Peoplecare Fund Rules

Effective 1 July 2025

All Registered Private Health Insurers are required to have Fund Rules under the Private Health Insurance Legislation.

These Fund Rules set out the general principles and rules of membership under which Peoplecare conducts its business.

IMPORTANT NOTES

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

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

We recommend that these Fund Rules be read together with your Cover Description, and Private Health Information Statement relevant to your cover.

Where terms are capitalised in these Fund Rules, they have the meaning given to them as determined in Section B of these Fund Rules.

A INTRODUCTION 4
A1 Rules Arrangement 4
A2 Health Benefits Fund 4
A3 Obligations to Insurer 4
A4 Governing Principles 4
A5 Use of Funds 5
A6 No Improper Discrimination 5
A7 Changes to Rules 6
A8 Dispute Resolution 7
A9 Notices 7
A10 Winding Up 7
B INTERPRETATION AND DEFINITIONS 8
B1 Interpretation 8
B2 Definitions 8
C MEMBERSHIP 14
C1 General Conditions of Membership 14
C2 Eligibility for Membership 16
C3 Dependants 16
C4 Membership Applications 16
C5 Duration of Membership 17
C6 Transfers 17
C7 Cancellation of Membership 19
C8 Termination of Membership 20
C9 Temporary Suspension of Membership 21
C 10 Other 24
D CONTRIBUTIONS 24
D1 Payment of Contributions 24
D2 Contribution Rate Changes 25
D3 Contribution Discounts 25
D4 Lifetime Health Cover 25
D5 Arrears in Contributions 25
D6 Other 26

E BENEFITS **26**
E1 General Conditions 26
E2 Hospital Treatment 27
E3 General Treatment 31
E4 Other 33
F LIMITATION OF BENEFITS **33**
F1 Excesses 33
F2 Waiting Periods 34
F3 Exclusions 35
F4 Restricted Benefits 36
F5 Compensation Damages and Provisional Payment of Claims 36
G CLAIMS **39**
G1 General 39
G2 Claims Must Be Accompanied By Required Information 40
G3 Time Limit for Lodgement of Claims 40
G4 Manner of Benefit payment 40

A INTRODUCTION

A1 Rules Arrangement

1. These Fund Rules consist of:

    (a) the General Conditions (Fund Rules A to G); and

    (b) the Schedules of Benefits and Specific Conditions (**Schedules**).

2. These Fund Rules apply to all Products and govern the rights and obligations of Members and Peoplecare in relation to the Fund.

3. The Fund Rules are publicly available on the Fund's website. The Schedules will be provided to Members upon joining and upon request. Where Schedules are amended, they will be provided to Members and made aware of the amendments.

A2 Health Benefits Fund

1. Peoplecare is a not-for-profit organisation incorporated under the Corporations Act 2001(Cth) and has established the Fund in accordance with the Private Health Insurance Legislation.

2. The purpose of the Fund is to provide Benefits to or on behalf of Members towards the cost of Hospital Treatment and/or General Treatment in accordance with the terms of these Fund Rules and the Private Health Insurance Legislation.

3. Peoplecare may supplement the Fund Rules with Fund Policies that are not inconsistent with the Fund Rules. These Fund Policies include:

    (a) Privacy policy; and

    (b) Complaints Handling Policy.

4. All Members of Peoplecare are bound by the Fund Rules and Fund Policies as amended from time to time.

A3 Obligations to Insurer

1. A Member shall provide such information as is reasonably requested from time to time to facilitate the management of the Member records and shall notify Peoplecare of any changes to this information as soon as reasonably possible after the change has occurred.

A4 Governing Principles

1. The operation of the Fund and the relationship between Peoplecare and each Member is governed by:

    (i) The Private Health Insurance Legislation

    (ii) The *Health Insurance Act* 1973 (Cth)

(iii) The *National Health Act* 1953 (Cth)

(iv) The Australian Consumer Law

(v) These Fund Rules

(vi) Fund Policies

A5 Use of Funds

1. Peoplecare shall keep proper accounts and records of the moneys received and expended by the Fund and matters in respect of which such receipts and expenditure take place and of the assets, credits and liabilities of the Fund.

2. There shall be credited to the Fund the whole of the Premiums paid by Policy Holders and all other income arising out of the carrying on by Peoplecare of business as a Registered Private Health Insurer and any "health related business" as defined by the Private Health Insurance Legislation.

3. No amount shall be debited to this Fund other than:

    (a) Payments by the Fund of Benefits payable under these Fund Rules in respect of Members;

    (b) Costs incurred by the Fund in the carrying on of a health insurance business or "health related business" as defined by the Private Health Insurance Legislation

    (c) Costs incurred by the Fund in providing, or arranging to provide Hospital Treatment or General Treatment for Members; or

    (d) To make investments in accordance with the Private Health Insurance Legislation; and

    (e) For any other purpose allowed under the Private Health Insurance Legislation.

A6 No Improper Discrimination

1. Peoplecare shall ensure that the conduct of the Fund shall at all times comply with the community rating provisions of the Private Health Insurance Legislation.

2. When operating the Fund and making decisions in relation to persons applying for a Policy or Members, Peoplecare will not have regard to the following matters:

    (a) 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;

    (b) the gender, race, sexual orientation or religious belief of a person;

    (c) except in relation to the calculation of a Lifetime Health Cover loading and the application of an age-based discount, the age of a person;

(d) where a person lives, except to the extent allowed under the Private Health Insurance Legislation (ie, different Premiums for the same Product based on the State/Territory in which the person resides);

(e) any other characteristic of a person (including, but not just, matters such as their occupation or leisure pursuits) that is likely to result in an increased need for Hospital Treatment or General Treatment;

(f) the frequency with which a person needs Hospital Treatment or General Treatment;

(g) the amount, or extent, of the Benefits to which a person becomes, or has become, entitled during a period, except to the extent allowed under the Private Health Insurance Legislation (ie, limits for General Treatment).

A7 Changes to Rules

1. Peoplecare may amend the Fund Rules in a manner consistent with the Private Health Insurance Legislation and any other law.

2. Peoplecare may in nominated circumstances waive the application of particular Fund Rules at its discretion, provided that the waiver does not result in any breach of any conditions imposed by the Private Health Insurance Legislation.

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

4. Where Peoplecare amends or proposes to amend a Fund Rule and the amendment is or might be detrimental to the interests of a Member, Peoplecare will provide reasonable prior notice of the amendment to the Policy Holders of affected Policies. To avoid doubt, any such notice must comply with the any relevant requirements of the Private Health Insurance Legislation, the Australian Consumer Law and the Private Health Insurance Code of Conduct.

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

6. In accordance with Private Health Insurance Legislation, Peoplecare will provide up to date Private Health Insurance Statements (PHIS):

    (a) to all persons on request;

    (b) to the Policy Holder at least annually;

    (c) to every new Policy Holder, along with details about what the Policy covers and how Benefits under it are calculated and a statement identifying that the Policy is referable to the Fund operated by Peoplecare; and

    (d) to the Policy Holder when a change to the Fund Rules that is or might be detrimental to the interests of a Member requires an update to the PHIS for that Member's Product.

A8 Dispute Resolution

1. The dispute resolution procedure available to Members and others shall be included in the Complaints Handling Policy and at all times will comply with the relevant Australian Standard and the Private Health Insurance Code of Conduct. The Complaints Handling Policy will be publicised via the Peoplecare information brochures and website and available to any person on request.

2. The Complaints Handling Policy includes escalation provisions to the Commonwealth Ombudsman responsible for private health insurance should the internal dispute resolution procedures not resolve the issue. Contact details for the Ombudsman are included in Peoplecare information brochures and on the Peoplecare website.

A9 Notices

1. Peoplecare shall send any necessary correspondence to the most recently advised postal address, or email address of the Policy Holder.

2. A Policy Holder who receives written notice from Peoplecare regarding their Policy that is not specific only to the Policy Holder, must inform all other Members on the Policy of the contents of that notice.

