Fund Rules

All registered Health Funds are required to have and maintain a set of Fund Rules under the Private Health Insurance Act, which set out the general principles and rules of membership with that Fund.

By taking out private health insurance with Health Partners, all members on a membership agree to be bound by these Rules, together with the terms and conditions set out in the Member Guide/Product Disclosure Statement and any other Health Partners policy relevant to Members such as the Privacy Policy, Dispute Resolution Policy, etc.

Fund Rules should be read in conjunction with the individual cover details Members receive on joining or changing cover. If you no longer have, or did not receive, a copy of your cover details please let us know on 1300 113 113.

Effective April 2018

Health Partners
Your Health Insurance Partner

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A - INTRODUCTION

A1 Rules Arrangement

A1.1 Contents of Rules

These Rules consist of:

(1) General Conditions (Rules A to G); and

(2) Schedules of Contribution (Premium) Rates, Benefits and Specific Conditions (schedule).

A1.2 Rules Arrangement

These Rules are arranged as follows:

Part A – Introduction	Clauses A.1 to A.10
Part B – Interpretation and Definitions	Clauses B.1 to B.2
Part C – Membership	Clauses C.1 to C.10
Part D – Contributions (Premiums)	Clauses D.1 to D.5
Part E – Benefits	Clauses E.1 to E.3
Part F – Limitation of Benefits	Clauses F.1 to F.7
Part G – Claims	Clauses G.1 to G.1
Schedules	Clauses H to M

A2 Health Benefits Fund

A2.1 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*.

Members need to read these Rules together with the *Government Rules*.

A2.2 Purposes

The purposes of the *Fund* are:

(1) to hold the assets relating to Health Partners health insurance business and the health related business;

(2) 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;

(3) to pay policy liabilities and other liabilities or expenses incurred in connection with Health Partners health insurance business and the health related business;

(4) to make investments and distributions permitted by the Government Rules; and

(5) for any other purpose permitted by the Government Rules.

A2.3 Purpose of 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*.

A2.4 Business of the Fund

The business of the *Fund* is Health Partners:

(1) health insurance business; and

(2) health-related business (each a health related business) 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.

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

A2.5 Health Related Business

(1) Health Partners must conduct the health related business for the benefit of members.

(2) A member may use the services of a health related business for treatment for which a benefit is provided under their membership.

(3) Health Partners may provide the optical and dental services of the health related business to persons who are not members provided:

- (a) *members* are as far as possible given priority;
- (b) the fee for each service is not less than an appropriate market rate; and
- (c) 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*.

A3 Obligations to Insurer

A3.1 Applicant or Member to Provide Information Requested

(1) A person must provide the information relating to their application or membership that Health Partners reasonably requires from time to time.

(2) Health Partners may withhold approval of an application for admission or refuse to pay or suspend payment of benefits to which a member may be entitled until the information is provided.

A4 Governing Principles

A4.1 Governance of the Fund

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

(1) the Government Rules; and

(2) these Rules.

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

A5 Use of Funds

A5.1 Credits to the Fund

Health Partners must credit to the *Fund*:

(1) all the *assets* of the Health Partners Fund as of the day this *Fund* is established;

(2) all premiums paid under memberships;

(3) all amounts received in connection with its conduct of the business of the *Fund*;

(4) any amount borrowed for the business of the *Fund*; and

(5) all other amounts required by the *Government Rules* to be paid to the *Fund*.

A5.2 Debits from the Fund

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

(1) meeting policy liabilities;

(2) meeting other liabilities or *expenses* of the business of the *Fund* including liabilities or *expenses*:

- (a) incurred in providing, or arranging to provide, professional medical services, *hospital treatment*, *out-patient* services or other related health services for *Members*;
- (b) 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
- (c) incurred in operating the health insurance business and the Health Related Business;

(3) making investments in accordance with the *Government Rules*;

(4) providing a mortgage or charge in accordance with the *Government Rules*;

(5) *transfer* to another Health Partners fund in accordance with the *Government Rules*;

(6) *transfer* to a *fund* of another *private health insurer* in accordance with the *Government Rules* where the *insurance* policies that are *referrable* to the *Fund* become *referable* to the fund of the other *private health insurer*; or

(7) any of the other purposes in the *Government Rules*.

A6 No Improper Discrimination

A6.1 Community Rating

Health Partners must not take or fail to take any action or in making a decision have regard or fail to have regard to any matter that would result in it *improperly discriminating* between people who are or wish to become *members* under a *complying health insurance product*.

A6.2 Improper Discrimination

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

(1) 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;

(2) the gender, race, sexual orientation or religious belief of a person;

(3) the age of a person;

(4) where a person lives;

(5) 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*;

(6) the frequency with which a person needs *hospital treatment* or *general treatment*;

(7) the amount, or extent, of the *benefits* to which a *member* becomes, or has become, entitled during a period; or

(8) any other matter set out in the *Government Rules* for this purpose.

A7 Changes to Rules

A7.1 Change to Rules

(1) Health Partners may vary these Rules at any time.

(2) A variation is not effective to the extent that it affects a *member's* rights which are accrued at the time of the variation.

A7.2 Notification of Changes

(3) If a change to these Rules is or might be detrimental to the interests of a *member* including a change to:

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

Health Partners must give an *adult* who is a *member* notice of the change within a reasonable time before the change takes effect.

(1) If there is any other change to these Rules including a change to:

- (a) positively vary the scope, level or amount of *benefits* payable to a *member*, or
- (b) decrease the *premium* rates (other than as an effect or rounding), or
- (c) *treatment* included in a *cover.*

Health Partners must give an *adult* who is a *member* under each *membership* notice of the change. Health Partners may give this notice after the change takes effect and by:

- (a) giving notice to the *adult*;
- (b) publishing the change in:
  - (i) a Health Partners publication distributed generally to *members*; or
  - (ii) a newspaper circulating generally in South Australia; or
- (c) by including the change in the *Standard Information Statement* it gives to the *adult* every 12 *months*.

A7.3 Standard Information Statements

(1) Health Partners must give an *adult* under each *membership* a copy of the *Standard Information Statement* for the relevant policy:

(a) when the person is first insured;

(b) at least once every 12 *months*: and

(c) if a change to these Rules is or might be detrimental to the interests of a *member*, as soon as practicable following the change.

