

Member Guide

Product Disclosure Document and Fund Rules

This Member Guide is designed to help you understand what you will be covered for when you take out private health cover with Health Partners. It should be read in its entirety and in conjunction with Health Partners individual cover details. We recommend that you always make enquires with Health Partners before going to hospital or undergoing a new course of *treatment*. This Member Guide is effective 1 April 2019.



(MEMBERS OWN)
HEALTH FUND

Table of Contents

Business Rules	4	Understanding Benefits and Obtaining a Benefit Quote	15
Purposes of the Fund	4	Benefit Rules	16
Purpose of the Rules	4	Injury Rules and the impact on Claims	19
Business of the Fund	4	Withholding Payment of Benefits relating to Injury	19
Health Related Business	5	Provisional Payments	19
The Governing Principles	5	Where Benefits have been paid by Health Partners	20
Membership Information	6	Rights of Health Partners	20
Membership Types	6	Claim Abandoned	20
Policyholder	6	Requirement to Repay Benefits may be waived	21
Membership and Treatment Covered	7	Benefits for Expenses subsequent to Compensation	21
Membership Eligibility	7	Other Insurance	21
Community Rating	7	Limits	22
Becoming a Member	8	Claiming	22
Transferring from another fund	8	How to Claim	22
Membership Commencement	8	Required information to include with your claim	23
Information you receive as a member	8	Refusing, Suspending, Withholding or Reducing Payment of a Claim or Benefit	24
Membership Card Rules	8	Subrogation of Rights in a Claim	24
Cooling-off period	9	Payment of a Claim	24
Refusal of an application	9	Claim Security	25
Once You're a member	10	Suspensions	25
Changing your Membership Type	10	Overseas Travel Suspension	25
Adding a newborn or dependant	10	Financial Hardship Suspensions	25
Removing dependants	10	Other Suspensions	25
Student dependants	10	Rules for Suspensions	26
Membership Changes and the impact to Premiums and Benefits	11	Loyalty Benefits and Length of Membership Rules	26
Payment Rules, Options and Frequency	11	Moving Interstate	26
Variation to Premium Rates	12	Delegation of Authority	26
Premium Discounts	12	Substitute Decision-makers	27
Arrears in Premiums	12	Cancellation of Membership	27
Refunds	13	Improper Conduct	28
Waiting Periods	13	Transfer Certificate	28
Transferring from another health fund and the impact on waiting periods	13	Notices and Changes to Rules	28
Transferring between covers with us and the impact on waiting periods	13	Private Health Information Statements	29
Transferring from your parents' cover and the impact to waiting periods	13	Australian Government Initiatives	30
Waiting periods for newborns, adopted or fostered children	14	The Rebate	30
Waiting periods for Gold Card Holders	14	Claiming the rebate	30
Waiver of waiting periods	14	Nominating a rebate tier	30
Rules for Pre-existing Conditions and the impact on waiting periods	14	Income thresholds table	30
Members Online	15	Rebate percentage table	30
Benefits	15	Lifetime Health Cover	31
		Certified Age	31
		Exceptions	32
		Permitted Days	32
		Removal of LHC	32

Youth Discount	32
Medicare Levy Surcharge	33
What you need to know about your extras cover	34
Membership types	34
Maximum Treatment	34
Ambulance Cover Conditions	34
Dental (including General, Major, Endodontic and Periodontics) Conditions	35
Optical Conditions	35
Orthodontic Conditions	35
Physiotherapy Conditions	35
Chiropractic, Osteopathic and Exercise Physiology Conditions	36
Pharmacy Conditions	36
PBS Prescription	36
Private Prescription	36
Vaccination	36
Hormone and Allergen Implant	37
IVF Associated Drugs	37
Podiatry Conditions	37
Orthotics Conditions	37
Psychology Conditions	37
Other Therapies Conditions	37
Aids and Appliances Conditions	37
Hearing Aids	38
Asthmatic Spray Appliance, Blood Glucose Monitoring Machine or Blood Pressure Machine	38
Sleep Apnoea Machine	38
Sleep Apnoea Machine Support Service	38
Low Vision Optical Magnification Aids	38
Circulation Booster	38
Royal District Nursing Service (RDN) Conditions	39
Healthier Living Conditions	39
Personal Health Assessment	39
Quit Smoking Program	39
Weight Management Program	39
Bowel Cancer Screening	40
Mole Check Body Scan	40
Diabetes Association Membership	40
Gym and Fitness	40
Post-natal Lactation Consultation	41
Agreements and General Treatment Providers	41
What you need to know about your hospital cover	42
Membership Types	42
Costs covered under your hospital cover	42
Before going to hospital	43

Excess Conditions	43
Co-payments Conditions	44
Restricted Benefits Conditions	44
Restricted Hospital Psychiatric Services Conditions	44
Ambulance Cover Conditions	45
Pharmaceutical Benefits Conditions	45
PBS government subsidised prescriptions	45
Non-PBS government subsidised prescriptions	46
Surgically Implanted Prostheses Conditions	46
Non-surgically Implanted Prosthesis and Appliances	46
Aids for Recovery	47
Compression Garments	47
Hip Safety Kit	47
Replacement Insulin pumps	47
Replacement Speech/Sound Processors	47
Surgical Podiatry	48
Health Management Programs Conditions	48
Health Coaching	48
Newborn Support Program	48
Asthma Foundation Membership	48
Bone Density Test	49
Diabetes Education	49
Home Sleep Studies	49
Home Nursing	49
Home Birth	49
Hospital to Home Conditions	50
Hospital Guide	50
Hospital in the Home	50
Rehabilitation in the Home	50
Closed Products	51
Privacy Policy	52
Dispute Resolution	54
Member Care Charter	56
Use of Monies	57
Winding Up	58
Definitions and Interpretation	59



Health Partners is a signatory to the Private Health Insurance Code of Conduct. Go to ahia.org.au/codeofconduct.

This Member Guide contains important information about the general terms of *membership*, Fund Rules and cover with Health Partners. It is the *policyholder's responsibility* to understand what is and what is not covered by their health insurance *policy*, therefore this information should be read in its entirety and retained in conjunction with individual cover details. This information is correct at time of printing; however, we reserve the right to make changes to prices, *cover* / benefit specifications and other conditions relating to Health Partners products, programs and services at any time, with appropriate notice provided to *members* where required. Please contact us on 1300 113 113 or visit healthpartners.com.au prior to purchasing any health insurance products to make sure you have the latest information available.

Where you see a word in italics *like this*, it means the word is defined at the back of this guide in the Definitions and Interpretation section, or in the *Government Rules*. This will assist you in gaining a reasonable understanding of the Rules.

Business Rules

Health Partners Limited (ABN 43 128 282 904) (**Health Partners**) conducts its *health insurance business* and *health related business* under these Rules and the *Government Rules*.

All *members* are bound by these rules, the Health Partners Constitution, and the applicable *Government Rules*.

We recommend *you* read the *Rules* and all relevant policy documents in their entirety, as they work together to provide the rules associated with your *membership*. Only referring to sub-sections may provide incomplete details when they are not read in totality.

Purposes of the Fund

The purposes of the *Fund* are:

- a. to hold the *assets* relating to Health Partners *health insurance business* and the *health related business*;
- b. to receive amounts which must or may be credited to the *Fund* under the *Government Rules* in connection with Health Partners *health insurance business* and the *health related business*;
- c. to pay *policy* liabilities and other liabilities or expenses incurred in connection with Health Partners *health insurance business* and the *health related business*;
- d. to make investments and distributions permitted by the *Government Rules*; and
- e. for any other purpose permitted by the *Government Rules*.

Purpose of the Rules

The purpose of these Rules is to set out the rules which relate to the operation of Health Partners *health insurance business* and the *health related business*.

Business of the Fund

The business of the *Fund* is Health Partners:

- a. *health insurance business*; and
- b. *health related business* (each a health related business) of:
 - i. providing optical and dental services and goods;
 - ii. undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare for costs associated with providing *treatment*, goods or services that are provided to those people in Australia and are provided to manage or prevent diseases, injuries or conditions; and
 - iii. providing a financial service to assist people insured under *complying health insurance products* to meet the costs associated with *treatment*, goods or services that are provided to manage or prevent diseases, injuries or conditions.

The dominant purpose of the *Fund* relates to Health Partners *health insurance business*.



Health Related Business

- a. Health Partners must conduct the *health related business* for the benefit of *members*.
- b. A *member* may use the services of a *health related business* for treatment for which a benefit is provided under their *membership*.
- c. Health Partners may provide the optical and dental services of the *health related business* to *persons* who are not *members* provided:
 - i. *members* are as far as possible given priority;
 - ii. the fee for each service is not less than an appropriate market rate; and
 - iii. the predominant purposes for providing services generally to *persons* who are not *members* are to:
 - (i) support the *Fund* in operating the *health related business* more efficiently;
 - (ii) permit Health Partners to take advantage of economies of scale; and
 - (iii) support the more efficient provision of services to *members*.

The Governing Principles

The operation of the *Fund* and the relationship between Health Partners and each *member* is governed by:

- a. the *Government Rules*; and
- b. these Rules.

If there is any inconsistency between them, to the extent of the inconsistency, the above order of precedence applies.

Membership Information

Here you'll find information on *membership* types, *policyholder* requirements, eligibility, how to become a *member*, rules on transferring from another fund and what you'll need to provide to become a member.

Membership Types

We offer a range of different *membership* types to suit your life stage, they include:

- a. Single, for *yourself* only (including *responsible adult*);
- b. Couple, for *you* and *your partner*;
- c. Family, for a couple and all registered *child dependants*, which is defined as:
 - i. *Child dependant* under the age 21; or
 - ii. Registered student *dependants* up to their 25th birthday, who do not have a *partner* or family of their own. They can either be living at home or out of home.
- d. Family Focus, for a couple and all registered *child dependants* that are aged 21 and under 25. *Child dependants* must not be studying full-time and not have a *partner* or family of their own. They can either be living at home or out of home;
- e. Single/sole parent family, for *you* and all registered *child dependants*, which is defined as:
 - i. *Child dependant* under the age 21; or
 - ii. Registered student *dependants* up to their 25th birthday, who do not have a *partner* or family of their own. They can either be living at home or out of home.

- f. Single/sole parent Family Focus, for *you* and all registered *child dependants* that are aged 21 and under 25. *Child dependants* must not be studying full-time and not have a *partner* or family of their own. They can either be living at home or out of home.

Policyholder

A *policyholder* is the person applying for cover that will be responsible for ensuring *premium* payments are made. The *policyholder* has full authority over the *membership* and must be 18 years or older. Most correspondence will be addressed to the *policyholder*.

As a *policyholder*, you must agree on behalf of the whole *membership* to our Privacy Policy and abide by our Fund Rules and policies. You also agree to let us know of any change in circumstances relating to everyone on the *membership*. This is required to be done as soon as possible to ensure the information we hold remains correct.

Policyholders can only take out one *Hospital cover* and/or one *Extras cover* under a *membership*. Everyone under the same *membership* will have the same cover and must belong to one of our defined *membership* types, the only exception is for children that are held under different memberships.



Membership and Treatment Covered

The types of *treatment* covered by a *membership* include and as permitted or required by the *Government Rules*:

- a. *hospital treatment*;
- b. *hospital treatment* and *general treatment* (also known as extras); or
- c. *general treatment* (also known as extras) excluding *hospital-substitute treatment*.

We understand everyone has different needs, so we have developed a range of cover types to suit *your* needs. *You* can find details of our *cover* types on our website, over the phone or in *person* at one of our locations.

Membership Eligibility

Membership with Health Partners is open to all Australian residents. Any *person* wishing to claim hospital benefits with Health Partners must hold an eligible Medicare card. Health Partners does not offer private health *cover* to overseas visitors or overseas students.

Only those listed on the *membership* will be eligible to receive the *benefits* outlined on the *cover* details. However, the Medicare status may impact benefit entitlements. To find out more contact us.

Community Rating

Under the Community Rules, we must take steps to ensure we do not improperly discriminate between people who are or wish to become a *member* under a *complying health insurance product*.

In this part improperly discriminating is, except to the extent allowed under the *Government Rules*, discriminating on the grounds of:

- a. the *suffering* by a *person* from *chronic disease*, illness or other medical condition or from a disease, illness or medical condition of a particular kind;
- b. the gender, race, sexual orientation or religious belief of a *person*;
- c. the age of a *person*;
- d. where a *person* lives;
- e. any other characteristic of a *person* (including not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for *hospital treatment* or *general treatment*;
- f. the frequency with which a *person* needs *hospital treatment* or *general treatment*;
- g. the amount, or extent, of the *benefits* to which a *member* becomes, or has become, entitled during a period; or
- h. any other matter set out in the *Government Rules* for this purpose.

Membership Information

continued

Becoming a Member

All *policyholders* need to complete and submit an application. This can be done:

- a. by calling 1300 113 113;
- b. online at healthpartners.com.au; or
- c. by downloading the application from our website, collecting a copy from a Health Partners centre or requesting one to be posted and providing it back to *us*. This can be by mail or in person at one of *our* centres.

If the required information is not provided, we may do the following until received:

- a. withhold approval of an application;
- b. refuse to pay benefits that *you* may be entitled to under *your* individual cover; and
- c. suspend payment of benefits that *you* may be entitled to under *your* individual cover.

Transferring from another fund

Transferring couldn't be easier. Just include your *membership* details and *member* number from your current Australian health fund with your application and we will take care of the rest for *you*. Under the *Government Rules* we will also obtain a transfer certificate from your old insurer.

And, if *you* switch within 30 days to an *equivalent cover* you will not have to re-serve your waiting periods. This rule also applies to *pre-existing conditions*, where you have already served your 12 month *waiting period* with your current Australian health fund provider. As long as the *treatment* was not an exclusion or restricted service.

Membership Commencement

Your *membership* commences on the date your application is lodged and accepted by *us* or the date nominated in your application, whichever is the later. Backdating is not permitted.

Benefit entitlements will commence once *premiums* are paid and any applicable *waiting periods* are served as outlined in your individual cover.

Information you receive as a member

We will provide the *policyholder* with the below:

- a. *Private Health Information Statement* for the cover and *membership* type selected; and
- b. details of what the *membership* covers and how benefits are determined.

Once your *premiums* have been paid as outlined in your cover details, we will send a *membership* card to the *policyholder* and include a card for your *partner* where applicable, according to your *membership type*. You can also request additional cards for any *child dependants* registered and active on your *membership*.

