Fund Rules

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A Introduction

A1 Rules Arrangement

These Rules consist of:

a) the General Conditions in Rules A to G; and

b) the Schedules.

Note: Defence Health makes available Product Guides and Private Health Information Statements that reflect Members' specific Cover and which summarise the material information set out in the Schedules. Defence Health provides Product Guides and Private Health Information Statements to Members on joining and as required by the Private Health Insurance legislation. Copies of the Schedules can be provided to Members on request, made by calling Defence Health.

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 as a Private Health Insurer, the Fund, or both, depending on the context.

A2.2 Purpose of the Fund

To protect the health of those who protect our country.

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, including changes to such 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:

a) the Private Health Insurance legislation, including subordinate legislation;

b) the Rules;

c) the Constitution of Defence Health; and

d) the Policies.

A5 Use of Funds

A5.1 Financial Control

Defence Health shall:

a) keep proper accounts and records of the transactions and affairs of the Fund
b) ensure that all payments from the Fund are correctly made and properly authorised, and
c) maintain adequate control over:
   I. the assets in the custody of the Fund; and
   II. 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:

a) all Premiums paid by Policy Holders, and
b) 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:

a) to pay Benefits in accordance with these Rules;
b) to make payments to the Private Health Insurance Risk Equalisation Trust Fund;
c) to make investments for the health insurance business;
d) to pay for a purpose specified in the Private Health Insurance Act; and
e) 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, or where it would be unconscionable to apply them, waive the application of particular Rules at its discretion, provided that the waiver does not reduce the relevant Policy Holder’s entitlement to Benefits.

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 Private Health 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 updated Private Health 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, insured under that Product it shall give reasonable prior notice 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 Commonwealth Ombudsman

8.2.1 The Commonwealth 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 to Policy Holders on request. The Rules are also available on the Defence Health website.

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.

B Interpretations 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 means the 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 unplanned or unforeseen event leading to bodily injuries caused solely and directly by external means and requiring immediate Treatment from a Recognised Provider. It does not include unforeseen Conditions attributable to medical causes.

Accidental Injury Benefit means admissions for Clinical Categories that are Restricted or Excluded Services under your Hospital Product and will be treated as Included Services in relation to any non-Compensable Accident occurring after commencement of the Product. Treatment must be sought from a registered practitioner with 72 hours and any required hospitalisation must occur within 180 days of the Accident. With the exception of the change of Included Services for this Benefit as above, the other rules of operation of your Product apply.

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

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

(a) includes a newborn 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 newborn 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, Dependent Student or Dependent Non-student.

Ambulance Benefit means the Benefit payable to a Member for an Ambulance Treatment, or, at the discretion of Defence Health, the provision of a Benefit for an ambulance subscription to a State or Territory government ambulance service in the State or Territory of residence of the Member. Should a Member incur an out of pocket expense for an Ambulance Treatment, and this out of pocket expense arises from a shortfall between the entitlements received under an ambulance subscription and the Benefit that would be payable by Defence Health for an Ambulance Treatment if no ambulance subscription existed, then Defence Health will pay a Benefit amounting this difference.

Ambulance Treatment means transport and medical Treatment services provided by a registered ambulance service accredited and engaged by a Federal, State or Territory government within Australia, and is approved by Defence Health. It does not include transport services between hospitals, repatriation to or from a state for non-clinically necessary reasons, or services by patient transport vehicles.

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

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

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, the Territory of Christmas Island and Norfolk Island, but
(b) excludes other Australian external territories.

Benefit means any amount payable for a 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 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.

Child means one of the following:

(a) a natural Child (including a newborn 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).

Children Only Membership is the Membership Category defined at C1.1(c).

Claim means a claim for a Benefit.

Clinical Category has the same meaning as in the (Complying Product) Rules 2015

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 Recognised Provider and
(b) generally accepted in the relevant profession as being necessary for the appropriate Treatment of the Patient.

Closed Product has the same meaning as in the Private Health Insurance Act.

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 including the National Disability Insurance Scheme.
(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.

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

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

Continuous Hospitalisation has the same meaning as in Fund Rule E2.13.

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 D1.2.

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 Commonwealth Medicare Benefits Schedule.

Couples Membership is the Membership Category defined at C1.1(b).