(2) Health Partners must provide an up to date copy of a *Standard Information Statement* to anyone who requests a copy.

A8 Dispute Resolution

A8.1 Member complaints

A *Member* may approach Health Partners at any time with issues or concerns regarding their *Membership*. Health Partners will promptly respond to the *Member* and endeavour to resolve any issues or concerns in a timely manner in accordance with its *Resolution Policy*.

A8.2 Private Health Insurance Ombudsman

If there is a dispute which is not resolved in accordance with the *Resolution Policy* the *Member* may refer the dispute to the Private Health Insurance Ombudsman.

A9 Notices

A9.1 Correspondence

Any notice under these Rules must be in writing. It may be delivered personally, sent by prepaid post, facsimile or email to the address, facsimile number or email address of the recipient shown in Health Partners records as amended from time to time and is effective, in the case of delivery, on delivery, in the case of post five business days after posting, or in the case of facsimile or email, the day after transmission.

A10 Winding Up

A10.1 Termination of Fund

(1) Health Partners may only terminate the *Fund* under and in accordance with the *Government Rules*.

(2) Health Partners must comply with the *Government Rules* that relate to termination of the *Fund* including:

(3) not entering into *insurance* policies *referable* to the *Fund* after termination is approved;

(4) giving notice to *members* stating the day from which it will not renew *insurance* policies *referable* to the *Fund*;

(5) not renewing these *insurance* policies after this time; and

(6) paying the *assets* remaining after termination is complete in accordance with the *Government Rules*.

A11 Other

n/a

B - INTERPRETATION AND DEFINITIONS

B1 Interpretation

In these Rules, words written *like this* are defined in this part or in the *Government Rules*.

B1.1 Interpretation

In these Rules, headings do not affect interpretation and unless the context otherwise requires:

(1) the singular includes the plural and *vice versa*;

(2) a gender includes the other genders;

(3) where two or more *persons* are a party they are bound jointly and severally;

(4) where a word or phrase is defined its other grammatical forms have a corresponding meaning;

(5) anything after ***including*** or ***includes*** does not limit what else might be included;

(6) an ***application*** must be in writing, contain the information and be in the form that Health Partners may require from time to time;

(7) 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; and

(8) a word that is not defined but which is given a meaning in the *Government Rules* has the same meaning.

B2 Definitions

In these Rules:

Accident means an unforeseen event, occurring by chance and caused by an external force or object, which results in involuntary *injury* to the body, in Australia.

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

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.

Child means:

(1) a natural *child*;

(2) an adopted *child*;

(3) a foster *child*;

(4) a step-*child* (that is a natural, adopted or foster *child* of the *policyholder's partner*); and

(5) another *child* deemed by Health Partners to be in full care and the responsibility of the *policyholder*.

See also *Dependant* Child.

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, they cannot re-join it.

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

(1) Community rating requirements; and

(2) Coverage requirements; and

(3) If the policy covers hospital treatment, benefit requirements; and

(4) Waiting period requirements; and

(5) Portability requirements; and

(6) Quality Assurance requirements; and

(7) Any other requirements as set out in the Private Health Insurance (Complying Product) Rules.

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:

(1) complex causality, with multiple factors leading to their onset;

(2) a long development period, for which there may be no symptoms;

(3) a prolonged course of illness, perhaps leading to other health complications;

(4) 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*.

Contribution group means a group in relation to which Health Partners agrees to provide a discount on *premiums* on the basis that the *members* of the group will provide goods or services to Health Partners at rates which result in a reduction of *expenses* to the *Fund*.

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

Cover means a defined group of *benefits* payable under these Rules for *expenses* incurred by the *member*.

Dependant means a person who is:

(1) the *policyholder's* partner, or

(2) a dependant child

Dependant Child/Child Dependant means a person who:

(1) is a child of the policyholder or the policyholder's partner;

  (a) aged under 21, or

  (b) a *full time student* over 21 and under 25 (also known as 'student dependant'), or

  (c) a *non-student* over 21 and under 25 (also known as 'young adult dependant'); and

(2) does not have a *partner* (spouse or de facto).

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

(1) aged between 21 and 24 (inclusive); and

(2) is a *dependant child* under the Rules of the insurer that insures the person as referred to in subparagraph (a) (ii) of the definition of '*dependant child'* in the Private Health Insurance Act 2007, whether or not the person is wholly or substantially dependant on an *adult* insured under the same health insurance policy; and

(3) does not have a *partner*; and

(4) is not receiving 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 m*ember* agrees to pay towards the cost of *hospital treatment*, in exchange for lower *premiums*.

Expenses mean *expenses* which qualify for *benefits*.

Extras Cover see *General Treatment*.

Full-time student means a person who is undertaking a full-time workload for a course at a school, college or university. Because of possible variation to the definition of "full-time workload", Health Partners may consider such variations at its discretion.

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 ('Rules') means Private Health Insurance Act 2007 and the Private Health Insurance 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 physiotherapy scheme means the network of participating physiotherapists who have entered into an agreement with Health Partners.

Health related business means Health Partners *health related businesses* of:

(1) providing optical and dental services and goods;

(2) 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

(3) 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 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.

Injury includes disease.

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.

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 category means a category described below containing the number and kind of people described:

(1) single *membership*, which comprises only one person;

(2) couples *membership*, which comprises only two *adults* who are the *policyholder* and their *partner*;

(3) single/sole parent *membership*, which comprises only one *adult*, who is the *policyholder* and one or more *dependant children*

(4) family *membership*, which comprises only two *adults*, who are the *policyholder* and their *partner* and one or more *dependant children.*

Month or Monthly means a calendar *month*.

Out-patient means a patient of a hospital who is not an admitted patient.

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

(1) is married to the *policyholder*;

(2) is a de facto spouse of the *policyholder*; or

(3) irrespective of gender, is in a genuine domestic relationship with the *policyholder* with them together being a couple.

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

(1) is married to the *dependant child*;

(2) is a de facto spouse of the *dependant child,* or

(3) irrespective of gender, is in a genuine domestic relationship with the *dependant child,* with them together being a couple.

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

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*.

Pre-existing condition means an ailment, illness or condition, the signs or symptoms of which, in the opinion of a *medical practitioner* appointed by Health Partners, existed at any time during the six *months* preceding the day on which the *member* became insured under a *policy* of the *Fund* or transferred to a higher level of *cover* as defined by the *Government Rules*.