Membership Card Rules

- a. your *membership* card is not transferable;
- b. your *membership* card gives you on-the-spot benefits where HICAPS or HealthPoint electronic payment systems are used;
- c. your *membership* card must be presented at Health Partners Participating Pharmacies when claiming pharmacy benefits and the 20% participating pharmacy discount;



- d. if you forget your membership card you will need to pay for your treatment in full, obtain an itemised receipt or account from the provider and submit your claim to us for payment. This excludes the 20% participating pharmacy discount – you must present your card to receive the discount;
- e. Health Partners Participating Pharmacies have the authority to confiscate Health Partners' cards and return them to us if they suspect misuse by a customer, for example the card is being used by someone not on the membership;
- f. your membership card must not be left with any health care provider or other third parties;
- g. your membership card remains the property of Health Partners;
- h. members must notify Health Partners if their card is lost or stolen;
- i. replacement cards can be requested using Members Online or by calling 1300 113 113;
- j. members must return or destroy their membership card if their membership is cancelled; and
- k. not all claims are payable via electronic claiming, for example some orthodontic claims.

In addition to the above, benefits are only paid in accordance to your individual cover and will only be paid where your premiums are not in arrears.

Cooling-off period

There is a 30 day 'cooling-off period' on all of our covers.

So if you're a new member and decide the cover chosen is not right for you, you can cancel your membership within 30 days and we will provide a full refund of any premiums you have paid – as long as no claims have been made.

If you're an existing member who has changed your level of cover, you can revert back to your previous level of cover within 30 days without affecting your waiting periods. The difference in premiums will be credited to your account (if applicable). This does not apply to members changing out of a closed product, members may not transfer back into a product that has been closed.

Where a claim has been made during the 30 day cooling-off period, the membership can only be cancelled (or changed) the day after the most recent claim. Refunds in premiums, if any will be calculated from this date.

Refusal of an application

We have the right to refuse an application for membership or cover type in any or all of the below situations;

- a. fraudulent activity by the proposed member;
- b. provision of misleading or untrue information;
- c. non-disclosure of required information; and
- d. unacceptable behaviour or misconduct as determined by us.

Once You're a Member

Now that *you're a member*, it's important to know how to make changes, payments and claim. We have also outlined important rules and conditions related to *your membership* that you need to know.

Changing your Membership Type

At Health Partners we understand *your* life stage can change. So you can change *your membership* type to suit *your* needs. Just simply contact *us* and we can help *you* through the process. Changes to *your membership* type will become effective once the request is accepted by *us*.

Below are some of the common changes that *you* might need to make to *your membership*.

Adding a newborn or dependant

Adding a *dependant* should be done within 60 days of *your child's* date of birth, or in the event of adoption or fostering, the date of obtaining legal guardianship. This will help *you* to avoid waiting periods. If a *dependant* is added after 60 days, waiting periods will apply, refer to *your* individual *cover* for details.

The *dependant* becomes active on *your membership* on the date *your* application is accepted by *us* or the date nominated in *your* application, whichever is the later. *Benefit* entitlements will commence once *premiums* are paid and any applicable waiting periods are served as outlined in *your* individual *cover details*.

Adding a *dependant* is done by the person applying for *membership* or the existing *policyholder*. This may result in a change in *membership* type and premium, for example, going from couple to family. We will advise *you* at the time of change any change in *your membership*.

Removing dependants

Removing a *dependant* can be done by giving notice to *us* of the change. The removal is effective on the date the notice is accepted by *us* or the date nominated in *your* request, whichever is the later.

Removing a *dependant* is done by the *policyholder* or can be done by the *dependant* if they are aged 18 or over. This may result in a change in *membership* type, for example, going from family to couple. We will advise the *policyholder* at the time of any change in *your membership*.

Benefit entitlements will cease on the effective date.

Student dependants

If a *child dependant* is a full time student, the *policyholder* for the *child dependant* must complete a Student Dependant Registration form and return it to us by the end of February in each year. This is done from when they turn 21.

We may require written information in relation to that *person* to ensure they qualify as a *child dependant*.

We hold the right to remove the *child dependant* from the *membership* and adjust the *membership* type accordingly, where the required written information is not received or complete.

At *our* discretion, we may allow a student who is not taking on a full-time study to be accepted as a *child dependant*.



Membership Changes and the Impact to Premiums and Benefits

A change in *membership* may result in a change to *premiums*.

- a. Where the *premium* is higher, the *policyholder* will be responsible for ensuring the required additional *premiums* are paid by the effective date.
- b. Where the *premium* is lower, we will re-calculate and extend the time period your *premiums* are due. Calculations are made in accordance with the *Government Rules*.
- c. Instead of extending the period for which *premiums* are paid, we may at *our* discretion refund some or all of the *excess premiums* relating to the period after the change. We may deduct an administration charge from any refund.

Payment Rules, Options and Frequency

For all payment options, it is the *policyholder's* responsibility to ensure *premiums* are paid in advance as set out in *your* individual *cover*. It is important to understand that where *premiums* become overdue, *your membership* may lapse, meaning *you* will not be able to access the benefits as detailed in *your* individual *cover* and you may be required to re-serve *your* waiting periods.

The maximum *premium* amount payable is 18 *months* in advance, or up to 31 July in the following year, whichever lesser. If *you* exceed the maximum amount permitted, a refund of any additional *premiums* will be processed.

We understand how *you* pay *your premiums* is a personal choice, so we have the below options available to *you*.

a. Direct Debit

Direct Debit provides an easy way to manage your *premiums*, your payments can also be made from either a nominated bank account or credit card.

Setting up *your* payments through this method entitles *you* to an extra 3% discount on *your premiums*.

Your payment frequency can be one of the following:

- i. Fortnightly – debits occur on Fridays only;
- ii. Monthly – debits occur on either the 1st, 8th, 15th or 22nd of a *month*;
- iii. Quarterly – debits occur on either the 1st, 8th, 15th or 22nd of a *month*;
- iv. Half-yearly – debits occur on either the 1st, 8th, 15th or 22nd of a *month*; or
- v. Yearly – debits occur on either the 1st, 8th, 15th or 22nd of a month.

Before establishing a Direct Debit please read and agree to the terms in the Direct Debit Service Agreement. A copy can be found on our website healthpartners.com.au

Once You're a Member

continued

b. Account notice

You can nominate to receive an Account Notice, we will post this to you and you can pay using any of the methods below:

- i. BPAY;
- ii. Australia Post Billpay;
- iii. 24 hour Australia Post BillPay phone service
131 816 – Visa and Mastercard accepted only
(payments via the above methods may take up to 48 business hours to be loaded on to your membership); and
- iv. Direct to us using Visa, Mastercard, American Express and EFTPOS. This can be done:
 - (i) By using Members Online;
 - (ii) By calling Member Care on 1300 113 113; or
 - (iii) In person at any Health Partners centre.

Your payment frequency can be one of the following and the account notice will be sent out before the 15th of the payment month:

- i. Quarterly;
- ii. Half-yearly; or
- iii. Yearly.

a. Payroll

Payroll is linked to your pay cycle and is only available for registered groups with us. Either contact your employer or call us for details.

Variation to Premium Rates

We may vary your premium rates at any time, in accordance with the *Government Rules*.

Where the premium is lower, we will re-calculate and extend the time period your premiums are due. Calculations are made in accordance with the *Government Rules*.

Premium Discounts

We may offer a discount to eligible members in accordance with the *Government Rules*. We will advise you if a discount can apply to you.

Arrears in Premiums

Premiums are considered to be arrears if a required payment has not been made by the date as set out in your cover details.

If your membership is in arrears, the below rules apply:

- a. for treatment provided within the arrears period benefits are not payable;
- b. we may deduct from any benefits payable to you the amount of these arrears;
- c. we can terminate your membership if premiums are more than three months in arrears, unless the policyholder and Health Partners come to an arrangement to recover the amount in arrears; and
- d. if a membership has been terminated, we may (at our discretion) reinstate a membership upon application by the policyholder, subject to the payment of any outstanding premiums.



Refunds

We are only required to refund *premiums* where:

- a. we have stated as part of these *Rules*; or
- b. the *Government Rules* require us to.

Waiting Periods

Different services, *treatments* and goods may have different *waiting periods*, please refer to *your* individual *cover* details for information specific to *you*.

Transferring from another health fund and the impact on waiting periods

If *you* are transferring from another Australian Health Fund and *you* have served the waiting period for an *equivalent cover*, meaning a *policy* with the same inclusions and limits, *you* will not need to serve the waiting periods again. This rule also applies to *pre-existing conditions*, where *you* have already served your 12 month *waiting period* with *your* current Australian health fund *provider*. As long as the *treatment* was not an exclusion or restricted service.

If *you* are transferring to a higher level of *cover*, waiting periods will only apply to any additional services, *treatments*, goods and any higher limits. During this time *you* will receive the same benefits *you* received on your previous *cover* – for a Health Partners *equivalent cover*. *You* will also continue to pay the same *excess* and *co-payments* (where applicable). Limits and benefits already claimed will count towards any yearly or lifetime limits.

If *you* have only partially served waiting periods with *your* previous fund, the remainder of the waiting period will be served with *us*. Any loyalty bonuses or accrued entitlements with *your* previous fund are not transferable to Health Partners.

The transfer must occur within 30 days of ceasing to be insured by the other insurer, otherwise all waiting periods will apply.

Transferring between covers with us and the impact on waiting periods

If *you're* a current member with *us* and change your level of *cover*, waiting periods apply for any increased benefits and limits of cover. During this period *you* will receive the same benefits. For *hospital cover* *you* will also pay the same *excess* and *co-payment* as *your* previous level of *cover*, if applicable.

When *you* change your *cover*, we will explain to *you* which benefits *you* can claim immediately and any waiting periods that may apply.

Transferring from your parents' cover and the impact to waiting periods

If *you* were registered as a *dependant* and become a *policyholder* or *partner* to a Health Partners membership within 60 days of ceasing to be *dependant*, *you* will not need to serve *your* waiting periods again.

If *you* are transferring to a higher level of *cover*, waiting periods will only apply to any additional benefits. During this time *you* will receive the same benefits *you* received on *your* previous *cover* – for a Health Partners *equivalent cover*. *You* will also continue to pay the same *excess* and *co-payments* (if applicable). Limits and benefits already claimed will count towards yearly and lifetime limits.

Once You're a Member

continued

Waiting periods for newborns, adopted or fostered children

Waiting periods do not apply to newborns, provided *you* add them to *your membership* within 60 days from their date of birth and any required *premiums* are paid.

Adopted or fostered *children* can also receive immediate cover (except for *pre-existing conditions*) provided *you* add them to *your membership* within 60 days of obtaining legal guardianship.

For the above to apply, *you* must provide appropriate documentation to us that verifies you (the *policyholder*) has full legal and financial responsibility for the *child/children* being added to a *membership*.

Children adopted from overseas must be eligible for full Medicare benefits before health insurance benefits can be paid for *hospital treatment*.

If *you* do not add *your* newborn, adopted or fostered child within the allocated 60 day period, full waiting periods will be applied from the date their *cover* commences.

Waiting periods for Gold Card Holders

Waiting periods do not apply to a *person* who:

- a. holds a *gold card*;
- b. was entitled to *treatment* under a gold card before applying for *insurance*; and
- c. applies for *insurance*, no longer than *two months* after ceasing to hold a *gold card*

Waiver of waiting periods

Waiting periods do not apply to *benefits* for *treatment* provided immediately after and related to an *accident* – this applies to hospital covers only, not extras.

Accidents must not have occurred within 1 day of membership commencement. When an accident has occurred within 1 day of membership commencing, the accident rule does not apply and waiting periods apply.

We may also at *our* discretion waive or reduce *waiting periods*. In addition, some *covers* may offer waiting period waivers, please refer to *your* individual *cover* details for information specific to *you*.

Rules for Pre-existing Conditions and the impact on waiting periods

In relation to *benefit* claims for *hospital treatment* or *hospital substitute treatment*, a 12 month *waiting period* applies for *pre-existing conditions*.

We will appoint a medical practitioner to advise *us* on whether or not a condition, illness or ailment for which *treatment* has been or is to be provided, is a *pre-existing condition*. In forming their opinion, *our* appointed medical practitioner must consider any information in relation to the condition given to them by the medical practitioner(s) who treated the *member*.



Members Online

Members Online is accessible to the *policyholder* through the *member* login page at healthpartners.com.au. Once registered, *you* can securely log in and access, view and update various *membership* details.

Correspondence is also accessed from Members Online (unless *you* have advised *us* otherwise).

By providing an email address when applying for *cover*, *you* will automatically be registered for the service and *you* will receive a confirmation email from Health Partners, including a user name and temporary password.

Terms and conditions of the service are available on the Members Online homepage at healthpartners.com.au.

Existing *policyholders* not already registered for this service can easily do so via the Members Online homepage at any time.

Benefits

Unless otherwise stated, *your benefits* are per *member* and per calendar year, meaning they reset on 1 January each year. As there are some exceptions, please refer to *your individual cover* details for information specific to *you*.

Understanding Benefits and Obtaining a Benefit Quote

There can be thousands of items and service codes linked to *your* benefits, for this reason *we* do not itemise them on *your* individual *cover* details.

To check if a specific item or service is covered, please contact *us* for a benefit quote. *You* will need to provide *us* with:

- a. *provider* name;
- b. *provider* number;
- c. item number(s) *you* wish to claim as given by *your provider*;
- d. the fees charged by *your provider* for each item; and
- e. for dental, *we* will require the tooth numbers.

The benefit covered can be represented in the following ways:

- a. Set Benefit – this is a specified *benefit you* receive back when *you* make a claim for that service or item.
- b. Benefit Percentage – the amount *you* get back is calculated as a percentage of the fee charged.
- c. Maximum amount – *you* can claim up to the maximum amount.
- d. Number of visits – *you* can claim up to the maximum number of visits during the specified period.
- e. Loyalty benefit – benefit is based on continuous length of *membership*.

The benefits can vary, refer to *your individual cover* details to see what benefits apply to *you*.

Once You're a Member

continued

Benefit Rules

Any benefits we pay are subject to all of the rules and conditions outlined below.

