



HealthGuard Fund Rules
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A INTRODUCTION

A1 Rules Arrangement

These Fund Rules are the rules which govern the day to day operation of the Fund conducted by HealthGuard to ensure compliance with the Private Health Insurance Act and the requirements of the Department and the Private Health Insurance Administration Council.

The following schedules make up the Fund Rules:

- General Conditions (Schedules A-G);
- Schedule of Hospital Products (Schedule H);
- Schedule of Ancillary Products (Schedule I);
- Schedule of Combined Products (Schedule J);
- Schedule of Premium Rates (Schedule K); and
- Other schedules (Schedule M).

A.1.1 Commencement

These Fund Rules will apply from 1 April 2008 and will replace all previous fund rules. These Fund Rules co-exist with the HealthGuard Governance Regulations. Where a Member became entitled to receive a Benefit at a time when a previous Fund Rule applied, the Benefit specified in that Fund Rule will be payable.

A2 Health Benefits Fund

HealthGuard is a Company limited by guarantee, incorporated under the Corporations Act 2001 and is a Private Health Insurer under the Private Health Insurance Act.

HealthGuard established, conducts and administers the Fund.

The Fund relates solely to the Health Insurance Business and some or all of the Health Related Businesses of HealthGuard as defined in section 131-10 and 131-15 of the Private Health Insurance Act.

A3 Obligations to Fund

A person applying for admission to the Fund and a Member must comply with Fund Rules and any other requirements of HealthGuard and provide all information requested by HealthGuard.

A Member will inform HealthGuard as soon as reasonably possible after a change in any Membership details.

A4 Governing Principles

The provisions of the Private Health Insurance Act and the Private Health Insurance Rules govern important aspects of the operation of the Fund and the relationship between the Fund and its Members and take precedence over any inconsistency in the Fund Rules.

A5 Use of Funds

To the extent provided by the Private Health Insurance Act, the whole of the income of the Fund arising out of HealthGuard carrying on Health Insurance Business or Health Related Business as a Private Health Insurer (including any income arising from investment of money not immediately required for payment of Benefits to Members) must be credited to the Fund.

Payments from the Fund may not be made for any purpose other than:

- a. to meet the Membership liabilities and other liabilities or expenses incurred for the purposes of the business of the Fund;
- b. to make a distribution under Division 149 of the Private Health Insurance Act;
- c. to make investments for HealthGuard in accordance with the Private Health Insurance Act; and
- d. any other purpose that is specified in the Private Health Insurance (Health Benefit Fund Policy) Rules 2007.

A6 No Improper Discrimination

As required by the Private Health Insurance Act, when conducting the Fund and making decisions in relation to Members, HealthGuard will not take into account:

- a. the suffering by a Member from a chronic disease, illness or other medical condition;
- b. the age of a Member, except in relation to the calculation of Lifetime Health Cover loading;

- c. where a person lives, except in relation to different risk equalisation jurisdictions;
- d. the frequency with which a Member needs Ancillary or Hospital Treatment;
- e. any characteristic of a person that is likely to result in an increased need for Ancillary or Hospital Treatment;
- f. the amount, or extent of the Benefits to which a Member becomes or has become entitled during a period; or
- g. the race, gender, religious belief or sexual orientation of a Member, unless it has been permitted to under any legislative or regulatory provision.

A7 Changes to Rules

A.7.1 Fund Rules

HealthGuard may change the Fund Rules (consistent with the Private Health Insurance Act) and will ensure at least one Adult Member on each Membership is informed of changes to premiums, treatments or benefits on their Product a reasonable time before the change takes effect if the change is or might be detrimental to the interests of any Member on that Membership. This communication will occur in writing whether or not the change will require an update to the Standard Information Statement for that Member's Product.

A.7.2 Hardship

Where circumstances beyond the control of a Member arise or the loss of Benefits by any Member will cause hardship, HealthGuard may (at its discretion and within the requirements of the Private Health Insurance Act) waive or vary the application of a Fund Rule.

A.7.3 Discretion

HealthGuard, (at its discretion and within the requirements of the Private Health Insurance Act) may waive strict compliance with any time period or date by which an action will take place under these Fund Rules in the interests of efficiency, administration practice and convenience to HealthGuard.

A.7.4 Standard Information Statements

HealthGuard will issue a Standard Information Statement (SIS) to one Adult Member on every Membership:

- a. at least once every twelve months;
- b. when a change to Fund Rules requires an update to the SIS for that Member's Product;
- c. upon request;
- d. that is commenced with HealthGuard, along with details of what the Membership covers and how benefits under it are calculated and a statement identifying that the Membership is referable to the Fund operated by HealthGuard; and
- e. that is transferred from another Product or Private Health Insurer.

A SIS is available to any person on request.

A8 Dispute Resolution

A Member may make a complaint to HealthGuard about their Membership or any action taken by HealthGuard and HealthGuard will respond to and make every effort to resolve the complaint as soon as possible under HealthGuard's Internal Dispute Resolution Process. The Private Health Industry Ombudsman is available to assist Members who have been unable to resolve a complaint with HealthGuard.

A9 Notices

Unless stated otherwise in these Fund Rules, a written notice sent by post to the address last supplied by the Member or Provider will be deemed notice to the Member or Provider under these Fund Rules.

Members may contact HealthGuard to request a copy of the Fund Rules at any time.

A10 Winding Up

Subject to the provisions of the Private Health Insurance Act, in the event of the winding up or dissolution of the Fund, any property that remains after payment of all its debts and liabilities will not be paid to or distributed to any Board members, officers or constitutional members of HealthGuard, but will be given to some other institution which is not carried on for the profit or gain of its members or shareholders. This institution, to be determined by the constitutional members of HealthGuard at or before the time of the dissolution, must have objectives similar to the objectives of HealthGuard and its constitution must prohibit the distribution of its income and property among its members or shareholders.

A11 Other

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

The following applies to the interpretation of these Fund Rules:

- a. nothing in these Rules will require HealthGuard to act in breach of its constitution;
- b. words and expressions used in the Private Health Insurance Act and the Health Insurance Act have the same meaning in the Fund Rules, unless otherwise specified; and
- c. words in the singular will include the plural and words in the plural will include the singular.

B2 Definitions

In these Fund Rules, unless otherwise stated, the following definitions apply:

Accident

An unforeseen event, occurring by chance and caused by an external force or object, which results in involuntary injury to the body requiring immediate treatment.

Acute Care (Certificate)

After 35 days of continuous hospitalisation, HealthGuard requires a certificate from the Medical Provider confirming the need for continued acute Hospital care to maintain full Hospital Benefits. If this certificate is not issued, Benefits payable will be reduced to the Nursing Home Type Patient Benefit.

Adult Member

A person, other than a Dependant, who is defined in the Private Health Insurance Act as a policyholder and who holds a Membership which is referable to the Fund.

Where the only person on a Membership is under 18, Adult Member means the parent or legal guardian of the person.

