These Fund Rules set out the general principles and rules of membership applicable to the Cessnock District Health Benefits Fund (also known as CDH and Hunter Health Insurance), the health insurance business of Cessnock District Health Benefits Fund Limited.

These Rules are in effect from 3 November 2022.

INTRODUCTION AND GENERAL CONDITIONS

1. Rules Arrangement

The format of these Rules is as follows:

(a) General Conditions (this document). This includes an introduction which covers a statement of the nature of CDH Benefits Fund ("the Fund") and general issues affecting the Fund. The General Conditions are ordered under the headings:

1. Introduction and General Conditions
2. Membership
3. Definitions
4. Premiums
5. Contributions
6. Benefits (which includes a list of the Products offered as part of the health insurance business of the Fund)
7. Limitations of Benefits
8. Claims.

(b) Schedules including the Benefit Tables applicable to Products issued as part of the health insurance business of the Fund. The Schedules are set out in sections covering:

A. Hospital Products
B. Combined Products
C. General Treatment Products
D. Contribution Rates
E. Other Dental

A copy of the Rules (General Conditions) is available for perusal by Members in all Fund offices and a copy may be obtained by contacting the Fund on 02 4990 1385. A copy of the Schedules can be made available by contacting the Fund on 02 4990 1385.

2. Health Benefits Fund

2.1. These are the Rules of the Cessnock District Health Benefits Fund operated by Cessnock District Health Benefits Fund Limited, which is registered as a private health insurer under the *Private Health Insurance Act 2007*.

2.2. The business address of Cessnock District Health Benefits Fund Limited is 151 Vincent St., Cessnock, NSW, 2325. The postal address is PO Box 183, Cessnock 2325.

2.3. The Fund trades as the CDH Benefits Fund, CDH and Hunter Health Insurance.

2.4. These Rules govern the establishment and operation of the Fund and describe the obligations, requirements and entitlements of Members of the Fund and the obligations, requirements and entitlements of Cessnock District Health Benefits Fund Limited in the operation of the Fund.

2.5. The business of Cessnock District Health Benefits Fund Limited includes health insurance business and health-related business as defined in the *Private Health Insurance Act 2007*, which businesses are conducted within the Health Benefits Fund.

2.6. CDHBF Limited has established in the Fund a Risk Equalisation Account.

3. Use of Funds

3.1. The following amounts must be credited to the Fund:

(a) Premiums payable under Policies that are referable to the Fund;

(b) amounts paid to the Fund in relation to a liability under Division 9 of the *Private Health Insurance (Prudential Supervision) Act 2015* in relation to the Fund;

(c) income from the investment of assets of the Fund;

(d) money paid to or by the Fund under a judgment of a court relating to any matter concerning the business of the Fund or any failure to comply with the Act in relation to the Fund;

(e) any other money received by the Fund in connection with its conduct of the business of any Fund;

(f) any other amounts that the *Private Health Insurance (Health Benefits Fund Policy) Rules* specify.

3.2. The assets of the Fund must not be applied for any purpose other than:

(a) meeting Policy liabilities and other liabilities, or expenses, incurred for the purposes of the business of the Fund (including Policy liabilities and other liabilities that are treated, in accordance with a restructure or arrangement approved under Division 4 of the *Private Health Insurance (Prudential Supervision) Act 2015*, as Policy liabilities and other liabilities incurred for the purposes of the Fund); or

(b) making investments in accordance with the *Private Health Insurance (Prudential Supervision) Act 2015*; or

(c) making a distribution under Division 5 of the *Private Health Insurance (Prudential Supervision) Act 2015*; or

(d) a purpose specified in the *Private Health Insurance (Health Benefits Fund Policy) Rules* for the purposes of s28 of the *Private Health Insurance (Prudential Supervision) Act 2015*.

4. No Improper Discrimination

4.1. When operating the Fund and making decisions in relation to Members or persons seeking to become Members, the Fund will not have regard to the following matters:

(a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or

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

(c) the age of a person, except to the extent allowed under Part 2-3 (Lifetime Health Cover) of the Act;

(d) where a person lives, except to the extent allowed under subsection 66-10(2) or section 66-20 of the Act; or

(e) any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for Hospital Treatment or General Treatment; or

(f) the frequency with which a person needs Hospital Treatment or General Treatment; or

(g) the amount or extent of the Benefits to which a person becomes entitled during a period under a complying health insurance policy, except to the extent allowed under section 66-15 of the Act; or

(h) any matter set out in the *Private Health Insurance (Complying Product) Rules* for the purposes of section 55-5(2)(h) of the Act.

5. Changes to Rules

5.1. The Fund may vary, delete or add to these Rules at any time in accordance with the Act.

5.2. The Fund may waive at its discretion the application of particular Rules provided that the waiver does not reduce the relevant Member's entitlement to Benefits.

5.3. The Rules that are in force at the date of the provision of a Service, for which a Benefit under these Rules is provided, are the Rules which shall govern the provision of that Benefit. If a Benefit is claimed for a Service that occurred before the commencement of these Rules and the Primary Member was entitled to Benefit under the previous Rules then the Benefit payable shall be in accordance with the previous Rules.

5.4. Premiums paid in advance for Policies provided under previous set of Rules shall be credited to Policies provided under these Rules in such manner as to establish a common due date to which the Premium is paid to each Policy held by a Primary Member under these Rules.

5.5. For the purpose of these Rules, a Policy under a previous set of Rules shall be regarded as a Policy under these Rules if the Fund has effected an automatic transfer to Members under the previous Policy to the Policy specified in these Rules.

5.6. Any specified entitlements accrued to a Member under the previous set of Rules shall be deemed to accrue to the Member under these Rules if the Member is automatically transferred to a Policy that contains the specified entitlement that accrues.

5.7. Any specified accrual for the purpose of a Deductible, limitation or qualification of Fund Benefits to be provided to a Member under a Policy of a previous set of Rules, shall be deemed to have accrued for the same or similar Deductible, limitation or qualification under these Rules if the Member is automatically transferred to a Policy that contains a Benefit which is subject to the same or similar limitation or qualification.

5.8. The Fund will give a relevant Standard Information Statement (SIS) or Private Health Insurance Statement (PHIS) to the Primary Member at least once when a policy commences. A newly insured Primary Member, an existing Primary Member changing cover, or any other person upon request will be given a Standard Information Statement (SIS) or Private Health Insurance Statement (PHIS) by the most efficient and practical means in the circumstances.

5.9. If a proposed change to the Rules:

(a) is or might be detrimental to a Member; and

(b) will require an update to the Standard Information Statement (SIS) or Private Health Insurance Statement (PHIS) relevant to the Member,

The Fund will ensure that the Primary Member:

(c) is informed of the proposed change a reasonable time before the change takes effect; and

(d) is given the relevant updated Standard Information Statement (SIS) or Private Health Insurance Statement (PHIS) as soon as practicable after the statement is updated.

5.10. If a proposed change to the Rules:

(a) is or might be detrimental to a Member; and

(b) will not require an update to the Standard Information Statement (SIS) or Private Health Insurance Statement (PHIS) relevant to the Member,

The Fund will ensure that the Primary Member:

(a) is informed of the proposed change a reasonable time before the change takes effect.