3. These Fund Rules and the associated schedules are available to Members upon request.

A10 Winding Up

1. The winding up of the Fund shall be undertaken at the time in accordance with these Fund Rules and the relevant legislation that is applicable at the time.

2. Adequate notice must be given to Policy Holders of the winding up of the Fund so they can arrange for alternate coverage. A minimum of 12 months' notice must be given to each Policy Holder.

3. When the Fund gives notice under Clause A10.2, that notice shall stipulate the termination date. The Fund will not renew any Policies that are referable to the Fund on or after the termination date. Peoplecare will accept any valid claim for Benefits under a Policy that is or was referable to the Fund if the claim is made before the end of the period of 12 months following the expiry of the last Policy that was referable to the Fund.

4. After all claims have been paid and expenses of the Fund paid, any surplus then remaining shall revert to the Australian Prudential Regulation Authority and then subsequently to the Risk Equalisation Special Account.

5. In winding up the Fund and paying all amounts due to Policy Holders, the Fund shall observe all requirements of the relevant legislation and any regulations in force applicable at the time in relation to the winding up of a Registered Private Health Insurer.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

1. The definitions as set out in the Private Health Insurance Legislation shall be read in conjunction with these Fund Rules and shall be deemed to be part of these Fund Rules and shall have the same meaning as that which is defined in the Private Health Insurance Legislation.

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

3. These Fund Rules are to be interpreted as far as possible in a manner that is consistent with the Private Health Insurance Legislation.

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

B2 Definitions

1. **'Accident'** means an unforeseen event, occurring by chance and caused by an external force or object, which causes involuntary bodily injury to a member, requiring medical treatment by a Registered Medical Practitioner or Emergency Department (excluding by anyone on the same Policy) within 48 hours of the event. Any further treatment required must be completed within 90 days of the event or timeframe otherwise agreed to by Peoplecare.

2. '**Acute Care Certificate'** means a certificate required by Peoplecare from a Medical Practitioner in a form approved by Peoplecare confirming the need for continued acute Hospital care after 35 days of Continuous Hospitalisation.

3. **'Age-based discount'** means a discount which may be applied to Hospital Product Premiums for Members aged between 18 and 29 at the time of purchasing the Hospital Product.

4. **'Agreed Service'** means a treatment, good or service that constitutes Hospital Treatment provided by an Agreement Hospital to a Member, which is specified as an agreed service in the Hospital Purchaser Provider Agreement with that Agreement Hospital.

5. **'Agreement Hospital'** means a Hospital which:

   (a) is subject to a Hospital Purchaser Provider Agreement; or

   (b) Peoplecare deems to be a participating hospital from time to time.

6. **'Ambulance Services'** means services provided by an Ambulance Service Provider for the transport and/or paramedical treatment of persons requiring medical attention including:

   (a) the transport and/or paramedical treatment of persons requiring emergency treatment; and

(b) transport that is requested by the Member's treating doctor because the Member's medical condition requires a level of support and medical monitoring in transit that only an Ambulance Service Provider can provide.

7. **'Ambulance Service Provider'** includes the following service providers:

   (a) ACT Ambulance Service;

   (b) NSW Ambulance;

   (c) Non-Emergency Patient Transportation NSW;

   (d) Ambulance Victoria;

   (e) Queensland Ambulance Service;

   (f) South Australia Ambulance Service;

   (g) St John Ambulance ServiceNT;

   (h) St John Ambulance ServiceWA; and

   (i) Tasmanian Ambulance Service.

8. **'Benefit'** means an amount of money or service that may be provided to a Member, or on behalf of or for the benefit of a Member to a Medical Practitioner, Hospital or other provider by the Fund, in accordance with the terms of a Product and these Fund Rules.

9. **'Child'** means someone who is under the age of 18 years old.

10. **'Chronic Disease Management Program'** means a program approved by Peoplecare that is General Treatment and intended to either:

    (a) reduce the 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.

11. **'Combined Hospital and Extras Product'** means a Product referred to in the Schedules that includes Benefits towards all or some services defined as General Treatment and as Hospital Treatment through a single Product.

12. **'Compensation'** means any of the following:

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

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

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

(d) a payment for negligence; or

(e) any other payment that, in the opinion of Peoplecare, is a payment in the nature of compensation or damages.

13. **'Continuous Hospitalisation'** means any two (2) periods between which there was no break of more than seven (7) days in the provision of Hospital Treatment. Such Hospital Treatment may have been provided in any Hospital.

14. **'Contribution Group'** means a group of Members approved by Peoplecare for the purposes of Fund Rule C1.1.

15. **'Default Benefit'** means the minimum benefit payable as required in the Private Health Insurance Legislation.

16. '**Dependant**' means a person who is the natural child, adopted child, foster child of, or a child being cared for under guardianship by, the Policy Holder or the Policy Holder's Partner and:

(i) who is:

i. a Child; or

ii. a Non-Classified Dependant Person; or

iii. a Student Dependant.

17. '**Dependant Person with a Disability**' means a person who is the natural child, adopted child, foster child of, or a child being cared for under a guardianship by, the Policy Holder or the Policy Holder's Partner and:

(i) aged 18 or above; and

(ii) a participant in the National Disability Insurance Scheme.

18. '**Non-Classified Dependant Person**' means a person who:

(i) is aged between 18 and 20 (inclusive); and

(ii) does not have a Partner.

19. '**Student Dependant**' means a person who:

(i) is aged between 21 to 30 (inclusive);

(ii) is a full-time student; and

(iii) does not have a Partner.

20. **'Non-Student Dependant'** means a person who is the natural child, adopted child, foster child or a child being cared for under a guardianship by the Policy Holder or the Policy Holder's Partner and:

(i) is aged 21 to 30 (inclusive);

(ii) is not a full-time student;

(iii) does not have a Partner; and

(iv) is residing with the Policy Holder.

21. **'Excluded Service'** means services for which Benefits are not payable.

22. **'Ex-Gratia'** means providing a payment for a service or good that is not covered by the relevant Policy or an extension of a Benefit or limit to that entitled under the relevant Policy.

23. **'Extras Product'** means a Product referred to in the Schedules which includes Benefits towards services that constitute General Treatment only.

24. **'Financial Year'** means the period between 1st July and 30th June (inclusive) the following year.

25. **'Fund'** means the health benefits fund established and operated by Peoplecare in accordance with the Private Health Insurance Legislation.

26. **'Fund Policy'** means a policy relating to the operation of the Fund by Peoplecare which supplements the Fund Rules.

27. **'Fund Rules'** means these rules relating to the operation of the Fund by Peoplecare.

28. **'General Treatment'** means treatment (including the provision of goods and services) that is intended to manage or prevent a disease, injury or condition that is not Hospital Treatment. General Treatment includes Hospital-Substitute Treatment.

29. **'Hospital'** means a facility which is declared by the Minister for Health and Aged Care as being a hospital under the Private Health Insurance Legislation.

30. **'Hospital Product'** means a Product referred to in the Schedules which includes Benefits towards services that constitute Hospital Treatment only.

31. **'Hospital Purchaser - Provider Agreement'** means an agreement entered into between Peoplecare and a Hospital (or Hospital operator) and as amended from time to time.

32. **'Hospital-Substitute Treatment'** is treatment that substitutes for an episode of Hospital Treatment and 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.

33. **'Hospital Treatment'** is treatment (including the provision of goods and services) that:

(a) is intended to manage a disease, injury or condition; and

(b) 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

(c) either:

(iii) is provided at a Hospital; or

(iv) is provided, or arranged, with the direct involvement of a Hospital; and

(v) includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance Legislation as "hospital treatment".

34. **'Medical Practitioner'** means a person as defined in section 3(1) of the *Health Insurance Act 1973* (Cth).

35. **'Medical Purchaser-Provider Agreement'** means an agreement entered into, between Peoplecare and a Medical Practitioner, as described under section 172-5 (1) of the *Private Health Insurance Act* 2007 (Cth) and as amended from time to time.

