



DEFENCE HEALTH LTD

FUND RULES

Effective 1 April 2012

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A INTRODUCTION

A1 Rules Arrangement

These Rules consist of:

- the General Conditions in Rules A to G; and
- the Schedules.

A2 Health Benefits Fund

A2.1 Name

Defence Health Limited (ACN 008 629 481) (“Defence Health”) is a Private Health Insurer and administers a Health Benefits Fund the affairs of which are separately recorded (“the Fund”).

A reference in the Rules to Defence Health means either Defence Health, the Fund, or both, depending on the context.

A2.2 Purpose of the Fund

The Fund is established for charitable objects only existing for the patriotic purpose of offering peace of mind to and reducing the financial burden on members and former members of the Defence community by providing products and services to them and their immediate families to assist in treating, managing or preventing, or in meeting the costs associated with treating, managing or preventing diseases, injuries or conditions.

A2.3 Purpose of the Rules

These Rules set out the arrangements for Membership of, and the payment of Benefits by, Defence Health.

A2.4 Policies

Defence Health may supplement the Rules with Policies that are not inconsistent with the Rules.

A3 Obligations to Insurer

A3.1 A person applying for admission to the Fund shall comply with the requirements of the Fund and give full and complete disclosure on all matters required by the Fund.

A3.2 The Policy Holders shall inform the Fund of any Membership details in the manner and within the time prescribed in these Rules.

A3.3 All Insured Persons are bound by the Rules and Policies as amended from time to time.

A4 Governing Principles

The operation of the Fund and the relationship between the Fund and each Insured Person is governed by:

1. the Private Health Insurance Act;
2. the Private Health Insurance Rules;
3. the Rules;
4. the Constitution of Defence Health; and
5. the Policies.

A5 Use of Funds

A5.1 Financial Control

Defence Health shall:

- 5.1.1 keep proper accounts and records of the transactions and affairs of the Fund
- 5.1.2 ensure that all payments from the Fund are correctly made and properly authorised, and
- 5.1.3 maintain adequate control over:
 - (a) the assets in the custody of the Fund; and
 - (b) the incurring of liabilities by the Fund.

A5.2 Audit

Defence Health shall arrange for its accounts and records to be audited by a registered company auditor each year.

A5.3 Income to be Credited to the Fund

Defence Health shall credit to the Fund:

- 5.3.1 all Premiums paid by Policy Holders, and
- 5.3.2 all other income arising from the conduct of the business of the Fund.

A5.4 Drawings on the Fund

Defence Health may draw on the Fund only:

- 5.4.1 to pay Benefits in accordance with these Rules
- 5.4.2 to make payments to the Private Health Insurance Risk Equalisation Trust Fund
- 5.4.3 to make investments for the health insurance business,
- 5.4.4 to pay for a purpose specified in the Private Health Insurance (Health Benefits Fund Policy) Rules; and
- 5.4.5 for any other purpose directly related to the business of the Fund.

A6 No Improper Discrimination

Defence Health will comply with the principle of community rating as prescribed in the Private Health Insurance Act unless it has been permitted to do otherwise under any legislative or regulatory instrument, or in any condition of registration.

A7 Changes to Rules

A7.1 Amendments to the Rules

Defence Health may amend the Rules in accordance with the Private Health Insurance Act.

A7.2 Overriding Waiver

Defence Health may, in nominated circumstances, waive the application of particular Rules at its discretion, provided that the waiver does not reduce the relevant Policy Holder's entitlement to Benefits and subject to the Private Health Insurance Act.

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

A7.3 Notification to Policy Holders

7.3.1 Whenever Defence Health amends a Rule such that:

- (a) it will or may be detrimental to the interests of an Insured Person under a Product; and
- (b) will require an update to the Standard Information Statement for that Product

Defence Health shall inform all Adults insured by that Product of the change within a reasonable time of the change taking effect and also provide them with an update Standard Information Statement for that Product.

7.3.2 Whenever Defence Health amends the Rules such that they will or may be detrimental to an Insured Person, other than as provided in 7.3.1, it shall notify any Adult insured under that Product of the change within a reasonable period before the change takes effect.

A8 Dispute Resolution

A8.1 Insured Person Complaints

8.1.1 An Insured Person may make a complaint to Defence Health at any time.

8.1.2 Defence Health will make reasonable endeavours to respond to complaints quickly and efficiently and will not charge a fee for such a service.

A8.2 Private Health Insurance Ombudsman

8.2.1 The Private Health Insurance Ombudsman ("Ombudsman") is available to assist Insured Persons who have been unable to resolve issues with the Fund.

8.2.2 Nothing in these Rules prevents an Insured Person from approaching the Ombudsman at any time.

A9 Notices

A9.1 Correspondence

Defence Health shall send any necessary correspondence to one of either the most recently advised postal address, fax number, telephone or e-mail address of the relevant Policy Holder.

A9.2 Availability of Rules to Policy Holders

These Rules are available at the registered office of Defence Health and Policy Holders may read them there on request.

A10 Winding Up

If on the winding-up (which includes dissolution) of the Fund there remains any assets after satisfaction of all the Fund's debts and liabilities, those assets shall not be paid to or distributed among the Policy Holders, but shall be distributed in accordance with the Private Health Insurance Act.

A11 Other

This Rule is left intentionally blank.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

These Rules shall be interpreted so as not to conflict with the Constitution of the Fund.

Any terms used in these Rules and also in the Constitution shall have the same meaning in these Rules as they bear in the Constitution.

Unless otherwise specified, the meanings attached to the words and expressions in the Private Health Insurance Act shall apply to these Rules.

Words in the singular number shall include the plural and words in the plural shall include the singular.

B2 Definitions

Access Gap or Access Gap Cover is the Approved Scheme used by the Fund for the payment of medical Benefits in excess of the Medicare Benefits Schedule to provide no Gap or known Gap Benefit.

Accident means an unforeseen event, occurring by chance resulting in a non-compensable trauma necessitating the need for hospitalisation.

Acupuncture means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as an acupuncturist

ADF or Australian Defence Forces or Defence Forces means the arms of the Defence Force referred to in the Defence Act 1903 (Cth).

ADF Children Only Membership means an Insured Group which comprises two or more people, none of whom is an adult provided that the Insured People are the Dependent Children of either a member of the Regular Army, Permanent Air Force or Permanent Navy or the Partner of a member of the Regular Army, Permanent Air Force or Permanent Navy.

ADF Family Membership is an Insured Group which comprises two or more people where only one of whom is an Adult provided that:

- (a) where the Policy Holder is a member of the Regular Army, Permanent Air Force or Permanent Navy, the Adult is the Policy Holder's Partner and the non Adults are the Dependent Children or Dependent Child Non-students of the Policy Holder; or
- (b) in other cases, the Adult is the Partner of a member of the Regular Army, Permanent Air Force or Permanent Navy and is the Policy Holder and the non Adults are the Dependent Children or Dependent Child Non-students of the Policy Holder.

ADF Single Membership is an Insured Group which comprises only one person who is either a member of the Regular Army, Permanent Air Force or Permanent Navy or is a Dependant of a member of the Regular Army, Permanent Air Force or Permanent Navy.

Admitted Patient means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment. This definition:

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

Adult means an Insured Person who is not a Dependent Child.

Alternative Therapies means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as an alternative health care provider.

Ambulance Treatment means transport and medical Treatment services provided by a registered ambulance service within Australia which is approved by Defence Health. This includes emergency services, non-emergency services, mobile intensive care, air and sea ambulance services.

Applicable Benefits Arrangement has the meaning described in the Private Health Insurance Act.

Approved Appliance means an appliance, device, etc. approved by Defence Health from time to time for payment of Benefit purposes.

Approved Credit Facility means a credit-card type arrangement approved by Defence Health to enable Policy Holders to pay their Premiums automatically.

Approved Practitioner or Approved Provider means a professional practitioner approved by Defence Health from time to time for payment of Benefit purposes.

Approved Scheme has the same meaning as that defined under the Private Health Insurance Act.

Arrears means the amount of unpaid Premiums of a Policy Holder represented by the period prior to the current date.

Associated Professional Services means Professional Services rendered to an Insured Person by a Medical Practitioner while undergoing Hospital Treatment.

Australia for the purposes of these Rules:

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

Australian Army consists of the Regular Army; and the Army Reserve.

Australian Defence Forces see ADF.

Benefit means any amount payable or product or service provided to a Policy Holder in respect of Insured Persons to assist in treating, managing or preventing diseases, injuries or conditions or which is incidental thereto, in accordance with the Constitution and the Rules.