Agreed Hospital Fees

Fees which:

- a. are subject to a negotiated agreement between a Hospital and HealthGuard; or
- b. have been notified by a Hospital in writing to HealthGuard and have been approved by HealthGuard (but does not include any notified fees not approved by HealthGuard).

Ancillary

General Treatment (including the provision of goods and services) that is intended to manage or prevent a disease, injury or condition, and is not Hospital Treatment but may or may not include cover for Hospital-substitute Treatment as defined in Section 121-10 of the Private Health Insurance Act.

Approved Provider

An Ancillary or Medical Provider recognised by HealthGuard for Benefits and registered with HealthGuard as a provider of treatment or services.

Assisted Reproductive Services (ARS)

All aspects of a program of ARS (inclusive of IVF) including treatment leading up to pregnancy.

Benefit

An amount of money payable to a Member, or on behalf or for the benefit of a Member to an Approved Provider or Hospital by the Fund in accordance with the terms of these Fund Rules.

Board

The Board of HealthGuard or its delegate.

Class Physiotherapy Consultation

The personal attendance of an Approved Provider for the purpose of simultaneously providing a homogenous Medically Necessary treatment to more than one individual, where there has been an individual assessment by a physiotherapist.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Clinical Psychology Consultation

The attendance of an Approved Provider upon the Member, or where clinical circumstances require, a person responsible for support or care of the member, on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary clinical psychology treatment.

The treatment rendered must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation.

Complying Health Insurance Policy

A private health insurance policy that meets all the requirements of a particular Complying Health Insurance Product.

Complying Health Insurance Product

A Product that meets all the requirements set out in Chapter 3 of the Private Health Insurance Act and any other requirements set out in the Private Health Insurance (Complying Product) Rules.

Consultation

The personal attendance of an Approved Provider upon the individual Member (except in the case of Clinical Psychology Consultation) on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary Ancillary treatment.

The treatment rendered must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation (except in the case of a Class, Group or Small Group Physiotherapy Consultation).

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Co-payment

A predetermined out-of-pocket expense that is payable by the Member towards treatment or services.

Corporate Membership

A Membership subject to an agreement that has been negotiated between HealthGuard and a particular employer which may include terms and conditions that benefit the Member relating to payment of premiums and/or excesses.

Cover

A defined group of Benefits payable under a Membership, subject to relevant Fund Rules, for approved expenses incurred by a Member.

Department

The Department of Health and Ageing of the Commonwealth of Australia or its successor or replacement.

Dependant

A Member's dependant child (including a step-child and/or foster child), who does not have a Partner, is considered a dependant up until the end of the calendar year during which they turn 21, or later if they:

- a. are aged up to 25 years;
- b. are fully dependent on their parents;
- c. do not have a Partner; and
- d. do not have a taxable income in excess of the amount published by HealthGuard.

Emergency Treatment

Medically Necessary Hospital Treatment required for the diagnosis and management of acute and urgent illness or injury.

Equivalent Product

A Product offered by another Private Health Insurer that, in the opinion of HealthGuard, offers similar Benefits to a Product offered by HealthGuard.

Excess

An amount of money a Member agrees to pay for a Hospital stay before Benefits are payable.

[Example: where a Member's Product has an excess of \$200, the Member will be required to pay the first \$200 of their Hospital costs should they go to Hospital for an overnight stay as a Private Patient.]

Exclusion

Members may elect to pay a lower Premium and take out a Hospital Product with one or more exclusions for a particular condition.

Where a Product features an exclusion for a particular condition, Members will receive no Benefit for treatment as a Private Patient in a Participating Hospital for that condition.

[Example: if a Member purchases a Product that excludes Maternity or joint replacements, and they go into Hospital as a Private Patient for one of these conditions, HealthGuard will not pay any Benefits towards the Hospital or medical costs.]

Fund

The Fund conducted by HealthGuard in accordance with the Private Health Insurance Act.

Fund Rules

These rules relating to the operation of the Fund by HealthGuard.

Gap Cover

An arrangement that offers Known Gap or No Gap for Medical Gap, where:

- a. a Known Gap agreement exists that covers Members for all but a specified amount of the full cost of inpatient medical treatments; or
- b. a No Gap agreement exists that covers Members for the full cost of inpatient medical treatments.

Gold Card

A card issued by the Department of Veterans' Affairs (DVA) to veterans and dependants who are eligible under the Veterans' Entitlements Act 1986 or under Section 286 of the Military Rehabilitation and Compensation Act 2004 for treatment at the DVA's expense.

Group or Class Consultation

The attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment to more than one individual (except in the case of Class, Group and Small Group Physiotherapy Consultations).

The treatment provided must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Group or Family Clinical Psychology Consultation

The attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary clinical psychology treatment to more than one individual.

The treatment provided must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Group Physiotherapy Consultation

The personal attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment, to four or more individuals, where there has been an individual assessment by a physiotherapist.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

HealthGuard

HealthGuard Health Benefits Fund Limited trading as GMF Health, and Central West Health Cover.

Health Insurance Act

The Health Insurance Act 1973 (Cwlth) as amended from time to time.

Health Insurance Business

The business of providing insurance that relates to Hospital or Ancillary treatment (inclusive of Hospital-substitute Treatment) as defined in Section 121 of the Private Health Insurance Act.

Health Related Business

Business that is not Health Insurance Business and that provides goods or services (or both) in order to manage or prevent diseases, injuries or conditions, as defined in Section 131-15 of the Private Health Insurance Act.

Hospital

A Hospital, including a day Hospital that is declared by the Minister as a Hospital.

Hospital-substitute Treatment

Treatment that substitutes for an episode of Hospital Treatment, is a subset of General Treatment and is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition. A Membership that includes cover for Hospital-substitute Treatment must cover Hospital Treatment for the same types of treatment covered by the Hospital-substitute Treatment Product.

Hospital Treatment

Treatment (including the provision of goods and services) that is intended to manage a disease, injury or condition, where that treatment is provided by a person who is authorised by a Hospital to provide the treatment or a person under the control of such a person; and is provided at a Hospital or in the direct control of a Hospital, as defined in Section 121-5 of the Private Health Insurance Act.

Individual Physiotherapy Consultation

The personal attendance of an Approved Provider upon the individual Member on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary physiotherapy treatment.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

In Vitro Fertilisation (IVF)

See Assisted Reproductive Services (ARS).

Maternity

Any admission to a Hospital and or medical and surgical attention for birth, miscarriage, threatened miscarriage or any illness or disability relating to and experienced during pregnancy or birth.

Medical Gap

The difference between the Medical Provider's fees for services provided in Hospital and the Medicare Benefits Schedule fee as set by the Commonwealth Government.

Medical Provider

A person who:

- a. is registered or licensed as a Medical Provider under a law of a State or Territory; and
- b. satisfies the provider eligibility requirements for the payment of Medicare benefits.

Medical Purchaser-Provider Agreements (MPPA)

An agreement entered into between HealthGuard and a Medical Provider.

Medically Necessary

Medically necessary in the opinion of a Medical Provider or other suitably qualified person appointed by HealthGuard.

