HEALTHIER, LONGER, BETTER LIVES

AIA Health Insurance

FUND RULES

These Fund Rules should be read in conjunction with our Member Guide and your individual Product Fact Sheet.

These Fund Rules are effective 24 March 2025

aia.com.au/health

Contents

These Fund Rules set out the general principles and rules of membership under which AIA Health Insurance Pty Ltd conducts its business.

Before taking out private health insurance with AIA Health Insurance Pty Ltd, you and all other persons to be covered on your Policy must read these Fund Rules.

By taking out private health insurance with AIA Health Insurance Pty Ltd, you and all the other persons on your Policy become Members of our Fund and agree to our Fund Rules as amended from time to time.

A. Introduction

A1: Rules Arrangement

A1.1 Application of Fund Rules

AIA Health Insurance Pty Ltd issues private health insurance policies under the AIA Health brand. These Fund Rules apply to all policies and govern the rights and obligations of Members and AIA Health Insurance Pty Ltd in relation to the Fund.

A1.2 Content of the Fund Rules

These Rules consist of:

a) the general conditions (A to G); and
b) the Schedules (H to L).

A2: Health Benefits Fund

A2.1 Purpose of Fund

AIA Health Insurance Pty Ltd operates as a Health Benefits Fund for the purposes of its health insurance and health related business in accordance with the Private Health Insurance Act and these Fund Rules.

A2.2 Purpose of Rules

These Rules set out:

a) the requirements for all Members;
b) the rules regarding payment of Benefits by AIA Health Insurance Pty Ltd;
c) the ways in which AIA Health Insurance Pty Ltd will conduct the Fund and make decisions regarding all Members; and
d) all Members are bound by these Rules as amended from time to time.

A3: Obligations to Insurer

A3.1 Disclosure of information

A person applying for any Membership and all Members making a claim must:

a) provide all information reasonably required by AIA Health Insurance Pty Ltd in relation to all Memberships;
b) Give full, complete and true disclosure on all matters reasonably required by AIA Health Insurance Pty Ltd.

A3.2 Policyholder must update details

All Policyholders must inform AIA Health Insurance Pty Ltd as soon within 60 days after a change in any Memberships details.

A3.3 Consent of All Members

All Policyholders:

a) authorise AIA Health Insurance Pty Ltd to request and receive personal information from a healthcare provider or any other person in respect of a claim made under all Memberships; and

b) Warrant that in relation to all Memberships they have obtained the consent of all Members under that Policy to the authority provided by all Policyholders in Rule A3.3(a).

A4: Governing Principles

If any provision of these Rules is inconsistent with the Private Health Insurance Act, the National Health Act 1953 (Cth) or the Health Insurance Act it will be read down or severed to the extent necessary to ensure compliance with those Acts.

A5: Use of Funds

A5.1 Income to be credited to the Fund

AIA Health Insurance Pty Ltd will credit to the Fund all income arising out of the conduct of its private health insurance business and health related business as required under the Private Health Insurance Legislation, including:

a) all Premiums paid; and

b) other such moneys or income as required by the Private Health Insurance Act to be credited to the Fund.

A5.2 Limitations on drawings on the Fund

AIA Health Insurance Pty Ltd will only draw on the assets of the Fund:

a) for meeting liabilities to pay Benefits in accordance with these Fund Rules;

b) for meeting other liabilities and expenses incurred for the purposes of the business of the Fund;

c) for making investments of Fund assets; and

d) for making such other distributions, payments and transfers as may, from time to time, be permitted under the Private Health Insurance Legislation or which may from time to time be required to be paid under the Private Health Insurance Legislation.

A5.3 Management and Control of the Fund

AIA Health Insurance Pty Ltd will manage the Fund in accordance with the requirements in the Private Health Insurance Legislation, including by:

a) keeping proper accounts and records of the transactions and affairs of the Fund;

b) ensuring that all payments from the Fund are correctly made and properly authorised;

c) maintain adequate control over:

i. the assets in its custody; and

ii. the incurring of liabilities by the Fund.

A6: Improper Discrimination

In conducting the Fund and making decisions, AIA Health Insurance Pty Ltd will not engage in improper discrimination and will act in a manner which otherwise complies with the Private Health Insurance Legislation.

A6.1 Community Rating

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

1. that a person suffers from a Chronic Disease, illness or other medical Condition or from a particular kind of disease, illness or medical Condition;
2. of a person's gender, race, sexual orientation or religious belief;
3. of the age of a person, except to the extent that the Fund is required or permitted to do so by the Private Health Insurance Act in relation to matters dealt with under Part 2-3 of that Act;
4. of where a person lives, except as permitted by the Private Health Insurance Act;
5. of any other characteristic of a person (including his or her occupation or leisure pursuits) that is likely to increase his or her need for Treatments;
6. of the frequency with which a person needs Treatment;
7. of the amount or extent of the Benefits to which a person becomes entitled during a period, other than as permitted by the Private Health Insurance Act; or
8. of matters which are, from time to time, prohibited by the Private Health Insurance Act for these purposes.

A6.2 Exceptions to Community Rating

The restrictions in Fund Rule A6.1 do not apply where:

1. the Private Health Insurance Legislation otherwise permits; or
2. these Fund Rules otherwise permit.

A7: Changes to Rules

A7.1 Amendment

AIA Health Insurance Pty Ltd may amend these Rules in accordance with the Private Health Insurance Act and any other law.

A7.2 Notification of Amendment

a) Where AIA Health Insurance Pty Ltd amends or proposes to amend a Fund Rule and the amendment is or might be detrimental to the interests of a Member, AIA Health Insurance Pty Ltd will provide reasonable prior notice of the amendment to the Policyholders of affected Policies. For the avoidance of doubt, any such notice must comply with the any relevant requirements of the Private Health Insurance Legislation and the Australian Consumer Law;

b) Notice under Rule A7.2(a) will:

   i. be in writing addressed to all Policyholders who are Members under all Memberships;

   ii. be given before the change takes effect; and

   iii. explain in plain English the details of the Rule change.

c) AIA Health Insurance Pty Ltd will also notify all Members of changes with reasonable notice to the Member Guide, these Rules and Product Fact Sheets, including any necessary amendments to Private Health Information Statements which arise from the change in the Rules, as soon as practicable after the publication or Private Health Information Statement is updated.

d) Where a Member became entitled to receive a Benefit at a time when a previous Rule applied, the Benefit specified in that earlier Rule will be payable.

A7.3 Availability of Rules

These Rules are available on AIA Health Insurance's website - aia.com.au/health.

A8: Dispute Resolution

A8.1 Complaints

All Members may make a complaint about any aspect of the Fund or Memberships to AIA Health Insurance Pty Ltd at any time orally or in writing. Complaints will be dealt with by the Fund in accordance with its then current complaints policy and any codes of conduct to which it is a party at that time and otherwise in a timely and responsible manner.

A8.2 Private Health Insurance Ombudsman

a) The Private Health Insurance Ombudsman is available to assist all Members with problems they have with their private health insurer or any healthcare provider.

b) Without limiting a Member's other rights, Members may raise any issue regarding their Memberships with the Private Health Insurance Ombudsman at any time.

A9: Notices

The Fund will send all notices and correspondence to the email address supplied by all Policyholders.

A10: Winding Up

The Fund may be terminated at any time in accordance with the Private Health Insurance Legislation.

a) In the event of AIA Health Insurance Pty Ltd ceasing to be registered under the Private Health Insurance Legislation, the Fund shall be terminated in accordance with the requirements of the Private Health Insurance Legislation and these Fund Rules.

b) In the event of termination of the Fund all monies standing to the credit of the Fund and not required for meeting outstanding liabilities of the Fund, including Benefits, staff entitlements or allowances, contracted payments and all

c) other expenses of termination including the

d) requirements of the Private Health Insurance Legislation shall be utilised in such manner as may be determined by the board of directors of AIA Health Insurance Pty Ltd in accordance with the constitution of AIA Health Insurance Pty Ltd.

A11: Other

a) The Fund may waive the application of particular Rules (as identified in these Rules) in its discretion, provided the waiver does not reduce the relevant Member's entitlement to Benefits or breach the principle of community rating under the Private Health Insurance Act.

b) The waiver of a particular Rule in a given circumstance does not require the Fund to waive the application of that Rule in any other circumstance, including where a circumstance similar to the given circumstance arises again.

B. Interpretation and definitions

B1: Interpretation

In these Rules:

a) Words and phrases commencing with capital letters are defined in Rule B2.
b) Unless otherwise specified, the definitions in Rule B2 apply throughout the Rules.
c) Where a word or phrase is defined, its other grammatical forms have a corresponding meaning.
d) Where not defined, words and expressions are intended to have their ordinary meaning.
e) Headings are for convenience only and do not affect interpretation.
f) The singular includes the plural and vice versa.
g) A reference to any legislation or a provision of legislation includes all amendments, consolidations or replacements and all regulations or instruments issued under it.
h) A reference to the word 'include' in any form is not a word of limitation.

B2: Definitions

Accident: An unforeseen event, occurring by chance and caused by an external force or object which results in involuntary injury to the body requiring immediate treatment. For an accident to be covered, the Accident must have occurred at least 24 hours after the time at which the Membership was taken out with AIA Health Pty Ltd. Treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury.

Acute Care Certificate: A certificate in a form approved and required by the Fund from a Medical Practitioner confirming the need for an Admitted Patient to continue to receive acute Hospital care. An Acute Care Certificate is valid for 30 days and is required after 35 days of Continuous Hospitalisation.

Admitted Patient: means a person who has been admitted to a Hospital as a patient and is receiving services under the direction of a Medical Practitioner or dentist.

Adult: A person who is not a Child.

Age Based Discount: a Premium discount on eligible Hospital Products of two per cent for each year that a person is aged under 30 when they first purchase hospital insurance, to a maximum of 10 per cent for 18 to 25 year olds. The discount then reduces by two per cent each year from age 41.

