Effective December 2019

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

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

**A1 Rules Arrangement**

**A1.1 Application of the Fund Rules**
Medibank Private Limited issues private health insurance *Covers* under two different brands, ‘Medibank Private’ and ‘ahm Health Insurance’.

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

**A1.2 Contents of the Fund Rules**
These Fund Rules consist of:
1. the ‘Main Rules’ (Fund Rules A to G), and
2. the ‘Schedules’ (Fund Rules H to J, and L).

**A2 Health Benefits Fund**

**A2.1 Establishment and Administration of the Fund**

1. Medibank Private Limited (ABN 47 080 890 259) is a *Private Health Insurer* trading as ‘Medibank Private’ and ‘ahm Health Insurance’.

2. A *Health Benefits Fund* is established in accordance with the Constitution of Medibank Private Limited in order to carry on health insurance business and health-related business as defined under, and in accordance with, the *Private Health Insurance Act*.

3. Medibank Private Limited administers the *Health Benefits Fund* referred to in [2].

**A2.2 Purpose of the Fund**
The purpose of the *Health Benefits Fund* is to provide *Benefits* to or on behalf of *Members* in accordance with the terms of these Fund Rules.

**A2.3 Purpose of the Fund Rules**
These Fund Rules set out the arrangements for *Membership* of, and the payment of *Benefits* by, the *Fund*.

**A2.4 Fund Policies**
The *Fund* may supplement the Fund Rules with Fund Policies that are not inconsistent with the Fund Rules.

**A2.5 Members Bound by Fund Rules and Policies**
All *Members* of the *Fund* are bound by the Fund Rules and Fund Policies as amended from time to time.

**A3 Obligations to Insurer**

**A3.1 Applicants and Members to Provide Requested Information**
An applicant for *Membership* of the *Fund* shall provide any information requested relevant to their *Membership* application.

Existing *Members* shall notify the *Fund* of any changes to information required by the *Fund* as soon as reasonably possible after the change.
**A4 Governing Principles**

**A4.1 Governance of the Fund**

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

1. the Private Health Insurance Act
2. the National Health Act 1953
3. the Health Insurance Act 1973
4. these Fund Rules
5. Fund Policies, and
6. the Constitution of Medibank Private Limited.

**A5 Use of Funds**

**A5.1 Financial Control**

Medibank Private Limited shall:

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

**A5.2 Income to be Credited to the Fund**

Medibank Private Limited shall credit to the Health Benefits Fund:

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

**A5.3 Drawings on the Fund**

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

1. for meeting liabilities to pay Benefits in accordance with these Fund Rules;
2. for meeting other liabilities and expenses incurred for the purposes of the business of the Fund;
3. for making investments of Fund assets; and
4. for making such other distributions, payments and transfers as may, from time to time, be permitted under the Private Health Insurance Act or which may from time to time be required to be paid under that Act.
A6 No Improper Discrimination

A6.1 Community Rating
When making decisions in relation to any person who is, or seeks to become, a Member, the Fund will not improperly discriminate on the basis:

(1) that a person suffers from a Chronic Disease, illness or other medical Condition or from a particular kind of disease, illness or medical Condition;

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

(3) of the age of a person, except to the extent that the Fund is required or permitted to do so by the Private Health Insurance Act in relation to matters dealt with under Part 2-3 of that Act;

(4) of where a person lives, except as permitted by the Private Health Insurance Act;

(5) of any other characteristic of a person (including his or her occupation or leisure pursuits) that is likely to increase his or her need for Treatments;

(6) of the frequency with which a person needs Treatment;

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

(8) of matters which are, from time to time, prohibited by the Private Health Insurance Act for these purposes.

A6.2 Exceptions to Community Rating
The restrictions in Fund Rule A6.1 do not apply where:

(1) the Private Health Insurance Act otherwise permits; or

(2) these Fund Rules otherwise permit.

A7 Changes to Rules

A7.1 Amendments to the Fund Rules
The Fund may amend the Fund Rules at any time, in a manner consistent with the Private Health Insurance Act.

A7.2 Overriding Waiver
(1) The Fund may waive the application of a Fund Rule at its discretion, provided that the waiver does not reduce any Member’s entitlement to Benefits.

(2) The waiver of a particular Fund Rule in a given circumstance does not require the Fund to waive the application of that Fund Rule in any other circumstance.

A7.3 Notification to Policy Holders or Principal Members
(1) Where the Fund amends (or proposes to amend) a Fund Rule and this amendment is or might be detrimental to the interests of a Member, Medibank Private or ahm Health Insurance will inform the Policy Holder or Principal Member of an affected Cover about the change a reasonable time before the change comes into effect.
(2) Where an amendment to the Fund Rules requires a change to the Information Statements for a Cover, Medibank Private or ahm Health Insurance will also give the Policy Holder or Principal Member of an affected Cover an updated Information Statement for that Cover as soon as practicable after it has been updated.

A8 Dispute Resolution

A8.1 Member Complaints
(1) A Member may make a complaint to Medibank Private or ahm Health Insurance about any aspect of their Membership at any time.

(2) Medibank Private or ahm Health Insurance will make reasonable endeavours to respond to complaints quickly and efficiently.

A8.2 Private Health Insurance Ombudsman
(1) The Private Health Insurance Ombudsman (the Ombudsman) is available to assist health fund Members who have been unable to resolve issues with their Fund.

(2) Nothing in these Fund Rules prevents a Member from approaching the Ombudsman at any time.

A9 Notices

A9.1 Correspondence
Medibank Private or ahm Health Insurance shall send any correspondence to the most recently advised postal address, phone number, fax number or email address of the relevant Member.

A9.2 Availability of Fund Rules to Members
These Fund Rules are available for Members to view at any Medibank store or online at medibank.com.au, or ahm.com.au

A10 Winding Up

A10.1 In the event of Medibank Private Limited ceasing to be registered under the Private Health Insurance Act, the Health Benefits Fund shall be terminated in accordance with the requirements of the Private Health Insurance Act and these Fund Rules.

A10.2 In the event of termination of the Fund all monies standing to the credit of the Health Benefits Fund and not required for meeting outstanding liabilities of the Fund, including Benefits, staff entitlements or allowances, contracted payments and all other expenses of termination including the requirements of the Private Health Insurance Act shall be utilised in such manner as may be determined by the board of directors of Medibank Private Limited in accordance with the constitution of Medibank Private Limited.
B
Interpretation and Definitions

B1 Interpretation

B1.1 Interpretation of the Fund Rules

(1) The Fund Rules are written using ‘plain English’.

(2) The names of individual Covers are referred to in italics, and are not intended to be interpreted more generally.

(3) Words or expressions in Initial Capital Bold Italic are defined in Fund Rule B2.1 and are intended to be interpreted accordingly.

(4) Unless otherwise specified, the definitions and sub-definitions in Fund Rule B2.1 apply throughout the Fund Rules.

(5) A sub-definition is a part of the definition to which it belongs, and is not meant to be read in isolation.

(6) Where not defined, words and expressions are intended to have their ordinary meaning.

(7) A reference to any legislation shall be taken as a reference to that legislation as amended from time to time.

(8) These Fund Rules are to be interpreted, so far as possible, in a manner that is consistent with the Private Health Insurance Act.

(9) Unless the context requires otherwise, a term that is not defined in these Fund Rules but is defined in the Private Health Insurance Act will be interpreted with the meaning that it is given in Private Health Insurance Act.

