



Health Benefits Fund Rules

Effective 3 September 2021

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A INTRODUCTION

A1 Rules Arrangement

A1.1 Application of the Fund Rules

These Fund Rules apply to all CUA Health Pty Ltd (ABN 98 098 685 459) private health insurance products.

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

A1.2 Contents of the Fund Rules

The Fund Rules consist of:

- The General Conditions (in Fund Rules A to G); and
- The Schedules (in Fund Rules H to M).

A2 Health Benefits Fund

A2.1 Establishment and Administration of the Fund

CUA Health is a proprietary company limited by shares, incorporated under the *Corporations Act 2001* and is a registered private health insurer under the *Private Health Insurance (Prudential Supervision) Act 2015*.

CUA Health has established, conducts and administers a Health Benefits Fund (the Fund) which relates to its health insurance business.

A2.2 Purpose of the Fund

The purpose of the Fund is to provide Benefits to, or on behalf of, Policy Holders in accordance with these Fund Rules.

A3 Obligations to Insurer

CUA Health Policy applicants shall provide any reasonable and relevant information to CUA Health.

Existing Policy Holders shall provide such information as reasonably requested from time to time to facilitate the management of Policy Holder records.

All Policy Holders of CUA Health are bound by the Fund Rules and Fund Policies as amended from time to time.

A4 Governing Principles

The operation of CUA Health is governed by:

- Private Health Insurance Act 2007 (the PHI Act)
- Private Health Insurance (Prudential Supervision) Act 2015 (the PHI(PS) Act)
- Private Health Insurance Rules
- *Corporations Act 2001* (the Corporations Act)
- Constitution of CUA Health
- these Fund Rules
- the Fund Policies.

A5 Use of Funds

A5.1 Income credited to the Fund

CUA Health shall credit to the Fund:

- a) all Premiums paid by Policy Holders; and
- b) Any other moneys or income as required by the PHI(PS) Act to be credited.

A5.2 Use of Assets

CUA Health may use the assets of the Fund to:

- a) pay Benefits in accordance with these Fund Rules;
- b) pay for other liabilities or expenses incurred for the business operations of the Fund;
- c) make investments; or
- d) Make other distributions, payments or transfers permitted or required under the PHI(PS) Act or Corporations Act.

A5.3 Audit

CUA Health accounts and records shall be audited in accordance with legislative requirements.

A6 No Improper Discrimination

When making decisions in relation to Policy Holders, CUA Health shall at all times comply with the community rating principle within the PHI Act and not improperly discriminate on the basis of:

- the suffering by a person of 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 a religious belief of a person; or
- the age of the person, except to the extent allowed under the PHI Act (lifetime health cover); or
- where a person lives, except to the extent allowed under 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 the PHI Act; or
- Any matter set out in the Private Health Insurance (Complying Product) Rules.

A7 Changes to Rules

A7.1 Amendments to the Fund Rules

CUA Health may amend these Fund Rules at any time in a manner consistent with the PHI Act and the PHI (PS) Act.

A7.2 Overriding Waiver

CUA Health may, in writing, waive the application of a particular Fund Rule at its discretion, provided that the waiver does not reduce the relevant Policy Holder's entitlement to Benefits and subject to the PHI Act.

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

A7.3 Notification to Policy Holders

Where CUA Health amends, or proposes to amend these Fund Rules and the amendment would be detrimental to a Policy Holder, CUA Health will inform the Policy Holder about the change a reasonable time before the change comes into effect, in accordance with the Private Health Insurance Code of Conduct.

Where an amendment to the Fund Rules requires a change to the Private Health Information Statement for a Product, CUA Health will also provide the Policy Holder of an affected Policy an updated Private Health Information Statement for that Policy as soon as practicable after it has been updated.

A7.4 Premiums

Before increasing premiums, CUA Health will provide each Policy Holder with a written notice of the increase in accordance with the *Private Health Insurance (Incentives) Rules*.

A8 Dispute Resolution

A8.1 Complaints

A Policy Holder may make a complaint to CUA Health at any time.

CUA Health will endeavor to respond to complaints quickly and efficiently and will not charge a fee for such a service.

A8.2 Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman is available to assist an Insured Person who has been unable to resolve issues with the CUA Health.

Nothing in these Fund Rules prevents an Insured Person from approaching the Private Health Insurance Ombudsman at any time.

A9 Notices

A9.1 Correspondence

CUA Health Pty Ltd will send any written correspondence to the most recently advised postal address, phone number, fax number or e-mail address of the relevant Policy Holder, except as otherwise agreed.

A9.2 Availability of Rules to Policy Holders

Copies of these Fund Rules are available to Policy Holders upon request.

A10 Winding Up

CUA Health's Fund may be terminated in accordance with the PHI (PS) Act.

A11 Other

This Rule is left intentionally blank.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

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

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

Unless otherwise specified, the meanings attached to the words and expressions in the PHI Act and the PHI (PS) Act shall apply to these Fund Rules.

