Effective as at 1 June 2024

Fund Rules

WESTFUND HEALTH INSURANCE

Contents

A INTRODUCTION

A1 Rules Arrangement

Words or expressions in **Capital Bold** are defined in Fund Rule B2 and are intended to be interpreted accordingly.

These rules consist of:

1. **General Conditions** (Fund Rules A-G)

2. **Product Schedules** (for Schedules I-M refer to Policy Summaries)

A2 Health Benefits Fund

A2.1 These are the rules of Westfund Ltd ABN 55 002 080 864 (Westfund), which trades as Westfund Health Insurance. These rules relate to the health benefits fund of Westfund that is registered under the Private Health Insurance (Prudential Supervision) 2015 (Cth) (**PHIPS Act**) as a private health insurer. The Constitution of Westfund Ltd refers to these rules as "by-laws".

A2.2 These rules govern the establishment and operation of the health benefits fund and describe the obligations, requirements and entitlements of **Members** and the obligations, requirements and entitlements of Westfund in the operation of its health benefits fund.

A2.3 The health benefits fund relates solely to the health insurance business and health-related business of Westfund, as defined in the Private Health Insurance Act 2007 (Cth) (**PHI Act**).

A3 Obligations to Insurer

A3.1 A person applying to be a **Member** shall:

- comply with the requirements of Westfund; and
- give full and complete disclosure on all matters required by Westfund.

A3.2 A **Member** shall inform Westfund as soon as reasonably possible after a change in any **Policy** details such as:

- change of address;
- change of contact details;
- change of name;
- change of marital status of a **Dependant**;
- a **Dependant** ceasing to be a **Dependant.**

A4 Governing Principles

A4.1 These rules govern the operation of the **Fund** in conjunction with:

- the **PHI Act** and any Rules made under that act;
- the **PHIPS Act** and any Rules made under that act;
- any conditions of registration imposed on Westfund, or any directions made by the **Minister**, under the **PHI Act**;
- the *Health Insurance Act 1973* and any regulations made under that act;
- the circulars of the Australian Prudential Regulation Authority;
- the circulars of the Department of Health and Aged Care;
- any conditions from the Commonwealth Ombudsman;
- Westfund's Constitution.

A4.2 Where the **PHI Act** or the **PHIPS Act** or the *Health Insurance Act 1973* is in clear conflict with these rules these acts take precedence over these rules. Where no clear conflict is in existence then these rules take precedence.

A5 Use of Funds

A5.1 The following amounts must be credited to the **Fund**:

a) **Premiums** payable under **Policies** of insurance that are referrable to the **Fund**;
b) amounts paid to Westfund in relation to a liability under Part 3 Division 9 of the **PHIPS Act** in relation to the **Fund;**
c) income from the investment of assets of the **Fund**;
d) money paid to or by Westfund under a judgement of a court relating to any matter concerning the business of the **Fund** or any failure to comply with Part 3 of the **PHIPS Act** in relation to the **Fund**;
e) any other money received by Westfund in connection with its conduct of the business of the **Fund**; and
f) any other amounts specified in **APRA** rules made for the purpose of section 27(1) of the **PHIPS Act**.

A5.2 The assets of the **Fund** must not be applied for any purpose other than:

- meeting **Policy** liabilities and other liabilities, or expenses, incurred for the purposes of the business of the **Fund** including **Policy** liabilities and other liabilities that are treated, in accordance with a restructure or arrangement approved under Division 4 of the **PHIPS Act**, as **Policy** liabilities and other liabilities incurred for the purposes of the **Fund**; or
- making investments in accordance with s30 of the **PHIPS Act**; or
- making a distribution under Part 3 Division 5 of the **PHIPS Act**; or
- a purpose specified in the **APRA** rules for the purposes of section 28(2)(b) of the **PHIPS Act**.

A6 No Improper Discrimination

A6.1 When conducting the **Fund** and making decisions in relation to **Members** or persons seeking to become **Members**, subject to section 55.5 of the **PHI Act,** Westfund will not have regard to the following matters:

- the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or
- the gender, race, sexual orientation or religious belief of a person; or
- the age of a person, except to the extent allowed under Part 2-3 (lifetime health cover) or subsection 63-5(4) of the **PHI Act** (refer to D5);
- where a person lives, except to the extent allowed under subsection 66-10(2) or section 66-20 of the **PHI Act**; or
- any other characteristic of a person (including, but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for **Hospital Treatment** or **General Treatment**; or
- the frequency with which a person needs **Hospital Treatment** or **General Treatment**; or
- the amount or extent of the **Benefits** to which a person becomes entitled during a period under a **Complying Health Insurance Policy**, except to the extent allowed under section 66-15 of the **PHI Act**; or
- any matter set out in the Private Health Insurance (Complying Product) Rules for the purposes of section 55-5(2)(h) of the **PHI Act**.

A7 Changes to Rules

A7.1 The **Fund** may vary, delete or add to these rules at any time in accordance with the **PHI Act** with effect as set out in the relevant notice, whether or not **Premiums** have been paid in advance. Changes to rules apply to all **Members** immediately regardless of a **Member's** paid to date.

A7.2 The **Fund** may waive at its discretion the application of particular rules provided that the waiver does not reduce the relevant **Member**'s entitlement to **Benefits**.

A7.3 The rules of the **Fund** that are in force at the date of the provision of a service for which a **Fund Benefit** under these rules is provided, are the rules which shall govern the provision of that **Fund Benefit**. If a **Benefit** is claimed for a service that occurred before the commencement of these rules and the **Member** was entitled to a **Benefit** under the previous rules then the **Benefit** payable shall be in accordance with the previous rules.

A7.4 The **Fund** will give a relevant **Private Health Information Statement** to the **Primary Member** at least once every 12 months.

A7.5 If a proposed change to the rules:

- is or might be detrimental to a **Member**; and
- will require an update to the **Private Health Information Statement** relevant to the **Member**,

then the **Fund** will ensure that the **Primary Member**:

- is informed of the proposed change a reasonable time before the change takes effect, as required by section 93-20 of the **PHI Act**; and
- is given the relevant updated **Private Health Information Statement** as soon as practicable after the statement is updated.

A7.6 If a proposed change to the rules is or might be detrimental to a **Member** and will not require an update to the **Private Health Information Statement** relevant to the **Member**, Westfund will ensure that the **Primary Member** is informed of the proposed change a reasonable time before the change takes effect.

A8 Dispute Resolution

A8.1 A **Member** may make a complaint about any aspect of his or her **Policy** at any time.

A8.2 The **Fund** will endeavor to respond to the complaint as quickly and efficiently as possible.

A8.3 Disputes involving claims shall be referred to the **Medical Adviser**, **Dental Expert** or other appropriate expert appointed by Westfund. If, following receipt of the expert's advice, Westfund rejects the claim, the expert's advice to Westfund shall be made available to the **Member** concerned.

A8.4 The Commonwealth Ombudsman is available to assist **Fund Members** who have been unable to resolve disputes. However, the **Member** should give Westfund the opportunity to resolve the dispute before going to the Ombudsman.

A9 Notices

A9.1 Rules requiring written notice in these rules such as changes in **Premiums** or detrimental changes in **Fund Benefits** will be communicated to the affected **Primary Member**, at the last address supplied to Westfund.

A9.2 Westfund may provide notice of changes (other than changes in **Premiums** or detrimental changes in **Fund Benefits**) or other information to a **Primary Member** by:

- publication on Westfund's internet web site; or
- any electronic transmission; or
- any other reasonable means.

A9.3 Copies of these rules are available to **Members** upon request.

A9.4 The **Primary Member** shall inform Westfund as soon as reasonably possible after a change in the **Primary Member's** address.

A10 Winding Up

A10.1 In the event of Westfund ceasing to be registered under the **PHIPS Act,** the **Fund** shall be wound up in accordance with the requirements of the **PHIPS Act**.

A10.2 In the event of the winding up of the **Fund** all monies not required for meeting outstanding liabilities, staff allowances, contracted payments and other expenses of winding up including the requirements of the **PHIPS Act**, shall be utilised in such manner as may be required by the **PHIPS Act**.

A11 Other

A11.1 **Premiums** paid in advance can be credited to another **Policy** should the **Member Transfer** to another Westfund **Policy**.

A11.2 Any specified entitlements accrued to a **Member** under a former **Policy** shall be deemed to accrue to the **Member** under a new **Policy** if the **Member Transfers** to a **Policy** that contains the specified entitlement that accrues.

A11.3 If a **Member Transfers** without interruption to a new **Policy**, any limitation or qualifying period being met on the former **Policy** shall be applied towards meeting the same or similar limitation or qualifying period on the new **Policy**.

A11.4 Where Westfund has paid any monies to a **Member** in error or the monies were not lawfully due to the **Member**, Westfund is entitled to recover such monies from the **Member,** including by way of offset against any future **Benefit** entitlements.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

B1.1 These rules shall be interpreted so as not to conflict with Westfund's Constitution;

B1.2 Where not defined, words and expressions are intended to have their ordinary meaning;

B1.3 The masculine gender shall include, where applicable, the feminine gender;

B1.4 Words in the singular number shall include the plural and words in the plural shall include the singular;

B1.5 Unless otherwise specified, words defined in the **PHI Act** (including Schedule 1 to the **PHI Act**), the **PHIPS Act** and the Health Insurance Act 1973 shall have the same meaning in these rules;

B1.6 In these rules, a reference to a statute or legislative instrument or a provision in a statute or legislative instrument shall be read as if the words "or any amendment or re-enactment thereof or provision substituted therefor" be added;

B1.7 In these rules, a reference to a **Contract** or a provision in a **Contract** shall be read as if the words "or any amendment thereof or provision substituted therefor" be added.

B2 Definitions

In these rules or other Westfund documentation unless the contrary intention appears:

Access Gap Scheme means the approved scheme conducted by the Australian Health Service Alliance providing above **MBS** benefit payments where medical practitioners charge within agreed fee schedules and provide **Informed Financial Consent** to patients.

Accident means accidental bodily injury caused solely and directly by external means requiring an Admitted Episode of Care within seven days of the accident. An accident is determined by the admitting Hospital.

Accident Excess Waiver means the **excess** amount that would normally be payable by the **Member**, will be paid by Westfund where a **Member** has required an **Admitted Episode of Care** as the direct result of an **Accident.**

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

Admitted Episode of Care means an admission to a **Hospital** in order to receive the level of care that is only available as an inpatient. The patient must have undergone the admission process and then the discharge/separation process by the facility before it can be classed as an admitted episode of care.

Admitted Patient Care means an admitted patient as defined in the National Health Data Dictionary.

Adult means a person who is not a **Dependant**.

Adult Dependant means**:**

- a person who is between the age of 25 and 30 (inclusive)
- is not in a relationship on a bona fide domestic basis.

Adult Disability Dependant means;

- is aged over 18
- defined as dependent person with a disability as outlined in the **PHI Act**.

Age-Based Discount means a discount on private health insurance for persons aged between 18 and 29 years.

Age-Based Discount Policy means an insurance **Policy** that provides **Age-Based Discounts**.

Ambulance means the **Policy** prescribed in Schedule I17.

Annual Group Limit means the maximum amount of **Benefits** that can be claimed for an individual service or group of services outlined within that group subject to **Item Limits** and **Sub-limits** that may apply. The **Annual Group Limit** is per **Calendar Year**.

APRA means the Australian Prudential Regulation Authority.

Athlete Core Extras means the **Policy** prescribed in Schedule I18.

Athlete Defend Extras means the **Policy** prescribed in Schedule I19.

Athlete Gold Hospital means the **Policy** prescribed in Schedule J58.

Athlete Guard Extras means the **Policy** prescribed in Schedule I20.

Athlete Protect Extras means the **Policy** prescribed in Schedule I22.

Athlete Shield Extras means the **Policy** prescribed in Schedule I23.

Athlete Silver Plus Hospital means the **Policy** prescribed in Schedule J59.