5.11. For the purposes of Rules A7.9 and A7.10, any change to Benefits or treatment shall be treated as a change which is or might be detrimental to a Member.

6. Dispute Resolution

6.1. Claims disputes should be notified in writing to the Fund in the first instance.

6.2. For disputes involving Hospital or Medical services, advice may be sought from the Medical Adviser with expertise in that particular discipline. On receipt of this advice the Fund will consider the level of Benefit to be paid and advise the Member of that amount.

6.3. For disputes involving Dental services, advice may be sought from the Dental Adviser. On receipt of this advice the Fund will consider the level of Benefit to be paid and advise the Member of that amount.

6.4. For disputes involving any other service, advice may be sought from an appropriate Adviser with expertise in that particular discipline. On receipt of this advice the Fund will consider the level of Benefit to be paid and advise the Member of that amount.

6.5. Where a dispute still exists in relation to a claim after reference to the adviser or expert, then the dispute will be referred to the Private Health Insurance Ombudsman.

6.6. Notwithstanding the above, Members may refer disputes directly to the Private Health Insurance Ombudsman without reference to the Fund.

7. Notices

7.1. Rules requiring written notice in these Rules such as changes in Premiums or detrimental changes in Fund Benefits will be mailed OR email (where electronic communication has been opted in as the primary method of communication) at the last policy address advised in reasonable time to the Fund.

7.2. The Fund may provide notice of changes (other than changes in Premiums or detrimental changes in Fund Benefits) or other information by:

(a) publication on Fund's website; or

(b) any electronic transmission; or

(c) any other reasonable means.

7.3. Notices of changes in Premium rates or any significant or detrimental changes in Fund Benefits will be mailed or emailed as soon as possible after the approval to make the change has been obtained.

7.4. List of Purchaser Provider Agreements

A Member shall be entitled to receive, upon request, an up-to-date list of:

(a) the Hospitals and Day Hospital Facilities with which the Fund has Hospital Purchaser Provider Agreements; and

(b) the persons with whom the Fund has Medical Purchaser Provider Agreements.

Such list may be provided by referring the Member to an up-to-date list published via the Fund's website.

Each list referred to in this Rule shall specify:

(a) the name of each Hospital or Day Hospital Facility or provider of Professional Services;

(b) such further information as the Board from time to time considers appropriate.

8. Winding Up

8.1. In the event of CDH Benefits Fund Limited ceasing to be registered under the Act, the Fund shall be wound up in accordance with the requirements of the Act.

8.2. In the event of the winding up of the Fund all monies not required for meeting outstanding liabilities, staff allowances, contracted payments and other expenses of winding up including the requirements of the Act, shall be utilised in such manner as may be determined by the Board.

8.3. In the event of winding up of CDH Benefits Fund, Benefits shall not be payable in respect of Hospitalisation, Professional Services and General Services provided after the date of termination

INTERPRETATION AND DEFINITIONS

1. Interpretation

i) These Rules relate to the operation of CDH Benefits Fund under the *Private Health Insurance Act 2007*.

ii) Where legal interpretation of the *Private Health Insurance Act 2007* or the *Health Insurance Act 1973*, or any rules made under either act, or any related legislative instrument, is in clear conflict with these Rules these acts or instruments take precedence over these Rules. Where no clear conflict is in existence then these Rules take precedence.

iii) In these Rules, words importing the masculine gender shall include the feminine gender and words importing the singular or plural number shall include the plural or singular number respectively.

iv) The meanings attached to definitions in the *Private Health Insurance Act 2007* as amended and the *Health Insurance Act 1973* as amended shall unless otherwise specified in this Rule B be deemed to apply to these Rules of the Fund.

v) In these Rules, a reference to a statute or a provision in a statute shall be read as if the words "or any amendment or re-enactment thereof or provision substituted therefor" be added.

vi) In these Rules, a reference to a Contract or a provision in a Contract shall be read as if the words "or any amendment thereof or provision substituted therefor" be added.

vii) In these Rules, a reference to a Private Hospital shall include by implication a reference to a Day Hospital Facility and a reference to a Hospital shall include by implication a reference to a Public Hospital, a Private Hospital and a Day Hospital Facility.

2. Definitions

In these Rules unless the contrary intention appears:

"**Accident**" means accidental bodily injury caused solely and directly by external means.

"**Accredited Private Hospital**" means a Private Hospital or Day Hospital Facility that is accredited with the Australian Council on Healthcare Standards.

"**Acupuncture service**" means a service or treatment by an acupuncturist in private practice who is accredited as an acupuncturist with an accreditation organisation recognised by the Australian Regional Health Group or CDH Benefits Fund.

"**Act**" means the *Private Health Insurance Act 2007* as amended.

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

"**Additional Gap Medical**" means the amount of Benefit, in addition to the Medical Gap, that is payable by the Fund in respect of a Professional Service that:

(i) is rendered by a Medical Practitioner, in respect of Inpatient Hospital Treatment provided in a Hospital or a Day Hospital Facility; and

(ii) is a Professional Service in respect of which a Medicare Benefit is payable; and

(iii) either the attending Medical Practitioner gives informed consent by way of written quotation or forwards the account to the Fund which will acknowledge no out of pocket expense; or

(iv) the attending Medical Practitioner meets the requirements of the Fund's Gap Cover Scheme, and

(v) has a Medicare Schedule Fee of less than $200.

"**Adult**" means a person who is not a Dependent Child.

"**Advanced Surgical Patient**" means a patient classification of a Hospital Patient for which certain Benefits are prescribed pursuant to the *Private Health Insurance (Benefit Requirements) Rules 2007*.

"**Associated Professional Services**" means Professional Services provided by a Medical Practitioner to, or in respect of, an inpatient of a Hospital;

"**Benefit Policy**" means a Policy providing a Benefit or a range of Benefits as specified in these Rules.

"**Benefits**" means the amount paid or payable in accordance with these Rules to or on behalf of a Primary Member by the Fund in respect of Hospital, Professional and General Services.

"**Board**" means the Board of Directors of the Cessnock District Health Benefits Fund Limited.

"**Contract**" means a Hospital Purchaser-Provider Agreement or a Medical Purchaser-Provider Agreement.

"**Couples Policy**" means a Policy containing two Members neither being a Dependent Child of the other Member.

"**Clinical Psychology Service**" means a service provided by a clinical psychologist in private practice. The clinical psychologist must be a clinical member of the Australian Psychological Society.

"**Critically Ill**" means a documented clinical condition of a patient where the attending Medical Practitioner certifies that in view of the medical signs evident the patient required treatment in an Intensive Care Unit because there was an immediate and significant threat to the patient's likely survival.

"**Current Continuous Membership**" means, in relation to the amount of Benefit to be provided, the current membership of the specific Product of the Fund that provides that Benefit. Membership in another Product of the Fund or the health benefits fund of another private health insurer prior to the membership of the specific Product may not be included in any Current Continuous Membership required for Benefit

"**Day Hospital Facility**" means a "**Hospital"** as defined in the Act to which a person is usually admitted for Hospital treatment and discharged prior to midnight on the day of admission.