B2 Definitions

B2.1 In these Fund Rules:

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

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

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

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

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

ADA Schedule means the Schedule of Dental Services published by the Australian Dental Association Incorporated.
**Admitted Patient** means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment.

This definition:

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

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

**Agreement** means an agreement entered into between a Hospital or group of Hospitals, or a Medical Practitioner or group of Medical Practitioners, and the Fund under which the Hospital or Medical Practitioner providing the service/s agrees to accept payment by Medibank Private or ahm Health Insurance in satisfaction of the amount that would, apart from the Agreement, be owed to the Hospital or Medical Practitioner in relation to the Treatment provided by the Hospital or Medical Practitioner to a Member.

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

**Australia** for the purposes of these Fund Rules:

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

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

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

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

**Board** means the board of directors of Medibank Private Limited.

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

**Child** means one of the following:

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

Chronic Disease for ahm Health Insurance means, a disease that has been, or is likely to be, present for at least six Months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes, a mental health Condition, arthritis and a musculoskeletal Condition.

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

(1) performed or rendered by a Medical Practitioner, Dental Practitioner or Optometrist; and

(2) generally accepted in the relevant profession as being necessary for the appropriate Treatment of the Patient.

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

Compensation means:

(1) a payment of compensation or damages pursuant to a judgment, award or settlement;

(2) a payment in accordance with a scheme of insurance or compensation provided for by Commonwealth or State law (e.g. workers compensation insurance);

(3) settlement of a claim for damages (with or without admission of liability);

(4) a payment for negligence; or

(5) any other payment that in the Fund’s opinion is a payment in the nature of compensation or damages.

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

(1) Community Rating Requirements; and

(2) Coverage Requirements; and

(3) if the Policy covers Hospital Treatment, Benefit Requirements; and

(4) Waiting Period Requirements; and

(5) Portability Requirements; and

(6) Quality Assurance Requirements; and

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

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

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

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

Co-payment means a daily amount that a member may be required to contribute towards the costs of Treatment at any Hospital, separate and in addition to any Excess applicable. The requirement for, and the amount of, the contribution is determined by reference to the cover held. Co-payment may also be referred to as a Daily Charge or Per-Day Payment.
**Contribution Group** means a group of **Members** approved under these Fund Rules.

**Contributions**: see **Premiums**.

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

**Couple** (membership): see **Membership Category**.

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

**Coverage Requirements** means that:

1. the only **Treatments** the **Policy** covers are:
   - (a) specified **Treatments** that are **Hospital Treatment**; or
   - (b) specified **Treatments** that are **Hospital Treatment** and specified **Treatments** that are **General Treatment**; or
   - (c) specified **Treatments** that are **General Treatment** but not that are **Hospital Substitute Treatment**; and

2. if the **Policy** provides a **Benefit** for anything else, the provision of the **Benefit** is authorised by the Private Health Insurance (Complying Product) Rules.

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

**Daily Charge**: see **Co-payment**.

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

**Day Only Admission** means admission to and discharge from a **Hospital** or **Day Facility** on the same day.

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

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

**Dental Treatment** means professional **Treatment** that is:

1. approved by Medibank Private; and

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

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

1. a **Child Dependant** being a **Child** of the **Policy Holder** or **Principal Member** who is under the age of 21.
(2) a **Student Dependant** being a **Child** of the **Policy Holder or Principal Member** who:

(a) has reached the age of 21 but is under the age of 25, and

(b) is undertaking **Full-Time Education**.

(3) an **Adult Dependant** being a **Child** of the **Policy Holder or Principal Member** who:

(a) has reached the age of 21 but is under the age of 25, and

(b) is not a **Student Dependant**; and

(c) is a **Member** of an eligible **Cover** or combination of eligible **Covers**.

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

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

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

**Excess** for ahm Health Insurance means an amount paid by a **Patient** towards the cost of **Hospital Treatment** received at any **Hospital** or **Day Facility** before any **Benefits** are payable. An **Excess** is payable per Hospital admission each **Membership Year**, determined by the relevant **Policy**.

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

**Ex-gratia** means providing a **Benefit** for a service or good that is not covered by the relevant level of **Cover** under a **Policy** or an extension of a **Benefit** or limit to that entitled under the relevant level of **Cover**.

**Family** (Membership): see **Membership Category**.

**Financial Date** of a **Policy** for ahm Health Insurance means the date to which the **Principal Member** has fully paid the **Premiums** in respect of the **Policy**.

**Financial Year** means a period of one year from 1 July to 30 June.

**Full-time Education** means a course of study:

(1) being undertaken at an Australian Educational Institution; and

(2) requiring a Full-Time Study Workload as determined by Medibank Private or ahm Health Insurance.

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

**Fund Benefit**: see **Benefit**.

**GapCover** means an arrangement or scheme adopted by the **Fund** where a **Medical Practitioner**, if they agree to participate in the arrangement or scheme, may raise charges for **Hospital Treatment** in accordance with the permitted charges under that scheme, and the **Fund** will cover **Members** for all or all but a specified amount or percentage
of that charge for the medical and associated professional services provided as part of the Member’s Hospital Treatment where Medicare benefits are payable.

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

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

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

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

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

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

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

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

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

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

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

**Information Statement** means either a Standard Information Statement or a Private Health Information Statement.

**Medically Necessary** for ahm Health Insurance in relation to ambulance transport means transportation by Ambulance that is necessary as, due to the Patient’s Condition, the Patient could not be transported by any other means. It includes transportation by road and air and between Hospitals. It does not include transportation for Outpatient services.

**Medical Practitioner** means Medical Practitioner as defined in the Act.

**Medicare Benefits Schedule (MBS; or Commonwealth Medicare Benefits Schedule (CMBS))** means the ‘Medicare Benefits Schedule Book’ published by the Commonwealth Department of Health, and includes any updates and Supplements to the Schedule published from time to time.

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

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

**Members’ Choice Provider** means one of the following:

1. **Members’ Choice General Treatment Provider** is a provider of a General Treatment Service with whom the Fund has entered into an arrangement under these Fund Rules which appoints the provider as a Members’ Choice Provider.

2. **Members’ Choice Advantage Provider** is a
B Interpretation and Definitions

Members’ Choice General Treatment Provider of a General Treatment Service with whom the Fund has entered into an arrangement under these Fund Rules which appoints the provider as a Members’ Choice Advantage Provider.

(3) Members’ Choice Hospital is a Contracted Hospital that forms part of the Fund’s Members’ Choice network.

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

Membership Category means one of the following:

(1) Single Membership, which includes one Member

(2) Couple Membership, which includes the Policy Holder or Principal Member and their Partner

(3) Family Membership, which includes the Policy Holder or Principal Member, their Partner, and one or more other Dependants

(4) Single Parent Family Membership, which includes the Policy Holder or Principal Member and one or more Dependants.

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

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

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

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

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

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

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

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

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

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

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

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

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

Patient: see Private Patient or Public Patient

PBS: see Pharmaceutical Benefits Scheme

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

PEC: see Pre-Existing Condition.

Per-Day Payment: see Co-payment.

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

Policy: see definition of Cover.

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

Pre-existing Condition (PEC) is an ailment, illness or Condition that in the opinion of a Medical Practitioner appointed by the Fund, the signs or symptoms of that ailment, illness or Condition existed at any time in the period of six Months ending on the day on which the person became insured under the Policy or changed their Cover. The appointed Medical Practitioner must have regard to any information in relation to the ailment, illness or Condition that the Medical Practitioner who treated the ailment, illness or Condition provides, or that the Fund provides.

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

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

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

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

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

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

Product: see Cover.