Athlete Silver Hospital means the **Policy** prescribed in Schedule J60.

Athlete Vital Extras means the **Policy** prescribed in Schedule I25.

Australia means the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), Norfolk Island, the Territory of Cocos (Keeling) Islands and the Territory of Christmas Island.

Australian Resident has the same meaning as set out in the Health Insurance Act 1973.

Base Rate means the same as set out in section 34-1 of the **PHI Act.**

Basic Hospital means the **Policy** prescribed in Schedule J57.

Benefit means an amount of money payable or the provision of appliances under a **Policy** specified in these rules.

Board means the Board of Directors of Westfund.

Bronze Hospital means the **Policy** prescribed in Schedule J63.

Bronze Plus Hospital means the **Policy** prescribed in Schedule J56.

Calendar Year means the twelve month period from 1 January to 31 December in a year.

Cardiac Monitors means Holter Monitors, Heart Event Monitors and Mobile Cardiac Telemetry.

Choice Extras means the **Policy** prescribed in Schedule I26.

Chronic Disease Management Program is a program approved by Westfund that is intended to

a) reduce complications in a person with a diagnosed chronic disease; or
b) prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease,

and otherwise meets the requirements set out in the Private Health Insurance (Health Insurance Business) Rules.

Claimable Period means a continuous period of time that can elapse for the maximum **Item Limit** to be exhausted.

Complying Health Insurance Policy is an insurance **Policy** that meets the following requirements of the **PHI Act**:

- the community rating requirements in Division 66 of the **PHI Act**; and
- the coverage requirements in Division 69 of the **PHI Act**; and
- if the **Policy** covers **Hospital Treatment** – the benefit requirements in Division 72 of the **PHI Act**; and
- the **Waiting Period** requirements in Division 75 of the **PHI Act**; and
- the portability requirements in Division 78 of the **PHI Act**; and
- the quality assurance requirements in Division 81 of the **PHI Act**; and
- any requirements set out in the Private Health Insurance (Complying Product) Rules for the purposes of section 63-10 of the **PHI Act**.

Complying Health Insurance Product is a product made up of **Complying Health Insurance Policies**. A product is all **Policies** that cover the same treatments, and that provide **Benefits** that are worked out in the same way, and whose other terms and conditions are the same as each other.

Contract has the same meaning as **Purchaser-Provider Agreement**.

Contribution Group means a group of **Members** approved by Westfund for the purposes of Rule D1.2 and may include a group based on employment, membership of a professional association, time as a **Policy** holder or other basis which is permitted by the **PHI Act**.

Co-Payment means an amount payable by a **Member** for each day of **Hospital Treatment** or **Hospital-Substitute Treatment**. The **Co-Payment** is either paid by the **Member** or subtracted from any **Benefit** which would otherwise be payable.

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

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

Dental Expert means a registered dental practitioner appointed by Westfund to give technical advice on dental matters.

Dental Schedule means the Schedule referred to in Schedule M1 used to determine **Benefits** payable per item number.

Dental Top Up means the additional dental **Benefit** that can be used for those **Members** on **Ultimate Pro Extras, Ultimate Extras, Athlete Defend Extras, Athlete Protect Extras** and **Athlete Shield Extras Policies**. The **Dental Top Up** can be used on any **General Dental** item (excluding 119, 141, 944, 949, 984, 990 and 999) or **Major Dental** item up to 100% of the difference between the cost of the service and the dental **Benefit** paid.

Dependant means:

- a natural, adopted or foster child of the **Primary Member**; or
- a stepchild of the **Primary Member** (that is, a natural, adopted or foster child of a **Partner**); or
- a child being cared for under guardianship arrangements granted by a court of law of the **Primary Member** or **Partner**.
- And includes, for the purposes of these rules, a **Dependant Child**, **Adult Dependant**, **Adult Disability Dependant** or **Non-Classified Dependant** of the **Primary Member** or **Partner**.

Dependant Child/ren means:

- a person under the age of 18; and
- is not in a relationship on a bona fide domestic basis.

Devices for Sleep Apnoea and diagnosed snoring means CPAP Machines, EPAP Treatment, oral appliances for diagnosed snoring , APAP Machines and BiPAP Machines.

Discount Assessment Date means whichever of the following is applicable in relation to a person who is insured under an **Age-Based Discount Policy**:

a) subject to paragraph (c), if the **Policy** provided **Age-Based Discounts** as at the date the person became insured – that date;
b) if the **Policy** provided **Age-Based Discounts** at a date after the person became insured – the date the person was first eligible for an **Age-Based Discount** under the **Policy**;
c) if:
   (i) the person transferred to the **Policy** (the new **Policy**) from another **Age-Based Discount Policy** (the old **Policy**); and
   (ii) at the time of the **Transfer**, the new **Policy** was stated to be **a Retained Age-Based Discount Policy**; and
   (iii) the person was not a **Dependant** under the old **Policy**; the person's **Discount Assessment Date** under the old **Policy**.

Emergency Ambulance Transport is ambulance transportation of an unplanned and non-routine nature for the purpose of providing immediate medical attention to a person in the opinion of the treating medical officer. This can include;

- transport to **Hospital** requiring treatment at an emergency department
- transport to **Hospital** requiring admission

Essential Pro Extras means the **Policy** prescribed in Schedule I14.

Excess means an amount payable by a **Member** for **Hospital Treatment** or **Hospital-Substitute Treatment** in a **Calendar Year** where the payment would normally attract the **Benefit** in accordance with the **Policy.** The **Excess** is either paid by the **Member** or subtracted from any **Benefit** which would otherwise be payable.

Excluded Natural Therapy Treatment means any of the following treatments:

- Alexander technique;
- aromatherapy;
- Bowen therapy;
- Buteyko;
- Feldenkrais;
- Western herbalism;
- homeopathy;
- iridology;
- kinesiology;
- naturopathy;
- Pilates;
- reflexology;
- Rolfing;
- shiatsu;
- tai chi; and
- yoga.

Exclusion means the **Policy** does not cover treatment for that condition**.**

Forced Retrenchment Suspension means the suspension of a **Policy** or **Member** as a result of the **Primary Member** or **Spouse/Partner** being unemployed due to retrenchment on the ground of redundancy.

Fund means the health benefits fund operated by Westfund as a private health insurer under the **PHIPS Act**.

General Dental means Diagnostic services (items 011-091), Preventive, Prophylactic and Bleaching services (items 111-171), Extractions (items 311-324), Restorative services (items 511-525, 531-535, 541-555, 571-579, 595-598), General services (items 911-972) and Miscellaneous (items 981-982, 985-999) performed by a **Recognised Provider.**

General Treatment as set out in section 121-10 of the **PHI Act.**

General Treatment Policies are those outlined in Schedule I.

Gold means the **Policy** prescribed in Schedule J1.

Gold Complete Hospital means the **Policy** prescribed in Schedule J61.

Gold Ultimate Hospital means the **Policy** prescribed in Schedule J62.

Gold Classic means the **Policy** prescribed in Schedule J25.

Gold Hospital means the **Policy** prescribed in Schedule J52.

Health Management Program means a program approved by Westfund that is intended to ameliorate a specific health condition or conditions, but does not include treatment that is **Excluded Natural Therapy Treatment**.

High Extras means the **Policy** prescribed in Schedule I12.

High Extras Over 50s means the **Policy** prescribed in Schedule I16.

Hospital means a private hospital, a public hospital or a day hospital facility declared by the **Minister** pursuant to section 121-5(6) of the **PHI Act**.

Hospital Policy means a **Policy** provided to meet the cost of **Hospital Treatment** and associated **Professional Services** prescribed under Schedule J.

Hospital-Substitute Treatment as set out in section 69-10 of the **PHI Act.**

Hospital Treatment as set out in section 121-5 of the **PHI Act.**

Hospital Treatment Policies are those outlined in Schedule J.

Informed Financial Consent is the consent to treatment obtained by a doctor from a patient prior to treatment whenever possible, after the doctor has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about costs.

Insured Group means, for the purpose of paragraph 63-5(2A)(b) of the **PHI Act**, the following groups specified by reference to the number and kind of people in the group:

- Only one person referred to as a Single **Policy**
- Only two **Adults** referred to as a Couple **Policy**
- Only one **Adult** and at least one **Dependant Child** or **Non Classified Dependant** referred to as a Sole Parent Family **Policy**
- Two **Adults** and at least one **Dependant Child** or **Non Classified Dependant** referred to as a Family **Policy**
- Only one **Adult** and at least one **Adult Dependant** and any number of **Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Dependant Sole Parent Family **Policy**
- Two **Adults** and at least one **Adult Dependant** and any number of **Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Dependant Family **Policy**
- Only one **Adult** and at least one **Adult Disability Dependant** and any number of **Adult Dependants, Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Disability Dependant Sole Parent Family **Policy**
- Two **Adults** and at least one **Adult Disability Dependant** and any number of **Adult Dependants, Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Disability Dependant Family **Policy**.

Item Limit means the **Benefit** payable per service.

Lifetime Health Cover means the scheme set out in Part 2-3 of the **PHI Act**.

Lifetime Health Cover Age has the meaning given in section 34-1 of the **PHI Act** (that is – generally – the person's age on the 1 July before the day on which the person took out **Hospital** cover). If the person took out **Hospital** cover before 1 July following their 31st birthday, the person would have a **Lifetime Health Cover Age** of 30.

Lifetime Limit means the maximum amount of **Benefits** that can be claimed for an individual service or group of services outlined within that group within a **Member's** lifetime subject to any **Item Limits, Sub-limits** and **Annual Group Limits** that may apply. This includes **Benefits** claimed from other Private Health Insurers or another Westfund **Policy.**

Major Dental means Periodontics (items 213-251), Oral Surgery (items 331-399), Endodontics (items 411-459) and Prosthodontics: crowns, bridges, veneers, implants, dentures & maxillofacial prosthetics (items 526, 536, 556, 586-588, 611-790) performed by a **Recognised Provider.**

MBS (Medicare Benefits Schedule) is a schedule of fees for **Professional Services** which attract **Medicare Benefits** maintained by the Department of Health and Aged Care.

Medical Adviser means a qualified medical practitioner appointed by Westfund to give technical advice on professional matters, in particular in relation to **Pre-existing Condition** rulings.

Medical Gap is the difference, if any, between the cost of a **Professional Service** and the combined **Medicare Benefit** and Westfund **Benefit**.

Medically Necessary/Justified means where the treating doctor requests ambulance transport because the medical condition requires that level of support.

Medicare Benefit means a Medicare benefit under Part II of the Health Insurance Act 1973. The **Medicare Benefit** is 75% of the **MBS** fee for in-hospital **Professional Services**.

Member means an insured person under a **Policy**.

Mid Extras means the **Policy** prescribed in Schedule I13.

Minister means the Minister for Health and Aged Care or his or her delegate with the powers vested in the **Minister** by the **PHI Act** or the **PHIPS Act**.

Non-Classified Dependant means**:**

- a person who is between the age of 18 and 24 (inclusive)
- is not in a relationship on a bona fide domestic basis.

Non-Emergency Patient Transport is ambulance transportation including on the spot treatment where a time critical ambulance response is not essential however clinical monitoring is required for the purpose of providing medical attention to a person in the opinion of the treating medical officer. Transport will be provided to a person where he or she is assessed by a medical practitioner as medically unsuitable for community, public or private transport. **Non-Emergency Patient Transport** must be requested from the treating medical practitioner and be provided under a state-based ambulance service scheme and recognised with Westfund. This may include services such as:

- Ambulance service fees where subsequent transport is not required
- Inter **Hospital** transfers (excluding public hospital to public hospital)
- Admissions to **Hospital** from home

Nursing-Home Type Patient has the same meaning as in Schedule 4 of the Private Health Insurance (Benefit Requirement) Rules.

Orthodontic means dental item numbers 811-882 performed by a **Recognised Provider.**

Overseas has the same meaning as set out in section 34-30 of the **PHI Act.**

Partner means a person who:

- is married to the **Primary Member**, or
- lives with the **Primary Member** in a relationship on a bona fide domestic basis.

