatment*.
3. This Fund Rule does not apply to *Hospital Treatment* under a *Resident Cover* or a *Visitor Cover* that is hospital psychiatric services, rehabilitation or palliative care *Treatment*.

F3.4 PEC: Information from Treating Practitioner(s)

1. The *Fund* may appoint a medical or other relevant practitioner to determine whether or not a *Condition* for which *Treatment* has been provided and *Benefits* have been claimed is a *Pre-Existing Condition*.
2. A practitioner appointed under (1) shall take into account:
   (a) information provided by the practitioner(s) who treated the *Member* in the six *Months* prior to their becoming a *Member* or changing their *Cover*, and
   (b) any other material that the *Fund* reasonably considers is relevant to the claim.
3. The *Fund* may suspend consideration of a claim until such time as:
   (a) the *Member* authorises the release of the information referred to in (2), and
   (b) this information has been provided to the *Fund*.

F3.5 PEC Waiting Period Not to Apply Where the Fund Alters the Cover

1. Where the *Fund* has changed the terms of a *Cover*, any higher or additional *Benefits* now available to existing *Members* of the *Cover* are not subject to an additional *Pre-Existing Condition Waiting Period*.
2. This Fund Rule has no effect on any other *Waiting Period* or condition that applies to a newly available *Benefit*.

F | Limitation of Benefits.

F3.6 Waiting Periods When Adding a Child

Refer to Rule C5.1 for detail.

F3.7 Waiting Periods: Medibank Private Hospital Treatment

The following *Waiting Periods* apply to *Benefits* payable for the *Hospital Treatment* shown (where relevant to the *Member's Cover*), unless specified otherwise elsewhere in these Fund Rules for a particular *Cover*.

(1)	Two *Months*, subject to these Fund Rules	All *Treatment* (including hospital psychiatric services*, rehabilitation or palliative care treatment)
(2)	12 *Months*	*Treatment* for *Pregnancy and Birth*
(3)	12 *Months*	*Treatment* for *Pre-existing Conditions*

For *Visitors Covers* the two *Month* general *Waiting Period* is applied only to psychiatric care, rehabilitation and palliative care *Treatment*. The above *Waiting Periods* do not apply for outpatient/non-admitted services under *Visitors Covers* (where included under the cover).

* Unless an eligible *Member* elects to use their *Mental Health Waiver*.

F3.8 Waiting Periods: Medibank Private General Treatment

The following *Waiting Periods* apply to *Benefits* for the *Treatment* and items shown (where relevant to the *Member's Cover*), unless specified otherwise elsewhere in these Fund Rules for a particular *Cover*.

(1)	Nil	Mental health support - psychology and counselling
(2)	One day	*Ambulance* services*
(3)	Two *Months*, subject to these Fund Rules	All *Treatment*
(4)	Six *Months*	Optical appliances
(5)	12 *Months*	*CPAP-type device*
(6)	12 *Months*	Breathing appliances (nebulisers, peak flow meters, and spacing devices)
(7)	12 *Months*	*Dental Treatment:* • endodontic treatment • surgical extractions • surgical procedures • orthodontic • all major dental services
(8)	Two years	• Blood glucose monitors • Blood pressure monitors
(9)	Three years	Hearing aids
(10)	Three years	Laser eye surgery

* For *Visitors Covers* a *Waiting Period* is not applied to *Ambulance* services.

F3.9 Waiting Periods: ahm Health Insurance Hospital Treatment

The following *Waiting Periods* apply to *Benefits* for the *Treatment* and items shown (where relevant to the *Member's Cover*), unless specified otherwise elsewhere in these Fund Rules for a particular *Cover*.

(1)	One day	• *Hospital Treatment* that is required as a result of an *Accident*
(2)	Two *Months*	• *Hospital Treatment* (where there are no *Pre-existing Conditions*) • Hospital psychiatric services*, rehabilitation and palliative care *Treatment* (whether or not a *Pre-existing Condition*)
(3)	12 *Months*	• *Treatment* for *Pre-existing Conditions* • *Treatment* for *Obstetrics related services* • Speech processors and insulin pump replacements

* Unless an eligible *Member* elects to use their *Mental Health Waiver*.