Determinations made by the Minister from time to time in relation to CUA Health shall be deemed to form part of these Fund Rules and are to be read as part of these Fund Rules.

B2 Definitions

Under these Fund Rules, the following definitions shall apply:

“Access Gap Cover” means CUA Health’s Agreements that provides a no Gap or known Gap Benefit in excess of the Medicare Benefits Schedule.

“Accident” means an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or injury to the body, which requires immediate Treatment. This definition excludes unforeseen Conditions attributable to medical causes.

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

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

“Adult” means an Insured Person who is not a Dependant Child.

“Age-based Discount Policy” has the meaning ascribed to it under Rule 11A of the Private Health Insurance (Complying Product) Rules 2015.

“Agreement” means an understanding between a Hospital or a Medical Provider and CUA Health in which the Hospital or Medical Provider agree to an accepted payment by CUA Health for monies owed for Treatment to an Insured Person.

“Alternative Therapies” means professional Treatment that is:

- a) a General Treatment;
- b) approved by CUA Health; and
- c) provided during a Consultation with a practitioner who is recognised by CUA Health as an alternative health care provider.

“Approved Provider” means a provider of General Treatment (whether the provider is an individual or an organisation) who:

- a) is approved and registered by CUA Health as a provider of relevant treatment, goods or services pursuant to Fund Rule E3;
- b) holds all necessary registrations, licenses or approvals under relevant State or Territory legislation to render the relevant treatment, goods or services including in relation to the premises from which the treatment, goods or services are to be, or are being, provided; and
- c) Complies with all other requirements of the Private Health Insurance (Accreditation) Rules.

“Benefit” means the amount of money payable by the Fund to, or on behalf of, an Insured Person to an Approved Provider, Medical Provider or Hospital by the Fund in accordance with the terms of these Fund Rules.

“Child/children” means one of the following:

- a) a natural child (including a new-born child)
- b) an adopted child
- c) a foster child, or
- d) A step child (that is a natural, adopted or foster child of the person's partner / spouse).

“Chronic disease” is a disease that has been, or is likely to be, present for at least 6 months, including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis and a musculoskeletal condition.

“Chronic disease management program” means a program that:

- a) is intended to:
 - i. reduce complications in a person with a diagnosed chronic disease; or
 - ii. prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease; and
- b) requires the development of a written plan that:
 - i. specifies the allied health service or services and any other goods and services to be provided; and
 - ii. specifies the frequency and duration of the provision of those goods and services; and
 - iii. specifies the date for review of the plan; and
 - iv. has been provided to the patient for consent, and consent is given to the program, before any services under the program are provided; and
- c) is coordinated by a person who has accepted responsibility for:
 - i. ensuring the services are provided according to the plan; and
 - ii. monitoring the patient's compliance with the agreed goals and activities specified in the plan.

“Claim” means a claim for a Benefit.

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

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

“Cosmetic Surgery” means surgical procedures:

- a) listed in the Plastic and Reconstructive Section (Subgroup13) of the Medicare Benefits Schedule that:
 - i. are not Clinically Relevant; or
 - ii. do not meet the eligibility conditions for the payment of Medicare Benefits; or
- b) of a plastic or reconstructive nature that are not listed in the Medicare Benefits Schedule.

“Contribution Group” means any group of Policy Holders that have been approved by CUA Health as a belonging to a Contribution Group.

“Co-Payment” means a contribution a Policy Holder agrees to pay towards Hospital Treatment.

“Corporations Act” means the *Corporations Act 2001 (Cwth)*.

“CUA Health” means CUA Health Pty Ltd ABN 98 098 685 459.

“Dependant Child” means a Child of a Policy Holder that is:

- a) less than 23 years of age;
- b) does not have a partner / spouse; and
- c) Is substantially maintained and supported by a Policy Holder.

Or is:

- a) aged 23 to less than 25 years of age;
- b) a full-time student at a recognised school, college, tertiary institution or university; and
- c) does not have a partner / spouse; and
- d) is substantially maintained and supported by a Policy Holder.

“Excess” means an amount of money a Policy Holder agrees to pay towards Hospital Treatment before Benefits are payable.

“Fund” means the health benefits fund conducted by CUA Health in accordance with the PHI (PS) Act.

“Fund Policy” means a policy relating to the operation of the Fund by CUA Health which supplements the Fund Rules that are amended from time to time.

“Fund Rules” means these rules relating to the operation of the Fund by CUA Health.

“General Treatment” means treatment, including the provision of goods and services, that is:

- a) intended to manage or prevent a disease, injury or condition; and
- b) is not Hospital Treatment, but includes Hospital-Substitute Treatment; and
- c) is not excluded from being ‘general treatment’ under the PHI Act.

“Health management program” means a program that is intended to ameliorate a person's specific health condition or conditions approved by CUA Health and provided by a Medical Provider or an Approved Provider.