Medicare Benefits Schedule (MBS)

The schedule of medical services performed by a Medical Provider that have been assigned a schedule fee by the Commonwealth Government published in the 'Medicare Benefits Schedule Book'. This includes any updates and supplements to the schedule published from time to time.

[Explanation: By law, the only part of these services that can be covered by funds is the part of the MBS fee not covered by Medicare for medical services that are received as part of Hospital Treatment. If a Medical Provider charges above the MBS fee, funds cannot cover this amount unless they have an agreement with the Medical Provider or offer Gap Cover.]

Member

An Adult Member and any Dependents covered by a HealthGuard Membership.

Membership

A Complying Health Insurance Policy issued to one or more Adult Members and any Dependents under a particular Product or group of Products contained in these Fund Rules.

Minimum Default Benefit

An amount determined by the Minister under the Private Health Insurance Act to be the minimum Benefit payable for a particular episode or type of treatment in a Hospital.

Minister

The Minister for Health and Ageing in the Commonwealth Government.

Nursing Home Type Patient (NHTP)

A long-term Hospital patient who is not classified as requiring acute care.

NHTP Benefit

Where an Acute Care Certificate is either not issued or is revoked for any continuous period of hospitalisation exceeding 35 days, the NHTP Benefit is payable. The Government sets a patient contribution where the NHTP Benefit applies.

Out-of-pocket

The difference between HealthGuard Benefits for a particular treatment and the provider's fees.

Participating Hospitals

Australian Private Hospitals or Public Hospitals which have a negotiated agreement with HealthGuard concerning the fees that the Hospital may raise to Members and the Benefits HealthGuard will pay for Hospital Treatments provided to Members.

Participating Providers

Ancillary Approved Providers who have agreed to participate in arrangements with HealthGuard relating to the level of the Benefits HealthGuard will pay for specified treatment, goods or services that the Approved Provider may render to a Member.

Partner

A person who lives with an Adult Member, of the same or a different gender, in a marital or de facto relationship and who is covered under the same Membership.

For the purposes of this definition, a person who is temporarily living apart (eg. for work, study or family commitments, or to receive health-related treatment), but whose marital or de facto relationship is continuing is still regarded as a Partner.

Pharmaceutical Benefits Schedule (PBS)

The Commonwealth Government schedule that lists the pharmaceutical items for which the Government will pay a Benefit.

Pre-Existing Ailment

An ailment, illness or condition, the signs or symptoms of which, in the opinion of a Medical Provider appointed by HealthGuard, existed at any time in the period of 6 months ending on the day on which the Member joined a Hospital Product or upgraded to a higher level of Cover.

It is not necessary for the Member to be aware of a condition, ailment or illness for it to be considered Pre-existing.

Premiums

An amount of money a Member is required to pay to HealthGuard for a Membership for a specified period of Cover.

Premium Due Date

The due date for payment of Premium by a Member.

Private Health Insurance Act

The Private Health Insurance Act 2007 (Cwlth) as amended from time to time.

Private Health Insurance Rules

The Private Health Insurance Rules pursuant to the Private Health Insurance Act as amended from time to time.

Private Health Insurer

An insurer that is registered as a Private Health Insurer as defined in Division 126 of the Private Health Insurance Act.

Private Hospital

A Hospital, including a day Hospital, not operated by the State or Territory Government and declared by the Minister as an approved facility.

Private Patient

A person admitted to a Public or Private Hospital who is not a Public Patient.

Product

A defined group of Memberships that cover the same treatments and provide benefits that are worked out in the same way for approved expenses incurred by a Member and whose terms and conditions are the same as each other.

Prostheses List

Those prostheses as determined by the Minister under the Private Health Insurance Act.

Public Hospital

A Hospital that is operated by a State or Territory Government and declared by the Minister as an approved facility.

Relative

Any person covered by the same HealthGuard Membership of a Member who is also the Provider of any Ancillary treatment.

Restricted Services or Benefits

See Minimum Default Benefits.

Small Group Physiotherapy Consultation

The personal attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment to no more than three individuals, where there has been an individual assessment by a physiotherapist.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Standard Information Statements (SIS)

A SIS is a brief summary of the key features of a Complying Health Insurance Product that contains the information and is in the form set out in the Private Health Insurance (Complying Product) Rules.

Transfer

A transfer is where a person moves from one Product or one Private Health Insurer to another.

Transfer Certificate

A certificate provided by a Private Health Insurer that explains the Cover provided by the Membership and meets the required criteria as detailed in Section 99-1 of the Private Health Insurance Act.

Waiting Period

A period of time during which a Member must hold continuous Membership under a particular Product before the Member has an entitlement to receive a Benefit at the level payable on that Product.

B3 Other

C MEMBERSHIP

C1 General Conditions of Membership

C.1.1 Membership Categories

A Single Membership may only include one person; it must not include a Partner or Dependants.

A Family Membership may include one Adult Member, a Partner (or without a Partner) and any number of Dependants.

A Couples Membership may include one Adult Member and Partner only; it must not include Dependants.

C.1.2 Product Availability

Family Health is available as a Single Membership, a Family Membership or a Couples Membership to Central West Health Members.

Young and Healthy is available only as a Single Membership or a Couples Membership to Central West Health Members; it must not include dependants.

Young Singles Choice is available only as a Single Membership or a Couples Membership to GMF Health Members; it must not include Dependants.

All other HealthGuard Products are available as a Single Membership, or a Family Membership.

C.1.3 Levels of Cover

Subject to other Fund Rules, a Member may (at any one time) have a Membership under only one of the following:

a. any one Hospital Product, that covers Hospital Treatment, set out in Schedule H;

b. any one Ancillary Product, that covers General Treatment, set out in Schedule I;

c. any combination of a Hospital Product and an Ancillary Product, covering Hospital Treatment and General Treatment, set out in Schedules H and I;

d. any one of the special combined package Products, covering Hospital Treatment and General Treatment, set out in Schedule J.

C.1.4 Other Treatments

As provided in Section 69-1(1)(b) of the Private Health Insurance Act, Members who held Membership at the commencement of the Private Health Insurance Act under a Product that included funeral Benefits, will continue to receive those Benefits until the Member transfers to another Product that does not include those Benefits or until HealthGuard makes a change to the funeral Benefits.

No disability Benefits or bonus to help cover the initial expenses of a baby are payable under any HealthGuard Hospital or Ancillary Product.

C2 Eligibility for Membership

C.2.1 Eligible Person

Any person may be eligible for any HealthGuard Product or any combination of Products set out in Fund Rule C.1.3.

C.2.2 Interfund Preclusion

A Member of another Private Health Insurer is not eligible to also be a Member of HealthGuard for the same level of Cover, as defined in C.1.3, that is provided by the other Private Health Insurer.

C3 Dependants

C.3.1 Adding or Deleting a Dependant

Unless otherwise stated in these Fund Rules, an Adult Member may request to have a Dependant added to their Membership.

Where the Membership was a Single Membership prior to a Dependant being added, the Membership Category (as defined in Fund Rule C.1.1) will be amended from the date the Dependant is added. Premiums for the Membership will be adjusted accordingly.