AHSA Access Gap Cover: The approved scheme used by the Fund for the payment of medical Benefits in excess of the Medicare Benefits Schedule to provide a no gap or known gap Benefit.

Annual Benefit Limit: is the maximum amount of benefits we pay towards particular items or services, or a group of services and/or items within a calendar year.

AIA Health Insurance Pty Ltd: Includes AIA Health Insurance, myOwn Health Insurance and RACQ Health Insurance.

Ambulance: a registered road vehicle, boat or aircraft operated by an Ambulance Provider and equipped for the transport and/or paramedical treatment of persons requiring medical attention.

a) **Emergency Included Ambulance**: clinically necessary Ambulance treatment resulting in onsite treatment and/or transportation to Hospital. Onsite treatment not resulting in transport to Hospital is limited to two callouts per Member, per calendar year. Emergency Included Ambulance does not include:
    i. Ambulance Transport from a Hospital to your home, or Ambulance transfers between Hospitals;
    ii. Any services which are not operated by an Ambulance Provider recognised by the Fund;
    iii. Any non-emergency services, as determined by the Ambulance Provider.

b) **Ambulance Provider:** One of the following service providers:

i. ACT Ambulance Service;
ii. Ambulance Service of NSW;
iii. Ambulance Victoria;
iv. Queensland Ambulance Service;
v. Royal Flying Doctor Service (RFDS);
vi. South Australia Ambulance Service;
vii. St John Ambulance Service NSW (Norfolk Island Only)
viii. St John Ambulance Service NT;
ix. St John Ambulance Service WA; and
x. Tasmanian Ambulance Service.

Ambulance Transport: Where a patient is taken from point A to point B in an Ambulance and may be for emergency or non-emergency reasons.

Arrears: The amount of unpaid Premiums whenever the date to which Premiums have been paid is earlier than the current date.

Assisted Reproductive Services (ARS): Hospital Treatment for fertility treatments or procedures. For example: retrieval of eggs or sperm, In-vitro Fertilisation (IVF), and Gamete Intrafallopian Transfer (GIFT).

Australia: For the purpose of these Fund Rules includes the six states, Northern Territory, Australian Capital Territory, the Territory of Cocos (Keeling) Islands, Christmas Island and Norfolk Island, but excludes other Australian external territories.

Benefit: An amount of money or service that may be provided to a Member, on behalf of or for the benefit of a Member, to a Recognised Provider, Medical Practitioner or Hospital by the Fund in accordance with the terms of the Policy and these Fund Rules.

Benefit Replacement Period: A continuous period that must elapse between any two purchases of the same type of General Treatment item before Benefits are payable in respect of the later purchase (excluding the replacement for new models of items where the existing item is functioning correctly or the item is still under warranty). Applicable Benefit Replacement Periods are described in the associated Schedules.

Blood Glucose Monitor: A device that:

a) is a small, portable, battery-powered device for home blood glucose monitoring,
b) is approved by The Fund, and
c) has been recommended for use by the Member by a Medical Practitioner.

Blood Pressure Monitor: A device that:

a) Is used to measure blood pressure,
b) Is approved by the Fund, and
c) has been recommended for use by the Member by a Medical Practitioner.

Calendar Year: The period from 1 January to 31 December inclusive.

Certified Age of Entry: A person's certified age of entry is the age they are considered to be when they take out hospital cover. A person's certified age of entry is:

a) 30, regardless of their actual age, if they took out the cover before 1 July 2000
b) Their actual age when they took out the cover, if this occurred after 1 July 2000.

Child: Any one of the following aged under 25:

a) A natural child (including a newborn child)
b) An adopted child
c) A foster child
d) A step-child (that is, a natural, adopted or foster child of the person's Partner), or
e) A child being cared for under guardianship arrangements approved by the Fund.

Chronic Disease: A disease that has been, or is likely to be, present for at least six months including, but not limited to; asthma, cancer, cardiovascular illness, diabetes, a mental health condition, arthritis and a musculoskeletal condition.

Chronic Disease Management Program (CDMP): A program that:

a) Is intended to either:

   i. Reduce complications in a person with a diagnosed Chronic Disease; or

   ii. Prevent or delay the onset of Chronic Disease for a person with identified multiple risk factors for Chronic Disease; and

b) Requires the development of a written plan that:

   i. Specifies the allied health service or services and any other goods and services to be provided;

   ii. Specifies the frequency and duration of the provision of those goods and services;

   iii. Specifies the date for review of the plan; and

   iv. Has been provided to the patient for consent, and consent is given to the program, before services under the program are provided; and

c) Is coordinated by a person who has accepted responsibility for:

   i. Ensuring the services are provided according to the plan; and

   ii. Monitoring the patient's compliance with the agreed goals and activities specified in the plan.

Class: General treatment where all participants are provided with the same intervention simultaneously and all participants in a class do the same thing. The number of people in a class is not significant.

Clinical Categories: Categories of treatments designated by the Department of Health and Aged Care (for example joint reconstruction or ear, nose and throat).

Combined Product: A Product offered by the Fund which includes a Hospital Product and Extras Product.

Compensation: Any of the following:

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

b) A payment in accordance with a scheme of insurance or compensation provided for by Commonwealth or State law (for example, workers compensation insurance);

c) Settlement of a claim for damages (with or without admission of liability);

d) A payment for negligence; or

e) Any other payment that, in the opinion of the Fund, is a payment of compensation or damages.

Constitution: The Constitution of AIA Health Insurance Pty Ltd.

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

Contribution Group: A group of Members approved by AIA Health Insurance Pty Ltd for the purposes of Fund Rule D1.3.

Co-Payment: An amount that must be paid before a Benefit is available for non-PBS pharmaceuticals.

Cosmetic Surgery: A procedure, operation or treatment that is not medically necessary and is undertaken for the dominant purpose of improving appearance or improving self-esteem where:

a) There is no disease, deformity, injury or disorder; or

b) The deformity is the result of a normal physiological process such as pregnancy and ageing.

Cover: A defined group of Benefits payable, subject to these Fund Rules, in respect of approved expenses incurred by a Member.

Default Benefits: For the purposes of Hospital Treatment, the minimum amount payable by AIA Health Insurance Pty Ltd for that Hospital Treatment, as required in the Private Health Insurance Legislation.

Department of Health: The Department of Health and Aged Care of the Commonwealth of Australia or its successor or replacement.

Dependant: A person who is the Child of the Policyholder.

Doctor: Means a medical doctor, such as a General Practitioner or specialist.

Excess: An amount of money a Member agrees to pay a Hospital or AIA Health Insurance Pty Ltd towards the accommodation costs of a Hospital admission before Benefits are payable. The Excess is payable per person per Calendar Year.

Exclusion: A procedure, condition or service which is not Covered on the Membership and for which no Benefits are payable.

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

Extras: A Product offered by AIA Health Insurance Pty Ltd that Covers General Treatment only.

Extremity Pump: A device that:

a) designed to aid in the reduction and control of peripheral oedema, including lymphoedema of the extremities and post mastectomy lymphoedema, stasis dermatitis and venous stasis ulcers,
b) is approved by AIA Health Insurance Pty Ltd, and
c) has been recommended for use by the Member by a Medical Practitioner.

Fraud: Dishonestly obtaining a benefit, or causing loss, by deception or other means.

Fund: The health benefits fund conducted by AIA Health Insurance Pty Ltd in accordance with the Private Health Insurance Legislation.

General Treatment: Treatment (including the provision of goods and services) that is intended to manage or prevent a disease, injury or condition that is not Hospital Treatment (such as dental, optical, physiotherapy, other therapies and Ambulance). General Treatment also includes Hospital Substitution.

Health Insurance Act: *The Health Insurance Act 1973 (Cth)*.

Hearing Aids: A device that:

a) is approved by AIA Health Insurance Pty Ltd, and
b) is designed to improve a person's hearing.

Hospital: A facility which the Minister declares in writing is a hospital under the Private Health Insurance Legislation and which complies with the Private Health Insurance (Accreditation) Rules.

Hospital Product: A Product offered by AIA Health Insurance Pty Ltd which Covers Hospital Treatment and Hospital Substitution only.

Hospital Substitution: General Treatment that is treatment provided by a provider that is not a Hospital, but which substitutes for an episode of Hospital Treatment, i.e. it is the same treatment that is usually provided by a Hospital.

Hospital Treatment: Treatment (including the provision of goods and services) that is intended to manage a disease, illness, injury or condition, where the treatment is provided by a person who is authorised by a Hospital to provide the treatment or under the management or control of such a person and is either provided at a Hospital or with the direct involvement of a Hospital.

Lifetime Health Cover: Introduced by the federal government on 1 July 2000, allows health funds to charge different premiums according to a person's age when they first took out hospital cover.

Lifetime Health Cover Base Day: The later of 1 July 2000 or the 1st of July following the Member's 31st birthday.

Lifetime Health Cover Loading: If the Member does not have hospital cover on that Member's Lifetime Health Cover Base Day and decides to take out hospital cover after this time, the Member will pay a 2% loading on top of the Member's Premium for every year the Member is aged over 30. The maximum loading is 70%.

Loyalty Benefits: Some AIA Health products come with loyalty benefits and will reward you the longer you stay covered.

Medical Practitioner: A person who:

a) Is registered and 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: An agreement entered between AIA Health Insurance Pty Ltd and a Medical Practitioner as described under section 172-5(1) of the Private Health Insurance Act and as amended from time to time.

Medical Treatment: Treatment provided by a Medical Practitioner.

Medicare Benefits Schedule (MBS): The 'Medicare Benefits Schedule' published by the Department of Health and includes updates published from time to time.

Member: A person covered by a Membership.

