

Peoplecare Fund Rules

Effective 1 July 2019

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	4
A6 No Improper Discrimination	5
A7 Changes to Rules	5
A8 Dispute Resolution	5
A9 Notices	6
A10 Winding Up	6
B INTERPRETATION AND DEFINITIONS	6
B1 Interpretation	6
B2 Definitions	6
C MEMBERSHIP	8
C1 General Conditions of Membership	8
C2 Eligibility for Membership	9
C3 Dependants	9
C4 Membership Applications	10
C5 Duration of Membership	10
C6 Transfers	10
C7 Cancellation of Membership	10
C8 Termination of Membership	11
C9 Temporary Suspension of Membership	11
D CONTRIBUTIONS	12
D1 Payment of Contributions	12
D2 Contribution Rate Changes	12
D3 Contribution Discounts	13
D4 Lifetime Health Cover	13
D5 Arrears in Contributions	13
D6 Other	13
E BENEFITS	13
E1 General Conditions	13

E2 Hospital Treatment	14
E3 General Treatment	16
E4 Other	16
F LIMITATION OF BENEFITS	16
F1 Excesses.....	16
F2 Waiting Periods.....	17
F3 Exclusions	18
F4 Restricted Benefits	18
F5 Compensation Damages and Provisional Payment of Claims.....	18
G CLAIMS	18
G1 General.....	18

A INTRODUCTION

A1 Rules Arrangement

1. These rules set out the General Conditions (Fund Rules A to G) and the Schedule of Contribution Rates, Benefits and Specific Conditions applying to the operation of Peoplecare Health Insurance ("Peoplecare").

A2 Health Benefits Fund

1. Peoplecare Health Limited (ABN 95 087 648 753) is a registered Private Health Insurer, trading as "Peoplecare Health Insurance".
2. The health benefits fund is established in accordance with the Constitution of Peoplecare.
3. The purpose of the fund is to provide benefits to or on behalf of Policy Holders in accordance with the terms of these Fund Rules.
4. Peoplecare may supplement the Fund Rules with Fund Policies that are not inconsistent with the Fund Rules. These Fund Policies include;
5. Privacy policy
6. Complaints handling policy
7. All Policy Holders of Peoplecare are bound by the Fund Rules as amended from time to time.

A3 Obligations to Insurer

1. A Policy Holder of Peoplecare shall provide such information as is reasonably requested from time to time to facilitate the management of the Policy Holder records.

A4 Governing Principles

1. The operation of the fund and the relationship between Peoplecare and each Policy Holder is governed by:
 - (i) The *Private Health Insurance Act 2007*
 - (ii) The *Health Insurance Act 1973*
 - (iii) The Fund Rules
 - (iv) The Constitution of the company.

A5 Use of Funds

1. Peoplecare shall:
 - (i) Keep proper accounts 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.
 - (ii) There shall be credited to the Health Benefits Fund the whole of the income paid by Policy Holders and all other income arising out of the carrying on by the company of business as a Registered Private Health Insurer and other health related business.
 - (iii) No amount shall be debited to this Fund other than:
 - a. Payments by the Fund of benefits payable under these rules in respect of Policy Holders to the Fund or dependant children of such Policy Holders;
 - b. Costs incurred by the Fund in the carrying on of a health insurance or health related business.
 - c. Costs incurred by the Fund in providing, or arranging to provide Hospital Treatment or General Treatment for Policy Holders, or Policy Holders included in a class of Policy Holders, to that Fund or dependant children of such Policy Holders; or

- d. Any amount paid from that Fund to the Health Benefits Risk Equalisation Trust Fund in accordance with a determination of the Trustees under Part 6-7 of the *Private Health Insurance Act 2007*, and
- e. To make investments for the health insurance business or health related business.

A6 No Improper Discrimination

1. Peoplecare shall ensure that the conduct of the registered health benefits fund shall at all times comply with the community rating provisions of the *Private Health Insurance Act 2007*.
2. When making decisions in relation to Policy Holders, the fund will disregard:
 3. the suffering by the Policy Holder of a chronic disease, illness or other medical condition;
 4. the gender, race, sexual orientation or religious belief of a person;
 5. except in relation to the calculation of a *Lifetime Health Cover* loading or the application of an *age-based discount*, the age of the Policy Holder;
 6. any other characteristic of a person (including but not just matters such as their occupation or leisure pursuits) that are likely to result in an increased need for hospital treatment or general treatment;
 7. the frequency of the rendering of *professional services* to the Policy Holder;
 8. the amount, or extent, of the benefits to which a Policy Holder becomes, or has become, entitled during a period.