Benefits are only payable where:

- a. the *member* is covered for the *treatment* claimed;
- b. the *member* has served the *waiting period* for the *treatment* claimed on their *policy*;
- c. the *member* has limits remaining. If downgrading *your cover*, any *benefits* claimed on *your* previous cover will count towards *your* new lower limits for the same calendar year or period, and in some cases may mean limits are already exceeded for that year and no further *benefits* will apply;
- d. *premiums* on your *policy* are paid up to or in advance of the date of *treatment* claimed;
- e. the date of treatment is not within a *membership* suspension period on your *policy*;
- f. all required supporting documentation is provided, correctly completed and deemed satisfactory and accurate by *us*;
- g. *you* have authorised the *benefit* claim;
- h. the *benefit* claim is received within two years after the *treatment* date, please note benefits count towards limits for the year in which the *treatment* was provided;
- i. the *benefit* claim is for *treatment* provided within Australia by persons who satisfy *our recognition* criteria. Although uncommon, there are instances where a previously *recognised* provider may no longer be recognised by *us*. Please contact *us*, to determine if a *provider* is recognised and approved by *us*;
- j. the *benefit* claim is for *treatment* that has been provided - we will not pay *benefits* where pre-payment was made (including the purchase of any vouchers) for *treatment* not yet provided;
- k. the *member* has not exceeded a maximum of one *consultation* benefit per day, per provider;
- l. the *treatment* claimed cannot be claimed from any other source, including Medicare - we may pay a reduced benefit after *you* have claimed from another source where we are permitted to do so under the *Government Rules*;
- m. the *treatment* claimed has been provided to the *member* in person - consultations provided over the telephone or internet will not receive a benefit except where included as part of qualifying 'Health Management Programs' or 'Hospital to Home' as set out in these Rules;
- n. items are not purchased over the internet or telephone unless we have approved this provider to supply the items in this manner. Contact *us* prior to purchase to confirm item eligibility and *provider* recognition;
- o. required *co-payments* for eligible pharmacy prescriptions are paid for each pharmacy item dispensed. *Benefits* for multiple pack dispensing can vary and multiple *member co-payments* may apply;
- p. criteria has been met within Fund Rule 'Transferring from another Fund';
- q. criteria has been met within Fund Rule 'Transferring between covers with us and the impact on waiting periods';
- r. fees for goods claimed are not freight or postage charges;



- s. we believe the billing for *treatment* claimed is reasonable;
- t. *treatment* was required and was not provided in an unreasonable, improper or unlawful way. This includes for the intent of monetary gain or other advantage for yourself or any other member;
- u. *treatment* claimed was clinically appropriate and there is no pattern of over-servicing;
- v. the charge for *treatment* claimed is not lower than the *benefit* that would otherwise have been payable, in this case the *benefit* will be reduced to the amount of the charge;
- w. the charge is not higher than what would have been charged to an uninsured *person*, or *person* on a different cover for similar *treatment*; and
- x. criteria has been met within Fund Rules 'Provisional Payments' and 'Injury Rules and the impact on Claims', for *treatment* that we determine may be related to a claim for compensation.
- d. where *Medical Provider Agreements* are in place, *benefits* will be paid as set out in the schedules of each agreement;
- e. where *Medical Provider Agreements* are not in place, *benefits* will be paid according to *Government Rules*;
- f. where a medical *provider* has agreed to participate in the *medical provider agreement* referred to as 'Health Partners Access Gap Cover Scheme', *benefits* will be provided to cover the full cost, or all but a specified amount or percentage of the full cost of the medical *provider's* fee;
- g. *benefits* are not payable for hospital treatment for which no Medicare Benefits are payable, including cosmetic surgery, experimental treatment and clinical trials;
- h. *benefits* are not payable for procedures performed by a dentist;
- i. *benefits* are not payable for respite care;
- j. *benefits* are not payable for medical costs related to surgical podiatry, unless it is for the *treatment* of Podiatric surgery that is provided by a registered podiatric surgeon and is included in your cover;

There are also some additional rules relating to hospital benefits:

- a. hospital *benefits* are only payable when treatment is provided by an approved hospital, health care organisation or *provider* that meets our *recognition criteria*;
- b. where *Hospital Purchaser Provider Agreements* are in place, *benefits* will be paid as set out in the schedules of each agreement;
- c. where *Hospital Purchaser Provider Agreements* are not in place, *benefits* will be paid according to *Government Rules*;
- k. *benefits* are not payable for *hospital* treatment provided by a *medical practitioner* not authorised by the hospital to provide that *treatment*;
- l. *benefits* for *nursing home type patients*, will be paid according to *Government Rules*;
- m. *benefits* are not payable for emergency department fees;

Once You're a Member

continued

- n. *benefits* are not payable where *you* are considered an *out patient*. An *out patient* is where *treatment* is administered through the below and these are in most instances not be covered by private health insurance. These services may be claimable in part or in full through Medicare if you have an eligible Medicare card.
 - i. Emergency departments;
 - ii. *Treatment* rooms;
 - iii. *Out patient* clinics;
 - iv. Specialist *consultations*;
 - v. Lab tests and scans; and
 - vi. Any other hospital services that do not require *you* to be admitted to hospital as an in-patient (including *type 'C' procedures*, as detailed in the *Government Rules*).
- i. and your procedure results in a higher classification, the classification increases from the date of the procedure; and
- ii. where the procedure would otherwise have resulted in *you* moving to a lower classification, the classification is unchanged.
- d. continuous hospital – where *you* are discharged, and within seven days admitted to the same or different hospital for the same or a related condition. The two admissions are regarded as forming one period of continuous hospitalisation. 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; and
- e. continuous hospital stay greater than 35 days – if *you* are hospitalised continuously for a period of more than 35 days, *you* will be automatically classified as a *nursing home type patient* and *your* *benefits* will be reduced to the minimum default *benefits* for *nursing home type patients* according to *Government Rules*. The nursing home type patient classification will not apply if a medical practitioner responsible for *your* care in hospital provides us with certification that you require ongoing *acute care hospital treatment*, including the details of the condition(s) requiring *treatment* and the treatment to be provided.

Hospital conditions that impact on your hospital benefits:

- a. in calculating *benefits* for hospital accommodation, the day of admission will be counted as a day for *benefit* purposes and the day of discharge will not be counted as a day for *benefit* purposes, unless it is the day of admission;
- b. multiple procedures – if *you* undergo more than one operative procedure during the one theatre admission, the procedure with the highest fee in the Medicare Benefits Schedule determines your classification. Subject to the rules for continuous hospital;
- c. subsequent procedure – if *you* undergo a subsequent operative procedure during the same period of hospitalisation:

Where the *benefit* rules and conditions are not met, the *benefit* claim may be refused, suspended, withheld or reduced.



Injury Rules and the impact on Claims

In this rule:

- a. **Claim** means a reference to a demand or action (other than a *claim* for *Fund benefits*).
- b. **Compensation** means a monetary reimbursement an injured party receives to help make reparations after an injury.
- c. **Injury** includes any condition, ailment or injury for which *benefits* would, or may otherwise be, payable by *us* for expenses incurred in relation to its *treatment*.

If *you* have the right to receive *compensation* to an injury *you* must:

- a. inform *us* as soon as *you* know or suspect that such a right exists;
- b. inform *us* of any decision to *claim compensation*;
- c. include in any *claim for compensation* the full amount of all expenses for which *benefits* are, or would otherwise be, payable;
- d. take all reasonable steps to pursue the *claim for compensation* to our reasonable satisfaction;
- e. keep *us* informed of the progress of the *claim for compensation*;
- f. inform *us* immediately upon the determination or settlement of the *claim for compensation*; and
- g. upon settlement supply *us*, if requested, copies of all related settlement documentation and/or associated medical information in relation to the *claim for compensation* and damages.

Withholding Payment of Benefits relating to Injury

Subject to Fund Rule 'Benefits for Expenses subsequent to Compensation', where *you* appear to have a right to make a *claim for compensation* in respect of an injury but that right has not been established, we may withhold payment of *benefits* in respect of expenses incurred in relation to that injury.

Provisional Payments

Where a *claim for compensation* in respect of an injury is in the process of being made, or has been made and remains unfinalised, we may in our absolute discretion make a provisional payment of *benefits* in respect of expenses incurred in relation to the injury.

In exercising *our* discretion, we may consider factors such as unemployment or financial hardship or any other factors that it considers relevant.

A provisional payment is conditional upon *you* signing a legally binding undertaking and authority supplied by *us*, that contains an agreement by *you*, in consideration for the payment:

- a. to comply with the Injury Rules as outlined in this document;
- b. that the provisional payment is bound by these Fund Rules;
- c. to disclose to *us*, on request, all matters pertaining to the progress of the *claim* and details of any determination made or any settlement reached in respect of the *claim*;

Once You're a Member

continued

- d. to repay *us* the full amount of the provisional payment as a debt immediately repayable upon the determination or settlement of the *claim*, whether or not the terms of such a settlement specify that the sum of money paid under the settlement relates to expenses past or future for which *Fund benefits* are otherwise payable; and
- e. that we have specified rights of subrogation whereby *we* acquire all rights and remedies of you in relation to the *claim*.

Where Benefits have been paid by Health Partners

You must repay *us* the full amount *we* have paid in relation to the injury, upon the determination or settlement of the *claim* for *compensation*.

- a. Subject to Fund Rule 'Requirement to Repay Benefits may be Waived' where:
 - i. *we* have paid *benefits*, whether by way of provisional payments or otherwise, in relation to an injury; and
 - ii. *you* have received *compensation* in respect of that injury.

Rights of Health Partners

If *you* make a *claim* for *compensation* in relation to an injury and fail to:

- a. comply with any obligation as outlined in the Injury Rules or the rules relating to 'Where Benefits have been paid by Health Partners'; or
- b. include in *your* claim for compensation any payments of *benefits* by *us* in relation to an injury, *we* may without prejudice to our rights (including our broader subrogation rights) in our absolute discretion take any action permitted by law to:
 - i. assume that all expenses in relation to the injury have been met from the *compensation* payable or received pursuant to the *claim*; and/or
 - ii. pursue *you* for repayment of all *benefits* paid by *us* in relation to the injury; and/or
 - iii. assume legal rights in respect of all or any parts of *claim*.

Claim Abandoned

Benefits are payable (subject to other Fund Rules) if *you* sign a legally binding undertaking supplied by *us* and agree, in consideration for the payment of *benefits*, not to pursue the *claim*.

Where:

- a. *you* have or may have a right to make a *claim* for *compensation* in respect of an injury; and
- b. *we* have reasonably determined that *you* have abandoned or chosen not to pursue the *claim*.



Requirement to Repay Benefits may be waived

We may at *our* absolute discretion and subject to any conditions that we consider appropriate, determine that you need not repay any part or the full amount of the *benefits* paid by *us* in respect of the injury.

Where in respect of a *claim for compensation* in relation to an injury:

- a. *you* have complied with the Injury Rules outlined in this document; and
- b. we have 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 *us*.

Benefits for Expenses subsequent to Compensation

We may, in *our* absolute discretion, pay *benefits* where:

- a. expenses have been incurred as a result of:
 - i. a complication arising from an injury that was the subject of a *claim for compensation*; or
 - ii. the provision of service or item for treatment of an injury that was subject of a *claim for compensation*; and
- b. that the *claim* has been the subject of a determination or settlement; and
- c. there is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

Other Insurance

For the avoidance of doubt, *you* are not entitled to *benefits* for as much of the expenses as the *member* is entitled to recover under another *insurance policy* or would have been entitled but for this *insurance*. *You* must first *claim* under that *insurance policy*. This applies whether the other *insurance policy* provides full or partial coverage.

Benefits payable in accordance with these Rules will not exceed 100% of the fee charged for *treatment*, less any amounts recoverable from any other source.

Once You're a Member

continued

Limits

Unless otherwise stated, *your benefit* limits are calculated per *member* and per calendar year, meaning they reset on 1 January each year. As there are some exceptions, please refer to *your* individual *cover* details for information specific to *you*.

Where a limit applies, it can either be a:

- a. Annual limit - this is the maximum amount of *benefits* claimable in a calendar year for that service or item;
- b. Lifetime limit - the total amount *you* can claim in *your* lifetime across all health funds (for example, orthodontics). Once *you* reach the *limit*, no further *benefits* will apply in future;
- c. Combined limit - one *limit* across more than one service, as opposed to a single *limit* for one service. This provides flexibility for *you* to use the *limit* on the service that is more important to *you*, but provides security to know *you* still have cover just in case *you* need it; or
- d. Sub-limit - is part of (rather than in addition to) an overall *limit*. It indicates the total amount claimable for that particular service/item within an overall limit.

Claiming

How to claim

When it comes to claiming, choose the option that best suits *you*.

- a. Health Partners MyHealth phone app

Simply download the free app to *your* smartphone, register your details, take a photo of *your* itemised account and submit. With no paperwork or hassle, most *benefits* are generally paid within two to five business days of *your* claim being submitted. Please note *you'll* need *your* dependant code which is the number in front of *your* name on the *membership* card.

- b. Online

Policyholders can submit claims for anyone on the *membership* in three simple steps via Members Online at healthpartners.com.au. With no paperwork or hassle, most benefits are generally paid within two to five business days of *your* claim being submitted.

- c. On-the-spot

In most cases *your* claim can be processed on-the-spot whenever you visit a provider that utilises electronic claiming (such as HICAPS or HealthPoint). Simply present *your* membership card at the time of service and *you* will only have the gap to pay – or nothing at all, depending on *your* level of *cover* and available limit.



d. Post

Claim forms are available on *our* website, at *our* centres and upon request. Once the form is completed (with itemised accounts attached), *you* can mail it freepost to:

Health Partners Claims
Reply Paid 1493
Adelaide SA 5001

If *you* prefer, submit *your* claims in person at any Health Partners centre. Please note that over-the-counter cash claiming is not available.

Required information to include with your claim

Your claim must include an account and receipt from the *provider*. The account and receipt must include:

- a. the *provider's* name, ABN, *provider* number and address;
- b. the *patient's* full name and address;
- c. the date of service;
- d. the description of the service including any item numbers;
- e. the amount charged;
- f. any amounts already paid;
- g. any other information that Health Partners may reasonably requests;
- h. it must appear on the *provider's* letterhead or include the *provider's* official stamp; and
- i. any claim for hospital treatment expenses shall also be accompanied by a certificate of hospitalisation in a form approved by *us*.

By submitting a claim for *benefits*, *you* authorise *us* to contact the *provider* to clarify or obtain further information about the claim.

We may request a certificate from the *person* who provide the *treatment* relating to any matter which *we* determine is relevant to consideration of *your* claim, including:

- a. the precise nature of the *patient's* illness, injury or condition;
- b. the precise nature of the services or *treatment* provided;
- c. whether the *patient's* condition needed the use of medical, nursing, pathological, radiological and other diagnostic services, operating theatre, recovery room and anaesthetic facilities available at the premises;
- d. the period the *patient* was hospitalised; and
- e. any other information appropriate to the circumstances of the *claim*.

Where *we* request such information direct from the *person* who provided the *treatment*, *you* will, if required, authorise the *person* to make the information available direct to Health Partners for use by *us* or relevant government body.

Once You're a Member

continued

Refusing, Suspending, Withholding or Reducing Payment of a Claim or Benefit

We have the right to refuse, suspend, withhold or reduce a payment *claim* if *our benefit* rules and conditions are not satisfied.

We also have the right to refuse, suspend, withhold or reduce a *benefit* claim where the *treatment* was provided by to *you* by a family member/relative or business partner, this is at our discretion.