If a Dependant does not meet the criteria under the definition of a Dependant (as defined in these Fund Rules):

- a. the Dependant will become ineligible for Cover under the parents' Membership;
- b. the Dependant will be removed from the parents' Membership; and
- c. HealthGuard will automatically offer a new single Membership for the Dependant.

C4 Membership Applications

C.4.1 Application in the approved form

A person may make any application required by these Fund Rules in writing, by telephone or by any other oral or electronic means approved by HealthGuard.

All relevant information requested by HealthGuard in order to establish and maintain a Membership must be supplied by the applicant.

HealthGuard may from time to time introduce or vary procedures or requirements with respect to applications made under this Fund Rule.

C.4.2 Refusal of Application to Join

As described in Fund Rule A.6, HealthGuard will not reject any Membership application for reasons described as improper discrimination under the Private Health Insurance Act. HealthGuard reserves the right to reject any application for admission as a Member for any other reason.

HealthGuard may refuse an application from a former Member of the Fund whose Membership was cancelled under the Termination of Membership Fund Rule (C.8)

C.4.3 Acceptance of Application to Join

HealthGuard will provide one Adult Member with the relevant up to date SIS. HealthGuard will also provide details of what the Membership covers and how Benefits are calculated and a statement identifying that the Membership is referable to the Fund operated by HealthGuard.

C5 Duration of Membership

C.5.1 Membership Commencement Dates

The commencement date of a Membership will be the day the Membership application is accepted by HealthGuard.

Exceptions to this Fund Rule are:

- a. where the applicant is transferring from another Private Health Insurer, the new Membership will be effective from the day after the date the other Private Health Insurer policy is paid up to; and
- b. Memberships created by HealthGuard for people who are no longer eligible to be covered on their parents' Membership as Dependents. These new Memberships will commence on a date determined by HealthGuard during the year the person becomes ineligible to be a Dependant.

C.5.2 Membership End Dates

Memberships will end on the cancellation or termination dates determined under Fund Rules C.7 or C.8.

C6 Transfers

C.6.1 Transfers From Another Private Health Insurer

When a Member of another Private Health Insurer transfers to HealthGuard within 2 months of the date the Member ceased to be covered by the other Private Health Insurer under a policy (the "Old Policy"), and the other Private Health Insurer provides a Transfer Certificate:

- a. HealthGuard may, at its discretion, recognise a period of cover under the Old Policy in determining maximum entitlements for Benefits for Ancillary under the new HealthGuard Membership;
- b. the Member will not be required to serve Waiting Periods except:
 - i. for services not covered by the Old Policy,
 - ii. the unexpired portions of any Waiting Periods not fully served under the Old Policy, and
 - iii. for Benefits greater than those payable under the Old Policy; and
- c. the new Membership will commence from the day after the Premium Due Date of the Old Policy.

When a Member of another Private Health Insurer transfers to HealthGuard more than 2 months after the Member ceased to be covered under the Old Policy, HealthGuard will treat the person as a new Member for all purposes except those relating to Lifetime Health Cover as specified at Fund Rule D.4.

When the Old Policy had an Excess and the new Product with HealthGuard does not, the Excess of HealthGuard's Equivalent Product will apply during any applicable Waiting Periods.

HealthGuard will provide one Adult Member with the relevant up to date SIS for the new Product. HealthGuard will also provide details of what the Membership covers and how Benefits are calculated and a statement identifying that the Membership is referable to the Fund operated by HealthGuard.

HealthGuard does not take into account any agreements between the other Private Health Insurer and any Provider for the purposes of calculating the level of Benefits covered under the Old Policy.

C.6.2 Transfers Between Products

An Adult Member may apply to transfer from any Product to any other Product and HealthGuard reserves the right (subject to these Fund Rules) to either approve or refuse the application.

The Membership under the new Product will be effective from the date the request was accepted by HealthGuard and the Membership under the previous Product will be cancelled from the day prior. However, claims for Benefits for treatment or services provided during Membership under the previous Product will be paid under the previous Product.

Where a Member transfers to a Product with a higher level of Benefits, HealthGuard will pay Benefits at the level of the previous Product for treatment or services provided during any Waiting Period applicable to the new Product.

Where a Member transfers to a Product with a lower level of Benefits, HealthGuard will pay Benefits at the level of the new Product for treatment or services provided during Membership under the new Product.

When the Membership under the previous Product had an Excess and the Membership under the new Product does not, the Excess will apply for treatment or services provided during the applicable Waiting Periods.

HealthGuard will provide one Adult Member with the relevant up to date SIS for the new Product. HealthGuard will also provide details of what the Membership covers and how Benefits are calculated and a statement identifying that the Membership is referable to the Fund operated by HealthGuard.

C.6.3 Transfers to Another Private Health Insurer

A Member transferring to another Private Health Insurer will receive a Transfer Certificate within 14 days to be provided to the other Private Health Insurer to enable continuity of Membership.

C7 Cancellation of Membership

C.7.1 Cancellation Requests

An Adult Member may request to cancel a Membership or remove a Dependant from a Membership by providing notice to HealthGuard in the form determined under Fund Rule C.4.1 and the cancellation will be effective from the Premium Due Date unless otherwise agreed by HealthGuard.

Exceptions to this Fund Rule are:

- a. where the Member is transferring to another Private Health Insurer, the Membership will be cancelled effective from the day prior to the date the other Private Health Insurer policy commenced; and
- b. where the Member is deceased, the Membership will be cancelled effective from the day after the date of death.

C.7.2 Reinstatement

Where a Membership has been cancelled, HealthGuard may in its discretion reinstate the Membership at the request of an Adult Member, with continuity of entitlements, subject to the payment of all Premiums as required under Fund Rule D.5.

C.7.3 Refund of Premiums

A pro-rata refund of not less than \$10.00 may be payable when a Membership is cancelled effective prior to the Premium Due Date.

Where no Benefits have been paid, an Adult Member may cancel within a period of 30 days from the commencement date of their Membership and receive a full refund of any Premiums paid.

C8 Termination of Membership

C.8.1 Termination by HealthGuard

HealthGuard may terminate a Membership:

- a. immediately by written notice where a Member misleads or deceives HealthGuard in accordance with Fund Rule C.8.2; or
- b. at a time determined by HealthGuard, without notice, if a Member has not paid a Premium due under the Membership within 2 months of the Premium Due Date.

C.8.2 Member Must Not Mislead or Deceive

If at any time HealthGuard determines that any Member (either whilst a Member or an applicant to become a Member) or any person acting on behalf of a Member or applicant has:

a. provided information to HealthGuard which in the opinion of HealthGuard is false or misleading; or

b. misled or deceived HealthGuard in any other manner including (without limitation) by failing to provide true and full information at any time, HealthGuard may at its discretion:

- i. terminate immediately by written notice the Membership of the Member, after which time:
 - (a) the Member will not be entitled to payment of Benefits regardless of when the treatment was rendered;
 - (b) the Member must reimburse the money paid by HealthGuard as a result of false, misleading or deceptive information or conduct; and
 - (c) HealthGuard will, after deducting all monies payable by the Member under (b) above, repay the Member any balance of Premiums paid by the Member for the period after the date of cancellation; or
- ii. not pay any Benefits where the information or conduct has been provided or committed in or connection with the claim for those Benefits and, in addition, recover from the Member all monies paid by HealthGuard arising from the information or conduct.