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 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.

Delegated Authority means the assignment of responsibility by the Policy Holder to an authorised representative to carry out specific actions as determined by Defence Health on behalf of 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.

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 Student;
(d) the Policy Holder's Dependent Non-student; or,
(e) 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 person who:
(a) is the Child of the Policy Holder;
(b) is aged under 18 years; or
(c) is a **Non-classified Dependent**; and
(d) does not have a partner.

Dependent Non-student means a person who:
(a) is the Child of the Policy Holder;
(b) is aged between 21 and 30 (inclusive);
(c) is not receiving full time education at a school, college or university; and
(d) does not have a partner.

Dependent Student means a person who:
(a) is the Child of the Policy Holder;
(b) is aged between 21 and 30 (inclusive);
(c) is receiving full time education at a school, college or university; and
(d) does not have a partner.

Excess means an amount of money a Member agrees to pay towards a hospital admission, same day or overnight, before Benefits are payable.

Excluded Service means services for which Benefits are not payable.

Family Membership is the Membership Category defined at C1.1(f).

Family Plus Membership is the Membership Category defined at C1.1(g).

Full-time Serving means people who are members of the Permanent forces rendering full-time service or a pattern of service other than full-time, who are subject to the same service obligations as members rendering full-time service. 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 means the amount of money payable above the Medicare Benefits Schedule payments made under a Medical Purchaser Provider Agreement, Hospital Purchaser Provider Agreement or other scheme.

Gap Cover Scheme means an arrangement where a Medical Practitioner agrees to raise charges for Hospital Treatment and associated Professional Services in accordance with the permitted charges under that scheme. The Fund will cover Members for all, known as No Gap, or all but a specified amount or percentage of that charge, known as Known Gap, where Medicare benefits are payable.

General Benefits are amounts paid by Defence Health for, or towards, the costs of approved General Treatment.

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

General Treatment has the same meaning as in the Private Health Insurance Act, and is Treatment that is intended to manage or prevent a disease, injury or condition that is not Hospital Treatment.

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

Health Services Entitlements means health services funded or part-funded through a health service funding body or source, such as the Department of Veterans' Affairs (DVA).

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 has the same meaning as in the Private Health Insurance Act, and is a Policy that covers Hospital Treatment.

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

Hospital Psychiatric Services has the same meaning as in the Private Health Insurance (Complying Product) Rules 2015.

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

Hospital-Substitute Treatment has the same meaning as in the Private Health Insurance Act, that substitutes for an episode of hospitalisation.

Hospital Treatment has the same meaning as in the Private Health Insurance Act, and is Treatment that is intended to manage or prevent a disease, injury or condition that is provided at or with the direct involvement of a Hospital.

Included Services means services for which Benefits are payable.

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

Initial Consultation means the first consultation in which a Recognised Provider will diagnose and assess a Patient for Treatment related to a specific Condition.

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.

Lifetime Health Cover has the same meaning as 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) means an agreement between Defence Health and a Medical Practitioner.

Medicare Benefits Schedule (MBS; or Commonwealth Medicare Benefits Schedule (CMBS)) means the 'Medicare Benefits Schedule Book' published by the Department of Health, Disability 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.

Member means a person who is the Policy Holder or another person insured under a Policy of the Fund.

Membership means Membership of the Fund.

Membership Category is defined at C1.1.

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.

Nominated Circumstances means events beyond the control of the Fund including acts of God, civil or military authority, pandemics (whether called by an Australian government or relevant world authority), acts or threats of terrorism, civil disturbance, war, riot, strike or labour dispute, fires, floods or acts of government, or other like circumstance.

Non-classified Dependent means a person who:
(a) is the Child of the Policy Holder;
(b) is aged between 18 and 20 (inclusive); and
(c) does not have a partner.

Nursing Home Type Patient has the same meaning as in the Private Health Insurance (Benefit Requirements) Rules, and means a patient who has been provided with Hospital Treatment for a continuous period exceeding 35 days and is then provided with accommodation and nursing care as an end in itself as part of a continuous period of hospitalisation.

Open Product means a Hospital Treatment Product, General Treatment Product, or Combined Treatment Product that a new or existing Member can join.