36. **'Member'** means a Policy Holder, Policy Holder's Partner, Dependant, Non-Student Dependant and Dependant Person with a Disability.

37. **'Minister'** means the Commonwealth Minister for Health and Aged Care.

38. **'NHTP Benefit'** means the Benefit determined by the Minister for any Hospital Treatment provided to a person while they are a Nursing Home Type Patient.

39. **'Non-Agreed Service'** means a treatment, good or service that constitutes Hospital Treatment provided by an Agreement Hospital to a Member which is not an Agreed Service.

40. **'Nursing Home Type Patient (NHTP)'** has the same meaning as in Schedule 4 of the *Private Health Insurance (Benefit Requirements) Rules* (Cth).

41. **'Out-of-pocket'** means the difference between the Benefit for a particular treatment and the Hospital's or other provider's fees for that treatment.

42. **'Palliative Care'** means Hospital care provided to a person when a person's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

43. **'Partner'** means a person who lives with a relevant person in a marital or de facto relationship.

44. **'Peoplecare'** means Peoplecare Health Limited (ABN 95 087 648 753) a Registered Private Health Insurer, trading as "Peoplecare Health Insurance".

45. **'Policy'** means a health insurance policy issued by Peoplecare covering Hospital Treatment and/or General Treatment taken out by a Policy Holder.

46. '**Policy Holder**' means the person in whose name an application for a Policy has been accepted and who is responsible for Premium payments.

47. **'Prescribed List'** means the list of medical devices and human tissue products in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules (Cth), as amended from time to time.

48. **'Pre-Existing Ailment'** means an ailment, condition or illness of a Member, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by Peoplecare, existed at any time during the six months preceding the day on which the Member became insured under the relevant Policy.

49. **'Premium'** means the amount payable by a Policy Holder in respect of their Policy.

50. **'Private Health Insurance Legislation'** means the Private Health Insurance Act 2007 (Cth), Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and their regulations, rules and other instruments under them and consolidations, amendments, re-enactments or replacements of any of them.

51. **'Private Practice'** means a professional practice (whether sole, partnership or group) that is self-supporting. This means that its accommodation, facilities and services are not provided or subsidised by another party (as is the case with a public hospital or publicly funded facility) but through the leveraging of fees directly to recipients of treatment, goods or services.

52. **'Product'** means a collection of insurance policies issued by Peoplecare:

    (a) that cover the same treatments;

    (b) that provide Benefits that are worked out in the same manner; and

    (c) whose other terms and conditions are the same as each other.

53. **'Recognised Provider'** means a provider of General Treatment (whether the provider is an individual or an organisation) who:

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

    (b) complies with all other requirements of the Private Health Insurance (Accreditation) Rules; and

    (c) is registered with or otherwise approved or recognised by Peoplecare as a provider of relevant treatment, goods or services pursuant to Fund Rule E3.

54. **'Registered Private Health Insurer'** means an organisation that is registered as a provider of private health insurance in Australia under the Private Health Insurance Legislation.

55. **'Restricted Benefit'** means the Default Benefit that applies to a service or treatment under a Hospital Product.

56. **'Transfer Certificate'** means a certificate provided by a private health insurer, in a form approved under the Private Health Insurance Legislation, setting out health insurance cover details and claims histories of a person transferring from that private health insurer and meeting the required criteria as detailed in the Private Health Insurance Legislation.

C MEMBERSHIP

C1 General Conditions of Membership

1. Policy Categories:

   (i) For the purpose of this section, an **adult** is defined as someone who is not a dependant.

   (ii) Insured groups for Peoplecare shall be:

   (a) single - only one Member

   (b) couple – two adults (and no one else)

   (c) children only – two or more dependants and no adults

   (d) single parent family – two or more people (only one of whom is an adult the rest of whom are Dependants)

   (e) single parent family disability dependant – two or more people (only one of whom is an adult, at least one Dependant Person with a Disability) as well as any Dependants and Non-Student Dependants

   (f) single parent family extended (family plus) – two or more people, (only one of whom is an adult, and at least one of whom is a Non-Student Dependant), as well as any Dependant

   (g) family – three or more people (only two of whom are adults, the rest of whom are Dependants)

   (h) family disability dependant– three or more people (only two of whom are adults, at least one Dependant Person with a Disability) as well as any Dependants and Non-Student Dependants

   (i) family extended (family plus) – three or more people (only two of whom is an adult, at least one of whom is a Non-Student Dependant), as well as any Dependants

(iii) Peoplecare may, at its discretion, approve any group of Members as a contribution group.

2. The Products offered to the insured groups by Peoplecare are:

(i) Hospital Products;

(ii) Extras Products;

(iii) Any combination of a Hospital Product and Extras Product allowed to be purchased concurrently in the Schedules; or

(iv) A Combined Hospital and Extras Product.

3. Rights of Policy Holders and Members:

(i) The Policy Holder or their Partner may authorise in writing or other means approved by Peoplecare, another person to operate the Policy as if that person is the Policy Holder (**Authorised Person**). This authorisation may be withdrawn at any time by the Policy Holder by providing written notice to Peoplecare.

(ii) Only a Policy Holder, their Partner or Authorised Person can:

i. Terminate the Policy;

ii. Lodge a claim;

iii. Add Dependants or other Members to the Policy;

iv. Remove Dependants or other Members from the Policy;

v. Amend the type and level of cover; and

vi. Amend Policy details.

(iii) Any Member over the age of 16 may:

i. Prevent other Members, including the Policy Holder, from accessing that Member's claim history;

ii. Leave the Policy.

(iv) Any Member under the age of 16 may leave the Policy with the agreement of the Policy Holder, the Policy Holder's Partner or Authorised Person.

(v) Any Member may access their personal information and request its correction by contacting Peoplecare.

C2 Eligibility for Membership

Subject to these Fund Rules, any natural person whether or not they are eligible for Medicare benefits, is eligible to be a Member of Peoplecare.

C3 Dependants

1. Dependant is as defined in section B2 of these Fund Rules.

2. Non-Student Dependant is as defined in section B2 of these Fund Rules.

3. Subject to these Fund Rules, a Member who ceases to be eligible to be covered as a Dependant or as a Non-Student Dependant of a Policy Holder may become a Policy Holder by choosing a currently available Product and by paying the relevant Premium.

4. No additional waiting periods for Benefits will apply for a Dependant or Non-Student Dependant becoming a Policy Holder in their own right, provided that:

   (i) The new Product offers an equivalent or lower level of Benefits to that offered under the existing Product;

   (ii) All waiting periods that apply to the existing Product have been served; and

   (iii) The person applies for and commences a Policy within two (2) months of ceasing to be a Dependant or Non-Student Dependant.

C4 Membership Applications

1. The form of application will be as specified by Peoplecare from time to time.

2. The application to become a Policy Holder will be accepted only where accompanied by payment of the Premium for the minimum period relevant to the application or by the provision of the relevant documents or authorities that will facilitate the payment of the relevant Premium. Peoplecare may waive this Fund Rule at its discretion.

3. The person applying for a Policy must make full, true and proper disclosure in the application form as to all matters referred to therein.

4. All relevant information reasonably requested by Peoplecare to establish and maintain a Policy must be supplied by the applicant.

5. If the application to become a Policy Holder is accepted by Peoplecare, and once the application has been processed by Peoplecare, the Policy Holder will receive a welcome pack that will include a Private Health Insurance Statement (PHIS) and the other information required to be provided by Peoplecare in accordance with A7.6(c).

6. Peoplecare may, acting reasonably, reject any application to become a Policy Holder, including where the applicant was a former Member whose Policy was cancelled under

these Fund Rules. Peoplecare will not reject any application for reasons described as improper discrimination under the Private Health Insurance Legislation.

C5 Duration of Membership

1. The Policy commences on the date nominated on the application form, provided that the Policy Holder has paid Premiums from the date of commencement and all application procedures are completed to the reasonable satisfaction of Peoplecare. The Policy will continue until cancelled or terminated in accordance with C7 or C8 (as applicable).