“Hospital” means a facility which the Minister has declared a hospital under the PHI Act.

“Hospital-Substitute Treatment” means General Treatment that:

- a) substitutes for an episode of Hospital Treatment; and
- b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and
- c) Is not specified in the *Private Health Insurance (Complying Product) Rules* as a treatment that is excluded from this definition.

“Hospital Treatment” shall mean treatment (including the provision of goods and services) that:

- a) is intended to manage a disease, injury or condition; and is provided to a person:
 - i. by a person who is authorised by a Hospital to provide the Treatment; or
 - ii. under the management or control of such a person; and
- b) either:
 - i. is provided at a Hospital; or
 - ii. Is provided, or arranged, with the direct involvement of a Hospital.

“Insured Person” means a Policy Holder or a Dependant Child covered by a Policy in accordance with these Rules.

“Maximum Benefit Limit” or **“Lifetime Limit”** means the amount determined by CUA Health or another private health insurer at which no further benefits shall be payable for that person for services.

“Medical Practitioner” means a person as defined in sub-section 3(1) of the *Health Insurance Act 1973 (Cth)*.

“Medical Provider” means a person who:

- a) is registered or licensed as a Medical Practitioner under a law of a State or Territory;
- b) satisfies the provider eligibility requirements for the payment of Medicare benefits; and
- c) Complies with all other requirements of the *Private Health Insurance (Accreditation) Rules*.

“Medicare Benefit” means a Medicare benefit under Part II of the *Health Insurance Act 1973 (Cth)*.

“Mental Health Upgrade” means the waiver of the two month waiting period on Psychiatric Services for an upgrade to a higher level of hospital cover for an eligible member. This can only be used once in a Member's lifetime across any Private Health Insurer in accordance with Division 78 of the Act.

“Minister” means the Minister for Health in the Commonwealth Government.

“Nursing Home Type Patient” means a nursing-home type patient as defined in the *Private Health Insurance (Benefit Requirements) Rules*.

“Nursing Home Type Patient Benefit” means the Benefit determined by the Minister for any Hospital Treatment provided to a person while they are a Nursing Home Type Patient.

“PHI (PS) Act” means the Private Health Insurance (Prudential Supervision) Act 2015 (Cth).

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

“Policy Holder” means a person who is insured under the Policy and who is not a Dependant Child.

“Policy” means a complying health insurance policy within the meaning of the PHI Act that is issued by CUA Health.

“Pre-Existing Ailment” or **“Pre-Existing Condition”** is an ailment or illness or condition the signs or symptoms of which a Medical Practitioner appointed by CUA Health considers, after examining information furnished by the Insured Person's Medical Practitioner who treated the ailment or illness, and other material relevant to the Claim for Benefits, were in existence (as opposed to in evidence) at any time during the six months ending on the day and time the Insured Person commenced with CUA Health or upgraded to a higher level of Cover.

“Private Practice” is a practice operated on an independent and self-supporting basis either as a sole, partnership or group practice but not under an agreement with, or the subsidy by, another party for the provision of accommodation, facilities or services. Practitioners in practice at a public hospital or any other type or class of publicly funded facility do not normally meet the guidelines applicable to Private Practice.

“Private Room” is a room designed and equipped specifically for the care of one patient. Charges at the private room rate may be levied where placement in a private room is at the discretion and choice of the Insured Person and not for medical or nursing convenience.

“Product” has the meaning set out in subsection 63-5(2) of the PHI Act.

“Psychiatric” or **“Rehabilitation”** patient classifications and the accreditation of particular treatment programs shall be a matter for the CUA Health who will make reference to the guidelines provided by the Royal Australian & New Zealand College of Psychiatrists and the Australian College of Rehabilitation Medicine.

“Risk Equalisation Trust Fund” means the Private Health Insurance Risk Equalisation Trust Fund continued in existence under Part 6-7 of the Act.

“Risk factors for chronic disease” include, but are not limited to:

- a) lifestyle risk factors, including, but not limited to, smoking, physical inactivity, poor nutrition or alcohol misuse; and
- b) biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; and
- c) family history of a chronic disease.

“**Waiting Period**” is a period of time a Policy Holder must serve on a Cover before benefits are payable. Benefits are not payable for goods and services obtained during a Waiting Period and are further detailed in Fund Rule F3.

B3 Other

This Rule is left intentionally blank.

C MEMBERSHIP

C1 General Conditions of Membership

C1.1 Policy Categories

CUA Health may from time to time offer the following Policy categories:

- Single Policy - Only one Adult
- Single Parent Policy – Two or more people (only one of whom is an Adult the rest of whom are Dependant Children)
- Family Policy, incorporating the following insured groups:
 - 2 Adults (and no-one else);
 - 2 or more people, none of whom is an Adult;
 - 3 or more people, only 2 of whom are Adults.