Subrogation of Rights in a Claim

- a. If a *person*, in *our* opinion, incorrectly charges a *member* for a service for which a *benefit* is payable, we may in the name of the *member* take or defend any action in connection with the charge, including an action to recover money overpaid.
- b. For this purpose *you* must do all acts and sign all documents that *we* require.
- c. If *you* fail to do this *we* may withhold benefits or not pay *benefits* for this service.

Payment of a Claim

By default, claim payments will be paid to the *policyholder*, or to the *provider* if the account is unpaid.

For claims made by a *policyholder's partner* or *dependant* (over the age of 18) for themselves, the payment can be made directly to them if requested by them at the time of claiming.

If an account for a claim is paid by a person other than the *policyholder* or *member*, Health Partners does not need to pay or require the *policyholder* or *member* to pay, that *person*.

Please note *benefits* cannot be paid into a credit card account.

Benefit payments are deposited by direct credit directly into *your* preferred bank account (or a cheque is provided if required). Simply supply *your* bank account details on *your membership* application, on the Member Claim form or any time via a Benefit Payments form.

You only need to supply these details once – the next time *you* submit a claim (either through our app, online or a claim form), simply tick the “direct credit” box and *we* will transfer *your benefit* to that same account.

Direct credit claim payments allow *benefits* to be put into *your* account much quicker than waiting for a cheque to be posted and subsequently deposited into your bank account and then waiting for it to be cleared.

Once direct credit payments have been processed, a Remittance Statement will be sent to *you* outlining the *benefits* paid.



Claims Security

All private health insurers are run according to the same strict solvency, capital adequacy and governance standards set out by the Australian Government, so *you* can feel secure when it comes time to claim.

We are regulated by the Australian Prudential Regulation Authority (APRA) and have Board approved strategies in place to assist in complying with our obligations under the Governance, Capital and Risk Management standards.

Suspensions

Overseas Travel Suspension

At *our* discretion we may approve suspending *your membership* for the period of time *you* are absent from Australia.

Your initial application for suspension for travel will only be considered where *you've* held continuous *membership* for at least one month and all *premiums* are paid to the date of departure. The minimum duration is three weeks to a maximum of two years.

Once reactivated for a duration no less than three months, a further suspension may be available at *our* discretion for a minimum duration of three weeks to a maximum of two years.

Over the life of the *membership*, suspending *your membership* for travel reasons cannot exceed a maximum of four years per event.

Where the reasons for suspension cease to apply, or the maximum period of suspension is reached the *policyholder* must reactivate the *membership* within one month.

Otherwise the *membership* and its related members are taken to be new for the purposes of these Rules and the *Government Rules*.

Your suspension commences the day after you leave Australia.

A suspension form must be completed prior to suspension, outlining all rules and conditions.

Financial Hardship Suspension

At *our* discretion we may approve suspending *your membership* for the period of time *you* are experiencing financial hardship.

Your initial application for suspension for financial hardship will only be considered where *you've* held continuous membership for at least six months, unless special approval is given.

The duration is only while *you're* experiencing financial hardship and cannot exceed 12 months.

Over the life of the *membership*, suspending *your membership* for financial hardship reasons cannot exceed three times.

Your suspension period commences on the day after the period ends for which *premiums* are paid or when suspended under 'Other' suspension rules.

A suspension form must be completed prior to suspension, outlining all rules and conditions.

Other Suspensions

We may at *our* discretion suspend a *membership* for any reason we see fit, for the terms and time period determined by *us*.

Once You're a Member

continued

Rules for Suspensions

For the duration of any suspended *membership*, the below rules apply:

- a. no *benefits* are payable;
- b. the period of suspension does not count towards any *waiting period* or *loyalty bonuses*; and
- c. a suspension is subject to the conditions, if any, which we may impose from time to time.

Loyalty Benefits and Length of Membership Rules

The below rules apply when calculating length of *membership* to be eligible for loyalty bonuses:

- a. each *member* must achieve the minimum length of *membership* on their *cover* to be eligible to receive any *loyalty benefits* available on your *cover*;
- b. your length of *membership* transfers with you between Health Partners equivalent *covers*, without breaking the continuous length of *membership* count;
- c. if you have terminated your *membership* and re-join us at another point in time, for the purpose of *loyalty benefits*, your length of *membership* will restart at the time you re-join us;
- d. the start date is when your *membership* has been processed and is financial, meaning the required *premium* amount has been received as outlined in your *cover* details;
- e. Health Partners do not recognise length of membership in another fund for the purposes of *loyalty benefits*; and
- f. where an approved suspension of *membership*

occurs, the below rules will apply:

- i. the period of suspension will not count for the purposes of *loyalty benefits*; and
- ii. the length of *membership* prior to the suspension will be included in any length of *membership* after the *membership* is reactivated.

Loyalty benefits do not apply on all *covers*. Please refer to your individual cover details for information specific to you.

Moving Interstate

Premiums and some *benefits* may vary slightly from state to state. If you are moving interstate, you will need to advise us of your new address within 14 days. We will then make the required changes and provide you with notice of any updates to your *premiums* and *benefits*.

Delegation of Authority

Delegation of Authority is automatically provided to any *partner* of the *membership* at the time of joining. This can be revoked at the request of the *policyholder* at any stage.

The *policyholder* can also give Delegation of Authority to anyone over the age of 18, even if they are not listed on the *membership*. Anyone who holds the Delegation of Authority can manage most aspects of the *membership*, including:

- a. updating personal details (e.g. address, phone number);
- b. changing the level of *cover*;



- c. changing the payment method;
- d. adding or removing a *dependant*;
- e. suspending and reactivating the *membership*;
- f. submitting claims on behalf of any *member* on the *membership* (excludes claims submitted via the MyHealth phone app);
- g. make general enquiries about the *membership*, including dental and optical appointments; and
- h. access personal health information such as medical details or conditions regarding other *members* covered on that *membership*.

This authorisation does not allow the nominated *person* to:

- a. cancel the *membership*;
- b. change the status of the *policyholder*;
- c. nominate further delegated authorities; and
- d. access or change passwords for the *policyholder's* Members Online account.

Any changes to the Delegation of Authority can be done by the *policyholder* at any time by contacting *us*.

Where other forms of legal authority apply, for example Power of Attorney, you will need to provide a copy of the document. This will enable us to determine what levels of authority apply.

Substitute Decision-makers

Designated substitute decision-makers can be nominated by the *policyholder* or by someone that holds an Advance Care Directive (including the Power of Attorney designation), an administration or guardianship order, from a relevant judicial body. Supporting documentation will be required at the time of adding a Substitute Decision-maker.

This enables them to make decisions on behalf of individuals who cannot do this for themselves. Substitute Decision-makers have all the functions held by someone with Delegation of Authority, plus:

- a. cancel the *membership*;
- b. change the status of the *policyholder*; and
- c. operate the *policyholder's* Members Online account.

Cancellation of Membership

Cancelling *your membership* can be done by either:

- a. removing *yourself* from a *membership*, but other *members* remain; or
- b. cancelling the entire *membership*, so all parties to the *membership* are also cancelled.

The *policyholder* may cancel the *membership* by giving us 30 days' notice from its commencement date, provided no *member* has claimed under the *membership*. This applies to any new *member* taking out *cover* or existing *members* taking out new *cover* with *us*.

Once You're a Member

continued

A *policyholder* that terminates their *membership* can apply to reinstate their *membership* with us without re-serving waiting periods. The request must be accepted by us and done within 30 days of the date of termination.

If the product is no longer available for new business, you will be reinstated to an equivalent product, waiting periods will apply to any additional *benefits*. During this time you will receive the same *benefits* you received on your previous cover. You will also continue to pay the same *excess* and *co-payments* (if applicable). Limits and *benefits* already claimed will count towards yearly and lifetime limits.

Improper Conduct

We may terminate or suspend a *membership*, or remove a *member* from a *membership* if in our opinion;

- a. a *member* gives misleading or untrue information to us for any reason including in an application, when making a claim or answering a request for further information;
- b. a *member* obtains or attempts to obtain any monetary or other advantage for themselves or for any other *member*, which they or the other *member* is not entitled to; or
- c. there is a pattern of over-servicing to a *member* or any other form of abuse by or for a *member*.

Transfer Certificate

In the event a *membership* is cancelled, we will provide you with a certificate as required by the *Government Rules*.

Notices and Changes to Rules

We may vary our Fund Rules at any time and will provide the required notice in line with the *Government Rules*.

We will provide an *adult member* with reasonable notice of the change where the change is considered to be detrimental to your interest, this applies to:

- a. the scope, level or amounts of *benefits* payable to you; or
- b. increase in *premium* rates (other than as an effect of rounding); or
- c. *treatment* included in a cover.

We will also provide an *adult member* with notice if the change:

- a. positively varies the scope, level or amount of *benefits* payable to you; or
- b. decreases the *premium* rates (other than as an effect or rounding); or
- c. the *treatment* included in your cover.



We may also provide notice of changes by:

- a. publishing the change in:
 - i. a Health Partners publication distributed generally to *members*; or
 - ii. a newspaper circulating generally in South Australia; or
- b. by including the change in the *Private Health Information Statement* given to an *adult* every 12 months.

Private Health Information Statements

- a. Health Partners must give an *adult* under each *membership* a copy of the *Private Health Information Statement* for the relevant *policy*:
 - i. when the *person* is first insured;
 - ii. at least once every 12 *months*; and
 - iii. if a change to these Rules is or might be detrimental to the interests of a *member*, as soon as practicable following the change.
- b. Health Partners must provide an up-to-date copy of a *Private Health Information Statement* to anyone who requests a copy.

Australian Government Initiatives

The Rebate

The Australian Government Rebate on Private Health Insurance was introduced as a financial incentive to help Australians afford private health cover. The rebate depends on *your* age, is income-tested and applies to all Health Partners products.

The rebate is indexed by the lesser of CPI of the percentage change in *your premium* each year, using a government calculated formula.

Claiming the rebate

You may claim the rebate as a reduction in *your premiums* by nominating a rebate tier. Alternatively, *you* can claim the rebate via *your* tax return.

Please note that if *you* have a Lifetime Health Cover (LHC) loading, the rebate is not claimable on the LHC component of *your* private health cover premiums.

Nominating a tier

You can determine *your* Rebate Tier by referring to the income thresholds and Rebate percentage tables. Nominate the tier appropriate to *your* circumstances when *you* join, or at any time by contacting us or using Members Online at healthpartners.com.au.

As we are not permitted to advise *you* on which rebate tier to select, if *you* are unsure, we recommend *you* contact your *tax* agent.

The income thresholds are subject to change and are determined by the Federal Government.

For more information please visit:

- healthpartners.com.au/health-insurance/rebate
- privatehealth.gov.au
- ato.gov.au

The information in the income threshold table relates to the 2018-2019 financial year.

Income thresholds

Base Tier	Singles	\$90,000 or less
	Families	\$180,000 or less
Rebate Tier 1	Singles	\$90,001 to \$105,000
	Families	\$180,001 to \$210,000
Rebate Tier 2	Singles	\$105,001 to \$140,000
	Families	\$210,001 to \$280,000
Rebate Tier 3	Singles	\$140,001 or more
	Families	\$280,001 or more

Single parents and couples are subject to the family tiers.

Rebate percentage

Private health insurance rebate effective from 1 April 2019 to 31 March 2020.

Base Tier	Aged under 65	25.059%
	Aged 65-69	29.236%
	Aged 70 or over	33.413%
Rebate Tier 1	Aged under 65	16.706%
	Aged 65-69	20.883%
	Aged 70 or over	25.059%
Rebate Tier 2	Aged under 65	8.352%
	Aged 65-69	12.529%
	Aged 70 or over	16.706%
Rebate Tier 3	Aged under 65	0%
	Aged 65-69	0%
	Aged 70 or over	0%



Lifetime Health Cover

Lifetime Health Cover (LHC) is a government initiative designed to encourage *you* to purchase and maintain *private patient* hospital insurance cover earlier in life.

If you have not taken out and maintained *private hospital* health insurance from the year *you* turn 31, *you* will pay a 2% LHC loading on top of *your premium* for every year *you* are aged over 30 if *you* decide to take out *hospital cover* later in life.

For example, if *you* wait until *you* are 40 years old *you* could pay an extra 20% on the cost of *your hospital cover*. If *you* wait until *you* are 50 years old, *you* could pay 40% more. The maximum LHC loading that can be applied is 70%.

LHC loading is not paid by all *people*. To avoid incurring an LHC loading, residents of Australia must ensure they hold an appropriate level of *private patient hospital cover* before they reach their LHC 'base day'.

For many people, LHC base day is 1 July following their 31st birthday, but this can change depending on personal circumstances.

LHC loadings apply only to *private patient hospital cover* – they do not apply to general *treatment cover* (also known as ancillary or extras cover).

The *premium* payable by a *policyholder* will be increased by an amount, if any, required by the Lifetime Health Cover provisions in the *Government Rules*.

For more information, visit privatehealth.gov.au

Certified age

In most cases, *your* certified age is the age on the 1st of July before the day on which *you* first took out *private hospital cover*. This is used to calculate *your* LHC loading. The minimum certified age is 30.

If *you* know *your* certified age, use the Certified Age table to determine the loading that may apply to *you*. For couples and families, look up the loading for each *partner*, add the loadings together and divide by two.

Certified age	LHC loading	Certified age	LHC loading
30	0%	48	36%
31	2%	49	38%
32	4%	50	40%
33	6%	51	42%
34	8%	52	44%
35	10%	53	46%
36	12%	54	48%
37	14%	55	50%
38	16%	56	52%
39	18%	57	54%
40	20%	58	56%
41	22%	59	58%
42	24%	60	60%
43	26%	61	62%
44	28%	62	64%
45	30%	63	66%
46	32%	64	68%
47	34%	65	70% (max)

Australian Government Initiatives

continued

Exceptions

You may be eligible for an exemption to the LHC loading if:

- you were born on or before 1 July 1934;
- you have been living overseas since 1 July following your 31st birthday or since 1 July 2000;
- you have migrated to Australia and became eligible for Medicare benefits in the last 12 months;
- you hold or have held a Gold Card; or
- you are an active *member* of the Australian Defence Force.

Permitted days

Permitted days are the number of days you are able to drop your *hospital cover* without affecting your loading. You can drop your *hospital cover* for a cumulative period of 1,094 days (i.e. 3 years less 1 day). Once you have used these permitted days without hospital cover, a 2% loading will apply for each year or part year you are without *hospital cover*.

You can drop your cover without using permitted days and without affecting your loading when:

- you have suspended your membership with us; and
- you are overseas for at least 12 months. You can return to Australia for visits of up to 90 days at a time and still be considered as being overseas.

Please be aware that if you do drop your *hospital cover*, you will need to re-serve hospital waiting periods upon re-joining.

