

Note: This is only an extract of the Health Benefits Fund Rules of Teachers Health. We have not included the General Treatment, Hospital Treatment and Combined Treatment tables, a summary of which can be found in the current Teachers Health Insurance Product Guide. This means the numbering in these Rules may have gaps in some places, but all the Rules that relate to your cover are included.

A1 Rules Arrangement

These Rules are the Health Benefits Fund Rules of Teachers Federation Health Limited (TH) ABN 86 097 030 414, a company limited by guarantee.

A2 Health Benefits Fund

These Rules govern the establishment and operation of the registered health benefits fund of TH, which is a not-for-profit fund, and describe the obligations, requirements and entitlements of Primary Members and TH in relation to the Fund.

TH's health-related businesses are part of the health benefits fund and include eye care centres, dental centres, care coordination, health management programs and services as well as acting as agent for the provision of travel insurance and general insurance to Insured Members. TH must not, as part of the business of the Fund, enter into agency or re-insurance arrangements with any person conducting other health insurance business which is not registered under the *Private Health Insurance Act 2007* (Cth) ("PHI Act") or the *Private Health Insurance (Prudential Supervision) Act 2015* ("PHIPS Act") (together, the Acts).

A3 Obligations to Insurer

- (a) These Rules, along with the Application Form, constitute a contract between TH and the Primary Member and govern the relationship between TH and all Insured Members under the Policy. TH and the Insured Members will be bound by these Rules.
- (b) In the event that a Benefit has been paid erroneously through an error by TH to an Insured Member, subject to any other rights which the Primary Member may have, TH will, within 24 months of making the erroneous payment, be entitled to recover the amount that should not have been paid under these Rules.
- (c) Any such amount so required to be refunded will be a debt due to TH from the Insured Member and will be payable on demand or after such period as TH may permit.
- (d) All information requested in the Application Form and any additional information requested by TH that is relevant to the application must be supplied by the applicant.

A4 Governing Principles

- (a) The Fund is established under the Constitution of TH.
- (b) If there is any inconsistency between these Rules and the TH Constitution, the Constitution prevails to the extent of the inconsistency.
- (c) These Rules are made subject to the Acts. If any provision of these Rules is inconsistent with the requirements of the Acts, the provision is of no effect to the extent of the inconsistency.

A5 Use of Funds

- (a) The Fund must be maintained solely to accept Premiums for Policies, to pay Benefits to Insured Members, to pay administration and management costs incurred in the conduct of the Fund and to earn surpluses on operations which will be retained by TH in the Fund to

- financially support its health insurance and health-related businesses or be used to reduce Premiums and increase Benefits to Insured Members.
- (b) TH may accept Premiums from Primary Members and must credit them to the Fund.
 - (c) TH may invest assets of the Fund in any way that is likely to further the business of the Fund, subject to the requirements of the PHIPS Act.
 - (d) No amount will be debited to the Fund other than:
 - (i) payments by TH of Benefits payable under these Rules to Insured Members;
 - (ii) costs attributed to the Fund incurred by TH in carrying on health insurance and health-related businesses as a registered private health insurer;
 - (iii) costs incurred by TH in providing or arranging to provide access to Hospital Treatment or General Treatment to Insured Members;
 - (iv) any amount paid to the Private Health Insurance Risk Equalisation Special Account as required by the Act; and
 - (v) administration and management costs incurred in the management of the Fund, including doing all such things required to comply in all respects with the *Corporations Act 2001* (Cth) and the Acts.
 - (e) TH may borrow money and give security by way of charge over any property or business of the Fund for a purpose consistent with these Rules.

A6 No Improper Discrimination

In relation to the acceptance of any Policy application and any decisions relating to the Policy, TH must not take or fail to take any action, or have regard to or fail to have regard to any matter that would result in TH improperly discriminating between people who are or wish to be insured under a Policy of TH. Improper discrimination is discrimination that relates to:

- (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 the lifetime health cover schedule; or
- (d) where a person lives, except for allowing a different amount of Benefits depending on which state people live in; or
- (e) any other characteristic of a person (including but not only 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 Policy, except for determining a person's entitlement to a Benefit for General Treatment (other than Hospital-Substitute Treatment) in respect of a period by having regard to the amount of Benefits for that kind of treatment already claimed for the person in respect of the period.

A7 Changes to Rules

- (a) TH may amend, vary, delete, add to or replace these Rules at any time.
- (b) Alterations to these Rules relating to changes in Premiums which require the prior notification and approval of the Minister will be implemented from such dates approved by the Minister.
- (c) Alterations to these Rules will be notified to Primary Members and, if required, to Adult Insured Members a reasonable time before the change takes effect where the alterations are determined by the Board to be material alterations or detrimental alterations to Insured Members in relation to Benefits. If under the PHI Act TH is required to give notice of the alteration to the Minister, or obtain the Minister's consent to the alteration, TH will notify the Primary Members or Adult Insured Members, as applicable, after the Minister has been informed. Notice of those alterations may be given by post, email or SMS.

- (d) Notice of all other alterations to these Rules will be given on TH's website www.teachershealth.com.au. Changes to these Rules may be viewed at the website or by inspecting a copy of the amended Rules at the registered office of TH at Level 4, 260 Elizabeth St, Sydney NSW, 2000.
- (e) If an alteration to these Rules will require an update to the Private Health Information Statements (**PHIS**) for a policy, Adult Insured Members will be provided with an updated PHIS as soon as practicable after the statement is updated.
- (f) Despite any other provision of these Rules, but subject to the requirements of the Acts such as in relation to improper discrimination, TH has the right to waive or relax a provision in relation to one or more Insured Members, including by making an Ex-Gratia Payment of a Benefit, upon such terms as it may decide.

A8 Dispute Resolution

TH will maintain a dispute resolution policy and mechanism as determined by the Board from time to time. This will include provision that:

- (a) an Insured Member can make complaints, either orally or in writing, to TH who will endeavour to assist in the speedy resolution of the complaint;
- (b) if the issue is not resolved, it will be escalated internally and, if necessary, the Chief Executive Officer may escalate it to the Board.
- (c) if the Insured Member is unsatisfied with the resolution finally proposed by TH, the Insured Member will be advised to contact the Private Health Insurance Ombudsman regarding the issue and TH will cooperate in having the issue resolved by the Ombudsman.
- (d) Insured Members may view a summary of this policy by visiting TH's website at www.teachershealth.com.au or may request a copy from TH.

A9 Notices

- (a) Notice given by TH to Insured Members will be given in accordance with the requirements of the PHI Act.
- (b) Where there is no relevant provision in the PHI Act:
 - (i) notices will be effective if given to the Primary Member on behalf of all Insured Members covered by a Policy; and
 - (ii) Notices to Insured Members will be in writing and sent by post or email to the address last given to or known by TH or posted on TH's website at www.teachershealth.com.au.
- (c) Notices to TH must be sent in writing by post to GPO Box 9812, Sydney, NSW, 2001 or by email to the email address notified on TH's website at www.teachershealth.com.au.