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

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

Permitted Days Without Hospital Cover has the meaning given in section 34-20 of the **PHI Act**.

Pharmaceutical Benefits Schedule means the Schedule of Pharmaceutical Benefits kept by the Department of Health and Aged Care.

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

PHIPS Act means the Private Health Insurance (Prudential Supervision) 2015 (Cth).

Policy means a **Hospital Policy** (specified in Schedule J and L) or a **General Treatment Policy** (specified in Schedule I) or a combined **Hospital** and **General Treatment Policy** (specified in Schedule J and L) that provides entitlement to **Benefits** payable in respect of approved expenses incurred by the **Members** of that **Policy** as specified in these rules.

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

Pre-existing Condition as set out in section 75-15 of the **PHI Act** means an ailment, illness or condition that, in the opinion of a medical practitioner appointed by Westfund, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the **Policy**. In forming the opinion, the medical practitioner must have regard to any information in relation to the ailment, illness or condition that the medical practitioner who treated the ailment, illness or condition gives him or her.

Premium means an amount of money a **Member** is required to pay for a specified period for a **Policy.**

Primary Member means the person in whose name the **Policy** is registered with Westfund and who is a policy holder as defined in the **PHI Act**.

Private Health Information Statement for a **Complying Health Insurance Product** is a statement about the product that contains the information, and is in the form, set out in the Private Health Insurance (Complying Product) Rules.

Professional Service means a service provided by a medical practitioner to, or in respect of, an inpatient of a **Hospital** for which a **Medicare Benefit** is payable.

Protected Industrial Action means protected industrial action as defined in section 408 of the Fair Work Act 2009 (Cth) including lockouts as described in section 19 of the Fair Work Act 2009 (Cth), provided that such protected industrial action causes the **Primary Member** or **Spouse/Partner's** income from the **Primary Member's** or **Spouse/Partner's** only or principal employer to cease for the period of that protected industrial action.

Purchaser-Provider Agreement means a Hospital **Purchaser-Provider Agreement** or a Medical **Purchaser-Provider Agreement** or a Practitioner Agreement which is an agreement between Westfund and a provider in respect of the provision of services to **Members**.

Recognised Provider means a provider recognised by Westfund for the purpose of paying **Benefits**. To become a **Recognised Provider**, the provider must be in **Australia** and among other things, satisfy the standards in the Private Health Insurance (Accreditation) Rules. **Recognised Providers** include **Hospitals**, medical practitioners providing a **Professional Service** and providers of **General Treatment** that meet Westfund's **Recognition Criteria**.

Recognition Criteria in relation to **Recognised Providers** of **General Treatment** are:

- the provider is professionally qualified or belongs to a professional body recognised by Westfund;

- the provider is in independent private practice;
- the provider is registered, or holds a licence under State or Territory legislation within **Australia**;
- other recognition criteria determined by Westfund.

Respiratory Aids means Nebulisers, Peak Flow Meters, Spacer Devices and Mucus Clearing Devices.

Respite Care refers to the accommodation of a patient in a **Hospital** where the primary reason for the admission is to provide temporary relief from the home care of the patient to the person who is administering the home care, rather than to provide care for the patient. No **Benefit** is payable for **Respite Care**.

Restricted Benefit means a **Benefit** for a particular type of admitted **Hospital Treatment**, which covers the charges up to the public hospital, shared room accommodation rate, as set out by the Private Health Insurance (Benefit Requirement) Rules and determined by the **Minister**.

Retained Age-Based Discount means the **Age-Based Discount** that a **Member** held on a previous health insurance product. The **Member** will retain the same discount that they were eligible for on their previous product unless they do not fulfil the criteria for a **Retained Age-Based Discount** as set out in the Private Health Insurance (Complying Product) Rules.

Retained Age-Based Discount Policy means a **Policy** that is an **Age-Based Discount Policy** and that states it is a **Retained Age-Based Discount Policy.**

Silver Hospital means the **Policy** prescribed in Schedule J55.

Silver Plus Assure Hospital means the **Policy** prescribed in Schedule J53.

Silver Plus Nurture Hospital means the **Policy** prescribed in Schedule J54.

Spouse has the same meaning as **Partner.**

Starter Extras means the **Policy** prescribed in Schedule I15

State of Residence means the **State/Territory** in which the **Primary Member** currently resides. For the purposes of these rules:

- A **Primary Member** living in the Australian Capital Territory (ACT) or Norfolk Island is taken to be a resident of New South Wales (NSW)
- A **Primary Member** living in the Territory of Cocos (Keeling) Islands or the Territory of Christmas Island is taken to be a resident of the Northern Territory (NT).

Sub-limit means the maximum limit within the **Annual Group Limit** that the **Item Limit** can be claimed up to.

TGA Approved means an item that has been listed or registered on the Australian Register of Therapeutic Goods for sale in Australia.

Therapeutic Goods Administration (TGA) means that part of the Department of Health and Aged Care with responsibility to regulate and approve therapeutic goods in Australia including how they are manufactured and advertised.

Transfer has the meaning as set out in section 75-10 of the **PHI Act**.

Ultimate Extras means the **Policy** prescribed in Schedule I11.

Ultimate Pro Extras means the **Policy** prescribed in Schedule I10.

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

Vaccination means a preventive measure, in the form of injection or orally, taken to prevent a disease.

Waiting Period as set out in section 75-5 of the **PHI Act** means the period that applies to a person for a **Benefit** under a **Policy** being the period:

- starting at the time the person becomes insured under the **Policy**; and
- ending at the time specified in the **Policy**;

during which the person is not entitled to the **Benefit**.

B3 Other

C MEMBERSHIP

C1 General Conditions of Membership

C1.1 **Members** shall have the right to obtain from Westfund, the **Benefits** and/or services as provided under these rules.

C1.2 All **Members** under the same **Policy** shall belong to the same **Insured Group**, and have the same **Policy**.

C1.3 There are eight types of **Insured Group** representing **Policies** Westfund may choose to offer from time to time:

- Only one person referred to as a Single **Policy**
- Only two **Adults** referred to as a Couple **Policy**
- Only one **Adult** and at least one **Dependant Child** or **Non Classified Dependant** referred to as a Sole Parent Family **Policy**
- Two **Adults** and at least one **Dependant Child** or **Non Classified Dependant** referred to as a Family **Policy**
- Only one **Adult** and at least one **Adult Dependant** and any number of **Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Dependant Sole Parent Family **Policy**
- Two **Adults** and at least one **Adult** and any number of **Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Dependant Family **Policy**
- Only one **Adult** and at least one **Adult Disability Dependant** and any number of **Adult Dependants, Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Disability Dependant Sole Parent Family **Policy**
- Two **Adults** and at least one **Adult Disability Dependant** and any number of **Adult Dependants, Dependant Children** and/or **Non-Classified Dependants** referred to as an Adult Disability Dependant Family **Policy**.

C1.4 A **Member** may contribute to any of the following **Policies** offered by Westfund in the **Member's State of Residence**:

- any one **Policy** set out in Schedule J that provides **Hospital Treatment**
- any one **Policy** set out in Schedule I that provides **General Treatment** but not including **Hospital-Substitute Treatment**
- any combination of a **Hospital Treatment Policy** and **General Treatment Policy** (that may include **Hospital-Substitute Treatment**) set out in Schedules I and J
- any one **Policy** set out in Schedule J that provides both **Hospital Treatment** and **General Treatment** (which may include **Hospital-Substitute Treatment**).

C2 Eligibility for Membership

C2.1 Subject to these rules any person who is 18 years of age or more is entitled to apply in his or her own right as a **Primary Member.** Persons aged 14 to 17 years (inclusive) will be considered on a case by case basis.

C2.2 Any person who applies for a **Policy** shall be known as the **Primary Member**. The **Primary Member** may also apply to cover his or her **Partner** or **Dependants**. A **Primary Member** may not receive **Benefits** in respect of any person other than the **Primary Member** unless that person is registered on the **Policy** as a **Dependant**.

C2.3 A person may not concurrently have a **Policy** that covers **Hospital Treatment** with the health benefits fund of another private health insurer and Westfund.

C2.4 Subject to Westfund's discretion a person may not concurrently have a **Policy** that covers **General Treatment** with the health benefits fund of another private health insurer and Westfund.

C2.5 A person may be a **Member** of Westfund and a policy holder with another health benefits fund of another private health insurer, where a **Hospital Treatment Policy** is held with one private health insurer and a **General Treatment Policy** is held with the other private health insurer.

C3 Dependants

C3.1 A **Primary Member** may register their **Partner** and/or **Dependant** on an appropriate **Policy** other than a **Policy** for an **Insured Group** of one person.

C3.2 A newborn child of a **Member** will be covered if they are added to an eligible **Policy** (refer Rule C1.3) within three months of birth. In this case, continuity of cover applies to the newborn child. The child must be added prior to making a claim.

C3.3 Westfund, at its discretion, may allow a **Primary Member** to register as a **Dependant**, a person already registered as a **Dependant** on another **Policy** (even if with another health benefits fund), provided that the **Primary Member** is the parent or guardian.

C3.4 A person who ceases to be a **Dependant** (even if with another private health insurer) may join Westfund as a **Primary Member** without any additional **Waiting Periods** provided the new **Policy** does not provide a higher level of **Benefits**. Where the new **Policy** provides a higher level of **Benefit, Waiting Period**s will apply to the difference in **Benefits**.

C3.5 If a person was a **Member** (even if with the health benefits fund of another private health insurer) immediately prior to becoming a **Dependant** on a different **Policy**, the person's **Policy** will be regarded as continuous.

C4 Membership Applications

C4.1 A person may apply to be a **Member** by:

a) completing the specified application form; or
b) completing an application online and providing an online acknowledgement and acceptance of the terms and conditions of membership; or
c) completing an application over the phone and providing a recorded acknowledgement and acceptance of the terms and conditions of membership, and by providing any additional information relevant to the application requested by Westfund.

By making an application pursuant to paragraphs (a), (b) or (c) the applicant agrees that, in respect of any application or claim form signed by the applicant or another person covered under the relevant **Policy** and permitted by these rules, the signing of the form constitutes consent given by the signatory of the form (and if the form is not signed by the applicant, an undertaking by the applicant to procure such consent) in favour of the **Hospital** or other relevant authorities authorising them to supply any information to Westfund or its agent.

C4.2 The applicant must be the person who will be the **Primary Member** unless an application is being submitted by an agent approved by Westfund on behalf of the applicant.

C4.3 An applicant who intends to pay his or her **Premiums** by direct debit must accompany his or her application with a payment equivalent to at least:

- one week in the case of weekly direct debit
- one fortnight in the case of fortnightly direct debit
- one month in the case of monthly direct debit
- one year in the case of yearly direct debit for **Ambulance Members.**

C4.4 Applicants who intend to pay their **Premiums** directly (over the counter/mail/BPAY) or through a payroll group must provide at least one month's **Premium** with their application. In the case of **Ambulance Members**, they must pay one year's **Premium.**

C4.5 Westfund will not refuse any **Policy** application on the ground of any of the matters set out in Rule A6.1.

C4.6 If Westfund has exercised its rights to terminate a **Policy**, Westfund shall have the right to refuse an application for a **Policy** from a former **Member** who has been terminated.

C4.7 Where an application is refused, Westfund shall provide a reason for the refusal.

C4.8 The **Partner** of a **Primary Member** may deal with Westfund in respect of all other matters concerning the **Policy** except for the addition or subtraction of a **Dependant** and the change of **Policy**. The **Primary Member** may provide his or her **Partner** with these additional powers by granting spousal authority via written authorisation or by recorded acknowledgement over the telephone.

C4.9 Westfund may require proof of identity, age, and previous health cover at the time of an initial application for a **Policy** and at the time of any application to change the **Policy** or **Dependants**.