"**Deductible**" means that amount of Benefits of a Policy not provided by a lesser Benefits option of that Policy.

"**Default Benefit**" means, in relation to Hospital Treatment, the minimum Benefit as set out in the *Private Health Insurance (Benefit Requirements) Rules*.

"**Dental Adviser**" means a registered Dental Practitioner appointed by the Fund to determine disputes concerning the payment of Dental Benefits under these Rules.

"**Dental Service**" means a service, treatment, item or appliance provided by a registered dentist or dental prosthetist in private practice and included in the ADA Schedule.

"**Dependant**" means a person who during any part of the financial year

(a) Was a dependent child less than 21 years of age and who does not have a Partner; or

(b) a child of the Primary Member not less than 21 years of age but less than 25 years of age, does not have a Partner and receiving education at a school, college or university; (see definition of Student Dependant); and
(c) did not derive an income in excess of the Medicare Levy Exemption Threshold

"**Dependant Extension Cover**" means coverage available to any child of the Primary Member who does not have a Partner, who is not a Dependant or Student Dependant, who is under the age of 25 years and the Family Policy is for one of the top Hospital (EH) or Gold Hospital (T) Products listed in the Schedules to these Rules.

"**Dietetic Services**" means a service or advice provided by a dietician in private practice who is a member of the Dieticians Association of Australia, or any other organisation approved by Australian Regional Health Group or who has proved conclusively to Australian Regional Health Group that he/she is qualified to become a member of the Dieticians Association of Australia.

"**Emergency Benefits**" means a situation where the patient presenting at a Hospital or other medical facility is assessed as Category 1, 2 or 3 on the Australasian Triage Scale. Refer ACEM Guidelines - Implementation of ATS.

"**Episode duration**" in relation to a particular kind of payment made in accordance with an Applicable Benefits Arrangement, means the number of days worked out in accordance with the information provided by a Hospital or Day Hospital Facility concerned to the Fund under the Hospital Casemix Protocol.

"**Extra Gap Medical**" means the amount of Benefit payable by the Fund in respect of a Professional Service that:

(i) is not a Pathology or Radiology service, and

(ii) is rendered to a patient, while or in conjunction with Inpatient Hospital Treatment provided in a Hospital or a Day Hospital Facility by a Medical Practitioner; and

(iii) is a Professional Service in respect of which a Medicare Benefit is payable; and

(iv) has a Medicare Schedule Fee of at least $200; and

(v) the attending Medical Practitioner informs the insured person in writing, where the circumstances make it appropriate, of any amounts that the insured person can reasonably be expected to pay for the treatment; and

(vi) the insured person acknowledges receipt of the advice.

"**Family Policy**" means a Policy that includes more than two members of the same Family, including a Couples Policy.

"**Fund**" means CDH Benefits Fund.

"**Fund Benefit**" or "**Benefit**" means a Benefit payable under these Rules.

"**Gap Cover**" is a scheme provided by a private health insurer under which it is able to offer no gap or known gap policies.

"**Gap Cover Scheme**" means the amount of Benefit payable by the Fund in respect of Hospital Treatment or associated professional attention that:

(i) is provided from an approved scheme prepared by a private health insurer under which it is able to offer No Gap or Known Gap policies; and

(ii) is rendered to a patient, while or in conjunction with inpatient Hospital Treatment provided in a Hospital or a Day Hospital Facility by a Medical Practitioner; and

(iii) is a Professional Service in respect of which a Medicare Benefit is payable; and

(iv) the attending Medical Practitioner discloses to the insured person any financial interest that the first mentioned person has in any products or services recommended or given to the insured person; and

(v) the attending Medical Practitioner informs the insured person in writing, where the circumstances make it appropriate, of any amounts that the insured person can reasonably be expected to pay for treatment; and

(vi) the insured person acknowledges receipt of the advice.

"**Gap Medical Benefits**" means the amount of Benefit payable by the Fund in respect of a Professional Service that:

(i) is rendered to a patient, while with inpatient Hospital Treatment is provided to the patient in a Hospital or a Day Hospital Facility, or in conjunction with their Treatment, by a Medical Practitioner with whom the Fund does not have a Medical Purchaser-Provider Agreement that applies to that Professional Service; and

(ii) is a Professional Service in respect of which a Medicare Benefit is payable, and

is to be an amount equal to:

a. if the medical expenses incurred in respect of the service are greater than or equal to the Medicare Schedule Fee within the meaning of Part II of the *Health Insurance Act 1973* in respect of the service - 25% of that Schedule Fee; or

b. if the medical expenses incurred in respect of the services are less than that Medicare Schedule Fee - the amount (if any) by which the medical expenses exceed 75% of that Schedule Fee.

"**Health Screening Services**" means a medical examination or test that is not reasonably required for the medical condition of the patient or is not a clinically relevant service.

"**Health Insurance Act**" means the *Health Insurance Act 1973* as amended from time to time and the *Private Health Insurance Act 2007* and amendments from time to time.

"**Homoeopathic service**" means a service or treatment by a homoeopath in private practice who is accredited as a Homoeopath with an accreditation organisation recognised by the Australian Regional Health Group or the Fund.

"**Hospital**" means a means a hospital as defined in the *Private Health Insurance Act 2007* and includes a Private Hospital, a Public Hospital or a Day Hospital Facility.

"**Hospital Pharmaceuticals**" means pharmaceuticals as defined in the Act meaning any drug or medicine listed in the PBS that is dispensed to a Hospital patient and is intrinsic to the Hospital Treatment provided, clinically indicated and essential for the meeting of satisfactory health outcomes for that patient.

"**Hospital Purchaser-Provider Agreement**" or "Contract with a Hospital" means an agreement entered into between the Fund and a Hospital or Day Hospital Facility that includes provisions to the effect that, except to the extent (if any) provided in the agreement, the Hospital agrees to accept payment by the Fund in satisfaction of any amount that would, apart from the agreement, be owed to the Hospital in relation to an episode of Hospital treatment, by a Member or Dependant under a Policy.

"**Hospital Policy**" means a policy of hospital insurance that provides Benefits prescribed under Schedule A.

"**Hospital Treatment**" means the rendering of Professional Services to, or in respect of, an inpatient of a Hospital.

"**Intensive Care Unit**" means a licensed intensive care unit in a Private Hospital.

"**Inpatient**" means an admitted patient as defined in the National Health Data Dictionary

"**Known Gap**" refers to a Policy that covers all but a specified amount or percentage of the full cost of particular Hospital Treatment and associated Professional Services for a Member.

"**Medical Adviser**" means a qualified Medical Practitioner appointed by the Fund to give technical advice on professional matters.

"**Medical Practitioner**" means a person as defined in Section 3 (1) of the *Health Insurance Act 1973*.

"**Medical Purchaser Provider Agreement**" or "**Contract with a Medical Practitioner**" means an agreement entered into between the Fund and a Medical Practitioner that includes provisions to the effect that, except to the extent (if any) provided in the agreement, the Medical Practitioner agrees to accept payment by the Fund in satisfaction of any amount that would, apart from the agreement, be owed to the Medical Practitioner in relation to an episode of treatment, by a Member or Dependant under a Policy.