A10 Winding Up

- (a) In the event of TH ceasing to be registered as a private health insurer under the PHIPS Act, all Insured Members will be transferred to another registered private health insurer and the Fund will be terminated in accordance with the requirements of the PHIPS Act.
- (b) In the event of termination of the Fund all money standing to the credit of the Fund and not required to meet outstanding liabilities, staff allowances, contracted payments or any other expenses of termination will be paid to APRA.

A11 Other

- (a) **Actuary**
The Fund must appoint an Actuary in accordance with the PHIPS Act.
- (b) **Continuity of the Rules**
If these Rules are amended (which includes being replaced) Insured Members will continue to be Insured Members under the new Rules and the following will apply:

- (i) The Rules of TH in force at the date of the provision of a Service for which a Benefit is payable are the Rules governing the payment of that Benefit.
 - (ii) Where a Premium has been paid for a period after the alteration to these Rules, the Premium payable under the new Rules will be deemed to have been paid for the same period.
 - (iii) Where a Policy is replaced under the amended Rules (Old Policy), Insured Members will be transferred to a Policy with the same Benefits as, or the closest Benefits to, the Old Policy.
 - (iv) Any Accrued Benefit Entitlements of an Insured Member under an Old Policy will apply to a Policy under the amended Rules if that Policy provides for Accrued Benefit Entitlements.
- (c) **Inspection of these Rules**
 Insured Members may examine a copy of these Rules or a summary of these Rules at the registered office of TH at Level 4, 260 Elizabeth St, Sydney, NSW 2000.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

The following apply in the interpretation of these Rules, unless the context requires otherwise.

- (a) A reference to any Act, regulation, rule or similar instrument includes any consolidations, amendments or re-enactments of it, any replacements of it, and any regulation or other statutory instrument issued under it.
- (b) A reference to the singular includes the plural number and vice versa.
- (c) A reference to a gender includes a reference to each gender.
- (d) A reference to a party or a person, including an Insured Member, includes that party's or person's executors, legal personal representatives, successors, liquidators, administrators, trustees in bankruptcy and similar officers and, where permitted under these Rules, their substitutes and assigns.
- (e) An agreement on the part of, or in favour of, two or more persons binds or is for the benefit of them jointly and severally.
- (f) **Includes** means includes but without limitation.
- (g) Where a word or expression has a defined meaning, its other grammatical forms have a corresponding meaning.
- (h) A reference to a clause, schedule or annexure is a reference to a clause of, or a schedule or an annexure to these Rules.
- (i) A heading is for reference only. It does not affect the meaning or interpretation of these Rules.

B2 Definitions

The following words have the following meanings in these Rules, unless the context requires otherwise.

Access Gap Cover Scheme means arrangements with specific medical specialists where TH pays Benefits for Inpatient medical services above the Medicare Benefits Schedule Fee to eliminate or reduce out-of-pocket expenses for the Insured Member.

Accident means an injury to the body inflicted as a result of unintentional, unexpected actions or events caused by an external force or object, which occurred in Australia after joining the Fund and serving the 2-month waiting period, that requires, within 7 days of the Accident, treatment by a recognised Medical Practitioner, or Dentist, but excludes pregnancy. Benefits are payable for the initial inpatient hospital treatment for injuries resulting from the Accident, as well as ongoing inpatient hospital treatment where the services are provided within 180 days of the date of the Accident and which form part of the initial course of treatment covered by the Fund.

Accredited Mental Health Social Workers are registered providers with Services Australia. They have been assessed on behalf of the Commonwealth Government by the Australian Association of Social Workers (AASW) as having specialist mental health expertise.

Accrued Benefit Entitlements means a Benefit that accrues to an Insured Member in relation to certain years of continuous membership under one Policy with TH.

Acupuncture Service means acupuncture treatment provided by a Recognised Provider.

Actuary means a person who is eligible for appointment as a private health insurer's actuary under the PHIPS Act.

Adopted Child means a legally adopted Dependent Child or Dependent Non-Student.

Adult does not include a Dependent Child, Dependent Non-Student or Student Dependant.

Adult Dependant see definition for **Dependent Non-Student**.

Allergy Cover means a mattress or pillow cover purchased on the recommendation of a Health Care Provider for the relief of a patient's allergy.

Ambulance Cover means the General Treatment benefit for which maximum Benefits are prescribed in Rule 13.

Ante and Post Natal Classes means ante and post-natal courses or classes provided by a Recognised Provider.

Application Form means an application for a Policy made by a person who will become the Primary Member, in such form as TH determines from time to time.

APRA means the Australian Prudential Regulation Authority.

Arrears means a period during which Policy Premiums are not paid to the current date.

Artificial Aids means artificial aids that are recognised by TH as essential to an Insured Member's health care needs.

Audiology Service means an audiology service provided by a Recognised Provider.

Australian Government Rebate on private health insurance or **Rebate** means the incentive rebate offered by the Federal Government to reduce Premiums of private health insurers. The Rebate is offered to encourage permanent residents, interim and reciprocal Medicare card holders in Australia to take out private health insurance. It applies to both Hospital and Extras Policies.

Benefit means a benefit payable under these Rules and includes access to a Service to be provided directly to the Insured Member in lieu of a payment.

Blood Glucose Monitor means a machine recognised by TH as essential to aid the management of an Insured Member's diabetes related condition.

Board means the board of directors of TH.

Boarder Fees means the fee charged by a public hospital for accommodation of an individual, which is considered part of General Treatment rather than Hospital Treatment since the benefit only applies where, in the opinion of a medical practitioner, it is necessary for the care and management of a disease, injury or condition of an Insured Member who is undergoing Inpatient treatment that the individual stay overnight at the public hospital with the Insured Person.

Broader Health Cover means the private health insurance that covers services that prevent, are part of, or substitute for hospitalisation, including chronic disease management programs, hospital in the home, transitional care and rehabilitation in the home.

Calendar Year means 1 January to 31 December of the same year.

Chiropractic Service means chiropractic Service provided by a chiropractor who is a Recognised Provider.

Class Therapy in respect of a Physiotherapy, Exercise Physiology or Chiropractor Service is the class-based provision of a common intervention to a number of clients simultaneously which may be land or water based. A class participant must be individually assessed by a physiotherapist, exercise physiologist or chiropractor (as applicable) prior to participation.

Clinical Category means a category of treatments as defined in Schedule 4 of the *Private Health Insurance (Reforms) Amendment Rules 2018 (Cth)*, or as amended.

Compression Garments means compression garments used for the treatment of lymphoedema or the treatment of vascular conditions or to minimise scarring following burns or prescribed post-surgery. It does not include sports compression garments used to improve performance or post-

exercise recovery. Claim must be supported by a written request from a medical professional prescribing the use of a garment for a specific condition and compression based on the needs of the patient.

Contribution Group means a group of Insured Members approved by TH under these Fund Rules.