2. A new born child may be added to a Policy from its date of birth, without any additional waiting periods being applied, provided that the Policy commenced no later than the child's date of birth and the child was added to the Policy within 12 months of being born.

C6 Transfers

1. **Transfers from another private health insurer within 30 days**

   Where a member of another private health insurer transfers to Peoplecare within 30 days of the date the member ceased to be covered by the other private health insurer under a policy (**Previous Cover**), and a Transfer Certificate is provided to Peoplecare:

   (i) Peoplecare may, at its discretion, recognise a period of cover under the Previous Cover in determining maximum entitlements for Benefits for General Treatment under the new Policy;

   (ii) The Member will not be required to serve waiting periods except:

   (a) for services not covered by the Previous Cover;

   (b) the unexpired portions of any waiting periods not fully served under the Previous Cover; and

   (c) for Benefits greater than those payable under the Previous Cover;

   (iii) Any relevant Benefits that have been paid within a specified time period under the Previous Cover for General Treatment may be taken into account by

Peoplecare in determining Benefits payable under the new Policy for General Treatment;

(iv) Peoplecare will recognise excess paid in the proceeding 12 months from join date for new joiners;

(v) Peoplecare will not take into account any agreements between the other private health insurer and any provider for the purposes of calculating the level of Benefits covered under the Previous Cover.

2. Transfers from another private health insurer outside 30 days

Where a person who was insured under a Previous Cover transfers to Peoplecare more than 30 days after the member ceased to be covered under the Previous Cover, the person will be treated as a new Member to the extent permitted under the Private Health Insurance Legislation and Peoplecare may apply any applicable waiting periods in full.

3. Transfers between Products

(i) A Member may apply to transfer from any Product to any other Product and Peoplecare reserves the right (subject to this part of the Fund Rules) to either approve or refuse the application.

(ii) Claims for Benefits for treatment or services provided during membership under the previous Product will be paid under the previous Product.

(iii) Where a Member transfers to a Product with a higher level of Benefits:

(a) Peoplecare will pay Benefits at the level of the previous Product for treatment or services provided during any waiting period applicable to the new Product;

(b) The Member will not be required to serve waiting periods except:

i) for services not covered by the previous Product;

ii) the unexpired portions of any waiting periods not fully served under the previous Product; and

iii) where the Benefit limits under the new Product are greater than those that were payable under the previous Product;

(iv) Where a Member transfers to a Product with a lower level of Benefits, Peoplecare will pay Benefits at the level of the new Product for treatment or services provided during membership under the new Product.

(v) Any relevant Benefits that have been paid within a specified time period for General Treatment under the previous Product may be taken into account by Peoplecare in determining Benefits payable for General Treatment under the new Product.

(vi) When the membership under the previous Product had an excess and the membership under the new Product does not have an excess or has a lower excess, the excess under the previous Product will apply for treatment or services provided during the applicable waiting periods.

4. Transfers to another private health insurer

If a Member transfers to a policy of private health insurance with another private health insurer, Peoplecare will provide the Policy Holder, or another such person as they nominate, with a Transfer Certificate.

C7 Cancellation of Membership

1. Where a person joins the Fund or where an existing Policy Holder changes their level of cover and within a period of 30 days decides that they wish to cancel the relevant Policy, then a full refund will be paid by the Fund and the Policy cancelled (provided that no claims have been made against the relevant Policy during that period). The request for cancellation of the Policy or change in Policy will be accepted in a form approved by Peoplecare.

2. The period of 30 days during which the Policy Holder may make the determination to cancel their Policy and receive a full refund of their Premiums (provided that no claims have been made against the relevant Policy during that period) will be deemed to be the "cooling off period".

3. If a Member has made a claim against the relevant Policy during the cooling off period, the Policy Holder may cancel their Policy during the cooling off period but will only be entitled to a refund of Premiums paid in advance of the cancellation date. Premiums when the Policy ceases. Any refund will be calculated from the date of cancellation of the Policy.

4. After the cooling off period, a Policy Holder may cancel their Policy entirely at any time.

5. A Policy Holder may remove any Dependant, Partner, Non-Student Dependant or Dependant Person with a Disability from the Policy.

6. The Policy Holder, Partner or a Dependant aged at least 16 years of age may leave the Policy without the agreement of any other Policy Holder.

7. A Dependant under the age of 16 years of age may leave the Policy with the agreement of a Policy Holder, Partner or Authorised Person.

8. The actions referred to under clauses C7 3-5 will be accepted in a form approved by Peoplecare and may not have a retrospective effect unless otherwise agreed by Peoplecare.

9. Where a Policy has been cancelled Peoplecare has the discretion to reinstate the Policy at the request of the Policy Holder with continuity of entitlements, subject to the payment of all relevant Premiums.

10. Peoplecare will refund Premiums paid in advance of the cancellation date when a Policy ceases. Any refund will be calculated from the date of cancellation of the Policy.

C8 Termination of Membership

1. Peoplecare may terminate a Policy by written notice to the Policy Holder:

   (i) if a Member has not paid a Premium due under the Policy within 60 days of the due date; or

   (ii) after the current maximum period of suspension as specified in Fund Rule C9.

2. If at any time Peoplecare determines that any Member (either whilst a Member or an applicant to become a Member) or any person acting on behalf of a Member or applicant has:

   (i) provided information to Peoplecare which in the reasonable opinion of Peoplecare is false or misleading and has a material impact on the Fund;

   (ii) misled or deceived Peoplecare in any other manner that has a material impact on the Fund, including by failing to provide true and full information at any time;

   (iii) acted or attempted to act improperly which has, or is likely to have, resulted in or may result in:

      (a) the Member obtaining an unfair advantage for himself/herself and/or another person; or

      (b) loss or damage to Peoplecare; or

   (iv) materially or repeatedly breached any of the Fund Rules or any other term or condition of membership,

   Peoplecare may at its discretion:

   (v) terminate the Policy by providing reasonable written notice, after which time:

(a) the Member will not be entitled to payment of Benefits regardless of when the treatment was rendered;

(b) the Member must reimburse the money paid by Peoplecare as a result of the improper conduct; and

(c) Peoplecare will, after deducting all monies payable by the Member under (b) above, repay the Member any balance of Premiums paid by the Member for the period after the date of cancellation;

(vi) not pay any Benefits where the information or conduct has been provided or committed in or connection with the claim for those Benefits and, in addition, recover from the Member all monies paid by Peoplecare arising from the information or conduct; and/or

(vii) set-off any amount payable by Peoplecare to the Member under this part of the Fund Rules against any amount payable by the Member to Peoplecare under this part of the Fund Rules.

3. The termination or cancellation of a Policy under Fund Rules C7 or C8 will not affect the right of Peoplecare to recover from a former Member any monies payable or otherwise owing by that Member to the Fund.