Removal of LHC

We will remove your LHC loading after you have completed 10 years of continuous cover with one or more health funds, as outlined in the *Government Rules*.

Please note that although you can break up your 10 years of continuous cover with any of the above permitted periods without *hospital cover*, the breaks in cover do not count towards the 10 years.

You should also note that if you use up your full 1,094 permitted days, the continuity of your 10-year period of cover is broken. If you re-join *hospital cover* after exceeding the 1,094 days, you will have to pay an increased loading and you will have to restart your 10 years of continuous cover from the date of re-joining.

Youth Discount

The Youth Discount is an initiative designed by the Australian Government that allows Private Health Insurers to offer an aged based discount on *hospital cover* for 18 to 29 year olds. This does not apply to *dependants* on family covers.

This discount is completely voluntary, meaning insurers aren't obligated to give the discount.



We will be applying the discount to all hospital products for new and existing members from 1 April 2019.

Here are the maximum discounts by age that we will automatically apply to *your membership*:

Your age when you take out hospital cover	Your discount
18-25	10%
26	8%
27	6%
28	4%
29	2%

Once *you* have *your* age-based discount, it will stay in place until you turn 41 years old, unless otherwise notified by us. Calculations are based on the formula outlined in the *Government Rules*.

All *you* have to do is keep *your hospital cover* with Health Partners. If *you* upgrade or downgrade *your hospital cover* *your* discount will still stay in place.

Once *you* turn 41, *your* discount will then gradually phase out at 2% each year.

For more information refer to www.health.gov.au.

Medicare Levy Surcharge (MLS)

The Medicare Levy Surcharge (MLS) is a maximum 1.5% surcharge imposed on people who earn above a certain income and who do not have applicable private *hospital cover*. The level of surcharge depends on *your* level of income for MLS purposes and is payable in addition to the standard Medicare Levy. It may apply for any period during which *you* suspend *your hospital cover*; for example, if *you* suspend *your cover* for overseas travel.

The income thresholds table and Medicare Levy Surcharge table will help *you* determine if the MLS may apply to *you*. This information relates to the 2018-19 financial year.

Income thresholds

Base Tier	Singles	\$90,000 or less
	Families	\$180,000 or less
Rebate Tier 1	Singles	\$90,001 to \$105,000
	Families	\$180,001 to \$210,000
Rebate Tier 2	Singles	\$105,001 to \$140,000
	Families	\$210,001 to \$280,000
Rebate Tier 3	Singles	\$140,001 or more
	Families	\$280,001 or more

Medicare Levy Surcharge

Base Tier	Rate	0.0%
Rebate Tier 1	Rate	1.0%
Rebate Tier 2	Rate	1.25%
Rebate Tier 3	Rate	1.5%

For more information, including when the levy applies, levy percentages and surcharge thresholds, please visit ato.gov.au or call the Australian Taxation Office on 13 28 61.

What you need to know about your extras cover

With *extras cover*, you can claim for a range of services that generally aren't covered by Medicare and that aren't covered by *hospital cover*. The level of *extras cover* you choose will determine whether you are covered for a particular service.

Details on the services included with each *cover* can be found in individual cover details or on the Health Partners website. Any conditions mentioned below need to be read in conjunction with the Benefit Rules.

Membership types

The below *membership* types are available for all of our Extras (*General Treatment*) products:

- a. Single;
- b. Couple;
- c. Sole Parent;
- d. Sole Parent Family Focus;
- e. Family; and
- f. Family Focus.

Maximum Treatment

Benefits are limited to one *consultation per member*, per provider, per day for the same services, unless we approve additional consultations, which is at our discretion or unless stated on your individual cover.

Dental is the exception, allowing multiple consultations on the same day where a referral and *treatment* is required.

Ambulance Cover Conditions

At our discretion, we may allow you to use your Ambulance *benefit* to claim for a subscription to a state ambulance service. In these cases, this will be taken as **full use** of your annual ambulance *benefit*.

There are two types of ambulance services – non-emergency ambulance and emergency ambulance.

a. Non-emergency ambulance

If this is included in your *cover*, you will be covered for the cost of any service required on medical grounds that are classified as non-emergency (excluding clinic-car type transport).

Additionally, you will be covered for treatment where no transport is required. This will count towards your annual limit.

b. Emergency ambulance

You will be covered for the cost of service required on medical grounds (excluding clinic-car type transport) that is deemed or classed as 'emergency' only (emergency classification determined by approved ambulance provider). Additionally, you will be covered for *treatment* where no transport is required. This will count towards your annual limit.

Where you have both hospital and extras cover and each provide separate ambulance *cover*, both are applicable. The limit per service remains at \$20,000 per *person*.

Holding private health insurance does not restrict you from purchasing a separate ambulance subscription in your state of residence, if required.

Ambulance *benefits* do not extend to Norfolk Island.

Benefits and limits vary by cover, please refer to your individual *cover* to see what benefits apply to you.



Dental (including General, Major, Endodontic & Periodontics) Conditions

We will pay a *benefit* where *treatment* or services are provided by a recognised *provider*. Different *benefits* apply for Health Partners Dental versus *outside providers*. Please refer to *your* individual cover details to see what benefits apply to *you*.

Optical Conditions

We will pay a *benefit* where *treatment* or services are provided by a recognised *provider*. Different *benefits* apply for Health Partners Optical versus *outside providers*. Please refer to *your* individual cover details to see what *benefits* apply to *you*.

Benefits include prescription frames, lenses & contact lenses. Prescription lens add-ons items are limited to one item per lens, with the exception of lens hard coating and hardening. No *benefits* are payable for contact lens tinting, contact lens consumables or Orthokeratology contact lenses.

Orthodontic Conditions

We will pay a *benefit* where *treatment* or services are provided by a recognised *provider* and a treatment plan has been provided by the orthodontist or dentist (including estimated length of *treatment*). Waiver of the requirement for a treatment plan is at *our* discretion.

Please refer to *your* individual cover details to see if *benefits* apply to *you*.

Physiotherapy Conditions

We will pay a *benefit* where treatment is provided by a recognised *provider* for the *treatment* of a diagnosed clinical condition. Different benefits apply when *treatment* is provided within the *Health Partners physiotherapy scheme* versus *outside providers*.

If a physiotherapist provides *treatment* at a practice that is part of the *Health Partners physiotherapy scheme*, but that physiotherapist only holds 'limited registration' with the Australian Health Practitioner Regulation Agency (AHPRA), *benefits* will be paid according to the schedule for *outside providers*.

Treatment for any excluded natural therapy, as outlined in the Private Health Insurance Amendment Rules 2018 will not receive a *benefit*, unless the *treatment* forms part of an exercise-based intervention program prescribed by a health professional and is specific to you. Any *treatment*, including group sessions and classes, must be preceded by an individual assessment for a current health problem. Services will be considered excluded Natural Therapy *treatments* if they are in any way advertised, promoted or invoiced as such.

Please refer to your individual cover details to see if benefits apply to you.

What you need to know about your extras cover continued

Chiropractic, Osteopathic and Exercise Physiology Conditions

We will pay a *benefit* where *treatment* is provided by a recognised provider for the *treatment* of a diagnosed medical condition. Please refer to *your* individual cover details to see if *benefits* apply to *you*.

Pharmacy Conditions

Please refer to *your* individual cover details to see if *benefits* apply to *you*.

PBS Prescription

We will pay a *benefit* for *PBS* listed prescriptions that do not attract a government subsidy. They must be dispensed at a pharmacy which is a *Health Partners participating pharmacy*. You will only need to contribute the dispensing price, but no more than the maximum amount as detailed on *your individual cover* – whichever is the lesser.

Benefits will not apply for *PBS* prescriptions, where the prescription is dispensed for a greater quantity than the maximum quantity specified in the *PBS*.

Private Prescription

A private prescription is defined as a prescription other than those listed on the *PBS*, and that is dispensed as per a doctor's *S4* prescription or a pharmacist's *S3B* (recordable) prescription. This also includes compounding prescriptions.

For items listed on the *PBS* with authority conditions that do not meet these conditions and are dispensed as private prescriptions, benefits will be paid under the same conditions as a private prescription, as outlined below.

They must be dispensed at a pharmacy which is a *Health Partners participating pharmacy* or for members covered with National Extras who cannot access a *Health Partners participating pharmacy*, at *their* local pharmacy that meets *our* recognition criteria. You will only need to contribute the dispensing price, but no more than the maximum amount as detailed on *your individual cover* – whichever is the lesser.

Benefits do not apply for the below:

- a. if the medication is an over-the-counter purchase (including *S1*, *S2*, and *S3* non-recordable scripts);
- b. if the prescription is dispensed for a greater quantity than the manufacturers' largest listed pack size specified (including when written as an authority prescription and not listed as "authority required" in the Schedule); and
- c. Section 100 Schedule Authority prescriptions (excluding *IVF/GIFT treatment* prescriptions).

Vaccination

We will pay *benefits* for selected prescription vaccinations recognised by Health Partners. But only when they are supplied by:

- a. an approved vaccination provider that meets *our recognition criteria*; and
- b. a *medical practitioner*.

The same conditions and rules apply to those detailed above for private prescriptions.



Hormone and Allergen Implant

We will pay *benefits* for prescriptions recognised by Health Partners and supplied by a *medical practitioner*. The same conditions and rules apply to those detailed above for private prescriptions.

IVF Associated Drugs

We will pay *benefits* for prescriptions approved by Health Partners prior to a hospital admission for the purpose of In Vitro Fertilisation *treatment*. The same conditions and rules apply to those detailed above for private prescriptions.

Podiatry Conditions

We will pay a *benefit* where *treatment* is provided by a recognised *provider* for the treatment of a diagnosed clinical condition.

Benefits for 'in-rooms' surgical podiatry procedures are payable only when the *provider* is a Fellow of the Australian College of Podiatric Surgeons and the procedure is not performed in a hospital. This *benefit* is subject to the *Government Rules* for Surgical Podiatry.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Orthotics Conditions

Benefits for orthotics are payable only when fitted by a *recognised provider*. This is not eligible on all *covers*, please refer to *your* individual *cover* to see if *benefits* apply to *you*.

Psychology Conditions

We will pay a *benefit* where *treatment* is provided by a *recognised provider* for the *treatment* of a diagnosed clinical condition. *Benefits* are not payable for counselling or any other *treatment* not provided by a Health Partners recognised psychologist.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Other Therapies Conditions

We will pay a *benefit* where *treatment* is provided for Hypnotherapy, Acupuncture, Massage, Dietitian, Speech Therapy, Occupational Therapy, Eye Therapy and inclusions under Natural Therapies (Wellness add-on product). *Benefits* are only payable when performed by a *recognised provider* and where the recognition criteria has been satisfied.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Aids and Appliances Conditions

A health appliance is an item prescribed by a medical or health practitioner such as your doctor, physiotherapist or other specialist to help treat a particular medical condition or to compensate for reduced functionality. Like health aids, if included on *your* level of *cover*, some additional information will be required with each *benefit* you make.

What you need to know about your extras cover continued

Hearing Aids

You will need to provide evidence of the clinical need for this device from an Audiologist, Ear, Nose and Throat Specialist or other Medical Specialist, if requested by us.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Asthmatic Spray Appliance, Blood Glucose Monitoring Machine or Blood Pressure Machine

You will receive a *benefit* when prescribed by a *medical practitioner*. The *medical practitioner* must satisfy the recognition criteria and supporting documentation needs to be included with *your benefit* claim.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Sleep Apnoea Machine

You will need to provide satisfactory evidence from a *medical practitioner* or accredited Sleep and Respiratory Physician and include this with *your benefit* claim. You can purchase the Sleep Apnoea Machine using a reputable Australian online retailer with a valid ABN. The item must be TGA approved.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Sleep Apnoea Machine Support Service

If you purchase *your* prescribed apparatus from a Health Partners preferred *provider*, you will have an option to purchase a support service package. To receive a *benefit*, you will need to include the receipt with *your* claim.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Low Vision Optical Magnification Aids

You may be required to provide supporting documentation from a GP or Optometrist/Ophthalmologist, confirming *your* condition and requirement for Low Vision Optical Magnification Aids. In addition to the above, you will need to include a purchasing receipt with *your* claim. General daily living aids are not covered.

The Low Vision Optical Magnification Aids must be purchased from one of the below in order to receive a benefit:

- a. registered Optical store;
- b. the Royal Society for the Blind of SA (RSB); or
- c. *medical practitioner*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Circulation Booster

To receive a *benefit*, you will need to include with *your* claim the receipt for a Circulation Booster appliance and where requested from us, supporting documentation from a *medical practitioner* recommending the appliance. The Circulation Booster appliance must be purchased from a:

- a. surgical medical *provider*;
- b. pharmacy;
- c. *medical practitioner*; or
- d. Health Partners recognised *provider*.

This is not eligible on all *covers*, please refer to *your* individual *cover* details to see if *benefits* apply to *you*.



Royal District Nursing Service (RDNS) Conditions

You will receive a *benefit* for Royal District Nursing Service (RDNS), when the service is provided by a registered nurse who satisfies the *recognition criteria*. The service must be for management of an illness, injury or condition which does not require admission to a hospital, and is not *hospital-substitute treatment*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Healthier Living Conditions

Healthier Living benefits are designed to support *members* who are looking to improve the way they manage their health condition(s) and overall wellness.

Personal Health Assessment

You can perform a wellness health assessment using *our* Members Online portal through *our* website. The online assessment helps *you* identify areas in *your* health where *you* are doing well or may need improvement. The report you receive can also alert *you* to potential health or lifestyle risks, plus help *you* set targets to help *you* get to a healthy point in *your* life.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Quit Smoking Program

We recognise certain government quit smoking programs. If *you* successfully complete a program recognised by *us*, *you* will receive a *benefit* as details on *your* individual *cover*. This will be for the cost of nicotine replacement therapy, but it must be purchased from a Health Partners participating pharmacy.

To claim the *benefit*, *you* will need to provide *your* receipts as proof of purchase, along with the certificate of completion that is issued by the recognised government organisation.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Weight Management Program

You will receive a benefit as detailed on *your* individual *cover*, for the first months' membership or program joining fee. You will also receive a further *benefit* once *your* goal weight is reached through that program.

You will need to provide evidence that the program has been approved by *your medical practitioner*, if requested by *us*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

What you need to know about your extras cover continued

Bowel Cancer Screening

You will receive a *benefit* towards the cost of bowel cancer screening at a Health Partners participating pharmacy or recognised *provider*. To claim the *benefit*, you will need to include the receipt and supporting documentation that confirms *your* test is finalised along with *your* claim.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Mole Check Body Scan

You will receive a benefit towards a full or part body scan where a Medicare rebate is not applicable. It must be performed by a:

- a. Qualified Dermatologist;
- b. GP with qualifications in Primary Care Dermatology or Skin Cancer Medicine; or
- c. Registered Nurse or Melanographer who undertakes the examination but results are diagnosed by the Specialist GP or Dermatologist.