Couples Policy means a Policy containing two Insured Members neither being a Dependant of the other Insured Member.

Day Hospital Facility means a facility declared as a Hospital under section 121-5(6) of the PHI Act.

Dental Services means Services provided by a Recognised Provider such as a dentist, dental prosthetist or orthodontist.

Dependant means Dependent Child, Dependent Non-Student, Student Dependant or Non-Classified Dependent Person of the Policy Holder or their covered Partner.

Dependent Child means a child, Adopted Child, Stepchild or Foster Child of the relevant Primary Member or their Partner, registered with TH, and:

(i) is aged under eighteen, and

(ii) does not have a Partner.

For the purpose of these Fund Rules, references to Dependent Child include Non-Classified Dependent Person.

Dependent Non-Student (previously **Adult Dependant**) means a child, Adopted Child, Stepchild or Foster Child of the relevant Primary Member or their Partner and:

(i) is aged between twenty one and thirty one (inclusive),

(ii) does not have a Partner, and

(iii) is not receiving full-time education at a school, college or university.

Dietetic Service means dietetic Service or advice provided by a dietician who is a Recognised Provider.

Emergency Ambulance means an ambulance service provided by a State Government ambulance service (or a private ambulance service substituted for a State Government ambulance service) or a private ambulance service recognised by TH. Benefits are payable where the Insured Member is transported directly to a Hospital or treated at the scene due to a medical emergency and excludes transportation to hospital for the routine management of an ongoing medical condition or inter-Hospital transfers (other than emergency transfers).

Erectile Dysfunctional Products means pharmaceutical products prescribed, after a face to face consultation, to treat erectile problems and available only on prescription.

Excess means an amount of a benefit that a Primary Member agrees to forgo in return for a lower Premium.

Excess Option means an option of a Hospital Policy under which reduced Benefits are payable through the application of an Excess.

Exercise Physiology means a Service provided by an exercise physiologist who is a Recognised Provider.

Ex-Gratia Payment means an act of grace payment without any liability or legal obligation.

Extended Family Cover (EFC) means a Policy that covers the Primary Member, their Partner and the Dependants of the Primary Member, of which at least 1 person is a Dependent Non-Student.

Extended Family Cover - Single Parent means a Policy that covers the Primary Member and the Dependants of the Primary Member, of which at least 1 person is a Dependent Non-Student.

Extras Policy means a Policy that provides Benefits for General Treatment as prescribed under Rules I and J.

Family Policy means a Policy that covers the Primary Member, their Partner and at least 1 Student Dependant or Dependent Child.

Foster Child means a Dependant who is a state ward placed in the care of a Primary Member or their Partner by court order or formal arrangement.

Fund means the Health Benefits Fund conducted by TH.

Funeral Benefit means the Benefit payable following the funeral of an Insured Member eligible for funeral benefits.

General Treatment means treatment, including the provision of goods and services, that is intended to manage or prevent a disease, injury or condition, and is not Hospital Treatment, but includes Hospital-Substitute Treatment.

Group Therapy in respect of a Physiotherapy, Exercise Physiology, Chiropractor Service or Occupational Therapy Service is when a small group of clients are provided with different interventions concurrently which may be land or water based. Group interventions are characterised by the following features:

- (i) pre-intervention assessment;
- (ii) individually designed intervention provided and re-assessed during the consultation; and
- (iii) clinical record keeping.

Gym Membership means standalone gym membership provided by a Recognised Provider undertaken as part of a health management program intended to ameliorate a specific health condition or conditions on the recommendation of a Health Care Provider.

Health Benefits Fund has the meaning given in the PHI Act.

Health Care Provider means a person who provides goods or services as, or as part of, Hospital Treatment or General Treatment, or a person who manufactures or supplies goods provided as, or as part of, Hospital Treatment or General Treatment.

Healthy Lifestyle Programs means weight loss programs, stop smoking courses, stress management courses and other activities approved by TH and provided by a Recognised Provider.

Hearing Aid means a device for personal use that amplifies sound to allow improved hearing.

Home Nursing Service means essential home nursing of an Insured Member provided by a Recognised Provider.

Hospital means a hospital as defined by the PHI Act.

Hospital Pharmaceuticals means any drug or medicinal preparation listed in the PBS that is dispensed to a Hospital patient and is part of the episode of care of the Hospital Treatment provided.

Hospital Policy means a Policy that provides Benefits for Hospital Treatment as prescribed under Rule J.

Hospital Treatment means treatment, including the provision of goods and services, that is intended to manage a patient's disease, injury or condition and is provided by a person who is authorised by a Hospital to provide the treatment, or under the control or management of such person, and is provided at a Hospital or arranged with the direct involvement of a Hospital.

Hospital-Substitute Treatment means General Treatment that:

- (i) substitutes for an episode of Hospital Treatment; and
- (ii) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and
- (iii) is not excluded by the Private Health Insurance (Complying Product) Rules.

HPPA means Hospital Purchaser Provider Agreement which is an agreement between a Health Benefits Fund and a Hospital or Day Hospital Facility relating to fees for the provision of Hospital Treatment.

Increasing Limit means yearly limit per person increase based on the number of years the relevant product is continuously held with TH.

Inpatient means a patient who is formally admitted to a Hospital but excludes an emergency department attendance.

Insured Member means a person who is covered by a Policy and is entitled by these Rules to Benefits and includes the Primary Member.

Lactation Nursing means Services provided by lactation nurses who are Recognised Providers.

Major Dental means periodontics, endodontics, occlusal therapy, oral surgery, prosthodontics, inlays, onlays, bridges, crowns, dentures and tooth bleaching.

Medical Gap is the amount of Benefit payable for a professional service rendered to a patient in respect of Hospital Treatment received in a Hospital or a Day Hospital Facility for which a Medicare Benefit is payable.

Medical Adviser means a qualified Medical Practitioner appointed by TH to give technical advice on clinical matters.

Medical Practitioner means a person registered or licensed as a medical practitioner under a law of a State that provides for the registration or licensing of medical practitioners but does not include a person so registered or licensed:

- (i) whose registration, or licence to practise, as a medical practitioner in any State has been suspended, or cancelled, following an inquiry relating to his or her conduct; and
- (ii) who has not, after that suspension or cancellation, again been authorised to register or practise as a medical practitioner in that State.

Medicare means Australia's health care system established under the *Medicare Australia Act 1973* (Cth).

Medicare Benefits Schedule Fee or Schedule Fee means the fee set by the Federal Government for medical services that are listed in the Medicare Benefits Schedule Book published by the Department of Health and Aged Care, and includes any updates and supplements to the schedule.

Minimum Default Benefit means the minimum Hospital Benefit prescribed by the Minister from time to time as prescribed under the *Private Health Insurance (Benefit Requirements) Rules 2011*.

Minister means the Commonwealth Government Minister for Health and Aged Care and such other Minister of the Commonwealth who may subsequently have similar responsibility in relation to private health insurance.