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

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 a person who normally lives with the Policy Holder on a bona fide permanent domestic basis and includes a person to whom the Policy Holder is legally married.

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 Aged Care).

Policies mean a private health insurance policy of the Fund.

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, with the exception of termination of the policy, 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 ending on 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) mean 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 means the Private Health Insurance Act 2007 (Cth) and the Private Health Insurance (Prudential Supervision) Act 2015 (Cth) as amended from time to time and any legislative instruments made under these Acts.

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.

Private Room means, for the purposes of a private room in a public hospital, a room in a hospital that is suitable for one single admitted adult patient.

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

Product Guide means a summary of the material information applicable to a particular Open or Closed Product issued by Defence Health to Members, but is not an exhaustive statement of the Product's terms and conditions.

Professional Attention has the same meaning as in the Health Insurance Act.

Professional Service has the same meaning as 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 item fitted in association with a medical procedure at a Hospital and listed as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules, or
- (b) in relation to a 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 has the same meaning as in the Private Health Insurance Act.

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

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, physical or for services described under Rule E4.3 remote, 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.

Registered Podiatric Surgeon means a person who holds current specialist registration in the specialty of podiatric surgery under the National Law.

Reservist means a person who is actively serving in the Army Reserve, Air Force Reserve or Naval Reserve of Australia, with a Service Category (SERCAT) of 3, 4 or 5.

Restricted Access Group means the Defence Health Ltd Restricted Access Group as defined in these rules.

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

Retained Age-Based Discount Policy has the meaning described in the Private Health Insurance (Complying Product) Rules.

Rules means the Rules defined in clause A1 and made by the Board pursuant to the powers conferred by the Constitution.

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

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

Schedule means any of the schedules to these Rules (which can be made available to Members upon request and which are summarised in the Product Guides and Private Health Information Statements).

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 Membership is the Membership Category defined at C1.1(a).

Single Parent Family Membership is the Membership Category defined at C1.1(d).

Single Parent Family Plus Membership is the Membership Category defined at C1.1(e).

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.

Private Health Information Statement is a summary of product features and contains the information and form of words as prescribed by the Private Health Insurance Act.

Subsequent Consultation means, in the reasonable opinion of Defence Health, a consultation for the same Condition in which a Recognised Provider provides additional Treatment to a Patient after an Initial Consultation.

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 F3.

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 (**Membership Categories**):

(a) only one person (**Single Membership**);
(b) the Policy Holder and their Partner (**Couples Membership**);
(c) two or more Dependent Children, Dependent Students or Dependent Non-students (**Children Only Membership**);
(d) the Policy Holder and one or more Dependent Children or Dependent Student (**Single Parent Family Membership**);
(e) the Policy Holder and at least one Dependent Non-student and any number of Dependent Students or Dependent Children (**Single Parent Family Plus Membership**);
(f) the Policy Holder and their Partner and at least one Dependent Children or Dependent Student (**Family Membership**);
(g) the Policy Holder and one or more Dependent Non- student and any number of Dependent Children or Dependent Students (**Family Plus Membership**).

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;
(b) any one level of General Cover;
(c) any defined combination of one level of Combined Cover with one level of General Cover;
(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 membership category, 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 to part-time or defers study;
(i) change of Partner.

C2 Eligibility for Membership

C2.1 Defence Health Restricted Access Group

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

I. persons who are already insured with the Company immediately before the commencement of the Private Health Insurance (Registration) Rules 2007 (No 2); and

II. persons who are or were:
   - a member of an arm of the Defence Force as referred to in the Defence Act 1903 (Cth); or
   - 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
   - an employee of:
     - a contractor to any of the Bodies; or
     - 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

III. who is or was involved in supplying goods or services to any of the Bodies; and

IV. persons who are or become officers or employees (including contractors) of the Company; and

V. the partners and dependent children of Principal Insureds; and

VI. the former partners and adult children of Principal Insureds; and

VII. the siblings, grandchildren and parents of Principal Insureds; and

VIII. the partners and dependent children of persons who are the adult children of Principal Insureds; and

IX. the partners and dependent children of persons who are the siblings of Principal Insureds.

(b) The Company is prohibited from issuing a complying health insurance product to a person who does not belong to the Restricted Access Group.