To claim the *benefit*, you will need to submit the receipt as proof of completion. This needs to be included with *your* claim.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Diabetes Association Membership

You will receive a *benefit* for *membership* to the diabetes association. This must be in the State you reside in. You will need confirmation of diabetes diagnosis from *your* medical practitioner, if requested by *us*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Gym and Fitness

You will receive a *benefit* for approved gym or fitness programs where it is required and designed to treat or relieve a specific health condition or conditions. The program must be supported by an approval form signed by *your* medical *practitioner*. The form signed by *your* medical *practitioner* must confirm the specific health condition or conditions being managed.

No *benefits* are payable if used for general fitness and for items excluded under the Private Health Insurance Amendment Rules 2018, including Pilates, Yoga and Tai Chi.

To claim the *benefit*, you will need to include the form with *your* claim.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.



Post-natal Lactation Consultation

Where a Medicare rebate is not applicable, *you* will receive a *benefit* for *consultations*. The *consultation* must be provided by a registered, qualified specialist midwife who is an International Board Certified Lactation Consultant (IBCLC).

To claim the *benefit*, *you* will need to include an itemised invoice for *treatment* with *your* claim.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Agreements and General Treatment Providers

Health Partners may enter into a special arrangement with a *person* who provides *general treatment* or a group of such providers, to provide *benefits* for particular *general treatment* services. *Providers* who enter into any such arrangements must at all times comply with the terms and conditions set out in the Health Partners General Treatment Recognition Policy.

The *benefits* that apply under these arrangements may differ from, and will take precedence over, those shown in *our* product schedules.

What you need to know about your hospital cover

Membership Types

The below *membership* types are available for those products listed:

Product	Membership Type
Gold Hospital	Single
Silver Hospital Plus	Couple
Silver Hospital	Sole Parent
Bronze Hospital	Sole Parent Family Focus
	Family
	Family Focus

If your product does not appear in the list it could be a closed *product* (not available for new members). Please refer to Closed Product section for further details.

Any conditions mentioned below need to be read in conjunction with the Benefit Rules.

Costs covered under your hospital cover

We pay *benefits* to contribute towards to cost of *your* medical expenses when you are admitted to hospital as an 'in-patient'. *Benefits* do not apply if *you* are treated by a hospital as an *out patient*.

You need to be formally admitted into a hospital or approved private day hospital by a doctor, for a stay to be considered 'in patient'. This includes admissions for day procedures and overnight stays. Hospitals and private day hospitals sometimes perform minor day procedures that would not normally require hospital admission, which are classed as '*out patient*' treatment. Care *you* receive in a hospital emergency departments is also *out patient* treatment.

You may choose to be admitted to a *private hospital*. Health Partners has contracts known as hospital *purchaser-provider agreements* with most *private hospitals* in Australia, which help to reduce *your* out-of-pocket expenses. If *you* are admitted to a *private hospital* that we do not have a *hospital purchaser-provider agreement* with, *you* may experience higher out-of-pocket costs.



If the *hospital treatment* you require is included in your *cover*, we will pay *benefits* for the following during your hospital admission:

- a. hospital accommodation;
- b. treating specialist(s)/doctors' fees;
- c. theatre fees;
- d. intensive care;
- e. dressings and other medical consumables;
- f. diagnostic tests;
- g. an extensive range of government-recognised surgically implanted prostheses;
- h. pharmaceutical prescription benefits relating to your admission, refer to Pharmaceutical conditions for details;
- i. we also cover allied health services provided during your admission, such as dental, physiotherapy and dietetics where they are included in our agreement with the hospital (*hospital purchaser-provider agreement*) or according to your level of extras cover, if held; and
- j. other additional services, depending on your individual *cover* for details.

We also support you before and after your hospital admission with a range of support programs such as Hospital to Home.

Any *benefits* payable are subject to the rules and conditions as detailed in Benefit Rules in the Once You're a Member section of this guide. Inclusions also vary between *covers*, for this reason please refer to your individual *cover* details for the inclusions specific to you.

Before going to hospital

Our 'Going to Hospital' brochure will provide you with everything you need to know. This includes important information you should know about out-of-pocket costs.

Excess Conditions

An excess is the amount you agree to pay towards your hospital accommodation. An excess assists in lowering your annual *premiums*, helping to keep your *cover* affordable.

An excess is payable by you for an overnight or same day hospital admission. It is paid to the approved hospital at the commencement of the admission.

You only pay the excess amount per rolling year. Where there is more than one *person* on a membership, there is a maximum of two excesses per membership, per rolling year. A rolling year is defined as 12 *months* from the commencement of the first day of any admission to an approved hospital.

Please refer to your individual *cover* to see if an excess applies to you and any additional rules.

What you need to know about your hospital cover continued

Co-payment Conditions

A *co-payment* is the daily amount *you* agree to pay towards *your* hospital accommodation. *Co-payments* are payable by *you* for an overnight or same day hospital admission.

You must pay the daily *co-payment* amount each time *you* go to hospital, but only to the maximum amount per rolling year. The *co-payment* is limited to a maximum of 5 days per person to a maximum of 10 days per *membership*, per rolling year. A rolling year is defined as 12 *months* from the commencement of the first day of any admission to an approved hospital.

They are paid to the approved hospital at the commencement of the admission. Please refer to *your* individual *cover* details to see if a *co-payment* applies to *you*. *Your* individual *cover* will also provide the daily amount payment, the maximum *you* will be required to pay and when the amount may not be payable.

If *you* have an *excess* on *your* individual *cover* this will be required in addition to the *co-payment*, unless otherwise stated in *your* *cover*.

Restricted Benefits Conditions

Restricted benefits may apply to *your* *hospital treatment*, which means *you* are only covered for minimum benefits, as determined by the *Government Rules*. This can lead to large out-of-pocket expenses.

In addition, where a *Medicare rebate* does not apply for *hospital treatment* that is included in *your* *cover*, *benefits* paid are in accordance with the default payment schedule as determined by *Government Rules*. This may result in large out-of-pocket expenses and limits may apply.

Please refer to *your* individual *cover* details to see if restricted *benefits* apply to *you*.

Restricted Hospital Psychiatric Services Conditions

Restricted Hospital Psychiatric Services means *you* are only *covered* for minimum *benefits*, as determined by the *Government Rules*. This can lead to large out-of-pocket-expenses. *You* have the ability to upgrade to a product that includes this service, without serving a waiting period to access the higher *benefits*. *You* can only do this once. *You* will still need to serve waiting periods for the additional inclusions on *your* upgraded policy, meaning those conditions that were excluded on *your* current *cover*.

Please refer to *your* individual *cover* details to see if restricted *benefits* for psychiatric services apply to *you*.



Ambulance Cover Conditions

At our discretion, *we* may allow *you* to use *your* Ambulance benefit to claim for a subscription to a state ambulance service. In these cases, this will be taken as **full use** of *your* annual ambulance *benefit*.

There are two types of ambulance services – non-emergency ambulance and emergency ambulance.

a. Non-emergency ambulance

If this is included in *your cover*, *you* will be covered for the cost of any service required on medical grounds that are classified as non-emergency (excluding clinic-car type transport).

Additionally, *you* will be covered for *treatment* where no transport is required. This will count towards *your* annual limit.

b. Emergency ambulance

Emergency ambulance *cover* is provided on all our other policies, giving *you* peace of mind.

You will be covered for the cost of service required on medical grounds (excluding clinic-car type transport) that is deemed or classed as 'emergency' only (emergency classification determined by approved ambulance provider). Additionally, *you* will be covered for *treatment* where no transport is required. This will count towards *your* annual limit.

Where *you* have both hospital and extras *cover* and each provide separate ambulance cover, both are applicable. The limit per service remains at \$20,000 per *person*.

Holding private health insurance does not restrict *you* from purchasing a separate ambulance subscription in *your* state of residence, if required.

Ambulance *benefits* do not extend to Norfolk Island.

Benefits and limits vary by *cover*, please refer to *your* individual *cover* to see what *benefits* apply to *you*.

Pharmaceutical Benefits Conditions

PBS government subsidised prescriptions

You will receive the full cost for *PBS* government subsidised prescriptions. The *benefit* only applies where the prescription is for *treatment* directly related to the reason for *your* hospital admission, and dispensed either while *you* are an in-patient or supplied on discharge.

The full cost referred to above includes *your co-payment*, and any special or member contribution, brand *premium* or therapeutic group *premium* otherwise payable by *you* under the *PBS*.

This *benefit* is not included on all *covers*, please refer to *your* individual *cover* details to see if *benefits* apply to *you* and any applicable limits.

What you need to know about your hospital cover continued

Non-PBS government subsidised prescriptions

You will receive *benefits* for Health Partners approved drugs or medicinal preparations not listed on the *PBS*.

The *benefit* only applies where the prescription is TGA approved for the condition for which you were admitted for *hospital treatment*, and dispensed either while you are an in-patient or supplied on discharge. *Benefits* will not be paid where the cost is covered under a *Hospital Purchaser-Provider Agreement*.

This *benefit* is not included on all covers, please refer to your individual cover details to see if *benefits* apply to you and any applicable limits.

Surgically Implanted Prostheses Conditions

Surgically Implanted Prostheses are pieces of equipment that are surgically implanted into the body during a hospital procedure, to replace or assist a bodily function.

For all items on the 'Prosthesis List' produced and published according to *Government Rules*, the benefit we pay will be 100% of the amount referred to as the 'minimum benefit' for each item. If the fee charged for an item is less than the 'minimum benefit', the *benefit* paid will be equal to the fee charged.

For surgically implanted prostheses that are ordered by a *medical practitioner* in private practice, but not listed on the Commonwealth Prostheses List, a *benefit* is payable on certain covers. Please refer to your individual cover details to see if *benefits* apply to you and any applicable limits.

The *benefit* only applies for surgically implanted prostheses when the devices are:

- a. supplied during hospital admission;
- b. successfully implanted and deployed during the approved procedure;
- c. TGA approved; and
- d. associated with an approved Medical Benefit Scheme (MBS) procedure, where a *Medicare rebate* applies.

Non-Surgically Implanted Prostheses and Appliances Conditions

Non-Surgically Implanted Prostheses are items that assist the body following a hospital procedure, helping to replace or assist a bodily function.

Benefits apply for wigs, prosthetic bras or erectile dysfunction prostheses following surgery and artificial eyes and limbs. *Benefits* do not cover any applicable freight charges, and are only applied after any applicable discounts, government payments or subsidies.

Please refer to your individual cover details to see if *benefits* apply to you and for details on any applicable limits.



Aids for Recovery Conditions

You will receive *benefits* for the purchase or hire of recovery aids up to six *months* following hospital admission. The *benefit* only applies where the item has been recommended by a registered *medical practitioner* or physiotherapist, with the purpose of assisting recovery and related to the hospital admission.

Items could include braces, splints, moon boots, crutches, wheelchair and bed pulley. You will need to provide an invoice from a recognised agency or pharmacy and submit it with *your benefit* claim.

Please refer to *your individual cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Compression Garments Conditions

You will receive *benefits* for the purchase of compression garments when an invoice is provided by a recognised agency or pharmacy and the item has been recommended by a registered *medical practitioner*, physiotherapist or occupational therapist.

The item must be required for the management of a specific medical condition. Items could include pregnancy shorts, lymphoedema garments, surgical and pressure stockings.

Please refer to *your individual cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Hip Safety Kit Conditions

You will receive *benefits* for the purchase of a hip safety kit if *you* have been diagnosed with osteoporosis or *you* have been assessed as at risk of hip fracture by a registered *medical practitioner*. You will need to provide an invoice from a recognised agency or pharmacy and submit it with *your* claim.

Please refer to *your individual cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Replacement Insulin Pumps Conditions

Benefits are only payable for a replacement Insulin Pump once a current pump's warranty has expired, supporting documentation is provided and *our* required form is completed by an accredited Diabetes Educator or Endocrinologist.

Please refer to *your individual cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Replacement Speech/Sound Processors Conditions

Benefits are only payable for a non-surgically implanted replacement speech/sound processor once a current processor's warranty has expired and replacement is clinically necessary. Supporting documentation and *our* required form is provided by an Audiologist or Medical Specialist.

Please refer to *your individual cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

What you need to know about your hospital cover continued

Surgical Podiatry Conditions

Benefits for surgical podiatry procedures are payable only when the *provider* is a registered podiatric surgeon who holds specialist registration in the specialty of podiatric surgery and meets *our recognition criteria*. *Benefits* cover:

- a. accommodation; and
- b. the cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Prostheses) Rules, as in force from time to time.

We also offer *benefits* paid to the Podiatric Surgeon. The procedure must be performed in a hospital or accredited day surgery.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Health Management Programs

Health Management programs are only available where an agreement is in place with a registered health care organisation and if it's included in *your* individual *cover*.

Health Coaching

If *you* are suffering from *chronic disease*, complex health or mental health issues and we determine that *you* require ongoing medical support, *you* will be entitled to register for a *Health Coaching* program. 100% benefit will be paid. This is a telephone-based information and support line, providing *you* support with self-management of these health conditions.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Newborn Support Program

Eligible *members* need to enrol for this program through Members Online, or by completing an enrolment form (available on *our* website or by calling us). Details of this program can be found on our website healthpartners.com.au.

Limit of one per pregnancy, per *policy*. Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Asthma Foundation Membership

You will receive a *benefit* for membership to Asthma Australia Ltd in the State *you* reside if *you* have a supporting letter from a *medical practitioner* confirming *you* are diagnosed with asthma.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.



Bone Density Test

Where a *Medicare rebate* is not applicable, you will receive a *benefit* for a Dual Energy X-ray Absorptiometry (DEXA) scan performed by a Medicare recognised radiologist. They must hold a Location Specific Provider Number (LSPN).

Please refer to *your* individual *cover* details to see if *benefits* apply to you.

Diabetes Education

You will receive a *benefit* for *consultations* with a recognised diabetes educator (credentialed by the Australian Diabetes Educators Association) for *members* diagnosed with Type 2 Diabetes. You must have a referral by a *medical practitioner* or specialist. The *consultation* must be in *person* and you must not be an admitted *patient* of a hospital at the time of *consultation*.

Please refer to *your* individual *cover* details to see if *benefits* apply to you.

Home Sleep Studies

You will receive *benefit* for sleep studies performed in *your* home if you have satisfactory evidence from a *medical practitioner* and if performed by one of our *preferred providers*.

Please refer to *your* individual *cover* details to see if *benefits* apply to you.