MPPA means a Medical Purchaser Provider Agreement which is an agreement between a Health Benefits Fund and Medical Practitioners relating to fees for the provision of medical services.

MRI means magnetic resonance imaging.

Natural Therapies means Remedial Massage, Myotherapy, Chinese herbal medicine and Acupuncture Services provided by a Recognised Provider

New South Wales or NSW includes the Australian Capital Territory.

Non-Classified Dependent Person means a child, Adopted Child, Stepchild or Foster Child of the relevant Primary Member or their Partner and:

- (i) is aged between eighteen and twenty (inclusive); and
- (ii) does not have a Partner.

For the purpose of these Fund Rules, references to Dependent Child include Non-Classified Dependent Person.

Non-Emergency Ambulance means an ambulance service provided by a State Government Ambulance Service or by a private ambulance service recognised by TH for:

- (i) a call out or attendance by an ambulance where no transport occurs;
- (ii) admission to a hospital from home where transport is deemed medically necessary;
- (iii) discharge from hospital to home where transport is deemed medically necessary, and does not include inter-hospital transfers.

All medically necessary ambulance transport must be supported by a letter from the treating doctor explaining the medical requirement for ambulance transport. Medically necessary ambulance transport is classified as:

- (i) patient requiring stretcher transport, is not able to travel in a normal seated position or has impaired cognitive function; and
- (ii) patient requiring active management or monitoring while in transit.

Nursing Home Treatment means any medical or medical-related treatment provided by a Recognised Provider to an Insured Person in a nursing home.

Nursing Home Type Patient means a person who has been admitted as an Inpatient for a period of continuous hospitalisation exceeding 35 days and there is no longer a certified requirement for acute care.

Nursing Home Type Patient Rate means the minimum Hospital Benefit for Nursing Home Type Patients prescribed by the Minister from time to time under the *Private Health Insurance (Benefit Requirements) Rules 2011*.

Nursing Service means essential home nursing of an Insured Member that is provided by a Recognised Provider.

Occupational Therapy Service means a Service provided by an occupational therapist who is a Recognised Provider.

Optical Service means a sight-correcting appliance provided upon prescription by a Recognised Provider or a repair of such appliance by a Recognised Provider.

Osteopathic Service means a Service (including x-ray) provided by an osteopath who is a Recognised Provider.

Partner means a person married to or living in a de-facto relationship with another person.

PBS means, in relation to drugs or medicines, the Commonwealth Pharmaceutical Benefit Scheme listed pharmaceuticals.

PBS co-payment means the maximum general co-payment for PBS listed pharmaceuticals as determined by the Minister from time to time.

Per Admission means each occasion when an Insured Member is admitted to Hospital for treatment as an Inpatient.

Pharmaceutical means a substance that:

- (i) has been prescribed by a Medical Practitioner or a dentist; and
- (ii) has been supplied by a pharmacist in private practice or a Medical Practitioner; and
- (iii) can only be supplied on prescription under applicable State law, but does not include a substance which:
 - (A) is available under the PBS in any formulation, presentation, strength or pack size, with or without repeat dispensing, regardless of whether such availability is subject to the Specified Purpose, Authority Required, Pensioner Concession or Special Patient Premium conditions of that scheme; or
 - (B) was prescribed in the absence of illness or disease or for enhancement of sporting or employment performance.

(iv) has been approved by the Therapeutic Goods Administration Division of the Department of Health and Aged Care.

PHI Act means the *Private Health Insurance Act 2007* (Cth).

Physiotherapy Service means a physiotherapy Service provided by a physiotherapist who is a Recognised Provider.

Podiatry means a podiatry Service provided by a podiatrist who is a Recognised Provider.

Policy means a complying health insurance policy as defined in section 63-10 of the PHI Act which is issued by TH.

Practitioner Agreement means an agreement between a Hospital or Day Hospital Facility and a Medical Practitioner for the provision of medical services at the Hospital or facility.

Pre-existing Condition means an ailment, illness or condition the signs or symptoms of which, in the opinion of the Medical Adviser or other Medical Practitioner appointed by TH, existed at any time during the six months ending on the day on which the person became insured under the relevant Policy. In forming this opinion, the person must have regard to any information in relation to the ailment, illness or condition furnished by the Medical Practitioner providing treatment for it.

Pregnancy Compression Garments are used both pre- and postpartum to reduce swelling, provide relief of pain associated with pregnancy & assist in postpartum recovery. This includes both recovery shorts and leggings that are TGA approved. Pregnancy active wear such as sports-related or body enhancing garments are not included. Claim must be supported by a written request from a medical professional prescribing the use of a garment during and after pregnancy.

Premium means the insurance premium or contribution payable by the Primary Member under the Policy as determined by TH from time to time in accordance with these Rules.

Primary Member means the Insured Member who has legal responsibility for the membership and for ensuring that Premiums are kept up to date.

Principal Insured has the meaning set out in the *Private Health Insurance (Registration) Rules 2017 (No 2)* and means the persons described in Rule C2(b).

Private Practice means a professional practice that is self-supporting principally through fees received from patients and whose accommodation, facilities and services are not provided or subsidised by another party such as a public hospital or publicly funded facility.

Product means one or more Policies marketed together by TH.

Prosthesis / Prostheses refers to products defined in the Prescribed List of Medical Devices and Human Tissue Products as published by the Department of Health and Aged Care, and updated from time to time.

Psychology Services means psychological assessment, treatment or group therapy sessions, counselling and other Services provided by a psychologist, recognised counsellor or an Accredited Mental Health Social Worker who is a Recognised Provider.

Purchaser Provider Agreement means an HPPA or MPPA and includes a purchaser-provider agreement between TH and any Health Care Provider.

Rebate – see **Australian Government rebate on private health insurance**.

Recognised Provider means a health care professional recognised by TH for the purposes of the payment of Benefits for General Treatment provided to eligible members. Providers are recognised as per the General Treatment Provider policy available through the website.

Schedule Fee – see **Medical Benefits Schedule Fee**.

Service means a treatment, consultation or approved item including Broader Health Cover provided personally by a Recognised Provider, or under the direct supervision of a Recognised Provider or Hospital, for which TH pays a Benefit under these Rules.

Single Policy means a Policy that covers only the Primary Member.

Single Parent Family Policy means a Policy that covers the Primary Member and at least 1 Student Dependent or Dependent Child.

SMS stands for Short Message Service and means the service for sending text messages to mobile phones.

Speech Pathology Service means a Service provided by a speech pathologist who is a Recognised Provider.

State means a State or a Territory of Australia.

Stepchild means a child of the Insured Member's Partner by a previous union.

Student Dependant means a child, Adopted Child, Stepchild or Foster Child of the relevant Primary Member or their Partner, registered with TH, and:

- (i) is aged between twenty-one and thirty one (inclusive),
- (ii) does not have a Partner,

and is either:

- (iii) a full-time student at a school, college, TAFE or university; or
- (iv) a registered apprentice or trainee.