Benefit Limitation Period means a period of time during the continuous Membership of relevant Hospital Cover, in which the Benefit for a specified service or Treatment is no higher than the Minimum Benefit. For the purposes of this definition, 'relevant Hospital Cover' is any Hospital Cover (or Covers) with Defence Health or another Fund which includes higher or additional Benefits for the service or Treatment than their previous Cover with Defence Health or another Fund. To avoid doubt, a Benefit Limitation Period applies only once to an Insured Person who maintains continuous Membership of relevant Hospital Cover.

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

Benefit Year means the period from 1 July to 30 June.

Board means the members of the Board of Directors of Defence Health appointed in accordance with the Constitution.

Chief Executive Officer means the Chief Executive Officer of the Fund and is the person who is primarily and directly responsible to the Directors of the Fund for the general and overall management of the Fund.

Child means one of the following:

- (a) a natural Child (including a new-born Child)
- (b) an adopted Child
- (c) a foster Child, or
- (d) a step-Child (that is, a natural, adopted or foster Child of the person's Partner).

Chiropractic and Osteopathy means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as a chiropractor or an osteopath.

Claim means a claim for a Benefit.

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

- (a) performed or rendered by a Medical Practitioner, Dental Practitioner or Optometrist or other Approved Practitioner and
- (b) generally accepted in the relevant profession as being necessary for the appropriate Treatment of the Patient.

Combined Cover means a Cover that combines Hospital Treatment and General Treatment as set out in Schedule J.

Compensation means:

- (a) a payment by way of damages
- (b) a payment (other than a payment of Fund Benefits) under a scheme of insurance or compensation provided for by a law of a State or Territory
- (c) a payment, whether with or without admission of liability, in settlement of a claim for damages or of a claim under a scheme referred to in (b)
- (d) a payment by way of damages (or, whether with or without admission of liability, in settlement of a claim for damages) for professional negligence in relation to a claim for payment referred to in (a), (b) or (c), or
- (e) any other payment that, in the opinion of Defence Health, is a payment in the nature of Compensation or damages.

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

Constitution means the Constitution of Defence Health as amended from time to time.

Consultation means an attendance on a Patient by an Approved Provider or Hospital, in a manner approved by Defence Health.

Continuous Hospitalisation has the same meaning as in Fund Rule E 2.13.

Contribution means the premium payable by Policy Holders for the products offered by the Fund in accordance with the Constitution and the Rules.

Contribution Group means a group of Policy Holders approved for the purposes of Rule D 1.2.

Cosmetic Surgery means surgical procedures that:

- (a) are not Clinically Relevant, or
- (b) do not meet the eligibility conditions for the payment of Medicare Benefits, or
- (c) are of a plastic or reconstructive nature that are not listed in the Medicare Benefits Schedule.

Couples or Couples Membership is an Insured Group which comprises the Policy Holder and the Partner of the Policy Holder.

Cover means a defined group of Benefits payable, subject to relevant Rules, in respect of approved expenses incurred by a Policy Holder or other Insured Persons under a Cover.

Date of Joining or transfer to the Fund in relation to a Policy Holder means the date from which that person's Contributions commenced.

Date of registration or change of Membership Cover or status in relation to a Policy Holder means the date of written notification, provided it is received by the Fund within 30 days of that date. If not received within that period, the effective date will be the date of receipt by the Fund.

Defacto Spouse means a person who normally lives with the Policy Holder on a bona fide permanent domestic basis although not legally married to the Policy Holder.

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

Dental means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a person who is recognised by Defence Health as a Dental Practitioner.

Dependant means a resident of Australia who is:

- (a) the Policy Holder's Partner;
- (b) the Policy Holder's Dependent Child;
- (c) the Policy Holder's Dependent Child Non-student; or,
- (d) subject to the Private Health Insurance Act, any other person who has been determined by Defence Health as being dependent upon a Policy Holder.

Dependent Child means:

- (a) a person who:
 - (i) is aged under 21 years; and
 - (ii) does not have a Partner; or
- (b) a person who:
 - (i) is aged between 21 and 24 (inclusive) and is receiving full time education at a school, college or university; and
 - (ii) does not have a Partner or a child who is wholly or substantially dependent on the person; or
- (c) a Dependent Child Non-student.

Dependent Child Non-student means a person who:

- (a) is aged between 21 and 24 (inclusive);
- (b) is not receiving full time education at a school, college or university; and
- (c) does not have a Partner or a child who is wholly or substantially dependent on the person.

Dietetics means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as a dietician.

Direct Contributor means a contributor other than a Direct Debit Contributor or a Group Contributor.

Direct Debit Contributor means a contributor whose Premiums are automatically paid to Defence Health using an Approved Credit Facility or from a financial institution account, in accordance with Rule D1.3.

Excess or Front End Deductible means an amount of a Benefit that a Policy Holder agrees to forgo, in return for a lower Premium than would otherwise apply.

Exercise Physiology means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognised by Defence Health as an exercise physiologist.

Family has the same meaning as in Family Membership.

Family Membership is an Insured Group which comprises three or more people only two of whom are Adults provided that the two Adults are the Policy Holder and the Partner of the Policy Holder and the non Adults are the Dependent Children and/or Dependent Child Non-students of the Policy Holder.

Front End Deductible or **Excess** means an amount of a Benefit that a Policy Holder agrees to forgo, in return for a lower Premium than would otherwise apply.

Full-time Serving shall mean those people who are members of the Regular Army, Permanent Navy and Permanent Air Force and includes a member of the Navy

Reserve, Army Reserve and Air Force Reserve on full time duty for more than 28 days. Full Time Service shall have a corresponding meaning.

Full time Study means a course of study at a secondary school or tertiary college which is at least three quarters of the normal full-time work load or deemed by Defence Health as being full time study.

Fund means the Health Benefits Fund operated by Defence Health, unless the context refers to another Health Benefits Fund.

Gap refers to the amount of money payable above the Medicare Benefits Schedule payments made under a Medical Purchaser Provider Agreement, Hospital Purchaser Provider Agreement or Approved Scheme.

Gap Cover Scheme means a Gap Cover Scheme that is able to offer No Gap Policies or Known Gap Policies.

General Benefits are amounts paid by Defence Health for, or towards, the costs of approved General Treatments and includes but are not limited to:

- (a) approved relevant health services including nursing, Dental, chiropody, Chiropractic and Osteopathy, eye therapy, Occupational Therapy, Orthoptics, Podiatry, Physiotherapy, Psychology, Speech Therapy or similar services or Treatment;
- (b) Approved Appliances involving the supply, alteration, maintenance or repair of Hearing Aids, spectacles, contact lenses, artificial teeth (including parts of teeth), eyes or other medical, surgical, prosthetic or dental aids, equipment or appliances;
- (c) approved drugs or medicinal preparations.

General Cover means any cover approved by Defence Health that is not Hospital Cover and is in respect of General Treatments.

General Treatment shall have the same meaning as in the Private Health Insurance Act.

Group Contributor means a contributor whose Premiums are paid by payroll deduction by an employer approved by Defence Health.

Health Benefits Fund has the same meaning as in the Private Health Insurance Act.

Hearing Aid means an appliance approved by Defence Health that is designed to improve a person's hearing.

Home Nursing means nursing by a duly Registered Nurse in the Policy Holder's home or some other place when such nursing is approved by Defence Health.

Hospital has the same meaning as in the Private Health Insurance Act.

Hospital Cover shall have the same meaning as in the Private Health Insurance Act.

Hospital Purchaser Provider Agreement (HPPA) is an agreement entered into between Defence Health and a Hospital.

Hospital Service means professional attention or any other item in respect of which Benefits are payable from a Hospital Cover.

Hospital Substitute Treatment shall have the same meaning as in the Private Health Insurance Act.

Hospital Treatment shall have the same meaning as in the Private Health Insurance Act.

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

Insured Group shall have the same meaning as in the Private Health Insurance Act.

Insured Person means a person insured under a Defence Health Policy or where the context permits, a person insured under a health insurance policy from another Private Health Insurer. Insured People shall have a corresponding meaning.

Known Gap Policy means a scheme that covers Policy Holders for all but a specified amount or percentage of the full cost of particular Hospital Treatment and associated Professional Services. Policy Holders insured under a Known Gap Policy must be informed:

- (a) in writing of any amounts the Policy Holder can reasonably be expected to pay for Hospital Treatment and Associated Professional Services, if possible before the provision of such Treatment and services, or otherwise as soon as practical; and
- (b) of any financial interest a person providing Hospital Treatment or Associated Professional Services has in products or services recommended or provided to the Policy Holder.

The Policy Holder must acknowledge the receipt of (a).

Lifetime Health Cover is as defined in the Private Health Insurance Act.

Medical Practitioner means a person who:

- (a) is registered or licensed as a Medical Practitioner under a law of a State or Territory, and
- (b) satisfies the provider eligibility requirements for the payment of Medicare Benefits.

Medical Purchaser Provider Agreement (MPPA) is an agreement between Defence Health and a Medical Practitioner.