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

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*.

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 in relation to a person:

(1) the *person* is registered, or holds a licence, under relevant legislation to render *treatment* for which recognition is sought;

(2) if the *person* is a *hospital*, it is a *hospital* approved by the Minister under S121-5 of the Private Health Insurance Act 2007.

(3) the *person* is professionally qualified and a member of a professional body recognised by Health Partners;

(4) the *person* provides facilities that meet the standards determined or recognised by Health Partners and the *Government Rules*; and

(5) 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.

Schedule(s) means the schedules of *premium* rates, *benefits* and specific conditions as varied by the *Board* from time to time.

Standard 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*.

Table means a defined group of *benefits* payable under a *membership* for *expenses* incurred for *treatment* by a *member*.

Treatment means:

(1) in respect of *hospital cover*, hospital services and *hospital treatment*; and

(2) in respect of *general treatment*, *treatment* and or services for which *benefits* are payable under these Rules. To avoid doubt, a 'service' excludes any *treatment* that is not provided by the provider personally or under the direct supervision of the provider.

Wellness for Life program (prev. Health management program) means a program that is intended to ameliorate a person*'s* specific health condition or conditions and which complies with the *Government Rules*.

B3 Other

n/a

C - MEMBERSHIP

C1 General Conditions of Membership

C1.1 Membership Category

(1) All *members* under the same *membership* have the same *cover*.

(2) Each membership belongs to a membership category.

C1.2 Levels of Cover

(1) A *membership* may only cover specified *treatments* that are:

- (a) hospital treatment;
- (b) hospital treatment and general treatment; or
- (c) general treatment but none that are hospital-substitute treatment,

together with the *treatment* permitted or required by the *Government Rules*, but excluding the *treatment* not allowed by the *Government Rules*.

C1.3 Multiple Membership

(1) A *policyholder* may not take out more than one *Hospital cover* and/or one *Extras cover membership* offered by the *Fund*.

(2) A *member* may be *covered* under more than one *membership* subject to approval by the *Fund*.

(3) Only one claim for *benefits* may be made per incident of *treatment* and only one limit shall apply for each *member*.

C2 Eligibility for Membership

C2.1 Eligibility for Membership

Subject to these Rules, any *person* wishing to become insured under a *complying health insurance policy* of Health Partners can be a *member*.

C3 Dependants

C3.1 Registration of Dependants

(1) A *dependant* must be registered on a *membership* to receive a *benefit*.

(2) A *person* may be registered as a *dependant* by:

- (a) the *person* who applies for *membership* including the information Health Partners requires about the *person* in the *application* for *membership*; or
- (b) the relevant *policyholder* notifying Health Partners in the form and providing the information Health Partners requires,

and registration is effective:

- (a) if the information is in the *application* for *membership*, when Health Partners accepts the *application*;
- (b) if the *policyholder* gives the notice to Health Partners within 2 *months* after the *person* becomes a *dependant*, when the *person* became a *dependant*; and
- (c) in all other cases, when Health Partners registers the *person* in its *records* as a *dependant* of the *policyholder*.

C3.2 Removing Dependants

(1) A *policyholder* may remove a *dependant* from the *membership* by giving notice to Health Partners. The removal is effective when Health Partners receive the notice.

(2) A *dependant*, aged at least 16 years, may cease to be a *member* by giving notice to Health Partners.

C3.3 Adjusting Membership

(1) If the *membership category* for the *membership* after the registration or removal of a *dependant* no longer applies, the *membership category* for the *membership* changes to the *membership category* that Health Partners determines properly applies to the *membership* having regard to number and kind of *persons* then comprising the *membership*.

(2) The *policyholder* must pay, when Health Partners requests, the further *premiums*, if any, which apply for the changed *membership category* determined from the time the change is effective.

(3) If the changed *membership category* requires lesser *premiums*, the period for which *premiums* are paid extends by the time that Health Partners determine is the period calculated by multiplying the period paid in advance of the date of the change (ignoring part days) by the former *premiums* and dividing the *product* by the new *premiums* (ignoring part days in the answer).

(4) Health Partners may in its discretion, instead of extending the period for which *premiums* are paid, refund some or all of the excess *premiums* relating to the period after the change. Health Partners may deduct an administration charge from any refund.

C3.4 Student Dependants

If a *dependant child* is a *full time student*, the *policyholder* for the *dependant child* must by the end of February in each year complete a Student Dependant Registration form and provide this to Health Partners. Health Partners at its discretion may require written information in relation to that *person* to substantiate that he or she still qualifies as a *dependant child*. Failure to provide the required information may result in the *dependant child* being removed from the *membership*. Health Partners, at its discretion, may allow a student who is not taking on a full-time study load to be accepted as a *dependant child*.

C4 Membership Applications

C4.1 Application to Become a Member

Any person who wishes to become a *policyholder* must give an *application* to Health Partners.

C4.2 Refusal of Application for Membership

(1) Health Partners may refuse an *application* for admission as a *member* or refuse admission to any *table* for which *application* is made.

(2) Reasons for refusal may include:

- (a) fraudulent activity by the proposed *member*
- (b) provision of misleading or untrue information, or
- (c) non-disclosure of required information.

(3) Where an *application* is refused, Health Partners shall provide a reason for the refusal.

C4.3 Information

When an *adult* becomes a *member*, Health Partners must give him or her:

(1) a Standard Information Statement for the product sub-group to which the membership belongs; and

(2) details of what the *membership covers* and how *benefits* are determined.

If more than one *adult* becomes a *member* under one *membership*, Health Partners need only provide the *policyholder* with this information.

C4.4 Cooling Off

The *policyholder* may cancel the *membership* by giving notice to Health Partners within 30 days from its commencement date, provided no *member* has claimed under the *membership*.

This rule applies to:

(1) new *members* that take out *cover* with Health Partners; and

(2) existing Health Partners *members* that take out a new *cover*.

A *policyholder* that terminates their *membership* may upon application to the fund reinstate their *membership* with Health Partners without re-serving waiting periods providing the application is received and accepted by Health Partners within 30 days of the date of termination.

C5 Duration of Membership

C5.1 Commencement of Membership

Membership commences:

- (a) on the date on which the *application* is lodged with Health Partners or the date nominated in the *application*, whichever is the later;
- (b) for a *dependant* when registration is effective.