(c) The Company is prohibited from ceasing to insure a person for the reason that the person has ceased to belong to the Restricted Access Group.

(d) The Company is prohibited from adding new persons to the Restricted Access Group in addition to the persons included in the group by the operation of this Constitution, the Private Health Insurance Act and legislative instruments made under the Private Health Insurance Act.

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

C2.3.1 A person who is eligible for Membership under Rule C2.1 and who, as a member of the Australian Defence Force, has health services provided by or through the Australian Defence Force, will have all Waiting Periods waived if an application to join is made within 60 days of the date of discharge.

C2.3.2 A person eligible for Membership under Rules C2.1 may apply to rejoin. All Waiting Periods will apply unless the application to rejoin is made within 60 days of the date of ceasing to be an Insured Person.

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, Dependent Students and Dependent Non-students 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 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, provided:

(a) the new Cover is no higher than the existing Cover,
(b) the person applies for Membership within 60 days of ceasing to be a Dependant.

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 Newborn and adopted Children

A newborn or adopted Child may be added to a Membership without Waiting Periods, provided the newborn or adopted Child is added no later than 60 days after their date of birth or date of adoption.

C4.4 Cooling Off Period

A 30 day cooling off period applies to all Memberships. Premiums are fully refundable if a Policy Holder decides to cancel the Membership within the first 30 days of its commencement providing no Claims have been made during that time.

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, for new members and changes in cover, in its absolute discretion, an earlier date nominated in the application.

C6 Transfers

C6.1 Transfers from Other Funds within 60 days – Waiting Periods

When a member of another Fund transfers to Defence Health with a break in coverage of 60 days 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.

C6.2 Transfers from Other Funds Outside 60 days

When a member of another Fund transfers to Defence Health with a break in coverage of greater than 60 days, 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 60 days.

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 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, or in circumstances of overseas travel, continuous Full-time Service or imprisonment, to suspend individual Members other than the Policy Holder from their Membership after 12 months of Membership. 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 - While experiencing financial hardship, a Policy Holder may apply to suspend their Membership for a minimum period of three months and a maximum period of 12 months. Each Policy Holder is permitted a maximum of three hardship Suspensions in a lifetime. However, in Nominated Circumstances, or where it is unconscionable or impractical to apply the Rules, exceptions to these Rules may be approved by Defence Health in its absolute discretion. Defence Health may do this by varying this Rule C9.2 (a) to permit one or more of the following exceptions:

   I. Suspensions within the first 12 months of Membership, for a maximum period prescribed by the Fund at its discretion;

   II. Suspensions within 12 months of a previous suspension of a Membership, for a maximum period prescribed by the Fund at its discretion;

   III. Additional suspensions beyond the lifetime maximum, for a maximum period prescribed by the Fund at its discretion.

(b) Overseas travel - for a minimum of 28 days and a maximum of two years, where a Policy Holder is, or individual Members of the Policy are, overseas.

(c) Continuous Full-time Service – for a minimum of 28 days and a maximum of two years, where a Policy Holder is, or individual Members of the Policy are, undertaking a period of continuous Full-time Service. In the case of a Full-time Serving Policy Holder or a policy held by the Partner of a Full-time Serving person who is on continuous full-time military service overseas a maximum of three years applies. Defence Health may exercise its discretion in allowing a longer period of Suspension, for example to the length of the continuous Full-time Service.

(d) Imprisonment – for a minimum of 28 days and a maximum of two years, where a Policy Holder is, or individual Members of the Policy, are imprisoned. The supply of documentation issued by the sentencing Court or State or Territory correctional services department is required.

(e) Any other circumstances, including Nominated Circumstances, Defence Health may permit 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 or individual Members of the Policy are suspended:

(a) Benefits are not payable for Treatment received by the Policy Holder and Dependants, or individual Members of the Policy who are suspended and

(b) The period does not count for any purpose in relation to the Insured Person, including Waiting 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) No minimum period – Continuous Full-time Service

(b) Six months – overseas travel

(c) 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 30 days

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 30 days, continuity of previous Coverage will apply, but
(b) if reactivation occurs later than 30 days, 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 (e) 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 F3 prior to the date of commencing Suspension and restitution is successful within three months, or after three 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.