A7 Changes to Rules

1. Peoplecare may amend the Fund Rules in accordance with the *Private Health Insurance Act 2007*.
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 Act 2007*.
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.
4. Whenever a Fund Rule is amended; such that a detrimental, material change is made to the scope, level or amount of treatments or benefits payable to a Policy Holder; or the premiums payable by a Policy Holder are increased (other than as an effect of rounding); Peoplecare shall, before the change takes effect, take all reasonable steps to directly notify all affected Policy Holders in writing, explaining the change in "Plain English" in accordance with the provisions of the private health insurance Code of Conduct .
5. Peoplecare will issue Private Health Insurance Statements (PHIS) at least annually in accordance with the *Private Health Insurance Act 2007*.
6. Peoplecare will issue every new Policy Holder with an up to date copy of the relevant Private Health Insurance Statement (PHIS) details about what the policy covers and how benefits are provided and identifying the referable health benefits fund when they join.

A8 Dispute Resolution

1. The dispute resolution procedure available to Policy Holders 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 industry Code of Conduct. The Complaints Handling Policy will be publicised via the fund information brochures and web site and available to any person on request.
2. The Complaints Handling Policy of the Fund shall include escalation provisions to the Private Health Insurance Ombudsman (PHIO) should the internal dispute resolution

procedures not resolve the issue. Contact details for PHIO will also be included in the Fund information brochures and on the Fund website.

A9 Notices

1. Peoplecare shall send any necessary correspondence to the most recently advised postal address, fax number or email address of the Policy Holder.
2. These Fund Rules and the associated schedules are available to Policy Holders upon request.

A10 Winding Up

1. The winding up of the fund shall be undertaken at the time in accordance with these 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 of the Health Benefits Fund.
3. A further period must be allowed to enable claims to be lodged where such claims arose prior to the date of termination of the fund.
4. When the fund gives notice under Clause A10.1, that notice shall stipulate the termination date. The fund will not entertain any claims arising after that date but, in relation to claims arising prior to the termination date Policy Holders have a period of 12 months from the termination date within which to lodge any outstanding claims.
5. After all claims have been paid and expenses of the fund paid, any surplus then remaining shall revert to the Risk Equalisation Trust Fund.
6. 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 Act 2007* shall be read in conjunction with these rules and shall be deemed to be part of these rules and shall have the same meaning as that which is defined in the above Acts.
2. These Rules shall be interpreted so as not to conflict with the Constitution of Peoplecare.
3. Any terms used in these Rules and also in the Constitution shall have the same meaning in these Rules as they bear in the Constitution.
4. Unless otherwise specified, the meanings attached to the words and expressions in the *Private Health Insurance Act 2007* shall apply to these Rules.
5. Words in the singular number shall include the plural and words in the plural shall include the singular.

B2 Definitions

1. **'Age-based discount'** means a discount which may be applied to an *eligible person* as defined in the Private Health Insurance (Complying Product) Rules.
2. **'Accident'** means any unforeseen event which causes bodily injury and needs urgent hospitalisation.
3. **'Board'** shall mean the executive body appointed as provided for in Rule 5 of the Constitution of Peoplecare.