C9 Temporary Suspension of Membership

Peoplecare may consider suspending memberships for 4 reasons:

1. Overseas travel;
2. Financial hardship (Centrelink assistance);
3. Financial Stress / Hardship; or
4. Natural Disaster

Note: Peoplecare may also suspend a Policy for audit purposes, if there is a reasonable suspicion of inappropriate claims, to allow time for investigation (up to 14 days)

	Overseas Travel	**Financial Hardship (Centrelink Assistance)**	**Financial Stress / Hardship**	**Natural Disaster**
Requirements	• All suspensions are at Peoplecare's absolute discretion to allow or not • A Policy cannot be suspended in the first 12 months of membership • Must have a Hospital Product (no Extras Product only)			

	Overseas Travel	Financial Hardship (Centrelink Assistance)	Financial Stress / Hardship	Natural Disaster
	• Must be paid up to date at date of request • If a policy is reactivated before the maximum reactivation date, the Member will not be able to suspend the policy again until they have held and maintained their Policy for the required period as outlined under 'Maximum Period' for each suspension type.			
	• Must be overseas full time for at least 4 weeks	• Policy Holder or Partner on short term unemployment benefit from Centrelink.	• Policy Holder or Partner suffering from financial stress / hardship	• Policy Holder or Partner suffering from financial hardship as a result of a being impacted by a Natural Disaster declared within their LGA (as issued by a Federal, State or Territory Government)
Maximum period	• 2 years • Individual consideration for longer suspensions may be considered only for long term absences where Policy Holder or a Member on the Policy is working overseas. • After reactivation, must have at	• Maximum 6 months • After 6 month's suspension, must reactivate and have at least 6 months of premiums paid before any more suspensions will be considered.	• Maximum 6 months • After 6 month's suspension, must reactivate and have 18 months of premiums paid before a further suspension for Financial Stress / Hardship OR 6 months for all other	• Maximum 6 months • After 6 month's suspension, must reactivate and have 18 months of premiums paid before a further suspension for Natural Disaster OR 6 months for all other

	Overseas Travel	Financial Hardship (Centrelink Assistance)	Financial Stress / Hardship	Natural Disaster
	least 3 months of premiums paid before any more suspensions will be considered.		suspension types.	suspension types.
Documentation required	Proof of leaving/arrival date in Australia: • Boarding pass • Passport • Copy of ticket	• Proof of Centrelink benefits	• Completion and approval of Financial Stress / Hardship Form	• Completion and approval of Natural Disaster Form
Effective Date of Suspension	• Where the suspension has been approved, it will be effective from the date specified by the Member for a future date, or where no date is specified, the date the suspension was applied for, unless an earlier date is agreed by Peoplecare.			
Effect of Suspension	• No Benefits for services provided during the period of suspension will be payable by the Fund. • Periods of suspension will not count as Lifetime Health Cover absent days. Any absence beyond an approved suspension period will be treated as "days without hospital cover" for the purposes of Lifetime Health Cover. • The period of suspension will not count towards any unserved waiting periods.			
Reactivating	• Within 1 month of returning to Australia OR • Within 1 month of maximum (2 years). (whichever's earlier)	• Within 1 month of the cessation of Centrelink benefits OR • Within 6 months (whichever's earlier)	• Anytime during suspension period, but no later than 6 months after the suspension commenced	• Anytime during suspension period, but no later than 6 months after the suspension commenced

	Overseas Travel	Financial Hardship (Centrelink Assistance)	Financial Stress / Hardship	Natural Disaster
Waiting periods	• When policy is reactivated within the prescribed rules, Peoplecare will recognise all previous waiting periods already served. Any outstanding waiting periods must be served upon resumption of the Policy.			
Termination	• If policy is not reactivated by the agreed date and is in arrears, Peoplecare may terminate the Policy on providing notice to the Policy Holder.			

C 10 Other

1. Peoplecare may, in its discretion, decide not to allow anyone to take out, or transfer to, a Product from a specified date (**Closed Product**).

2. In relation to all the Members who are covered under the Closed Product, Peoplecare may either:

   (i) migrate those Members to another Product in accordance with C10.3; or

   (ii) allow those Members to continue holding Policies under that Closed Product.

3. If Peoplecare decides to close a Product, it may migrate some or all Members who hold that Product to another comparable Product as determined by Peoplecare, subject to the Private Health Insurance Legislation. Peoplecare will provide affected Policy Holders with prior written notice of the details of the migration to a comparable Product, in accordance with the Private Health Insurance Legislation. Members may transfer to another Product of their choosing prior to the date of migration.

4. The rules in relation to the recognition of waiting periods in Rule C6 will apply when Members are migrated to another Product by Peoplecare or if Members voluntarily transfer to another Product due to an impending migration under this Rule.

D CONTRIBUTIONS

D1 Payment of Contributions

1. Subject to Fund Rules D3 and D4, all Premiums are to be paid by Policy Holders in advance, at least monthly in accordance with the amounts specified in the Private Health Information Statement for the Policy Holder's Product, State/Territory of residence and insured group available at www.privatehealth.gov.au, or by contacting the Fund directly.

2. Peoplecare may refuse to accept a payment of Premiums or any part thereof that would cause the period of cover to exceed 12 months in advance of the date of payment. Where through any circumstance the period of cover exceeds 12 months from

the current date Peoplecare may refund the portion of the Premiums in excess of 12 months.

D2 Contribution Rate Changes

1. Peoplecare may change the Premiums for any Product in accordance with these Fund Rules and any requirements set out in the Private Health Insurance Legislation.

2. Peoplecare may amend the Premiums referable to a Product in a State/Territory as permitted by the Private Health Insurance Legislation and will provide Policy Holders notice of such amendments as set out in these Fund Rules and required by Private Health Insurance Legislation.

   Where Policy Holders are paid in advance of the date of an announcement of an increase in Premium rates, the date paid to shall be preserved and no adjustment to the Premiums due shall be effected. This rate protection shall apply for a maximum period of 12 months and where the Premiums are paid in excess of that date, an adjustment or refund of excess Premiums shall be made in respect of those Premiums only.

D3 Contribution Discounts

1. Any discounts applicable to Premium payments shall only be in accordance with the Private Health Insurance Legislation, including in relation to Members of a Contribution Group.

D4 Lifetime Health Cover

1. Peoplecare will apply Lifetime Health Cover Rules, where applicable in accordance with the *Private Health Insurance Act 2007*.

D5 Arrears in Contributions

1. A Policy (other than a suspended Policy) is in arrears whenever the date to which Premiums have been paid is earlier than the current date.

2. A Policy Holder who is in arrears for a period of up to two (2) months and pays all such arrears before the end of that period is entitled to retain all benefits of the Policy and submit claims for Benefits for eligible Hospital Treatment or General Treatment rendered during that period.

3. A Policy Holder more than two (2) months in arrears with their Premiums shall be regarded as un-financial and as having forfeited their right to a Policy under these Fund Rules. In these circumstances Peoplecare may terminate the Policy from the last 'paid to' date of the Policy by written notice to the Policy Holder.

4. Peoplecare may review any case and extend the period beyond two (2) months and up to twelve (12) months. The Policy may also be reinstated at the request of the Policy

Holder with continuity of entitlements, subject to payment of all relevant Premiums and with the authority of Peoplecare.

5. Benefits are not payable for eligible Hospital Treatment and/or General Treatment provided to a Member during a period of arrears unless and until the arrears are paid to Peoplecare by the Policy Holder and accepted by Peoplecare.

D6 Other

1. Peoplecare may refuse to accept Premiums where a third party seeks to pay them on behalf of a Policy Holder where there is evidence of "improper advantage" being gained as a result of such payment.

2. Policy Holders are required to pay the Premium rate applicable to the State/Territory of residence in which they reside.

E BENEFITS

E1 General Conditions

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

2. Peoplecare will pay Benefits to Members out of the Fund in accordance with the terms and conditions of the Product referable to the Member's Policy and these Fund Rules. All Benefits and conditions of Benefits are those which are applicable at the date a service is received by a Member.

3. Benefits payable shall not exceed the fees and/or charges raised for any treatment and/or services rendered, being treatment and/or services covered for Benefits under the Policy, after taking into account benefits paid from any other source.

4. Peoplecare may make Benefit payments to:

   (a) a Member where the claims are submitted by the Member and the claims are paid and supported by receipts for the claims;

   (b) a Member, where the claims are submitted by the Member and the claims are unpaid and supported by appropriate claims information (where required) and invoice for payment of the claim and where the Benefit is unable to be paid to the Recognised Provider;

   (c) the Recognised Provider, where the claims are submitted by the Recognised Provider (or transmitted to Peoplecare by Medicare on behalf of the Recognised Provider) the

claims are unpaid and supported by appropriate claims information including (where required) an invoice for payment of the claim and where valid electronic funds transfer details are available; or

(d) the Recognised Provider where accounts are submitted as unpaid and supported by documents providing valid claim details and where valid electronic funds transfer details are available.