D Contributions

D1 Payment of Contributions

D1.1 Premiums Payable for each Product

Premiums payable for each Product can be found on Private Health Information Statements, located at www.privatehealth.gov.au. Premiums are relevant at the date of viewing or downloading.

D1.2 Contribution Groups

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.

D1.3 Premiums Payable in Advance

(a) All Premiums are payable in advance.

(b) For all Covers, the available advance payment periods are:

I. Payment by credit card: monthly, quarterly, half-yearly and yearly

II. Payment by direct debit (other than by credit cards): fortnightly, monthly, quarterly, half-yearly and yearly, and

III. Invoices: quarterly, half-yearly and yearly.

(c) Defence Health may, in its absolute discretion, accept premium payments for amounts less than the advance payment periods outlined in Rule D1.3(b).

(d) Defence Health may, in its absolute discretion, pass onto Policy Holders any bank charges associated with payment of premiums by credit or debit cards.

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) Where a change to a Cover pursuant to rule D2.2 and D2.3 occurs and results in the Premium being paid more than 12 months in advance from the date of payment, Defence Health may in its absolute discretion, refund any portion of the Premium that is in excess of 12 months in advance from the date of payment.

(d) 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

(a) Subject to Rules D1.4 and D2.3, where Premiums have been accepted in advance, the Premium applicable at the time of receipt by Defence Health will apply for the full period of prepayment.

(b) For the purposes of this Fund Rule, the rate protection in clause D2.2(a) above also applies in situations of Cover change.

A Cover change includes:

I. the addition or removal of a Cover

II. a change in Cover

III. a change in the risk equalisation jurisdiction of the Cover, or

IV. a change of Membership Category resulting in a change in Premiums.

For clarity, where a Cover change is made during the pre-paid period, the Premium paid for the new Cover is the one that applied for that new Cover when the pre-payment was made.

D2.3 When Rate Protection Does Not Apply

The rate protection referred to in rule D2.2 does not apply in the following circumstances:

(a) Where a suspended Membership is reactivated, the Premium current as at the date of the reactivation applies to the Cover from that date.

(b) Where a change in Cover to a Product that did not exist at the time Premiums were paid in advance, the Premium current as at the date of the Cover change applies to the Membership from that date.

D3 Contribution Discounts

D3.1 Discounts on Contribution Group Premiums

(a) 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.

(b) Documentary evidence may be requested as proof of membership of a Contribution Group. If documentation is not provided in a timeframe specified by Defence Health, a Policy Holder may forfeit any applicable Premium discount.

(c) Defence Health may, from time to time, apply a time-limited discount during a Nominated Circumstance for Policy Holders in a Contribution Group.

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. Defence Health will remove any loading on the amount of premiums payable by a Member once Hospital cover has been held for a continuous period of 10 years, which has only been interrupted by permitted days as specified 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 an 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 60 days, 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 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, recognised by the Australian Regional Health Group; and
  IV. 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) at premises or facilities that do not meet the definition of Hospital as set out in Fund Rules, or
(b) by a General provider who 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 Themselves, 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, parents, siblings, or business partner, or
   II. the provider themselves, or
   III. the Partner or Dependants of the provider's business partner.

(b) Defence Health may at its discretion pay Benefits in these cases 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 until Contributions are no longer in Arrears
(c) in respect of any Treatment or service during a period when a Policy Holder or individual Members on a Policy are suspended;
(d) in respect of any Treatment or service for which no fee was charged;
(e) 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 made 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 of monies 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, such as, but not limited to, a Member who has a Health Services Entitlement, where restitution may be sought in line with Fund Rule F7.7.

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 the Consultations are relating to two separate conditions. This is limited to a maximum of two services on any one day, unless specified elsewhere.
(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.

   This is limited to a maximum of two services on any one day, unless specified elsewhere.

E2 Hospital Treatment

E2.1 Hospital Benefits Payable according to the Schedules

The Benefits payable in respect of Hospital Treatment and the conditions relevant to those Benefits are set out in the Fund Rules and associated Schedules (and as summarised in the Product Guides).

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 the Private Health Insurance Act.

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 Private Health Insurance Act. The classifications are:

I. An advanced surgical patient;

II. A surgical patient;

III. An obstetric patient;

IV. A psychiatric patient;

V. A rehabilitation patient, or

VI. Other (Medical)

(c) Defence Health may permit further sub-classifications of Patients when not inconsistent with the Private Health Insurance Act.