4. **"Child"** means someone who is under the age of 18 years old.
5. **'Dependant child'** shall mean a person:
 - (i) who is:
 - i. aged under 18; or
 - ii. a dependant child aged 19 to 20;
 - iii. a dependant child who is a full-time student; and
 - (ii) who is not aged 25 or over; and
 - (iii) who does not have a partner.
 - (iv) Such other persons approved by the Board as are deemed to be entirely dependant on the Policy Holder.
6. **'Dependant Child Non Student'** means a person who is aged 21 to 24, not a full-time student, and who is residing with the Policy Holder.
7. **'Spouse / Partner'** means a person who lives with a relevant person in a marital or de facto relationship.
8. **'Single'** means does not have a spouse or partner.
9. **'Policy'** means a health insurance policy taken out by a Policy Holder to the fund.
10. **'Policy Holder'** of a health benefits fund, means a *holder* of a policy that is referable to the fund.
11. **'Holder'** of an insurance policy, means a person who is insured under the policy and who is not a dependant child.
12. **'The Financial Year'** means the period between 1st July and 30th June the following year.
13. **Applicable Benefits Arrangement** means an applicable benefits arrangement within the meaning of the *National Health Act 1953* as in force before 1 April 2007.
14. **Hospital Purchaser - Provider Agreement** means a "*private health insurance arrangement*" as described in Schedule 1 of the *Private Health Insurance Act 2007* entered into between Peoplecare and a Hospital Facility and as amended from time to time.
15. **Medical Purchaser-Provider Agreement** means a "*private health insurance arrangement*" as described in Schedule 1 of the *Private Health Insurance Act 2007* entered into between Peoplecare and a Medical Practitioner and as amended from time to time.
16. **Peoplecare** means Peoplecare Health Limited (ABN 95 087 648 753) a registered Private Health Insurer, trading as "Peoplecare Health Insurance".
17. **Pre-Existing Ailment** means an ailment or illness, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the organisation, existed at any time during the six months preceding the day on which the Policy Holder commenced the relevant level of cover.

18. **Medical Practitioner** means a person as defined in the *Health Insurance Act 1973*.
19. **Hospital Facility** means a hospital declared or authorised by the Minister for Health and Ageing as being a hospital under the *Private Health Insurance Act 2007*.
20. **Palliative Care** An episode of palliative care occurs 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.
21. **Restricted benefit** means a benefit which is paid at the default benefit rate disclosed in the Private Health Insurance (Benefit Requirements) Rules.
22. **Default Benefit** means the minimum benefit paid as disclosed in the Private Health Insurance (Benefit Requirements) Rules.
23. **Family member, relative:** Parent or grandparent, sibling, sibling-in-law, partner or former partner (spouse or defacto), child, son or daughter-in-law, grandchild, aunt/uncle or cousin or other common-law family relationship in the reasonable opinion of the fund. The above include whether the relationship is natural, adopted, step or foster (or similar).
24. **Business associate, partner or practice partner:** A current or former business partner, practice partner, employee or employer, contractor (or similar) – whether on a formal basis, contracted basis, locum basis or any other employee/employer type relationship between the provider and the patient, in the reasonable opinion of the fund.

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 child.
 - (ii) Insured groups for Peplecare shall be:
 - (a) single - only one adult person
 - (b) couple – two adults (and no one else)
 - (c) single parent family – two or more people (only one of whom is an adult the rest of whom are dependant children)
 - (d) single parent family extended (family plus) – two or more people, (only one of whom is an adult, and only one of whom is a dependant child non-student), as well as any dependant children
 - (e) family – three or more people (only two of whom are adults, the rest of whom are dependant children)
 - (f) family extended (family plus) – three or more people (at least one of whom is an adult, at least one of whom is a dependant child non-student), as well as any dependant children

2. The insurance policies offered to the insured groups by Peoplecare are:
 - (i) Hospital Treatment – Covering treatments provided in a recognised hospital, excluding;
 - (a) Treatment that does not normally require hospital treatment – procedures that do not normally require hospital treatment (Type C Procedures) if no certificate has been given by a medical practitioner stating that the person required hospital treatment;
 - (b) Treatment provided to a person at an emergency department of a hospital;
 - (c) Treatment provided to a newly-born child whose mother also occupies a bed in the hospital.
 - (d) Treatments that do not have a recognised Medicare benefit schedule number (MBS). This does not apply to the clinical category “Podiatric Surgery (provided by a registered podiatric surgeon)”.
 - (ii) General Treatment – Covering treatments, including hospital substitute and hospital prevention programs, but excluding;
 - (a) Hospital Treatment;
 - (b) Services provided by registered general practitioners and any other services covered by Medicare;
 - (c) Benefits paid in connection with the birth of a baby;
 - (d) Funeral benefits;
 - (e) Disability benefits;
 - (f) Goods or services that are primarily for the purposes of sport, recreation or entertainment other than such treatment which is part of a chronic disease management program or a health management program.