C4.10 Westfund will inform any person enquiring in relation to **Complying Health Insurance Products** about **Private Health Information Statements** and how to obtain a copy. Westfund will provide a copy of the relevant statement if the person so requests.

C4.11 Westfund will provide an up to date copy of the relevant **Private Health Information Statement** when an **Adult** first becomes insured. This statement will be provided to the **Primary Member**.

C5 Duration of Membership

C5.1 Provided that the first **Premium** has been paid, the commencement date of a **Policy** shall be the later of:

- the day the **Policy** application is accepted by Westfund; or
- the date nominated by the applicant and accepted by Westfund;

except that in the case of transferring members, an earlier date may be agreed at the discretion of Westfund being a date up to 2 months prior to the date the application is received for the purposes of maintaining continuity of cover.

C5.2 A **Policy** will continue while **Premiums** continue to be paid until cancellation by the **Primary Member**, **Partner** with spousal authority or cancellation by Westfund due to failure of a **Member** to observe these rules.

C5.3 In respect of **Policy** review period (cooling off period), new **Members** and **Members** who have transferred to another Westfund **Policy** are entitled to a review period of 30 days from the date the **Policy** or the changed **Policy** commences.

Primary Members who decide during this review period that they do not want the **Policy** or want to change it in any way, will either be refunded their **Premiums** or transferred to a more appropriate **Policy** effective from the original date of application.

If a **Primary Member** chooses to change to a **Policy** with greater **Benefits** from the original date of application he or she will be required to pay any difference in **Premiums** from that date and will be subject to **Waiting Periods** associated with the higher level of cover.

The review period does not apply if a **Member** makes a claim in respect of the 30-day review period.

C6 Transfers

C6.1 When a member of another private health insurer **Transfers** to Westfund without a break in coverage:

- Westfund may apply all relevant **Waiting Periods** to any **Benefits** under the Westfund **Policy** that were not provided under the previous policy;
- the unexpired portions of any **Waiting Periods** not fully served under the previous policy will apply**;**
- where the **Benefits** that would have been provided under the previous policy are lower than the **Benefits** payable by Westfund, the lower **Benefits** will apply for the relevant **Waiting Period**;
- where the previous policy carried a higher **Excess** or **Co-Payment**, the difference between any **Excess** or **Co-Payment** payable under the previous policy and the new **Policy** will apply for the relevant **Waiting Period**.

This Rule C6.1 is subject to Rule F3.7.

C6.2 Where a Westfund **Member Transfers** to another Westfund **Policy** he or she shall be treated as a **Transfer** from the health benefits fund of another private health insurer in relation to the application of **Waiting Periods**.

C6.3 Where a **Member Transfers** from the health benefits fund of another private health insurer or to a different Westfund **Policy**, any **Benefits** that have been paid that were subject to an annual or other limits under the previous policy may be taken into account in determining the **Benefits** payable under the new **Policy**.

C6.4 Incremental **Benefits** or **Benefit** limits paid in relation to the policy held at the health benefits fund of the previous insurer or with Westfund may be taken into account when determining any incremental **Benefit** or **Benefit** limit where the increment requires an accrued term of a specific **Policy.**

C6.5 A **Waiting Period** will not apply to a **Policy** that covers a person who holds a gold card or was entitled to treatment under a gold card (as defined in the **PHI Act**) or to members of the Australian Defence Force or people in Antarctica who have health cover provided as part of their employment.

C6.6 Westfund will provide in the approved form and within the period set out in the Private Health Insurance (Complying Product) Rules a **Transfer** certificate where a person ceases to be insured with Westfund.

C6.7 Westfund will request in the approved form and within the period set out in the Private Health Insurance (Complying Product) Rules a **Transfer** certificate from a person's previous insurer where this has not been provided within 7 days of the person becoming insured by Westfund.

C7 Cancellation of Membership

C7.1 A **Primary Member** or a **Partner** with spousal authority may:

- cancel the **Policy;**
- remove **Dependants** from the **Policy.**

C7.2 Westfund will refund **Premiums** paid in advance when a **Policy** ceases only where required to do so by law or where specified in these rules. Westfund may at its discretion upon written request refund **Premiums** paid in advance from the date of receipt of that request and after allowing an appropriate administrative charge.

C7.3 A **Dependant** aged at least 16 years of age may leave the **Policy.** A **Dependant** under 16 years of age may leave the **Policy** with the agreement of the **Primary Member.** Westfund will notify a change of this nature in writing to the **Primary Member** and the **Dependant**.

C7.4 A request to cancel a **Policy** must be in writing, in person or by recorded confirmation.

C7.5 The date of cessation of a **Policy** will be the later of the date requested by the **Member** or the date of receipt by Westfund of the relevant communication from the **Member** except that in the case of **Transferring Members**, an earlier date may be agreed at the discretion of Westfund being a date up to 2 months prior to the date the cancellation request is received for the purposes of avoiding overlap of cover.

C7.6 A **Primary Member** who has been given rate protection due to his or her **Premiums** being paid in advance and who cancels his or her **Policy** before the end of the period paid in advance will lose his or her rate protection.

C8 Termination of Membership

C8.1 Westfund shall not have the right to terminate the **Policy** of any **Member** on the ground of any of the matters set out in Rule A6.1.

C8.2 Westfund shall have the right to terminate the **Policy** of a **Member** from the date of notification to that **Member**, if any **Member** in that **Policy** has, in the opinion of Westfund, committed or attempted to commit fraud upon Westfund. Any **Premiums** paid in advance of the date of cancellation of the **Policy** may be first applied by Westfund to offset the cost of the fraud or attempted fraud, with Westfund being only liable to the **Member** of the cancelled **Policy** for any balance remaining.

C8.3 Westfund shall have the right to terminate the **Policy** of a **Member** if the application for the **Policy** for that **Member** contained inaccurate or incomplete information in a material respect and such right may be effected from the date such **Policy** commenced. "Material" means that Westfund could have made a different decision if provided with accurate and/or complete information.

C8.4 Westfund shall have the right to terminate a **Policy** if any **Member** with a **Hospital Treatment Policy** concurrently has a **Hospital Treatment Policy** with the health benefits fund of another private health insurer.

C8.5 Where permitted by law, Westfund may terminate a **Policy** in circumstances other than those specified at C8.2, C8.3 or C8.4. In these circumstances Westfund will communicate with the **Primary Member** advising of the reason for the termination and provide the **Primary Member** with at least one month's notice of the date of the termination.

C8.6 Westfund will refund any **Premiums** paid in advance as at the date of the termination but may deduct an appropriate amount from the refund for administrative expenses associated with processing the termination and any amounts wrongfully paid to or on behalf of the **Member**.

C8.7 Where **Premiums** are more than two months in arrears the **Policy** is terminated except at the discretion of Westfund. The **Member** remains liable for unpaid **Premiums**.

C8.8 Where a **Policy** has been terminated for non-payment of **Premiums**, the **Member** must complete a new application. Westfund may at its discretion and subject to payment of the **Premium** arrears, agree to waive **Waiting Periods** and reinstate any accumulated **Benefit** entitlements.

C8.9 Westfund will notify the **Primary Member** in writing where the **Policy** has been or will be terminated.

C8.10 A **Member** can be terminated from a **Policy** due to death under the following circumstances:

- If the termination is requested by an existing **Spouse** on the same **Policy** that has been granted spousal authority
- If the termination is requested by a person with power of attorney (power of attorney documentation to be supplied)
- If a Death Certificate is supplied
- In the event that any of the above circumstances cannot be met, Westfund may terminate a **Member** from a **Policy** due to death after receiving appropriate documentation as determined by Westfund.

C9 Temporary Suspension of Membership

C9.1.1 Westfund may allow suspension of a **Policy** or **Member** on grounds other than those listed in C9.2, C9.3, C9.4 for such periods and subject to such criteria as it, in its absolute discretion, allows.

C9.1.2 Any **Policy** (excluding **Ambulance**) is eligible for suspension.

C9.1.3 A **Member** listed on a **Policy** (excluding **Ambulance**) is eligible for suspension.

C9.1.4 Health services provided during a suspension of a **Policy** or **Member** shall not be eligible for **Benefits**.

C9.1.5 A suspension of a **Policy** or **Member** shall not qualify for the purpose of completing any **Waiting Periods** or **Claimable Periods** that are to be served by a **Member** before the **Member** is eligible to receive **Benefits**.

C9.1.6 A minimum of six months must elapse from the end of the previous suspension period for the same suspension reason.

C9.1.7 Continuity of the **Policy** for the purposes of **Lifetime Health Cover** is subject to the provisions of section D5 of these rules.

C9.1.8 Westfund may suspend a **Policy** or **Member** upon application by the **Primary Member** or **Spouse/Partner** with spousal authority.

C9.1.9 If any criteria set out in C9.2, C9.3 or C9.4 or determined under C9.1 are not met, Westfund will terminate the **Policy** or **Member**. Westfund at its discretion may allow reinstatement of the **Policy** or **Member** if all abovementioned criteria are met.

C9.2 Overseas Suspension

C9.2.1 Suspension of a **Policy** or **Member** may be granted by Westfund if the reason for the suspension is the temporary absence from **Australia** for more than two months and no more than 24 months provided that **Premiums** are paid from the date of return to **Australia**.

C9.2.2 A **Policy** will not be suspended unless paid to the suspension commencement date.

C9.2.3 Proof of departure such as a boarding pass, itinerary or airline ticket must accompany the Overseas Travel Suspension Form prior to leaving **Australia**.

C9.2.4 If a **Policy** or **Member** is leaving **Australia** within 6 months of a previous suspension period, proof of departure and the Overseas Travel Suspension Form must be supplied prior to leaving **Australia**; however the suspension commencement date must be 6 months from the end of the previous suspension period.

C9.2.5 A **Policy** or **Member** must be reinstated from the date of return to **Australia**. Reinstatement must be within one month of returning to **Australia** and proof of entry such as a boarding pass, itinerary or airline ticket must be supplied.

C9.3 **Forced Retrenchment Suspension**

C9.3.1 Westfund may suspend a **Policy** or **Member** (excluding a **Dependant**) who has had 3 continuous years of membership at the date of application for the **Forced Retrenchment Suspension**.

C9.3.2 Suspension of a **Policy** or **Member** may be granted by Westfund only if the following conditions have been met by the **Member** who has applied for the **Forced Retrenchment Suspension**:

- The **Member** is currently unemployed and has been unemployed for more than seven (7) consecutive days
- The **Member's** unemployment was a result of forced retrenchment and not caused by a voluntary act
- The **Spouse/Partner** of the **Member**, who has applied for the **Forced Retrenchment Suspension**, earns no more than the National Minimum Wage (Fair Work Commission) plus 30% per week
- The **Member's** employment, at the time of retrenchment, was within **Australia**
- Where the **Member** was self-employed, then the business must have been either legally declared bankrupt or have been placed into involuntary liquidation
- Where the **Member's** engagement was entered into on a "contractor" type arrangement, the forced retrenchment was not a result of a contract expiring. If the contractor is forced into retrenchment during the period of the contract and he or she satisfies all other criteria in C9.3 then he or she may be eligible for the suspension.

C9.3.3 The initial application for suspension due to forced retrenchment must be made within 3 months of the last day of paid employment.

C9.3.4 The **Forced Retrenchment Suspension** is applied from the date as declared on the Forced Retrenchment Suspension Form and is valid for one (1) calendar month or until such time that the criteria set out in C9.3.2 are no longer met, up to a maximum of six (6) consecutive calendar months.

C9.4 **Protected Industrial Action Suspension**

C9.4.1 Westfund may suspend a **Policy** or **Member** (excluding a **Dependant**) who has had 3 continuous years of membership at the date of application for the **Protected Industrial Action** suspension.