Medicare Benefits Schedule (MBS; or Commonwealth Medicare Benefits Schedule (CBS)) means the 'Medicare Benefits Schedule Book' published by the Department

of Health and Ageing, and includes any updates and Supplements to the Schedule published from time to time.

Member Priority network means a network of providers in a particular modality who are approved by Defence Health and who provide Insured Persons with different benefits to other providers in that modality.

Membership means Membership of the Fund.

Minimum Benefits are equal to the minimum Hospital Benefits determined by the Rules of the Private Health Insurance Act.

Minister means the Federal Minister or their delegate with the powers vested in the Minister by the Private Health Insurance Act.

Month means calendar month.

No Gap Policy means a scheme that covers Policy Holders for the full cost of particular Hospital Treatment and Associated Professional Services. Policy Holders insured under a No Gap Policy must be informed of any financial interest a person providing Hospital Treatment or Associated Professional Services has in products or services recommended or provided to the Policy Holder.

Nursing Home Type Patient has the same meaning as in the Private Health Insurance (Benefit Requirements) Rules 2007..

Occupational Therapy means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as an occupational therapist.

Optometrist means a person registered or licensed as an Optometrist or optician under a law of a State or Territory.

Orthoptics means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health to provide Orthoptics Treatment.

Out-Patient means a Patient of a Hospital who is not an Admitted Patient.

Overnight Stay means a period of time in a Hospital that spans both daylight hours and midnight.

Partner means the Spouse or DeFacto Spouse of the Policy Holder.

PBS means the Pharmaceutical Benefits Scheme.

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

Pharmaceutical Benefits Schedule means the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing).

Physiotherapy means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as a physiotherapist.

Podiatry means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as a podiatrist.

Policies mean the private health insurance policies approved by Defence Health from time to time.

Policy Holder means a person who is eligible to be a policy holder of Defence Health and pays Contributions in relation to a health insurance policy. A Policy Holder is deemed to be the owner of the health insurance contract between the Policy Holder and Defence Health. In situations other than where the Fund is bound to take instructions from the Policy Holder, a reference in the Rules to Policy Holder can, at the discretion of Defence Health, be extended to all Insured Persons under the Policy Holder's Cover.

Pre-existing Condition means an ailment, illness or condition the signs or symptoms of which were considered to be in existence at any time during the six months preceding the day on which the Policy Holder or the Dependants of the Policy Holder joined the fund or upgraded to a higher level of Cover. The consideration shall be by a Medical Practitioner appointed by the fund who shall examine information furnished by the Insured Person's Medical Practitioner who treated the illness or condition, and other material relevant to the Claim for Benefits.

Premiums (or Contributions) means an amount of money a Policy Holder is required to pay to Defence Health in respect of a specified period of Cover.

Private Health Insurance Act shall mean the Private Health Insurance Act 2007 (Cth) as amended from time to time and any legislative instruments made under this Act.

Private Health Insurance Rules means the Rules for which provision is made in the Private Health Insurance Act.

Private Health Insurance Ombudsman has the same meaning as in the Private Health Insurance Act.

Private Health Insurer has the same meaning as in the Private Health Insurance Act.

Private Hospital has the same meaning as in the Private Health Insurance Act.

Private Practice means a practice operated on an independent and self- supporting basis either as a sole, partnership or group practice but not under an arrangement or agreement with, or the subsidy by, another party for the provision of accommodation, facilities or services.

Product means any of the Defence Health products which are complying health insurance products under the Private health Insurance Act.

Professional Attention is as defined in the Health Insurance Act.

Professional Service is as defined in the Health Insurance Act.

Program means a specified group of services or Treatments that is:

- (a) provided at a Hospital, and
- (b) recognised by Defence Health for the purpose of paying Benefits.

Prosthesis means:

- (a) in relation to a Hospital Cover: a surgically implanted appliance or device approved by Defence Health, fitted in association with a medical procedure at a Hospital, or
- (b) in relation to an General Cover: an external appliance or device approved by Defence Health, normally associated with a physical replacement of some part of the human body.

Public Hospital is a recognised Hospital as defined in the Private Health Insurance Act.

Public Patient means an Admitted Patient of a Public Hospital who receives Treatment without charge.

Psychology means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognised by Defence Health as a psychologist.

Recognised Provider means a provider recognised by Defence Health for the purpose of paying Benefits.

Recognition Criteria, in relation to Providers recognised under these Rules, means:

- (a) the provider provides facilities that meet the standards determined or recognised by Defence Health, and
- (b) any other criteria that Defence Health considers reasonable.

Registered Nurse means a person registered as a nurse with the Nurses Board or relevant authority of the State or Territory in which they practise.

Reservist Member means a Policy Holder serving in the Army Reserve, the Air Force Reserve or the Naval Reserve.

Restricted Access Group shall have the same meaning as in the Private Health Insurance Act and is described in C2.1.

Royal Australian Air Force consists of the Permanent Air Force and the Air Force Reserve.

Royal Australian Navy consists of the Permanent Navy and the Naval Reserve.

Rules mean any Rules made by the Board pursuant to the powers conferred by the Constitution.

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

Second Tier Benefits are as defined in the Private Health Insurance Act.

Schedule means any of the schedules attached to these Rules.

School Accident means an Accident which causes an injury to a Dependant who is a pre-school, primary or secondary school student while attending, or traveling to or from, school or an organised school activity.

Single or Single Membership, is an Insured Group which comprises only one person.

Single Parent Family Membership is an Insured Group which comprises two or more people where only one of whom is an Adult provided that the Adult is the Policy Holder and the non Adults are the Dependent Children or Dependent Child Non-students of the Policy Holder.

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

Speech Therapy means professional Treatment that is:

- (a) approved by Defence Health, and
- (b) provided during a Consultation with a practitioner who is recognized by Defence Health as a speech therapist.

Standard Information Statement has the same meaning as in the Private Health Insurance Act.

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

Treatment means:

- (a) in respect of Hospital Covers: Hospital Services and Hospital Treatment, and
- (b) in respect of General Covers: services and items for which Benefits are payable under these Rules. To avoid doubt, a 'service' excludes any Treatment

that is not provided by the provider personally or under the direct supervision of the provider.

Waiting Period means a period during which, except in the case of an Accident to a Policy Holder or his Dependants, Fund Benefits are not payable as defined in Rule F 3.

B3 Other

This Rule is left intentionally blank.

C MEMBERSHIP

C1 General Conditions of Membership

C1.1 Membership Categories

Defence Health may from time to time offer Products to the following combinations of Insured Persons (Insured Groups):

- (a) for policies other than a Policy referred to in paragraph (b), the insured groups are:
 - (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.
- (b) for policies that cover a Dependent Child Non-student which have as conditions of the policy that the non-student is not covered for General Treatment, other than Hospital substitute treatment, and must have his or her own policy with the same insurer covering General Treatment (other than Hospital substitute treatment), the insured groups are:
 - (i) 2 or more people, only one of whom is an Adult;
 - (ii) 3 or more people, only 2 of whom are Adults.

C1.2 Levels of Cover

A person may be admitted as a Policy Holder in respect of the following Covers:

- (a) any one level of Combined Cover set out in Schedules J1, J2, J6 and J7;
- (b) any one level of General Cover set out in Schedules I1 and I2;
- (c) any combination of one level of Combined Cover set out in Schedules J1, J2, J6 and J7 with one level of General Cover set out in Schedules I1 and I2;
- (d) any other Covers determined by Defence Health from time to time.

All Insured People under the same Membership shall:

- (a) belong to the same Insured Group, and
- (b) have the same Cover or Covers.

C1.3 Change of Membership Details

Policy Holders are required to advise Defence Health of any changes to Membership details within two months of such changes. Suspensions cannot be made retrospectively unless with the approval of the Fund. Defence Health is not obliged to allow any changes to have effect greater than two months prior to the date advised.

Changes in Membership details may include, but are not limited to:

- (a) Changes of address of the Policy Holder;
- (b) Change of contact details such as telephone or email address;
- (c) Change of Australian residency status;
- (d) Change of method of payment of Contribution;
- (e) Change of method of receipt of payments of Benefits;
- (f) A Dependant no longer being a Dependant;
- (g) Change of name;
- (h) A Dependent Child who ceases, goes part-time or defers study;
- (i) Change of Partner.

C1.4 Young Adult Policy

A Young Adult Policy is a Policy which covers a Dependent Child Non-student which has as conditions of the Policy that the Dependent Child Non-student is not covered for General Treatment, other than Hospital substitute Treatment, and must have his or her own Top Extras Cover with Defence Health covering General Treatment other than Hospital substitute Treatment. This is known as the Young Adult Support Plan.