Professional Attention for Medibank Private means:

1. medical or surgical Treatment by or under the supervision of a Medical Practitioner,
2. obstetric Treatment by or under the supervision of a Medical Practitioner or a Registered Nurse with obstetric qualifications,
3. Dental Treatment by or under the supervision of a Dental Practitioner, or
4. podiatric Treatment by or under the supervision of an Accredited Podiatrist.
Interpretation and Definitions

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

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

Prosthesis means:

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

Psychiatric Patient means a Patient undergoing Treatment in a Private or Public Hospital under the supervision of a psychiatrist, and the Treatment Program has been approved by Medibank Private or ahm Health Insurance.

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

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

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

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

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

Recognised Provider means:

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

Recognition Criteria means the following conditions applying to Recognised Providers:

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

(5) any other criteria that Medibank Private or ahm Health Insurance consider reasonable.

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

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

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

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

Risk Factors for Chronic Disease for ahm Health Insurance means:

(1) lifestyle risk factors, including, but not limited to, smoking, physical inactivity, poor nutrition or alcohol misuse; and

(2) biomedical risk factors, including, but not limited to, high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; and

(3) family history of a Chronic Disease.

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

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

Single (membership): see Membership Category.

Single Parent Family (membership): see Membership Category.

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

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

State of Residence means the State or Territory in which the Policy Holder or Principal Member currently resides.

For the purposes of these Fund Rules:

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

(2) a Policy Holder or Principal Member living in the Territory of Cocos (Keeling) Islands or the Territory of Christmas Island is taken to be a resident of the Northern Territory (NT).

State means the State or Territory of Australia.

Suspendable Cover means any Cover other than Ambulance Cover.
B Interpretation and Definitions

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

Territory: see State.

Transfer for Medibank Private means:

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

2. a change of Cover within Medibank Private.

Treatment means:

1. in respect of Hospital Covers: Hospital Services and Hospital Treatment, and

2. in respect of General Treatment Covers: services and items for which Benefits are payable under these Fund Rules.

To avoid doubt, a ‘service’ excludes any Treatment that is not provided by the provider personally or under the direct supervision of the provider.

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

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

Youth Discount: see Aged-based Discount.

C Membership

C1 General Conditions of Membership

C1.1 Same Membership Category and Covers

All Members under the same Membership shall:

1. belong to the same Membership Category, and

2. have the same Cover or Covers.

C1.2 GST

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

C1.3 Medibank Private or ahm Health Insurance may from time to time declare that, for an additional premium, a Cover can include an Adult Dependant.

C2 Eligibility for Membership

C2.1 Membership Eligibility: General

Subject to these Fund Rules, any person is entitled to apply as a Member.
C2.2 Membership Eligibility: Medibank Private Visitors Covers

(1) *Membership* of a *Visitors Cover* is available only to persons who:

(a) are not eligible for full Medicare benefits; and

(b) meet the eligibility requirements for the *Visitors Cover*.

(2) To enable Medibank Private to determine eligibility, it may, upon reasonable notice to the *Member*, require production of proof of eligibility to become, or to continue as, a person insured under a particular *Cover*.

(3) If a *Member* fails to provide documentary evidence to the reasonable satisfaction of Medibank Private, Medibank Private may deem that *Member* to be ineligible to be insured under that *Cover*. then Medibank Private may, at its discretion do all or any or any combination of the following:

(1) terminate the *Membership*;

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

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

C2.3 Ineligible Members: Medibank Private Visitors Cover

Where:

(1) a *Member* joins a *Visitors Cover* which the *Member* was ineligible to join; or

(2) a *Member* insured under a *Visitors Cover* ceases to be eligible to hold that *Cover* (whether due to any change of visa or residency status or otherwise); or

(3) a *Visitors Cover* is issued to a *Policy Holder* and neither that *Policy Holder* nor any *Partner* of that *Policy Holder* who is also insured under the *Cover* meets the visa requirement specified in these Fund Rules at that time or, having met that visa requirement at the time of issue of that *Visitors Cover*, ceases to meet that requirement;
C Membership

Where Medibank Private migrates Members to a substituted Cover with retrospective effect, it may also reassess Premiums payable by or on behalf of the affected Members and Benefits paid to or in respect of affected Members, notify the Members of any underpayment of Premiums or any overpayment of Benefits and require immediate payment or repayment to Medibank Private of the same, apply any pre-paid Premiums standing to the credit of the Membership towards any amount owed to Medibank Private by way of repayment of Benefits and treat any Membership as being in Arrears until all such underpayments of Premium and overpayment of Benefits have been made good.

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

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

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

C2.5 State of Residence (Resident Covers)

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

C2.6 Minimum Age of Policy Holder or Principal Member

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

C3 Partner and Dependents

C3.1 Partner Ceasing Eligibility

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

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

C3.2 Dependents Ceasing Eligibility

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

Subject to these Fund Rules, a person who ceases to be eligible to be a Dependant may become a Policy Holder or Principal Member by choosing a currently marketed Cover.
C4 Membership Applications

C4.1 Form of Application
Applications to become a Member must be in the form required by Medibank Private or ahm Health Insurance.

C4.2 Refusal of Applications: Medibank Private Visitors Cover
(1) Medibank Private may refuse an application for a person to join Medibank Private Visitors Cover as a Policy Holder, a Policy Holder’s Partner, or as a Dependant.
(2) Where Medibank Private refuses such an application, it shall give the applicant a reason for the refusal.

C4.3 Reinstatement of Cancelled Membership
Where a Membership has been cancelled under these Fund Rules, Medibank Private or ahm Health Insurance may, at its discretion, reinstate the Membership at the request of the Policy Holder or Principal Member, with continuity of entitlements, subject to the payment of all Premiums as required under these Fund Rules.

C4.4 Information in Support of an Application for Membership
A person seeking to become a Member is required to provide such information as considered necessary.

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

C5 Duration of Membership

C5.1 Membership Commencement Date: Resident and Visitors Covers
(1) Membership commences on the latest of:
   (a) the date on which an application is lodged with the Medibank Private or ahm Health Insurance, or
   (b) where Medibank Private or ahm Health Insurance agrees, a later date nominated in the application, or
   (c) for ahm Health Insurance, a date mutually agreed between the Member and ahm Health Insurance, or
   (d) in the case of a Medibank Private Visitors Cover, the Policy Holders date of arrival in Australia.
(2) A newborn Child may be added to a Single Parent Family, Couple or Family Membership from its date of birth provided the application is received by the Fund within 12 Months of the date of birth. Only those Waiting Periods applying to the Policy Holder or Principal Member at that time will apply to the Child, provided the Membership commenced no later than the Child’s date of birth.
(3) Any Child added to a Single Parent Family, Couple or Family Membership more than 12 Months after the date of birth will be added from the date of application. Only those Waiting Periods applying to Policy Holder or Principal Member at that time will apply to the Child, provided that the Membership commenced no later than the Child’s date of birth.
C Membership

(4) A newborn Child may be added to a Single Membership from its date of birth and only those Waiting Periods applying to the Policy Holder or Principal Member at that time will apply to the Child, provided that:

(a) the Membership commenced no later than the Child’s date of birth;

(b) the application is received by the Fund within two Months of the date of birth; and

(c) the Membership Category is amended to Family or Single Parent Family Membership, as agreed.