E2 Hospital Treatment

1. **Benefits available**
   The Benefits payable with respect to Hospital Treatment and the conditions relevant to those Benefits are set out on the Schedules.

2. **Calculation of Benefits**
   Where Benefits are payable in respect of admission for an overnight stay in a Hospital, those Benefits will be paid according to patient classification and length of stay. Patients are classified according to the medical procedure they are admitted for and as per the guidelines issued by the Commonwealth Department of Health and Aged Care. The classifications are: Surgical, Advanced Surgical, Obstetric, Other (Medical), Psychiatric Care and Rehabilitation.

   A procedure is identified by reference to the relevant item number within the Medicare Benefits Schedule (MBS) or by reference to the Private Health Insurance Legislation.

   Where Benefits are payable in respect of admission to Hospital for a same day procedure, those Benefits will be paid according to the Banding System as issued by the Commonwealth Department of Health and Aged Care from time to time plus (where relevant) any Benefits payable in respect of theatre fees.

   In the absence of any term to the contrary appearing in a Hospital Purchaser Provider Agreement, the following Rules will apply in calculating Benefits:

   (i) For a Surgical patient, Benefits at the Advanced Surgical and Surgical rates will be payable commencing from the day prior to the day upon which the surgery was performed, provided that Peoplecare may approve the payment of additional Benefits at the Advanced Surgical or Surgical rates after consideration of medical evidence and satisfactory proof that a longer pre-operative period was necessary for the particular procedure.
   (ii) For an Obstetric patient, benefits at the Obstetrics rate will be payable only from the day upon which labour (including induction of labour) commences. Benefits are not payable for admission for bed rest or observation prior to commencement of labour, provided that Peoplecare may approve additional Benefits at the Obstetrics or Other (Medical) rate in respect of other hospitalisation directly relating to Obstetrics, after consideration of the medical evidence.
   (iii) For a Psychiatric patient, Benefits at the Psychiatric rate will be payable only where the Hospital Treatment is for a Psychiatric condition that is grouped to a mental disorder diagnostic related group (DRG) and is provided as part of a program approved by Peoplecare and is supported by a psychiatric certificate approved by Peoplecare.

Benefits for Psychiatric patients who receive Hospital Treatment other than in a psychiatric program approved by Peoplecare are payable at the Other (Medical) rate.

(iv) For a Rehabilitation patient, Benefits at the Rehabilitation rate will be payable only where the Hospital Treatment is supported by a Rehabilitation certificate approved by Peoplecare that medically evidences the Member's need for a rehabilitation program to recover from an acute illness or injury.

(v) Where a Member is discharged from Hospital and readmitted (to the same Hospital or another Hospital) within a period of seven days, both periods of hospitalisation will be regarded as continuous, unless the re-admitting Hospital establishes to the satisfaction of Peoplecare that the readmission was for a different medical condition from the previous admission.

(vi) Where a Member undergoes more than one operative procedure during one theatre admission, the procedure which attracts the highest fee under the Medicare Benefits Schedule (MBS) will be used for patient classification purposes.

(vii) Benefits at the Advanced Surgical and Surgical/Obstetrics rates are payable only in respect of the period of hospitalisation at the Hospital where the procedure was performed. Where a Member is subsequently transferred to another Hospital, the medical/other rates of Benefits will be payable from the date of transfer to that other Hospital.

3. Hospital Purchaser Provider Agreements

Where a Member is charged for an Agreed Service provided in an Agreement Hospital which is included in the Member's Product, the Benefit will be determined in accordance with the relevant Hospital Purchaser Provider Agreement.

4. Medical Purchaser Provider Agreements

Peoplecare may, from time to time, for the benefit of Members enter into agreements with Medical Practitioners. Where a Member is charged for a professional medical treatment or service that is included in the Member's Product where a Medical Purchaser Provider Agreement applies, the Benefits will, unless otherwise stated in this part of the Fund Rules, be as specified in the Medical Purchaser Provider Agreement.

5. Non-Agreement Hospitals and Non-Agreed Services

Notwithstanding any other Fund Rules, for treatment, goods or services provided at non-Agreement Hospitals or for Non-Agreed Services provided at Agreement Hospitals which are covered by the Member's Hospital Product, Peoplecare will pay Benefits as determined by Peoplecare from time to time which will be at least equivalent to the Default Benefit. Out-of-pockets may apply.

6. Medical gap

Where a Member is admitted to Hospital as a private patient and incurs a fee for a medical service rendered as part of Hospital Treatment that has an MBS item number and is included in the Member's Hospital Product, the Benefit paid:

(i) where the Medical Practitioner charges less than the MBS, is the difference between 75% of the MBS fee and the amount charged by the Medical Practitioner; or

(ii) where the Medical Practitioner charges the MBS fee or more, is 25% of the MBS fee.

Where the Medical Practitioner has a Medical Purchaser Provider Agreement or is part of the AHSA Access Gap Cover Scheme, an additional Benefit may be payable by Peoplecare.

Members may still need to pay Out-of-pockets for medical services rendered as part of Hospital Treatment included in the Member's Hospital Product.

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.

8. Location of Treatment

Benefits will only be payable for Hospital Treatment included in the Member's Product that is provided by a person who is authorised by a Hospital to provide treatment or under the management or control of such a person. Treatment must be provided either at a Hospital or with the direct involvement of a Hospital.

9. Surgically implanted medical devices and human tissue products

Peoplecare will pay a Benefit equal to the minimum benefit determined by the Minister for any medical devices and human tissue products on the Prescribed List implanted during a medical procedure for which a Medicare benefit is payable and which is provided as part of Hospital Treatment that is included in the Member's Hospital Product. Members may incur an Out-of-pocket.

No Benefit is payable for items that are not on the Prescribed List or which are not surgically implanted.

10. Pharmaceuticals Provided During Hospital Treatment

Peoplecare will pay a Benefit for PBS pharmacy items provided as part of the Member's Hospital Treatment if it is directly related to the treatment for which the Member was admitted.

No Benefit is payable for non-PBS pharmacy items provided as part of the Member's Hospital Treatment unless it is in an Agreement Hospital, the Benefit is specifically included in the relevant Hospital Purchaser Provider Agreement and the pharmaceutical is directly related to the treatment for which the Member is admitted.

Notwithstanding the above, no Benefits are payable for pharmaceuticals:

(i) which are not approved by the Therapeutic Goods Administration for use in Australia or listed on the Pharmaceutical Benefits Scheme;

(ii) where the item is not intrinsic to the Member's episode of care;

(i) dispensed for the sole purpose of use at home.

11. Limitation of Benefits for Podiatric Surgery

Where podiatric surgery is included in a Hospital Product and the service is performed by a registered podiatric surgeon, Peoplecare will pay either the Default Benefit and the fee up to the benefit determined by the Minister for any surgically implanted medical device or human tissue product on the Prescribed List that is associated with the surgery, or a higher Benefit as determined from time to time by Peoplecare. Members are likely to incur an Out-of-pocket, including in relation to the podiatric surgeon's fees.

12. Non-Admitted Services

Unless otherwise determined by Peoplecare, no Benefit is payable for non-admitted services under a Hospital Product.

13. Nursing Home Type Patients

Peoplecare will pay the NHTP Benefit for a Member while they are classified as a Nursing Home Type Patient for Hospital Treatment covered by the Member's Hospital Product. Members will be required to pay an Out-of-pocket while they are classified as a Nursing Home Type Patient.

14. Hospital-Substitute Treatment

Peoplecare will only pay Benefits towards Hospital- Substitute Treatment where:

A Medical Practitioner has certified that the treatment being provided replaces hospitalization.

15. Accident Cover

To be eligible for accident cover:
(a) the Member must be covered under a Product which includes coverage for Accidents;
(b) the event causing the injury must have occurred after coverage commenced;
(c) the event causing the injury must have occurred in Australia;
(d) the subsequent injury/injuries must have been obtained by said Member;
(e) an accident declaration form must be completed by a registered medical practitioner (excluding anyone on the same Policy) and provided to Peoplecare.