Surgical Braces and Corsets means braces or corsets required as a result of surgery or prescribed to avoid the necessity of surgery.

Surgical Shoes means shoes that must be custom made by a surgical shoe maker, prescribed by a podiatrist or medical practitioner.

Surgical Stockings means stockings obtained on the recommendation of a Medical Practitioner following surgery.

TH means Teachers Federation Health Limited.

Travelling Expenses means country health-related travel required to obtain treatment for a serious medical or dental condition requiring specialist services not available closer than 100km from the patient's home.

Usual and Reasonable Charge in relation to a Service, means the usual or customary fee charged for that Service by other similarly qualified practitioners or providers, or a reasonable charge for that Service as determined by TH having regard to the usual charges for a similar service or item or advised by the practitioner's or provider's professional association or body.

Waiting Period means the period of time from the date a Policy commences to the date when Benefits become payable for particular Services under these Rules and will unless otherwise indicated be:

- (i) two years for wheelchair benefits;
- (ii) twelve months for Pre-Existing Conditions, Hearing Aids, Orthodontia and Major Dental;

- (iii) nine months for pregnancy and birth
- (iv) six months for Optical Services and Healthy Lifestyle Programs;
- (v) one day for Ambulance Cover; and
- (vi) two months for all other items or services including rehabilitation, palliative and psychiatric care.

C MEMBERSHIP

C1 General Conditions of Membership

- (a) All persons included in an Application Form that is accepted by TH will be, whilst eligible under these Rules, included as Insured Members within the Policy.
- (b) TH has the following categories of Policy as set out in these Rules:
 - (i) Single Policy;
 - (ii) Couples Policy;
 - (iii) Single Parent Family Policy;
 - (iv) Family Policy;
 - (v) Extended Family Policy; and
 - (vi) Extended Family – Single Parent Policy.
- (c) An Insured Member may simultaneously be covered by up to two Hospital and/or Extras Policies or combined Products, at any level.

C2 Eligibility for Membership

- (a) TH is a restricted access insurer, as defined in the PHIPS Act. The persons set out in Rules C2(b) and C2(c) are deemed to be included in TH's restricted access group and are eligible to apply for a policy.
- (b) The following persons are Principal Insured:
 - (i) A person who is, or was, a financial member of the following:
 - A. Australian Education Union New South Wales Teachers Federation (NSWTF) Branch;
 - B. Australian Education Union or its state or territory branches and unions affiliated to that union;
 - C. Independent Education Union of Australia (IEU) or its state or territory branches and unions affiliated to that union;
 - D. Institute of Senior Education Administrators NSW;
 - E. National Tertiary Education Union;
 - F. State School Teachers Union (SSTUWA), or successor organisations.
 - (ii) A person who is, or was, employed as school administration staff and who is, or was at the time, covered by their appropriate union where one exists.
 - (iii) A person who is, or was, employed as support staff by a state or territory Department of Education (or like organisation), a state or territory Board of Studies, Teaching and Educational Standards (or like organisation), or successor organisations, and who is, or was at the time, a member of the appropriate union, where one exists.
 - (iv) A person who is, or was, a permanent employee of the following:
 - A. Australian Education Union New South Wales Teachers Federation (NSWTF) Branch; or
 - B. Teachers Mutual Bank Limited; or
 - C. Federation Law; or
 - D. Aware Super Pty Ltd; or
 - E. An organisation listed in (b)(i) above and who is, or was at the time, a member of their appropriate union, where one exists or existed.
 - (v) A person who is, or was, a student undergoing training who is, or was at the time, a full member of a union listed above in Rule (b)(i).
 - (vi) A person who:
 - A. Is, or was, employed as support staff in a public school or college; or

- B. Is, or was at the time, employed by a state or territory Department of Education (or like organisation) or in TAFE, or successor organisations; and
 - C. Is, or was at the time, a member of their appropriate union, where one exists or existed.
- (vii) A person who was insured with TH immediately before 12 October 2007.
- (viii) A person who is, or becomes, an officer or employee of, or a contractor to, Teachers Federation Health Ltd and who is, at the time at which they seek to become insured by Teachers Federation Health Ltd, a financial member of a union, where one exists of which they are eligible to be a member.
- (ix) A person who is, or was, any of the following:
- A. A registered nurse;
 - B. An enrolled nurse;
 - C. A registered midwife;
 - D. A nurse practitioner;
 - E. A nurse in mental health services;
 - F. A psychiatric nurse;
 - G. An assistant in nursing or an assistant in midwifery;
 - H. A nursing student undergoing training or student nurse or trainee enrolled nurse in Victoria or Tasmania;
 - I. Employees, however described or titled, employed to provide or assist in the provision of nursing care or nursing services or both; and who is, or was, a financial member of the Australian Nursing & Midwifery Federation or a state or territory branch or relevant state union of same (see 1. – 8. Following) or a union affiliated to that union, including any successor organisations:
 1. NSW Nurses and Midwives' Association;
 2. Australian Nursing & Midwifery Federation (Victorian Branch);
 3. Queensland Nurses & Midwives Union;
 4. Australian Nursing and Midwifery Federation (SA Branch);
 5. Australian Nursing Federation (WA Branch);
 6. Australian Nursing & Midwifery Federation (ACT Branch);
 7. Australian Nursing & Midwifery Federation (Tasmanian Branch); and
 8. Australian Nursing & Midwifery Federation (NT Branch).
- (x) A person who is, or was, an officer of or employed in any of the organisations set out in 1. – 8. Above.
- (c) The following persons may also be Insured Members:
- (i) A Partner or Dependent Child of a Principal Insured;
 - (ii) A Partner or Dependent Child of an adult child of a Principal Insured;
 - (iii) A former Partner or Dependent Non-Student of a Principal Insured;
 - (iv) A parent, grandchild or sibling of a Principal Insured;
 - (v) A Partner or a Dependent Child of a sibling or grandchild of a Principal Insured, whether that relationship arises by virtue of blood, marriage or other legal affinity;
 - (vi) A person who is related to a Principal Insured in the manner contemplated in paragraph 7 (f), (g), (h) or (i) of the Private Health Insurance (Registration) Rules as amended from time to time; and
 - (vii) A person who otherwise qualifies under the Private Health Insurance (Registration) Rules as amended from time to time.
- (d) TH is prohibited from issuing a complying health insurance product to a person who does not belong to the restricted access group set out in Rule C2(b) and C2(c).

C3 Dependants

C4 Membership Applications

- (a) Applications for a Policy must be in the form required by TH.
- (b) TH may refuse to accept an application for a Policy from a person whose Policy was cancelled through the application of Rule C7.

C5 Duration of Membership

- (a) The commencement date of a Policy will be the day on which the application is accepted by TH unless an alternative starting date is advised by the applicant and agreed in writing by TH.
- (b) An Insured Member has the right to continue to be an Insured Member after the death of the relevant Primary Member, or the divorce or separation of the Insured Member from the Primary Member, subject to the following conditions.
 - (i) the Premiums are paid according to these Rules;
 - (ii) each Insured Member covered by the Policy observes the Policy requirements of these Rules and the Constitution; and
 - (iii) one of the Insured Members becomes the Primary Member.