C6 Transfers

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

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

(1) to any Benefits under the Medibank Private Cover that were not provided under the previous Cover

(2) to the difference (if any) between the Benefit payable by Medibank Private in respect of a service and that payable by the previous Fund as at the date of service

(3) to the unexpired portion of any Waiting Periods not fully served under the previous Cover, and

(4) to the unexpired portion of a Benefit Replacement Period or limit governing the supply or replacement of an appliance or Prosthesis.

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

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

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

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

(1) to any Benefits for services or Treatment under the ahm Health Insurance Cover that are services or Treatments that were not provided under the previous Cover

(2) to the difference (if any) between a higher Benefit payable (or any annual or other limit) by ahm Health Insurance in respect of a service and that payable by the previous Fund as at the date of service

(3) to the unexpired portion of any Waiting Periods not fully served under the previous Cover, and

(4) to the unexpired portion of a Benefit Replacement Period or limit governing the supply or replacement of an appliance or Prosthesis.

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

When a Member of another Private Health Insurer transfers to ahm Health Insurance with a gap in Cover of more than 30 days, ahm Health Insurance will treat the person as a new Member for all purposes.
C6.5 Cover Changes
Where a Member transfers to a different Cover that is:

(1) deemed to be a lower level of Cover, Benefits (where payable) are payable at the level of the new Cover provided that the relevant Waiting Period has been served as at the date of Treatment.

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

C6.6 Previous Benefits will be Taken into Account

(1) Subject to other Fund Rules, where a Member transfers from another Private Health Insurer or to a different Cover, any relevant Benefits that have been paid in a specified time period under the previous Cover will be taken into account in determining the Benefits payable under the new Cover.

(2) ‘Any relevant Benefits’ include, but are not limited to, Benefits that are subject to an annual or other limit or a maximum number of days of hospitalisation.

C6.7 Equity Transfers

(1) Where a Member has transferred to Medibank Private from another Health Insurer, Medibank Private may at its discretion recognise a period of Cover with the previous organisation in determining annual limits for Benefits under the new Cover.

(2) Where a Member Transfers from one Medibank Private Cover with Equity for a General Treatment Service to another Medibank Private Cover with Equity for that same General Treatment Service, the Member will be provided with advanced standing in relation to the Equity entitlements for that General Treatment Service.

C6.8 Non-Resident Covers: Transfers

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

(1) makes a claim for Benefits during the first two Months of Membership of the new Hospital Cover, or

(2) makes a claim for Benefits under the new Hospital Cover to which these Fund Rules would otherwise apply. Benefits are payable as if the Policy Holder were still a Member of a Visitors Cover.

C6.9 Transfers from Non-Resident Covers: Qualifying Periods

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

(1) any additional level of Benefits provided under the new Cover

(2) Benefits for any item offered under the new Cover but not under the original Cover, and

(3) any unexpired portions of any Qualifying Periods not served under the original Cover.
C Membership

C6.10 Transfers from Non-Resident Covers: Exemption from Qualifying Periods
Subject to these Fund Rules, a Member who Transfers from a Visitors Cover to another Medibank Private Cover is not required to serve any Qualifying Period, provided that:

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

C7 Cancellation of Membership

C7.1 Cancellation of Membership
(1) Subject to (2):
   (a) a Policy Holder or Principal Member may cancel their Membership entirely,
   (b) a Policy Holder or Principal Member may remove any Dependents from their Membership,
   (c) the Policy Holder or Principal Member’s Partner or a Dependant aged at least 16 years of age may leave the Membership,
   (d) a Dependant under 16 years of age may leave the Membership with the agreement of the Policy Holder or Principal Member.

(2) Unless otherwise permitted by the Fund, the above actions:
   (a) may not have retrospective effect from the date of receipt of the request for cancellation, and
   (b) must be in accordance with any other arrangements specified by the Fund.

C7.2 Refunds of Premiums
(1) the Fund has an obligation to refund excess Premiums when a Membership ceases only where required to do so by a law or where specified in these Fund Rules.

(2) the Fund may at its discretion refund some or all of the excess Premiums after receiving a request from a former Policy Holder or Principal Member. Such a refund will generally be calculated from the date of receipt of the request.

(3) the Fund may also deduct an administrative charge from any refund at its discretion.

C7.3 Cooling Off Period
A Policy Holder or Principal Member who has not yet made any claim for Benefits under the Policy and who terminates that Policy within a period of 30 days from the start date of the Policy (‘cooling off period’) is entitled to receive a full refund of any Premiums paid.

C8 Termination of Membership

C8.1 Termination of Membership Where a Member Acts Improperly
(1) Where, in the opinion of Medibank Private or ahm Health Insurance, a Member has obtained or attempted to obtain an improper advantage, for themselves or for any other Member, the Fund may terminate the relevant Membership immediately, by written notice to the Policy Holder or Principal Member.
(2) For the purposes of this Fund Rule, ‘improper advantage’ means any advantage, monetary or otherwise, to which a Member is not entitled under the Fund Rules. This includes (but is not limited to) any situation where a Member has been insured under a Cover under which the Member was not eligible to be insured.

C8.2 Termination of Membership in Other Circumstances

(1) In any circumstance other than as specified in these Fund Rules, Medibank Private or ahm Health Insurance may terminate a Membership immediately.

(2) If the Fund invokes this Fund Rule, it shall:

(a) provide the Policy Holder or Principal Member with notice in writing including a reason for the termination, and

(b) refund any Premiums paid in advance as at the date of the termination above a prescribed minimum refundable amount and/or less any Benefits paid.

(3) Where a Membership has been terminated under this Fund Rule, Medibank Private or ahm Health Insurance has discretion to reinstate the Membership at the request of the Policy Holder or Principal Member, with continuity of entitlements, subject to the payment of all Premiums as required under these Fund Rules, or can refuse a future application from any Member insured under that Policy.

C9 Temporary Suspension of Membership

C9.1 Suspension of Membership Policy

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

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

A Membership of a Resident Cover may be suspended in the following circumstances:

(1) Membership Suspension for a maximum of two years, while the Policy Holder or the Policy Holder’s Partner continues to receive a form of short-term income maintenance paid by Centrelink (such as Youth, NewStart or Sickness Allowance)

(2) Membership Suspension for a maximum of two years, where the Policy Holder is recognised by a government agency or Medibank Private as suffering financial hardship caused by naturally occurring conditions determined from time to time according to criteria established by Medibank Private

(3) Membership Suspension or Partial Suspension for a minimum of two Months and a maximum of four years, where a Member is (or Members are) overseas

(4) Partial Suspension for a maximum of four years, where a Member is in jail, and

(5) Any other circumstances that Medibank Private may approve from time to time.
C Membership

C9.3 Reasons and Time Limits: ahm Health Insurance

A Membership of a Cover may be suspended in the following circumstances:

1. **Membership Suspension** for a maximum of two years, where the Principal Member is recognised by a government agency or ahm Health Insurance as suffering financial hardship caused by naturally occurring conditions determined from time to time according to criteria established by ahm Health Insurance.

2. **Membership Suspension** for a maximum of two years, while the Principal Member or the Principal Member’s Partner continues to receive a form of short-term income maintenance paid by Centrelink (such as Youth, NewStart or Sickness Allowance).

3. **Membership Suspension** for a minimum of 30 days and a maximum of two years, where all Members on the Cover are overseas.

4. Any other circumstances that ahm Health Insurance may approve from time to time.

C9.4 Suspension Arrangements: Medibank Private Visitors Cover

1. **Membership Suspension** or Partial Suspension of a Visitors Cover may occur only where a Member is overseas for a continuous period of at least two Months.