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:

I. the date on which labour commenced, or

II. the date on which an obstetric procedure took place, or

III. 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 (i.e. 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:

   I. 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

   II. for any subsequent readmission as a rehabilitation patient that does not constitute Continuous Hospitalisation.

E2.8 Hospital Psychiatric Services

Hospital Psychiatric Services shall have:

(a) once-per-lifetime upgrade benefits as described in these Rules and the Private Health Insurance (Complying Product) Rules 2015; and

(b) the same portability, waiting periods, and retrospective cover as is prescribed by the Private Health Insurance (Complying Product) Rules 2015.

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 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. A longer period may be applicable as defined in individual Hospital Purchaser Provider Agreements.

(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

Subject to Rule E4.2, Defence Health may enter into Medical Purchaser Provider Agreements or Hospital Purchaser Provider Agreements.

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 Medical Practitioner who provides Hospital Services under a Gap Cover Scheme 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
3) any financial interest the practitioner may have in products or services recommended or provided to the Insured Person are specified.

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:

   I. the Benefit is specifically included in the agreement with the Hospital, and
   II. the pharmaceutical is directly related to the Treatment of the Condition for which the Insured Person is admitted.

E3 General Treatment

E3.1 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 the Schedules (and as summarised in the Product Guides). General Treatment Benefits are not payable where a Medicare benefit has been or is available to be claimed.

E3.2 Agreements with General Treatment Providers

Defence Health may, from time to time, enter into agreements with providers of General Treatment. The Benefits that apply under these agreements may differ from, and will take precedence over, those shown in general information about Products. Specific information about Benefits is available by contacting Defence Health.

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.

E4.3 Remote provision of Treatment

(a) Benefits are payable for General Treatment rendered remotely for the following services, subject to other provider Recognition Criteria:

I. Dietetics

II. Psychology

III. Speech Therapy

IV. Physiotherapy

V. Exercise Physiology, and

VI. Occupational Therapy.

(b) Other benefits may be payable for services rendered remotely in Nominated Circumstances at the sole discretion of Defence Health.

F Limitation of Benefits

F1 Co Payments

This Rule is left intentionally blank.

F2 Excesses

Excesses: Definition and Explanation

The amount of the Excess and relevant limits and conditions are specified in the Schedule relevant to the Policy Holder's Cover (and as summarised in the Product Guides).

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:

I. any other Waiting Period, or

II. 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 and F3.5 for Treatment required as the result of an Accident occurring within the two-month period.

F3.4 Waiting Periods: Hospital Treatments

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

(a) Pregnancy and birth - 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 rehabilitation, hospital psychiatric services and palliative care regardless of whether it is a Pre-Existing Condition - 2 months

(d) All other services and items - 2 months.

(e) If you are on a hospital policy which provides restricted services for psychiatric care, you can upgrade without having to serve additional waiting period to access higher benefits for psychiatric care in a private hospital. This exemption applies only once per lifetime and can only be accessed if you have already completed an initial two months of membership on any level of hospital Product.

F3.5 Waiting Periods: General Treatments

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

(a) All services and items except those listed below – 2 months
(b) Laser Refractive Eye Surgery – 12 months
(c) For the supply of medically prescribed health appliances including, mobility aids, blood pressure monitor, TENS machine, splints and braces, orthopaedic shoes, foot orthoses, compression garments, non-cosmetic prostheses, nebulisers and spacers, blood glucose monitors, PAP machines, hearing aids and joint fluid replacement - 12 months
(d) Major dental Treatments including periodontics, oral surgery, endodontics, crowns and bridge work, high cost dentistry and prosthodontics - 12 months
(e) Orthodontic Treatments - 12 months
(f) Midwifery – Home /registered Hospital birthing facility delivery – 12 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 Hospital 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:
    I. information provided by the practitioner(s) who treated the Insured Person in the six months ending on the day of becoming an Insured Person or changing their Cover, and
    II. 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:
    I. the Insured Person (or Policy Holder where appropriate) authorises the release of the information referred to in (b), and
    II. this information has been provided to the Fund, and
    III. the relevant practitioner referred to in (a) has reviewed the information referred to in (b), and
    IV. 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