Membership: A policy issued by AIA Health Insurance Pty Ltd providing Cover for Hospital Treatment and/ or General Treatment for which Premiums are paid in accordance with these Fund Rules.

Membership Category: Any one of the following:

a) Single Membership – The Policyholder

b) Couple Membership – The Policyholder and their Partner

c) Family Membership – The Policyholder, their Partner and one or more Dependants

d) Single Parent Membership – The Policyholder and one or more Dependants.

Mental Health Waiting Period Exemption: Members with Cover where psychiatric care is a Restricted Service are able to upgrade their Cover to access higher Benefits for in-Hospital treatment without serving a Waiting Period, subject to AIA Health having a Hospital product open that includes cover for Hospital Psychiatric Services. Members are only able to use this exemption from the existing two month Waiting Period once in a lifetime.

MIMS: Monthly Index of Medical Specialities is the leading supplier of trusted, quality, independent medicine information to Australian healthcare professionals.

Minimum Benefit: See Default Benefits

Minister: The Minister for the Department of Health or his or her delegate with powers vested in the Minister by the Private Health Insurance Legislation.

National Health Act: The National Health Act 1953.

Nebuliser Pump: A device that:

a) administers medication to people in forms of a liquid mist to the airways,

b) is approved by AIA Health Insurance Pty Ltd, and

c) has been recommended for use by the Member by a Medical Practitioner.

Nursing Home Type Patient (NHTP): A patient in a Hospital who has been a patient for a continuous period exceeding 35 days and for whom an Acute Care Certificate is currently not in force.

NHTP Benefit: The Benefit determined by the Minister for any Hospital Treatment provided to a person while they are a Nursing Home Type Patient.

Open Product: A product that is available for sale.

Optical: The provision of a sight-correcting appliance upon prescription by a Recognised Provider.

Orthopaedic Appliance: A custom made device that is used to correct disabilities, designed to increase function and decrease pain. It must be:

a) approved by AIA Health Insurance Pty Ltd;

b) custom made; and

c) recommended for use by the Member by a Medical Practitioner.

Orthotic Appliance: An item that:

a) is approved by AIA Health Insurance Pty Ltd;

b) has been custom made; and

c) has been provided by a podiatrist or orthotist.

Out of Pocket: The difference between the Benefit for a treatment or service and the provider's fees.

Participating Private Hospital Agreement: An agreement between AIA Health Insurance Pty Ltd and a Private Hospital which specifies, amongst other things, the fees that the Private Hospital may raise to Members and the Benefits AIA Health Insurance Pty Ltd will pay for certain Hospital Treatment provided to Members.

Participating Private Hospital: A Private Hospital which has entered into a Participating Private Hospital Agreement.

Partner: A legally married spouse or de facto partner, living together in a bona fide domestic relationship with the Policyholder.

Pharmaceutical Benefits Scheme (PBS): The Schedule of pharmaceutical benefits published by the Department of Health.

Policyholder: A person in whose name an application for Membership has been accepted and who is responsible for Premium payments.

Pre-Existing Condition (PEC): An ailment, illness or condition of a Member, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by AIA Health Insurance Pty Ltd (not the Member's own doctor), existed at any time during the six months preceding the day on which the Member purchased a Hospital Product or upgraded to a higher Hospital Product and/or Benefit entitlement.

It is not necessary for a Member to be aware of the ailment, illness or condition for it to be considered pre-existing.

Premium: The amount of money a Policyholder is required to pay AIA Health Insurance Pty Ltd for a Membership to remain financial.

Pressure Garments: An item that:

a) is a tight fitting elastic glove, sock, facemask or body jacket, that when worn places pressure on the body;

b) is approved by AIA Health Insurance Pty Ltd; and

c) has been recommended for use by the Member by a Medical Practitioner, physiotherapist or occupational therapist.

Previous Cover: a private health insurance product that was previously held by an individual that is a complying health insurance product under the Private Health Insurance Act.

Private Health Information Statement: A summary of the key features of a Product that contains the information and is in the form set out in the Private Health Insurance (Complying Product) Rules.

Private Health Insurance Act: *The Private Health Insurance Act 2007 (Cth)*.

Private Health Insurance Legislation: The Private Health Insurance Act, Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and their regulations, rules and other instruments under them and consolidations, amendments, re-enactments or replacements of any of them.

Private Hospital: A Hospital, including a day Hospital, not operated by a State or Territory Government and declared by the Minister to be a private Hospital.

Private Patient: A person who is admitted to a Public Hospital or Private Hospital who is not a Public Patient.

Private Practice: 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 (as is the case with a Public Hospital or publicly funded facility) but through the leveraging of fees directly to recipients of treatment, goods or services.

Product: A defined group of Memberships that Cover the same treatments and provide Benefits that are worked out in the same way for approved expenses incurred by a Member and whose terms and conditions are the same as each other.

Public Hospital: A Hospital which is owned by a State or Territory government, receives government funding and is declared by the Minister as a public Hospital.

Public Patient: A person admitted to a Public Hospital who receives treatment, goods or services by a doctor appointed by the Public Hospital without charge to the person.

Recognised Provider: A provider of General Treatment (whether the provider is an individual or an organisation) who:

a) is approved by AIA Health Insurance Pty Ltd as a provider of relevant treatment, goods or services;

b) holds all necessary registrations, licences or approvals under relevant State legislation to render the relevant treatment, goods or services including in relation to the premises from which the treatment, goods or services are to be, or are being, provided; and

c) complies with all other requirements of the Private Health Insurance (Accreditation) Rules.

Restricted Service: Hospital Treatment for which only the Default Benefit is payable.

Schedule: Any of the Product Schedules attached to these Fund Rules.

Sleep Apnoea Monitor: A device that:

a) Involves a mask worn at night attached to a monitor that keeps the back of the throat open by forcing air through the nose;
b) Is approved by AIA Health Insurance Pty Ltd; and
c) Has been recommended for use by the Member by a Medical Practitioner.

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

Suspension: The temporary discontinuation of a Membership in accordance with these Fund Rules.

Tens Monitor: A device that:

a) Is a battery-powered unit which sends electrical impulses through electrodes placed on or near the painful site,
b) Is approved by AIA Health Insurance Pty Ltd; and
c) Has been recommended for use by the Member by a Medical Practitioner.

Transfer Certificate: a certificate issued by a private health insurer, in a form approved under the Private Health Insurance Legislation, detailing full health insurance cover details and claim histories of a person transferring from the fund operated by that insurer and meeting the required criteria as detailed in the Private Health Insurance Legislation.

Waiting Period: A period during which a Member must hold continuous Membership under a particular Product before the Member has an entitlement to receive a Benefit at the level payable on that Product.

C. Membership

C1: General Conditions of Membership

C1.1 Applicable Benefits Arrangements

Members who are covered under the same Membership must:

a) belong to the same Product Category; and
b) have the same Product or Products.

C1.2 Policy Categories

Unless otherwise stated in the Schedules, a person may be admitted as a Member of one of the Membership Categories in respect of one of the following Products:

a) Any level of Hospital Product set out in Schedule H or I;
b) One of the Extras Products only available as Combined Products set out in Schedule J or L;
c) One of the Extras Only products set out in Schedule K.

C1.3 Change of Membership Details

Policyholders are required to advise AIA Health Insurance Pty Ltd of any changes to Membership details within 60 days of such changes. AIA Health Insurance Pty Ltd is not obligated to allow any changes to have effect greater than two months prior to the date advised.

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

a) Change of residential and/or postal address;
b) Change of contact details such as email address or telephone number;
c) Change of Premium payment details or Premium payment method;
d) Change of details or method for receipt of Benefits;
e) Change of Dependant status;
f) Change of name;
g) Change of Partner;
h) Additions to a policy such as a newborn baby.

C2: Eligibility for Membership

C2.1 Generally

Any person may be eligible for any Product or combination of Products as set out in and in accordance with Fund Rule C1.2.

AIA Health Insurance Pty Ltd Products are designed for people who have full Medicare eligibility and, while AIA Health Insurance Pty Ltd will not refuse Membership to people on the basis of their residency or Medicare status, potential Members who are classed as overseas visitors may be responsible for large Out of Pocket expenses if they are not a permanent resident or do not have full Medicare eligibility.

C2.2 Minimum Age of Contributors

Unless otherwise approved by AIA Health Insurance Pty Ltd, a person under 18 is not eligible to be a Policyholder.

C2.3 Dual Memberships

To the extent that a Member has made a claim for a particular treatment or service under a private health insurance policy of another private health insurer, the Member will not be able to submit a claim for that treatment or service to AIA and AIA will not pay Benefits towards that treatment or service.

C3: Rights of Policyholders

C3.1 the Policyholder

a) Is responsible for the payment of Premiums;
b) May make any changes to the Membership as required;
c) Can submit claims on behalf of all Members of the Membership;
d) Can cancel the Membership
e) Can, in writing or in any other approved way, request that the Partner be treated as authorised to operate the Membership (except to cancel the Membership) as if the Partner is the Policyholder. The Policyholder may withdraw this authority at any time by written notice.
f) Can, in writing or in any other approved way, request a person not on the Policy be treated as authorised to access personal and sensitive information about the Membership and claim on the Policyholder's behalf. This person will not be authorised to make any changes to the Membership, and will only be able to access information to the extent required to administer the policy and lodge claim. This person will not be able to access sensitive health information about another Member on the Membership without that Member's express consent to AIA Health Pty Ltd..
g) Can, in writing and with an accompanied legal document, request that a Power of Attorney (POA) be treated as authorised to operate the Membership (including cancelling the membership) as if the as if the POA is the Policyholder.