C6 Transfers

- (a) If a person who is an insured member of another Health Benefits Fund applies for a Policy within two calendar months of the date to which the premium for the policy of the other fund (**Fund Policy**) was paid then, subject to satisfying the eligibility criteria in Rule C2, that person will be accepted as a Primary Member of the Policy provided that any balance of any waiting period under the Fund Policy that would not have expired at the commencement of the Policy for a benefit similar to a Benefit under the Policy will also apply under the Policy, but that period will not exceed the usual Waiting Period for that Benefit.
- (b) In accepting a transfer of a policy from another fund, TH may include any condition, except any benefit limitation period, which applied under the Fund Policy during a waiting period which would not have expired at the commencement of the Policy for benefits similar to Benefits under the Policy so that it will also apply under the Policy for that unexpired period, but that period will not exceed the usual Waiting Period for that Benefit. If no, or lesser, benefits for a particular service were payable under the Fund Policy, then TH will include Waiting Periods for the whole of, or the increase in, those Benefits under the Policy.
- (c) A transfer initiated by a Primary Member from one Policy to another Policy providing similar Benefits, or from one Policy option to a different option of the same Policy, will be treated in the same way as a transfer from another fund, except that any Accrued Benefit Entitlements will be retained, if applicable, under the new Policy.
- (d) TH may transfer Insured Members from one Policy (**Original Policy**) to another Policy providing the most equivalent Benefits or from one Policy option to a different option of the same Policy in situations where the Original Policy is affected by amendments to these Rules or other situations as determined by the Board.
- (e) A transfer by TH will not require any extra Waiting Periods to be served for additional Benefits that may be provided other than those Waiting Periods that would otherwise have been required under these Rules. Where the transfer is to a Policy which provides higher Benefits than the Original Policy, the unserved Waiting Period will apply to the additional Benefit and the lower Benefit will be paid during the unserved Waiting Period.
- (f) If a Primary Member is transferred by TH to a Policy that contains a Benefit which is subject to an Excess, limitation or qualification under these Rules then any specified accrual under the previous Rules, for the purpose of the Excess, limitation or qualification will be deemed to have accrued for the same or similar Excess, limitation or qualification under these Rules.

C7 Cancellation of Membership

- (a) TH will not cease to insure an Insured Member for the reason that the Insured Member has ceased to meet the eligibility criteria set out in Rule C2.
- (b) TH will not cancel a Policy on the grounds of the health of any Insured Member.
- (c) TH may cancel a Policy, from the date of notification to the Primary Member, if any Insured Member has committed or, in the opinion of TH, attempted to commit fraud upon TH. Any Premiums paid in advance of the date of cancellation of the Policy may be first applied by TH to offset the cost of the fraud or attempted fraud, with TH being only liable to the Primary Member of the cancelled Policy for any balance remaining.
- (d) TH may cancel a Policy by notification to the Primary Member if the Application Form for that Policy, or any relevant information subsequently requested by TH in relation to the application, contained inaccurate or incomplete information in a material respect. The cancellation may be effected from the date the Policy commenced.
- (e) TH may cancel a Policy if any Insured Member of that Policy is concurrently an insured member of another Health Benefits Fund under a policy which duplicates, in whole or in part, Benefits under the Policy.
- (f) Where TH has cancelled a Policy under this Rule, TH will have the right to refuse an application for a further Policy from any Insured Member covered by the cancelled Policy.
- (g) TH may, after appropriate investigation and subject to the express approval of the Chief Executive Officer of TH, cancel a Policy if an Insured Person covered by that Policy has acted in any way that can be construed as threatening to any of TH's employees or contractors or could be viewed as negatively affecting the working environment, or the health and safety, of any of TH's employees or contractors.
- (h) TH may cancel a Policy if the period of arrears in respect of that Policy exceeds two months.

C8 Termination of Membership

- (a) The Primary Member may terminate a Policy from any due date for payment of Premiums on or after the date when a notice of termination of the Policy has been received by TH from the Primary Member.
- (b) If a Primary Member terminates a Policy during the course of a Hospital admission, TH will only pay Benefits up to the day before the termination of the Policy becomes effective.
- (c) A Primary Member may, by notice to TH, terminate the cover of one or more Insured Members covered by the Policy but continue the cover of any other Insured Members covered by the Policy.

C9 Temporary Suspension of Membership

- (a) A Policy may be suspended by TH upon application by the Primary Member. Any suspension will apply to all Insured Members covered by the Policy.
- (b) Suspension of Policy coverage will be granted by TH, subject to suspension guidelines established by TH from time to time, if the reason for suspension is:
 - (i) the temporary absence from Australia of the Primary Member or a relevant Insured Person;
 - (ii) leave of absence without pay of the Primary Member or a relevant Insured Person from their place of employment; or
 - (iii) financial hardship,for a period exceeding 2 months but not being more than 36 months.
- (c) Services provided to an Insured Member during a period of suspension of the Policy will not be eligible for Benefits. Ailments, illnesses or conditions which develop during the suspension period will be considered to be Pre-Existing Conditions and a 12-month Waiting Period will apply from the date of recommencement of the Policy. Any new Waiting Periods may be pro-rated to the period of suspension at the discretion of TH.

- (d) All Policy entitlements, other than Benefits, under a suspended Policy will remain unchanged during the period of suspension. Any period of suspension will not be counted towards Accrued Benefit Entitlements.
- (e) Policies suspended on one or more occasions for the reason of financial hardship for an aggregate total of two years are not eligible for suspension again for the same reason for five years from the date of recommencement of the Policy after the date of expiry of the last suspension.
- (f) If a suspended Policy is recommenced within one calendar month after the expiry of the suspension period or other agreed recommencement date, no Waiting Periods will be imposed under the Policy except for Pre-Existing Conditions as detailed in (c) above.

C10 Other

(a) Cooling Off Policy

- (i) Any Primary Member who has not yet made a claim can cancel their Policy within 30 days of the commencement of the Policy and receive a full refund of any Premiums paid, provided the request to cancel the Policy is:
 - A. made by the Primary Member;
 - B. received by TH within 30 days of the commencement of the Policy.
- (ii) Any Primary Member who has changed the type of cover or the level of cover on a Policy can cancel the change within 30 days of the commencement of the change and receive a full refund of any additional Premiums paid provided the request to cancel the change is:
 - A. made by the Primary Member;
 - B. received by TH within 30 days of the commencement of the Policy; and
 - C. no claims have been made under the changed Policy.
- (iii) When a Primary Member cancels a Policy or cancels a change to a Policy within the 30-day cooling off period, TH will:
 - A. record the details of any advice or information given;
 - B. advise the Primary Member of the cancellation of the Policy or the change;
 - C. issue a refund of any Premiums paid, or any additional Premium payable in relation to the change; and
 - D. advise any direct salary or superannuation fund deductions to discontinue or return to the previous deduction. If a deduction has been received after a cancellation, TH will refund it.