F3.10 Waiting Periods: ahm Health Insurance General Treatment

The following *Waiting Periods* apply to *Benefits* for the *Treatment* or items shown (where relevant to the *Member's Cover*), unless specified otherwise elsewhere in these Fund Rules for a particular *Cover*.

(1)	Nil	Psychology and counselling
(2)	One day	*Ambulance* services
(3)	Two *Months*, where specified in the relevant *Schedule* and subject to these Fund Rules	All *Treatment*
(4)	Two *Months*	Health checks
(5)	Six *Months*, where specified in the relevant *Schedule* and subject to these Fund Rules	Optical appliances
(6)	12 *Months*	• Complex dental • Major dental • Orthodontics • Podiatric surgery • Orthotics and orthopaedic shoes • Hearing aids • Pre and post natal services • Medical gases • Joint fluid replacement injections • Midwife assisted home births • Disease management appliances
(7)	Two years	Refractive sight correcting laser eye surgery

F | Limitation of Benefits.

F4 Exclusions.

F4.1 Resident Covers: Benefit Exclusions

1. Unless expressly provided for in these Fund Rules, *Benefits* are not payable under *Resident Covers*:
   (a) for claims for services provided while *Premiums* are in *Arrears* or the *Membership* is suspended, except where the *Premiums* are in *Arrears* or the *Membership* is suspended due to the *Fund's* negligence, fraud or willful misconduct
   (b) for claims for services rendered outside *Australia* or for items purchased or hired from overseas suppliers
   (c) where the *Member* has received, or established a right to receive, *Compensation* for *Treatment*
   (d) for claims for *Treatment* rendered by a provider other than a *Recognised Provider*
   (e) for pharmaceuticals that are available under the *Pharmaceutical Benefits Scheme (PBS)*
   (f) for oral contraceptives for the purpose of contraception
   (g) where an application form or claim form contains false or inaccurate information
   (h) for services rendered in an aged care service
   (i) where the *Treatment* is otherwise excluded by the operation of a Fund Rule
   (j) for *Cosmetic Treatment*, unless Medibank is satisfied, acting reasonably, that there is a material medical need, or
   (k) for medications prescribed for cosmetic purposes.
2. In addition to the above, a *Cover* may exclude *Benefits* for *Hospital Treatment* as detailed in the associated *Schedules* to these Fund Rules.

F4.2 Benefit Exclusions: Medibank Private Visitors Cover

1. Unless expressly provided for in these Fund Rules, *Benefits* are not payable under *Visitors Covers* for *Treatment*:
   (a) arranged before coming to *Australia*
   (b) for claims for services provided while *Premiums* are in *Arrears* or the *Membership* is suspended except where the *Premiums* are in *Arrears* or the *Membership* is suspended due to the *Fund's* negligence, fraud or willful misconduct
   (c) provided outside *Australia*, including while en route to or from *Australia* (this includes any item purchased or hired while the *Member* is outside *Australia*, or from an overseas supplier)
   (d) where the *Member* has received, or established a right to receive, *Compensation* for *Treatment*
   (e) for claims for *Treatment* rendered by a provider other than a *Recognised Provider*
   (f) provided in an aged care service
   (g) for pharmaceuticals that are available under the *Pharmaceutical Benefits Scheme (PBS)*
   (h) which would not otherwise attract Medicare benefits, e.g. health screening services
   (i) for oral contraceptives for the purpose of contraception
   (j) where the *Treatment* is otherwise excluded by the operation of a Fund Rule
   (k) where an application form or claim form contains false or inaccurate information
   (l) for medications prescribed for cosmetic purposes, or

(m) for *Cosmetic Treatment*, unless Medibank is satisfied, acting reasonably, that there is a material medical need.

2. In addition to the above, a *Cover* may exclude *Benefits* for *Hospital Treatment* as detailed in *Schedule L* to these Fund Rules.