C5.2 End of Membership

A person ceases to be a *member* if:

(a) he or she is removed from a *membership* or ceases to be a *member* under these Rules; or

(b) their *membership* is cancelled or terminated.

C6 Transfers

C6.1 Transfers Between Tables

(1) A *policyholder* may change from a *table* to another *table* by giving an *application* to Health Partners.

(2) The change is effective when Health Partners notify the *policyholder* that it accepts the change.

C6.2 Transfers from other Funds

If a person becomes a *member* 30 days or more after ceasing to be insured by another *private health insurer*, he or she is treated as a new *member*.

C6.3 Benefits from Previous Cover May be Taken into Account

If a person:

(1) changes from a *table* to another *table*; or

(2) becomes a *member* within 30 days after ceasing to be insured by another *private health insurer*,

then during any *waiting period* which applies to the *member*, *benefits* are payable at the level of the *member's* previous *cover* or existing *cover*, whichever is lesser.

C6.4 Transfer Certificates

(1) If a person ceases to be a *member*, Health Partners will provide him or her a certificate as required by the *Government Rules*.

(2) If a person becomes a *member* after ceasing to be insured by another *private health insurer*, the *member* or the old insurer must provide a certificate to Health Partners as required by the *Government Rules*.

C7 Cancellation of Membership

C7.1 Cancellation as a Member

A *policyholder* may cancel their *membership* by giving notice to Health Partners.

C7.2 Refunds

(1) Health Partners do not have to refund any *premiums* unless:

(a) these Rules or the *Government Rules* require; or

(b) the *premiums* are paid for more than two *months* in advance of the time the *membership* ends.

(2) Health Partners may in its discretion refund some or all *premiums* relating to the period after a person ceases to be a *member* if Health Partners believe it would be just to provide a refund.

(3) Health Partners must refund all *premiums* if a *member* has not claimed under a *membership* and the *policyholder* has cancelled the *membership* by giving notice to Health Partners within 30 days from its commencement date.

(4) Health Partners may deduct an administration charge from any refund.

C8 Termination of Membership

C8.1 Improper Conduct

(1) If, in Health Partners opinion:

(a) a *member* gives misleading or untrue information to Health Partners 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;

(c) there is a pattern of over-servicing to a *member* or any other form of abuse by or for a *member*,

Health Partners may in its discretion immediately by notice to the *policyholder*:

(a) terminate their *membership*; or

(b) remove the *member* from their *membership*.

C8.2 Arrears

A *membership* will be terminated if *premiums* are more than 3 months in arrears at the end of the month unless the *policyholder* and Health Partners come to an arrangement to recover the amount in arrears.

C8.3 Reinstatement of Terminated Membership

If a *membership* has been terminated, Health Partners may in its discretion reinstate a *membership* upon *application* by the *policyholder*, subject to the payment of any outstanding *premiums*.

C9 Temporary Suspension of Membership

C9.1 Overseas Travel Suspension

(1) If:

(a) a *membership* has continued for at least one (1) *month*; and

(b) all *premiums* for it are paid to the time of the date of departure from Australia,

Health Partners may in its discretion upon *application*, suspend the *membership* for the period the *policyholder* is absent from Australia up to two (2) years.

(2) A *policyholder who* has suspended their *membership* under this provision, may after reactivating their *membership* for a period of three *months* suspend it for up to a further two (2) years.

(3) The minimum period of suspension is three (3) weeks.

(4) The maximum period of suspension is four (4) years for each period the *policyholder* does not reside in Australia.

(5) Where the reasons for suspension cease to apply, or the maximum period of suspension is reached the *policyholder* must reactivate the *membership* within one (1) *month* otherwise the *membership* and its related *members* are taken to be new for the purposes of these Rules and the *Government Rules.*

C9.2 Suspension Due to Financial Hardship

(1) If:

(a) a *membership* has continued for at least six (6) months; and

(b) a *member* is experiencing financial hardship,

Health Partners may in its discretion upon *application* by the *policyholder*, suspend the *membership* in full, for the period during which the *member* is experiencing financial hardship or twelve (12) months whichever is less.

(2) A *membership* may not be suspended again on this ground unless *premiums* after the suspension are continuously maintained for at least six (6) months unless special approval is granted.

(3) A *membership* may only be suspended a maximum of three (3) times under this provision.

C9.3 Suspension due to Improper Conduct

If in Health Partners opinion:

(1) a *member* gives misleading or untrue information to Health Partners for any reason including in an *application*, when making a claim or answering a request for further information.

(2) 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;

(3) there is a pattern of over-servicing to a *member* or any other form of abuse by or for a *member*;

(4) a *member* has unreasonably or improperly incurred *expenses* for *treatment*; or

(5) a *member* fails to provide the information that Health Partners reasonably requires from time to time,

Health Partners may in its discretion:

(1) withhold *benefits* or not pay *benefits* to or for the *member* for the relevant services; and

(2) require the *member* to repay on demand any *benefit* paid in connection with the relevant services.

C9.4 Other Suspensions

Health Partners may in its discretion and on any other basis that it sees fit suspend a *membership* on the terms and for the period it determines.

C9.5 General Conditions

(1) No *benefits* are payable during suspension.

(2) Suspension commences on the day after the period ends for which *premiums* are paid or when suspended under C9.3 or C9.4;

(3) A person who has their own *membership* from the date they cease to be a registered *dependant* under the *policyholder's membership* is entitled to include their years of *cover* as a *dependant* under the *policyholder's membership* in their new *membership*.

(4) The period of suspension does not count towards any *waiting period*.

(5) The period of *membership* before suspension counts towards satisfaction of a *waiting period* after suspension. If *membership* reactivates, a *waiting period* does not recommence.

(6) A suspension is subject to the conditions, if any, which Health Partners may impose from time to time.

C10 Other

N/A

D – CONTRIBUTIONS (PREMIUMS)

D1 Payment of Premiums (Contributions)

D1.1 Rates

The *policyholder* must pay in advance the *premiums (contributions)* set out in the *schedule* for the *membership category* and *table* which relates to their *membership*.

D1.2 Premiums

Unless otherwise provided in the *schedule*:

(1) All *premiums* must be paid fortnightly, *monthly*, quarterly, half-yearly or annually and may be paid by cash, cheque, direct debit, or credit card (cash payments only accepted in person at Member Service counters at Adelaide and Modbury sites).