C9.4.2 Suspension of a **Policy** or **Member** may be granted by Westfund only if the following conditions have been met by the **Member** who has applied for the **Protected Industrial Action** suspension:

- The **Member's** union has been taking **Protected Industrial Action** for more than seven (7) consecutive days
- The **Member's** engagement, at time of **Protected Industrial Action**, was within **Australia**
- The **Spouse/Partner** of the **Member**, who has applied for the **Protected Industrial Action** suspension, earns no more than the National Minimum Wage (Fair Work Commission) plus 30% per week

- Where the **Member's** engagement was entered into on a "contractor" type arrangement, **Protected Industrial Action** was not a result of a contract expiring. If **Protected Industrial Action** is undertaken during the period of the contract and he or she satisfies all other criteria in C9.4 then he or she may be eligible for the suspension.

C9.4.3 The initial application for suspension due to **Protected Industrial Action** must be made within 3 months of the last day of paid work.

C9.4.4 A **Protected Industrial Action** suspension may be granted provided the Protected Industrial Action Suspension Form is supported by written confirmation from the **Member's** union that the **Member** is unable to work due to **Protected Industrial Action**. The written confirmation is effective for the period of **Protected Industrial Action** or one (1) week from the date of the written confirmation, whichever is longer. The written confirmation may be renewed, and the suspension may be extended for successive periods of one (1) week to a maximum of six (6) consecutive calendar months.

C10 Other

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 **Premiums** payable for each **Policy** are set out in Schedule K – the Schedule of **Premiums**.

D1.2 Westfund may, at its discretion, approve any group of **Members** as a **Contribution Group**.

D1.3 A **Member** must pay **Premiums** at the rate for the chosen **Insured Group** and **Policy**. **Premiums** may be paid by a **Member** or on behalf of a **Member** by an agent approved by Westfund.

D1.4 Any **Premiums** paid by a **Recognised Provider** on behalf of a **Member** other than the **Provider's Spouse**, **Partner** or **Dependant** shall be returned to that provider if the **Member** attempts to claim **Benefits** for services rendered by the provider. The **Member's Premium** status will be adjusted accordingly.

D1.5 All **Premiums** must be paid in advance, but a **Policy** cannot be more than 18 months **Premiums** in advance in total.

D1.6 An amount received as a **Premium** for a particular **Policy** shall be applied first in payment of any arrears of **Premiums** and then applied in respect of future periods.

D1.7 **Premiums** may vary between States. A **Member** will be required to pay the **Premium** for the State in which he or she resides as advised to Westfund. If a **Member** changes his or her **State of Residence**, the **Premium** for that new State or Territory will apply from the date of the change of residence.

D1.8 Any refund of **Premiums** received will be limited to the period of 2 years prior to the date of the receipt by Westfund of written notification of the circumstances which would render a **Member** or **Dependant** ineligible to receive **Benefits**. This circumstance may arise for example where a **Member** concurrently held equivalent **Policies** with two private health insurers. A **Member** would be ineligible for a refund if a **Benefit** has been paid under the **Policy**.

D2 Contribution Rate Changes

D2.1 Westfund has the right to change **Premiums** in accordance with the requirements of the **PHI Act**.

D2.2 Westfund will advise the **Primary Member** in writing of the new **Premiums** before they take effect in accordance with the requirements of the **PHI Act**.

D2.3 In respect of changed **Premiums**, where a **Member's Premiums** are paid in advance, Westfund will apply the new **Premiums** from the date to which those **Premiums** are paid in advance.

D2.4 A **Member** who has been given rate protection due to his or her **Premiums** being paid in advance and who cancels his or her **Policy** before the end of the period paid in advance will lose his or her rate protection and his or her **Policy** period will be adjusted accordingly.

D3 Contribution Discounts

D3.1 The only discounts provided will be those permitted as set out in section 66-5 of the **PHI Act**. The maximum percentage discount allowed is 12% per annum.

D3.2 The discount for a **Policy** is the difference between the full **Premium** and the net **Premium** and is calculated in accordance with the Private Health Insurance (Complying Product) Rules. The full **Premium** for a **Policy** is the **Premium** without any reductions due to circumstances as set out in section 66-5 of the **PHI Act.**

D3.3 Westfund may offer to all eligible **Members** in a **Contribution Group** a discount which:

(i) is also available for that reason under every **Policy** in the product;
(ii) is determined at the same time as Westfund's **Premium** changes are determined;
(iii) subject to (i) above, is offered on such conditions as are determined by Westfund;
(iv) is certified by Westfund's Appointed Actuary as being prudent and equitable;
(v) applies from the date and for the period specified by Westfund.

D4 Age-Based Discounts

D4.1 The **Fund** may operate the **Age-Based Discount** arrangement referred to in section 66-5(3)(ea) of the **PHI Act**. An insurance **Policy** must not provide an **Age-Based Discount** unless;

a) the **Policy** covers:
   (i) **Hospital Treatment**; or
   (ii) **Hospital Treatment** and **General Treatment**; and
b) the discount will be a reduction in the amount that would otherwise be payable by the person for the **Policy**, equal to the dollar amount calculated in accordance with the **PHI Act**; and
c) the discount will apply to each person insured under the **Policy** who, on the **Discount Assessment Date** for the person:
   (i) was within one or more ranges of ages, between 18 and 29 (inclusive), that are specified in the **Policy** as eligible for the discount; and
   (ii) was not a **Dependant** under the **Policy**; and
d) while **Age-Based Discounts** are available under the **Policy**, the discount will continue to apply until it is reduced to zero in relation to each such person insured under the **Policy**; and
e) the **Policy** states whether it is a **Retained Age-Based Discount Policy**.

D4.2 A person's base percentage is calculated using the formula as set out in the **PHI Act** and corresponds to the person's age at the **Discount Assessment Date:**

Person's age at **Discount Assessment Date**	Percentage
18 or older, but under 26	10%
26	8%
27	6%
28	4%
29	2%

D4.3 Once an eligible person turns 41 years of age; the **Age-Based Discount** will be removed incrementally as set out in the **PHI Act**; as per the below table:

If, for that period, the person is aged:	the person's percentage for the period is:
18 or older, but under 41	the person's base percentage
41	the person's base percentage minus 2 percentage points
42	the person's base percentage minus 4 percentage points
43	the person's base percentage minus 6 percentage points
44	the person's base percentage minus 8 percentage points
45 or older	zero

D5 Lifetime Health Cover

D5.1 The **Fund** shall operate the **Lifetime Health Cover** (LHC) arrangements in accordance with the **PHI Act.** Without limiting the foregoing:

- The **Fund** is required to charge different **Premiums** for **Hospital Policies** depending on the age at which a person first takes out a **Policy** which covers **Hospital Treatment** and the continuity of such coverage;
- A person who joins a health fund earlier in life and maintains a **Policy** which covers **Hospital Treatment** pays a lower **Premium** than someone who joins later in life due to **Lifetime Health Cover** loading;
- From 1 July 2000, **Premiums** for people taking out a **Hospital Policy** after turning 30 years of age must include a loading of 2 per cent on the **Base Rate Premium** for the person's **Hospital Policy** each year his or her **Lifetime Health Cover Age** exceeds 30 years. The maximum loading is 70 per cent of the **Base Rate Premium** for the **Member's Hospital Policy**;
- Where a **Hospital Policy** covers more than one **Adult**, the amount of any increase in the **Premium** due to the application of **Lifetime Health Cover** loading is calculated using the averaging method in section 37-20 of the **PHI Act**;
- **Premium** increases stop after 10 years continuous 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 **PHI 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;
- Continuity for the purposes of **Lifetime Health Cover** is preserved during a period in which the **Member** ceases to have a **Policy** which covers **Hospital Treatment** for a cumulative period of 1,094 days or otherwise in accordance with the **PHI 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 **Base Rate 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 Policy** 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.
- People born on or before 1 July 1934 are not affected by **Lifetime Health Cover**. If people in this age group take out a **Hospital Policy** at any time in the future they will pay the **Base Rate Premium**, with no loading for late entry.

D6 Arrears in Contributions

D6.1 If a **Member** has not made a **Premium** payment prior to the 'paid to' date, then that **Member** shall be regarded as being in arrears.

D6.2 If a **Member** is less than two months in arrears, the **Member** may pay all **Premiums** in respect of the period in arrears and the **Member** will then be eligible for **Benefits** in respect of that period.

D6.3 When a **Member** is more than two months **Premiums** in arrears then his or her **Policy** shall be terminated from the last 'paid to' date of the **Policy** except at the discretion of Westfund.

D6.4 No **Benefits** shall be paid for services rendered to a **Member** during the period in which his **Policy** is in arrears until the arrears in **Premiums** are paid.

D7 Other

D7.1 Some **Policies** provide for waiver of **Premiums** for financial hardship. Where this is provided in a **Policy**, the circumstances, terms and conditions are as follows.

D7.2 **Hardship Provision**

D7.2.1 Westfund may allow upon application by the **Primary Member** or **Spouse/Partner** who is covered by the same Westfund **Policy,** who has had 3 continuous years of membership at the date of application for the hardship provision. Payment of **Premiums** may be delayed by up to 6 months under this hardship provision where application has been received by Westfund within two (2) months of the **Policy's** "paid to" date being in arrears.

D7.2.2 If a **Policy** is in arrears on a **Hospital** (Schedule J) or combined **Hospital** and **General Treatment Policy** (Schedule J) because of being temporarily unable to work due to illness or other incapacity, strikes, lockouts or any other hardship provision agreed to by Westfund and provided that the **Member** undertakes in writing that, after he or she resumes work, **Premiums** will be paid weekly, at double the weekly rate, until such arrears are repaid, then notwithstanding other rules to the contrary, and at the discretion of Westfund, **Benefits** for any **Member** on the **Policy** shall continue to be paid while the **Policy** is in arrears, but for not more than six (6) months after the "paid to" date. Payment of **Benefits** is conditional on the **Member**, who has applied for the hardship provision, having furnished such evidence as Westfund requires as to his or her good faith in the making to the undertaking.

E BENEFITS

E1 General Conditions

E1.1 Westfund offers health **Benefit** entitlements to its **Members** in accordance with the chosen **Policy** and the rules in force and the **Benefits** payable at the date on which the service was provided, subject to any applicable limits.

E1.2 **Benefits** are only payable for:

a) **Hospital Treatment,** and/or
b) **General Treatment.**

E1.3 Westfund may request any medical or other evidence, which it considers necessary to determine eligibility for **Benefits**.

E1.4 **Benefits** are only payable where services or appliances are provided by a **Recognised Provider.**

E1.5 Westfund has no liability to a **Member** for negligence, losses, costs, damages, suits or actions arising through the provision of services to any **Member** by any **Recognised Provider**.

E1.6 The following conditions apply to all **Benefits**:

- **Benefits** are only payable for services rendered by providers who are recognised by Westfund and in private practice (**Recognised Provider**); as per the Private Health Insurance (Accreditation) Rules. Recognition by Westfund is for **Benefit** payment purposes only and is not to be construed as any recommendation of the qualifications and services provided by a provider;
- **Benefits** shall not be payable for services which occurred earlier than 24 months before the lodgement of a valid claim;
- **Benefits** must not exceed 100% of the documented cost to the **Member** of any service or item for which **Benefits** are payable;
- Where monies are payable from more than one source for a service, Westfund may limit the **Benefit** so that the amount payable from all sources does not exceed the amount charged;
- **Benefits** are not payable in respect of services or treatment performed by a **Recognised Provider** to a **Member** where **Premiums** in respect of that **Member** have been paid, or contributed to, by that **Recognised Provider;**
- **General Treatment Benefits** are not payable for services or treatment performed or recommended by a **Recognised Provider** to the provider's business partner, or to the **Spouse**, **Partner**, parents or **Dependants** of the provider**;**
- **Benefits** are not payable in respect of **Dependants** of **Dependants** registered on a **Policy**.

E1.7 Westfund may, in lieu of **Benefits**, provide services or appliances to a **Member** or **Dependants**.

E1.8 Where **Benefits** are determined as a percentage of the receipted cost of a service and the receipted cost of a service appears excessive, Westfund has the right to determine the **Benefit** from the **Usual, Customary and Reasonable Charge** it determines for that service.