C2 Eligibility for Membership

The following persons shall be eligible to be a Policy Holder to the Fund:

- (i) Subject to these rules, any natural person whether or not they are eligible for Medicare benefits, is eligible to be a Policy Holder of Peoplecare and shall complete a policy application, in accordance with the provisions of Clause C4.

C3 Dependants

1. Dependant Child is as defined in section B2.2 of these rules. Dependant children can be covered by any of the family policy options offered by the fund from time to time.
2. Dependant Child Non Student is as defined in section B2.2 of these rules. A dependant child non-student can remain on a policy, on which they were formerly a dependant child, up to age 24 for an additional premium as provided in section K1 of these rules.
3. Subject to these Fund Rules, a person who ceases to be eligible to be covered as a Dependant Child or as a Dependant Child Non Student of a Policy Holder may become a Policy Holder by choosing a currently available cover and by paying the relevant premium.
4. No additional waiting periods for benefits will apply for such a Policy provided that:
 - (i) The new cover is no higher than the existing cover, and in accordance with S. 78-1 (3) of the *Private Health Insurance Act 2007*.

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

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. Once the application to become a Policy Holder has been processed by Peoplecare the Policy Holder will receive a welcome pack that will include a Private Health Insurance Statement (PHIS). The PHIS will also be provided to Policy Holders at least annually and are also available on request.
4. There is no specific requirement for a new Policy Holder to provide proof of their details however, if the Policy Holder changes these details at a later date, an identity check will be undertaken before disclosing any policy information to them in order to comply with the *Privacy Act (1988)*.

C5 Duration of Membership

1. The Policy commences on the date the application is lodged with Peoplecare or where agreed a date as nominated on the application form.
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.

C6 Transfers

1. All health insurance products offered by the fund comply with the Portability Requirements as required under Division 78-1 of the Act. Waiting periods applicable are covered under rule F3.
2. Policy Holders who transfer from another Registered Private Health Insurer within a period of 30 Days from the date to which contributions were paid last, shall be accepted with rights and benefit entitlement not in excess of those pertaining to the policy to which the Policy Holder transfers in this organisation and in accordance with S. 78-1 (3) of the *Private Health Insurance Act 2007*.
3. On the transfer of a Policy Holder to another Registered Private Health Insurer and upon his/her acceptance of that registered organisation there shall be no further liability on this Fund in respect of such Policy Holder in respect of services incurred after the date of transfer.
4. Where the Policy Holder transfers to another Registered Private Health Insurer a transfer certificate will be provided to the Policy Holder within fourteen days of the cessation of the policy with Peoplecare.
5. For those Policy Holders transferring from another Registered Private Health Insurer, Peoplecare will require a transfer certificate to be provided by that insurer, otherwise normal waiting periods for that policy will apply.

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 transaction then a full refund will be paid by the fund and the cover 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 will be deemed to be the "cooling off period"
3. A Policy Holder may cancel their Policy entirely
4. A Policy Holder may remove any dependant children from the Policy.
5. The Policy Holder or a dependant child aged at least 16 years of age may leave the Policy without the agreement of any other Policy Holder, and a dependant child under the age of 16 years of age may leave the Policy with the agreement of a Policy Holder.
6. 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.
7. 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.
8. Peoplecare has an obligation to refund excess premiums when a Policy ceases only where required to do so by law or where specified in these Fund Rules. The fund may at its discretion refund some or all of the excess premiums after receiving a request from a former Policy Holder. Such a refund will generally be calculated from the date of receipt of the request.

C8 Termination of Membership

1. Where in Peoplecare's opinion a Policy Holder has obtained an improper advantage for themselves or for any other Policy Holder, Peoplecare may terminate the relevant Policy immediately, by written notice, to the Policy Holder.
2. For the purposes of this Fund Rule "improper advantage" means any advantage, monetary or otherwise to which a Policy Holder is not entitled under the Fund Rules.
3. Where a Policy has been terminated under this Fund Rule, Peoplecare has discretion to reinstate the Policy at the request of the Policy Holder with continuity of entitlements subject to the payment of all premiums as required under Fund Rule D5.2 (ii).