(2) *Premiums* paid for a *group scheme* may be paid in arrears.

D1.3 Premiums in Advance

We may refuse to accept a payment that would result in your Policy being paid more than 12 *months* in advance. If you pay your premiums more than 12 *months* in advance, a refund of any additional premiums may be processed. In accepting payments in advance in excess of twelve (12) *months*, a *members'* pay to date will not exceed 31 July in any given year.

D1.4 Family Focus

A *dependant child non-student* may be covered under a Family or Sole Parent membership (see definition of *'membership category'*) upon payment of the loading being the difference between the *premiums* that are specified in the *schedule* as payable for Family Focus *membership* and those that are specified for Family or Sole Parent *membership*.

D2 Premium (Contribution) Rate Changes

D2.1 Variation to premium rates

(1) Health Partners may at any time vary any or all *premium* rates for the respective *tables* in accordance with requirements set out in the *Government Rules*.

(2) In the event of a reduction in premium rates, the period of *cover* extends from the date of the reduced rate by the period calculated by multiplying the period paid in advance of the date of the reduced rate (ignoring part days) by the former rate and dividing the *product* by the new rate (ignoring part days in the answer).

D3 Premium (Contribution) Discounts

A *member* may be eligible for a discounted *premium* rate if the *member* makes payments using one of the following options:

(1) a discount of 3% shall be allowed for payment of *premiums* when payment is made by direct debit through a financial institution.

(2) a discount of up to 12% for payment of *premiums* by a *policyholder* who belongs to a *contribution group*.

D4 Lifetime Health Cover

D4.1 Lifetime Health Cover Contributions

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*.

D4.2 Removal of Lifetime Health Cover Loading

Health Partners will stop increasing the *premiums* after ten (10) years of *cover* for *hospital treatment* as required by Lifetime Health Cover provisions in the *Government Rules*.

D4.3 Norfolk Island Residents

Effective 1 July 2016, Norfolk Island residents who are aged over 31 will have a 12 month grace period to purchase health insurance without incurring a Lifetime Health Cover loading. If they purchase from or after 1 July 2017, a loading will apply. For younger residents, they will have until their normal LHC base day of the 1 July following their 31st birthday to purchase insurance without incurring a loading.

D5 Arrears in Premiums (Contributions)

Premiums ('contributions') are in arrears if the period for which *premiums* are paid has ended.

(1) Health Partners need not pay *benefits* while *premiums* are in arrears.

(2) If *premiums* are in arrears for less than 3 months and *premiums* are paid for this period and for the minimum period in advance required for the *policyholder's membership*, *benefits* become payable for this period.

(3) If *premiums* are in arrears, Health Partners may, in its discretion, deduct from any *benefits* payable to or for a *member* the amount of these arrears.

(4) This rule applies in concurrence with rule C8.2.

D6 Other

n/a

E - BENEFITS

E1 General Conditions

E1.1 Treatment to be Provided by Recognised Providers

Benefits are payable only for *treatment* provided by a recognised provider. A recognised provider is a *hospital* or *person* which satisfies the *recognition criteria*.

E1.2 Providers who Fail to Meet Recognition Criteria

If Health Partners believe on reasonable grounds that a *person* is not a recognised provider it need not pay *benefits* for a claim for *treatment* provided at the *premises* of or by the *person*.

E1.3 Recognised Providers who Cease to Meet Recognition Criteria

If Health Partners believe on reasonable grounds that a *person* ceases to be a recognised provider it:

(1) need not pay *benefits* for a claim for *treatment* at the *premises* of or by the *person*; and

(2) may suspend or cancel the *person's* recognition for the purpose of paying *benefits*.

E1.4 Reduced Benefit Entitlement

Benefits may be reduced where:

(1) the charge is lower than the *benefit* that would otherwise have been payable, the *benefit* is reduced to the amount of the charge;

(2) a *benefit* is claimable from another source for the same service, the *benefit* payable by Health Partners may be reduced by the amount claimable from the source; or

(3) Health Partners believe that the charge is higher than that which would have been charged to an uninsured person, or for a person on a different *cover* for similar services.

E1.5 Benefits Rendered Outside Australia

Health Partners will not pay any *benefit* for goods or services supplied or rendered outside Australia.

E1.6 Providers treating Family Members or Business Partners

Health Partners will decline to pay *benefits* for *treatment* rendered by a provider to:

(1) the provider, the provider's spouse, *partner*, *child/ren*, *dependants*, business associates; or

(2) the spouse, *partner, child/ren* or *dependants* of the providers business associates; or

(3) any person who is covered on the same *membership.*

Except for the following circumstances:

(1) where Health Partners is satisfied that the charge is raised as a legally enforceable debt; or

(2) in respect of the invoiced cost of materials required in connection with any *treatment*.

E1.7 Multiple Services

Where multiple services are provided by the same provider on the same day for the same condition, *benefits* will only be payable for the first service.

E1.8 Telephone and Internet Consultations

Except where otherwise permitted by these Rules, *benefits* are only payable for services or *treatments* performed in person (telephone/internet/Skype consultations are not payable).

E2 Hospital Treatment

E2.1 Hospital Benefits Payable

The *benefits* payable for *hospital treatment* and the conditions relevant to those *benefits* are set out in the *schedule*.

E2.2 Patient Classification

Benefits for accommodation in *private hospitals* are payable according to the classification of the *member*.

(1) The classifications are:
- (a) Surgical;
- (b) Advanced Surgical;
- (c) Obstetric;
- (d) Other (Medical);
- (e) Psychiatric Care; and
- (f) Rehabilitation

E2.3 Surgical and Advanced Surgical Patients

Subject to Rule E2.10, the *benefit* payable under the Surgical and Advanced Surgical classifications applies:

(1) from the date of admission, where the operative procedure is performed on the first or second day of admission; or

(2) from the date of the procedure, where the operative procedure is performed on the third day of admission or later.

E2.4 Obstetric Patients

The Obstetric classification applies only where childbirth occurs following the mother's admission to a *hospital*.

(1) Where labour resulting in childbirth commenced before admission, the Obstetric classification applies from date of admission.

(2) Where labour commenced after admission, the Obstetric classification applies from the earliest of:

- (a) the date on which labour commenced, or
- (b) the date on which an obstetric procedure took place.