The classes of people in the insured groups are Adults and Dependant Children as defined in Section B2 of these Rules.

C1.2 Levels of Cover

A person may be admitted as a Policy Holder to CUA Health in one of the Policy categories in respect of one of the following Products:

- Any one level of Hospital Product
- Any one level of General Treatment Product
- Any combination of one level of Hospital Product and one level of General Treatment Product within the scope of product rules as defined in Schedules
- Any other Product determined by CUA Health from time to time.

All Insured Persons under the same Policy shall:

- Belong to the same Policy category, and
- Have the same level of Product or Products.

C2 Eligibility for Membership

Subject to these Fund Rules, any person is eligible to be a Policy Holder of any CUA Health Product.

A person may not be covered by a CUA Health Policy if that person has an equivalent or corresponding Policy with another private health insurer.

C3 Dependants

C3.1 Dependants of Policy Holders

A Dependant Child, as defined in section B2 of the Fund Rules, shall be eligible for cover under a Single Parent Policy or a Family Policy as defined in section C1 of these Fund Rules.

C3.2 Dependants Previously Insured

A person who ceases to be a Dependant Child of a Policy Holder of CUA Health or any other private health insurer may join CUA Health as a Policy Holder. If the application is made within two (2) months of ceasing to be a Dependant Child, no waiting periods will be applied except:

- I. The balance of a waiting period not served under the previous Policy;
- II. The difference in coverage of treatment between the Policies.

C4 Membership Applications

C4.1 Application to Join

An eligible person as defined in section C2 of these Fund Rules may make an application to become a Policy Holder in writing, by telephone or by any other oral or electronic means approved by CUA Health.

All relevant information reasonably requested by CUA Health in order to establish and maintain a Policy must be supplied by the applicant.

C4.2 Acceptance of Application to Join

An application to join the Fund will only be accepted by CUA Health when the relevant Premium required from the applicant is received by CUA Health, as specified in Rule D1.

Upon acceptance of an application to join the Fund, CUA Health will provide one Policy Holder with:

- a) the relevant, up to date Private Health Information Statement; and
- b) Details of what the Policy covers and relevant Benefits limits.

C4.3 Non-Acceptance of Application to Join

CUA Health may refuse an application to join an Insured Person, including a Policy Holder or as a Dependant, where the applicant does not comply with these Fund Rules.

CUA Health must not refuse to join an Insured Person under a Policy if to do so would result in Improper Discrimination as described in A6 of these Fund Rules.

C4.4 Reinstatement of cancelled Policy

If a Policy has been cancelled, CUA Health has the absolute discretion to re-instate the Policy at the request of the Policy Holder. Continuity of Benefit entitlements will be subject to the payment of all outstanding premiums in accordance with Fund Rules D5.

C5 Duration of Membership

C5.1 Commencement Date

Policies shall commence on:

- a) the date the application is accepted by CUA Health; or
- b) where CUA Health agrees, a later commencement date nominated in the application; or
- c) Where CUA Health agrees, in its absolute discretion, an earlier date of no greater than two months as nominated in the application.

A newborn Dependant Child may be added to a Single Parent, Couple or Family Policy from its date of birth provided the application is received by CUA Health within 12 Months of the date of birth. No waiting periods will apply to the child, providing the Policy commenced no later than the Child's date of birth.

A newborn Dependant Child may be added to a Single Policy from its date of birth and no waiting periods will apply to the child provided that:

- a) the Policy commenced no later than the Child's date of birth;
- b) the application is received by CUA Health within 2 Months of the date of birth; and
- c) the Policy Category is amended to Family or Single Parent, as agreed.

A Dependant Child that is added to a Single Parent, Couple or Family Policy more than 12 Months after the date of birth will be added from the date of application.

C5.2 End Date

A Policy continues until the date the Policy Holder notifies CUA Health in writing that the Policy Holder wishes to cease the Policy under rule C7, or CUA Health notifies the Policy Holder that the Policy has ceased under rule C8.

C6 Transfers

C6.1 Transfers from another private health insurer within two months

Policy Holder or Dependant Child who transfers from another private health insurer within a period of two months from the date to which premiums were last paid shall be accepted as a Policy Holder or Dependant Child to the nearest equivalent Product operated by CUA Health at an equivalent level of benefits, without Waiting Periods, except:

- a) for services not covered by the previous Policy
- b) the unexpired portions of any Waiting Periods (and/or Benefit Limitation Periods for General Treatment) not fully served under the previous Policy; and
- c) for Benefits greater than those payable under the previous Policy.

Transferees from another private health insurer who have reached a Maximum Benefit Limit or Lifetime Limit entitlement for specialist dental services with that insurer shall be required to serve a waiting period of 12 months for Major Dental and Orthodontics services under General Treatment Tables of these Fund Rules.

CUA Health will commence the Policy from the day after cessation with the other insurer and the Policy Holder or Dependant will be required to pay Premiums from that date.