F5 Benefit Limitation Periods.

F6 Restricted Benefits.

F6.1 Restricted Services

Depending on the level of *Cover* chosen by the *Member*, *Benefits* may have restrictions on particular *Hospital Treatments* as detailed in the associated *Schedules* and *Cover Summary*.

F7 Compensation.

F7.1 Definitions

In Fund Rules F7:

1. a reference to a claim (other than a claim for *Fund Benefits*) includes a reference to a demand or action,

2. a reference to a *Member* receiving *Compensation* includes:

   (a) *Compensation* paid to another person at the direction of the *Member*, and

   (b) *Compensation* paid to another *Member* on the same *Membership* in connection with a *Condition* suffered by the *Member*, and

3. a reference to a *Compensable Condition* means a *Condition*:

   (a) for which *Benefits* would, or may otherwise, be payable by the *Fund* in relation to *Treatment* for that *Condition*; and

   (b) in respect of which the *Member* has received, or is entitled to receive, *Compensation*.

F7.2 Obligations of a Member

1. A *Member* who has, or the *Member* believes may have, a right to receive *Compensation* in relation to a *Condition*, must:

   (a) inform the *Fund* as soon as reasonably practicable after the *Member* knows or reasonably suspects that such a right exists,

   (b) promptly inform the *Fund* of any decision of the *Member* to claim for *Compensation*, and

   (c) include in any claim for *Compensation* the full amount of all hospital, medical, *General Treatment* and related expenses (including future expenses, where applicable) for which *Benefits* are, or would otherwise be payable.

2. If a *Member* has, or may have, a right to receive *Compensation* in relation to a *Condition*, in addition to the obligations set out in Rule F7.2(1):

   (a) to the extent permitted by law the *Member* must, in a reasonably timely manner, keep the *Fund* informed of and updated as to all matters relevant to the progress of the claim for *Compensation*, including the time and place of negotiations, mediations or hearings, and medical reports prepared for the purpose of assessing the claim, and ensure that the *Member's* legal advisers disclose the same to the *Fund* (for which purpose the *Member* authorises disclosure by his or her legal advisers), so that the *Fund* may:

      (i) accurately calculate recoverable amounts (including future medical expenses); and

      (ii) consider any requests for reductions and/or waivers of recoverable amounts,

F | Limitation of Benefits.

(b) to the extent permitted by law the *Member* must, and must ensure that the *Member's* legal advisers, disclose to the *Fund* as soon as reasonably practicable upon the determination or settlement of a claim for *Compensation* (or the establishment of a right to receive *Compensation*), including by providing to the *Fund* a copy of the settlement or award and (if not evident from the settlement or award) an explanation of how *Compensation* has been allocated,

(c) the *Fund* has a common interest with the *Member* as the *Fund* indemnifies the *Member* for *Benefits* for the *Condition*,

(d) the *Fund* must keep the information disclosed by the *Member* or the *Member's* legal advisers in accordance with these Fund Rules confidential, and

(e) the disclosure of a document or information in accordance with these Fund Rules is not a waiver of, or disclosure of any intention to waive, confidentiality or privilege existing over the document or information.

3. The obligations in Fund Rule F7.2(2) apply regardless of whether or not the *Fund* has paid or agreed to pay *Benefits* for *Treatment* in respect of the *Condition*, and if *Benefits* have been paid, whether they have been paid on a final or provisional basis.

F7.3 Entitlement to Benefits for a Compensable Condition

Subject to these Fund Rules, *Benefits* are not payable for expenses incurred in relation to a *Compensable Condition*.

F7.4 The Fund may Provisionally Withhold Payment

1. In order for the *Fund* to determine the amount of any reduction to *Benefits* otherwise payable, due to the application of Fund Rule E1.3, F7.3 or F7.10, the *Member* must make reasonable enquiries in relation to pursuit of the claim for *Compensation*.