C2 Eligibility for Membership

C2.1 Defence Health Restricted Access Group

The only persons to whom complying health insurance products are or will be available (the Restricted Access Group) are:

- (a) persons who are already insured with the Fund immediately before the commencement of the Private Health Insurance (Registration) Rules 2007 (No 2); and
- (b) persons who are or were:
 - (i) a member of an arm of the Defence Force as referred to in the Defence Act 1903 (Cth) ; or
 - (ii) an employee of the Department of Defence or an entity which has a reporting obligation to, or is within the portfolio responsibility of, the Minister for Defence or a Minister Assisting such Minister or a Parliamentary Secretary to either Minister (such Department and entities collectively called “the Bodies”); or
 - (iii) an employee of:
 - (1) a contractor to any of the Bodies; or
 - (2) a prescribed agency (as referred to in the Financial Management and Accountability Act 1997 (Cth)) or a Commonwealth authority or Commonwealth company (as referred to in the Commonwealth Authorities and Companies Act 1997 (Cth)) or other entity, which agency, authority, company or entity supplies goods or services to any of the Bodies; and
who is or was involved in supplying goods or services to any of the Bodies; and
- (c) persons who are or become officers or employees (including contractors) of the Fund; and
- (d) the Partners and Dependent Children of those people described in paragraphs (a), (b) and (c) above; and
- (e) the former Partners and Adult Children of those people described in paragraphs (a), (b) and (c) above; and
- (f) the siblings, grandchildren and parents of those people described in paragraphs (a), (b) and (c) above; and
- (g) the Partners and Dependent Children of persons who are the Adult Children of those people described in paragraphs (a), (b) and (c) above; and
- (h) the Partners and Dependent Children of persons who are the siblings of those people described in paragraphs (a), (b) and (c) above.

Defence Health is prohibited from issuing a complying health insurance product to a person who does not belong to the Restricted Access Group.

Defence Health is prohibited from ceasing to insure a person for the reason that the person has ceased to belong to the Restricted Access Group.

C2.2 Proof of Eligibility

The Fund may request information from the Policy Holder or their employer at the time of joining the Fund, prior to or after becoming a Policy Holder, to validate eligibility for Membership to the Fund. The Fund may rely upon the advice of the person wishing to join as to their eligibility.

C2.3 Continuation of Membership

A person who is eligible for Membership under Rule C.2.1 and who, as a member or Dependant of a Member of the Australian Defence Force on continuous full time service, whose health services are provided by or through the Australian Defence Force, will have all qualifying and Waiting Periods waived if application is made within two months of date of discharge and Contributions are paid from that date.

A person eligible for Membership under Rules C2.1 may apply to rejoin. All qualifying and Waiting Periods will apply unless application to rejoin is made within two months of the date of ceasing to be an Insured Person and Contributions are paid from the date of cessation.

C2.4 Dual Membership: Different Funds

- (a) An Insured person to a Hospital Cover with another Fund is not eligible to be an Insured Person to a Hospital Cover with Defence Health.
- (b) Subject to Defence Health's discretion, an Insured Person to a General Cover with another Fund is not eligible to be an Insured Person to a General Cover with Defence Health.
- (c) Subject to these Rules, a person may be an Insured Person to both Defence Health and another fund, where Hospital Cover is held with one fund and General Cover is held with the other fund.
- (d) At the absolute discretion of Defence Health, this Rule C2.4 may be altered in circumstances where Dependent Children of a Policy Holder need to be covered both under a private health insurance cover of a Policy Holder and the Policy Holder's estranged Partner.

C2.5 Dual Memberships: Other

A person cannot take out two Hospital Covers or two General Covers with the Fund.

C2.6 State of Residence

- (a) A Policy Holder may hold Membership only in respect of the Policy Holder's State of residence.
- (b) Defence Health may transfer a Policy Holder's Membership to the Cover corresponding to the Policy Holder's State of residence.
- (c) Defence Health may waive this Rule at its discretion.

C2.7 Minimum Age of Policy Holders

Unless Defence Health otherwise determines, a person must be aged 18 or over to be a Policy Holder.

C3 Dependants

C3.1 Dependants of Policy Holders

In the absence of a legally binding determination to the contrary, the Fund shall take direction from the Policy Holder for all matters and decisions related to the private health insurance requirements of Dependants.

C3.2 Dependants Previously Insured

A person who ceases to be a Dependant of a Policy Holder of Defence Health or any other Fund and is eligible to join Defence Health in their own right, may join Defence Health as a Policy Holder without any additional Waiting Periods or Benefit Limitation Periods, provided:

- (a) the new Cover is no higher than the existing Cover,
- (b) the person applies for Membership within two (2) months of ceasing to be a Dependant; and
- (c) Contributions are paid back to the date at which the previous Cover ceased.

C4 Membership Applications

C4.1 Application for Admission to Membership

A person who is eligible for Membership, may apply for Membership by:

- (a) lodging with Defence Health an application in an approved form; and,
- (b) payment of the appropriate Contribution.

C4.2 Non Acceptance of Application for Admission to Membership

Defence Health may refuse any application for admission as a Policy Holder to the Fund where the applicant does not satisfy the requirements of the Rules. When any application for Membership is refused, the applicant is to be advised of the reasons for refusal.

C4.3 New born Children

A new-born Child may be added to a Membership from its date of birth, provided the Membership commenced no later than the Child's date of birth. Where an Insured Group needs to be changed to accommodate the new born Child, the addition of the new born Child must be undertaken within two months of the date of birth and Contributions paid from the date of birth.

C5 Duration of Membership

Membership Commencement Date

Membership commences on:

- (1) the date on which an application is lodged with Defence Health; or
- (2) where Defence Health agrees, a later date nominated in the application; or
- (3) where Defence Health agrees, in its absolute discretion, an earlier date nominated in the application.

C6 Transfers

C6.1 Transfers from Other Funds Within 2 Months – Waiting Periods

When a Member of another Fund transfers to Defence Health with a break in coverage of two (2) months or less, Defence Health may apply all relevant Waiting Periods:

- (a) to any Benefits under the Defence Health Cover that were not provided under the previous Cover
- (b) to the difference (if any) between the Benefit payable by Defence Health in respect of a service and that payable by the previous Fund as at the date of service
- (c) to the unexpired portions of any Waiting Periods not fully served under the previous Cover, and
- (d) to the unexpired portion of a Benefit Replacement Period or limit governing the supply or replacement of an appliance or Prosthesis.

C6.2 Transfers from Other Funds Outside Two Months

Where a Member of another Fund transfers to Defence Health with a break in coverage of greater than two (2) months, the person will be treated as a new Member for all purposes.

C6.3 Cover Changes Within Defence Health

- (a) A Policy Holder may apply to transfer from one product to another product by applying to Defence Health in a form approved by Defence Health. Defence Health may accept or reject such an application.
- (b) If an application for transfer is rejected, it shall be for non-compliance with these Rules and the reasons for rejection will be given.
- (c) If Defence Health accepts an application, it may require the Policy Holder to comply with such conditions as set out in these Rules.
- (d) Where a Policy Holder transfers to a different Defence Health Cover, during any Waiting Period applicable to the new Cover, Benefits are payable at the level of the previous Cover or the new Cover, whichever are the lesser.

C6.4 Previous Benefits May be Taken into Account

- (a) Subject to other Rules, where a Policy Holder transfers from another fund or to a different Defence Health Cover, any relevant Benefits that have been paid in a specified time period under the previous Cover may be taken into account in determining the Benefits payable under the new Cover.
- (b) ‘Any relevant Benefits’ include, but are not limited to, Benefits that are subject to an annual or other limit or a maximum number of days of Hospitalisation.

C7 Cancellation of Membership

C7.1 Cancellation of Membership

Subject to (e):

- (a) a Policy Holder may cancel their Membership entirely
- (b) a Policy Holder may remove any Dependants from their Membership
- (c) the Policy Holder's Partner or a Dependant aged at least 16 years of age may leave the Membership, and
- (d) a Dependant aged under 16 years of age may leave the Membership with the agreement of the Policy Holder.
- (e) Unless otherwise permitted by Defence Health, the above actions:
 - (i) must be authorised by the Policy Holder in the manner approved by the Fund
 - (ii) may not have retrospective effect, and
 - (iii) must be in accordance with any other arrangements specified by Defence Health.

C7.2 Refunds of Premiums

Subject to the Private Health Insurance Act, Defence Health may refund that portion of any premium paid more than 12 months in advance.

C8 Termination of Membership

C8.1 Termination of Membership Where an Insured Person Acts Improperly

- (a) Where in Defence Health's opinion an Insured Person has obtained or attempted to obtain an improper advantage, for themselves or for any other Policy Holder or for any Insured Person, Defence Health, subject to the Private Health Insurance Act may terminate the relevant Membership immediately, by written notice to the Policy Holder.
- (b) For the purposes of this Fund Rule, 'improper advantage' means any advantage, monetary or otherwise, to which an Insured Person is not entitled under the Rules.