C6.2 Transfers between products within the Fund

Where a Policy Holder transfers Products, and through such transfer, the level of cover and/or benefit entitlements is upgraded or increased, the Policy Holder will be subject to the applicable Waiting Periods before being eligible for benefits at the upgraded or increased level.

Where a Policy Holder transfers to a Product with a higher Benefit, CUA Health will pay Benefits at the previous Product level for treatment or services provided during the Waiting Periods applicable to the new Product.

Where a Policy Holder transfers to a Product with a lower Benefit, CUA Health will pay Benefits at the new Product level for treatment or services provided from the date of transfer.

If a higher excess or higher co-payment applied on the previous Product, the higher excess or higher co-payment will continue to apply for a Benefit for Hospital Treatment or Hospital-Substitute Treatment to a Policy Holder that transfers Products for a period no longer than the maximum allowable Waiting Periods.

C6.3 Previous Benefits will be taken into account

Subject to other Fund Rules, where a Policy Holder transfers from another Private Health Insurer or to a different Product within the Fund, any relevant Benefits that have been paid in a specified time period under the previous Policy may be taken into account in determining the Benefits payable under the new Policy.

'Any relevant Benefits' include, but are not limited to, Benefits that are subject to an annual or other limit or a maximum number of days of hospitalisation.

C6.4 Transfers without continuity of coverage

When a Policy Holder or Dependant Child transfers from another private health insurer to CUA Health with a break in coverage of two (2) months or more in between, CUA Health may treat that person as a new Policy Holder for all purposes, including the application of all relevant Waiting Periods and Benefit Limitation Periods, except those relating to Lifetime Health Cover as specified at rule D4.

C7 Cancellation of Membership

A Policy Holder must authorise cancellation of a Policy or cessation of a Product under their Policy for any Insured Persons as defined in these Rules.

A transfer certificate in the approved form will be provided within 14 days:

- To the person if that person ceases to be a Policy Holder,
- To the new insurer upon request.

C8 Termination of Membership

C8.1 Termination of Policy in Arrears

A Policy Holder whose Premiums are more than two (2) months in Arrears shall be deemed to be no longer a Policy Holder, provided however that CUA Health may at its absolute discretion allow for Arrears to be paid and the Policy continuity maintained.

C8.2 Termination of Policy where a Policy Holder acts improperly

CUA Health may elect to terminate a Policy, in whole or in part, on notice to the Policy Holder or an Insured Person, including, without limitation, if, in CUA Health's reasonable opinion the Policy Holder and/or an Insured Person has been involved in any act to gain an improper advantage, and/or any fraudulent, negligent and/or criminal act in relation to the operation of the Fund and/or CUA Health.

C9 Temporary Suspension of Membership

C9.1 Absence from Australia

Policy Holders who have held a Policy with CUA Health for more than 12 months may apply in writing requesting suspension of a Policy for periods in excess of two months and no more than three years in situations of absence from Australia.

The Policy Holder must provide overseas travel documents to verify departure and return dates from Australia.

The Policy Holder must make an application for suspension for an absence from Australia prior to the date of departure. Suspensions for absences from Australia take effect from the day after departure.

If the Policy has not been terminated, the Policy will recommence with the applicable Premium payments due and payable upon the return date from overseas travel.

If the Policy Holder has identified their proposed date of return on or before the date of departure, then CUA Health will require that the Policy Holder notify CUA Health of this date and the Policy will automatically recommence from the identified date of return. The Policy Holder must pay the relevant Premium to confirm the recommencement of the Policy.

C9.2 No benefits payable during suspension

No benefits are payable for treatment during a period of suspension. Waiting Periods and Benefit Limitation Periods that were applicable to the Policy Holder at the start of suspension continue to apply on resumption of the Policy Holder.

Periods of suspension do not count towards the serving of Waiting Periods or Benefit Limitation Periods.

C10 Other

This Rule is left intentionally blank.

D CONTRIBUTIONS

D1 Payment of Contributions

Premiums payable for each Product are set out in Schedule K of these Fund Rules. Policy Holders of CUA Health must pay Premiums in advance, in the agreed frequency (being weekly, fortnightly, monthly, quarterly, six monthly or yearly). Premiums may be paid up to twelve months in advance.

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

D2 Contribution Rate Changes

CUA Health may amend the Premiums that apply to its Products in accordance with the PHI Act.

Amendments to Premiums will be advised to Policy Holders in accordance with the PHI Act.

Subject to Rule D1, Premiums which have been paid in advance may not be affected by rate changes until a new payment period commences.

D3 Contribution Discounts

CUA Health may from time to time apply a discount up to the maximum discount allowed under the PHI Act.

D4 Lifetime Health Cover

Lifetime Health Cover loadings will be applied to Premiums in accordance with the PHI Act.

Premiums which have been increased for a continuous period of 10 years, or for a period of 10 years that have only been interrupted by permitted days, will have the Lifetime Health Cover loading removed in accordance with the PHI Act.