C3.2 a Partner

a) May make changes to their own details;
b) May submit claims on behalf of all Members of the Membership;
c) If authorised as set out in Rule C3.1.e, make any changes to the Membership as required;
d) Who ceases to be a Member on a Membership with a Policyholder can join AIA Health Insurance Pty Ltd without serving any Waiting Periods (other than the balance of the unexpired Waiting Period for that Benefit under the previous Membership) if:
    i. the Benefits provided under the new Product are no higher than the Benefits provided under the previous Membership;
    ii. the person applies for a Membership within 60 days of ceasing to be a Member on the previous Membership; and
    iii. the person backdates their policy start date to the day after the termination of their previous Membership.

C3.3 Any other Member on the Membership

a) May submit claims on behalf of all Members on the Membership.

C4: Dependants

Dependants are Covered on a Family or Single Parent Membership until they are 25 years of age.

A person who ceases to be eligible to be a Dependant on a Membership can join AIA Health Insurance Pty Ltd without serving any Waiting Periods (other than the balance of the unexpired Waiting Period for that Benefit under the previous Membership) if:

a) The Benefits provided under the new Product are no higher than the Benefits provided under the previous Membership; and
b) The person applies for a Membership within 60 days of ceasing to be a Dependant.
c) The Dependant backdates their policy start date to their 25th birthday and pays the relevant Premium.

C5: Membership Applications

C5.1 Form of Application

a) Applications for Memberships will be in the form required by AIA Health Insurance Pty Ltd from time to time.

b) Applications for Memberships must be accompanied by any proof of details reasonably required by AIA Health Insurance Pty Ltd from time to time.

C5.2 Payment of Premiums with Application

An application for a AIA Health Insurance Pty Ltd Policy will be accepted only where the Premiums for the minimum period relevant to the applicant as specified by AIA Health Insurance Pty Ltd from time to time have been paid. AIA Health Insurance Pty Ltd may waive this Rule in its discretion.

C5.3 Refusal of Applications

a) Subject to these Rules and the Private Health Insurance Act, AIA Health Insurance Pty Ltd may at its discretion refuse an application to join as a Member.

b) If AIA Health Insurance Pty Ltd refuses an application, AIA Health Insurance Pty Ltd will provide a reason for the refusal to the applicant.

C5.4 Cooling Off Period

A 30-day cooling off period applies to all Memberships. Premiums for new Members are fully refundable if they decide to cancel the Policy within the first 30 days of the commencement of the Policy providing no claims have been made during that time.

C5.5 Changes to Cover

Members who have changed their level of cover under a Policy can also revert to the previous cover within 30 days with no impact on Waiting Periods or Loyalty Benefits (if applicable) providing the Member was on an Open Product and no claims have been made during that time. If a claim is made within 30 days the Policy can only be cancelled or changed from the day after the date of service of the claim.

C6: Duration of Membership

C6.1 Commencement of Policy

Subject to AIA Health Insurance Pty Ltd.'s acceptance of an application for a Policy, a Policy commences on the date on which an application for the relevant Policy is accepted with AIA Health Insurance Pty Ltd in accordance with Rule C5 or where AIA Health Insurance Pty Ltd agrees, such other date nominated in the application.

C6.2 Termination of Policy

A Policy terminates:

a) On the date it is cancelled by a Policyholder in accordance with Rule C8; or

b) On the date the Policy is terminated in accordance with Rule C9.

C7: Transfers

C7.1 Transfers from another private health insurer or Visitors Cover within 2 months

Where a person who was insured under a Previous Cover transfers to a Product with a break in coverage of 2 months or less:

a) AIA Health Insurance Pty Ltd may apply all relevant Waiting Periods to any Benefits under the new Product that were not provided under the Previous Cover;

b) where a Benefit payable by AIA Health Insurance Pty Ltd under the new Product is higher than that payable under the Previous Cover, the lower benefit will be paid from AIA Health Insurance Pty Ltd until the required Waiting Period with AIA Health Insurance Pty Ltd has been served;

c) AIA Health Insurance Pty Ltd may apply all relevant Waiting Periods to the unexpired portions of any Waiting Periods not fully served under the Previous Cover; and

d) Where the Excess on the new Product is lower than the Excess on the Previous Cover, the Excess on the Previous Cover will apply until the unexpired Waiting Period has been served.

e) Visitors Cover: includes Overseas Visitors Health Cover, (OVHC) Overseas Workers Health Cover (OWHC) and Overseas Student Health Cover. (OSHC)

To assess if Waiting Periods may apply, new Members must provide a transfer certificate or appropriate policy documentation from their previous insurer.

C7.2 Transfers from another private health insurer outside 2 months

Where a person who was insured under a Previous Cover transfers to a Product with a break in coverage of more than 2 months, the person will be treated as a new Member to the extent permitted under the Private Health Insurance Act and AIA Health Insurance Pty Ltd may apply the Waiting Periods in full.

C7.3 General Treatment Benefits paid under Previous Cover may be taken into account

Where a person who was insured under a Previous Cover transfers to a Product with a break in coverage of 2 months or less, AIA Health Insurance Pty Ltd will take into account any General Treatment Benefits that have been paid in the relevant Calendar Year under the Previous Cover in calculating Annual Benefits Limits and determining the General Treatment Benefits payable under the new Product for the remainder of that Calendar Year.

C7.4 Transfers to another private health insurer

If a Member transfers to a policy of private health insurance with another private health insurer, AIA Health Insurance Pty Ltd will provide the Member, or another such person as they nominate with a Transfer Certificate in accordance with the Private Health Insurance Act.

C8: Cancellation of Membership

C8.1 Cancellation Requests

The Policyholder (or their Power of Attorney) may cancel a Membership by advising AIA Health Insurance Pty Ltd in writing or as otherwise agreed by us. The date of cessation of the Membership will be the later of the:

a) date requested by the Policyholder or their Power of Attorney (provided the Membership is paid to that date); or

b) date of the most recent claim paid in respect of the Membership.

If the Policyholder (or their Power of Attorney) does not nominate a date of cessation, it will be the date on which AIA Health Insurance Pty Ltd received the Policyholder's (or their Power of Attorney's) request for cancellation.

A Partner or Dependant Child who is aged 18 or over may remove himself or herself from a Membership by notifying AIA Health Insurance Pty Ltd in writing. The date of cessation will be the later of the date requested by the Partner or Dependant Child and the date AIA Health Insurance Pty Ltd receive the notice.

AIA Health Insurance Pty Ltd will issue the Policyholder a Transfer Certificate within 14 days of the Policyholder ceasing to be Covered under a Membership.

If a Membership is to be cancelled due to the death of a Policyholder, the cancellation will take effect from the day after his or her death.

C8.2 Refund of Premiums

If the Policyholder cancels the Membership before the date on which the next Premium is due, AIA Health Insurance Pty Ltd will reimburse any Premiums paid in advance of the termination date.

Where a refund is owing following the death of a Policyholder, AIA Health Insurance Pty Ltd will refund any Premiums paid in respect of the period after the cancellation date to the Estate of the Policyholder.

C9: Termination of Membership

C9.1 Termination Generally

AIA Health Insurance Pty Ltd may terminate the Policy of any Policyholder or terminate a Member from a Membership by providing notice on any of the following grounds:

a) the application for the Membership is discovered to have been incomplete or inaccurate in a manner that has a material impact on the Fund;

b) the Membership is in Arrears for a period of more than 2 months.

c) Economic Sanctions

AIA Health Insurance Pty Ltd are subject to certain laws and economic sanctions (both local and international) which may prohibit AIA Health Insurance Pty Ltd from completing some financial transactions and/or dealings with the Policyholder and any Members.

AIA Health Insurance Pty Ltd will not deal with any actual or proposed Policyholder or Members or complete a financial transaction under the terms of the Membership if AIA Health Insurance Pty Ltd is prohibited from doing so by law (including a law relating to sanctions). AIA Health Insurance Pty Ltd may also take such other action as permitted or required by law (including a law relating to sanctions).

C9.2 Termination of Membership Where Member Acts Improperly

AIA Health Insurance Pty Ltd may, by notice in writing to the Policyholder, terminate the Policy of any Policyholder or terminate a Member from a Membership where, in the opinion of AIA Health Insurance Pty Ltd:

a) any Member had committed or attempted to commit Fraud upon AIA Health Insurance Pty Ltd;

b) any Member materially or repeatedly breached any of these Fund Rules or any other term or condition of Membership

c) any Member included in the Membership has behaved inappropriately towards staff, providers or other Members of AIA Health Insurance Pty Ltd in a serious or material manner, or repeatedly continues to act inappropriately following warnings to cease that inappropriate behaviour.

C9.3 Member Entitlements on Termination

Unless Fund Rule 9.1.a or 9.2.a apply, if a Membership is terminated or cancelled in accordance with Fund Rules 8 and 9:

a) the termination of the Membership will not affect any rights accrued by the Member prior to the date of termination; and

b) the Member will be entitled to a pro-rata refund of any Premium paid for any period beyond the date of termination, subject to the Membership not being in the cooling off period where no claims have been made.

C10: Temporary Suspension of Membership

C10.1 Overseas Travel

Members may suspend their Membership for periods of overseas travel by advising AIA Health Insurance Pty Ltd over the phone or as otherwise agreed by AIA Health Insurance Pty Ltd provided they:

a) Have held 12 months continuous Membership with AIA Health Insurance Pty Ltd since joining;
b) Have had a minimum of 6 months active Cover since any previous Suspension for overseas travel;
c) Have paid Premiums to the date of departure;
d) Will be overseas for at least 4 weeks and not more than 3 years; and
e) Apply for Suspension prior to departure.

A Policyholder with two different types of Cover (i.e. a Hospital Product and Extras) may not suspend one Cover without also suspending the other.

Suspensions can apply to the Membership or individual Members as required; however, Dependants cannot remain on a policy without a Policyholder.

C10.2 Effect of Suspension

During the Suspension of a Membership:

a) The Policyholder is not required to pay Premiums in respect of the Membership; and
b) Any Member Covered by the Policy is not entitled to payment of Benefits for services provided during the Suspension.