C.8.3 Member Entitlements on Termination

Unless Fund Rule C.8.2 applies:

- a. the termination of the Membership will not affect any rights accrued by the Member prior to the date of termination; and
- b. the Member will be entitled to a pro-rata refund of any Premium paid for any period beyond the date of termination.

C9 Temporary Suspension of Membership

C.9.1 Overseas Travel

- C.9.1.1 An Adult Member may request to suspend a Membership if all Members will be overseas for a minimum period of 3 months and Premiums are paid up to the date of departure.
- C.9.1.2 Suspension will be effective from:
the day after the date of departure if the application to suspend is received prior to travelling; or
the day after the date of departure or the day after the Premium Due Date (whichever is earliest), when the Member has already left Australia.
- C.9.1.3 During the period of suspension:
no Benefits are payable for treatment or services received during the period of suspension;
the period of suspension does not count towards the serving of Waiting Periods or length of Membership;
a Member is not entitled to the Federal Government Rebate;
the Medicare Levy Surcharge may apply; and
any Premiums paid in advance are held in credit pending resumption of Membership.
- C.9.1.4 Any outstanding Waiting Periods must be served upon resumption of the Membership.
- C.9.1.5 A Membership is resumed from the date of the Member's arrival back into Australia. A boarding pass or similar document showing the date of arrival must be sighted as confirmation.
- C.9.1.6 A Membership will be resumed on the same Product covered under the Membership prior to suspension.
- C.9.1.7 If the Membership was under a Product that is no longer available at the time of resumption, HealthGuard will offer the Equivalent Product and waive Waiting Periods for any increased Benefits.
- C.9.1.8 A suspended Membership may not be resumed where the Member is:
a. Returning to Australia for less than 6 months;
b. Returning to Australia for a holiday; or
c. Returning to Australia to receive treatment where permanent residence is not resumed.

C.9.2 Unemployment

Suspension of all or part of an Adult Member's level of cover (as outlined in C.1.3) due to unemployment is available to Adult Members in receipt of New Start or Sickness Benefits. Full details of entitlements must be supplied.

- C.9.2.1 Eligibility
- a. A Member requesting suspension due to unemployment, must:
 - i. have held Membership for at least 2 months with HealthGuard;
 - ii. be in receipt of either Newstart or Sickness Allowance benefits from Centrelink.
 - b. The Membership Premiums must be paid up to the time their suspension application commences.
- C.9.2.2 The terms of suspension of Membership are:
The Member does not pay Premiums and HealthGuard will not pay for eligible claims for treatment or services during the suspended Membership periods;
the suspension period commences from the latter of the day after the Premium Due Date or the date the Centrelink benefit commences;
The period of suspension is not included in the length of membership.
A Member is not entitled to the Federal Government Rebate during the period of suspension.

If the Centrelink benefits are withdrawn during the 'suspension' period the member must contact HealthGuard within two months. Payment of Premiums will re-commence from the date the Centrelink benefits are withdrawn.

Memberships will be reinstated from the date Centrelink payments are withdrawn, with benefits available on an equivalent product to that held prior to suspension.

If Waiting Periods or Benefit Limitation Periods have not been served prior to suspension, the unexpired portion must be served on resumption of Membership.

C10 Other

D CONTRIBUTIONS

D1 Payment of Premiums

D.1.1 Premiums Payable in Advance

Members must pay Premiums in advance, by the agreed frequency, on or before the Premium Due Date.

Premiums may not be paid more than 18 months in advance.

D.1.2 State Premiums

Premiums may differ based on the State or Territory in which the Member permanently resides.

D2 Premium Rate Changes

D.2.1 Rate Change

HealthGuard may vary the Premiums for any Product in accordance with these Fund Rules and any requirements set out in the Private Health Insurance Act.

D.2.2 Variations of Premium Rates and Premium Due Dates

Members paid in advance of the effective date of a Premium rate change, will not be required to pay the new rate of Premium until their next Premium Due Date.

D3 Premium Discounts

D.3.1 Rebates for Premiums paid in advance

A Member will be entitled to the following discounts on Premiums for a Membership under any Hospital or Ancillary Product.

- | | |
|-----------------------------------|---------|
| a. Annual payment in advance | - 3.83% |
| b. Six monthly payment in advance | - 1.92% |

D.3.2 Direct Payment Discount

A Central West Health Cover Member who pays Premiums from an account with a financial institution by a direct debit arrangement will receive a 4% discount on Premiums for a Membership under any Product.

D.3.3 Cumulative Discounts

The discounts for Premiums paid in advance and by direct payment, as outlined in D.3.1 and D.3.2, may not be applied simultaneously.

D.3.4 Corporate Membership Discounts

A discount up to 12% may apply to Corporate Memberships. This discount may not be applied in conjunction with any other discount detailed in Fund Rule D3.

D4 Lifetime Health Cover

HealthGuard will comply with the Federal Government's initiative for Lifetime Health Cover as required by law.

[Explanation: Premiums are based on the age of a Member when that Member first takes out Membership covering Hospital Treatment with a Private Health Insurer. To ensure the lowest Premium, a Member needs to take out a Hospital Product in the year ended June 30 in which they turn 31. If a Member decides to take out a Hospital Product after that date, the Member will pay a 2% loading on top of the Premium for every year the Member is aged over 30 at the time of joining. For example, a Member who joins aged 40 will pay 20 percent more for any Hospital Product than someone who joined aged 30.]

Therefore it recognises the length of time that a Member has had a Hospital Product and rewards that loyalty by offering lower Premiums if they join before the Member turns 31. Members who take out a Hospital Product early in life will be charged lower Premiums throughout the Member's life relative to Members who take out a Hospital Product later.

Where a Member has had Membership under a Hospital Product for 10 continuous years, the loading will cease to be charged and the Member's Premium will be reduced to the lowest Premium. For the purposes of calculating 10 years continuous cover, any periods (whether permitted or not) where the Member has not had Membership under a Hospital Product will not be included. For example, after 10 years of continuous Membership under a Hospital Product, the same Member who joined at age 40 and has a loading of 20% will no longer need to pay that additional 20%.]

D5 Arrears in Premiums

D.5.1 Unfinancial Members

HealthGuard deems a Member to be unfinancial and a Membership to be in arrears, if a Premium has not been paid on or before the Premium Due Date.

If a Premium is more than two months in arrears, then the Membership may be automatically terminated.

D.5.2 Acceptance of Arrears

D.5.2.1 Period of Arrears up to 2 Months

If a Member pays all Premiums for the period of arrears within 2 months of the Premium Due Date, HealthGuard will pay Benefits for treatment or services received during the period of arrears.