D5 Arrears in Contributions

Whenever the date to which Premiums have been paid passes, other than a Policy that has been suspended in accordance with Rule C9, the Policy will be in Arrears.

Benefits are not payable for Treatment provided to an Insured Person during a period of Arrears.

A Policy Holder whose Premiums are less than two (2) months in Arrears and pays such Arrears before the end of that period is entitled to services rendered during that period.

A Policy Holder whose Premiums are more than two (2) months in Arrears shall be deemed to be no longer a Policy Holder, provided however that CUA Health may at its absolute discretion allow for Arrears to be paid and the Policy continuity maintained.

D6 Other

This Rule is left intentionally blank.

E BENEFITS

E1 General Conditions

E1.1 Benefits Available

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

E1.2 Reduction in Benefits Payable

CUA Health will not pay Benefits that exceed the actual charge for treatment, goods or services received by the Policy Holder.

The Benefit payable may be reduced in the following circumstances:

- Where the amount paid by a Policy Holder for treatment is lower than the Benefit payable, the Benefit will be reduced to the amount paid;
- Where money is payable from more than one source for the same treatment, CUA Health may reduce its Benefit so that the total money payable from all sources does not exceed the amount charged; and
- Where in the opinion of CUA Health the charge is higher than the provider's usual charge for the treatment, good or service, in which case CUA Health may assess the claim as if the provider's usual charge had applied.

E1.3 Benefits Not Payable

Benefits are not payable:

- For treatment, goods or services provided to a Policy Holder during the Waiting Period;
- During a period for which the Premiums have not been paid (other than in the conditions specified in Fund Rule D5);
- For treatment or services or an item where the expense was incurred by the employer of the Policy Holder or if the Policy Holder obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at CUA Health's discretion;
- Where the provider is not a Hospital, Medical Provider or Approved Provider at the time the treatment, goods or services were provided to the Policy Holder;
- Where the Policy Holder has received, or established a right to receive, Compensation for treatment, goods or services;
- Where the Policy Holder has received, or has the right to receive, and to the extent the Policy Holder has received, or has the right to receive, payment (in full or in part) for the treatment, goods or services from a third party including:
 - Another Private Health Insurer; or
 - In the case of General Treatment, through publicly available funding;
- For treatments, goods or services provided outside of Australia or by a provider without an ABN;
- If false or misleading information is provided in respect of the treatment, goods or services;
- Where the Medical Provider or Approved Provider:
 - at the time the treatment, good or service was provided, has ceased to be engaged in Private Practice; or
 - does not provide the treatment, good or service while engaging in Private Practice; or
 - provides the treatment, good or service from the premises of a Public Hospital, or premises made available to the Medical Provider or Approved Provider from the operator of a Public Hospital, or an entity authorised or allowed by the operator of a Public Hospital to make the premises available to the Approved Provider, unless otherwise agreed to by CUA Health at its absolute discretion
- For a procedure which is:
 - not covered by Medicare;
 - Cosmetic Surgery, except where the procedure is Clinically Relevant;
 - experimental; or
 - relates to clinical trial pharmaceuticals.
- For outpatient services: that is, services provided to patients who are not Admitted Patients, unless otherwise specified by CUA Health;
- For treatment provided to a person at an Emergency Department.
- For benefits in relation to sport, recreation or entertainment unless they are part of a chronic disease management or a health management program approved by CUA Health.

- For General Treatment, services for which a Medicare benefit is payable, except as allowable as hospital substitute treatment or the PHI Act.
- Under Hospital Product, Benefits for Treatment that does not normally require Hospital Treatment.
- For Treatment provided to a newborn child whose mother occupies a bed in the hospital, except where the newborn child is classified as a patient under Section 3 of the Health Insurance Act 1973.
- For treatments or services provided by a family member.

E2 Hospital Treatment

E2.1 Hospital Benefits payable according to Agreements

Hospital Benefits are only payable for Hospital Treatment provided by a person authorised by a Hospital to provide Hospital Treatment.

Benefits in respect of the Hospital Treatment shall be payable in accordance with level of Benefits payable under the Hospital Product as selected by the Policy Holder and will be determined in accordance with the relevant Hospital Agreement.

E2.2 Non-contract Hospitals

For Treatment provided in a non-contract Hospital, CUA Health will pay Benefits that at a minimum are the amounts specified in the *Private Health Insurance (Benefit Requirements) Rules*.

E2.3 Pharmaceuticals provided during Hospital Treatment

Where the cost to an Insured Person for a PBS item is less than the pharmaceutical benefit co-payment (as determined by the Commonwealth Department of Health and Ageing), these drugs are not covered by CUA Health under this section of the Rules.

Where pharmaceuticals are provided as part of a Treatment under a Hospital Agreement, the cost so covered includes the whole of the amount that, but for the Arrangement, would be the cost to the Insured Person of pharmaceutical benefits dispensed to the Insured Person while the Insured Person is an Admitted Patient at the Hospital.