E1.9 In the event that a **Benefit** has been erroneously paid (claim was not properly payable under these rules) then Westfund shall be entitled to recover any such amount or deduct the amount from any other **Benefits** payable in respect of the **Policy** or any **Premiums** paid in advance.

E1.10 Notwithstanding these rules, Westfund shall have the right to relax any particular term or condition in specific instances and Westfund shall also have the right to provide, without prejudice, an ex gratia payment.

E1.11 **Benefit**s are only payable for treatments, health care goods and services provided in **Australia**.

E1.12 **Waiting Periods** are as detailed in Part F3 of these rules.

E1.13 Other conditions relating to **Benefits**, Limitation of **Benefits** and Claims are detailed in Parts E, F and G of these rules.

E2 Hospital Treatment

E2.1 **Hospital Benefits** are payable in relation to the cost of **Hospital Treatment.**

E2.2 **Hospital Treatment Benefits** provided in **Policies** set out in Schedules J excludes:

- treatment which involves a procedure that has an item number that is specified in clause 8 of Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules, if no certificate for that procedure has been provided under clause 7 of that Schedule;
- treatment provided to a person at an emergency department of a **Hospital**;
- treatment provided to a person who is not a patient within the meaning of that word in paragraph (b) of the definition of 'patient' in subsection 3(1) of the Health Insurance Act 1973 ('patient' does not include a newly born child whose mother also occupies a bed in the **Hospital** except in certain specified circumstances);
- treatment which is part of a **Chronic Disease Management Program** that is intended to delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease;
- the cost of care and accommodation in an aged care service (within the meaning of the Aged Care Act 1997);
- a charge for a pharmaceutical benefit supplied under Part VII of the National Health Act 1953, unless the circumstances of the charge are covered by section 92B of that Act;
- any other treatment specified in the Private Health Insurance (Complying Product) Rules as a treatment for which **Benefits** must not be provided.

E2.3 Westfund will pay **Benefits** for **Hospital Treatment** at least equivalent to the following:

- The amount detailed in the Private Health Insurance (Benefit Requirement) Rules as the minimum **Benefit** for **Hospital Treatment** that is psychiatric, rehabilitation, and palliative care if the treatment is provided in a **Hospital** and no **Medicare Benefit** is payable for that part of the treatment;
- Up to 25% of the **MBS** Fee for **Hospital Treatment** covered under the **Policy** for which a **Medicare Benefit** is payable;
- The amount detailed in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules as the minimum **Benefit** where a medical device or human tissue product is provided in circumstances in which a **Medicare Benefit** is payable or in other circumstances set out in those Rules;
- Up to 100% of the fee for **PBS Items** that are administered according to **PBS** approved indications during an **Admitted Episode of Care.**

E2.4 Westfund may enter a **Contract** with a **Hospital** or a group of **Hospitals** for **Hospital Treatment**. **Contracts** specify the total charge for any **Hospital Treatment** and the **Benefit** payable. The **Member's** entitlement to a **Benefit** in a contracted **Hospital** is determined in accordance with the terms of the **Contract** and the **Policy**. A list of contracted **Hospitals** is available to **Members** on our website: www.westfund.com.au.

E2.5 **Benefits** for **Hospital Treatment** provided in a private **Hospital** which does not have a **Contract** with Westfund are payable at the minimum and second tier **Default Benefits** as applicable, determined under the Private Health Insurance (Benefit Requirements) Rules.

E2.6 Westfund will also pay on some **Hospital Treatment Policies**, all or part of the fee that is above the **MBS** fee in cases where the medical practitioner either has a **Contract** with Westfund or participates in Westfund's **Access Gap Scheme** arrangements.

E2.7 For the purposes of determining the level of **Benefit** paid for **Hospital Treatment**, unless otherwise specified, where a **Member** is readmitted, the **Hospital Treatment** is regarded as a continuation of the preceding admission where there is a related reason for the readmission.

E2.8 In determining the **Benefit** payable where a daily **Benefit** is paid for services provided by the **Hospital**, the day of discharge and the day of admission are counted as one day.

E2.9 Where a patient is designated a **Nursing-Home Type Patient**, **Benefits** shall be limited to the current amounts determined under the Private Health Insurance (Benefit Requirements) Rules.

E2.10 Physiotherapy is covered in some **Contracts** with **Hospitals.** In **Contracts** where physiotherapy is not covered, Westfund will pay a **Benefit** in accordance with the specific product rules.

E2.11 For Medical Treatment in **Hospital**, Medicare pays a **Benefit** of 75% of the **MBS** fee for **Professional Services.**

E2.12 For Medical Treatment in **Hospital**, Westfund will pay a **Benefit** of 25% of the **MBS** fee for **Professional Services**.

E2.13 Where the charge for the **Professional Service** is less than the **MBS** fee, Westfund will pay a **Benefit** equal to the amount by which the charge exceeds 75% of that **MBS** fee.

E2.14 Westfund shall have the right to dispute any claim for **Benefits** in respect of **Professional Services** or **Hospital Treatment**. In the event Westfund disputes a claim for **Professional Services** or **Hospital Treatment**, the **Fund** may at its absolute discretion refer the claim to its **Medical Adviser**. The **Medical Adviser's** fees shall be paid by the **Fund**. If, following the advice of the **Medical Adviser**, Westfund decides not to pay the **Benefits**, this advice shall also be made available to the **Member**.

E2.15 Accommodation **Benefit**

E2.15.1 An Accommodation **Benefit** is payable for costs incurred as the result of boarding at a **Hospital** or nearby motel by the patient or one **Member** covered by the same Westfund **Policy**. **Benefits** are paid for the night before admission, for the nights during the hospitalisation and the night of discharge; where there is a corresponding hospitalisation record on the **Members Policy**. This **Benefit** is not claimable for the patient while admitted.

E2.15.2 The Accommodation **Benefit** is an uncapped **Benefit** payable per **Policy** per **Calendar Year**. A higher **Benefit** is payable for the first four nights claimed per **Policy**. All subsequent nights claimed will be paid at a lower nightly rate per **Policy.**

E2.15.3 To be eligible for the Accommodation **Benefit** the **Member** must be admitted as a private patient.

E2.16 Inpatient Travel **Benefit**

E2.16.1 An Inpatient Travel **Benefit** is payable for travel expenses incurred by a **Member** when receiving inpatient medical specialist services, where there is a corresponding hospitalisation record on the **Members Policy**.

E2.16.2 **Benefits** will be paid on a grouped kilometre basis, in excess of 150 kilometres round trip from the **Member's** home locality to the locality of the hospitalisation. This **benefit** is not available if transport is provided by Ambulance or **Non-Emergency Patient Transport**.

E2.16.3 This **Benefit** is limited to one service per **Member** per episode of hospitalisation.

E2.16.4 To be eligible for the Inpatient Travel **Benefit** the **Member** must be admitted as a private patient.

E2.16.5 The following limits apply to **Benefits** for inpatient travel expenses:

Distance Travelled	**Benefit**
0-149km	Nil
150km-200km	$40
201km-250km	$50
251km-300km	$60
301km-350km	$70
351km-400km	$80
401km-450km	$90
451km+	$100

E3 General Treatment

E3.1 The **Benefits** payable in respect of **General Treatment**, and the conditions relevant to those **Benefits**, are set out in Schedules I and J.

E3.2 **General Treatment** provided in **Policies** set out in Schedules I and J excludes:

1. Services for which a **Medicare Benefit** is payable except:
   a) the professional medical therapeutic services identified in Groups T1 to T11 of the Health Insurance (General Medical Services Table) Regulation that are:
      - items in the table without the symbol (H); or
      - not stated in the item to be services that are to be performed in a **Hospital** for the **Medicare Benefit** to be payable; and
   b) oral and maxillofacial services set out in Groups O1 to O11 of the Health Insurance (General Medical Services Table) Regulation that are:
      - items in the table without the symbol (H); or
      - not stated in the item to be services that are to be performed in a **Hospital** for the **Medicare Benefit** to be payable; and

c) the associated services in the:
- Health Insurance (Pathology Services Table) Regulations; and
- Health Insurance (Diagnostic Imaging Services Table) Regulation, that are integral to the provision of the services specified in paragraphs (a) and (b)

but only when any of the services in the above classes are provided as part of **Hospital-Substitute Treatment.**

2. Treatment which primarily takes the form of sport, recreation or entertainment, other than such treatment which is part of a **Chronic Disease Management Program** or a **Health Management Program** where the program has been approved by Westfund.

3. Treatment which is **Excluded Natural Therapy Treatment**.

4. **Benefits** paid in connection with the birth of a baby, funeral benefits, and disability **Benefits**, other than where **Members** were entitled to these **Benefits** as at the commencement of the **PHI Act**, i.e. funeral benefit prior to 1 April 2007.

E3.3 Some **Policies** may incorporate **Hospital-Substitute Treatment**. For these **Policies**, Westfund will pay:

- up to 25% of the **MBS** fee for **Hospital-Substitute Treatment** covered under the **Policy** for which a **Medicare Benefit** is payable, provided a **Medicare Benefit** of 85% or more of the **MBS** fee is not payable for the treatment (in which case no **Benefit** is payable);
- the amount detailed in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules as the minimum **Benefit** where a medical device or human tissue product is provided in circumstances where a **Medicare Benefit** is payable or in other circumstances set out in those Rules.

E3.4 Westfund may make **Chronic Disease Management Programs** and other **Health Management Programs** available to **Members** under one or more **Policies** from time to time. **Benefits** payable in respect of **Chronic Disease Management Programs** and other **Health Management Programs** are subject to the **Member** meeting any applicable enrolment or eligibility criteria specified by Westfund from time to time. A **Lifetime Limit** per **Member** per program applies to **Chronic Disease Management Programs.**

E3.5 **Benefits** for **General Treatment** are only payable where the service or item is provided by a **Recognised Provider** of **General Treatment**.

E3.6 Westfund may **Contract** with **Recognised Providers** of **General Treatment**. The **Benefits** that apply within these **Contracts** may differ from those shown in these rules.

E3.7 Westfund may declare that a provider is no longer a **Recognised Provider** in the event that the provider fails to adhere to any requirements set down by Westfund.

E3.8 **Benefits** payable in respect of **General Treatment** will be the lesser of:
- the actual charge; or
- the **Benefit** payable under these rules for the service or item.

E3.9 Unless Westfund considers there are justifiable circumstances; a **Member** may only receive **Benefits** for one service or appliance per day per **Recognised Provider**. Exceptions to this rule are:
- Chiropractic where a **Member** may receive **Benefits** for one x-ray and a general consultation per day per **Recognised Provider**.
- Podiatry where a **Member** may receive **Benefits** for a diagnostic service (item numbers 101 – 118, 142 – 148) and a general consultation per day per **Recognised Provider**.

- Clinical Psychology where a **Member** may receive **Benefits** for a Clinical Psychology consultation and Psychometric/Learning Assessment per day per **Recognised Provider**.

E3.10 Dental **Benefits**

E3.10.1 Dental **Benefits** are payable as set out in schedule M1 of these rules and in accordance with the dental item guidelines as maintained by Westfund.

E3.10.2 Where **Benefits** are available for dental services or appliances, **Benefits** are only payable when the services or appliances are not considered excessive or unnecessary for the wellbeing of the **Member** by Westfund's **Dental Expert** and where they are primarily non-cosmetic.

E3.10.3 Westfund shall have the right to dispute any claim for **Benefits** in respect of dental treatment. In the event Westfund disputes a claim for dental treatment, it may appoint a **Dental Expert** to examine the **Member** who received the dental treatment and/or any records deemed by the **Dental Expert** to be relevant to verify the claim. Westfund shall notify the **Member** in writing of the disputed claim and advise the **Member** of the **Dental Expert** appointed. The **Dental Expert's** fees shall be paid by Westfund.