D CONTRIBUTIONS

D1 Payment of Contributions

- (a) Premiums may be paid by a Primary Member or on behalf of a Primary Member through such arrangements as are authorised by TH from time to time.
- (b) Premiums for Ambulance Cover taken as a separate Policy must be paid on an annual basis.
- (c) The Premiums for a Product offered by TH will be the sum of the Premiums for the Policies that comprise that Product.
- (d) Premiums for varying periods will be calculated using the Policy's weekly rates. The weekly rate will be annualised to 52 weeks and the resulting amount will then be divided by 12, 4, 2 and 1 to determine the monthly, quarterly, half yearly and annual premium rates, respectively.
- (e) Premiums for Single Policies is the amount listed at Schedule K, subject to Rule D4.
- (f) Premiums for Family and Couples Policies is the amount listed at Schedule K, subject to Rule D4.
- (g) Premiums for Single Parent Policies is the amount listed at Schedule K, subject to Rule D4.
- (h) Premiums for Extended Family Policies is the amount listed at Schedule K, subject to Rule D4.

- (i) Premiums for Extended Family – Single Parent Policies is the amount listed at Schedule K, subject to Rule D4.
- (j) TH may at its discretion approve any group of Insured Members as a Contribution Group.
- (k) TH may refuse to accept any Premium paid that would cause the period of cover to exceed 12 months in advance of the date of payment. Where TH receives pre-payment of Premium that exceeds the 12 month period, the Fund may refund the Premium amount in excess of the 12month period. ‘Refusal to accept’ also includes the refunding of any payments accepted in good faith.

D2 Contribution Rate Changes

Where a Premium change occurs, Primary Members will not be required to pay the new Premium until further Premiums would have been due prior to the Premium change.

D3 Contribution Discounts

- (a) TH has the power to offer discounts on Premiums in accordance with the PHI Act and the Private Health Insurance (Complying Product) Rules 2015.
- (b) **Australian Government Private Health Insurance Rebate**
 - (i) Insured Members for Policies who are eligible for full Medicare benefits may be entitled to the Rebate subject to prescribed income tiers.
 - (ii) Primary Members can claim the Rebate by:
 - (A) registering to receive the Rebate as a reduced Premium by correctly completing and submitting to TH the relevant form; or
 - (B) claiming via an annual tax return.
 - (iii) TH will send a statement to the Primary Member in respect of each prescribed person in accordance with the Private Health Insurance (Incentives) Rules 2012 (No. 2).

D4 Lifetime Health Cover

Lifetime Health Cover loadings will be applied to Premiums in accordance with Part 2-3 of the PHI Act.

D5 Arrears in Contributions

- (a) If a Primary Member has not paid a Premium prior to the end of the period covered by the previous Premium, then the Policy will be in Arrears.
- (b) Any period of arrears is calculated as commencing on the last date a Premium relating to a Policy was paid up to.
- (c) Benefits are not payable for Services rendered to an Insured Member during the period in which the Policy is in Arrears until the Premiums in Arrears are paid and accepted by TH.
- (d) TH may refuse to accept outstanding contributions for a membership if that membership has lapsed.
- (e) A membership lapses when it has been in arrears for a continuous period of more than two months at which point the membership can be terminated at the Fund’s discretion.

E BENEFITS

E1 General Conditions

- (a) A Benefit is not payable to the Insured Member in respect of a Service that has been provided to an Insured Member through a Purchaser Provider Agreement between TH and the Health Care Provider.
- (b) Benefits are calculated based on the date the cost was incurred and will not exceed 100% of the cost to the Insured Member of any Service for which Benefits are payable. However, TH

- may at its discretion agree to pay directly to a Hospital Benefits payable for Inpatient treatment.
- (c) Where Benefits are determined as a percentage of the cost of a Service and TH determines that the cost of a Service is excessive, TH has the right to determine the Benefit for the Service by reference to the Usual and Reasonable Charge.
 - (d) Benefits are not payable in respect of Services provided to an Insured Member as a result of an Accident for which there is the right to receive compensation from other insurance or another third party that includes an amount equivalent to the Benefit.
 - (e) When a Benefit has been paid and the Insured Member subsequently obtains compensation equivalent to the whole or part of that Benefit, the Primary Member must, on demand, repay to TH the Benefit up to the amount of the compensation received.
 - (f) Hospital Benefits will, where applicable, be paid in accordance with the PHI Act and will be paid as prescribed in the PHI Act.
 - (g) Benefits are not payable for Nursing Home Treatment or the cost of care and accommodation in aged care within the meaning of the Aged Care Act 1997 (Cth).
 - (h) Benefits are not payable where an Insured Member provides services as a Health Care Provider:
 - (i) To themselves;
 - (ii) To anyone insured on the same Policy as themselves or their Partner or their Dependants; or
 - (iii) To the Insured Member's business partner / associate or anyone insured on the business partner's / associate's Policy or their spouse / partner or their Dependants.
 - (i) Benefits are not payable in respect of a period during which an Insured Member does not meet the eligibility criteria set out in Rule C2.
 - (j) Benefits are not payable for any Services which an Insured Member is entitled to receive without charge, for example, repatriation or social security benefits.
 - (k) Benefits are not payable in respect of Dependants who have not been notified to and accepted by TH.
 - (l) Benefits are not payable for a Service provided by a person who is not a Recognised Provider.
 - (m) Benefits are not payable for a Service that is not received face-to-face, with the exception of:
 - (i) telepsychology services provided by a registered psychologist, a recognised counsellor or an Accredited Mental Health Social Worker;
 - (ii) Speech Pathology Services;
 - (iii) Dietetic Services;
 - (iv) Lactation Nursing; and
 - (v) Physiotherapy and Exercise Physiology Services;
 - (vi) Occupational Therapy Services; and
 - (vii) Podiatry Services.
 - (n) Benefits are not payable where an Insured Member is unable to provide a receipt in such form as TH may reasonably require.
 - (o) Benefits are not payable where a Service is not provided in accordance with these Rules.
 - (p) Benefits are not payable for Hospital and General Treatment received or goods purchased overseas including items sourced over the internet.
 - (q) The Benefit payable may be reduced in the following circumstances:
 - (i) where the amount paid by a Member for treatment is lower than the Benefit payable, the Benefit will be reduced to the amount paid;
 - (ii) where money is payable from more than one source for the same treatment, TH may reduce its Benefit so that the total money payable from all sources does not exceed the amount charged; and
 - (iii) where in the opinion of TH the charge is higher than the provider's usual charge for the treatment, good or service, in which case TH may assess the claim as if the provider's usual charge had applied.