C8.2 Termination of Membership due to Arrears

Defence Health may terminate a Membership where a Policy Holder is in Arrears in their Membership by more than 2 months.

C8.3 Termination for other Reasons

- (a) In any circumstance other than as specified in this Rule C8, Defence Health may terminate a Membership.
- (b) If Defence Health invokes this Fund Rule, it shall:
 - (i) provide the Policy Holder with at least two (2) months notice in writing including a reason for the termination, and
 - (ii) refund any Premiums paid in advance as at the date of the termination.

C8.4 Non-Payment of Benefits

The Fund is not obliged to pay any Benefits or continue Membership or Cover if a Membership is in Arrears or an application form or a Claim form contains false or inaccurate information.

C9 Temporary Suspension of Membership

C9.1 Suspension of Membership Policy

Subject to this Rule 9, Defence Health may permit a Policy Holder to suspend their Membership. In the case of a suspension for financial hardship, a Policy Holder with two different types of Cover (i.e. Hospital and General) may not suspend one Cover without also suspending the other.

C9.2 Criteria and Time Limits

Subject to the lifetime health cover provisions of the Private Health Insurance Act, a Membership may be suspended in the following circumstances:

- (a) Financial hardship - Whilst experiencing financial hardship, a Policy Holder may apply to suspend their Membership for a minimum period of 3 months and a maximum period of 12 months. Each Policy Holder is permitted three hardship Suspensions in a lifetime. No Suspension for financial hardship will be permitted within the first 12 months of a Hospital Cover except for exceptional circumstances in the opinion of Defence Health.
- (b) Membership Suspension for a minimum of 28 days and a maximum of 2 years, where a Policy Holder is (or Policy Holders are) overseas. In the case of a Full Time Serving Policy Holder who is on continuous full-time military service overseas, Defence Health may exercise its discretion in allowing a longer period of Suspension.
- (c) Subject to the provisions of the Private Health Insurance Act, any other circumstances that Defence Health may approve from time to time in its absolute discretion.

C9.3 Membership to be Current

A Membership may not be suspended unless the Premiums have been paid up to the date of Suspension.

C9.4 Arrangements during Suspension Period

During the period in which a Policy Holder is suspended:

- (a) Benefits are not payable for Treatment received by the Policy Holder and Dependants, and
- (b) The period does not count for any purpose in relation to the Insured Person, including Waiting Periods, Benefit Limitation Periods and Benefit Replacement Periods.

C9.5 Minimum Period Between Suspensions

Unless Defence Health in its absolute discretion agrees to the contrary, a Membership may be suspended only where the following minimum periods have elapsed since the reactivation from a previous Suspension for the same reason:

- (a) 6 months – overseas travel
- (b) 12 months – all other allowable circumstances.

C9.6 Documentation to be Provided

A Policy Holder who wishes to suspend or reactivate a Membership must provide all relevant documentation in support of their application that Defence Health may specify.

C9.7 Reactivation to Occur Within One Month

Where the relevant reason for Suspension ceases to apply, or the maximum period of Suspension has been reached:

- (a) if the Policy Holder reactivates the Membership within one month, continuity of previous Coverage will apply, but
- (b) if reactivation occurs later than one month, the Policy Holder will be considered a new Policy Holder for all purposes.

C9.8 Benefit Restitution

The Fund may suspend a Membership where restitution is being sought in situations described in Rule E1.8 (a) and (d) with the following effect:

- (a) A Policy Holder is not entitled to Benefits from the Fund during a period of Suspension.
- (b) The Policy Holder is responsible for ceasing allotment payments.
- (c) The Fund is responsible for ceasing direct debit payments.
- (d) Contributions received during the Membership Suspension may be applied towards the amount of restitution.
- (e) Provided the applicable full Waiting Periods have been served as prescribed by Rule F 3 prior to the date of commencing Suspension and restitution is successful within 3 months, or after 3 months from the date of the initial request and prior to termination, the Policy Holder will be eligible for the Benefits under the product for which they are contributing from the date their Membership is restored from Suspension.
- (f) Where the Recovery is successful and Contributions have been paid during the Suspension period, Contributions may be applied from the date the Suspension is lifted.
- (g) Where restitution is unsuccessful after 3 months from the date of the initial request for payment, the Fund may terminate the Membership in accordance with Rule C8.

C10 Other

This Rule is left intentionally blank.

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Premiums Payable for Each Cover

Premiums payable for each Cover are set out in the Schedule K Contribution Rate.

D1.2 Contribution Groups

- (a) Defence Health may at its discretion approve any group of Policy Holders as a Contribution Group for the purposes of sub paragraph 66-5 (3)(e) of the Private Health Insurance Act.
- (b) Without limiting the foregoing, Defence Health has established eight Contribution Groups comprising members of the Regular Army, Permanent Navy and Permanent Air Force and their families in:
 - (i) the Australian Capital Territory;
 - (ii) New South Wales;
 - (iii) Northern Territory
 - (iv) Queensland;
 - (v) South Australia;
 - (vi) Tasmania;
 - (vii) Victoria; and
 - (viii) Western Australia.
- (c) Without limiting the foregoing, Defence Health has established eight Contribution Groups comprising members of the Army Reserve, Naval Reserve and the Air Force Reserve and their families in:
 - (i) the Australian Capital Territory;
 - (ii) New South Wales;
 - (iii) Northern Territory
 - (iv) Queensland;
 - (v) South Australia;
 - (vi) Tasmania;
 - (vii) Victoria; and
 - (viii) Western Australia.
- (d) Without limiting the foregoing, Defence Health has established eight Contribution Groups comprising past members of the Regular Army, Permanent Navy and Permanent Air Force who within 12 months of discharge from the ADF have covered themselves with Hospital Cover or combined Hospital Cover and General Cover with Defence Health in:
 - (i) the Australian Capital Territory;
 - (ii) New South Wales;
 - (iii) Northern Territory
 - (iv) Queensland;
 - (v) South Australia;
 - (vi) Tasmania;
 - (vii) Victoria; and
 - (viii) Western Australia.

D1.3 Premiums Payable in Advance

- (a) All Premiums are payable in advance.
- (b) For all Covers, the available advance payment periods are:
 - (i) Direct Debit Contributors by credit card: monthly, quarterly, half-yearly and yearly
 - (ii) Direct Debit Contributors (other than by credit cards): fortnightly, monthly, quarterly, half-yearly and yearly
 - (iii) Group Contributors: weekly, fortnightly, monthly, quarterly, half-yearly and yearly, and
 - (iv) Invoices: quarterly, half-yearly and yearly.

D1.4 Premiums Limited to 12 Months in Advance

- (a) A Policy Holder (or person paying on their behalf) may not make a payment of Premiums that would cause the period of cover to exceed 12 months in advance of the date of payment.
- (b) Defence Health will either decline to accept any payment tendered, or part thereof, or refund any amount received that would otherwise breach (a).
- (c) Defence Health may waive this Fund Rule at its discretion.

D2 Contribution Rate Changes

D2.1 Premiums May be Changed

Defence Health may change the Premium for any Cover in accordance with the requirements set out in the Private Health Insurance Act, and subject to Rules D2.2 and D2.3.

D2.2 Rate Protection

Subject to Rules D1.4 and D2.3, where Premiums have been accepted in advance, a Premium change that takes effect during the advance period will not affect the date to which Premiums have been paid.

D2.3 When Rate Protection Does Not Apply

- (a) Where a Cover change occurs, or a suspended Membership is reactivated, the Premium current as at the date of the Cover change or reactivation applies to the Membership from that date.
- (b) For the purposes of this Fund Rule, and subject to (c), 'Cover change' includes:
 - (i) the addition or removal of a Cover component
 - (ii) a change in the level of existing Cover
 - (iii) a change in the State of Membership, or
 - (iv) a change of Insured Group resulting in a change in Premiums.
- (c) Where the State of Membership is changed but the Cover and the Membership are otherwise entirely unchanged, Defence Health may permit Fund Rule D2.2 to apply.

D3 Contribution Discounts

D3.1 Discounts on Contribution Group Premiums

Where a Policy Holder is a member of a Contribution Group, Defence Health may allow Premiums to be discounted by up to the amount permitted under the Private Health Insurance Act and may be limited in duration.

D3.2 Promotional discounts

From time to time Defence Health may offer a promotional discount to a person who is taking out cover for the first time with Defence Health. The promotion will be provided in the first year after the person purchases the policy and will not be greater than the amount permitted under the Private Health Insurance Act.

D4 Lifetime Health Cover

D4.1 Lifetime Health Cover Premiums

The Premiums payable by a Policy Holder will be increased by a nominated percentage where required under the Lifetime Health Cover provisions in the Private Health Insurance Act.