E2.5 Rehabilitation Patients

Benefits for Rehabilitation *patients* are payable subject to the following condition:

(1) *treatment* must be supported by a Rehabilitation Certificate (a certificate in a form approved by Health Partners supporting the need of a special rehabilitation program to recover from a condition that has severe symptoms of immediate onset).

E2.6 Psychiatric Care Patients

Benefits for Psychiatric Care *patients* are payable subject to the following condition:

(1) *treatment* must be supported by a Psychiatric Care Certificate (a certificate in a form approved by Health Partners, to the effect that the *member* is in need of special program of acute psychiatric care).

E2.7 Length of Stay

The day on which a person became an admitted *patient* and the day of the discharge are counted as one day for the purpose of assessing *benefits* payable.

E2.8 Multiple Procedures

Subject to *Fund* Rule E2.10, where a *member* undergoes more than one operative procedure during the one theatre admission, the procedure with the highest fee in the Medicare Benefits Schedule determines the *member's* classification.

E2.9 Subsequent Procedures

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

(1) where the procedure results in the *member* having a higher classification, the *member's* classification increases from the date of the procedure, and

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

E2.10 Continuous Hospital

(1) Where an admitted *member* is discharged, and within seven (7) days is admitted to the same or different *hospital* for the same or a related condition, the two (2) admissions are regarded as forming one period of continuous hospitalisation.

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

E2.11 Agreements with Doctors and Hospitals

(1) Health Partners may enter into an agreement with a *medical practitioner*, group of *medical practitioners* or a *hospital* or group of *hospitals*, under which any of the following items, or any combination of the following items, are to remain fixed throughout the term of the agreement:

- (a) the total charge for any *treatment*;
- (b) the *benefit* payable by Health Partners; and
- (c) any out-of-pocket expenses payable by the *member.*

E2.12 Pharmaceutical in Hospital

(1) Where a *hospital cover* includes *benefits* of PBS medications supplied to an admitted *member*, the *benefit* will meet the full cost of the pharmaceutical if it is directly related to the *treatment* of the condition for which the *member* was admitted.

(2) The 'full cost' referred to in (1) includes the *member co-payment*, and any special or *member* contribution, brand premium or therapeutic group premium otherwise payable by the *member* under the Pharmaceutical Benefits Scheme.

(3) *Benefits* for Non-PBS medications supplied to an admitted *member* are payable in accordance with the agreement with the *hospital*:

- (a) the *benefit* is specifically included in the agreement with the *hospital.*
- (b) the pharmaceutical is directly related to the *treatment* of the condition for which the *member* is admitted.

E3 General Treatment

E3.1 General Treatment Benefits

Pursuant to sections F and G of the Rules, the *benefits* payable for *general treatment* services, and the conditions relevant to those *benefits*, are set out in the *schedule*.

E3.2 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.

E3.3 Health Related Business – Services, Fees and Conditions

A *member* may use a service offered by a *health related business* for *treatment* for which a *benefit* applies under their *membership.*

E4 Other

E4.1 Ex Gratia Benefits

Health Partners may pay *benefits* on an ex gratia basis, at its discretion.

E4.2 Health Partners Agreement Providers

(1) Details of *benefits* payable by Health Partners, *benefit* conditions and dates of effect for agreements or arrangements made under this Rule for each Health Partners Agreement Provider are contained in separate *schedules* maintained by Health Partners.

(2) Unless otherwise specified in these Rules, the payment of *benefits* for *treatment* provided by Health Partners Agreement Providers is subject to all relevant Rules.

E4.3 Appliance/Apparatus and Orthotics Benefits

For benefits in schedules I and J to apply, all apparatus appliances and orthortics must be:

(1) approved by the Therapeutic Goods Association (TGA); and

(2) prescribed and supplied for the treatment or management of a diagnosed health condition.

F - LIMITATION OF BENEFITS

F1 Co Payments

F1.1 Co-Payments

Co-payments apply only under the following closed *covers*:

(1) Gold Hospital 25;
(2) Gold Hospital 50;
(3) Silver Hospital 250 with CoPay;
(4) Silver Hospital 500 with CoPay; and
(5) Bronze Hospital 500 with CoPay.

F1.2 Maximum Co-payment Amount and Limit

The *co-payment* amounts and limits are specified in the *schedule* relevant to the *member's cover*.

F1.3 Co-payments for Dependant Children

Co-payments do not apply for a *dependant child* or *dependant child non-student* under the following closed covers:

(1) Gold Hospital 25;
(2) Gold Hospital 50;
(3) Silver Hospital 250 with CoPay; and
(4) Silver Hospital 500 with CoPay.

F2 Excesses

F2.1 Excesses

Excesses apply only under the following *covers*:

(1) Silver Hospital 250 with CoPay (closed product);
(2) Silver Hospital 500 with CoPay (closed product);
(3) Bronze 500 with CoPay (closed product);
(4) Singles Starter Package;
(5) Couples Choice Package;
(6) Family Essentials Package;
(7) Gold Value Hospital with Maternity;
(8) Gold Value Hospital excluding Maternity;
(9) Silver Hospital; and
(10) Bronze Hospital.

The amount of the *excess* and relevant limits and conditions are specified in the *schedule* relevant to the *member's cover*.

F2.2 Excess for Dependant Children

Excesses do not apply for a dependant child or dependant child non-student under the following covers:

(1) Silver Hospital 250 with CoPay (closed product);
(2) Silver Hospital 500 with CoPay (closed product);
(3) Family Essentials Package;
(4) Gold Value Hospital with Maternity;
(5) Gold Value Hospital excluding Maternity; and
(6) Silver Hospital.

F3 Waiting Periods

F3.1 Waiting Periods for Hospital Treatment

The following waiting periods apply to benefits payable for hospital treatment, hospital-substitute treatment or other special general treatments:

Pre-existing conditions (refer to rule F3.6)	12 months
Obstetric related items and services	12 months
Sleep Study Support	12 months
Home Nursing	12 months
IVF related drugs	12 months
Psychiatric, Rehabilitation or Palliative care (whether or not pre-existing)	2 months
Newborn Support program	2 months
All other items and services	2 months

F3.2 Waiting Periods for General Treatment

The following waiting periods apply to benefits for general treatment:

(1) Laser Eye Surgery	36 Months
(2) Pre-existing conditions (refer to rule F3.6)	12 months
(3) Endodontics	12 months
(4) Major Dental Treatment	12 months
(5) Periodontics	12 months
(6) Orthodontics	12 months
(7) All Aids and Appliances / Apparatus, including but not limited to:	12 months

Asthmatic Spray Appliances, Blood Glucose Monitoring Machines, Blood Pressure Machines, Circulation Booster (eg. TENS machine), Hearing Aids, Low Vision Optical Magnification Aids, Sleep Apnoea/CPAP Apparatus & support service.