C9 Temporary Suspension of Membership

Peoplecare may consider suspending memberships for 2 reasons:

1. Overseas travel
2. Financial hardship

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

	Overseas Travel	Financial Hardship
Requirements	<ul style="list-style-type: none"> • All suspensions are at Peoplecare's absolute discretion to allow or not • Memberships cannot be suspended in the first 12 months of membership • Must have hospital cover (no extras only) • Must be paid up to date at date of request • No claims will be paid for period of suspension • Periods of suspension will not count as Lifetime Health Cover absent days • The period of suspension will not count towards any unserved waiting periods. 	

	Overseas Travel	Financial Hardship
	<ul style="list-style-type: none"> Must be overseas full time for at least 4 weeks 	<ul style="list-style-type: none"> Member or Spouse on short term unemployment benefit from Centrelink.
Maximum period	<ul style="list-style-type: none"> 2 years individual consideration for longer suspensions may be considered only for long term absences where policy holder or a person on the policy is working overseas. After reactivation, must have at least 3 months paid membership before any more suspensions will be considered 	<ul style="list-style-type: none"> Maximum 6 months After 6 month's suspension, must reactivate and have at least 6 months paid membership before any more suspensions will be considered
Documentation required	Proof of leaving/arrival date in Australia: <ul style="list-style-type: none"> Boarding pass Passport Copy of ticket 	<ul style="list-style-type: none"> Proof of Centrelink benefits
Reactivating	<ul style="list-style-type: none"> Within 1 month of returning to Australia OR Within 1 month of maximum (2 years). (whichever's earlier)	<ul style="list-style-type: none"> Within 1 month of the cessation of Centrelink benefits OR Within 1 month of maximum suspension (6 months) (whichever's earlier)
Waiting periods	<ul style="list-style-type: none"> When policy is reactivated within the prescribed rules, Peplecare will recognise all previous waiting periods already served . 	
Termination	<ul style="list-style-type: none"> If policy is not reactivated by the agreed date and is in arrears, Peplecare may terminate the policy. 	

D CONTRIBUTIONS

D1 Payment of Contributions

- All Policy Holder contributions are to be paid in advance, at least monthly in accordance with the amounts specified in Schedule K.
- Peplecare 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 Peplecare may refund the portion of the premiums in excess of 12 months.

D2 Contribution Rate Changes

- Peplecare may change the premiums for any cover in accordance with the requirements set out in the *Private Health Insurance Act 2007* and subject to the Fund Rules D2.2.
- Where Policy holders are paid in advance of the date of an announcement of an increase in contribution rates, the date paid to shall be preserved and no adjustment to the contributions due shall be effected. This rate protection shall apply for a maximum period

of 12 months and where the contributions are paid in excess of that date, an adjustment or refund of excess premiums shall be made in respect of those contributions only.

3. A Policy Holder may not amend their standard payment frequency in order to obtain a greater benefit (an additional period of rate protection) than that which would normally apply.

D3 Contribution Discounts

1. Any discounts applicable to premium payments shall only be in accordance with the provisions of the *Private Health Insurance Act 2007* or other regulatory directions as issued from time to time.

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 services rendered during that period.
3. A Policy Holder more than two (2) months in arrears with their contributions shall be regarded as un-financial and as having forfeited their right to a Policy under the Rules of the Fund. In these circumstances the Policy may be terminated with immediate effect and with 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, and/or cancel arrears. 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 treatment provided to a Policy Holder during a period of arrears however this rule may be waived at the discretion of 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 contribution rate applicable to the state of residence in which they reside.

E BENEFITS

E1 General Conditions

1. Health Fund 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 Health Benefits Fund, after taking into account benefits paid from any other source.
2. There shall be established and maintained on and from 1st April, 2007 in the Health Benefits Fund conducted by this organisation a Risk Equalisation account to make payments to the

Risk Equalisation Trust Fund as required under section 318-5 of the *Private Health Insurance Act 2007*.