"**Medicare Benefit**" means a Medicare Benefit under Part II of the *Health Insurance Act 1973*.

"**Member**" means a Policy Holder, and in the case of a Family or Couples Membership, a Dependant, covered by that membership who is entitled by these Rules to Fund Benefits.

"**Membership Year**" means a year from the date of commencement of a Policy or from the anniversary date of the commencement of a Policy.

"**Minimum Benefit**" means in the relation to Hospital Treatment the minimum Benefit payable from a Hospital Policy as prescribed by the Minister from time to time.

"**Minister**" means the Federal Minister or his or her delegate with the powers vested in the Minister by the *Private Health Insurance Act 2007*.

"Multiple Services Rule" is the method of calculating payments for services provided by Medical Providers where those services fall within the Multiple Operations category in the MBS. This rule provides that, for all items except Pathology and Radiology Services items:

1. The first item, if greater than $200 is paid at 50% payment over the schedule fee, if lower than $200 at 20% payment over the schedule fee

2. For the second item the MBS rate is divided by 2. If greater than $200 it is paid at 50% over the divided schedule fee, if lower than $200 at 20% payment over divided schedule fee

3. For subsequent items the MBS rate is divided by 4. If greater than $200 it is paid at 50% over the divided schedule fee, if lower than $200 a 20% payment over divided schedule fee

"**National Health Act**" means the *National Health Act 1953*.

"**Naturopathy Service**" Removed from Benefits 1/4/2019.

"**No Gap**" refers to a Policy that covers the full cost of particular Hospital Treatment and associated professional attention for Members.

"**Nursing Home Type Patient**" in relation to a Hospital, means a patient in the Hospital who has been provided with Hospital Treatment whether:

(i) acute care; or

(ii) accommodation and nursing care, as an end in itself; or

(iii) a mixture of both,

for a continuous period of hospitalisation exceeding 35 days (**35-day period**), but a patient receiving acute care immediately after the 35-day period does not become a nursing-home type patient unless the period of acute care ends and the patient is then provided with accommodation and nursing care, as an end in itself, as part of a continuous period of hospitalisation.

"**Occupational Therapy Service**" means a service or treatment provided by an occupational therapist in private practice who is a member of the Occupational Therapists' Association or the NSW Association of Occupational Therapists, or any other organisation recognised by the Australian Regional Health Group or CDH Benefits Fund or has proved conclusively to the Australian Regional Health Group that he/she is qualified to become a member of the Occupational Therapists Association.

"**Optical Service**" means a repair or appliance provided by a registered optician or optometrist in private practice and excludes sunglasses.

"**Optical Repair**" means the fitting of new frames to existing lenses, or the fitting of new lenses to an existing frame and includes the repair of a frame or the replacement of a broken lens.

"**Organisation**" means CDH Benefits Fund including when trading under any other name.

"**Orthoptic Therapy Service**" means a service provided by an orthoptist in private practice who is a member of the Orthoptic Association of Australia or who has proved conclusively to the Australian Regional Health Group or the Fund that he/she is qualified to become a member of the Orthoptic Association of Australia.

"**Palliative Care**" refers to the episode of care provided to a patient whose condition has progressed beyond the stage where curative treatment is effective and attainable or, where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

"**Partner**" means a person who is living with a person on a bona fide domestic basis whether or not legally married to that other person.

"**PBS**" means the Commonwealth Government's Pharmaceutical Benefits Scheme.

"**PBS Item**" means any drug listed in the Pharmaceutical Benefits Schedule.

"**Pharmaceutical Benefits Schedule**" means the Schedule of Pharmaceutical Benefits kept by the Commonwealth Department of Health and Ageing.

"**Per Annum**" means per Membership Year.

"**Physiotherapy Service**" means a service or treatment provided by a registered physiotherapist in private practice.

"**Podiatry Service**" means a service or treatment provided by a registered podiatrist in private practice.

"**Policy**" means a Hospital Policy or a General Treatment Policy or a Combined Policy as set out in the Schedules to these Rules that provides an entitlement to Benefits under these Rules.

"**Policy Holder**" has the same meaning as in the Act.

"**Pre- Existing Condition**" means an ailment, illness or condition, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by the Fund, existed at any time during the six months preceding the day on which the Member became insured under the relevant Policy. In forming the opinion the 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 gives him or her.

"**Premium**" means the amount of money a Primary Member is required to pay to be eligible for Benefits under a Policy.

"**Prescribed 35 Day Period**" means a patient's continuous period of hospitalisation of 35 days without a break of 7 days or more during the last 12 months.

"**Primary Member**" means the person in whose name the Policy is registered with the Fund.

"**Private Hospital**" has the same meaning as in the Act.

"**Product**" means health insurance cover including one or more Policies marketed by the Fund.

"**Professional Service**" means a professional service as defined in the *Health Insurance Act 1973*.

"**Psychiatric Patient**" means a patient undergoing a psychiatric program under the supervision of a psychiatrist in a Public or Private Hospital, which has a Contract with the Fund to provide such a program.

"**Purchaser-Provider Agreement**" means a Hospital Purchaser-Provider Agreement or a Medical Purchaser-Provider Agreement and includes a purchaser-provider agreement between the Fund and any other provider.

"**Remedial Massage Therapy Service**" means a service or treatment by a remedial massage therapist in private practice who is accredited as a Remedial Massage Therapist with an accreditation organisation recognised by the Australian Regional Health Group or the Fund.

"**Registered or Recognised**" in relation to a health care practitioner means a practitioner who is registered by a state registry body, if existing for that particular modality, or otherwise a practitioner accredited to practise privately with an accreditation with a practitioners' body nominated or to be nominated in these Rules or by the Australian Regional Health Group.

"**Rehabilitation Patient**" means a patient undergoing a rehabilitation program under the supervision of a specialist in rehabilitative medicine in a Public Hospital or a Private Hospital, which has a contract with the Fund to provide such a program.

"**Respite Care**" refers to the accommodation of a patient in a Hospital where the primary reason for the admission is to provide temporary relief from the home care of the patient to the person who is administering the home care, rather than to provide care for the patient.

"**Schedule of Pharmaceutical Benefits**" means the Schedule of Pharmaceutical Benefits provided under the National Health Service and maintained by the Commonwealth Department of Health and Ageing.

"**Single Membership**" relates to a Policy that only includes one person.

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"**Specialist Dental Treatment**" means that treatment provided by a dentist registered as a specialist and provided according to the conditions of practice of that specialty as required by the specialist's dental registration body.

"**Student Dependant**" for Fund Benefit purposes is one who is 21 years of age or over and who:

(i) does not have a Partner

(ii) is a student at a school, college or university

(iii) is under the age of 25 years

(iv) does not derive an income in excess of the Medicare Levy Exemption Threshold.

"**Unfinancial**" A Primary Member is deemed to be unfinancial when Premiums are more than two months in arrears.

"**Usual Customary and Reasonable Charge**" means in relation to a service, the usual or customary fee charged for that service by other similarly qualified practitioners or a reasonable charge for that service as determined by the Fund having regard to the usual or customary charges for a similar service and/or advice from the practitioner's professional association or body.