D5 Arrears in Contributions

D5.1 Memberships in Arrears

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

D5.2 Treatment During Arrears

- (a) Benefits are not payable for Treatment provided to a Insured Person during a period of Arrears. Defence Health may waive this Fund Rule at its discretion.
- (b) Subject to Rules D5.3 and D5.4, a Policy Holder may regain an entitlement to Benefits for such Treatment by paying all outstanding Premiums including the minimum amount of advance Premiums relevant to the Policy Holder, as specified in Fund Rule D1.3.

D5.3 Maximum Period of Arrears

When a period of Arrears exceeds two (2) months, Defence Health may terminate a Membership with immediate effect without written notice to the Policy Holder.

D5.4 Reinstatement of a Terminated Membership

Where a Membership has been terminated under Fund Rule D5.3, Defence Health has a discretion to reinstate the Membership at the request of the Policy Holder, with continuity of entitlements, subject to the payment of all Premiums as required under Fund Rule D5.2(b).

D6 Other

D6.1 Sponsored Memberships

Defence Health may refuse to accept Premiums where a third party seeks to pay them on behalf of a Policy Holder.

E BENEFITS

E1 General Conditions

E1.1 Treatment to be Provided by Recognised Providers

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

Defence Health recognises the following providers:

- (a) Hospitals (as defined in these Rules), and
- (b) General providers who are:
 - (i) in Independent Private Practice,
 - (ii) for each relevant class of service or Treatment, satisfy all applicable Recognition Criteria;
 - (iii) in relation to Alternative Therapies, but not including Exercise Physiology, be recognised by the Australian Regional Health Group;
 - (iv) in relation to Exercise Physiology, be an Approved Provider; and
 - (v) approved by Defence Health in its absolute discretion.

E1.2 Providers who Fail to Meet Recognition Requirements

Where Defence Health has reasonable grounds to believe that at the time the services were provided:

- (a) premises or facilities do not meet the definition of Hospital as set out in Fund Rules, or
- (b) a General provider is not in Independent Private Practice, or does not meet a relevant Recognition Criterion,

Defence Health will decline to pay Benefits in respect of any Claim.

E1.3 Recognised Providers Who Cease to Meet Recognition Requirements

Where Defence Health has reasonable grounds to believe that at the time the services were provided:

- (a) a Hospital has ceased to meet the definition as set out in these Rules, or
- (b) a Recognised General Provider has ceased to be in Independent Private Practice, or has ceased to meet any Recognition Criterion,

Defence Health may:

- (c) decline to pay Benefits in respect of any Claim, and
- (d) suspend or cancel the provider's recognition for the purpose of paying Benefits.

E1.4 No Benefit payment unless permitted by legislation

Irrespective of anything else contained in these Rules, Defence Health will not pay a Benefit to Insured Persons for a Treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules, unless it has been permitted to do otherwise under any legislative or regulatory instrument, or in any condition of registration.

E1.5 Benefit Reductions

Benefits may be reduced in the following circumstances:

- (a) where the charge is lower than the Benefit that would otherwise have been payable, the Benefit shall be reduced to the amount of the charge
- (b) where a Benefit is claimable from another source for the same service, the Defence Health Benefit may be reduced by the amount claimable from the other source, and

- (c) where in the opinion of Defence Health the charge is higher than the provider's usual charge for the service, Defence Health may assess the Claim as if the provider's usual charge had applied.

E1.6 Hospital Substitute Treatments

Benefits will not be payable for hospital-substitute Treatments where a Medicare benefit of 85% or more of the schedule fee is claimed for the Treatment.

E1.7 Providers Treating Family Members, and Business Partners and Family

- (a) Subject to (b), Benefits are not payable for Treatment rendered by a provider to:
 - (i) the provider's Partner, Dependants, or business partner, or
 - (ii) the Partner or Dependants of the provider's business partner.
- (b) Defence Health may at its discretion pay Benefits in these cases:
 - (i) where it is satisfied that the charge is raised as a legally enforceable debt, or
 - (ii) in respect of the invoiced cost of materials required in connection with any Treatment.

E1.8 Exclusion of Benefits

Benefits are not payable in the following cases:

- (a) in respect of any Treatment or service occurring within the Waiting Periods;
- (b) in respect of any Treatment or service during a period when Contributions are in Arrears;
- (c) Treatment or service for which no fee was charged;
- (d) if a Membership application or Claim form contains false or misleading information.

E1.9 Benefit Assessment

The Fund may request information from an Insured Person or their health service provider prior to or after the disbursement of Benefits. Information requested will be directly related to a Claim where the Insured Person has signed a declaration requesting Benefit entitlement to be paid to the Policy Holder or their health service provider.

Such information may include but is not limited to:-

- (a) Prescriptions
- (b) Signed receipts
- (c) Invoices
- (d) Treatment plans
- (e) Medical/Patient records, and
- (f) Appointment schedule.

E1.10 Benefit Restitution

The Fund may seek restitution where:

- (a) A Claim contains false or misleading information
- (b) A Claim is incorrectly assessed
- (c) A Claim is paid after the termination date of the Membership; or
- (d) Information is received after the Claim has been paid which establishes that the Benefit should not have been paid.

E1.11 Limitations on Consultations provided on the Same Day

The Fund has limitations on Consultations provided on the same day.

- (a) Where an Insured Person has two or more Consultations for the same type of service or Treatment on the same day, Benefits are payable where:
 - (i) there is a time lapse of three hours or more between Consultations; and
 - (ii) the Consultations are relating to two separate conditions.
- (b) Where an Insured Person has two Consultations with the same provider on the same day, Benefits are payable where:
 - (i) two different types of services are provided; and
 - (ii) the provider is qualified to provide both types of services.
- (c) Unless specified elsewhere, a maximum of two services are payable on any one day for the same type of service or from the same provider.

E2 Hospital Treatment

E2.1 Hospital Benefits Payable According to the Schedules

The Benefits payable in respect of Hospital Treatment and the conditions relevant to those Benefits are set out in Schedule J.

E2.2 Same-Day Patients

Benefits for Same Day Hospital accommodation are payable only where the Insured Person is an Admitted Patient or where a Benefit is applicable under a Hospital Purchaser Provider Agreement with that Hospital.

E2.3 Day Hospital Facilities

Benefits for Admitted Patients of Day Hospital Facilities are payable in accordance with guidelines issued by the Minister.

E2.4 Patient Classification: Principles

- (a) Benefits for accommodation in Private Hospitals are payable according to the classification of the Patient.
- (b) Patients are classified in accordance with the guidelines issued by the Department of Health and Ageing. The classifications are:
 - (1) Surgical
 - (2) Advanced Surgical
 - (3) Obstetric
 - (4) Other (Medical)
 - (5) Psychiatric Care, and
 - (6) Rehabilitation.
- (c) Defence Health may permit further sub-classifications of Patients where not inconsistent with these guidelines.

E2.5 Patient Classification: Surgical and Advanced Surgical Patients

Subject to Fund Rule E2.11, the Benefit payable under the surgical and advanced surgical classifications applies:

- (a) from the date of admission, where the operative procedure is performed on the first or second day of admission, or
- (b) from the date of the procedure, where the operative procedure is performed on the third day of admission or later.

E2.6 Patient Classification: Obstetric Patients

- (a) The Obstetric classification applies only where childbirth occurs following the mother's admission to a Hospital.
- (b) Where labour resulting in childbirth commenced before admission, the Obstetric classification applies from the date of admission.
- (c) Where labour commenced after admission, the Obstetric classification applies from the earliest of:
 - (1) the date on which labour commenced, or
 - (2) the date on which an obstetric procedure took place, or
 - (3) any other date that Defence Health may at its absolute discretion specify.
- (d) Defence Health has a further discretion to pay Benefits additional to those provided in (b) and (c).

E2.7 Patient Classification: Rehabilitation Patients

Benefits for rehabilitation patients are payable subject to the following conditions:

- (a) Treatment must be supported by a rehabilitation certificate (ie. A certificate in a form approved by Defence Health to the effect that the patient is in need of a special rehabilitation program to recover from an Acute Catastrophic Illness or Injury), and
- (b) a further rehabilitation certificate is required:
 - (1) for each period specified in any certificate issued under a Hospital Purchaser Provider Agreement where Treatment as a rehabilitation patient beyond 35 days is provided, and
 - (2) for any subsequent readmission as a rehabilitation patient that does not constitute Continuous Hospitalisation.

E2.8 Patient Classification: Psychiatric Care Patients

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

- (a) Treatment must be supported by a Psychiatric Care Certificate (ie. A certificate in a form approved by Defence Health, to the effect that the patient is in need of a special program of acute psychiatric care)
- (b) a further Psychiatric care certificate is required:
 - (1) for each period specified in any certificate issued under a Hospital Purchaser Provider Agreement where Treatment as a Psychiatric care patient beyond 35 days is provided, and
 - (2) for any subsequent readmission as a Psychiatric care patient that does not constitute Continuous Hospitalisation, and
- (c) Psychiatric care Benefits are not payable for any patient under the custodial care of a State or Territory.