E2 Hospital Treatment

- (a) Where a Hospital Policy provides entitlements to Benefits for Inpatient treatment in a private hospital or Day Hospital Facility, Benefits will be as follows:
 - (i) where a Hospital or Day Hospital Facility has an HPPA with TH, a Benefit of the amount specified in that agreement for that treatment;
 - (ii) where a Hospital or Day Hospital Facility does not have an HPPA with TH, the Minimum Default Benefit for that treatment.
- (b) Where a Hospital Policy provides entitlements to Benefits for Inpatient treatment in a public hospital, Benefits will be in the amount of the Minimum Default Benefit for that treatment.
- (c) All Hospital Policies will also provide entitlement to Benefits for Inpatient treatment as follows.
 - (i) Where there is an Access Gap Cover Scheme in place, a Benefit of the amount agreed above the Medicare Benefits Schedule Fee.
 - (ii) For interstate hospitalisation, Benefits will be payable in accordance with the Benefits set by TH for the State in which the hospitalisation occurred irrespective of the State in which Premiums are paid.
 - (iii) In relation to Hospital Treatment and Hospital-Substitute Treatment:
 - (A) where the incurred medical expense is greater than or equal to the Medicare Benefits Schedule Fee, a Benefit of 25% of that Schedule Fee is payable; and
 - (B) where the medical expense incurred is less than the Medicare Benefits Schedule Fee, a Benefit is payable of the amount by which the incurred expense exceeds 75% of that Schedule Fee.However, no Benefit is payable for Hospital-Substitute Treatment if a Medicare benefit of at least 85% of the Schedule Fee is able to be claimed for that treatment.
 - (iv) For Hospital Pharmaceuticals a Benefit of 100% of the cost to the patient in accordance with the HPPA.
 - (v) For Inpatient non-cosmetic surgically implanted Prostheses approved by the Department of Health and Aged Care, the minimum benefit specified for the Prosthesis in the Prescribed List of Medical Devices and Human Tissue Products.
 - (vi) For Emergency Ambulance services where the Insured Member is not otherwise covered, 100% of the cost of such services.
 - (vii) Where there is a MPPA or Practitioner Agreement within an HPPA in place, a Benefit of the amount agreed above the Medicare Benefits Schedule Fee.
 - (viii) For an overnight stay in a shared room of a public hospital, the Minimum Default Benefit for that treatment.
 - (ix) Benefits for anaesthetic services will be paid at a rate equal to the Benefit TH would pay under the Access Gap Cover Scheme if the anaesthetist had an agreement with TH or at a rate equal to 25% of the Schedule Fee if no agreement exists.
 - (x) In relation to inpatient podiatric surgery, benefits for accommodation, theatre fees and implanted Prostheses will be paid at a rate equal to the amount of Benefit that would have been paid had the surgery been rendered by an orthopaedic surgeon in accordance with the Hospital Policy of the patient.
 - (xi) For psychiatric care, rehabilitation and/or palliative care provided in a Hospital where no Medicare benefit is payable, the Minimum Default Benefit for that treatment will be payable.
 - (xii) Where TH has an agreement or arrangement with a particular Health Care Provider (other than a Medical Practitioner), all Hospital Treatment or Hospital-Substitute Treatment provided to Insured Members under the same type of Policy will be charged the same amount.
- (d) All Benefits payable from all Hospital Policies will be reduced to the Minimum Default Benefits on the expiration of 35 days continuous hospitalisation as a patient, when the patient will thereafter be classified as a Nursing-Home Type Patient.

E3 General Treatment

- (a) Recognised Providers of General Treatment must be in Private Practice and the Services must be performed by the Recognised Provider.
- (b) Benefits are limited to one Benefit each day for each Insured Member, for a Recognised Provider. If a Recognised Provider performs multiple services within one consultation or on the same day during separate visits, the treatment that attracts the highest Benefit will be paid.
- (c) Benefits for General Treatment are limited as set out in the Insured Member's policy schedule, the General Treatment Provider policy and these Rules.
- (d) Where covered by the Policy, a Insured Member on a mental health treatment plan will only be able to claim Benefits for Psychology Services once Medicare entitlements have been exhausted for the calendar year.

F LIMITATION OF BENEFITS

F2 Excesses

- (a) An Excess in relation to Hospital Treatment is an amount paid towards the cost of Hospital Treatment (including Day Only Admissions). The amount of the Excess and relevant limits and conditions are set out in the Schedules.
- (b) An Excess may apply to each Member on the Policy. Excess limits for each Member or for each Policy are set out in the Schedules.
- (c) An Excess does not apply to admissions of Dependents on Top Hospital (Gold), Mid Classic (Silver Plus) and Mid Hospital (Basic Plus).
- (d) If changing to a level of hospital cover with a lower level of Excess a Member will have to serve the relevant Waiting Period before the lower Excess applies.

F3 Waiting Periods

- (a) Benefits are not payable in respect of Services provided to an Insured Member during a Waiting Period.
- (b) A Waiting Period will not apply to a newborn child of an Insured Member under a Family Policy, Extended Family Policy, Single Parent Family Policy or Extended Family – Single Parent Policy for whom application for cover by the Policy is made within twelve months of the date of birth.
- (c) Certain Insured Members may be eligible for a one-off exemption from the Waiting Period for psychiatric care, subject to meeting the relevant criteria specified in the *Private Health Insurance (Complying Product) Rules 2015* as amended from time to time.

F4 Exclusions

No Benefit is payable for Services under Hospital or Combined Policies for which no Medicare Benefit is payable.

F5 Benefit Limitation Periods

F6 Restricted Benefits

As noted in Schedules I and J.

F7 Compensation Damages and Provisional Payment of Claims

Refer to Rule E1(d).

F8 Other

Lifetime limits apply to an Insured Member and are not tied to the duration of a Policy. The Benefits which are the subject of a lifetime limit can be accumulated over 2 or more Policies which cover an Insured Member and similar Benefits received by an Insured Member under Policies taken out with another Health Benefits Fund will be included in the total Benefits received.

G CLAIMS

G1 General

- (a) Claims for Benefits can either be made electronically (if available) at the Recognised Provider or by lodging a claim form approved by TH at a recognised TH member care centre or via TH online member services or mobile app.
- (b) At its sole discretion, TH may request an Insured Member or a relevant treatment provider to submit evidence in support of a claim prior to or after the payment of a Benefit. The Insured Member agrees to retain invoices and documentation submitted as part of a claim for at least 12 months from the date of claim's submission.
- (c) Benefits will not be payable for Services which occurred earlier than 2 years before the lodgement of a valid claim except where lodgement of the claim was deferred or delayed due to an action (or possible action) against a third party.
- (d) TH reserves the right to pay Benefits via electronic funds transfer (**EFT**) to a bank account nominated either by;
 - A. the Principle Insured; or
 - B. a Recognised Provider.

G2 Other

TH will not be liable to any Insured Member in respect of any losses, costs, damages, suits or actions arising by virtue of the provision of Services to an Insured Member or any person by a Recognised Provider.