"**Waiting Period**" means the period of time from the date a Policy commences or recommences after the Policy has lapsed to the date that either certain services or items provided to the Member may attract Fund Benefits under these Rules.

MEMBERSHIP

1. General Conditions of Membership

1.1. Members of CDH Benefits Fund shall have the right to obtain from the Fund, the Benefits and/or Services as provided under these Rules.

1.2. All Members under the same Policy shall belong to the same Insured Group and have the same Policy.

1.3. There are six types of Insured Group representing Policies the Fund may choose to offer from time to time:

(i) only one person;
(ii) 2 adults (and no-one else);
(iii) 2 or more people, none of whom is an adult;
(iv) 2 or more people, only one of whom is an adult;
(v) 3 or more people, only 2 of whom are adults;
(vi) 3 or more people, at least 2 of whom are adults.

1.4. A Member may contribute to any of the Policies offered by the Fund in the Member's State of residence as set out in the Schedules to these Rules, subject to the eligibility criteria applicable for that policy type.

2. Eligibility for Membership

2.1. Subject to these Rules any person who is aged 18 years of age or more, or as otherwise determined by the Fund, is entitled to apply for their own Primary Membership of the Fund .

2.2. Any person who applies for a Policy for themselves shall be known as the Primary Member. The Primary Member may also apply to cover their Dependants.

2.3. A person may not concurrently have a Policy that covers Hospital Treatment with the health benefits fund of another private health insurer and CDH Benefits Fund.

2.4. Subject to the Fund's discretion a person may not concurrently have a Policy that covers General Treatment with the health benefits fund of another private health insurer and CDH Benefits Fund.

2.5. A person may be a Primary Member to both CDH Benefits Fund and the health benefits fund of another private health insurer, where a Hospital Treatment Policy is held with one private health insurer and a General Treatment Policy is held with the other private health insurer.

3. Dependants

3.1. When a person reaches the age of 21 years, provided they are not a Student Dependant, and are not covered by one of the Hospital Products, they must join as a separate Primary Member to obtain cover. Providing that such a membership application is completed within six weeks of the 21st birthday, Benefits shall be available without Waiting Periods. However, if upon reaching 21 years, and the Dependant is covered by one of the Hospital products, the Member may, if they desire, continue to cover the Dependant until their 25th birthday by the payment of an additional Premium as defined by the "Dependant Extension Cover".

3.2. Any policyholder may deal with the Fund in respect of claims unless specific written notice to to the contrary has been validly provided to the Fund.

3.3. Any policyholder may deal with the Fund in respect of all other matters concerning the membership including the addition or subtraction of a Dependant. The Fund may require authorisation from all policyholders in relation to some change, e.g. change of Benefit Cover.

3.4. Any policyholder may authorise another person to deal with the Fund in relation to a policy on their behalf. Such authorisation must be provided in writing in the format determined by the Fund as required from time to time.

3.5. In the event of the death of the Primary Member the Partner included in the Policy shall become the Primary Member. If there is no Partner in the membership, then the eldest Dependant Child shall become the Primary Member unless the former Primary Member has specifically provided written nomination of who shall become the Primary Member in the event of their death.

4. Membership Applications

4.1. An applicant for admission as a Primary Member shall complete the application form as requested by the Fund and shall give full and complete information upon all matters required.

4.2. A person applying for admission to the Fund as a Member shall:

(a) comply with the requirements of the Fund; and

(b) give full and complete disclosure on all matters required by the Fund.

4.3. A Member shall inform the Fund as soon as reasonably possible of any change in Policy details including:

(a) change of address;

(b) change of contact details;

(c) change of name;

(d) change of marital status of a Dependant;

(e) a Dependant ceasing to be a Dependant.

4.4. A person will not be refused a Policy by reason of their state of health or that any of the persons included in the application.

4.5. The Board or an officer appointed by the Board shall consider all applications for Policies and shall confirm the acceptance or rejection of all such applications. Any applicant who is refused a Policy shall be furnished in writing with the reasons for such refusal.

4.6. An application for a Policy will be accepted from persons 18 years or older. Consideration may be given to accept an application for a Policy where the applicant is under the age of 18.

i. In the event of any policyholder knowingly supplying incorrect information in relation to a Policy, their Policy may be declared void and all money paid thereunder and the right accrued in respect thereof, deemed to be forfeited in the Fund

ii. The Fund shall have the right to refuse to accept an application for a Policy from a person whose Policy was cancelled through application of Rule C.7.

iii. All persons included in a Policy application that is accepted shall be, whilst eligible under the Rules, included as Members within the Policy granted.

iv. If the Fund has exercised its rights to cancel a Policy, the Fund shall have the right to refuse an application for a Policy from the cancelled Member.

5. Duration of Membership

5.1. The commencement date of an accepted Policy shall be the day the Policy application is accepted or deemed to be accepted by the Fund or such date nominated by the applicant and accepted by the Fund whichever is the later date.

5.2. A Policy may continue until the death of the last survivor of the Policy subject to the following conditions:-

(a) The Premiums appropriate to the status of the Policy are paid according to these Rules,

(b) Each Member under the Policy observes the Policy requirements of these Rules.

(c) The Member may terminate the Policy as provided in Rule C8.

6. Transfers

6.1. If a person who is a policy holder of the health benefits fund of another private health insurer, applies for a Policy of this Fund, and that person is eligible for a Policy, then that person shall be accepted for cover under that Policy. If the "immediately prior" Policy of the previous fund provided the same or similar benefits as the Policy of CDH Benefits Fund then that Policy shall count as a continuing Policy for the purpose of any Waiting Period to be served. A Policy of a previous fund shall not count for the purpose of any incremental Benefit or Benefit limit where the increment requires accrued membership of a specific Policy of CDH Benefits Fund but benefits paid by the previous fund shall be included when determining the limitations of Fund Benefit entitlements.

6.2. In accepting a transfer of a policy from the health benefits fund of another private health insurer, CDH Benefits Fund shall have the right to include Waiting Period conditions to the Policy for such portions of any Benefit payable under the Policy that are in excess of the previous Benefit entitlements. CDH Benefits Fund will normally treat a Policy with the previous fund as an "immediately prior" Policy if it was financial to within one month of the actual date of transfer.

6.3. A transfer initiated by a Primary Member from one Policy to another existing Policy providing similar Benefits, or from one option to a different existing option of the same Policy, shall be treated as a transfer from the health benefits fund of another private health insurer.

6.4. A transfer initiated by the Fund from one Policy to another existing Policy providing similar Benefits or from one option to a different existing option of the same Policy, shall not require any extra Waiting Periods to be served for additional Fund Benefits that may be provided other than those Waiting Periods that would otherwise have been required under these Rules. Cover under the previous Policy shall also be counted as cover under the new Policy for the purpose of any incremental Benefit or Benefit Limit based on accrued membership of the Policy.

6.5. No Waiting Period apart from the original Waiting Periods of an existing Policy, determined from the commencement of such Policy shall apply to any transfer of an existing Policy on to a newly introduced higher Policy, providing the transfer is effected within two months of the introduction of the higher Policy and no complaint which developed after the original acceptance to the Policy shall be classified as a "Pre-Existing Condition" for assessment of Benefit on transfer to the newly introduced higher Policy.