E2.9 Patient Classification: Counting of Days

- (a) The day on which a person became an Admitted Patient and the day of discharge are counted as one day for the purpose of assessing Benefits payable.
- (b) Days spent in a special unit (such as an intensive care, critical care, coronary care, or high dependency nursing care unit) do not interrupt the counting of days in relation to the patient classification on entering the unit. To avoid doubt, Benefits payable upon discharge from the special unit will be paid at

the classification applicable upon entering the unit, after taking into account any days spent in the unit.

E2.10 Patient Classification: Multiple Procedures

Subject to Fund Rule E2.11, where a patient undergoes more than one operative procedure during the one theatre admission, the procedure with the highest fee in the Medicare Benefits Schedule determines the patient's classification.

E2.11 Patient Classification: Subsequent Procedures

Where a patient undergoes a subsequent operative procedure during the same period of Hospitalisation:

- (a) where the procedure results in the patient having a higher classification, the patient's classification increases from the date of the procedure, and
- (b) where the procedure would otherwise have resulted in the patient moving to a lower classification, the patient's classification is unchanged.

E2.12 Special Care Unit Patients

The higher Benefits for patients of special care units are payable only for periods during which the patient occupies a bed in a facility approved by Defence Health for this purpose.

E2.13 Continuous Hospitalisation

- (a) Where an Admitted Patient is discharged, and within seven (7) days is admitted to the same or a different Hospital for the same or a related Condition, the two admissions are regarded as forming one period of Continuous Hospitalisation.
- (b) In the case where the Hospitals are different, Benefits at the advanced surgical, surgical or obstetric levels are payable in respect of the later admission only if an appropriate procedure is rendered following that admission.

E2.14 Agreements with Doctors and Hospitals

- (a) Subject to Rule E4.2, Defence Health may enter into an agreement with a Medical Practitioner or group of Medical Practitioners, or a Hospital or group of Hospitals, under which any of the following items, or any combination of the following items, are to remain fixed throughout the term of the agreement:
 - (1) the total charge for any Treatment
 - (2) the Benefit payable by Defence Health, and
 - (3) any out-of-pocket expenses payable by the Insured Person.
- (b) For the purposes of this Rule, 'Medical Practitioner' includes a person who meets the definition of 'Medical Practitioner' in the Private Health Insurance Act.

E2.15 Gap Cover Arrangements

The schedules referred to in Fund Rule E4.2 shall provide that the Benefits under Gap Cover arrangements are payable subject to the following conditions:

- (a) A Medical Practitioner who provides Hospital Services under a Known Gap Policy shall give the Insured Person (or Policy Holder where appropriate) written advice of any amount the Insured Person can reasonably be expected to pay for those services.

- (1) If possible the advice shall be given before such services are provided, or otherwise as soon as practical, and
 - (2) the recipient of the advice shall acknowledge receipt of the advice, and
- (b) A Medical Practitioner who provides Hospital Services under a Known Gap Policy or a No Gap Policy shall give the Insured Person (or Policy Holder where appropriate) written advice of any financial interest the practitioner may have in products or services recommended or provided to the Insured Person.

E2.16 Pharmaceuticals in Hospitals

- (a) Where a Hospital Cover includes Benefits for PBS Medications supplied to an admitted patient of a Hospital, the Benefit will meet the full cost of the pharmaceutical if it is directly related to the Treatment of the Condition for which the Insured Person was admitted.
- (b) The 'full cost' referred to in (a) includes the Patient co-payment, and any special or Patient Contribution, brand premium or therapeutic group premium otherwise payable by the Patient under the Pharmaceutical Benefits Scheme.
- (c) Benefits for non-PBS medications supplied to an Admitted Patient of a Hospital are payable in accordance with the agreement with the Hospital if:
 - (1) the Benefit is specifically included in the agreement with the Hospital, and
 - (2) the pharmaceutical is directly related to the Treatment of the Condition for which the Insured Person is admitted.

E3 General Treatment

General Benefits Payable According to the Schedules

The Benefits payable in respect of General Treatments, and the conditions relevant to those Benefits, are set out in Schedules I and J.

E4 Other

E4.1 Ex Gratia Benefits

Subject to the Private Health Insurance Act, Defence Health may pay Benefits on an ex-gratia basis, at its discretion.

E4.2 Providers

- (a) Subject to Fund Rule E2.15, details of Benefits payable by Defence Health, Benefit conditions, and dates of effect for agreements or arrangements made under this Fund Rule for each Provider are contained in separate schedules maintained by Defence Health.
- (b) Subject to (c), and unless otherwise specified in these Rules, the payment of Benefits for Treatment provided by Providers is subject to all relevant Rules.
- (c) Defence Health may pay a lower Benefit than as set out in a Schedule if:
 - (i) the Benefit is payable for Treatment provided under an agreement referred to in Fund Rule E2.14; and
 - (ii) the Insured Person is not subject to any increase in their out-of-pocket expenses for that Treatment.

F LIMITATION OF BENEFITS

F1 Co Payments

This Rule is left intentionally blank.

F2 Excesses

Excesses: Definition and Explanation

- (a) An Excess is an amount of a Benefit that a Policy Holder agrees to forgo, in return for a lower Premium than would otherwise apply.
- (b) The amount of the Excess and relevant limits and conditions are specified in the Schedule relevant to the Policy Holder's Cover.

F3 Waiting Periods

F3.1 Independence of Waiting Periods

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

F3.2 Waiver of Waiting Periods

- (a) Defence Health may at its discretion waive or reduce any Waiting Period.
- (b) The waiver or reduction of a Waiting Period has no effect on:
 - (1) any other Waiting Period, or
 - (2) any Benefit Limitation Period, or
 - (3) any other Fund Rule applicable to the same service.

F3.3 Waiver in Case of Accidents

Defence Health may at its discretion waive the two-month Waiting Period in Rules F3.4(a) and F3.5(a) for Treatment required as the result of an Accident occurring within the two-month period.

F3.4 Waiting Periods: Hospital Covers

The following Waiting Periods apply to a Benefit for Hospital Treatment or Hospital-Substitute Treatment (where relevant to the Policy Holder's Cover):

- (a) Obstetrics related Services - 12 months
- (b) Treatment for Pre-Existing Conditions (as provided in Rules F3.6 to F3.8) other than the Treatments covered by paragraph (c) - 12 months
- (c) All psychiatric, rehabilitation and palliative care regardless of whether it is a Pre-Existing Condition - 2 months.
- (d) All other services and items - 2 months

F3.5 Waiting Periods: General Covers

The following Waiting Periods apply to Benefits under General Covers for the services shown (where relevant to the Policy Holder's Cover):

- (a) All services and items except those listed below - 2 months
- (b) Pre-existing conditions - 12 months
- (c) Obstetrics related Services - 12 months

- (d) Laser Refractive Eye Surgery - 12 months
- (e) For the supply of medically prescribed health appliances including, mobility aids, blood pressure monitor, tens machine, splints and braces, orthopaedic shoes, compression garments, non-cosmetic prostheses, nebulisers and spacers, blood glucose monitors and C-PAP machines - 12 months
- (f) Foot orthoses - 12 months
- (g) Major dental Treatments including periodontics, oral surgery, endodontics, crowns and bridge work, high cost dentistry and prosthodontics - 12 months
- (h) Orthodontic Treatments - 12 months
- (i) Hearing Aids - 36 months

F3.6 Pre-Existing Condition (PEC): Waiting Period

- (a) Defence Health may refuse or reduce Benefits in respect of a Pre-Existing Condition that is the subject of Treatment within the first twelve months of Membership of any Cover.
- (b) To avoid doubt, this Fund Rule also applies where an Insured Person transfers to another Cover which provides higher Benefits for the relevant Treatment.

F3.7 PEC: Information from Treating Practitioner(s)

Subject to the Private Health Insurance Act:

- (a) Defence Health may appoint a medical or other relevant practitioner to determine whether or not a Condition for which Treatment has been provided and Benefits have been claimed is a Pre-Existing Condition.
- (b) A practitioner appointed under (a) shall take into account:
 - (1) information provided by the practitioner(s) who treated the Insured Person in the six months prior to their becoming an Insured Person or changing their Cover, and
 - (2) any other material that Defence Health considers is relevant to the Claim.
- (c) Defence Health may suspend consideration of a Claim until such time as:
 - (1) the Insured Person (or Policy Holder where appropriate) authorises the release of the information referred to in (b), and
 - (2) this information has been provided to the Fund, and
 - (3) the relevant practitioner referred to in (a) has reviewed the information referred to in (b), and
 - (4) the Fund is in receipt of the PEC report from the relevant practitioner referred to in (a).
- (d) the PEC report from the relevant practitioner referred to in (a) will determine whether the Pre-Existing Condition Waiting Period will be applied.