2. Each period of Suspension must be for at least two Months.

3. The Membership may not be suspended for more than a total of four Months at a time.

C9.5 Memberships to be Paid in Advance

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

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

C9.6 All Suspendable Covers to be Suspended

A Member with two different types (i.e. Hospital and General Treatment) of Suspendable Cover may not suspend one Cover without also suspending the other.

C9.7 Arrangements during Suspension Period

During the period in which a Member is suspended:

1. for Medibank Private, the Membership Category will be adjusted where appropriate

2. for Medibank Private, the Member will not be taken into account for the purposes of calculation of Premiums

3. Benefits are not payable for Treatment received by the Member, and

4. the period does not count for any purpose in relation to the Member, including Waiting Periods and Benefit Replacement Periods.
D Contributions

C9.8 Minimum Period Between Suspensions
A Membership may be suspended only where the following minimum periods have elapsed since the reactivation from a previous Suspension for the same reason:

Medibank Private Memberships:
- six Months – overseas travel
- 12 Months – all other allowable circumstances

ahm Health Insurance Memberships:
- one day – all allowable circumstances.

C9.9 Documentation to be Provided
A Member who wishes to suspend or reactivate a Membership must provide all relevant documentation in support of their application that the Fund may specify.

C9.10 Reactivation of a Suspended Membership
(1) For Medibank Private, a suspended Membership must be reactivated within one Month of:
   (a) the date on which the reason for Suspension ceases to apply, or
   (b) the date on which the maximum Suspension period has been reached, whichever is the earlier.

(2) For ahm Health Insurance, the Membership will be reactivated:
   (a) on the date of return to Australia; or
   (b) on the date of resumption of employment; or
   (c) two years from the date of Suspension, whichever is the lesser.

(3) Where the Membership is not reactivated by the relevant date, and has subsequently fallen into arrears, the Fund may terminate the Membership subject to these Fund Rules.

D1 Payment of Contributions

D1.1 Premiums Payable for Each Cover
Premiums payable for each Cover are determined by Medibank Private or ahm Health Insurance (in accordance, where applicable, with the Act).

D1.2 Contribution Groups
Medibank Private or ahm Health Insurance may at its discretion approve any group of Members as a Contribution Group.

D1.3 Premiums Payable in Advance
(1) All Premiums are payable in advance.
(2) For Members of ahm Health Insurance whose Premiums are not paid through a payroll deduction arrangement, they shall be required to make Premium payments at least one payment frequency in advance.

D1.4 Premiums Limited to 12 Months in Advance: Resident Covers
(1) The Fund may refuse to accept a payment of Premiums, or any part thereof, that would cause the period of Cover to exceed 12 Months in advance of the date of payment. ‘Refuse to accept’ includes the refund of any payment accepted in good faith.
(2) Where through any other circumstance the period of Cover exceeds 12 Months from the current date, the Fund may refund the portion of the Premiums in excess of 12 Months.
**D Contributions**

**D1.5 Premiums from Third Parties May be Refused**
The Fund may refuse to accept Premiums from a third party.

**D1.6 Premium Rates Applicable to State of Residence**
Members are required to pay the Premium rate applicable to the Policy Holder or Principal Member’s State of Residence.

**D2 Contribution Rate Changes**

**D2.1 Premiums May be Changed**
The Fund may change the Premium for any Cover in accordance with the requirements set out in the Act.

**D2.2 Rate Protection**
Subject to these Fund Rules, where Premiums have been accepted in respect of an existing Membership for a period in advance, a Premium change announced by Medibank Private or ahm Health Insurance to take effect during that advance period will not affect the date to which Premiums have been paid.

**D2.3 Cover Changes and Reactivated Memberships**
(1) Where a Cover change occurs, or a suspended Membership is reactivated, the Premium current as at the date of the Cover change or reactivation applies to the Membership from that date.

(2) For the purposes of this Fund Rule, ‘Cover change’ includes:
   
   (a) the addition or removal of a Cover component
   
   (b) a change in the level of existing Cover
   
   (c) subject to (3), a change in the State of Membership, or
   
   (d) a change of Membership Category resulting in a change in Premiums.

(3) Where the State of Membership is changed but the Cover and the Membership are otherwise entirely unchanged, the Fund may permit rate protection.

**D3 Contribution Discounts**

**D3.1 Discounts on Premiums**
Discounts may apply up to 12% per annum in addition to any Aged-based Discount in accordance with the Act.

**D4 Lifetime Health Cover**

**D4.1 Lifetime Health Cover Premiums**
Medibank Private and ahm Health Insurance will increase Premiums and apply other Lifetime Health Cover criteria as required, in accordance with the Act.
D5 Arrears in Contributions

D5.1 Memberships In Arrears

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

D5.2 Treatment During Arrears

(1) Benefits are not payable for Treatment provided to a Member during a period of Arrears.

(2) Subject to these Fund Rules, a Policy Holder or Principal Member may regain an entitlement to Benefits for such Treatment by paying:

(a) all outstanding Premiums as agreed with the Fund, and

(b) the minimum amount of advance Premiums relevant to the Policy Holder or Principal Member, as specified in these Fund Rules.

D5.3 Termination of a Membership in Arrears

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

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

D6 Other

D6.1 Health and Medical Research Fund

Australian Health Management Group Pty Ltd established the Health and Medical Research Fund in 1986 to support medical research. Any Member who holds an ahm Health Insurance Cover can make a voluntary contribution to the Health and Medical Research Fund. The general public can also make donations to the Health and Medical Research Fund. That fund is operated and accounted for separately from the Health Benefits Fund, and in accordance with the Health and Medical Research Fund Trust Deed. Australian Health Management Group Pty Ltd provides administrative support and services to the Health and Medical Research Fund. Australian Health Management Group Pty Ltd is a related body corporate of Medibank Private Limited but not part of the Health Benefits Fund conducted by Medibank Private Limited.
E

Benefits

E1 General Conditions

E1.1 Treatment to be Provided by Recognised Providers

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

E1.2 Recognised Providers Who Cease to Meet Recognition Requirements

The Fund may:

(1) refuse to pay Benefits in respect of any claim, and
(2) suspend or cancel the provider’s recognition for the purpose of paying Benefits where it has reasonable grounds to believe that:

   (a) a Hospital has ceased to meet the definition as set out in these Fund Rules, or
   (b) a Recognised General Treatment Provider has ceased to be in Independent Private Practice, or has ceased to meet any Recognition Criterion
   (c) a Recognised Provider has, in the opinion of the Fund, committed or participated in any fraudulent activity in relation to the provision of a service to a Member.

E1.3 Benefit Reductions

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

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

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

(1) Subject to (2), Benefits are not payable by the Fund for Treatment rendered by a provider to:

   (a) the provider’s Partner, Dependents, or business partner, or
   (b) the Partner or a Dependant of any business partner of the provider.

(2) The Fund may at its discretion pay Benefits in these cases:

   (a) where it is satisfied that the charge is raised as a legally enforceable debt, or
   (b) in respect of the invoiced cost of materials required in connection with any Treatment.
E1.5 Benefit Liability where Incorrect Information Provided

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

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

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

E1.7 Fraudulent Behaviour of a Recognised Provider

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

E2 Hospital Treatment

E2.1 Hospital Benefits Payable According to the Schedules

The *Benefits* payable in respect of *Hospital Treatment* and the conditions relevant to those *Benefits* are set out in the Fund Rules and associated *Schedules*.