Home Nursing

A *benefit* will be payable for *home nursing* services:

- a. When *treatment* is provided by a registered nurse who satisfies the *recognition criteria*; and
- b. Where that *treatment* is for an illness or injury which would otherwise require admission; and
- c. *Treatment* of the kind provided in an approved hospital with the agreed *benefit* inclusions as detailed in *your* individual *cover*.

This is considered to be a hospital substitute program, meaning the rules as set-out in the *Government Rules* apply.

Please refer to *your* individual *cover* details to see if *benefits* apply to you and applicable limits.

Home Birth

You will receive a *benefit* for pre-natal and post-natal *treatment* provided at home, if provided by a registered midwife who satisfies the *recognition criteria*. *Benefits* are not payable for:

- a. Home birth services and hospital services provided on the same day;
- b. Pre and post-natal services if you plan to have *your child* in a hospita; or
- c. Any midwife services provided in a hospital.

This is considered to be a hospital substitute program, meaning the rules as set out in the *Government Rules* apply.

Please refer to *your* individual *cover* details to see if *benefits* apply to you.

What you need to know about your hospital cover continued

Hospital to Home Conditions

For details on what is included in our Hospital to Home program, refer to our Going to Hospital' brochure'.

Hospital Guide

Hospital Guide helps *you* navigate through *your* hospital journey with the ultimate goal of getting *you* home sooner. There is no cost to *you* and the option is available under all Health Partners Hospital covers.

You will need to qualify for the service by contacting *us* so we can assess *your* individual situation. If extra care or support is required, *we'll* refer *you* for a personalised care program that's developed and tailored to *your* health condition or procedure.

Hospital in the Home

This program is designed to make *your* transition from hospital to home easier. There is no cost to *you* and the option is available under all Health Partners Hospital covers.

You will need to qualify for the service by contacting *us* so we can assess *your* individual situation. If extra care or support is required, *we'll* refer *you* for a personalised care program that's developed and tailored to *your* health condition or procedure.

This is considered to be a hospital substitute program, meaning the rules as set out in the *Government Rules* apply.

Rehabilitation in the Home

A great alternative to in-hospital rehab. There is no cost and the option is available under all *Health Partners Hospital covers*.

You will need to qualify for the service by contacting *us* so we can assess *your* individual situation. If extra care or support is required, *we'll* refer *you* for a personalised care program that's developed and tailored to *your* health condition or procedure.

This is considered to be a hospital substitute program, meaning the rules as set out in the *Government Rules* apply.



Closed Products

The below products are no longer available to new *members*. If *you* are on one of these covers *you* may retain *your cover*, unless otherwise notified. To remain on the *cover*, *you* need to have continuous and unchanged cover. This also means, *you* cannot leave and return to this *cover*. If changes are requested due to unforeseen circumstances, approval is at *our* discretion.

Product	Applicable Membership Type	Effective Date
Classic Hospital Gold 25 Classic Hospital Gold 50 Classic Hospital Gold 500 Classic Hospital Gold 250 Classic Hospital Silver Plus	Single Couple Sole Parent Sole Parent Family Focus Family Family Focus	1 April 2017
Heritage Hospital Silver Plus Classic Hospital Gold Prime Living Family Essentials	Single Couple Sole Parent Sole Parent Family Focus Family Family Focus	1 April 2019
Classic Hospital Bronze Plus	Single Couple Sole Parent Family	1 April 2019
Single Starter	Single	1 April 2019
My Choice	Single Couple	1 April 2019
Family Essentials	Couple Sole Parent Sole Parent Family Focus Family Family Focus	1 April 2019

Privacy Policy

Health Partners is committed to providing quality and affordable health care services in a way which meets *your* needs. We understand and value *our* relationship with *you* and *our* obligation to protect the personal information *you* entrust to *us*, whether *you* are a *member* or not. In accordance with privacy legislation, we comply with the Australian Privacy Principles (APPs) in the *Privacy Act 1988* (Cth) (Privacy Act) in relation to *our* handling of *your* personal information.

The following is a summary of our Privacy Policy. If *you* would like to know more about how *your* privacy is protected, *you* may view a full copy of the Health Partners Privacy Policy at *our* website or by contacting *us*.

Your personal information

The type of personal information *we* hold about *you* depends on the nature of *your* relationship with *us* and the extent to which *you* have utilised *our* services. Such information includes *your* name, address, age, *dependants*, contact details (including telephone and mobile numbers and email addresses). Certain financial information may also be collected from time to time, including bank account and credit card details, Medicare numbers and details about *your* *contribution* payments and claims history.

We may also hold information concerning *your* employer if *you* have elected to pay *contributions* via a payroll deduction scheme. Sensitive information about *you* (including health information) may also be collected from time to time. All sensitive information will be collected in accordance with Health Partners Privacy Policy or as otherwise prescribed by the APPs.

If your personal information is not provided

If *you* do not provide *us* with all of the information *we* request, *we* may be unable to provide *you* with the products or services *you* require.

How we use your personal information

The primary purpose of the collection of *your* personal information is to enable *us* to provide health *benefits* and services to *you* and to fulfil *our* legal obligations as a registered private health insurer. To ensure that *we* can effectively provide *you* with the quality of health *benefits* and other services that *you* expect, *we* will use your personal information for:

- Claims processing and administration;
- Product development, marketing and research purposes (including social media marketing and Google) to improve and extend our range of services to *you*;
- Information technology requirements and systems maintenance;
- Investigating and resolving complaints about the provision of services by *us* (or organisations associated with *us*);
- Direct marketing initiatives in accordance with the APPs; or
- Compliance with any legislative and regulatory provisions.

You may contact *us* at any time to indicate *you* do not wish to receive direct marketing information from *us*.



When we disclose your personal information

We may disclose *your* personal information to *our* agents, contractors or service *providers* who act or provide their professional services on *our* behalf. The identity of these agents, contractors and service *providers* may change from time to time. In general, the types of *persons* and organisations *your* information may be disclosed to include:

- Federal and State health authorities, and government agencies including Medicare Australia;
- The Private Health Insurance Administration Council;
- The Australian Prudential Regulation Authority (APRA);
- Health service *providers* including hospitals, doctors, specialists and other medical and related professionals;
- Other service *providers* providing services associated with *your* health and wellbeing;
- *Our* outsourced contracted service *providers*, including:
 - payment systems operators,
 - mail houses,
 - recruitment organisations, and
 - research providers;
- *Your* employer (if part of a payroll deduction scheme);
- Third party social media sites that provide marketing services; and
- Other parties to whom we are permitted, authorised or required by law or the APPs to disclose *your* personal information.

Any law that requires the particular information to be collected

Health Partners is required under Commonwealth and State health legislation to collect, store and disclose certain personal information about individuals from time to time. The *Private Health Insurance Act 2007* (Cth), for instance, requires *us* to collect certain sensitive information as a condition of registration as a registered private health insurer.

You can access your personal information

You may request access to the personal or sensitive information that *we* hold about *you* at any time (although under the APPs some requests may be denied in certain circumstances). All requests should be made by writing to *us*, or by contacting Member Care.

For verification purposes, *we* may ask *you* to complete a personal information access request form, and *we* may also charge an administrative fee for this service (the amount of which will be advised at the time of *your* request).

Your responsibilities

It is a condition of *membership* that *you* ensure that every *person* on *your membership* is aware of the Health Partners Privacy Policy.

Dispute Resolution

If you have any issues or concerns regarding *your membership*, we encourage you to contact us. We have developed a Dispute Resolution Process to ensure *your* feedback is heard, addressed and responded to in a timely manner.

Our procedures are in accordance with International Quality Standard ISO 10002–2014 (Quality Management – Customer Satisfaction).

Step 1

Provide your feedback by:

Calling

1300 113 113

Emailing

ask@healthpartners.com.au

Mailing

Health Partners
Reply Paid 1493
Adelaide SA 5001

In person at one of *our* locations.

So that we can provide a response as quickly as possible, we ask that you provide:

- Any supporting documentation
- *Your membership* details
- Details on what you require from us to help resolve the matter

Step 2

We will promptly respond to you and endeavour to resolve any issues or concerns in accordance with *our* Dispute Resolution Process.

Step 3

Is only required if you are not satisfied with the resolution provided in Step 2 and wish to escalate the matter.

Provide your feedback by contacting our Dispute Resolution Officer:

Call

1300 113 113

Email

complaints@healthpartners.com.au

Mail

Dispute Resolution Officer
Health Partners
Reply Paid 1493
Adelaide SA 5001

Step 4

Dispute Resolution Officer will promptly respond to you and endeavour to resolve any issues or concerns in accordance with *our* Dispute Resolution Process.

If, after this, you are still not satisfied with the outcome, we will refer the matter to the Health Partners Chief Executive Officer.



Step 5

Is only required if *you* are not satisfied with the resolution provided in Step 4 and wish to escalate the matter.

Provide *your* feedback to the Private Health Insurance Ombudsman, who offer an external review of the matter. To ensure they promptly respond to *you*, please ensure the matter is addressed to the correct area, depending on *your* dispute.

Optical and Dental related general service disputes

This is used where the matter has not been resolved in Step 4 and requires an explanation, apology, refund, compensation, access to *your* health records, a change in policy at the place of health service for **Optical** and **Dental** only.

Provide *your* feedback to Health and Community Services Complaints Commissioner (HCSCC):

Call

(08) 8226 8666
1800 232 007

*(Toll free from Country SA landline)
Available Mon-Fri 9.00am to 5.00pm*

Fax

(08) 8226 8620

Email

info@hcscsc.sa.gov.au

Mail

HCSCC
PO Box 199
Rundle Mall SA 5000

Internet

hcscsc.sa.gov.au

Optical and Dental related disputes regarding practitioners and their conduct

This is used where the matter has not been resolved in Step 4 and *you* believe a Health Partners Optical and/or Dental practitioner is placing the public at risk, they are performing their duties in an unsafe way, or *you* are concerned about a practitioner's ability to make safe judgments because of their health.

Provide *your* feedback to Australian Health Practitioner Regulation Agency (AHPRA):

Call

1300 419 495

Available Mon-Fri 9.00am to 5.00pm

Email

ahpra.gov.au/About-AHPRA/
Contact-Us/Make-an-Enquiry

Mail

AHPRA
GPO Box 9958
Adelaide SA 5001

In Person

Level 11, 80 Grenfell Street
Adelaide SA 5000

Internet

ahpra.gov.au

For all remaining Membership and Fund Related disputes

This is used for all other matters not listed above that relate to *your* membership with *us*, or matters relating to Health Partners. It is only used where the matter has not been resolved in Step 4.

Provide *your* feedback to Private Health Insurance Ombudsman (PHIO):

Phone

1300 362 072

(select option 4 for Private Health Insurance during business hours)

1800 640 695

(free call from anywhere in Australia, excluding mobile phone calls)

Fax

(02) 6276 0123

Email

phio.info@ombudsman.gov.au

Post

Private Health Insurance Ombudsman
Commonwealth Ombudsman
GPO Box 442
Canberra ACT 2601

Internet

ombudsman.gov.au



At Health Partners, *we're* committed to providing *you* with the best possible service. Take a look at what *you* can expect from *us*.

We're not only friendly, we're attentive as well

When *you* visit Health Partners, *you'll* be greeted with a smile by someone who's not only polite, but will identify themselves and listen carefully to what *you're* saying. Friendly service also means ensuring *you* have up-to-date information, having things explained clearly and simply and providing *you* with a contact name – in case *you* have any further questions.

Responsive action is a great responsibility

If *you* call Health Partners, *you'll* be greeted by a real person – not a machine. *We'll* aim to personally answer 80% of calls within 30 seconds. *We'll* also respond to *your* correspondence within two working days and process *your* claims within five working days (faster, if *you* choose the direct credit benefit payment option). Every enquiry is important and *we'll* explain to *you* how we make a decision, how long it will take and contact *you* directly by phone or in writing once it's made.

Honesty and integrity - it could almost be our motto

When *you* deal with Health Partners, *we* undertake to apply *our* policies fairly and with a healthy dose of respect. *We'll* inform *you* of your rights, respect *your* privacy, act respectfully to all cultures and importantly, not discriminate against *you* in any way. *You* can be confident *your* information will be recorded accurately and stored properly and safely. *We'll* also explain how *you* can seek a review if *you're* unhappy with a decision *we've* made.

Improving our service is something we'll always do

By measuring member satisfaction each year and responding to *your* feedback, *we're* ensuring our service to *you* is always given the highest priority. *We'll* make sure *you're* kept informed of any new or updated products or services and provide *our* staff with the necessary skills and training required.

You'll always get the best out of us

Health Partners will review *our* Member Care Charter annually, make any necessary or appropriate changes and make sure *you're* kept up-to-date each year. *We* also believe it's important to operate at all times within the Private Health Insurance Code of Conduct.

We expect the same in return

We'll always strive to give *you* the very best service – and there are little things *you* can do to help. Things like treating *our* staff with the same courtesy, honesty and respect as *we* show *you*; respecting *our* property; letting *us* know if *you're* having difficulty meeting *your* payment obligations; managing *your* dental and optical appointments responsibly and advising *us* if *you* can't attend; ensuring the information *you* provide *us* is accurate and up-to-date; and making sure *you* read correspondence *we* send *you* as it may contain important information that affects *your* benefit entitlements and/or premiums, which *we* are legally required to provide.

Health Partners values and welcomes *your* feedback; please let *us* be the first to know if *you're* unhappy with any aspect of *our* service.



Credits to the Fund

Health Partners must credit to the *Fund*:

- a. all the *assets* of the Health Partners *Fund* as of the day this *Fund* is established;
- b. all *premiums* paid under *memberships*;
- c. all amounts received in connection with its conduct of the business of the *Fund*;
- d. any amount borrowed for the business of the *Fund*; and
- e. all other amounts required by the *Government Rules* to be paid to the *Fund*.

Debits from the Fund

Health Partners may only apply the assets of the *Fund* for:

- a. meeting *policy* liabilities;
- b. meeting other liabilities or expenses of the business of the *Fund* including liabilities or expenses:
 - i. incurred in providing, or arranging to provide, professional medical services, *hospital treatment*, *out patient* services or other related health services for *members*;
 - ii. which are treated for a restructure or arrangement approved under the *Government Rules* as *policy* liabilities or other liabilities incurred for the purposes of the *Fund*; or
 - iii. incurred in operating the *health insurance business* and the *health related business*;
- c. making investments in accordance with the *Government Rules*;
- d. providing a mortgage or charge in accordance with the *Government Rules*;
- e. transfer to another Health Partners *Fund* in accordance with the *Government Rules*;
- f. transfer to a *fund* of another private health insurer in accordance with the *Government Rules* where the *insurance* policies that are **referable** to the *Fund* become referable to the *Fund* of the other private health insurer; or
- g. any of the other purposes in the *Government Rules*.