C10.3 Effect of Suspension on Waiting Periods

Periods of Suspension do not count towards Waiting Periods. Therefore, the balance of all outstanding Waiting Periods must be served upon reactivation of Membership.

C10.4 Reactivation of Policy

Memberships will be automatically reactivated based on the date provided by the Member. If the Member's reactivation date changes whilst overseas it is the Member's responsibility to inform AIA Health Insurance Pty Ltd.

C10.5 Date of Suspension

If an application for Suspension is accepted by AIA Health Insurance Pty Ltd, the Suspension will take effect from the day after departure or where AIA Health Insurance Pty Ltd agrees, such other date nominated in the application.

C10.6 Subsequent Suspensions

a) A Policyholder who has previously suspended their Policy may only apply for a subsequent Suspension where 6 months have lapsed since the reactivation of the Policy following a previous Suspension; and
b) AIA Health Insurance Pty Ltd may waive this Rule in its discretion.

C11: Other

C11.1 Private Health Information Statements

a) AIA Health Insurance Pty Ltd will provide a Private Health Information Statement to the Policyholder on commencement of a Policy and at least once every 12 months. On commencement of a Membership, the Policyholder will also receive details about what the Membership Covers and how Benefits under it are calculated, and a statement identifying the Membership is referable to the Fund.
b) AIA Health Insurance Pty Ltd will maintain and make available Private Health Information Statements to all Members on request.

D. Contributions

D1: Payment of Contributions

D1.1 Payment of Premiums

Members and/or their Employers must pay Premiums in advance by direct debit from a bank account or credit card. Available payment frequencies are fortnightly, monthly and yearly. Where agreed with AIA Health, an employer can also make payments on a quarterly or six monthly frequency.

D1.2 State Premiums

Premiums may differ based on the State or Territory in which the Member permanently resides.

D1.3 Contribution Groups

AIA Health Insurance Pty Ltd may, at its discretion, approve any group of Members to be a Contribution Group. A Contribution Group may include, but is not limited to:

a) Employees of an organisation;
b) Members of an association;
c) AIA Health Insurance Pty Ltd staff;
d) Brand ambassadors.

D2: Contribution Rate Changes

D2.1 Change of Premium Rates

AIA Health Insurance Pty Ltd may change the Premium rates for a Product in accordance with these Fund Rules and the Private Health Insurance Act, and will provide Policyholders with reasonable notice of any changes to Premiums before the change takes effect.

D2.2 Premium Rate changes as a result of changes to Products

Premium rates may change as a result of:

a) a change in Premiums in line with the Private Health Insurance Act;
b) a change in Product;
c) a change in Excess level;
d) a change in the State of residence; or
e) a change in Membership Category.

D2.3 Premium Rate Protection

Subject to changes under Rule D2.2, where Premiums are paid by or on behalf of a Policyholder in advance, a Premium rate change that takes effect during the period in which that Policyholder's Premiums have been paid in advance will not take effect until the Policyholder's next Premiums fall due.

D3: Contribution Discounts

D3.1 Discounts on Premiums

Discounts may be applied up to 12% per annum in accordance with Private Health Insurance Legislation, in addition to any Age Based Discounts.

D3.2 More than one discount

Subject to compliance with the Private Health Insurance Act, Fund Rule D3.1, and restrictions that AIA Health Insurance Pty Ltd may impose on combinations of discounts from time to time, a Policyholder is entitled to multiple discounts.

D3.3 Age Based Discounts

Premium discounts of up to 10% will be available to Members aged 18 to 29 on eligible Hospital Products.

Eligibility Criteria:

All AIA Health Basic, Basic Plus, Bronze, Bronze Plus, Silver and Silver Plus Hospital (excluding Silver Plus Advanced Hospital and Silver Plus Family Hospital) product variants (hospital only and combined) are eligible to receive an Age Based Discount. In addition, all AIA Health Corporate product variants (hospital only and combined) are eligible to receive an Age Based Discount.

D3.4 Age Based Discount Application

a) the Age Based Discount will be based on a Member's age when they become insured under an eligible Hospital Product.
b) Age Based Discounts start at 10% for Members aged 18-25 and decrease by 2% each year to age 29.
c) where a Hospital Product Covers more than one Adult the amount of discounted Premiums is calculated by averaging the discounted Premiums applicable to each Member.
d) a Member receiving an Age Based discount will continue to receive the discount until the age of 41 whilst they remain on an eligible Product. After age 41, the discount will be removed at a rate of 2% per year until the age of 45.
e) any Age Based Discount that a Member was receiving at a previous fund will be recognised by AIA Health Insurance Pty Ltd if that member joins, on an eligible Product and within 2 months of leaving their previous insurer.

D4: Lifetime Health Cover

D4.1 Lifetime Health Cover Application

Subject to the remainder of this Rule D4, AIA Health Insurance Pty Ltd must increase the Hospital Product Premiums applying to an Adult if the Adult:

a) was not Covered by a Hospital Product on his or her Lifetime Health Cover Base Day; or
b) ceases to be Covered by a Hospital Product after his or her Lifetime Health Cover Base Day.

D4.2 Certified Age of Entry

Any increase in Premiums under this Rule must be calculated based on the criteria required in relation to Lifetime Health Cover under the Private Health Insurance Legislation.

AIA Health Insurance Pty Ltd must stop increasing Premiums under Rule D4 where required by the Private Health Insurance Legislation.

D4.3 Loading Not to Apply

AIA Health Insurance Pty Ltd must not increase Premiums under Rule D4 if:

a) at the time the Adult first took out a Hospital Product with a private health insurer, the 1st of July following the Adult's 31st birthday had not arrived; or
b) the Adult was Covered by a Hospital Product on and since 1 July 2000 , unless otherwise required by the Private Health Insurance Legislation; or
c) the Adult was born on or before 1 July 1934; or
d) an Adult who turned 31 on or before 1 July 2000 was overseas on 1 July 2000; or
e) the Adult is the subject of a determination (with effect immediately before 1 April 2007) under clause 10 of Schedule 2 of the National Health Act.

D4.4 Lifetime Health Cover Loading

The Premium payable:

a) under rule D4.1.a increases by 2% of the Premium for each year the Adult's Lifetime Health Cover Age is above 30 up to 70% of the Premium where the Adult is not Covered by a Hospital Product; and

b) under rule D4.1.a increases by 2% for each year the Adult is not Covered by a Hospital Product (calculated in accordance with section 34-5 of the Private Health Insurance Act).

D4.5 Lifetime Health Cover Loading for Couples

Where a Hospital Product Covers more than one Adult the amount of increased Premiums is calculated by averaging the increased Premiums applicable to each Adult in accordance with section 37-20 of the Private Health Insurance Act.

D4.6 Lifetime Health Cover and Age Based Discount on the Same Policy

In circumstances where an Age Based Discount and Lifetime Health Cover loading are applicable on the same policy, the discount and loading will be applied to the relevant person's proportion of the policy's base rate for Hospital Cover.

D4.7 Lifetime Health Cover Loading Removal

The Lifetime Health Cover Loading is removed after 10 years continuous Hospital Cover (not counting any Permitted Days Without Hospital Cover) but may start again if the Member ceases to have a Policy which Covers Hospital Treatment as specified in the Private Health Insurance Act. Lifetime Health Cover recognises continuous Cover even if the Member has had a Policy which Covers Hospital Treatment from more than one health fund.

D4.8 Continuity of Cover

Continuity for the purposes of Lifetime Health Cover is preserved during a period in which the Member ceases to have a Policy that Covers Hospital Treatment for a cumulative period of 1,094 days or otherwise in accordance with the Private Health Insurance Act (known as Permitted Days Without Hospital Cover). However, after exceeding 1,094 Permitted Days Without Hospital Cover, a person must pay an additional loading of 2% of the Premium for every year without Hospital Cover (excluding Permitted Days Without Hospital Cover) on top of any previous loading. If a person takes out a Hospital Product again after exceeding 1,094 Permitted Days Without Hospital Cover, the person must re-serve 10 years of continuous Hospital Cover before Premiums stop increasing.

D5: Arrears in Contributions

D5.1 Memberships in Arrears

A Membership (other than a suspended Membership) is in 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 Member during a period of Arrears.

b) Subject to Rules D5.3 and D5.4, a Policyholder may regain an entitlement to Benefits for such treatment by paying all outstanding Premiums including the minimum amount of advance Premiums relevant to the Policyholder, as specified in Rule D1.1.

D5.3 Maximum Period of Arrears

When a period of Arrears exceeds 60 days, AIA Health Insurance Pty Ltd may terminate a Membership with effect from the date the last Premium was paid to with written notice to the Policyholder.

E. Benefits

E1: General Conditions

E1.1 Benefits Available

Details of Benefits available under each Product are set out in the relevant Schedule of these Fund Rules.

E1.2 Treatment to be provided by Recognised Providers

Benefits are payable only where treatment is provided by a Recognised Provider. AIA Health Insurance Pty Ltd recognises the following providers:

a) Hospitals (as defined in these Rules);
b) Medical Practitioners;
c) Pathology/imaging providers for in-hospital treatment;
d) Hospital substitution providers; and
e) General Treatment providers who are:
    i. In independent Private Practice,
    ii. For each relevant class of service or treatment, satisfy all applicable recognition criteria with Medicare or other industry body such as the Australian Regional Health Group and Australian Health Practitioner Regulation Agency (AHPRA) as approved by AIA Health Insurance Pty Ltd;
    iii. Holds all necessary registrations, licences or approvals under relevant State legislation to render the relevant treatment, goods or services including in relation to the premises from which the treatment, goods or services are to be, or are being, provided; and
    iv. complies with all other requirements of the Private Health Insurance (Accreditation) Rules.

E1.3 Providers who Fail to meet Recognition Requirements

AIA Health Insurance Pty Ltd will not pay Benefits in relation to any claim for a treatment or service that was provided to a Member by a provider who was not a Recognised Provider at the time of the treatment or Service.