E2.2 Same-Day Patients

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

E2.3 Benefits for Hospital Treatment

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

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

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

E2.4 Patient Classification: Rehabilitation Patients

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

1. *Rehabilitation Patient* means an *Admitted Patient* or *Outpatient* receiving *Treatment* for a rehabilitation *Condition* grouped to a Rehabilitation Diagnostic Related Group (DRG) as defined in the Australian Refined Diagnosis Related Groups Definitions Manual, published from time to time by the Commonwealth Department of Health.

2. Approved Rehabilitation *Program* means a *Program* that is approved by the *Fund* for the purpose of paying *Benefits* at the Rehabilitation *Patient* rate.

3. *Benefits* at the Rehabilitation *Patient* rate are payable subject to the following conditions:

   a. Rehabilitation *Treatment* in a *Private Hospital* must be provided as part of an approved rehabilitation Program.

   b. The *Fund* may require the *Treatment* to be supported by a Rehabilitation Care Certificate in a form approved by the *Fund* or some other form of documentation to support the need for the *Patient* to participate in a *Program* to assist in recovery from an *Acute Catastrophic Illness or Injury*.

   c. The service is not a Restricted Service under the *Cover*. 
Subject to the service not being a Restricted Service under the Cover, Benefits for Rehabilitation Patients who receive Treatment in other than an approved rehabilitation Program are payable at the applicable Other [Medical] Patient rate.

E2.5 Patient Classification: Psychiatric Patients

(1) Psychiatric Patient means an Admitted Patient or Outpatient receiving Treatment for a psychiatric Condition that is grouped to a Mental Disorder Diagnostic Related Group (DRG) as defined in the Australian Refined Diagnosis Related Groups Definitions Manual, published from time to time by the Commonwealth Department of Health.

(2) Approved Psychiatric Program means a Program that is approved by the Fund for the purpose of paying Benefits at the Psychiatric Patient rate.

(3) Benefits at the Psychiatric Patient rate are payable subject to the following conditions:

(a) Psychiatric Treatment in a Private Hospital must be provided as part of an approved psychiatric Program.

(b) The Fund may require the Treatment to be supported by a Psychiatric Care Certificate in a form approved by the Fund or some other form of documentation to support the need of the Patient to participate in a psychiatric Program.

(c) the Patient is not under the custodial care of a State or Territory.

(d) the service is not a Restricted Service under the Cover.

(4) Subject to the service not being a Restricted Service under the Cover, Benefits for Psychiatric Patients who receive Treatment in other than an approved psychiatric Program are payable at the Other [Medical] Patient rate.

E2.6 Patient Classification: Counting of Days

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

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

E2.7 Patient Classification: Multiple Procedures

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

E2.8 Patient Classification: Subsequent Procedures

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

(1) where the procedure results in the Patient...
having a higher classification, the Patient’s classification increases from the date of the procedure, and

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

E2.9 Special Care Unit Patients
The higher Benefits for Patients of Special Care Units are payable only for periods during which the Patient occupies a bed in a facility approved by the Fund for this purpose.

E2.10 Continuous Hospitalisation
(1) Where an overnight Admitted Patient is discharged, and within seven days is admitted to the same or a different Hospital for the same or a related Condition, the two admissions are regarded as forming one period of continuous hospitalisation.

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

E2.11 Agreements with Doctors and Hospitals
(1) Subject to these Fund Rules, the Fund may enter into an Agreement with a Medical Practitioner or a group of Medical Practitioners, or a Hospital or a group of Hospitals, specifying the total charge for any Treatment and the Benefits payable by the Fund.

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

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

E2.12 GapCover
The Schedules referred to in these Fund Rules shall provide that the Benefits under GapCover arrangements are payable subject to the following conditions:

(1) A Medical Practitioner who provides Hospital Services under GapCover shall give the Member written advice of any amount the Member can reasonably be expected to pay for those services.

(a) if possible the advice shall be given before such services are provided, or otherwise as soon as practical, and

(b) the recipient of the advice shall acknowledge receipt of the advice, and

(2) A Medical Practitioner who provides Hospital Services under GapCover shall give the Member written advice of any financial interest the practitioner may have in products or services recommended or provided to the Member.

E2.13 Pharmaceuticals in Agreement Hospitals
(1) Where a Hospital Cover includes Benefits for PBS Medications supplied to an Admitted Patient of a Contracted Hospital, the Benefit will meet the full cost of the pharmaceutical if:
E

Benefits

(a) it is directly related to the Treatment of the Condition for which the Member was admitted, and

(b) in the case of a Restricted or Excluded Services Cover, the Hospital Treatment is not in respect of a Restricted or Excluded Service.

[2] The ‘full cost’ referred to in (1)(a) includes the Patient Co-payment, and any special or Patient contribution, brand premium or therapeutic group premium otherwise payable by the Patient under the Pharmaceutical Benefits Scheme.

(3) Benefits for non-PBS medications supplied to an Admitted Patient of a Contracted Hospital are payable where:

(a) the Benefit is specifically included in the Agreement with the Hospital; or

(b) the Fund agrees to pay some or all of the cost of the medication at its discretion.

(4) Payment of a Benefit under sub-rule 3(b) is subject to the following conditions:

(a) the non-PBS medication must be directly related to the Treatment of the Condition for which the Member is admitted;

(b) the non-PBS medication must not be experimental or provided as part of a clinical trial; and

(c) in the case of a Restricted or Excluded Services Cover, the Treatment for which the Member is admitted must not be in respect of a Restricted or Excluded Service.

E3 General Treatment

E3.1 General Treatment Benefits Payable According to the Schedules

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

E3.2 Arrangements with General Treatment Providers

Subject to these Fund Rules, the Fund may enter into a special arrangement with a General Treatment provider, or group of such providers, to provide Benefits for particular General Treatment Services. An arrangement may appoint the provider as a Members’ Choice Provider, or such other category of provider as Medibank may establish from time to time.

E3.3 Loyalty Benefits: ahm Health Insurance

(1) Loyalty Benefits are based on a Principal Member maintaining a Policy with ahm Health Insurance for a continuous period. As loyalty limits apply to a Financial Year, the number of years a Principal Member has held an ahm Health Insurance Policy at 1 July each year determines the category of loyalty Benefits.

(2) The loyalty date for the whole Policy is determined by the length of time that the Principal Member has held an ahm Health Insurance Policy without interruption. If a person insured under that Policy is no longer insured under that Policy for any reason, including the death or other change in status of the Principal Member, each person’s entitlement to the loyalty Benefit will be calculated by reference to the joining date of that person.
If a change to a Policy is required, Members must consider who will be the Principal Member. This determines the loyalty years designated and the limits claimable.

**E4 Other**

**E4.1 Ex-Gratia Benefits**

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

**E4.2 Members’ Choice Providers**

(1) Subject to these Fund Rules, details of Benefits payable by the Fund, Benefit conditions, and dates of effect for agreements or arrangements made under this Fund Rule for each Members’ Choice Provider are contained in separate Schedules maintained by Medibank Private.

(2) Subject to (3), and unless otherwise specified in these Fund Rules, the payment of Benefits for Treatment provided by Members’ Choice Providers is subject to all relevant Fund Rules.

(3) the Fund may pay a lower Benefit than as set out in a Schedule if:

   (a) the Benefit is payable for Treatment provided under an agreement referred to in these Fund Rules; and

   (b) the Member is not subject to any increase in their out-of-pocket expenses for that Treatment.