6.6. A Waiting Period will not apply to a Policy that covers a person who holds a gold card or was entitled to treatment under a gold card (as defined in the Act).

6.7. The Fund will provide in the approved form and within the period set out in the Private Health Insurance (Complying Product) Rules a Transfer Certificate where a person ceases to be insured with CDH Benefits Fund.

6.8. The Fund will request in the approved form and within the period set out in the Private Health Insurance (Complying Product) Rules a Transfer Certificate from a person's previous insurer where this has not been provided within 7 days of the person becoming insured by CDH Benefits Fund.

7. Cancellation of Membership

7.1. The Fund shall not have the right to cancel the Policy of any Member on the grounds of the health of that Member or any of the grounds set out in Rule 4.

7.2. Any applicant who provides false or misleading information in the "Application for Policy or Supplementary Membership Declaration" forms will not be entitled to receive Fund Benefits.

7.3. Any Primary Member whose Premiums are two months in arrears shall cease to be a Primary Member of the Fund.

7.4. A Primary Member whose Premiums are in arrears for a period of up to two months and pays such arrears before the end of that two month period is entitled to Benefits for Services rendered during that period.

7.5. The Fund shall have power to terminate the Primary Member's Policy or any Product thereof in the event that, in the opinion of the Fund, such Primary Member or other Member under the Policy has received or obtained or attempted to receive or obtain any advantage (whether pecuniary or otherwise) to which the Member is not entitled under these Rules.

7.6. The Board will review the status of a Member who is absent from Australia for 12 months or more if that Member has not suspended their Policy in accordance with these Rules.

8. Termination of Membership

8.1. A Primary Member has the right to terminate a Policy from any due date for payment of Premiums on or after the date the advice in writing of termination of the Policy has been received by the Fund. On termination the Primary Member shall receive a refund of any premiums paid in advance of the date of termination.

8.2. A Primary Member has the right to terminate the cover of any one or more Members on a Policy for which they are the Primary Member. The Fund will notify any Member of a termination affecting their cover.

9. Temporary Suspension of Membership

9.1. The Fund may suspend a Policy upon application by the Primary Member.

9.2. Suspension of Policy may be granted by the Fund if the reason for the suspension is temporary absence from Australia for more than two months and no more than 24 months of every person covered by the Policy provided that the Policy is resumed within one month of return to Australia of any person covered by the Policy and Premiums are paid from the date of return to Australia.

9.3. Suspension of a Policy may be granted by the Fund for any other reason and for any other period that the Fund considers appropriate until such time as a further Premium is paid provided that such payments are resumed from the date as directed by the Fund. Further suspension of a Policy will only be granted six months after return of the previous suspension and financially covered for that period.

9.4. Services provided during a suspension of a Policy period to Members of a suspended Policy shall not be eligible for Benefits. Appropriate travel documentation must be provide showing dates of travel. Membership will be resumed to the same level of cover prior to your date of travel except for any condition or ailments that arise during the period of suspension which will be treated as pre-existing conditions and the appropriate waiting period apply. No Benefit will be considered if the service was incurred during the suspended period.

9.5. A period of suspension of a Policy shall not qualify for the purpose of completing any Waiting Periods that are to be served by a Member before the Member is eligible to receive Benefits.

9.6. Where a Benefit limit is defined in these Rules with reference to a period of time, or limit period, within which the maximum Benefit is payable, any Benefit entitlement payable to a Member within the limit period shall be reduced by any period of suspension which falls within the limit period in the same proportion as the period of suspension divided by the limit period.

CONTRIBUTIONS

1. Payment of Contributions

1.1. Premiums may be paid through a payroll deduction scheme arranged by the Fund or by direct debit to a bank, credit union or co-operative society account or such other arrangements as are authorised by the Fund from time to time. The onus shall be on the Primary Member to always keep their Premiums paid up to-date.

1.2. The periodic basis upon which Premiums are paid shall be in accordance with the original application for the Policy unless otherwise agreed between the Member and the Fund in writing. Premiums must always be paid in advance. If any Premiums are in arrears then no Benefits shall be payable.

1.3. Any amounts tendered as premiums by a health care provider on behalf of a Member other than the provider's Spouse or Dependant Child shall be returned to that provider if the Member attempts to claim Benefits in respect of services rendered by the provider who tendered the premiums.

1.4. The yearly, half-yearly, quarterly, monthly and fortnightly premiums for a Product will respectively be 52, 26, 13, 4.333 and 2 multiplied by that Product's weekly premium rate in accordance with Section K. The Yearly, Half-Yearly, Quarterly, Monthly and Fortnightly premium rates will be rounded to the nearest 5 cents.

1.5. An amount received as Premium to a particular Benefits Policy or Product shall be applied first in payment of any arrears of Premiums to that Benefit Policy or Product and then applied in respect of future periods in chronological order.

1.6. Mineworkers Concession Scheme

(a) Mineworkers who wish to qualify for the mineworkers concession scheme described below shall pay, in addition to the normal Premium rates, the additional amount determined by the Board, which is at the present time 20 cents per week.

(b) Retired mineworkers who have had at least ten years' continuous participation in this scheme and have attained their 60th birthday will be entitled to concessional Premium rates for a Basic Hospital Policy. The concessional Premium rate is 75% of the normal rate rounded to the nearest 5 cents. Provided that this concessional rate of Premium is paid in accordance with this Rule mineworkers and eligible Dependants in this category shall be deemed to be Members under a Basic Hospital Policy.

(c) Eligibility for the benefit of this Rule is only available for persons who have commenced contributions pursuant to paragraph (a) before 1st November 2007.

2. Contribution Rate Changes

2.1. The Fund has the right to change Premium rates in accordance with the requirements of the Private Health Insurance Act.

2.2. The Fund will outline what will be required of Members who have paid in advance before the Premium rate applicable to their level of Policy is changed.

3. Contribution Discounts

3.1. The only discounts provided will be those permitted by the Act. A total percentage discount may not exceed the percentage specified in the *Private Health Insurance (Complying Product) Rules* as the maximum percentage discount allowed.

3.2. The discount is the difference between the full Premium and the net Premium. The full Premium is the Premium without any reductions due to circumstances in paragraphs 66-5(3)(a) to (e) of the Act. The net Premium is the full Premium less the cost foregone of any of the following:

(a) incentive payment;

(b) promotional payment;

(c) rebate; and

(d) any other inducement whatsoever,

made available by the Fund in relation to the Policy.

The following costs are excluded from the calculation of the net Premium:

(a) a brokerage fee or commission paid in respect of the Policy; and

(b) the cost of any discount, product, service, waiver or other thing (promotion) offered to a person at the time the person first purchases a Policy from CDH Benefits Fund if:

i. the cost of the promotion does not exceed 12% of the full Premium, for a year, for the Policy purchased; and

ii. the promotion is provided in the first year after the person purchased the Policy.

3.3. Members of the Mineworkers Concession Scheme, who are eligible for the concessional Premium rate in respect of their Basic Hospital Policy are not entitled to Premium rate discounts under Rule D3.