E1.4 No Benefit payment unless permitted by legislation

Irrespective of anything else contained within these Rules, AIA Health Insurance Pty Ltd will not pay a Benefit to Members 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, AIA Health Insurance Pty Ltd Benefit may be reduced by the amount claimable from the other source, and
c) Where in the opinion of AIA Health Insurance Pty Ltd the charge is higher than the provider's usual charge for the service, AIA Health Insurance Pty Ltd may assess the claim as if the provider's usual charge had been applied.

E1.6 Providers Treating Themselves, Family Members, and Business Partners and Family

Benefits are not payable for treatment rendered by a provider to:

a) The provider's Partner, Dependants, or business partner, or
b) Family members of the provider and the provider's business partner including: wife/ husband, brother/sister, children, parents, grandparents and grandchildren, or
c) The provider themselves,
d) The Partner or Dependants of the provider's business partner, or
e) Any other person not independent from the practice.

E1.7 Benefit Assessment

AIA Health Insurance Pty Ltd may reasonably request information from a Policyholder or their health service provider prior to or after the payment of Benefits. Information requested will be directly related to a claim where the Policyholder has made a declaration requesting Benefits be paid to the Policyholder or their health service provider.

Such information may include but is not limited to:

a) Invoices;
b) Receipts;
c) Treatment Plans;
d) Prescriptions; and
e) Medical/Patient records and clinical notes.

Benefits are not payable if a claim contains false or misleading information or if the Recognised Provider has engaged in fraudulent activity.

E1.8 Benefit Restitution

AIA Health Insurance Pty Ltd 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;
d) Information is received after the claim has been paid which establishes that the Benefit should not have been paid.

E1.9 Limitations on Consultations provided on the Same Day

AIA Health Insurance Pty Ltd will only pay benefits towards one consultation per provider for the same or related treatment per day .

E1.10 Obligations of Recognised Providers

A Recognised Provider must:

a) Undertake in a diligent and professional manner the provision of treatment, goods or services to Members and maintain the quality of the treatment, goods or services;
b) Comply with each law, and each requirement arising from a law, and hold and maintain every required licence, permission and registration necessary to provide treatment, goods or services to Members including as required by the Private Health Insurance (Accreditation) Rules;
c) Conform to the general standards required by all relevant regulatory bodies;
d) Not act in a way which brings AIA Health Insurance Pty Ltd into disrepute;
e) Not provide information to AIA Health Insurance Pty Ltd which is false or misleading;
f) Not mislead or deceive AIA Health Insurance Pty Ltd in any other manner including by failing to provide true and full information at any time;

g) Not act or attempt to act improperly to:

   i. Obtain an unfair advantage for himself/ herself or another person; or

   ii. Cause loss or damage to AIA Health Insurance Pty Ltd; and

h) Only provide attendance on a patient one on one and the Recognised Provider must be in attendance and must remain accessible during the entire course of the consultation and treatment.

E1.11 Ex- Gratia Benefits

AIA Health Pty Ltd may pay Benefits on an Ex-gratia basis, at its discretion.

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 these Fund Rules and associated Schedules.

AIA Health Insurance will pay benefits towards MBS item numbers listed in clinical categories Covered by the Membership.

E2.2 Same Day Patients

Benefits for same day Hospital accommodation are payable only where the Member is an Admitted Patient in a Participating Private Hospital.

E2.3 Day Hospital Facilities

In order for Benefits to be payable towards treatment for Members when they are an Admitted Patient at a Day Hospital Facility, that Day Hospital Facility needs to be appropriately registered in accordance with the Private Health Insurance Legislation or other relevant laws.

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 Private Health Insurance Legislation. These patient classifications are:

   i. Surgical

   ii. Advanced Surgical

   iii. Obstetric

   iv. Other (Medical)

   v. Psychiatric Care

   vi. Rehabilitation

c) AIA Health Insurance Pty Ltd may permit further sub- classifications of Patients when not inconsistent with these guidelines.

E2.5 Patient Classification Surgical and Advanced Surgical Patients

Subject to 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 Obstetrics 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.

E2.7 Patient Classification Rehabilitation Patients

a) Rehabilitation Patient means an Admitted Patient or outpatient receiving treatment for rehabilitation.

b) Approved Rehabilitation Program means a program that is approved by AIA Health Insurance Pty Ltd for the purpose of paying Benefits at the Rehabilitation Patient rate.

c) Benefits at the Rehabilitation Patient rate are payable subject to the following conditions:

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

   ii. AIA Health Insurance Pty Ltd requires the treatment to be supported by a rehabilitation care certificate in a form approved by AIA Health Insurance Pty Ltd or some other form of documentation to support the need for the Member to participate in a Program to assist in recovery from an acute catastrophic illness or injury.

   iii. The service is not a Restricted Service under the Cover.

d) Subject to the service not being a Restricted Service under the Cover, Benefits for Rehabilitation for Members who receive treatment in other than an approved rehabilitation Program are payable at the applicable Other (Medical) rate.

E2.8 Patient Classification Psychiatric Patients

Benefits for psychiatric care patients are payable at the Psychiatric Care rate subject to the following conditions:

a) The Member is Covered for psychiatric admissions or has used the Mental Health Waiting Period Exemption to upgrade their level of Cover.

b) Treatment must be supported by a psychiatric care certificate;

c) A further psychiatric care certificate is required:

   i. For each period specified in any certificate where treatment as a psychiatric care beyond 35 days is provided; and

   ii. For any subsequent readmission as a psychiatric care patient that does not constitute Continuous Hospitalisation.

Psychiatric care Benefits are not payable for any Member under the custodial care of a State or Territory.

If Psychiatric admissions are a Restricted Service under the Cover, AIA Health will only pay Default Benefits.

Subject to the service not being a Restricted Service under the Cover, Benefits for psychiatric patients who receive treatment in other than an approved psychiatric Program are payable at the Other (Medical) rate.

E2.9 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 these Fund Rules, where a Patient undergoes more than one operative procedure during the one theatre admission, the procedure with the highest fee in the Medicare Benefits Schedule determines the Patient's classification.

E2.11 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 AIA Health Insurance Pty Ltd for this purpose.

E2.13 Continuous Hospitalisation

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

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) AIA Health Insurance Pty Ltd has negotiated Participating Private Hospital Agreements. These agreements provide Members Covered by a Hospital Product or Combined Product (subject to any Exclusions and/or Restricted Services) with Cover for accommodation (shared and/or private room depending on level of Hospital Product), theatre, delivery suite, intensive/coronary care and a range of services provided by the Participating Private Hospital (subject to any Excess and/or Co-Payment applying).

b) Where a Member is charged for a professional medical treatment or service where a Medical Purchaser-Provider Agreement applies, the Benefits will, unless otherwise stated in these Fund Rules, be as specified in the Medical Purchaser-Provider Agreement.

c) Where a Hospital does not have a Participating Private Hospital Agreement with AIA Health Insurance Pty Ltd or a Medical Practitioner does not have a Medical Purchaser-Provider Agreement with AIA Health Insurance Pty Ltd, Default Benefits will be paid in accordance with the Private Health Insurance Legislation. Significant Out of Pocket expense may be incurred for treatment in non-Participating Private Hospitals or for medical costs where there is no Medical Purchaser-Provider Agreement in place with AIA Health Insurance Pty Ltd. Members should contact AIA Health Insurance Pty Ltd for further details.

E2.15 AHSA Access Gap Cover

The Schedules referred to in these Fund Rules shall provide that the Benefits under AHSA Access Gap Cover arrangements are payable subject to the following conditions:

a) a Medical Practitioner who provides medical services in a Hospital under AHSA Access Gap Cover shall give the Member written advice of any amount the Member can reasonably be expected to pay for those services.

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

c) the recipient of the advice acknowledges receipt of the advice.

E2.16 Pharmaceuticals provided in Participating Private Hospitals

a) where a Hospital Product includes Benefits for PBS medications supplied to an Admitted Patient of a Participating Private Hospital, the Benefit will meet the full cost of the pharmaceutical if it is directly related to the treatment for which the Member was admitted and the treatment is Covered under the Hospital Product;

b) the full cost referred to in a) includes the patient Co-Payment, and any special or patient contribution, brand premium or therapeutic premium otherwise payable by the patient under the Pharmaceutical Benefits Scheme; and

c) benefits for non-PBS medications supplied to Members are payable in accordance with the Participating Private Hospital Agreement if:

   i. the Benefit is specifically included in the Participating Private Hospital Agreement; and
   ii. the pharmaceutical is directly related to the treatment for which the Member is admitted.

d) The Benefits described in E2.16.a–c are only payable for pharmaceutical items that are:

   i. approved by the Therapeutic Goods Administration for use in Australia only for the purposes of its permitted ARTG indications;
   ii. published within the MIMS schedule;
   iii. where the item is intrinsic to the patient's episode of care; and/or
   iv. not rendered as part of a research/clinical trial.

e) No Benefits are payable for:

   i. contraceptive drugs;
   ii. drugs issued for the sole purpose of use at home under a Hospital Cover;
   iii. ward drugs;
   iv. pharmacy items charged in a Public Hospital;

Any agreement under a Participating Private Hospital Agreement may override this Rule.

E2.17 Medical Devices and Human Tissue Products

AIA Health Insurance Pty Ltd will pay Benefits towards Hospital Treatment or Hospital-Substitute Treatment Covered by the Membership that involves the provision of a medical device or human tissue product of a kind listed in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules in circumstances:

a) in which a Medicare benefit is payable and, if those Private Health Insurance (Medical Devices and Human Tissue Products) Rules set out conditions that must be satisfied in relation to the provision of the medical device or human tissue product in those circumstances, those conditions are satisfied; or

b) set out in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for the purposes of this item and, if those Rules set out conditions that must be satisfied in relation to the provision of the medical device or human tissue product in those circumstances, those conditions are satisfied.