E2 Hospital Treatment

1. Policy Holders and their dependant children eligible for benefits shall also be entitled to the Applicable Benefits Arrangements provided by the Hospital Purchaser Provider Agreements. Hospital benefits will only be available for Hospital treatment provided by an authorised Hospital. Hospital and medical benefits will also only be payable for procedures listed in the Medicare Benefits Schedule (MBS), except in relation to the clinical category "Podiatric Surgery (provided by a registered podiatric surgeon)".
2. Hospital benefits payable will include:
 - i) any part of hospital treatment that is one or more of the following:
 - (a) psychiatric care;
 - (b) rehabilitation;
 - (c) palliative care;if the treatment is provided in a hospital and no Medicare benefit is payable for that part of the treatment.
 - ii) hospital treatment covered under the policy for which a Medicare benefit is payable.
 - iii) if the policy does not exclude it, Podiatric Surgery (provided by a registered podiatric surgeon)
 - iv) if the policy covers hospital-substitute treatment - hospital-substitute treatment covered under the policy for which a Medicare benefit is payable.
 - v) the provision of a prosthesis of a kind listed in the *Private Health Insurance (Prostheses) Rules* in circumstances:
 - (a) in which a Medicare benefit is payable; or
 - (b) set out in the *Private Health Insurance (Prostheses) Rules* for the purposes of this item.
 - vi) any treatment for which the *Private Health Insurance (Benefit Requirements) Rules* specify there must be a benefit.
3. For Hospital Treatment under this rule, benefits are payable to cover all costs that a Policy Holder or eligible dependant child incurs for pharmaceutical benefits dispensed to the Policy Holder or eligible dependant child while they are an admitted patient at the hospital facility with which the Fund has a Hospital Purchaser Provider Agreement.
 - (i) The costs that a Policy Holder or eligible dependant child incurs for pharmaceutical benefits are contingent upon whether the Policy Holder or eligible dependant child has reached the Safety Net Threshold under Commonwealth Government Pharmaceutical Benefits Scheme arrangements.
 - (ii) A 'pharmaceutical benefit' is defined as any medicine listed in the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing) that is dispensed to the Policy Holder or eligible dependant child.
 - (iii) A 'pharmaceutical benefit' referred to in this section of the fund rules must be intrinsic to the hospital treatment provided, clinically indicated and essential for the meeting of satisfactory health outcomes for the Policy Holder or the eligible dependant child. This does not include pharmaceutical benefits that are dispensed where these are not

directly related to treatment of the condition or ailment for which they have been admitted.

- (iv) The fund also covers the costs that a Policy Holder incurs for special patient contributions, brand premiums and therapeutic group premiums listed in the Schedule of Pharmaceutical Benefits that apply to certain pharmaceutical benefits, regardless of whether the Policy Holder or eligible dependant child has reached the Safety Net Threshold under Commonwealth Government Pharmaceutical Benefits Scheme arrangements.
- (v) The fund covers costs for pharmaceutical benefits up to a maximum quantity dispensed. The maximum quantity covered is as listed in the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing) or as recorded on an Authority Prescription Form (and authorised by Medicare Australia where the quantity dispensed is clinically indicated, intrinsic to the hospital treatment provided and essential to the meeting of satisfactory health outcomes for the Policy Holder or the eligible dependant child.
- (vi) Where the cost to a Policy Holder or eligible dependant child for a drug or medicinal preparation listed in the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing) is less than the pharmaceutical benefit co-payment (as determined by the Commonwealth Department of Health and Ageing), these drugs are not considered to be 'pharmaceutical benefits' and are not covered by the fund under this section of the rules.

4. The amount of medical services payments payable in respect of a professional service that:

- (i) are rendered to a policy holder or their dependant child while hospital treatment is provided to them in a hospital facility; and
- (ii) are a professional service in respect of which a Medicare benefit is payable;

Will be at least equal to:

- (iii) if the medical expenses incurred in respect of the service are greater than or equal to the Schedule fee (within the meaning of Part II of the Health Insurance Act 1973) in respect of the service—25% of that Schedule fee; or
- (iii) if medical expenses incurred in respect of the service are less than that Schedule fee—the amount (if any) by which the medical expenses exceed 75% of that Schedule fee.

The amount of benefit payable will not exceed the amount referred to in subparagraph (iii) or (iv) (whichever is applicable) unless:

- (v) the service is rendered by or on behalf of a medical practitioner with whom Peplecare has a Medical Purchaser Provider Agreement that applies to that service; or
- (vi) the service is rendered by or on behalf of a medical practitioner with whom the hospital or day hospital facility in question has a practitioner agreement that applies to the service; or

- (vii) the service is rendered by or on behalf of a medical practitioner under the “Access Gap Cover” scheme or any other gap cover scheme approved by the Minister and to which Peoplecare is a party.
5. Hospital benefits payable to nursing home type patients will be paid in accordance with schedule 4 of the *Private Health Insurance (Benefit Requirements) Rules 2007*.