**E4.3 Interstate Treatment: Members’ Choice Providers**

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

(1) Benefits for Hospital Treatment are payable in accordance with the Fund’s agreement with the provider

(2) Benefits for General Treatment Services are payable in accordance with the appropriate Members’ Choice schedule in the State or Territory in which the service is provided, and

(3) in the case of General Treatment Services, Benefits are payable only if the Member’s Cover provides Benefits for the Treatment in the State of Membership.

**E4.4 Interstate Treatment: non Members’ Choice Providers**

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

(1) in the case of Hospital Treatment, Benefits applicable to the State or Territory of Treatment are payable, and

(2) in the case of General Treatment Services or Treatment:

   (a) where the Member’s Cover includes Benefits for the Service or Treatment in the State of Membership, the Benefits applicable to that State or Territory are payable, but

   (b) where the Member’s Cover does not include Benefits for the Service or Treatment in the State of Membership, no Benefits are payable.

**E4.5 Funeral Benefits: ahm Health Insurance**

ahm Health Insurance has previously offered funeral Benefits as part of a health insurance Policy. Since 1 April 2007, ahm Health Insurance no longer offers that Benefit. However, nothing in this rule affects the rights of any person to a funeral Benefit, where that entitlement arose prior to 1 April 2007. Any entitlement that is preserved under this rule cannot be altered, redeemed or exchanged for other Benefits or any other entitlement.
F
Limitation of Benefits

E4.6 Disease Management and other Health Management Programs
The Fund may make disease management and other health management programs available under one or more of its Products from time to time. Where the Fund offers such a program, participation will be subject to a Member meeting any applicable participation criteria.

F1 Co-payments
F1.1 Co-Payments
Co-payments may apply to a Cover. Where a Co-payment applies, the amount of the Co-payment and any applicable conditions will be specified in the relevant Schedule.

F2 Excesses
F2.1 Excesses
The amount of the Excess and relevant limits and conditions are specified in the Schedule.

F3 Waiting Periods
F3.1 Waiver of Waiting Periods
Subject to the Act and the rules, the Fund reserves the right in its absolute discretion to waive any Waiting Period.

F3.2 Waiver in Case of Accidents: Medibank Private Hospital Covers
Medibank Private may at its discretion waive the one day and two Month Waiting Period for Treatment required as the result of an Accident occurring within that Waiting Period.

F3.3 Pre-Existing Conditions (PEC): Waiting Period
[1] The Fund may refuse or reduce Benefits in respect of a Pre-Existing Condition that is the subject of Treatment within the first 12 Months of Membership of any Cover.

[2] To avoid doubt, this Fund Rule also applies where a Member transfers to another Cover which provides higher Benefits for the relevant Treatment.

[3] This Fund Rule does not apply to Hospital Treatment under a Resident Cover or a Medibank Private Overseas Workers Health Cover that is psychiatric care, rehabilitation or palliative care Treatment.

F3.4 PEC: Information from Treating Practitioner(s)
[1] The Fund may appoint a medical or other relevant practitioner to determine whether or not a Condition for which Treatment has been provided and Benefits have been claimed is a Pre-Existing Condition.

[2] A practitioner appointed under [1] shall take into account:
(a) information provided by the practitioner[s] who treated the Member in the six Months prior to their becoming a Member or changing their Cover, and
(b) any other material that the Fund considers is relevant to the claim.

[3] The Fund may suspend consideration of a claim until such time as:
(a) the Member authorises the release of the information referred to in [2], and
(b) this information has been provided to the Fund.
F3.5 PEC Waiting Period Not to Apply
Where the Fund Alters the Cover
(1) Where the Fund has changed the terms of a Cover, any higher or additional Benefits now available to existing Members of the Cover are not subject to an additional Pre-Existing Condition Waiting Period.

(2) This Fund Rule has no effect on any other Waiting Period or condition that applies to a newly available Benefit.

F3.6 Waiting Periods When Adding a Child
Refer to Rule C5.1 for detail.

F3.7 Waiting Periods: Medibank Private Hospital Treatment
The following Waiting Periods apply to Benefits payable for the Treatment shown (where relevant to the Member’s Cover), unless specified otherwise elsewhere in these Fund Rules for a particular Cover.

<table>
<thead>
<tr>
<th>Waiting Period</th>
<th>Benefits</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two Months, subject to these Fund Rules</td>
<td>All Treatment (including hospital psychiatric services, rehabilitation or palliative care treatment)</td>
<td></td>
</tr>
<tr>
<td>12 Months</td>
<td>Treatment for Obstetrics-related Services</td>
<td></td>
</tr>
<tr>
<td>12 Months</td>
<td>Treatment for Pre-existing Conditions</td>
<td></td>
</tr>
</tbody>
</table>

For Overseas Workers Health Insurance Covers the two Month general Waiting Period is applied only to psychiatric care, rehabilitation and palliative care Treatment.

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

F3.8 Waiting Periods: Medibank Private General Treatment
The following Waiting Periods apply to Benefits for the Treatment and items shown (where relevant to the Member’s Cover), unless specified otherwise elsewhere in these Fund Rules for a particular Cover.

<table>
<thead>
<tr>
<th>Waiting Period</th>
<th>Benefits</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil/Two Months, where specified in the relevant Schedule and subject to these Fund Rules</td>
<td>Psychology</td>
<td></td>
</tr>
<tr>
<td>One day</td>
<td>Ambulance services</td>
<td></td>
</tr>
<tr>
<td>Two Months, subject to these Fund Rules</td>
<td>All Treatment</td>
<td></td>
</tr>
<tr>
<td>Six Months</td>
<td>Optical Appliances</td>
<td></td>
</tr>
<tr>
<td>12 Months</td>
<td>CPAP-type device</td>
<td></td>
</tr>
<tr>
<td>12 Months</td>
<td>Breathing Appliances (Nebulisers, Peak Flow Meters, and Spacing Devices)</td>
<td></td>
</tr>
<tr>
<td>12 Months</td>
<td>Dental Treatment:  • endodontic treatment  • surgical extractions  • surgical procedures  • orthodontic  • all major dental services</td>
<td></td>
</tr>
<tr>
<td>Two years</td>
<td>• Blood Glucose Monitors  • Blood Pressure Monitors</td>
<td></td>
</tr>
<tr>
<td>Three years</td>
<td>Hearing Aids</td>
<td></td>
</tr>
<tr>
<td>Three years</td>
<td>Laser Eye Surgery</td>
<td></td>
</tr>
</tbody>
</table>

For Visitors Covers a Waiting Period is not applied to Ambulance services.
## F Limitation of Benefits

### F3.9 Waiting Periods: ahm Health Insurance Hospital Treatment

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

<table>
<thead>
<tr>
<th>#</th>
<th>Waiting Period</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One day</td>
<td>Hospital Treatment that is required as a result of an <strong>Accident</strong></td>
</tr>
</tbody>
</table>
| 2 | Two Months     | Hospital Treatment (where there are no **Pre-existing Conditions**)  
Hospital psychiatric services, rehabilitation and palliative care Treatment (whether or not a **Pre-existing Condition**) |
| 3 | 12 Months      | Treatment for **Pre-existing Conditions**  
Treatment for Obstetrics related services  
Speech processors and insulin pump replacements |