Accident cover includes temporary hospital coverage for up to 90 days, or a timeframe otherwise agreed by Peoplecare, for services that may be restricted or excluded under hospital cover, so long as the hospital treatment is required for the injury/injuries sustained during the event.

Accident cover excludes:
(a) medical conditions including sudden illness;
(b) injuries caused by medical conditions;
(c) pregnancy, birth and IVF related services;
(d) accidents arising from or during surgical procedures;
(e) injuries arising from an accident where those injuries are compensable or otherwise

covered by a third party;
(f) aggravation of a pre-existing condition.

E3 General Treatment

1. **Benefits available**
   The Benefits payable with respect to General Treatment and the conditions relevant to those Benefits are set out in the Schedules.

   Peoplecare will pay Benefits for General Treatment (other than Hospital-Substitute Treatment) up to the relevant limits set out in the Schedules. Annual limits will reset each Financial Year.

   Any Benefit for General Treatment expressed as a percentage in a Schedule means that the amount of the Benefit will be calculated as that percentage of the cost of the General Treatment up to the relevant limits set out in the Schedules.

2. **Recognised Providers**
   Peoplecare will only pay Benefits for General Treatment where it is provided by or on behalf of a Recognised Provider. For the avoidance of doubt, Peoplecare will not pay Benefits for treatment provided by someone who was not a Recognised Provider at the time that person provided the treatment.

   Peoplecare will determine, acting reasonably, if someone becomes or remains a Recognised Provider and for which of their treatments Peoplecare will pay Benefits. Peoplecare may choose to "de-recognise" someone from being a Recognised Provider for reasons including, but not limited to, fraudulent behaviour or if the agreement governing the relationship between Peoplecare and that person comes to an end.

3. **Consultation limits**

   Where General Treatment Benefits are payable for initial consultations, they will be limited to one each Financial Year, except for physiotherapy services where two initial consultation services will be claimable.

   Peoplecare will only pay Benefits for one type of service of General Treatment provided by a Recognised Provider in Private Practice per day.

4. **Lifetime limits**

Lifetime Benefit limits or 'lifetime limits' apply equally to Members for particular General Treatments and are not tied to the length of membership. The amount of Benefits that count towards a lifetime limit can be accumulated over two or more Products that may cover a Member and Benefits received by Members for similar services and treatments from other insurance products provided by other private health insurers will be included in the calculation of a Member's total lifetime limit for a treatment or service. The applicable lifetime limit for a Product is stated in the relevant Schedule.

5. **Provider arrangements**
Peoplecare may enter into arrangements with Recognised Providers from time to time. These arrangements may include requirements in relation to agreed fees and services. The Benefits that apply under these agreements may differ from, and will take precedence over, those shown in the Schedules. Lists of Recognised Providers with whom Peoplecare has agreements (if any) are available on our website.

6. **Excluded treatment**
General Treatment does not include:
(i) services for which a Medicare benefit is payable, except as allowable as Hospital Substitute Treatment; and
(ii) treatment primarily for the purposes of sport, recreation or entertainment unless the treatment is provided as part of a "chronic disease management program" or a "health management program" (as those terms are defined in the Private Health Insurance (Health Insurance Business) Rules) approved by Peoplecare.

No Benefit is payable for the following treatments: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, Western herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi and yoga.

7. **Ambulance Services**
(i) Where a Product includes Benefits towards Ambulance Services, Benefits will be payable in accordance with the relevant Schedule.
(ii) There shall be no entitlement to Benefits:
(a) where coverage is included via a State levy included within the Premium referable to a Product;
(b) where the Member holds a State based ambulance membership subscription; or
(c) where the Member is a resident of a State that provides a free ambulance transportation scheme.

8. **Chronic Disease Management Programs**
Benefits for Chronic Disease Management Programs approved by Peoplecare and provided to a Member who is not an admitted patient of a Hospital are payable subject to the following conditions:
(i) relevant waiting periods have been served;
(ii) the Chronic Disease Management Program is not provided as part of Hospital Treatment; and
(iii) the Member holds a Hospital Product that pays Benefits towards Chronic Disease Management Programs.

E4 Other

1. Peoplecare may make payments on an Ex-Gratia basis, at its discretion.

2. Notwithstanding anything to the contrary in these Fund Rules, in respect of any Product, Peoplecare will not pay Benefits towards treatment or a person supplying treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules.

3. Peoplecare may recover from a Member any moneys incorrectly paid to them due to Peoplecare's error within 2 years of the date of the incorrect payment. This includes errors made by Peoplecare because:

   (a) it relied on a mistaken fact or interpretation of the law or a mixture of both;
   (b) it miscalculated figures; or
   (c) it made an administrative or clerical error.

4. If a Member owes any moneys to Peoplecare due to an error by Peoplecare or due to inappropriate claiming by the Member, the Member must pay the debt within 30 days of receiving a request from Peoplecare. If the Member does not pay within 30 days, Peoplecare can recover those amounts by setting them off against any Benefits payable to the Member or from any other moneys refundable to the Member.

F LIMITATION OF BENEFITS

F1 Excesses

1. An excess is an amount of Benefits that a Policy Holder agrees to forego on Hospital Products, in return for a lower Premium than would otherwise apply.

2. The relevant excess is determined each 12 months on a Financial Year basis.

3. The amount of excess and relevant limits and conditions for each Product are as specified in Schedule H.

F2 Waiting Periods

1. Persons eligible for a Policy not previously insured and joining the Fund or existing Policy Holders transferring to a Policy with a higher level of cover shall be subject to the following waiting periods from the date of application:

   (i) In respect to ambulance services – a one (1) day waiting period applies

   (ii) In respect to Accidents – no waiting period applies

   (iii) In respect of any other Hospital Treatment or General Treatment - 2 months, except

      (a) In respect to any optical benefits – 6 months

      (b) In respect of health management programs – 6 months

      (c) In respect of any high cost dentistry such as crowns / bridgework / implants and orthodontic - 12 months

      (d) In respect of laser eye surgery – 24 months

      (e) In respect of hearing aids – 24 months

      (f) In respect of Hospital Treatment or other services related Pregnancy and birth - 12 months

      (g) In respect of any Pre-Existing Ailment – 12 months, except:

         1. psychiatric care – 2 months;

         2. rehabilitation – 2 months;

         3. Palliative Care – 2 months.

      (h) Persons with a Policy covering Hospital Treatment that contains Restricted Benefits for psychiatric services and who have served the two month waiting

period, may upgrade their cover for psychiatric services with no waiting periods once per lifetime.

(iv) for any person who held and was entitled to a treatment under a Department of Veteran Affairs Gold Card – no waiting periods.

2. Dependants of all Policy Holders who are born after the Policy commences shall be entitled to Benefits immediately at birth providing the Policy is at the family rate, as from the date of the birth.

3. Where waiting periods are applicable, no Benefits are payable during said waiting period.

4. Peoplecare may at its discretion waive or reduce any waiting period.

F3 Exclusions

1. Notwithstanding any other provision of these Fund Rules, Benefits are not payable in respect of a Member when:

2.