D.5.2.2 Period of Arrears Exceeding 2 Months

Any person who is an unfinancial Member for a period exceeding 2 months may apply to continue Membership and pay all outstanding Premiums, and HealthGuard may in its absolute discretion either approve or reject such application.

In approving an application, HealthGuard may impose conditions not inconsistent with the Private Health Insurance Act.

D.5.3 Treatment Where Premiums in Arrears

Subject to Fund Rules C.8.1(b) and D.5.2, if the Member does not pay Premiums due under the Membership by the Premium Due Date, HealthGuard will not pay Benefit towards any treatment received after the Premium Due Date unless and until the arrears are accepted.

D6 Other

E BENEFITS

E1 General Conditions

E.1.1 100% Rule

HealthGuard will not pay Benefits that exceed the actual charge for treatment, goods or services received by the Member.

The Benefit payable may be reduced in the following circumstances:

- a. where the amount paid by a Member for treatment is lower than the Benefit payable, the Benefit will be reduced to the amount paid; and
- b. where money is payable from more than one source for the same treatment, HealthGuard may reduce its Benefit so that the total money payable from all sources does not exceed the amount charged.

E.1.2 Benefits Not Payable

Benefits are not payable:

- a. for treatment, goods or services provided to a Member during the Waiting Period;
- b. during a period for which the Premiums have not been paid;
- c. for treatment or services or an item where the expense was incurred by the employer of that Member or if the Member obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at HealthGuard's discretion;
- d. where the Provider is not an Approved Provider;
- e. where the Member has received (or established a right to receive) compensation or damages for treatment or services; and
- f. where treatment occurs overseas.

E2 Hospital

E.2.1 Provider Agreements

Where a Member is charged for the following:

- a. Hospital Treatment provided in a Participating Hospital; or
- b. a professional medical treatment or service provided where a Medical Purchaser-Provider Agreement applies, the Benefits will, unless otherwise stated in these Fund Rules, be as specified in the relevant Agreement.

E.2.2 Lists of Provider Agreements

Any Member will be entitled to receive an up-to-date list of:

- a. HealthGuard Participating Hospitals; and
- b. the Providers with whom HealthGuard has Medical Purchaser Provider Agreements.

E.2.3 Non Agreement Providers

For treatment or services provided at non-Participating Hospitals, HealthGuard will pay Benefits that are at least equivalent to the Minimum Default Benefit.

E.2.4 Nursing Home Type Patients (NHTP)

HealthGuard will pay the NHTP Benefit as determined by the Minister for any Hospital Treatment provided to a Member while they are classified as a Nursing Home Type Patient.

E.2.5 Medical Gap Cover

Where a Member is admitted as a Private Patient and incurs a fee for a medical service rendered as part of Hospital Treatment that has an MBS item number, HealthGuard will pay as a minimum a medical Benefit of 25% of the MBS fee.

Where the Medical Provider has a Medical Purchaser-Provider Agreement (MPPA) as part of HealthGuard's Gap Cover, an additional Medical Gap Benefit may be payable.

Gap Cover is available to Members with Membership under any Hospital Products except Basic Hospital and Bronze Hospital products.

E.2.6 Admission and Discharge Days

The date of admission to Hospital will be included in the period for which a claim may be made, but the date of discharge from Hospital will not be included.

E.2.7 Location of Treatment

Hospital Benefits will only be payable for Hospital Treatment provided by a person who is authorised by a Hospital to provide treatment. Treatment must be provided either at a Hospital or with the direct involvement of a Hospital, subject to any negotiated agreement between HealthGuard and the Provider.

E.2.8 Surgically Implanted Prostheses

HealthGuard will pay the fee up to the minimum Benefit determined by the Minister for any surgically implanted prostheses implanted during a medical procedure for which Medicare benefit is payable and which is provided as part of Hospital Treatment. Members may incur an out-of-pocket cost where "Gap Permitted" prostheses items are used.

No Benefit is payable for items that are not on the Prostheses List.

E.2.9 Pharmaceuticals Provided During Hospital Treatment

No Benefit is payable for PBS items provided as part of the Member's Hospital Treatment.

No Benefit is payable for Non-PBS pharmacy items unless they require a prescription.

E3 Ancillary

E.3.1 Benefits

The Benefits payable for HealthGuard Ancillary Products are described in Schedules I, J and/or M.

E.3.2 Purpose of Treatment

No Benefit is payable for treatment primarily for the purposes of sport, recreation or entertainment unless:

- a. the treatment is provided as part of a health management program intended to improve a person's specific health condition; and
- b. the treatment otherwise complies with the requirements for General Treatment as detailed in Section 121-10 of the Private Health Insurance Act.

E.3.3. Registration of Approved Providers

E.3.3.1 Benefits are not payable for Ancillary treatment unless the provider is an Approved Provider for Ancillary. HealthGuard has absolute discretion to approve or not approve a provider.

E.3.3.2 An Approved Provider continues to be approved until the registration is cancelled under Fund Rule E.3.3.7 or the provider is declared an Unacceptable Provider under Fund Rule E.3.4.

E.3.3.3 A provider who has not previously been registered by HealthGuard, or has been previously registered by HealthGuard and had their registration cancelled may apply to be registered by HealthGuard to be an Approved Provider for Ancillary.

E.3.3.4 An application for registration as an Approved Provider for Ancillary must be in the form requested and contain the information required by HealthGuard from time to time.

E.3.3.5 Unless HealthGuard otherwise requires, registration of an Approved Provider for Ancillary is limited to provision of treatment from one stipulated location. An Approved Provider may apply for and obtain separate registration for different locations.

E.3.3.6 HealthGuard may grant registration to an Approved Provider for Ancillary subject to compliance by the Approved Provider with conditions, which have been or may be specified by HealthGuard from time to time. These conditions may include but are not limited to requirements in relation to billing and accounting and provision of treatment records and repayment of Benefits paid to the Provider contrary to these Fund Rules

E.3.3.7 HealthGuard may cancel the registration of an Approved Provider for Ancillary if the provider has:

- a. failed to comply with any condition specified by HealthGuard;
- b. been served with formal written notice requiring compliance with that condition;
- c. failed to comply with the terms of that notice

E.3.3.8 Upon cancellation of registration of an Approved Provider for Ancillary, Fund Rules E.3.4.a – E.3.4.d will apply as though the registration was cancelled due to the provider being deemed unacceptable and the date of cancellation will be deemed the declaration date as per Fund Rule E.3.4.