2. Where a *Member* appears to have a right to make a claim for *Compensation* in respect of a *Condition* but has not yet established the right, the *Fund* may, at its discretion and upon reasonable notice, elect not to assess a claim for *Benefits* in respect of expenses incurred in relation to *Treatment* of that *Condition* until the *Member* has taken all reasonable steps to pursue enquiries in relation to the claim for *Compensation* to the *Fund's* reasonable satisfaction.

3. If it is established that there is no right to *Compensation* or the *Member*, after making reasonable enquiries elects not to pursue such *Compensation*, then *Benefits* will be payable in accordance with these Fund Rules.

F7.5 Provisional Payments

1. When a *Member* has not yet received, or established a right to receive, *Compensation* in respect of a *Compensable Condition*, and it appears that the *Member* has or may have a right to make a claim for *Compensation*, the *Fund* may, in its discretion, pay *Benefits* on a provisional basis in respect of expenses incurred in relation to *Treatment* of the *Condition*.

2. In exercising its discretion, the *Fund* may consider factors such as unemployment or financial hardship or any other factors that it considers relevant, acting reasonably.

3. Where a *Member* appears to have a right to make a claim for *Compensation* in respect of a *Condition*, the *Fund* may prior to making any provisional payment of *Benefits*, require the *Member* to sign a legally binding undertaking in favour of the *Fund*, acknowledging the *Fund's* rights in relation to provisional payments of *Benefits* (including the rights set out in Fund Rule F7.5(4)).

4. In addition to a *Member's* obligations in these Fund Rules and the *Fund's* rights at law, where the *Fund* makes provisional payment of *Benefits* to a *Member*, it is on condition that the *Member*:

   (a) acknowledges that the proceeds from the claim for *Compensation* are to be used to reimburse the *Fund* for any *Benefits* that were paid for the *Compensable Condition*,

   (b) acknowledges that the *Fund* has specified rights of subrogation whereby the *Fund* acquires all rights and remedies of the *Member* which the *Fund* is legally able to acquire in relation to the recovery of the amount that the *Fund* has paid in *Benefits*, including but not limited to the right to:

      (i) claim on behalf of the *Member* against a third party,

      (ii) recover any *Benefit* from a claim,

      (iii) require the *Member* to pursue the *Compensation* claim in good faith,

      (iv) require the *Member* to do nothing to prejudice the *Fund's* right of subrogation without the *Fund's* express prior written consent, including release, settle, diminish or compromise any rights the *Fund* has or may be entitled to under its right of subrogation.

F7.6 Where a Member has received Compensation

1. Subject to these Fund Rules, where:

   (a) the *Fund* has paid *Benefits*, whether by way of provisional payment or otherwise, in relation to a *Compensable Condition*, and

   (b) the *Member* has received *Compensation* in respect of that *Compensable Condition*, the *Member* must repay to the *Fund* the full amount that the *Fund* paid in relation to the *Compensable Condition* except where the *Fund* paid due to the *Fund's* negligence, fraud or willful misconduct.

2. The obligation to repay applies whether or not:

   (a) the *Fund* was aware, at the time it paid *Benefits*, that the *Member* was entitled, or might be entitled, to *Compensation*, or

   (b) the determination or settlement sum expressly includes reference or allocation for the full amount that the *Fund* paid, or

   (c) 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

   (d) the *Member* complied with his or her obligations under these Fund Rules, including the signing of a legally binding undertaking or acknowledgment supplied by the *Fund*.

F | Limitation of Benefits.

F7.7 Rights of the Fund

1. If a *Member* makes a claim for *Compensation* in relation to a *Compensable Condition* and fails to:

   (a) comply with any obligation in these Fund Rules, such that the *Fund* is adversely affected, or

   (b) include in his or her claim for *Compensation* any payment of *Benefits* by the *Fund* in relation to the *Condition*,

then provided the *Fund* has not engaged in negligence, fraud or willful misconduct, the *Fund* may, without prejudice to its rights (including its broader subrogation rights) and in its absolute discretion, take any action permitted by law to do any or all of the following:

   (c) assess whether all expenses in relation to the *Compensable Condition* have been met from the *Compensation* payable or received pursuant to the claim,

   (d) pursue the *Member* for repayment of all *Benefits* paid by the *Fund* in relation to the *Compensable Condition*, or

   (e) assume the legal rights of the *Member* in respect of all or any parts of the claim.