Termination of the Fund

- a. Health Partners may only terminate the *Fund* under and in accordance with the *Government Rules*.
- b. Health Partners must comply with the *Government Rules* that relate to termination of the *Fund* including:
 - i. not entering into *insurance* policies referable to the *Fund* after termination is approved;
 - ii. giving notice to *members* stating the day from which it will not renew *insurance* policies referable to the *Fund*;
 - iii. not renewing these *insurance* policies after this time; and
 - iv. paying the assets remaining after termination is complete in accordance with the *Government Rules*.

Definitions and Interpretation



Where *you* see a word in italics like *this*, it means the word is defined in this section, or in the *Government Rules*. This will assist *you* in gaining a reasonable understanding of the Rules.

Interpretation

In these Rules:

- headings do not affect interpretation;
- words and phrases written in *italics* are defined in Definitions;
- unless otherwise specified, the 'Definitions' apply throughout the Rules;
- where a word or phrase is defined, its other grammatical forms have a corresponding meaning;
- where not defined, words and expressions are intended to have their ordinary meaning;
- the singular includes the plural and vice versa;
- a gender includes the other genders;
- a reference to the word 'include' in any form is not a word of limitation; and
- a reference to any legislation includes all amendments to it and any legislation enacted in substitution for it and all statutory instruments and rules issued under it and in force.

Definitions

In these Rules:

Accident means an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or damage to the Insured Person's body that has occurred in Australia. It must result in the need for medical advice or *treatment* from a registered Medical Practitioner (other than anyone on the same Policy) within 72 hours of the event, and if needed, any further *treatment* within 180 days of the event. Accidents must not have occurred within 1 day of membership commencement. When an accident has occurred within 1 day of *membership* commencing the accident rule does not apply and waiting periods apply.

Acute care means *hospital treatment* where the primary clinical purpose or *treatment* goal is to, manage labour (obstetric), cure illness or provide definitive *treatment* of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce the severity of an illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, or to perform diagnostic or therapeutic procedures.

Adult means a *person* who is not a *child dependant*.

Asset means a resource with economic value that Health Partners owns or controls.

Benefit means an amount payable by Health Partners to or for a *member*, in respect of expenses incurred by a *member* for *treatment*, in accordance with the terms and conditions of these Rules.

Board means the Board of Directors of Health Partners.

Definitions and Interpretation

continued

Child means:

- a. a natural *child*;
- b. an adopted *child*;
- c. a foster *child*;
- d. a step-*child* (that is a natural, adopted or foster *child* of the *policyholder's partner*); and
- e. another *child* deemed by Health Partners to be in full care and the responsibility of the *policyholder*.

See also *Child Dependant*.

Closed Cover/Policy/Product is one which is no longer available for sale, but which continues to cover existing *members* still on it. Current *members* on these levels of *cover* may retain their *cover* whilst the *membership* remains continuous and unchanged. If they leave the *cover* at any time after its closure, either by choice, change of circumstances or by becoming unfinancial (*membership* payments have not remained up to date), they cannot re-join it.

Complying Health Insurance Product means an insurance *policy* that meets:

- a. Community rating requirements;
- b. Coverage requirements;
- c. If the *policy* covers *hospital treatment*, *benefit* requirements;
- d. Waiting period requirements;
- e. Portability requirements;
- f. Quality Assurance requirements; and
- g. Any other requirements as set out in the Private Health Insurance (Complying Product) Rules.

Chronic disease means an illness "that is prolonged in duration, does not often resolve spontaneously, and is rarely cured completely".

Features common to most *chronic diseases* include:

- a. complex causality, with multiple factors leading to their onset;
- b. a long development period, for which there may be no symptoms;
- c. a prolonged course of illness, perhaps leading to other health complications; and
- d. associated functional impairment or disability.

Consultation means an attendance by a relevant *provider* on, and in the physical presence of, a *patient* or as otherwise approved by Health Partners.

Contribution see *Premium*.

Contributor see *Policyholder*.

Co-payment means the amount a *member* agrees to pay each time a service is provided.

Cover (also referred to as *policy*) means a defined group of *benefits* payable under these Rules for expenses incurred by the *member*.

Dependant means a *person* who is:

- a. the *policyholder's partner*, or
- b. a *child dependant*.



Dependent Child/Child Dependant means a *person* who:

- a. is a *child* of the *policyholder* or the *policyholder's partner*;
 - i. aged under 21, or
 - ii. a full time student over 21 and under 25 (also known as '*student dependant*'), or
 - iii. a non-student over 21 and under 25 (also known as '*young adult dependant*'); and
- b. does not have a *partner*.

Dependent child non-student (also known as '*young adult dependant*') means a *person* who is:

- a. aged between 21 and 24 (inclusive);
- b. is a *dependent child*;
- c. does not have a *partner*; and
- d. is not completing full-time education at a school, college or university.

Equivalent cover means a level of *cover* offered by another fund which Health Partners considers to be equivalent to a level of *cover* offered by Health Partners.

Excess means an amount that a *member* agrees to pay towards the cost of hospital treatment, in exchange for lower *premiums*.

Extras Cover see *General Treatment*.

Fund means the health *benefits* fund established by Health Partners and governed by these Rules.

General treatment means *treatment* (including the provision of goods and services by a recognised *provider* in person) that is intended to manage or prevent disease, injury or condition, and is not *hospital treatment* but may or may not include *hospital substitute treatment* as defined in the *Private Health Insurance Act 2007*. Also referred to as *Extras Cover* or *Ancillary Cover*.

Government Rules means *Private Health Insurance Act 2007* and the Private Health Insurance Rules made under that Act, as well as the *Health Insurance Act 1973* and the rules made under that Act.

Group scheme means a scheme under which Health Partners and the employer of a *member* agree that the employer will deduct from amounts payable to the *member* at the *member's* direction, *premiums* due to Health Partners and pay the same to Health Partners.

Health Coaching (formerly "Chronic disease management program") means a program that is intended to either reduce complications in a *person* with a diagnosed *chronic disease* or prevent or delay the onset of *chronic disease* for a *person* with identified risk factors for *chronic disease* and which complies with the *Government Rules*.

Health Partners participating pharmacies means the network of pharmacies who have entered into an agreement with Health Partners.

Health Partners physiotherapy scheme means the network of participating physiotherapists who have entered into an agreement with Health Partners.

Definitions and Interpretation

continued

Health insurance business in compliance with the definition under the *Government Rules*, means Health Partners' *health insurance business* of undertaking liability relating to the *hospital treatment* and/or *general treatment* of its members, by way of *insurance*.

Health related business in compliance with the definition under the *Government Rules*, means Health Partners' *health related businesses* of:

- a. providing optical and dental services and goods;
- b. undertaking liability, by way of *insurance*, to indemnify people who are ineligible for Medicare for costs associated with providing *treatment*, goods or services, that are provided to those people in Australia and are provided to manage or prevent diseases, *injuries* or conditions; and
- c. providing a financial service to assist people insured under *complying health insurance products* to meet the costs associated with *treatment*, goods or services that are provided to manage or prevent diseases, *injuries* or conditions.

Home nursing means nursing in a home by a registered nurse who meets the *recognition criteria* and where the *treatment* is not *hospital treatment*.

Hospital cover means a *membership* which covers some or all *hospital treatment*.

Hospital Purchaser-Provider Agreement means an agreement between Health Partners and a private hospital or private day hospital, where Health Partners must pay and that hospital must accept a schedule of agreed prices in full payment for *hospital treatment* provided to Health Partners' *members covered* for this *treatment*.

Hospital substitute treatment means *treatment* that substitutes for an episode of *hospital treatment*, and is *general treatment* and is any of, or any combination of, nursing, medical, surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology, or goods and services intended to manage disease, injury or condition as defined in the *Private Health Insurance Act 2007*.

Hospital treatment means *treatment* (including the provision of goods and services) that is intended to manage disease, injury or condition, where that *treatment* is provided by a *person* who is authorised by a hospital to provide that *treatment* or, a *person* under the control of such a *person*; and is provided at a hospital or in direct control of a hospital, as defined in the *Private Health Insurance Act 2007*.

Main member see *Policyholder*.

Medical practitioner means a *person* who is registered or licensed as a *medical practitioner* under an Australian law and who satisfies the *provider* eligibility requirements for the payment of Medicare *benefits*.

Medical provider agreement means a contract between Health Partners and medical practitioners that allows us to pay *benefits* in excess of the Medicare Benefits Schedule fees for those practitioners' services.

Medicare Rebate means a payment made to an eligible person under the Australian Government's Medicare Scheme.

Member means each insured *person* being the *policyholder* and each of their *dependants* who are registered under these Rules and for the avoidance of doubt, includes any reference to a *contributor*.



Membership means a *policy* of health insurance referable to the *Fund*.

Membership type means a category described below containing the number and kinds of people described:

- a. *single membership*, which comprises only one *person*;
- b. *couples membership*, which comprises only two *adults* who are the *policyholder* and their *partner*;
- c. *single/sole parent membership*, which comprises only one *adult*, who is the *policyholder* and one or more *dependent children*; and
- d. *family membership*, which comprises only two *adults*, who are the *policyholder* and their *partner* and one or more *dependent children*.

Month or **Monthly** means a calendar *month*.

Nursing home type patient is defined in *Government Rules* and means a *patient* in hospital who has been provided with accommodation and nursing care for a continuous period exceeding 35 days and is then receiving accommodation and nursing care as an end in itself.

Out patient means a *patient* of a hospital who is not an admitted *patient*, with the exception of qualifying day procedures and treatments.

Outside provider means a *provider of general treatment* whose business is neither a *Health Partners health related business* nor do they have a contract with Health Partners for the provision of *general treatment*.

Partner in relation to a *policyholder* means a *person* who:

- a. is married to the *policyholder*;
- b. is a de facto spouse of the *policyholder*; or
- c. irrespective of gender, is in a genuine domestic relationship with the *policyholder* with them together being a couple.

Partner in relation to a *child dependant* means a *person* who:

- a. is married to the *child dependant*;
- b. is a de facto spouse of the *child dependant*, or
- c. irrespective of gender, is in a genuine domestic relationship with the *child dependant*, with them together being a couple.

Note: If a child dependant has a partner as defined within these Rules, they are not eligible to be covered as a dependant under a family membership.

Patient means a *person* receiving or registered to receive *treatment*.

PBS means the Australian Government's Pharmaceutical Benefits Scheme

Person includes a firm, a body corporate, an unincorporated association or any authority; a reference to a *person* includes its executors, administrators, successors and permitted assigns.

Policy means a *complying health insurance product* detailing the terms and conditions of that product.

Policyholder means a *person* whose name an application for membership of Health Partners has been accepted, and who is responsible for payment of *premiums*.

Definitions and Interpretation

continued



Pre-existing condition means where a *member* has an ailment, illness or condition that, in the opinion of a *medical practitioner* appointed by Health Partners, the signs or symptoms of which existed at any time during the six *months* preceding the day on which the *member* became insured for *treatment* relating to that ailment, illness or condition under a *policy*.

Premium means the amount a *policyholder* is required to pay for a specified period of *cover*.

Private Health Information Statement means a statement that is provided by Health Partners that provides a summary of a *complying health insurance product's* key features and *premium* as defined in the *Government Rules*.

Private hospital means a *hospital* that is approved as a *private hospital* under an Australian law or any other *hospital* recognised by Health Partners as a *private hospital*.

Private patient means a *person* who is admitted to a public or *private hospital* as an acute care *patient* and who is not a *public patient*.

Provider means:

- a. a *person* who provides goods or services as, or as part of, *hospital treatment* or *general treatment*; or
- b. a *person* who manufactures or supplies goods provided as, or as part of, *hospital treatment* or *general treatment*.

Public patient means a *person* who is admitted to a *public hospital* and who receives *treatment* as a Medicare patient without charge.

Recognition criteria means the following conditions apply to a *person* who is a *provider of treatment* that we will pay *benefits* for:

- a. the *person* is registered, or holds a licence, under any relevant State or Territory legislation to render *treatment* for which recognition is sought;
- b. the *person* is professionally qualified or a member of a professional body recognised by Health Partners;
- c. the *person* maintains comprehensive and accurate *patient* records that are made at the time of *treatment*, or as soon as practicable after, that clearly identify the *patient* and the *treatment* provided, and are written in English and understandable by a third party;
- d. the *person* provides facilities that meet the standards determined or recognised by Health Partners and the *Government Rules*; and
- e. the *person* fulfils the other criteria that Health Partners considers reasonable and appropriate from time to time.

Resolution policy means Health Partners policy for resolving disputes with *members* determined by the *Board* from time to time.

Responsible Adult has the same meaning as a Private Health Incentive Beneficiary (PHIB) as defined in the *Government Rules*.

Treatment means health or medical *treatment* to manage, prevent or alleviate a condition, disease or injury by the provision of either or both of a good or service.

Waiting Period means a specific period after a new *cover* has commenced during which benefits are not payable or *benefits* are only payable as per the entitlements of a previous cover or policy for *treatment* received.

We/Us/Our means Health Partners.

You/Your means the *member* and/or *policyholder*.

Where to find us

Health Partners Administration

(registered office)

Adelaide

Level 3, 101 Pirie Street, Adelaide SA 5000

Phone 1300 113 113

Fax (08) 8113 2259

Web healthpartners.com.au



Health Partners Member Care



Adelaide

101 Pirie Street, Adelaide SA 5000

Modbury

Level 1, 27 Smart Road, Modbury SA 5092

Morphett Vale

118-120 Main South Road, Morphett Vale SA 5162

Phone 1300 113 113

Fax (08) 8113 2259

Email ask@healthpartners.com.au

Webchat healthpartners.com.au

Health Partners Optical



Adelaide

101 Pirie Street, Adelaide SA 5000

Phone 1300 115 115

Goodwood

92 King William Road, Goodwood SA 5034

Phone 1300 116 116

Modbury

27 Smart Road, Modbury SA 5092

Phone 1300 127 127

Morphett Vale

118-120 Main South Road, Morphett Vale SA 5162

Phone 1300 191 191

Health Partners Dental



Adelaide

101 Pirie Street, Adelaide SA 5000

Phone 1300 114 114

Modbury

27 Smart Road, Modbury SA 5092

Phone 1300 114 114

Morphett Vale

118-120 Main South Road, Morphett Vale SA 5162

Phone 1300 114 114

Barossa Dental

37 Barossa Valley Way, Nuriootpa SA 5355

Phone (08) 8562 1444

Call 1300 113 113 (SA) or 1800 182 322 (interstate and SA country)

Visit healthpartners.com.au

Email us ask@healthpartners.com.au

Health Partners is a registered private health insurer since 1937.
All information in this brochure is effective 1 April 2019.
Health Partners Ltd ABN 43 128 282 904