E.3.4 Unacceptable Providers

If a provider is found by any court, relevant statutory board or tribunal or professional association to have (or HealthGuard is otherwise satisfied that a provider has) engaged in unlawful, improper or unprofessional conduct, HealthGuard may declare that provider to be unacceptable (an “Unacceptable Provider”) and the following will apply:

- a. Subject to the Private Health Insurance Act, no Benefits will be paid by HealthGuard for treatment or services rendered by that provider at any time later than 2 months after the date of the declaration (the “Effective Date”), unless:
 - i. HealthGuard is satisfied that the Member was not aware of the declaration at the time the treatment or services was or were rendered; or
 - ii. HealthGuard considers, in its absolute discretion, undue hardship would be caused to the Member if Benefits were not paid.
- b. Within 14 days after the date of the declaration, all Members who according to HealthGuard records have received Benefits within the 1 year prior to the declaration, will be notified by HealthGuard that the treatments or services rendered after the Effective Date will not be eligible for Benefits.
- c. Within 7 days after the date of the declaration, HealthGuard will notify that provider that they have been declared an Unacceptable Provider and that no Benefits will be paid for treatment or services rendered after the Effective Date.
- d. A provider declared unacceptable may apply to HealthGuard (in the form required and with any evidence required by HealthGuard) for HealthGuard to revoke the declaration, and HealthGuard may grant, with or without conditions, or refuse the application as HealthGuard in its absolute discretion considers fit.

E.3.5 Services Rendered to a Relative

No Benefit for Ancillary treatment is payable where the patient is a Relative of and is covered on the same Membership as the Approved Provider rendering the treatment.

E.3.6 Time Tiered Consultations

Ancillary consultations, described in Schedule I as a period of time, include only time during which a Member is receiving direct or active attention.

They do not include preliminary or subsequent attendances, such as the making of appointments and writing of reports. Preliminary or subsequent attendance cannot be treated as a separate consultation.

E.3.7 Private Practice

Ancillary Benefits outlined in Schedules I, J or M apply only for fees charged for a treatment or service provided by an Approved Provider who is engaged solely and exclusively in Private Practice, unless HealthGuard decides otherwise.

An Approved Provider is engaged in Private Practice for the purposes of this Fund Rule, if the provider (if a sole practitioner) or the practice for which the Approved Provider works (as director, consultant, group member, associate, employee or otherwise) does not:

- a. conduct its practice at (or from) any Public Hospital unless the practice or Approved Provider:
 - i. pays rent and other outgoings which, in the opinion of HealthGuard, are on an arms length commercial basis for use of rooms and other facilities at the Public Hospital; and
 - ii. does not receive payment or reward of any type from the Public Hospital for treatment or services provided by the practice or Approved Provider at or from the Public Hospital; or
- b. treat patients who, except for their having private health insurance, would in the opinion of HealthGuard normally be treated:
 - i. at or from a Public Hospital; or
 - ii. by a person who would be paid by an employer or any other person than the patient for provision of services; or
- c. conduct practice at or from premises, the operation of which is wholly or partly funded by a source other than:
 - i. payment for treatment or services made by or on behalf of patients of the practice or Approved Provider; or
 - ii. capital invested or borrowed by the owner or operator of the premises; or
- d. receive funding for the capital or operating overheads of the practice by a source other than:
 - i. payment for treatment or services made by or on behalf of patients or clients of the practice or Approved Provider; or
 - ii. capital invested or borrowed by the practice or Approved Provider.

E4 Other

F LIMITATION OF BENEFITS

F1 Co Payments

F.1.1 Participating Hospital

Benefit for Hospital Treatment in a Participating Hospital will be the Agreed Hospital Fee less any Co-payment defined in Schedule M, unless the Fund Rules relating to the Product state otherwise.

F.1.2 Co-payment Application

Co-payments apply on the Bronze Product for:

- a. day patient treatment,
- b. shared ward or single room accommodation in a Participating Hospital,
- c. intensive care treatment in a Private Hospital.

F2 Excesses

F.2.1 Excess Rule

An Excess is an amount by which the Hospital Benefit is reduced per person per year to a maximum per Membership.

[Example: a \$100/\$200 Excess means that Benefit payable for Hospital Treatment is reduced by \$100 per person per year to a maximum of \$200 per Membership per year. The Excess does not apply to same day Hospital Treatment.]

F.2.2 Excess Types

Certain Hospital Products are available with optional Excess. For some combined Hospital and Ancillary Products, the Excess is mandatory.

F.2.2.1 Optional Excesses are available on these Products:

- a. Gold Hospital may have a \$100/\$200, \$300/\$600 or \$500/\$1000 excess;
- b. Silver Hospital may have a \$100/\$200, \$300/\$600 or \$500/\$1000 excess
- c. Comprehensive Hospital may have either a \$100/\$200 excess or \$200/\$400 excess

F.2.2.2 Mandatory Excesses apply on these Products:

- d. Bronze Hospital has a \$200/\$800 excess;
- e. Young Singles Choice has a \$150/\$300 excess;
- f. Young and Healthy has a \$150/\$300 excess;
- g. Family Health has a \$300/\$600 excess.
- h. Family Choice has a \$150/\$300 excess

F3 Waiting Periods

F.3.1 Application of Waiting Periods

The Member must have paid Premiums on the chosen Product for a continuous period of time as specified in these Fund Rules, before the Member is entitled to receive a Benefit at the level payable on that Product.

HealthGuard reserves the right to waive Waiting Periods at any time.

F.3.2 Hospital Waiting Periods

The Waiting Periods that apply to all HealthGuard Hospital Products are:

Maternity – 12 months

Pre-Existing Ailments – 12 months

Psychiatric, rehabilitation or palliative care (whether or not for a Pre-Existing Ailment) – 2 months

Accident or Emergency Treatment – 1 Day

All other Hospital Treatments – 2 months

F.3.3 Ancillary Waiting Periods

The Waiting Periods that apply to all HealthGuard Ancillary Products are:

- Ambulance – 1 day
- Clinical Psychology – 12 months
- Contact Lenses – 12 months
- Spectacles – 3 months
- Foot Orthoses – 12 months
- Hearing Aid – 24 months
- Major Dental – 12 months
- General Dental – 6 months
- Health Management Aids – Appliances – Various (refer to Schedule M)
- Antenatal Classes – 12 Months
- All other Ancillary services – 2 months

F.3.4 Multiple Waiting Periods

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

When both a Waiting Period and Benefit Limitation Period apply to a treatment, they are served independently of and concurrently with each other.

F.3.5 Newborn Babies

If a newborn baby is added to the Membership within 30 days of birth (which means the joining date will be the baby's date of birth), the baby will be credited with the length of Membership of, and will be deemed to have already served the Waiting Periods served by, the parent with the longest period of HealthGuard Membership.

F.3.6 Gold Card Holders

Where a person entitled to treatment under a Gold Card becomes a Member of HealthGuard no more than 2 months after their Gold Card entitlements ceased, no Waiting Periods or Benefit Limitation Periods apply.

F.3.7 Pre-existing Ailment

Unless HealthGuard determines otherwise, a Member is not entitled to Benefits for any ailment, condition or illness where signs or symptoms existed at any time during the 6 months prior to and ending on the day on which the Membership under that Hospital Product to which the claim relates commenced.

Whether a Pre-existing Ailment exists will be determined by a Medical Provider appointed by HealthGuard, taking into account information provided by the Member's Medical Provider and any other material the appointed Medical Provider believes is relevant to the claim.

It is not necessary for the Member to be aware of a condition, ailment or illness for it to be considered pre-existing.

This Fund Rule applies for the first 12 months after the Member commences a Membership under a new Product or transfers to a Membership under a Product that offers increased or additional Benefits.