4. Lifetime Health Cover

4.1. The Fund will operate Lifetime Health Cover arrangements in accordance with the Act. Increased Premiums will stop after 10 years cover, but may start again, as specified in the Act.

5. Arrears in Contributions

5.1. If a Primary Member has not made a Premium payment prior to the 'paid to' date, then that Member shall be regarded as being in arrears.

5.2. If a Primary Member is less than two months in arrears, the Member may pay all Premiums in respect of the period in arrears and the Member will then be eligible for Benefits in respect of that period.

5.3. When a Member is more than two months Premiums in arrears then their Policy shall be terminated from the last 'paid to' date of the Policy except at the discretion of the Fund.

5.4. No Benefits shall be paid for services rendered to a Member during the period in which their Policy is in arrears until the arrears in Premiums are paid.

6. Other

6.1. In the event of a Member being out of work through strikes, lockouts or any other dislocations of industry and thus unable to pay their Premiums, they shall be deemed to be financial and thus entitled to Benefits provided that when they return to work they must pay all arrears at double the usual weekly or fortnightly payment rate until such arrears have been paid.

6.2. Eligibility for Benefits under this Rule D6 shall be determined by the Board in its absolute discretion.

BENEFITS

1. General Conditions

1.1. The Fund offers Benefits marketed in the form of the following Policies:

Product or Policy	Product Scale	Cover	Reference
Top Gold Hospital	EH	Hospital	Schedule A
Gold Hospital	T	Hospital	Schedule A
Silver+ Hospital	N	Hospital	Schedule A
Thrifty Silver+ Hospital	V	Hospital	Schedule A
Bronze+ Hospital	Q	Hospital	Schedule A
Basic+ Hospital	K	Hospital	Schedule A
Top Gold Hospital & Supplementary	EHS	Hospital & General Treatment	Schedule B
Bronze+ Packaged Cover	SY	Hospital & General Treatment	Schedule B
Supplementary / Optimum	S	General Treatment Only	Schedule C
Ambulance Only	Z	General Treatment Only	Schedule C
Elite Extras	U	General Treatment Only	Schedule C
Ideal Extras	J	General Treatment Only	Schedule C
Classic Extras	O	General Treatment Only	Schedule C
Healthy Extras	W	General Treatment Only	Schedule C

The following conditions apply to all Benefits:

1.2. Benefits payable shall not exceed the fees and/or charges raised for any treatment and/or services rendered for which Benefits are payable after taking into account Benefits paid from any other source.

1.3. Where the Member incurs fees or expenses in respect of:

(a) Hospital Treatment provided in a Hospital or Day Hospital Facility to which a Hospital Purchaser Provider Agreement applies; or

(b) a professional service rendered to which a Medical Purchaser Provider Agreement applies,

the amount of Benefits shall, notwithstanding anything to the contrary in these Rules, be as specified in the relevant Purchaser Provider Agreements. .

1.4. Benefits are not payable to a Primary Member in respect of a Service, which has been provided by the Fund or has been provided directly to a Member through a Purchaser-Provider Agreement between the Fund and the Provider.

1.5. Where Benefits are determined as a percentage of the receipted cost of a service and the receipted cost of a service appears to the Fund to be excessive, the Fund has the right to determine the Benefit from the Usual, Customary and Reasonable charge it determines for that service.

1.6. In the event that a Benefit has been erroneously paid then the Fund shall, within 24 months of making the erroneous payment, be entitled to recover any such amount that should not have been paid under these Rules.

1.7. Without prejudice to any remedy otherwise available to it, the Fund shall be entitled to set off against, and deduct from moneys otherwise payable then or thereafter by it to policyholders under the Policy, any amount recoverable by it by virtue of the previous Rule.

1.8. Notwithstanding the terms and conditions of these Rules, the Fund shall have the right to relax any particular term or condition in specific instances and also have the right to provide, without prejudice, an ex-gratia payment of Benefits under such terms and conditions as it shall decide.

1.9. The Fund may request any medical or other evidence, which it considers necessary to determine eligibility for Benefits. In the event that the supplier of any such evidence raises a charge, the Member shall be responsible for the charges incurred.

1.10. Increased Benefit limits, or loyalty bonuses, that are dependant on Current Continuous Membership are only available to Members with Current Continuous Membership in respect of the specific Product that provides the Benefit. Membership of another Product or another private health insurer with a similar product does not count as membership of the specific Product for the purposes of any loyalty bonus.

2. Hospital Treatment

The following conditions apply to Benefits payable from Hospital Policies, including where these are part of a Combined Hospital and General Treatment Policy:

2.1. Hospital Benefits and Professional Services Benefits shall, where applicable, be paid in accordance with the terms and conditions of the Act.

2.2. The day of admission into Hospital and the day of discharge from Hospital shall together be counted as one day. However, for administrative purposes, the day of admission will be counted as the Benefit day.

2.3. Higher Benefits are not payable in respect of advanced surgery or surgical/obstetric patients, until the day the procedure commences, except:

(a) for Advanced Surgical and surgical patients, one day pre-operative admission time will be permitted.

(b) for obstetric patients, two days pre-operative admission time will be permitted.

(c) where procedures to be performed warrant an extension of pre-operative admission time as determined by Medical Adviser of the Fund.

2.4. For the purpose of determining the Benefit payable where a patient undergoes multiple operative procedures, then the procedure with the highest Schedule fee outlined in the Medicare Benefits Schedule will generally determine the patient classification.

2.5. Hospital Benefits are not payable for Respite Care.

2.6. Where a patient is designated a Nursing Home Type Patient, Benefits shall be limited to the amounts prescribed by the Commonwealth Department of Health and Ageing.

2.7. Where a Member is transferred to another Hospital or re-admitted to the same or another Hospital for the same medical condition or for a medical condition, which, in the opinion of the Medical Adviser is closely related to the condition for which the earlier Hospital accommodation Benefits were payable, the Patient Classification at transfer or re-admission will be deemed to be a continuation of the previous Patient Classification for which there is an entitlement to accommodation Benefits under these Rules.

2.8. The Fund shall have the right to dispute any claim for Benefits in respect of Medical or Hospital Treatment. In the event the Fund disputes a claim for Medical or Hospital Treatment it may at its absolute discretion refer the claim to its Medical Adviser. The Medical Adviser's fees shall be paid by the Fund and their advice shall be binding on the Fund.

2.9. Gap and other Medical Benefits are not payable in respect of a Professional Service for which a Medicare Benefit is not payable.

3. General Treatment

3.1. The Fund shall have the right to dispute any claim for Benefits in respect of Dental Treatment. In the event the Fund disputes a claim for Dental Treatment it may at its absolute discretion appoint a Dental Adviser to examine the Patient who received the Dental Treatment and/or any records deemed by the Dental Adviser to be relevant to verify the claim. The Fund shall notify the Primary Member in writing of the disputed claim and advise the Primary Member of the Dental Adviser appointed. The Dental Adviser's fees shall be paid by the Fund.

3.2. The Dental Adviser shall be at liberty, should they think fit, to satisfy themself as to all matters in relation to the claim and make a decision as to the amount of the Benefits that are properly payable. The Primary Member is required to provide to the Dental Adviser all documents and records that the Dental Adviser may reasonably request in relation to the claim. The Fund shall pay all reasonable expenses of the Patient in attending an examination by the Dental Adviser.