(8) All Wellness for Life items, including but not limited to:	2 months

Online Personal Health Assessments, Asthma Australia / Diabetes Memberships, Bone Density Tests, Bowel Cancer Screening Kit, Diabetes Education, Gym & Fitness, Mole Check Body Scans, Quit Smoking and Weight Management Programs.

(9) All other services and items	2 months

F3.3 Effect of Waiting Periods

(1) A *member* must hold *membership* continuously for the *waiting period* at the level of *cover* before the *member* can receive *benefits* at that level. This includes:

- (a) a member who transfers to another cover within the Fund which provides higher benefits, in which case the member can only receive benefits on the basis of the former cover from the time of the transfer until the waiting period expires; and
- (b) a new member.

(2) *Waiting periods* do not apply to:

- (a) a new born registered as a *dependant child*; or
- (b) *benefits* for *expenses* incurred in connection with an *accident*, if in Health Partners opinion *treatment* is required immediately after the *accident*.

(3) If a person was registered as a *dependant* and becomes a *policyholder* to a *membership* within sixty (60) days of ceasing to be *dependant*, the *waiting period* is reduced by the period the person was continuously registered as a *dependant* prior to ceasing to be registered as a *dependant*.

F3.4 New Members Transferring from another Fund

(1) If a person who was insured by another *private health insurer* applies within thirty (30) days of ceasing to be insured by the other insurer to become a *policyholder*:

   (a) the *waiting period* for a *benefit* for *hospital treatment* or *hospital-substitute treatment* that was *covered* by that policy is the balance of any unexpired *waiting period* that applied to that person under that policy;

   (b) for a *benefit* for *hospital treatment* or hospital-substitute treatment that was covered by that policy and in respect of which a higher *excess* or *co-payment* applied under that policy, the period for which the higher *excess* or *co-payment* applies is the *waiting period* for that *benefit* in these Rules; and

   (c) the *waiting period* for any other *benefit* that was also covered by that policy for the same amount, is reduced by the number of days of the *waiting period* imposed by the former insurer for the comparable *benefit* as had expired at the time that the person became a *member* in relation to the relevant *benefit*.

(2) Where any *benefits* to which the person shall be entitled pursuant to these rules is subject to a limitation imposed by these Rules the *benefits* payable shall be reduced by taking into account any *benefits* received by the person from the other *Fund* from which the person transferred as if those *benefits* had been paid for services or *treatment* pursuant to these rules.

(3) For the purposes of this rule, if the comparable *benefit* could consist of either:

   (a) the actual payment of a *benefit*, or

   (b) the provision of services or *treatment*,

it shall be assumed that the *benefit* could consist only of the payment of the *benefit*.

F3.5 Gold Card

If a person held a *gold card* or was entitled to *treatment* under a *gold card* before applying for *insurance* and applies for *insurance* no longer than 2 months after ceasing to hold, or be untitled under, the *gold card*, a *waiting period* does not apply to that person.

F3.6 Pre-Existing Information from Treating Practitioners

(1) Health Partners may appoint a medical or other relevant practitioner to determine whether or not a condition for which *treatment* has been provided and *benefits* have been claimed is a *pre-existing condition*.

(2) A practitioner appointed under (1) shall take into account:

   (a) information provided by the practitioners who treated the *member* in the six (6) months prior to them becoming a *member* or changing their *cover*, and

   (b) any other material that Health Partners considers is relevant to the claim.

(3) Health Partners may assume that a condition is a *pre-existing condition* until:

   (a) the *member* authorises the release of information referred to in (2), and

   (b) this information has been provided to Health Partners.

F3.7 Waiver of Waiting Periods

Health Partners may in its discretion waive or reduce any *waiting period*.

F4 Exclusions

Some *cover* products are subject to exclusionary *treatments* and do not provide any benefits.

Details of any applicable exclusions are specified in the *schedule* relevant to the *member's cover*.

F5 Benefit Limitation Periods

Not applicable to any Health Partners products.

F6 Restricted Benefits

Any medical procedures not recognised for Medicare rebates by the Commonwealth Department of Health and Ageing. A *benefit* equivalent to the minimum default benefit determined by the *Government Rules* may be applicable.

Details of any additional applicable restrictions are specified in the *schedule* relevant to the *member's cover*.

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Obligations of a Member

Subject to *Fund* Rule F7.7 a *member* who has, or may have, a right to receive *compensation* in relation to an *injury* must:

(1) inform the *Fund* as soon as the *member* knows or suspects that such a right exists;

(2) inform the *Fund* of any decision of the *member* to *claim compensation*;

(3) include in any *claim* for *compensation* the full amount of all *expenses* for which *benefits* are, or would otherwise be, payable;

(4) take all reasonable steps to pursue the *claim* for *compensation* to the *Funds* reasonable satisfaction;

(5) keep the *Fund* informed of the progress of the *claim* for *compensation*;

(6) inform the *Fund* immediately upon the determination or settlement of the *claim* for *compensation*; and

(7) upon settlement supply to the *Fund*, if requested, copies of all related settlement documentation and/or associated medical information in relation to the *claim* for *compensation* and damages.

F7.2 Entitlement to Benefits for an injury

(1) Subject to *Fund* Rule F7.4 and unless otherwise permitted under this *Fund* Rule, *benefits* are not payable for *expenses* incurred in relation to an *injury* where the *member* has received, or may be entitled to receive, *compensation* in respect of that *injury*.

(2) The *expenses* referred to in (1) include *expenses* incurred after the *member* has received *compensation*.

F7.3 Health Partners may Withhold Payment

Subject to *Fund* Rule F7.9, where a *member* appears to have a right to make a *claim* for *compensation* in respect of an *injury* but that right has not been established, the *Fund* may withhold payment of *benefits* in respect of *expenses* incurred in relation to that *injury*.