E2.18 Hospital-Substitute Treatment

AIA Health Insurance Pty Ltd will only Cover Hospital- Substitute Treatment that is provided by a Recognised Provider who is appropriately qualified and experienced in that area where a Medical Practitioner has certified that the treatment being provided replaces hospitalisation.

E2.19 Nursing Home Type Patient

If the Member becomes a Nursing Home Type Patient, AIA Health Insurance Pty Ltd will pay Nursing Home Type Patient Benefits for the duration of the Member's classification as a Nursing Home Type Patient.

If a Member requires a hospital admission for longer than 35 days, that Member may be considered to be a Nursing Home Type Patient (NHTP). Benefits are payable at a different rate to non-NHTP patients. A Member will be required to make a contribution to the cost of the Member's care at a rate declared by the Minister from time to time to Cover the cost of the Members hospital accomodation charges.

E2.20 Regional Travel and Accommodation

a) Benefits will be paid for travel subject to the following conditions;

   i. This benefit only applies when an inpatient hospital procedure has taken place;
   ii. All calculations and rules apply to applicants primary place of residence;
   iii. Primary place of residence is defined as the residential address as listed on AIA Health Insurance Pty Ltd policy;
   iv. Service provider must be located more than 100kms from applicants primary place of residence;

v. Private car travel - benefit calculated based off the most direct route as per Google Maps;
vi. Benefits are payable towards Travel & Accommodation for the night prior, duration of, and night post admission. This includes same day procedures;
vii. Travel Benefits are available per member per episode; at a rate of $0.15 per km;
viii. This benefit will not be payable until a corresponding hospital account has been received and processed on the patients membership.

b) Benefits will be paid for a support person subject to the following conditions;
   i. Benefits payable for 1 support person to accompany the patient;
   ii. Support person(s) must travel together with the patient to be eligible to claim benefits;
   iii. All benefits relating to Travel & Accommodation claims will be paid against the patient's membership.

c) Benefits will be paid for accommodation subject to the following conditions;
   i. A member can claim a maximum benefit of $50 per day for accommodation

d) State based schemes
   i. Australian States and Territories offer assistance for Regional Travel and Accommodation. Please contact the Department of Health in your State or Territory for further information;
   ii. If you're entitled to receive a State or Territory benefit on your Travel & Accommodation expenses, you cannot claim your Out of Pocket with AIA Health Insurance Pty Ltd. Once you are no longer eligible to claim with your State or Territory, eligible claims can be processed by AIA Health Insurance Pty Ltd.

E3: General Treatment

E3.1 Annual Limits

AIA Health Insurance Pty Ltd will pay Benefits for General Treatment (other than Hospital-Substitute Treatment) up to any limit per period (if any) that applies to your Cover. Benefits will reset each calendar year on January 1.

E3.2 Recognised Providers

AIA Health Insurance Pty Ltd will only pay Benefits for General Treatment (not where provided as part of Hospital Treatment) where it is provided:

a) by or on behalf of a Recognised Provider in Private Practice; and
b) where services are provided face to face, or telehealth consultations.

For the avoidance of doubt, AIA Health Insurance Pty Ltd will not pay Benefits for treatment provided by someone who was not a Recognised Provider at the time that person provided the treatment. AIA Health Insurance Pty Ltd has sole and absolute discretion in determining if someone becomes or remains a Recognised Provider and for which of their treatments AIA Health Insurance Pty Ltd will pay Benefits. AIA Health Insurance Pty Ltd may choose to "de-recognise" someone from being a Recognised Provider for reasons including, but not limited to, fraudulent behaviour or the agreement governing the relationship between AIA Health Insurance Pty Ltd and that person comes to an end.

E3.3 Doctors Letter of Recommendation

The following services require a doctor's letter of recommendation in support of claims:

a) Blood Glucose Monitor;
b) Blood Pressure Monitor;
c) Extremity Pump;
d) Hearing aids;

e) Nebuliser Pump;
f) Orthopaedic Appliances;
g) Pressure Garments;
h) Sleep Apnoea Monitor;
i) Swimming Lessons;
j) Tens Monitors; and
k) Non-surgical prostheses.

E3.4 Agreements with General Treatment Providers

AIA Health Insurance Pty Ltd 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 our Products. Lists of providers of General Treatment with whom AIA Health Insurance Pty Ltd have agreements are available on our website.

E3.5 Benefit Restrictions

AIA Health Insurance Pty Ltd will only pay Benefits towards the same or related service of General Treatment provided by a Recognised Provider in Private Practice per day.

F. Limitation of benefits

F1: Co-Payments

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

F2: Excess

The amount of the Excess and relevant limits and conditions are specified in the Schedule relevant to the Policyholder's Cover.

F3: Waiting Periods

Waiting Periods will apply to:

a) New Memberships (previously uninsured);

b) Additions to a Membership (unless the addition/s has already served all Waiting Periods with AIA Health Insurance Pty Ltd or another private health insurer) except newborns; and

c) Existing Memberships and transfers to AIA Health Insurance Pty Ltd from another private health insurer where the level of cover and/or benefit entitlement is upgraded or increased (including by reducing the Excess payable) and/or where the Waiting Periods have not been completed.

F3.1 Application of Waiting Periods

Unless otherwise permitted by AIA Health Insurance Pty Ltd, subject to Fund Rule C6, a Member must serve the Waiting Periods set out in this Fund Rule F3 before Benefits are payable by AIA Health Insurance Pty Ltd under a Product.

F3.2 Waiting Periods for newborns, Adopted or Fostered Children

Newborns, adopted and/or fostered children who are added to a policy within 6 months of their date of birth or adoption/ fostering, where that Membership has been active for at least two months will not be required to serve any Waiting Periods. Step children who are added to a policy within 6 months of their biological parent being added to the Membership, where that Membership has been active for at least 2 months will not be required to serve any Waiting Periods.

Other Dependants that have not held Previous Cover will inherit any remaining waiting periods applicable to the Policyholder.

Normal portability rules will apply in the case where a Child is transferring from another private health insurer.

The Policyholder is required to provide foster/adoption paperwork when registering a foster or adopted child as a dependant.

F3.3 Waiting Periods Hospital Treatment

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

a) Obstetrics related Services – 12 months.

b) Treatment for Pre-Existing Conditions (as provided in Rules F3.5 to F3.7) other than those treatments specified in c) and d) – 12 months.

c) All rehabilitation and palliative care regardless of whether it is a Pre-Existing Condition – 2 months.

d) Psychiatric treatment – 2 months (regardless of whether the condition was a Pre-Existing Condition). Mental Health Waiting Period Exemption is available for upgrading members once in a lifetime after the initial 2 month wait has been served.

e) All other services – 2 months.

f) Accident Cover – 24 hours.

F3.4 Waiting Periods General Treatment

The following Waiting Periods apply to a Benefit for General Treatment for the services shown (where relevant to the Member's Cover):

All services and items except those listed below – 2 months

a) Optical services – 6 months;
b) Medically prescribed health appliances such as Blood Glucose Monitor, Extremity Pump, Pressure Garments, Sleep Apnoea Monitor, Tens Monitor, Blood Pressure Monitor, Nebuliser Pump, Orthopaedic Appliances, non-surgical prostheses – 12 months;
c) Major dental treatment including crowns and bridgework, oral surgery, endodontics, dentures and orthodontics – 12 months.

F3.5 Pre-Existing Condition (PEC) Waiting Period

a) AIA Health Insurance Pty Ltd 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) This rule also applies where a Member transfers to another Cover which provides higher Benefits for the relevant treatment.

F3.6 PEC Information from Treating Practitioner(s)

Subject to the Private Health Insurance Act:

a) AIA Health Insurance Pty Ltd may appoint a medical or other relevant practitioner to determine whether or not a condition for which treatment may be provided and Benefits may be 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 Member in the six months prior to their becoming a Member or changing their Cover, and
    ii. Any other material that AIA Health Insurance Pty Ltd reasonably considers as relevant to the claim.
c) AIA Health Insurance Pty Ltd may suspend consideration of a claim until such time as:
    i. The Member (or Policyholder where appropriate) authorises the release of the information referred to in b), and
    ii. This information has been provided to AIA Health Insurance Pty Ltd, and
    iii. The relevant practitioner referred to in a) has reviewed the information referred to in b), and
    iv. AIA Health Insurance Pty Ltd is in receipt of the PEC form 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.

F3.7 PEC Waiting Period Not to Apply Where AIA Health Insurance Pty Ltd Alters the Cover

a) Where AIA Health Insurance Pty Ltd has changed the terms of a Cover, any higher or additional Benefits now available to existing Members of the Cover are not subject to an additional Pre-Existing Condition Waiting Period.
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 Exclusion of Benefits

Benefits are not payable in the following cases:

a) For any treatment or service occurring within the Waiting Periods;
b) For any treatment or service during a period where contributions are in Arrears or the Membership is suspended;
c) For any treatment or service for which no fee was charged;

d) Treatment where the Member is eligible for free treatment under any Commonwealth or State Government Act or program;
e) For treatment or services or an item where the expense was incurred by the employer of that Member or if the Member obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances;
f) If a Membership application or claim contains false, misleading or fraudulent information.
g) For any treatment, service or good provided or purchased overseas
h) For pharmaceuticals that are available under the Pharmaceutical Benefits Scheme (PBS) (in respect of Extras Cover),
i) For pharmaceuticals not considered as a S4 or S8 drug by the Therapeutic Goods Administration;
j) All contraceptives;
k) For treatment provided more than two years ago;
l) For medical treatment provided to a Member who is an outpatient;
m) Services or treatment rendered by a practitioner not in Private Practice;
n) Foot orthotics by any provider who is not a podiatrist or orthotist; and/or the orthotic appliance is not custom made;
o) Orthopaedic Appliances that are not custom made and purchased for support purposes only; and
p) for any Cosmetic Surgery, unless there is a material medical need for such surgery to be performed.