F7.8 Claim Abandoned

1. Where:

   (a) a *Member* has or may have a right to make a claim for *Compensation* in respect of a *Condition*, and

   (b) the *Fund* determines that the *Member* has abandoned or chosen not to pursue the claim,

the *Fund* will pay *Benefits* in respect of expenses incurred in relation to *Treatment* of the *Condition*, subject to these Fund Rules.

F7.9 Requirement to Repay Benefits may be Waived

Where, in respect of a *Member's* claim for *Compensation* in relation to a *Compensable Condition*:

1. the *Member* has complied with these Fund Rules, and

2. the *Fund* 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 the *Fund*,

the *Fund* may in its discretion and subject to any conditions that it considers appropriate, determine that the *Member* need not repay any part or the full amount of the *Benefits* paid by the *Fund* in respect of the *Compensable Condition*.

F7.10 Benefits for Expenses Subsequent to Compensation

1. The *Fund* may, in its absolute discretion, pay *Benefits* where:

   (a) expenses have been incurred as a result of:

      (i) a complication arising from a *Compensable Condition* that was the subject of a claim for *Compensation*, or

      (ii) the provision of a service or an item for *Treatment* of a *Compensable Condition* that was the subject of a claim for *Compensation*,

   (b) that claim has been the subject of a determination or settlement, and

   (c) there is sufficient medical evidence that those expenses could not reasonably have been anticipated at the time of the determination or settlement.

2. Where, in the *Fund's* reasonable opinion, the amount of the *Compensation* is less than the *Benefits* that would otherwise be payable, the *Fund* may agree to pay *Benefits* in an amount not exceeding the difference between the amount of *Benefits* that would otherwise have been payable, and the amount of the entitlement for *Compensation*.

F7.11 Future Medical Expenses

1. The *Member* must upon a reasonable request provide evidence to the *Fund* to establish whether a determination or settlement includes an allocation for future medical expenses.
2. Where it is anticipated that the *Member* has future medical needs in respect of a *Compensable Condition*, the *Member* must use reasonable endeavours to procure an award or settlement that includes a specified allocation for future medical expenses.
3. Where, despite the *Member's* reasonable endeavours, a determination or settlement does not include a specified allocation for future medical expenses, the *Fund* may in its absolute discretion agree to pay *Benefits* for *Treatment* in respect of the *Compensable Condition* rendered after the determination or settlement.
4. 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 *Compensable Condition*:
   (a) the *Member* must use that allocation to pay for *Treatment* in respect of the *Compensable Condition*;
   (b) the *Fund* may refuse to pay *Benefits* for such *Treatment* until the allocation is exhausted;
   (c) the *Member* must keep and provide to the *Fund* evidence to reasonably establish that the allocation has been exhausted on expenses for *Treatment* of the *Compensable Condition*; and
   (d) if the *Member* cannot provide such evidence, or the allocation has been exhausted on expenses other than for *Treatment* of the *Compensable Condition*, the *Fund* may, acting reasonably, refuse to pay *Benefits* for *Treatment* in respect of the *Compensable Condition*.

F7.12 Cancellation/Termination of Membership

To the extent applicable, a *Member's* obligations under these Fund Rules continue despite any termination of the *Membership*.

G | Claims

G1 General.

G1.1 Form of Claim

Claims for *Benefits* must be made in a manner approved by the *Fund*.

G1.2 Claims to be Lodged within two Years

The *Fund* has the right to refuse to pay *Benefits* where a claim is lodged more than two years after the date of service.

G2 Other.

G2.1 Manner of Benefit Payment

The *Fund* may pay *Benefits* in accordance with arrangements it determines from time to time.

G2.2 Health Support Services and Programs

The *Fund*, at its discretion, may offer health support services or programs as part of its *Covers* from time to time.

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