F7.4 Provisional Payments

(1) Where a *claim* for *compensation* in respect of an *injury* is in the process of being made, or has been made and remains un finalised, the *Fund* may in its absolute discretion make a provisional payment of *benefits* in respect of *expenses* incurred in relation to the *injury*.

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

(3) A provisional payment is conditional upon the *member* signing a legally binding undertaking and authority supplied by the *Fund*, that contains an agreement by the *member*, in consideration for the payment:

   (a) to comply with *Fund* Rule F7.1,

   (b) that the provisional payment is bound by these *Fund* Rules,

   (c) to disclose to the *Fund*, 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*,

   (d) to repay the *Fund* 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 the *Fund* has specified rights of subrogation whereby the *Fund* acquires all rights and remedies of the *member* in relation to the *claim*.

F7.5 Where Benefits have been paid by Health Partners

(1) Subject to *Fund* Rule F 7.8 where:

   (a) the *Fund* has paid *benefits*, whether by way of provisional payments or otherwise, in relation to an *injury*, and

   (b) the *member* has received *compensation* in respect of that *injury*,

the *member* must repay the *Fund* the full amount that the *Fund* paid in relation to the *injury*, upon the determination or settlement of the *claim* for *compensation*.

F7.6 Rights of Health Partners

If a *member* makes a *claim* for *compensation* in relation to an *injury* and fails to:

(1) comply with any obligation in *Fund* Rule F 7.1 or F 7.5 or

(2) include in their *claim* for *compensation* any payments of *benefits* by the *Fund* in relation to an *injury*, the *Fund* may without prejudice to its rights (including its broader subrogation rights) in its absolute discretion take any action permitted by law to:

- (a) assume that all *expenses* in relation to the *injury* have been met from the *compensation* payable or received pursuant to the *claim*, and/or
- (b) pursue the *member* for repayment of all *benefits* paid by the *Fund* in relation to the *injury*, and/or
- (c) assume legal rights of the *member* in respect of all or any parts of *claim*

F7.7 Claim Abandoned

Where:

(1) a *member* has or may have a right to make a *claim* for *compensation* in respect of an *injury*, and

(2) the *Fund* reasonably determined that the *member* has abandoned or chosen not to pursue the *claim*,

benefits are payable (subject to other *Fund* Rules) if the *member* signs a legally binding undertaking supplied by the *Fund* by which the *member* agrees, in consideration for the payment of *benefits*, not to pursue the *claim*.

F7.8 Requirement to Repay Benefits may be Waived

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

(1) the *member* has complied with *Fund* Rule F7.1, and

(2) the *Fund* has given prior consent to the settlement of the *claim* for an amount that is less that the total *benefits* paid or which would otherwise have been payable by the *Fund*,

the *Fund* may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the *member* need not repay any part or the full amount of the *benefits* paid by the *Fund* in respect of the *injury*.

F7.9 Benefits for Expenses subsequent to Compensation

The *Fund* may, in its absolute discretion, pay *benefits* where:

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

- (a) a complication arising from an *injury* that was the subject of a *claim* for *compensation*, or
- (b) the provision of service or item for *treatment* of an *injury* that was subject of a *claim* for *compensation*, and

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

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

F7.10 Other Insurance

For the avoidance of doubt, a *member* is 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*. The *member* must first *claim* under that *insurance* policy. This applies whether the other *insurance* policy provides full or partial coverage.

F7.11 Interpretation

In this rule:

Claim means a reference to a demand or action (other than a *claim* for *Fund benefits*).

Compensation means a monetary reimbursement an injured party receives to help make reparations after an *injury*.

Injury includes any condition, ailment or *injury* for which *benefits* would, or may otherwise be, payable by Health Partners for *expenses* incurred in relation to its *treatment*.

F8 Other

n/a

G - CLAIMS

G1 General

G1.1 Claim Form

Claims for *benefits* must:

(1) be lodged on a form prescribed by Health Partners and in a manner approved by Health Partners,

(2) be supported by accounts and receipts on the provider's letterhead or showing the provider's official stamp, and showing the following information:

(a) the provider's name, 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, and

(f) any other information that Health Partners may reasonably request.

G1.2 Claims Procedure

(1) Health Partners may request a certificate from the *person* providing the services relating to any matter which in the opinion of Health Partners is relevant to consideration of a 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 anesthetic facilities available at the *premises*;

(d) the period the *patient* was hospitalised; and

(e) any other information appropriate to the circumstances of the claim.

(2) Where Health Partners requests such information direct from the *person* which provided the services, the *member* will, if required, authorise the *person* to make the information available direct to Health Partners for use by Health Partners or the relevant government body.

(3) Any claim for *hospital treatment expenses* shall also be accompanied by a certificate of hospitalisation in a form approved by Health Partners.

(4) If the claim is accompanied by a receipt for payment of the account of the *person* in respect of which *benefits* are claimed, Health Partners shall pay the *benefits* to the *policyholder* or *member*.

(5) If an account, which is subject of the 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*.

(6) If the claim is not accompanied by a receipt for payment of the account of the *person* in respect of which *benefits* are claimed, Health Partners as agent of the *member* shall pay any *benefit* due to the *member* direct to that *person*.

(7) If the *member* has not properly completed the claim form, failed or refused to supply any further information requested by Health Partners, failed or refused to supply a certificate of hospitalisation (if applicable) or any other action required by these Rules to be done by the *member*, Health Partners shall be entitled to withhold or suspend payment of *benefits*.

G1.3 Claims Lodgment Period

Benefits are not payable where a claim is lodged more than two (2) years after the date the service has been rendered. Health Partners may waive this rule at its discretion.

G1.4 Subrogation of Rights in a Claim

(1) If a *person*, in Health Partners opinion, incorrectly charges a *member* for a service for which a *benefit* is payable, Health Partners may in the name of the *member* take or defend any action in connection with the charge, including an action to recover money overpaid.

(2) For this purpose the *member* must do all acts and sign all documents that Health Partners requires.

(3) If the *member* fails to do this Health Partners may withhold *benefits* or not pay *benefits* to or for the *member* for this service.

G2 Other

n/a

SCHEDULES

Please refer to the Health Partners Member Guide, website or individual cover details for product information (*Schedules, Benefits* and *Special Conditions*).

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

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Health Partners is a registered private health insurer since 1937.
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