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

F4.2 Non-Residents

Hospital and medical Benefits to Members who are non-residents of Australia are limited by their Medicare entitlements. If a Member is a non-resident, holding an AIA Health Insurance policy allows you to avoid the Medicare Levy Surcharge if earning above the income threshold. However, it does not provide cover for in hospital services and could leave you with significant Out of Pocket expense.

F5: Benefit Limitation Periods

Effective 1 July 2018, no Benefit Limitation Periods apply to any Cover.

F6: Restricted Benefits

Default Benefits are only payable for Restricted Services as detailed in the associated Schedules.

F7: Compensation Damages and Provisional Payment of Claims

F7.1 Definitions

In Fund Rule F7:

a) A reference to a “Claim” includes a claim, demand, action, proceeding, litigation, judgment or award other than a claim for Benefits;
b) A reference to an “injury” includes a condition, ailment or injury for which Benefits would or may otherwise be, payable by AIA Health Insurance Pty Ltd 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 Member, and
    ii. Compensation paid to another Member on the same Membership in connection with an injury suffered by the Member.

F7.2 Obligations of a Member

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

a) Inform AIA Health Insurance Pty Ltd as soon as the Member knows or suspects that such a right exists;
b) Inform AIA Health Insurance Pty Ltd of any decision of the Member 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 AIA Health Insurance Pty Ltd.'s satisfaction;
e) Keep AIA Health Insurance Pty Ltd informed and updated as to the progress of the Claim for Compensation, and
f) Inform AIA Health Insurance Pty Ltd immediately upon the determination or settlement of the Claim for Compensation.

F7.3 Entitlement of 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 the injury where the Member has received, or may be entitled to receive, Compensation in respect of that injury.
b) The expenses referred to in Fund Rule F7.3a) include expenses incurred after the Member has received any Compensation.

F7.4 AIA Health Insurance Pty Ltd May Provisionally Withhold Payment

Where a Member appears to have a right to make a Claim for Compensation in respect of an injury but that right has not been established, AIA Health Insurance Pty Ltd may, at its discretion, elect not to assess a claim for Benefits in respect of expenses incurred in relation to that injury until the Member has taken all reasonable steps to pursue enquiries in relation to the Claim for Compensation to AIA Health Insurance Pty Ltd.'s satisfaction.

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, AIA Health Insurance Pty Ltd 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, AIA Health Insurance Pty Ltd may consider factors such as unemployment or financial hardship or any other factors it considers relevant.
c) A provisional payment is conditional upon the Member signing a legally binding undertaking and acknowledgement supplied by AIA Health Insurance Pty Ltd, which contains an agreement by the Member, in consideration for the payment:
    i. To disclose to AIA Health Insurance Pty Ltd on request, all matters pertaining to the progress of the Claim for Compensation and details of any determination made or any settlement reached in respect of the Claim for Compensation;
    ii. To repay to AIA Health Insurance Pty Ltd the full amount of the provisional payment as a debt immediately repayable upon the award or settlement of the Claim for compensation, 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
    iii. That AIA Health Insurance Pty Ltd has specified rights of subrogation whereby AIA Health Insurance Pty Ltd acquires all rights and remedies of the Member in relation to the Claim for Compensation.

F7.6 Where Benefits have been paid by AIA Health Insurance Pty Ltd

a) Subject to Fund Rule F7.9, where:
    i. AIA Health Insurance Pty Ltd has paid Benefits, whether by way of provisional payments or otherwise, in relation to an injury; and
    ii. The Member has received Compensation in respect of that injury,

The Member must repay to AIA Health Insurance Pty Ltd the full amount that AIA Health Insurance Pty Ltd paid in relation to the injury, upon the determination or settlement of the Claim for Compensation. If the full amount that AIA Health Insurance Pty Ltd paid in relation to the injury exceeds the determination or settlement of the Claim for Compensation, then the Member

is only required to repay the amount of the determination or settlement of the Claim for Compensation to AIA Health Insurance Pty Ltd (subject to the Member's compliance with Fund Rule F7.2).

b) This Fund Rule applies whether or not:

i. The determination or settlement sum includes the full amount that AIA Health Insurance Pty Ltd 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 Member complied with their obligations under Fund Rule F7.2.

F7.7 Rights of AIA Health Insurance Pty Ltd

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

a) Comply with any obligation in Fund Rule F7.2 or F7.6; or

b) Include in their Claim for Compensation any payments of Benefits by AIA Health Insurance Pty Ltd in relation to any injury,

AIA Health Insurance Pty Ltd 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 for Compensation; and/or

ii. Pursue the Member for repayment of all Benefits paid by AIA Health Insurance Pty Ltd in to the injury; and/or

iii. Assume the legal rights of the Member in respect of all or any parts of the Claim for Compensation.

F7.8 Claim Abandoned Where:

a) a Member has or may have a right to make a Claim for Compensation in respect of an injury, and

b) AIA Health Insurance Pty Ltd reasonably determines that the Member has abandoned or chosen not to pursue that Claim,

Benefits are payable (subject to other Fund Rules) if the Member signs a legally-binding undertaking supplied by AIA Health Insurance Pty Ltd by which the Member agrees, in consideration for the payment of Benefits, not to pursue that Claim.

F7.9 Requirements to Repay Benefits may be Waived

Where, in respect of a Member's Claim for Compensation in relation to an injury:

a) The Member has complied with Fund Rule F7.2, and

b) AIA Health Insurance Pty Ltd 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 AIA Health Insurance Pty Ltd, AIA Health Insurance Pty Ltd may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the Member need not repay any part or the full amount of the Benefits paid by AIA Health Insurance Pty Ltd in respect of that injury.

F7.10 Benefits for Expenses Subsequent to Compensation

AIA Health Insurance Pty Ltd 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 a 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.

F7.11 Future medical expenses

a) Where it is anticipated that a Member has future medical needs in relation to an injury, the Member must use reasonable endeavours to procure an award or settlement of a Claim for Compensation that includes a specified allocation for future medical expenses.

b) On request by AIA Health Insurance Pty Ltd, a Member must provide evidence to AIA Health Insurance Pty Ltd to establish whether a determination or settlement of a Claim for Compensation includes an allocation for future medical expenses.

c) Where a determination or settlement of a Claim for Compensation includes an allocation for future medical expenses in relation to an injury:

   i. the Member must use that allocation to pay for treatment of that injury;

   ii. AIA Health Insurance Pty Ltd may refuse to pay Benefits for treatment relating to that injury until the allocation is exhausted;

   iii. the Member must keep and provide to AIA Health Insurance Pty Ltd evidence to establish that the allocation has been exhausted on expenses for treatment of that injury; and

   iv. If the Member cannot provide such evidence, or the allocation has been exhausted on expenses other than for treatment of that injury, AIA Health Insurance Pty Ltd may refuse to pay Benefits for treatment relating to that injury.

d) Where a Member has complied with their obligations in Fund Rule F7.11a) but a determination or settlement of a Claim for Compensation does not include a specified allocation for future medical expenses, AIA Health Insurance Pty Ltd will pay Benefits for treatment rendered after the determination or settlement in relation to the relevant injury in accordance with the Membership terms.

F7.12 Cancellation/Termination of Membership

A Member's obligations under these Fund Rules continue despite any termination or cancellation of Membership.

G. Claims

G1: General

G1.1 Form of Claim

Claims for Benefits must:

a) Be in a manner approved by AIA Health Insurance Pty Ltd

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 full name, provider number, qualification and address;

   ii. The patient's full name and address;

   iii. The date of service;

   iv. A description of the service;

   v. Tooth numbers where a dental treatment has taken place on an individual tooth;

   vi. The amount charged; and

   vii. Any other information that AIA Health Insurance Pty Ltd may reasonably request.

G1.2 Documents to Remain Property of AIA Health Insurance Pty Ltd

All documents submitted in a claim become the property of AIA Health Insurance Pty Ltd, unless otherwise agreed by AIA Health Insurance Pty Ltd.

G1.3 Claims to be Lodged Within Two Years

Benefits are not payable when a claim for Benefits is lodged more than two years after the date of service. AIA Health Insurance Pty Ltd may waive this rule at its discretion.

G1.4 Claims to be Paid Within Two Months

Subject to Fund Rules F3.6.c and G1.3, AIA Health Insurance Pty Ltd shall, at a maximum within 60 days of receipt of a claim (but otherwise in a prompt manner), assess it and pay any Benefits payable under these Fund Rules.

G1.5 Claims to be Paid after Treatment Provided

Benefits are only payable after treatment has been provided.

G1.6 Incorrect or Fraudulent Claims

If a claim is found to be incorrect, AIA Health Insurance Pty Ltd may, at its discretion, do any one or more of the following:

a) Offset the amount paid against future claims; and

b) Seek repayment of the Benefit paid by AIA Health Insurance Pty Ltd.

G1.7 Fraudulent Claims

If a claim is found to be fraudulent, AIA Health Insurance Pty Ltd may, at its discretion, do any one or more of the following:

a) Suspend all claiming;

b) Offset the amount paid against future claims;

c) Seek repayment of the Benefit paid by AIA Health Insurance Pty Ltd;

d) Notify the appropriate authorities; and

e) Terminate the Membership in accordance with Fund Rule C9.2.

G2: Other

G2.1 Manner of Benefit Payment

AIA Health Insurance Pty Ltd pays Benefits by electronic funds transfer. AIA Health Insurance Pty Ltd may request information from a Member that it reasonably requires in order to assess a claim.

AIA Health
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AIA Health is a signatory to the Private Health Insurance Code of Conduct.

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AIA Health Insurance Pty Ltd (ABN 32 611 323 034)

03/25 – PHI8277