(i) A Member is given treatment without charge;

(ii) A Member has received, or has the right to receive, payment for the treatment, goods or services from a third party, including another Registered Private Health Insurer, an employer or sports club Insurance;

(iii) A Member has received, or established a right to receive, Compensation for treatment, goods or services;

(iv) A claim is submitted for optical appliances not requiring sight correction e.g. sunglasses;

(v) Treatment is rendered by a provider to:

(a) the provider's Partner, Dependants or business partner;

(b) family members of the provider and the provider's business partner including wife/husband, brother/sister, children, parents, grandparents and grandchildren;

(c) the provider themselves; or

(d) any other person not independent from the provider's practice;

(vi) the provider is not a Hospital, Medical Practitioner or Recognised Provider at the time the treatment, goods or services were provided to the Member;

(vii) the Recognised Provider:

(a) at the time the treatment, good or service was provided, has ceased to be engaged in Private Practice; or

(b) does not provide the treatment, good or service while engaging in Private Practice;

(viii) Services are provided outside the Commonwealth of Australia;

(ix) A claim is for goods or services that are deemed to be primarily for the purposes of sport, recreation or entertainment (unless provided as part of a chronic disease management program or health management program approved by Peoplecare);

(x) A claim is for Hospital Treatment where the goods or services are for cosmetic purposes and no Medicare benefit is payable;

(xi) A claim is in respect of an Excluded Service;

(xii) A claim is in respect of services or treatment rendered during a waiting period;

(xiii) A claim is submitted for a service which occurred while the Policy was suspended or in arrears;

(xiv) A claim is for treatment that is experimental or involves a clinical trial;

(xv) A claim relates to experimental drugs that are not listed on the Pharmaceutical Benefits Scheme or are not approved by the Therapeutic Goods Administration for the use in the specific condition;

(xvi) An application form or claim form contains false, inaccurate or misleading information.

F4 Restricted Benefits

1. A Policy may only pay Restricted Benefits for certain Hospital Treatment as detailed in the Schedules.

F5 Compensation Damages and Provisional Payment of Claims

1. Subject to Fund Rule F5 5, Benefits are not payable for treatment, goods or services for which the Member has received (or is entitled to receive) Compensation in respect of that treatment, good or service.

2. A reference to a Member receiving Compensation includes:

   (i) Compensation paid to another person at the direction of the Member; and

   (ii) Compensation paid to another Member on the same Policy in connection with a treatment, good or service received by the Member.

3. A Member who has, or may have, a right to Compensation in respect of a treatment, good or service received, must:

   (i) to the extent permitted by law, inform Peoplecare as soon as the Member knows or suspects that such a right exists;

   (ii) to the extent permitted by law, inform Peoplecare of any decision of the Member to claim for Compensation;

   (iii) where reasonable to do so, include in any claims for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable by Peoplecare including any allocation for future medical expenses and the treatments and services relating to those expenses;

   (iv) where requested by Peoplecare, identify any and all treatment, goods or services the subject of, or potential subject of, a Compensation claim for which Benefits have been or may be paid;

   (v) take all reasonable steps to pursue the claim for Compensation;

   (vi) to the extent permitted by law, keep Peoplecare informed of and updated as to the progress of the claim for Compensation;

   (vii) to the extent permitted by law, provide to Peoplecare all documents and information in relation to injuries sustained or conditions suffered for which Benefits were paid or may be payable and any claim for Compensation (including details of the insurer or statutory body responsible for paying Compensation) which will enable Peoplecare to assess the likelihood of recovering any or all Benefits paid;

   (viii) authorise Peoplecare to disclose to the Member's legal advisers any and all information held by Peoplecare which reasonably relates to the claim for Compensation; and

   (ix) to the extent permitted by law, inform Peoplecare immediately upon the determination or settlement of a claim for Compensation or the establishment of a right to receive Compensation and provide a copy of the settlement or award and if not evident from the settlement or award, an explanation of how Compensation has been allocated.

4. Where the amount of the Compensation is less than the Benefits that would otherwise be payable (if Fund Rule F5 1 did not apply), then Benefits are payable in an amount equal to the difference between the amount of Benefits that would otherwise have been payable and the amount of the entitlement for Compensation.

5. When a Member has not yet received, or established a right to receive, Compensation, and Peoplecare reasonably believes there may be a right to make a claim for Compensation, Peoplecare may, at its discretion, pay Benefits provided the Policy Holder signs for provisional payment in the form approved for this purpose by Peoplecare from time to time. In these circumstances, the Member agrees to make the claim for Compensation on the following conditions:

(i) the Member must not withdraw the claim for Peoplecare's expenses;

(ii) the Member must disclose (and authorise the Member's legal advisers to disclose) to Peoplecare, and keep Peoplecare informed of, all matters relevant to the progress of the claim for Compensation in a timely manner including the time and place of all settlement or other negotiations or hearings in relation to the claim for Compensation;

(iii) from the Compensation, the amount that Peoplecare paid in Benefits for the treatment, goods or services will be deducted and reimbursed to Peoplecare and will be a debt immediately repayable to Peoplecare upon the award or settlement of the claim and the Member must authorise the Member's legal adviser to pay that debt from the proceeds of any award or settlement following a claim for Compensation; and

(iv) Peoplecare has specified rights of subrogation whereby Peoplecare acquires all rights and remedies of the Member in relation to the recovery of the amount that Peoplecare paid in Benefits.

6. Peoplecare will pay Benefits where Peoplecare is satisfied that the Member has no right to payment for Compensation.

7. Where a Member receives (or establishes a right to receive) payment for Compensation and:

(i) by the terms of the settlement or award it is expressed or implied that the sum of money to be paid excludes or limits the expenses for which Peoplecare has paid Benefits; or

(ii) the Member abandons or compromises any part of the Member's claim so that such expenses are excluded or limited, Peoplecare may decline to pay the Benefits which are excluded or limited and any Benefits paid to that extent may be recovered by Peoplecare from the Member as a debt immediately repayable to Peoplecare.

8. Where:

(i) Peoplecare has paid Benefits, in accordance with Fund Rule F5 5 or otherwise, in relation to a treatment, good or service; and

(ii) the Member has received Compensation in respect of that treatment, good or service, the Member must, unless otherwise agreed, repay to Peoplecare the amount that Peoplecare paid in relation to the treatment, good or service up to the amount of Compensation, upon the determination or settlement of the claim for Compensation and Peoplecare may set off any amount payable by Peoplecare to the Member under this part of the Fund Rules against any amount payable by the Member to Peoplecare under this part of the Fund Rules.

9. This Fund Rule applies whether or not:

    (i) the determination or settlement sum includes the full amount that Peoplecare paid; or

    (ii) the Member complied with their obligations under Fund Rule F5 2.

10. The disclosure of a document or information in accordance with these Fund Rules is not a waiver of, or disclosure of any intention to waive, confidentiality or privilege existing over the document or information.

11. If a Member makes a claim for Compensation in respect of a treatment, good or service received and fails to:

    (i) comply with any obligation in Fund Rule F5; or

    (ii) unreasonably include in their claim for Compensation any payments of Benefits by Peoplecare in relation to a treatment, good or service, Peoplecare may, without prejudice to its rights (including its broader subrogation rights) in its discretion take any action permitted by law to:

    (iii) assume that all expenses in relation to the treatment, good or service have been met from the Compensation payable or received pursuant to the claim; and/or

    (iv) pursue the Member for repayment of all Benefits paid by Peoplecare in relation to the treatment, good or service; and/or

    (v) assume the legal rights of the Member in respect of recovery of the amount that Peoplecare paid in Benefits.

G CLAIMS

G1 General

Applications for Benefits must be made in the manner determined by Peoplecare from time to time, which may include by paper form, electronically or in person. Where forms are required by Peoplecare, they must be fully completed, including the Member's details and a signed authority for Peoplecare to request information from the provider as required.

Claims may only be made by a Policy Holder, their Partner or authorised person.

Benefits are only payable after treatment has been provided.

G2 Claims Must Be Accompanied By Required Information

The account for the treatment to be claimed must be received by Peoplecare and must note the treatment provided (descriptions and item numbers), the dates of the treatment, the patient's name, provider details and the fees charged and paid. Peoplecare may request further information reasonably required for validation of a claim from time to time.

Any hand-written alterations to a printed account or receipt are not acceptable. Where an account or receipt requires amendment, a new copy must be issued.

Peoplecare may, in its discretion, waive some or all of these requirements for claims submitted electronically.

All documents submitted in connection with a claim become the property of Peoplecare.

G3 Time Limit for Lodgement of Claims

Benefits are not payable where a claim is submitted more than twenty-four (24) months after the

date of service.

G4 Manner of Benefit payment

Peoplecare pays Benefits by electronic funds transfer only.