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

### F3.10 Waiting Periods: ahm Health Insurance General Treatment

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

<table>
<thead>
<tr>
<th>#</th>
<th>Waiting Period</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nil</td>
<td>Psychology</td>
</tr>
<tr>
<td>2</td>
<td>One day</td>
<td><strong>Ambulance</strong> services</td>
</tr>
<tr>
<td>3</td>
<td>Two Months, where specified in the relevant <strong>Schedule</strong> and subject to these Fund Rules</td>
<td>All <strong>Treatment</strong></td>
</tr>
<tr>
<td>4</td>
<td>Two Months</td>
<td>Doctors health checks and Healthy Heart checks</td>
</tr>
<tr>
<td>5</td>
<td>Six Months, where specified in the relevant <strong>Schedule</strong> and subject to these Fund Rules</td>
<td>Optical Appliances</td>
</tr>
</tbody>
</table>
| 6 | 12 Months      | Complex Dental  
Major Dental  
Orthodontics  
Podiatric surgery  
Orthotics and orthopaedic shoes  
Hearing Aids  
Pre and post natal services  
Medical gases  
Joint fluid replacement injections  
Midwife Assisted Home Births  
Disease Management Appliances |
| 7 | Two years      | Refractive sight correcting laser eye surgery |

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F4 Exclusions

F4.1 Resident Covers: Benefit Exclusions
(1) Unless expressly provided for in these Fund Rules, Benefits are not payable under Resident Covers:

(a) for claims for services provided while Premiums are in Arrears or the Membership is suspended

(b) for claims for services rendered outside Australia or for items purchased or hired from overseas suppliers

(c) where the Member has received, or established a right to receive, Compensation for Treatment

(d) for claims for Treatment rendered by a provider other than a Recognised Provider

(e) for pharmaceuticals that are available under the Pharmaceutical Benefits Scheme (PBS)

(f) for oral contraceptives for the purpose of contraception

(g) where an application form or claim form contains false or inaccurate information

(h) for services rendered in an aged care service

(i) where the Treatment is otherwise excluded by the operation of a Fund Rule

(j) for Cosmetic Treatment, unless Medibank is satisfied that there is a material medical need, or

(k) for medications prescribed for cosmetic purposes.

(2) In addition to the above, a Cover may exclude Benefits for Hospital Treatment as detailed in the associated Schedules to these Fund Rules.

F4.2 Benefit Exclusions: Medibank Private Visitors Cover
(1) Benefits are not payable under a Visitors Cover for Treatment:

(a) arranged before coming to Australia

(b) provided outside Australia, including while en route to or from Australia (this includes any item purchased or hired while the Member is outside Australia, or from an overseas supplier)

(c) where the Member has received, or established a right to receive, Compensation for Treatment

(d) provided in an aged care service

(e) which would not otherwise attract Medicare benefits, e.g. health screening services

(f) otherwise excluded by the operation of a Fund Rule

(g) for medications prescribed for cosmetic purposes, or

(h) for Cosmetic Treatment, unless Medibank is satisfied that there is a material medical need.

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

F5 Benefit Limitation Periods

F6 Restricted Benefits

F6.1 Restricted Services
Depending on the level of Cover chosen by the Member, Benefits may have restrictions on particular Hospital Treatments as detailed in the associated Schedules.

F7 Compensation

F7.1 Definitions
In Fund Rules F7:

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

(2) a reference to a Member receiving Compensation includes:

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

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

(3) a reference to a Compensable Condition means a Condition:

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

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

F7.2 Obligations of a Member

(1) A Member who has, or may have, a right to receive Compensation in relation to a Condition, must:

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

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

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

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

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

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

(ii) consider any requests for reductions and/or waivers of recoverable amounts,
(b) the Member must, and must ensure that the Member’s legal advisers, disclose to the Fund immediately upon the determination or settlement of a claim for Compensation (or the establishment of a right to receive Compensation), including by providing to the Fund a copy of the settlement or award and (if not evident from the settlement or award) an explanation of how Compensation has been allocated,

c) the disclosure by the Member (or his or her legal advisers) of information or a document in accordance with the Fund Rules is not voluntary or acting inconsistently with the maintenance of the confidentiality or any privilege existing over the document or information,

d) the Fund has a common interest with the Member as the Fund indemnifies the Member for Benefits for the Condition,

e) the Fund must keep the information disclosed by the Member or the Member’s legal advisers in accordance with these Fund Rules confidential, and

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

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

F7.3 Entitlement to Benefits for a Compensable Condition

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

F7.4 The Fund may Provisionally Withhold Payment

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

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

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

F7.5 Provisional Payments

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

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

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

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

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

(b) acknowledges that the Fund has specified rights of subrogation whereby the Fund acquires all rights and remedies of the Member in relation to the recovery of the amount that the Fund has paid in Benefits, including the right to:

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

(ii) recover any Benefit from a claim,

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

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

F7.6 Where a Member has received Compensation

(1) Subject to these Fund Rules, where:

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

(b) the Member has received Compensation in respect of that Compensable Condition,

the Member must repay to the Fund the full amount that the Fund paid in relation to the Compensable Condition.
The obligation to repay applies whether or not:

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

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

(c) the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future in respect of which Benefits are otherwise payable, or

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

F7.7 Rights of the Fund

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

(a) comply with any obligation in these Fund Rules, or

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

the Fund may, without prejudice to its rights (including its broader subrogation rights) and in its absolute discretion, take any action permitted by law to do any or all of the following:

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

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

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

F7.8 Claim Abandoned

(1) Where:

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

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

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

F7.9 Requirement to Repay Benefits may be Waived

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

(1) the Member has complied with these Fund Rules, and

(2) the Fund has given prior consent to the settlement of the claim for an amount that is less than the total Benefits paid or which would otherwise have been payable by the Fund,
the *Fund* may in its 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 *Compensable Condition*.

F7.10 Benefits for Expenses Subsequent to Compensation

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

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

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

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

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

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

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

F7.11 Future Medical Expenses

(1) The *Member* must upon request provide evidence to the *Fund* to establish whether a determination or settlement includes an allocation for future medical expenses.

(2) Where it is anticipated that the *Member* has future medical needs in respect of a *Compensable Condition*, the *Member* must use reasonable endeavours to procure an award or settlement that includes a specified allocation for future medical expenses.

(3) Where, despite the *Member’s* reasonable endeavours, a determination or settlement does not include a specified allocation for future medical expenses, the *Fund* may in its absolute discretion agree to pay *Benefits* for *Treatment* in respect of the *Compensable Condition* rendered after the determination or settlement.

(4) In addition to the *Member’s* obligations under the preceding Fund Rules, where a determination or settlement of a claim for *Compensation* includes an allocation for future medical expenses in respect of the *Compensable Condition*:

(a) the *Member* must use that allocation to pay for *Treatment* in respect of the *Compensable Condition*;

(b) the *Fund* may refuse to pay *Benefits* for such *Treatment* until the allocation is exhausted;

(c) the *Member* must keep and provide to the *Fund* evidence to establish that the allocation has been exhausted on expenses for *Treatment* of the *Compensable Condition*; and
[d] if the Member cannot provide such evidence, or the allocation has been exhausted on expenses other than for Treatment of the Compensable Condition, the Fund may refuse to pay Benefits for Treatment in respect of the Compensable Condition.

F7.12 Cancellation/Termination of Membership

A Member’s obligations under these Fund Rules continue despite any termination of the Member’s Policy.

G Claims

G1 General

G1.1 Form of Claim
Claims for Benefits must be made in a manner approved by the Fund.

G1.2 Claims to be Lodged within two Years
The Fund has the right to refuse to pay Benefits where a claim is lodged more than two years after the date of service.

G2 Other

G2.1 Manner of Benefit Payment
The Fund may pay Benefits in accordance with arrangements it determines from time to time.

G2.2 Health Support Services and Programs
The Fund, at its discretion, may offer health support services or programs as part of its Covers from time to time.