To be eligible for the Benefit, the pharmaceutical item must be:

- Intrinsic to the Hospital Treatment;
- Clinically indicated;
- Essential for the meeting of satisfactory health outcomes for the Policy Holder;
- Directly related to treatment of the condition or ailment for which the Policy Holder was admitted;
- A non-experimental drug or compound item;
- Provided by the Hospital during the Hospital admission and not provided upon discharge; and
- The reason for admission to Hospital was not solely for the administration of the pharmaceutical item.

E2.4 Coverage Requirements

Each Policy that covers Hospital Treatment shall cover any part of Hospital Treatment that is psychiatric care, rehabilitation or palliative care if the Treatment is provided in a Hospital and no Medicare benefit is payable for that part of the Treatment.

E2.5 Surgically Implanted Prostheses

Benefits are payable for a prosthesis, as listed in the *Private Health Insurance (Prostheses) Rules*, where the prosthesis is provided by a Hospital in the following circumstances:

- The prosthesis is provided as part of an episode of Hospital Treatment or hospital-substitute treatment; and
- A Medicare benefit is payable in respect of the professional service associated with the provision of the prosthesis, or the provision of the prosthesis is associated with podiatric treatment by an accredited podiatrist; and
- The person to whom the prosthesis is provided is a Policy Holder or Dependant Child under the Policy; and

- The person is covered by the Policy (wholly or partly) in respect of the episode of Hospital Treatment, hospital-substitute treatment or the professional service.

E2.6 Nursing Home Type Patients

CUA Health will pay the Nursing Home Type Patient Benefit for a Policy Holder while they are classified as a Nursing Home Type Patient.

E2.7 Admission and Discharge Days

The date of admission to Hospital will be included in the period for which a claim may be made, but the date of discharge from Hospital will not be included.

E2.8 Medical Gap Cover

Where a Policy Holder is admitted as a Private Patient and incurs a fee for a medical service rendered as part of Hospital Treatment that has an MBS item number, the Benefit paid:

- Where the provider charges less than the MBS, is the difference between 75% of the MBS fee and the amount charged by the provider; or
- Where the provider charges the MBS fee or more, is 25% of the MBS fee.

Where the Medical Provider has an Agreement as part of CUA Health's Access Gap Cover scheme, an additional Medical Gap Benefit may be payable.

Members may still need to pay an out-of-pocket for medical services rendered as part of Hospital Treatment.

Access Gap Cover is available under any Hospital Product.

E3 General Treatment

E3.1 Benefits Payable

The Benefits payable in respect of General Treatment Services, and the conditions relevant to those Benefits, are set out in the associated Schedules.

Benefits for Dental Treatment are payable in accordance with the schedule of dental benefits maintained by CUA Health.

Benefits are not payable for General Treatment unless the provider is an Approved Provider. CUA Health has absolute discretion to approve or not approve a provider as an Approved Provider under these Fund Rules.

The amount of benefits payable shall not exceed the cost of a professional service, treatment, appliance or other expense in respect of which benefits are payable after taking into account benefits payable from any other source.

The Benefits payable under each Product shall be the same for all policies selecting that Product.

E3.2 Pharmaceuticals

Where the cost to a Policy Holder for a PBS item is less than the pharmaceutical benefit co-payment, these pharmaceuticals are not covered by CUA Health.

E3.3 Hospital Substitute Treatment

Hospital Substitute Treatment Benefits will be paid as specified in the relevant Agreement.

E3.4 Limitations of General Treatment Benefits

As determined from time to time by CUA Health, the General Treatment Benefits specified in the Schedule may be subject to limitations of frequency of treatment for particular items and/or combinations of items, which may be provided at the same time or within particular periods.

E4 Other

Ex gratia payments may be paid at the discretion of CUA Health in respect of claims that would not otherwise attract benefits under these Fund Rules.

Where a Policy Holder receives Treatment outside their State of residence, Benefits applicable to the State or Territory where the Treatment was provided are payable.

F LIMITATION OF BENEFITS

F1 Co Payments

Policy Holders may choose a Policy that covers Hospital Treatment that requires a Co-payment be made.

The amount of Co-payment and relevant limits and conditions are specified in the relevant Product Schedule.

Co-Payments are not payable in relation to Hospital Treatment for Dependant Children.

F2 Excesses

Policy Holders may choose a Policy that covers Hospital Treatment that includes an Excess. The amount of Excess and relevant limits and conditions are specified in the relevant Product Schedules.