F3.8 PEC Waiting Period Not to Apply Where the Fund Alters the Cover

- (a) Where Defence Health has changed the terms of a Cover, any higher or additional Benefits now available to existing Insured Person of the Cover are not subject to an additional Pre-Existing Condition Waiting Period.
- (b) This Fund Rule has no effect on any other Waiting Period or condition that applies to a newly available Benefit.

F4 Exclusions

F4.1 Benefit Exclusions

Unless expressly provided for in these Rules, Benefits are not payable:

- (a) for Claims for services rendered while Premiums are in Arrears or the Membership is suspended
- (b) for Claims for services rendered outside Australia or for items purchased or hired from overseas suppliers.
- (c) where an entitlement exists, or may exist, to Compensation and/or damages
- (d) for Claims for Treatment rendered by a provider other than a Recognised Provider
- (e) for pharmaceuticals that are available under the Pharmaceutical Benefits Scheme (PBS)
- (f) for oral contraceptives
- (g) where an application form for Membership or Claim Form contains false or inaccurate information
- (h) for General Treatment provided at a Public Hospital
- (i) for services rendered in a nursing home
- (j) where the Treatment is otherwise excluded by the operation of a Rule.

F4.2 Non-Resident Insured Persons

Benefits to Insured Persons who are Non-Residents of Australia are limited by their Medicare entitlements.

F5 Benefit Limitation Periods

No benefit limitation periods apply to any Covers.

F6 Restricted Benefits

This Rule is left intentionally blank.

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Definitions

In Fund Rule F7:

- (a) a reference to a Claim (other than a Claim for Benefits) includes a reference to a demand or action
- (b) a reference to an injury includes a Condition (including an ailment or injury) for which Benefits would or may otherwise be, payable by Defence Health for expenses incurred in relation to its Treatment, and
- (c) a reference to a Member receiving Compensation includes:
 - (1) Compensation paid to another person at the direction of the Insured Person, and
 - (2) Compensation paid to another Insured Person on the same Membership in connection with an injury suffered by the Insured Person.

F7.2 Obligations of an Insured Person

Subject to Fund Rule F7.8, an Insured Person who has, or may have, a right to receive Compensation in relation to an injury, must:

- (a) inform Defence Health as soon as the Insured Person knows or suspects that such a right exists
- (b) inform Defence Health of any decision of the Insured Person to Claim for Compensation
- (c) include in any Claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable
- (d) take all reasonable steps to pursue the Claim for Compensation to Defence Health's reasonable satisfaction
- (e) keep Defence Health informed of and updated as to the progress of the Claim for Compensation, and
- (f) inform Defence Health immediately upon the determination or settlement of the Claim for Compensation.

F7.3 Entitlement to Benefits for an Injury

- (a) Subject to Fund Rule F7.5, and unless otherwise permitted under this Fund Rule, Benefits are not payable for expenses incurred in relation to an injury where the Insured Person has received, or may be entitled to receive, Compensation in respect of that injury.
- (b) The expenses referred to in (a) include expenses incurred after the Insured Person has received any Compensation.

F7.4 Defence Health may Withhold Payment

Subject to Fund Rule F7.10, where an Insured Person appears to have a right to make a Claim for Compensation in respect of an injury but that right has not been established, Defence Health may withhold payment of Benefits in respect of expenses incurred in relation to that injury.

F7.5 Provisional Payments

- (a) Where a Claim for Compensation in respect of an injury is in the process of being made, or has been made and remains unfinalised, Defence Health may in its absolute discretion make a provisional payment of Benefits in respect of expenses incurred in relation to the injury.
- (b) In exercising its discretion, Defence Health may consider factors such as unemployment or financial hardship or any other factors that it considers relevant.
- (c) A provisional payment is conditional upon the Insured Person signing a legally binding undertaking and acknowledgment supplied by Defence Health, that contains an agreement by the Insured Person, in consideration for the payment:
 - (1) to comply with Fund Rule F7.2
 - (2) that it is bound by these Rules
 - (3) to disclose to Defence Health on request, all matters pertaining to the progress of the Claim and details of any determination made or any settlement reached in respect of the Claim
 - (4) to repay to Defence Health the full amount of the provisional payment as a debt immediately repayable upon the award or settlement of the Claim, whether or not the terms of such settlement specify that the sum

- of money paid under the settlement relates to expenses past or future for which Fund Benefits are otherwise payable, and
- (5) that Defence Health has specified rights of subrogation whereby Defence Health acquires all rights and remedies of the Insured Person in relation to the Claim.

F7.6 Where Benefits have been paid by Defence Health

- (a) Subject to Fund Rule F7.9, where:
- (1) Defence Health has paid Benefits, whether by way of provisional payments or otherwise, in relation to an injury, and
 - (2) the Insured Person has received Compensation in respect of that injury, the Insured Person must repay to Defence Health the full amount that Defence Health paid in relation to the injury, upon the determination or settlement of the Claim for Compensation.
- (b) This Fund Rule applies whether or not:
- (1) the determination or settlement sum includes the full amount that Defence Health paid, or
 - (2) the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future in respect of which Benefits are otherwise payable, or
 - (3) the relevant Insured Person complied with their obligations under Rule F7.2.

F7.7 Rights of Defence Health

If an Insured Person makes a Claim for Compensation in relation to an injury and fails to:

- (a) comply with any obligation in Rules F7.2 or F7.6, or
- (b) include in their Claim for Compensation any payments of Benefits by Defence Health in relation to an injury, Defence Health may, without prejudice to its rights (including its broader subrogation rights) in its absolute discretion take any action permitted by law to:
 - (1) assume that all expenses in relation to the injury have been met from the Compensation payable or received pursuant to the Claim, and/or
 - (2) pursue the Insured Person for repayment of all Benefits paid by Defence Health in relation to the injury, and/or
 - (3) assume the legal rights of the Insured Person in respect of all or any parts of the Claim.

F7.8 Claim Abandoned

- (a) Where a Insured Person has or may have a right to make a Claim for Compensation in respect of an injury, and
- (b) where Defence Health reasonably determines that the Insured Person has abandoned or chosen not to pursue the Claim, Benefits are payable (subject to other Rules) if the Insured Person signs a legally-binding undertaking supplied by Defence Health by which the Insured Person agrees, in consideration for the payment of Benefits, not to pursue the Claim.

F7.9 Requirement to Repay Benefits may be Waived

Where, in respect of an Insured Person's Claim for Compensation in relation to an injury:

- (a) the Insured Person has complied with Fund Rule F7.2, and
- (b) Defence Health has given prior consent to the settlement of the Claim for an amount that is less than the total Benefits paid or which would otherwise have been payable by Defence Health, Defence Health may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the Insured Person need not repay any part or the full amount of the Benefits paid by Defence Health in respect of the injury.

F7.10 Benefits for Expenses Subsequent to Compensation

Defence Health may, in its absolute discretion, pay Benefits where:

- (a) expenses have been incurred as a result of:
 - (1) a complication arising from an injury that was the subject of a Claim for Compensation, or
 - (2) the provision of service or item for Treatment of an injury that was the subject of a Claim for Compensation, and
- (b) that Claim has been the subject of a determination or settlement, and
- (c) there is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

F8 Other

This Rule is left intentionally blank.

G CLAIMS

G1 General

G1.1 Form of Claim

Claims for Benefits must:

- (a) be made in a manner approved by Defence Health, and
- (b) be supported by accounts and/or receipts on the provider's letterhead or showing the provider's official stamp, and showing the following information:
 - (1) the provider's name, provider number, qualifications and address
 - (2) the Patient's full name and address
 - (3) the date of service
 - (4) the description of the service
 - (5) the amount(s) charged, and
 - (6) any other information that Defence Health may reasonably request.

G1.2 Documents to Remain Property of Defence Health

All documents submitted in connection with a Claim become the property of Defence Health, unless otherwise agreed by the Fund.

G1.3 Claims to be Lodged Within Two Years

Benefits are not payable where a Claim is lodged more than two (2) years after the date of service. Defence Health may waive this rule at its discretion.

G1.4 Claims to be Paid Within Two Months

Subject to Rules F3.7(c) and G1.3, Defence Health shall, within two (2) months of receipt of a Claim, assess it and pay any Benefits payable under these Rules.

G2 Other

G2.1 Policy Holders May Delegate

Defence Health may authorise a Policy Holder to delegate to another person the right to Claim or assign Benefits to which the Policy Holder may be entitled.

G2.2 Manner of Benefit Payment

- (a) Defence Health may pay Benefits by cheque or electronic funds transfer in accordance with arrangements it determines from time to time.
- (b) Defence Health may prescribe the method of payment of Benefits and insist that Benefits be paid using that payment method.