E3.10.4 The **Dental Expert** shall be at liberty, should they think fit, to satisfy himself or herself as to all matters in relation to the claim and provide advice to Westfund. The **Member** is required to provide to the **Dental Expert** all documents and records that the **Dental Expert** may reasonably request in relation to the claim. Westfund shall pay all reasonable expenses of the **Member** in attending an examination by the **Dental Expert**. In the event that the **Member** after being requested by Westfund fails, within a reasonable period of time, to attend the **Dental Expert** appointed by Westfund or fails or refuses to provide documents or records requested by the **Dental Expert**, Westfund may refuse payment of **Benefits** for all dental services associated with the claim.

E3.10.5 No **Benefits** for **Orthodontic** are payable until a service has been provided. Where a **Member** pays in advance of the service, **Benefits** will be paid progressively against certification of work completed by a **Recognised Provider**. **Benefits** will be paid up to the full value of work completed and invoiced within the **Benefit** limit entitlement (items 825 – 882).

E3.10.6 **Benefits** for **Orthodontic** items: Dental Retainers (items 811, 821, 823 and 824) are payable for a maximum of two services per item per **Member** per **Calendar Year.** These items are paid at set **Item Limits** and are not included in the **Orthodontic Lifetime Limit.**

E3.11 Optical **Benefits**

E3.11.1 Optical **Benefits** (other than sunglass **Benefit**) are only payable for sight correction. This includes Irlen lenses, specially tinted for dyslexia,when provided by a **Recognised Provider.**

E3.11.2 No **Benefits** available for tinting, coatings or add-ons.

E3.11.3 A sunglass **Benefit** is payable for sunglasses purchased through Westfund Care Centres and selected Optical Provider of Choice providers. This **Benefit** is available only for non-prescription "off the shelf" sunglasses. This **Benefit** can be used for fit overs.

E3.11.4 A Laser Eye Surgery **Benefit** is payable for Lasik, ASLA and Smile procedures and must be performed by an Ophthalmologist recognised as a specialist under the Health Insurance Act 1973.

E3.12 Consultations

E3.12.1 **Benefits** for all services are only payable for one on one consultations (in person, video and telecommunication). Exceptions to this rule are:

- Antenatal Classes, Exercise Physiology, Physiotherapy, Dietetics/Nutrition, Occupational Therapy, Clinical Psychology, Counselling, Speech Therapy and **Benefits** listed under **Health Management Programs**. These services can be provided in a group setting by a **Recognised Provider**.

E3.13 Non **PBS** Pharmaceuticals

E3.13.1 A Pharmaceutical **Benefit** for a prescription, **Vaccination** or injection is payable on an item that is prescribed or administered by a medical practitioner, must be a Schedule 4 or Schedule 8 item (per the Poisons Standard). Where the Non **PBS** Pharmaceutical is provided by a pharmacy the receipt must detail the pharmacy prescription number.

E3.13.2 A Pharmaceutical **Benefit** is only payable on the amount over the standard Pharmaceutical Benefit Scheme (**PBS**) co-payment charge. This is re-set each year, effective 1st January.

E3.13.3 Pharmaceutical **Benefits** for prescriptions, **Vaccinations** and injections are not payable for:

- **PBS Items** supplied under the **PBS**;
- medicinal preparations where not prescribed or administered by a medical practitioner;
- experimental and clinical trial pharmaceuticals;
- contraceptives, anabolic steroids or cosmetic injections (e.g. Botox) unless prescribed specifically for the treatment of a medical illness;
- items which have not been approved for sale in Australia by the authorities that regulate the sale of pharmaceuticals (**TGA**). This includes items that have been supplied under Special Access Scheme.

E3.14 Health Aids and Appliances

E3.14.1 Refer to Rule G – Claims for the following **Benefits** require a letter of recommendation or Health Management Declaration Claim Form from a Medicare Registered Practitioner to validate **Benefits** payable. A letter of recommendation or Health Management Declaration Claim Form is not required when Health Aids and Appliances are provided by or purchased from a Medicare Registered Practitioner.

Documentation is valid for lifetime of **Policy**:

- Artificial Limbs
- **Cardiac Monitors**
- Compression Garments/Devices
- **Devices for Sleep Apnoea and diagnosed snoring**
- INR Monitor
- Low Vision Aids
- Mammary Prostheses and Brassieres (no letter required if a hospitalisation for a mastectomy is on Westfund's system)
- Oximeter
- Oxygen and Oxygen Accessories
- Repairs to Devices (no letter required if initial purchase is recorded with Westfund)
- **Respiratory Aids**
- TENS Machine
- Wigs (no letter required if a hospitalisation for a medical condition is on Westfund's system)

Documentation is valid for one **Calendar Year**:

- Braces
- Burns Suit
- Mobility Aids
- Orthopaedic Boots
- Orthotics

E3.14.2 To be eligible for an Orthotic **Benefit**, orthotic items must be specifically made (custom made) or molded (preformed) for the **Member** and be for the support, alignment, prevention or correction of deformities of the feet. **Benefits** for orthotic models/impressions are eligible to be claimed to a maximum of two services per **Calendar Year** per **Member** (items 301-305).

E3.14.3 To be eligible for an Orthopaedic Boots **Benefit,** the orthopaedic boots must be individually made (custom made) for the **Member** and be for the correction of an abnormality.

E3.14.4 To be eligible for a Brace **Benefit** the brace must contain a solid support stabilizer component**.**

E3.14.5 To be eligible for a Compression Garment/Device **Benefit,** the compression garment/device or anti-embolism garment/device must be purchased as a consequence of a diagnosed health condition.

E3.14.6 To be eligible for **Benefits** for repairs to listed health aids and appliances, the claim for the repairs must be accompanied with a letter of recommendation or Health Management Declaration Claim Form from a Medicare Registered Practitioner stipulating the need for the device. A letter of recommendation or Health Management Declaration Claim Form is not required if the device being repaired has been previously claimed with Westfund. The warranty period for the device must have lapsed to be eligible for this **Benefit.**

E3.15 Prevention and Health Management **Benefits**

E3.15.1 **Benefits** for membership or class fees with a fitness or aquatic centre are only payable where:

- the membership or class is required to enable the **Member** to undertake a **Health Management Program** for the treatment of a specific health condition or conditions; and
- the **Health Management Program** has been recommended to the **Member** by a Medicare Registered Practitioner who is treating the **Member** for the specific health condition or conditions; and
- all documentation required by Westfund has been provided to Westfund; and
- the provider must be a **Recognised Provider** as per Westfund's **Recognition Criteria**.

E3.15.2 Vitamin **Benefits** are payable for vitamins and minerals listed with Therapeutic Goods Administration (**TGA Approved**) and approved by Westfund.

Vitamins and minerals must fulfil the following criteria;

- Vitamins must be any vitamin A-K or minerals must be iron, potassium, calcium, magnesium or zinc;
- Administered orally or intravenously;
- Intended to aid in a specific vitamin or mineral dietary deficiency;
- Excludes body building, weight loss, meal replacement or any consumable food or drink product;

- Excludes Schedule 4 and Schedule 8 (per the Poisons Standard) item/drugs;
- Excludes **PBS Items** supplied under the **PBS**.

E3.15.3 **Benefits** for Weight Loss Programs are payable only for joining or membership fees.

E3.15.4 For the purpose of chronic disease association fees **Benefits**, the chronic disease association must be either:

- Alzheimer's Australia
- Arthritis Australia
- Asthma Foundation
- Coeliac Association
- Crohn's and Colitis Australia
- Diabetes Australia
- Lupus Association of Australia
- MedicAlert Foundation
- Multiple Sclerosis (MS) Australia
- Myasthenia Gravis Associations
- National Association of People with HIV Australia (NAPWHA)
- Parkinson's Australia
- Stoma Associations (Ostomy, Colostomy)

E3.15.5 For the purpose of preventative health tests **Benefits**; the tests must not be Medicare claimable and be one of the following tests:

- Bone density test
- Bowel testing kit
- Calcium score
- Chronic disease health screen
- Mammogram
- Mole scan
- Thin prep pap test

E3.15.6 For the purpose of ear and eye preventative checks **Benefits**, the tests must not be Medicare claimable and be one of the following tests:

- Audiology Test
- Eye Health Test

E3.15.7 Omega 3 **Benefits** are payable for Omega 3 listed with Therapeutic Goods Administration (**TGA Approved**) and approved by Westfund. Omega 3 must contain the following active ingredients:

- Omega 3; or
- Fish Oil; or
- Krill Oil.

E3.15.8 Probiotic **Benefits** are payable for Probiotics listed with Therapeutic Goods Administration (**TGA Approved**) and approved by Westfund. Probiotics must contain the following active ingredients:

- Lactobacillus; or
- Bifidobacterium; or
- Streptococcus Thermophilus.

E3.16 Funeral Expenses

E3.16.1 A funeral **Benefit** of $1,750 per **Member** is available for **Members** who held any **Policy** (excluding **Ambulance** only cover) prior to 1st April 2007 and have maintained continuous Westfund membership (excluding **Ambulance** only cover).

E3.16.2 **Members** who have downgraded to **Ambulance** only cover within this period (1st April 2007 – present) are not eligible for the **Benefit**.

E3.16.3 **Members** who have terminated their Westfund membership and re-joined the **Fund** at a later date are not eligible for the **Benefit**.

E3.16.4 **Members** who were born after 1st April 2007 are not eligible for the **Benefit**.

E3.17 Outpatient Travel **Benefit**

E3.17.1 An Outpatient Travel **Benefit** is payable for travel expenses incurred by a **Member** to attend outpatient medical specialist services when referred by a Medicare Registered Practitioner. The provider must be a recognised specialist as per Westfund's **Recognition Criteria**.

E3.17.2 An Outpatient Travel **Benefit** will only be paid for medical specialist services where:

- in the case of an outpatient service, a Medicare item number is billed for that service;
- in the case of a Specialist Dentist, a dental consultation item number is billed for that service.

E3.17.3 Where a **Member** is not billed for a medical service (e.g. post-operative consultation), a letter of attendance from the medical specialist is required.

E3.17.4 **Benefits** will be paid on a grouped kilometre basis, in excess of 150 kilometres round trip from the **Member's** home locality to the locality of the consultation. This **Benefit** is limited to one service per **Member** per day.

E3.17.5 The following limits apply to **Benefits** for outpatient travel expenses:

Distance Travelled	**Benefit**
0-149km	Nil
150km-200km	$20
201km-250km	$25
251km-300km	$30
301km-350km	$40
351km-400km	$50
401km-450km	$60
451km+	$70

E4 Other

F LIMITATION OF BENEFITS

F1 Co Payments

F1.1 A **Co-Payment** may be required under particular **Policies** where detailed in Schedule J.

F1.2 A **Co-Payment** may also be required where the **Member** has transferred from a **Policy** with the health benefits fund of another private health insurer that applies **Co-Payments** and a **Waiting Period** still applies to his or her **Policy**.

F2 Excesses

F2.1 An **Excess** may be required under particular **Policies** where detailed in Schedule J.

F2.2 An **Excess** may also be required where the **Member** has **Transferred** from a **Policy** with the health benefits fund of another private health insurer that applies **Excesses** and a **Waiting Period** still applies to his or her **Policy**.

F2.3 If the **Hospital** admission fee is less than the **Excess** payable on the **Policy** for a **Member** for their first admission, the balance of the **Excess** shall be applied to any subsequent admissions within the same **Calendar Year**; up to the value of their **Excess**.

F3 Waiting Periods

F3.1 **Benefits** are not payable in respect of services provided to a **Member** during a **Waiting Period**.

F3.2 When a member of another private health insurer **Transfers** to Westfund without a break in coverage:

- Westfund may apply all relevant **Waiting Periods** to any **Benefits** under the Westfund **Policy** that were not provided under the previous policy;
- the unexpired portions of any **Waiting Periods** not fully served under the previous policy will apply;
- where the **Benefits** that would have been provided under the previous policy are lower than the **Benefits** payable by **Westfund**, the lower **Benefits** will apply for the relevant **Waiting Period**;
- where the previous policy carried a higher **Excess** or **Co-Payment**, the difference between any **Excess** or **Co-Payment** payable under the previous policy and the new **Policy** will apply for the relevant **Waiting Period**.