E3 General Treatment

1. The benefits payable in respect to General Treatment and the conditions relevant to those benefits are set out on the Schedules of Contribution Rates, Benefits and Specific Conditions.
2. Peoplecare may enter into special arrangements with general treatment providers or groups of providers from time to time to provide benefits for particular general treatment services.
3. General Treatment Benefits can include the provision of goods and services that are intended to manage or prevent a disease, injury or condition that is not hospital treatment.
4. General Treatment does not include:
 - (i) services for which a Medicare benefit is payable, except as allowable as hospital substitute treatment.
 - (ii) Benefits in relation to sport, recreation or entertainment unless they are part of a chronic disease management program or a health management program.

E4 Other

1. Peoplecare shall have the power to increase Hospital Treatment and/or Ancillary Treatment benefit payments, make new rules, amend or rescind rules.
2. The Minister for Health and Ageing must approve any premium changes to health insurance policies covered within these rules.
3. Peoplecare may pay benefits on an ex-gratia basis, at its discretion.
4. Benefits are not payable for goods or services rendered overseas.

F LIMITATION OF BENEFITS

F1 Excesses

1. An excess is an amount of benefit that a Policy Holder agrees to forego on Hospital Treatment 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 and assisted reproductive services - 12 months
 - (g) In respect of any ailment, condition or illness, the signs or symptoms of which, existed at any time during the six months preceding the day of joining or upgrading tables – 12 months, except:
 1. psychiatric care – 2 months;
 2. rehabilitation – 2 months;
 3. palliative care – 2 months.
 - (h) Persons with an existing hospital Policy that contains restrictions for Psychiatric services and who have served two months waiting period under this restricted cover, may upgrade to full 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. For the purposes of the Health Benefits Fund, pre-existing conditions or ailments are as defined in section 75-15 of the *Private Health Insurance Act 2007*.
3. Dependant children 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.
4. Peplecare may at its discretion waive or reduce any Waiting Period.

F3 Exclusions

1. Benefits are not payable when:
 - (i) A Policy Holder or dependant child is given treatment without charge
 - (ii) A Policy Holder or dependant child has an entitlement under any Compensation, Third Party or Sports Club Insurance or similar legislation relating thereto.
 - (iii) A claim is submitted for optical appliances not requiring sight correction e.g. sunglasses
 - (iv) The claim benefit is less than \$5, although this can be accumulated and submitted with other claims
 - (v) A service is provided by a family member, relative, business associate or partner or practice partner or self
 - (vi) Services are provided outside the Commonwealth of Australia, except if the Policy Holder or dependant child is a pre-approved overseas resident
 - (vii) The claim is for goods or services that are deemed to be primarily for the purposes of sport, recreation or entertainment
 - (viii) The claim is for hospital treatment benefits where the goods or services are for cosmetic purposes and no Medicare benefit is payable.
 - (ix) A claim is submitted for a service which occurred while the membership was suspended or in arrears.
 - (x) an application form or claim form contains false or inaccurate information.

F4 Restricted Benefits

1. 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.

F5 Compensation Damages and Provisional Payment of Claims

1. Fund benefits are not payable under any of the fund hospital policies in respect of expenses incurred for hospital treatment, where a Policy Holder or dependant child has received or established a right to receive a payment by way of compensation or damages (including a payment in settlement of a claim for compensation or damages) under the law that is or was in force in a State or Internal Territory, which, in the opinion of the Fund includes an amount for hospital expenses equivalent to the Fund Benefit that would otherwise be payable.
2. Where the amount of the entitlement for compensation or damages is, in the opinion of the Fund, less than the Fund Benefit that would otherwise be payable under the Health Benefits Fund and/or any hospital policy but for the preceding Rule in respect of the expenses incurred for that hospital treatment, Fund Benefit is payable. The amount of Fund Benefits payable shall not exceed the difference between the amount of Fund Benefit that would otherwise have been payable and the amount of the entitlement for compensation or damages.
3. Where rights have not been determined the Board may, at its discretion and on satisfactory proof of hardship being submitted, make provisional payment of benefits which will be recovered in whole or part when compensation or damages are paid.

G CLAIMS

G1 General

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