F3 Waiting Periods

The Waiting Periods to be served before a Benefit may be paid shall be:

- a) From one day after the date of joining for Accidents occurring after joining, and for Ambulance services.
- b) Twelve months in respect to a matter related to an obstetric condition.
- c) Twelve months in respect to a matter related to a pre-existing ailment or illness.
- d) Two months in respect of hospital or hospital-substitute treatment for psychiatric care, rehabilitation or palliative care (whether or not for a pre-existing condition).
- e) Twelve months from the date of joining in respect to a matter related to benefits for Wisdom Teeth, Crowns and Bridges, Dentures, Orthodontic, Periodontic, Endodontic, Veneers, Podiatry Related Aids, Orthotic Appliance, Prostheses benefits and CUA Health approved appliances.
- f) Twelve or twenty four months from the date of joining for benefits for Hearing Aids depending on product.
- g) Six months from date of joining in respect to a matter related to benefits for Optical services and Wellness Benefits
- h) Two months from the date of joining for all other services.
- i) As defined in (a) to (h) for Policy Holders who up-grade to a higher level of Product. During the respective Waiting Period, the Policy Holder or dependant's existing level of cover at the time of up-grade is used to pay any applicable benefit.
- j) Waiting Periods do not apply to a Policy that covers a person who held a gold card or was entitled to treatment under a gold card.
- k) Waiting Periods do not apply to newborn children, provided they are added to a Family or Single Parent Policy from the date of birth.

CUA Health shall have at its discretion the right to waive or reduce any Waiting Period applying to any of the Products operated by CUA Health provided that such waiver or reduction does not contravene any of the provisions of the PHI Act.

F4 Exclusions

Unless otherwise stated in these Rules, there are no total exclusions applicable to any types of Hospital Treatment on any of CUA Health's Hospital Treatment Products for Clinically Relevant treatment.

F5 Benefit Limitation Periods

This Rule is left intentionally blank.

F6 Restricted Benefits

A Product may restrict Benefits for Hospital Treatment as detailed in the associated Schedules to these Rules.

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Definitions

In Fund Rule F7:

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

F7.2 Obligations of an Insured Person

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

- Inform CUA Health as soon as the Insured Person knows or suspects that such a right exists;
- Inform CUA Health of any decision of the Insured Person to Claim for Compensation;
- Include in any Claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable;
- Take all reasonable steps to pursue the Claim for Compensation to CUA Health's reasonable satisfaction;
- Keep CUA Health informed of and updated as to the progress of the Claim for Compensation; and
- Inform CUA Health immediately upon the determination or settlement of the Claim for Compensation.

F7.3 Entitlement to Benefits for an Injury

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

The expenses referred to above include expenses incurred after the Insured Person has received any Compensation.

F7.4 CUA Health may Withhold Payment

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

F7.5 Provisional Payments

Where a Claim for Compensation in respect of an injury is in the process of being made, or has been made and remains unfinalised, CUA Health may in its absolute discretion make a provisional payment of Benefits in respect of expenses incurred in relation to the injury.

In exercising its discretion, CUA Health may consider factors such as unemployment or financial hardship or any other factors that it considers relevant.

A provisional payment is conditional upon the Insured Person signing a legally binding undertaking and acknowledgment supplied by CUA Health, that contains an agreement by the Insured Person, in consideration for the payment:

- to comply with Fund Rule F7.2;
- that it is bound by these Rules;
- to disclose to CUA Health on request, all matters pertaining to the progress of the Claim and details of any determination made or any settlement reached in respect of the Claim;
- to repay to CUA Health the full amount of the provisional payment as a debt immediately repayable upon the award or settlement of the Claim, whether or not the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future for which Fund Benefits are otherwise payable; and
- That CUA Health has specified rights of subrogation whereby CUA Health acquires all rights and remedies of the Insured Person in relation to the Claim.

F7.6 Where Benefits have been paid by CUA Health

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

F7.7 Rights of CUA Health

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

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

F7.8 Claim Abandoned

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

F7.9 Requirement to Repay Benefits may be waived

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

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

F7.10 Benefits for Expenses Subsequent to Compensation

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

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

F8 Other

This Rule is left intentionally blank.

G CLAIMS

G1 General

Applications for the payment of Benefits shall be in the form prescribed by CUA Health and may include by paper form, electronically or in person. Claims must be lodged with CUA Health within 24 calendar months of the date of the service.

CUA Health shall be empowered to extend the time for the lodgment of Claims beyond 24 calendar months if it deems that non-payment of Benefits would cause hardship to the Policy Holder.

A Policy Holder shall furnish such other evidence as required and advised by CUA Health.

CUA Health may keep copies of documents submitted in connection with a Claim to the extent required to assess the Claim.

The Policy Holder authorises the CUA Health to contact any hospital and/or provider of any professional service for clarification of details and information necessary to assist in the verification of any Claim pertaining to the Policy Holder or Insured Person. CUA Health is further authorised to withhold Benefits payable until the details requested by CUA Health is provided by the Hospital and/or Medical Provider or Approved Provider.

G2 Other

CUA Health may authorise a Policy Holder to delegate to another person the right to claim Benefits to which the Policy Holder or Insured Person may be entitled.