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

I. for Claims for services rendered while the Membership is suspended or, Premiums are in Arrears until Premiums are no longer in Arrears or

II. for Claims for services rendered outside Australia or for items purchased or hired from overseas suppliers, including where the supplier does not have a registered Australian Business Number or

III. any Treatment for which, in Defence Health's opinion, you may receive any Compensation, damages, or benefits from another source (even if the Compensation, damages, or benefits are stated to exclude any medical expenses) or

IV. for Claims for Treatment rendered by a provider other than a Recognised Provider or

V. for pharmaceuticals that are available under the Pharmaceutical Benefits Scheme (PBS) or

VI. for contraceptives for the purpose of contraception or

VII. where an application form for Membership or Claim Form contains false or inaccurate information or

VIII. for services rendered in an aged care service or

IX. Treatment for which no Medicare Benefits are payable, including any Cosmetic Surgery or experimental or clinical trials of pharmaceuticals or devices.

or

X. 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

A Cover may restrict Benefits for Hospital Treatment as detailed in the associated Schedules to these Rules (and as summarised in the Product Guides).

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:

I. Compensation paid to another person at the direction of the Insured Person, and

II. 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, which contains an agreement by the Insured Person, in consideration for the payment:
    I. to comply with Fund Rule F7.2
    II. that it is bound by these Rules
    III. 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
    IV. 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
    V. 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:

I. Defence Health has paid Benefits, whether by way of provisional payments or otherwise, in relation to an injury, and

II. 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:

I. the determination or settlement sum includes the full amount that Defence Health paid, or

II. 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

III. 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:

I. assume that all expenses in relation to the injury have been met from the Compensation payable or received pursuant to the Claim, and/or

II. pursue the Insured Person for repayment of all Benefits paid by Defence Health in relation to the injury, and/or

III. assume the legal rights of the Insured Person in respect of all or any parts of the Claim.

F7.8 Claim Abandoned

(a) Where an 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:

I. a complication arising from an injury that was the subject of a Claim for Compensation, or

II. 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.

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:
  I. the provider's name, provider number, qualifications and address
  II. the Patient's full name and address
  III. the date of service
  IV. the description of the service
  V. tooth numbers when a Dental Treatment has taken place on an individual tooth
  VI. the amount(s) charged, and
  VII. 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 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 months of receipt of a Claim, assess it and pay any Benefits payable under these Rules.

G1.5 Claims to be Paid after Treatment provided

Benefits are only payable after Treatment has been provided.

G1.6 Claims to be assessed having regard to the date of the Treatment

Benefits are only payable after Treatment has been provided.

G1.7 Incorrect or Fraudulent Claims

If a Claim is found to be incorrect or fraudulent, Defence Health may at its discretion:

(a) suspend all Claiming
(b) offset the amount paid against future Claims or premiums
(c) seek repayment of the funds.

G2 Policy Authorities

G2.1 Dependants aged 16 or over

Dependants aged 16 years or more can request Defence Health to take measures to keep their information confidential from other Insured People on the Policy. Given that many General Treatments are subject to limits which are shown to the Policy Holder, the amount and reduction in Claim limit cannot therefore be kept confidential.

G2.2 Policy authorities – self access for Dependants aged 16 or older

Dependants aged 16 or older have the authority to manage their own personal details, make their own claims, and terminate themselves from the Policy.

G2.3 Delegations of authority to Partner

The Policy Holder may delegate to their Partner the same access as the Policy Holder to manage the Policy with the exception of the ability to:

(a) remove the Policy Holder from the Policy, or
(b) terminate the Policy, or
(c) change the Policy Holder.

G2.4 Delegations of authority to Third Parties

The Policy Holder and Insured People on the Policy may delegate their authority to act on a Policy to a non-Insured Adult. The details and operation of this delegation will be determined by Defence Health.

G2.5 Further definition of Authorities and Delegated Authorities

Defence Health may issue further details and clarifications on the authorities provided in this Rule by publishing these details on the Defence Health website.

G3 Other

G3.1 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.

G3.2 Communication with Members

Defence Health may communicate policy or marketing related information with Members by email where an email address has been provided or alternatively in accordance with the individual's communication preference.