The Pre-existing Ailment Waiting Period does not apply for psychiatric, rehabilitation or palliative care.

F4 Exclusions

Some Products may exclude the Member from receiving Benefit for the cost of certain forms of Hospital Treatment. The following Products have exclusions:

- a. All Hospital Products exclude benefits for reversal of sterilisation;
- b. Bronze does not pay Benefit for Hospital Treatment involving heart procedures, ophthalmic surgery involving the lens, Maternity, Assisted Reproductive Services (including IVF), joint replacement, sterilisation, and cosmetic surgery;
- c. Young and Healthy does not pay Benefit for Hospital Treatment involving heart procedures, joint replacement, Maternity, Assisted Reproductive Services (including IVF) or sterilisation;
- d. Family Health does not pay Benefit for Hospital Treatment involving heart procedures, joint replacement;
- e. Young Singles Choice does not pay Benefit for Hospital Treatment involving heart procedures, Maternity, Assisted Reproductive Services (including IVF), joint replacement, or sterilisation.
- f. Family Choice does not pay Benefit for Hospital Treatment involving joint replacement,

F5 Benefit Limitation Periods

No benefit limitation periods apply on HealthGuard Products

F6 Restricted Benefits

Benefits payable by HealthGuard are restricted to the Minimum Default Benefit on the following Products:

- a. Bronze for psychiatric and rehabilitation;
- b. Young Singles Choice for psychiatric, cosmetic surgery and ophthalmic surgery involving the lens;
- c. Family Health for psychiatric, cosmetic surgery, and ophthalmic surgery involving the lens;
- d. Young and Healthy for psychiatric, cosmetic surgery, and ophthalmic surgery involving the lens.
- e. Family Choice for psychiatric, cosmetic surgery, and ophthalmic surgery involving the lens, Assisted Reproductive Services

F7 Compensation Damages and Provisional Payment of Claims

F.7.1 Entitlement

Benefits are not payable for treatment or services for which the Member has received (or established a right to receive) compensation or damages (including a payment in settlement or part settlement of a claim for compensation or damages).

F.7.2 Amount of Entitlement

Where, in HealthGuard's opinion, the amount of the compensation or damages is less than the Benefits that would otherwise be payable (if Fund Rule F.7.1 did not apply), then Benefits are payable in an amount not exceeding the difference between the amount of Benefits that would otherwise have been payable, and the amount of the entitlement for compensation or damages.

F.7.3 Claiming Restrictions

When a Member has not yet received, or established a right to receive, compensation or damages, and HealthGuard at its discretion is of the opinion that there may be a claim, HealthGuard may pay Benefits but only if an Adult Member signs the approved provisional payment forms known as the 'Irrevocable Authority and Direction' and 'Damages and Compensation Claim Agreement' or their replacements from time to time.

In doing so the Member agrees to make the claim for compensation or damages on the following conditions:

- a. the claim includes the expenses for which HealthGuard has paid or will pay Benefits;
- b. the Member will not withdraw the claim for HealthGuard's expenses unless the Member withdraws the entire claim for compensation or damages;
- c. the Member will disclose to HealthGuard (and to authorise the Member's legal advisers to disclose) all matters relevant to the progress of the claim;
- d. the Member will notify HealthGuard if the Member receives (or establish a right to receive) compensation or damages; and
- e. from the compensation or damages payment, the amount that HealthGuard paid in Benefits for the treatment or services will be deducted and reimbursed to HealthGuard.

HealthGuard may in its discretion decline to pay Benefits to a Member who has made a claim for compensation or damages until that claim is settled or damages or compensation has been awarded.

F.7.4 No Entitlement

HealthGuard will pay Benefits where HealthGuard is satisfied that the Member has no right to payment for compensation or damages.

F.7.5 Default of Entitlement Agreement

Where a Member receives (or establishes a right to receive) payment for compensation or damages and:

- a. by the terms of the settlement or award it is expressed or implied that the sum of money to be paid excludes or limits the expenses for which HealthGuard has paid Benefits; or
- b. the Member abandons or compromises any part of the Member's claim so that such expenses are excluded or limited.

HealthGuard may decline to pay the Benefits which are excluded or limited and any Benefits paid to that extent may be recovered by HealthGuard from the Member as a debt due to HealthGuard.

F8 Other

F.8.1 Services Rendered by a Government Body

HealthGuard will not pay Benefits for a treatment or service provided to a Member by, or on behalf of, or under an agreement with one of the following:

- a. the Commonwealth;
- b. a State;
- c. a local government; or
- d. an authority established by a law of the Commonwealth, a State or Internal Territory.

F.8.2 Benefit Not Payable for an Epidemic

HealthGuard will only pay Minimum Default Benefits where:

- a. HealthGuard has received certification from the appropriate Government Official in and for the relevant State or Territory, that an epidemic of any disease or illness exists in all or any part of that State or Territory of Australia; and
- b. it is HealthGuard's opinion that the interests of HealthGuard's Members warrant the change to Benefits.

HealthGuard will give at least 7 clear days' notice of its intention to pay Minimum Default Benefits for treatment relating to an epidemic by notice in a daily newspaper published in the capital city of the State or Territory in which the epidemic is declared.

F.8.3 Treatment Under the Care of a Psychiatrist

Where the main purpose for a Member's admission to a Private Hospital is for Hospital Treatment under the care of a psychiatrist, HealthGuard will not pay a Benefit exceeding the amounts listed in the Schedule of Accommodation Benefits for psychiatric patients.

F.8.4 Limitations of Ancillary Benefits

As determined from time to time by HealthGuard, the Ancillary Benefits specified in Schedules I, J and M are subject to limitations of frequency of treatment for particular items and/or combinations of items, which may be provided at the same time or within particular periods.

Unless otherwise stated, limitations apply to each Member covered by a Membership.



G CLAIMS

G1 General

G.1.1 Claims

Applications for Benefits must be made in the manner determined by HealthGuard from time to time.

[Explanation: Claims may be made by paper form, electronically or in person subject to HealthGuard's discretion. Where forms are required by HealthGuard, they must be fully completed, including the Member's details and a signed authority for HealthGuard to request information from the Provider as required.]

Claims may only be made or authorised by an Adult Member or Dependant aged 18 years or older.

G.1.2 Claims Must Be Accompanied By Account/Receipt

The invoice for the treatment to be claimed must be received by HealthGuard and must note the treatment provided (descriptions and HealthGuard item numbers), the dates of the treatment, the patient's name, provider details and the fees charged and paid.

Any alteration to the invoice or receipt must be initialled by or on behalf of the Provider.

If the invoice or receipt is a replacement or copy, it must be stamped "duplicate" or "copy".

HealthGuard may, in its discretion, waive some or all of these requirements for claims submitted electronically.

G.1.3 Time Limit for Lodgement of Claims

Applications for Ancillary Benefits are to be made within 2 years from the date of receiving treatment.

Applications for Hospital Benefits are to be made within 2 years from the date of treatment.

HealthGuard may, in its absolute discretion, grant Benefits after the 2 year period.

G2 Other