3.3. In the event that the Patient after being requested by the Fund fails, within a reasonable period of time, to attend the Dental Adviser appointed or fails or refuses to provide documents or records requested by the Dental Adviser, the Fund may refuse payment of Benefits for all Dental Services associated with the claim.

3.4. A dispute involving a claim for a General Service other than a Dental Service shall be resolved using the same methodology as for a Dental Service.

4. Other

4.1. Benefits are not payable for a treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules.

4.2. Benefits are not payable for treatment received outside of Australia.

LIMITATION OF BENEFITS

1. Co Payments

Nil.

2. Excesses

2.1. Where available under the relevant Product, a Member may elect to contribute a lesser premium as specified, and electing to an Excess option.

2.2. A Member who contributes to an Excess table, no excess is payable for a hospital admission for dependent children or for dependents registered under dependent-extension cover if they hold this type of cover.

3. Waiting Periods

3.1. Benefits are not payable in respect of services provided to a Member during the Waiting Period and for treatments in progress at the date of first obtaining the Benefit cover or during the Waiting Period for the Benefit.

3.2. The following Waiting Periods will apply for Benefits.

(a) In respect of Hospital and Professional Services related to an obstetric condition - twelve (12) months. However, in cases of premature births Benefit will be applicable where the Member giving birth would have completed twelve months as a Policy Holder of a relevant Policy at the date the birth was due to occur.

(b) In respect of Pre-Existing Conditions - twelve (12) months. All Services relating to Male Reproductive System are determined to be a Pre- Existing Condition for the purposes of these Rules.

(c) In respect of psychiatric treatment, rehabilitation or Palliative Care whether or not the condition is a Pre-Existing Condition – two months, HOWEVER, members with limited mental/psychiatric health cover on lower covered products are eligible to upgrade their cover to in-hospital mental/psychiatric health services and receive higher benefits without serving further waiting periods provided a 2 month waiting period had been served in that lower covered product and that product included psychiatric cover.

(d) In respect of artificial aids and appliances – twelve (12) months.

(e) In respect of optical (Extras tables) – two (2) months.

(f) Benefits for crowns and bridges, dentures and specialist or major dental treatment are not applicable for any service prior to twelve months from commencement of the Member's cover under the relevant General Policy.

(g) Bereavement Benefits: Only payable after two years continuous membership in the Fund . Members joining or re-joining subsequent to 2007 no benefits are payable.

(h) A health management program or a chronic disease management program as these are defined in the *Private Health Insurance (Health Insurance Business) Rules* twelve (12) months

(i) In respect of any other Hospital, Professional Services and General Treatment Services and items - two (2) months.

(j) In the case of an Accident, Waiting Periods will not apply except that Benefits will not be available for treatment resulting from an Accident that occurred on the first effective date of the Policy.

3.3. Hospital-substitute treatment as defined in the Act, that is obstetric treatment or for a Pre-Existing Condition (other than treatment covered by paragraph (c)) – twelve (12) months, and for any other Hospital Treatment – two (2) months.

3.4. The Board of Directors the Cessnock District Health Benefits Fund Limited shall in their absolute discretion have the right to waive Waiting Periods.

4. Exclusions

4.1. If a Member's Premiums under the relevant Policy are more than two (2) months in arrears at the time of the Member's admission to Hospital, or are in arrears at the date of admission and the Premiums subsequently become more than 2 months in arrears then no Benefit for Hospital Treatment is payable.

4.2. Where Premiums under the relevant Policy are in arrears but become paid up-to-date before Premiums are more than two (2) months in arrears, then covered services or treatment rendered during that arrears period to Members under that Policy shall become eligible for Fund Benefit.

4.3. No Benefits are payable for Pharmaceutical Benefit Scheme prescriptions other than those covered by a Contract with a Hospital.

4.4. No Benefits are payable for contraceptives or items normally available without prescription.

4.5. Benefits are not payable for Hospital outpatient services where such services are not covered by a Contract with the Hospital.

4.6. Benefits are not payable in respect of a service that has been rendered to a Member if the expenses in respect of that service were incurred by the employer of that Member or if the Member to whom that service was rendered, obtained that service in connection with, or in conjunction with, employment or application for employment or an industrial undertaking or profession or a life insurance examination or the like.

4.7. Benefits are not payable in respect of services provided to a Member being services that have been provided by a Defence establishment or other Government authority which under the normal course of events would not have raised a fee for such service had the Member not been covered by health insurance.

4.8. Benefits are not payable in respect of a service rendered in the absence of illness, disability or disease except at the discretion of the Fund.

4.9. Benefits are not payable for Health Screening Services.

4.10. Benefits are not payable in respect of services or treatment rendered by a Medical Practitioner or by a provider of General Treatment services to Dependants or Partners or Partner's Dependants if a legally enforceable debt is not incurred.

4.11. Benefits are not payable in respect for services that has already been paid by another source.

5. Restricted Benefits

5.1. Eligible claims will be paid at the Minimum Benefit levels as determined by the Minister from time to time. These benefits are generally not adequate to cover private hospital costs, but fully cover shared ward costs in a public hospital

6. Compensation Damages and Provisional Payment of Claims

6.1. Benefits are not payable in respect of services provided to a Member as a result of an Accident, illness, injury, condition or other incident for which there exists in the opinion of the Fund, a right to claim compensation from a third party or authority at law or under any insurance or scheme of arrangement.

6.2. Where the Fund makes an "ex gratia" payment in the interim period before the compensation is granted, the Member shall repay to the Fund any such ex gratia payment, including the payment of interest at no more than commercially applicable interest rates, where the Member subsequently becomes entitled to receive a payment or consideration in settlement of a claim for compensation or damages (howsoever described). The liability of the Member to repay shall apply regardless of whether or not the Member continues to be a Member of the Fund.

6.3. Where the Member receives, or becomes entitled to receive, a lesser amount than the sum of ex gratia payments made by the Fund, then the Member's liability to repay the Fund shall be limited to such lesser amount.

6.4. In addition to any other terms or conditions which the Fund may apply under this Rule, the Member shall provide:

(a) an undertaking in a form approved by the Fund to repay the amount of the ex gratia payment;

(b) an undertaking to keep the Fund informed of progress towards resolution of the claim and to provide the Fund access to any settlement terms reached; and,

(c) an undertaking to notify the Fund within fourteen (14) days when a settlement is reached.

6.5. Benefits are not payable where a Member receives services which, in the opinion of the Fund, relate to an Accident, illness, injury, condition or other incident for which the Member has personally received a payment or consideration in settlement of a claim for compensation or damages however the settlement is described, including payments by way of ex gratia and/or non-disclosed settlement.

CLAIMS

1. General

1.1. Claims shall be submitted to the Fund on the required form either by mail or via a Fund approved electronic format, or in person to the office of the Fund.

1.2. The Fund reserves the right to refuse a claim that is not submitted in the correct format.

1.3. A claim that is submitted more than two (2) years after the date of the service for which a benefit is claimed shall not usually be accepted by the Fund.