This rule F3.2 is subject to rule F3.7.

F3.3 Where a Westfund **Member Transfers** to another Westfund **Policy** he or she shall be treated as a **Transfer** from the health benefits fund of another private health insurer in relation to the application of **Waiting Periods.**

F3.4 **Waiting Periods** do not apply to a newborn child of a **Member** that has served all **Waiting Periods**. Any **Waiting Periods** that remain for a **Member** at the time of birth will apply to a newborn child. A newborn child of a **Member** will be covered if they have been added to an eligible **Policy** (refer Rule C3.2) within three months of birth. A child added to a **Policy** three months after their birth date will be subject to all **Waiting Periods**.

F3.5 A **Waiting Period** will not apply to a **Policy** that covers a person who held a gold card or was entitled to treatment under a gold card (as defined in the **PHI Act**) or to members of the Australian Defence Force or people in Antarctica who have health cover provided as part of their employment.

F3.6 **Benefits** are not payable in respect of services provided during a **Waiting Period**.

The following **Waiting Periods** apply to **Benefits** payable for **Hospital Treatment**, **Hospital-Substitute Treatment** and **Chronic Disease Management Programs:**

Accident-related hospitalisation	1 day
Hospital psychiatric services, Palliative care and Rehabilitation	2 months
Pregnancy and birth	12 months
Treatment of a **Pre-existing Condition** (excluding Hospital psychiatric services, Palliative care and Rehabilitation)	12 months
All other treatments (not listed above)	2 months
Accommodation **Benefit**, Inpatient Travel **Benefit**	12 months
Chronic Disease Management Programs	12 months

The following **Waiting Periods** apply to **Benefits** payable for **General Treatment:**

Emergency Ambulance Transport	1 day
Non-Emergency Patient Transport, **General Dental**, Optical (excluding Laser Eye Surgery), Other Therapies (excluding Surgical Treatment by a Podiatrist), Prescriptions, **Vaccinations**, Injections, Prevention and Health Management (excluding Antenatal Classes)	2 months
Major Dental, **Orthodontic**, **Dental Top Up**, Surgical Treatment by a Podiatrist, Antenatal Classes, Health Aids and Appliances (excluding Hearing Aids and Accessories, FM Systems), Outpatient Travel **Benefit**	12 months
Laser Eye Surgery, Hearing Aids and Accessories, FM Systems	36 months

F3.7 A **Member** who has held a policy with **Hospital** cover (whether as a member of Westfund or another private health insurer) and upgrades to a **Policy** which includes psychiatric treatment may elect to waive the 2 month **Waiting Period** that applies to psychiatric treatment upon upgrade. If the **Member** has held **Hospital** cover for at least 2 months, the **Waiting Period** is waived. If the **Member** has held **Hospital** cover for less than 2 months, the **Waiting Period** will be 2 months less the period during which the **Member** held **Hospital** cover under the previous policy. This waiver can only be accessed once in a **Member's** lifetime; as specified in the Private Health Insurance (Complying Product) Rules.

F4 Exclusions

F4.1 Some procedures may be excluded under particular **Policies** where detailed in Schedules I & J of these rules.

F5 Restricted Benefits

F5.1 **Restricted Benefits** may apply under particular **Policies** where detailed in Schedules I & J.

F6 Compensation Damages and Provisional Payment of Claims

F6.1 The following conditions apply to **Benefits** in respect of compensable services:

- **Benefits** are not payable in respect of services provided to a **Member** as a result of an **Accident**, illness, injury, condition or other incident for which there exists in the opinion of Westfund, a right to claim compensation from a third party or authority at law or under any insurance or arrangement or for which the **Member** has personally received a payment or consideration in settlement of a claim for compensation or damages however the settlement is described, including payments by way of ex gratia and/or non-disclosed settlement.
- In circumstances in which the preceding paragraph applies, and Westfund makes an ex gratia payment, the **Member** shall repay to Westfund any such ex gratia payment, and interest at no more than the Commonwealth Bank's 90 day bill rate at the relevant time, where the **Member** subsequently becomes entitled to receive a payment or consideration in settlement of a claim for compensation or damages (howsoever described). The liability of the **Member** to repay shall apply regardless of whether the **Member** continues to be a **Member** of Westfund.
- Where the **Member** receives, or becomes entitled to receive, a lesser amount than the sum of ex gratia payments made by Westfund, then the **Member's** liability to repay to Westfund shall be limited to such lesser amount.
- In addition to any other terms or conditions which Westfund may apply under this rule, the **Member** shall provide:
  (i) an undertaking in a form approved by Westfund to repay to Westfund the amount of the ex gratia payment;
  (ii) an undertaking to keep Westfund informed of progress towards resolution of the claim and to provide Westfund with full particulars of the settlement terms reached; and
  (iii) an undertaking to notify Westfund within 14 days either personally or through the **Member's** solicitor when a settlement is reached.

F7 Other

G CLAIMS

G1 General

G1.1 Claims shall be submitted to Westfund on the required form either by mail, in person to a Westfund Care Centre, via fax or email. A claim may also be submitted via the Westfund website (www.westfund.com.au) or via the Westfund App. Phone claims may only be submitted by a Westfund provider.

G1.2 Claim forms, where required, must be completed in full including declarations by the **Member** in relation to third party and workers compensation claims. A recorded verbal declaration over the phone can only be accepted for claims submitted by a Westfund provider.

G1.3 Westfund reserves the right to refuse a claim that is not submitted on the correct form.

G1.4 Documentation required in support of a **Benefit** claim is detailed below:

Claim Type	Claim Form and Account	Supplementary Information or Documentation Required
Medical (non-Access Gap)	Claim Form plus Medicare Account/Receipt	Nil
Dental • **General Dental** • **Major Dental**	Claim Form plus Account/Receipt	Nil
Dental • **Orthodontic**	Claim Form plus Account/Receipt	Certification of work completed for progress payments
Optical	Claim Form plus Account/Receipt	Nil
Other Therapies • Acupuncture • Chinese Herbalism • Chiropractic • Clinical Psychology • Counselling • Dietetic • Exercise Physiology • Home Nursing • Myotherapy • Nutrition • Occupational Therapy • Osteopathic • Physiotherapy • Podiatry • Remedial Massage	Claim Form plus Account/Receipt	Nil

• Speech Therapy • Vision (Eye) Therapy		
Non **PBS** Pharmaceuticals / **Vaccinations** / Injections	Claim Form plus Account/Receipt	Official Pharmacy Receipt required where provided by pharmacy Contraceptives, anabolic steroids or cosmetic injections must be accompanied with a letter from a medical practitioner detailing that the pharmaceutical is treating a specific health condition. (Letter is valid for the Lifetime of **Policy**)
Prevention and Health Management • Aquatic Programs • Fitness Centre • Mental Health Programs • Virtual Gastric Banding • Weight Loss Programs	Claim Form or Health Management Declaration Claim Form plus Account/Receipt	Letter of recommendation or Health Management Declaration Claim Form must be completed by a Medicare Registered Practitioner and detail the specific health condition being treated
Prevention and Health Management • Antenatal Classes • Audiology Test • Bone Density Tests • Bowel Testing Kits • Calcium Score • Chronic Disease Association Fees • Chronic Disease Health Screens • Diabetes Education • Eye Health Tests • Mammograms • Mole Scanning • Omega 3 • Probiotics • Hypnotherapy • Thin Prep Pap Tests • Vitamins	Claim Form plus Account/Receipt	Nil

Health Aids and Appliances • Artificial Limbs • Braces • Burns Suit • **Cardiac Monitors** • Compression Garments/Devices • **Devices for Sleep Apnoea and diagnosed snoring** • INR Monitor • Low Vision Aids • Mammary Prostheses and Brassieres • Mobility Aids • Orthopaedic Boots (custom made) • Orthotics (custom made/preformed) • Oximeter • Oxygen and Accessories • Repairs to Devices • **Respiratory Aids** • TENS Machine • Wigs	Claim Form or Health Management Declaration Claim Form plus Account/Receipt or: Claim Form plus Account/Receipt if Health Aid or Appliance is provided by or purchased/hired from a Medicare Registered Practitioner.	Letter of recommendation or Health Management Declaration Claim Form must be provided by a Medicare Registered Practitioner and detail the need for the appliance to treat the specific health condition. Lifetime documentation required: • Artificial Limbs • **Cardiac Monitors** • Compression Garments/Devices • **Devices for Sleep Apnoea and diagnosed snoring** • INR Monitor • Low Vision Aids • Mammary Prostheses and Brassieres (no letter required if a hospitalisation for a mastectomy is recorded with Westfund) • Oximeter • Oxygen and Oxygen Accessories • Repairs to Devices (unless initial purchase is recorded with Westfund) • **Respiratory Aids** • TENS Machine • Wigs (no letter required if a hospitalisation for a medical condition is recorded with Westfund) Documentation required every **Calendar Year**: • Braces • Burns Suit • Mobility Aids • Orthopaedic Boots • Orthotics
Health Aids and Appliances • Blood Glucose Monitors • Blood Pressure Monitors	Claim Form plus Account/Receipt	Nil

• Sleep Apnoea Accessories • Sleep Apnoea Masks • Hearing Aids and Accessories • FM Systems • TENS Accessories		
Ambulance • **Emergency Ambulance Transport** • **Non-Emergency Patient Transport**	Claim Form plus Account/Receipt	Nil
Funeral Expenses	Claim Form plus Funeral Account/Receipt	Confirmation of date of death is required (refer rule C8.10)
Accommodation	Travel & Accommodation Claim Form plus Hotel/Motel or Hospital Receipt	Record of hospitalisation on membership
Inpatient Travel	Travel & Accommodation Claim Form	Record of hospitalisation on membership
Outpatient Travel	Travel & Accommodation Claim Form	Receipt or letter of attendance from specialist

G1.5 Westfund will accept a photocopy, faxed or emailed copy of any account or receipt. In the case of photocopied, faxed and emailed accounts/receipts, original documents must be retained by the **Member** for a minimum of 24 months from the date the claim is made. Westfund may request to sight the original document during this time and may seek to recover **Benefits** paid where this cannot be produced.

G1.6 Westfund will not accept any account, receipt, prescription or any other document which has been altered in any way by any person so as to misrepresent any of the original details contained on those documents.

G1.7 Accounts or receipts issued by providers must be in English and contain the following information to permit payment of a **Benefit**:

- The name and provider number of the issuing provider
- The date of issue of the invoice
- The name of the patient
- Date of service
- Description of service and any applicable item number
- Cost of service or services should be shown as individual amounts (except in dental as these may be bulked as a total amount)
- Any amount paid to the provider and date paid including any discounts given
- Any amount outstanding

- Any notations such as ‘Quote’ or ‘Duplicate’ where necessary

Additional Information required for Prescriptions/**Vaccinations**/Injections where official pharmacy receipt is provided:

- Private/Non NHS/Non **PBS**
- Script number
- Prescriber Name(doctor)
- Prescriber Number

G1.8 **Benefits** are not payable if an application or claim form contains false or misleading information.

G1.9 All documents submitted in connection with a claim become the property of Westfund, unless otherwise agreed.

G1.10 Westfund reserves the right to request further information including a copy of any treatment plans.

G1.11 **Benefits** are not payable where a claim is lodged more than two (2) years after the date of service. Westfund may waive this rule at its discretion.

G1.12 **Benefits** paid by cheque are only payable to the Provider or the **Primary Member** unless the **Primary Member** requests otherwise.

G1.13 Any supplementary documentation required from a Medicare Registered Practitioner or medical practitioner as noted in G1.4 must be less than 12 months old at the date the service was provided.

G2 Other

G2.1 Westfund may require certain claims to be submitted on or accompanied by specific forms depending on the nature or circumstances of the service including but not limited to WorkCover, acute care, intensive care and specific services in contracted **Hospitals**.