Union Health Fund Rules effective 1 January 2026

Note: This is only an extract of the Health Benefits Fund Rules of Teachers Federation Health Ltd t/as Union Health. We have not included the Product Schedules A and B, a summary of which can be found in the current Union Health Product Guides.

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Fund Rules

I. About our Fund and these Fund Rules

These are the Fund Rules (Rules) of Teachers Federation Health Ltd (TH, we, us) (ABN 86 097 030 414), a company limited by guarantee.

These Rules apply to all TH private health insurance policies. An application to purchase a Policy from us will be taken as acceptance of all of the terms and conditions in these Rules. By taking out private health insurance with us, you and all the other persons on your membership become members of our Fund and agree to our Rules as amended from time to time.

A. Health benefits fund

These Rules, along with the Application Form, govern the establishment and operation of the registered health benefits fund of TH which is a not-for-profit fund, and describe the obligations, requirements and entitlements of **Primary Members** and TH in relation to the Fund.

TH's health-related business is part of the health benefits fund and include eye care centres, dental centres, care coordination, health management programs and services as well as acting as agent for the provision of travel insurance, overseas visitor health cover and general insurance to **Insured Members**.

B. Regulatory framework

The operations of the Fund and our relationship with you are governed by the:

a) the *Private Health Insurance Act* 2007 (Cth) (PHI Act) and any rules made under that act;
b) the *Private Health Insurance Legislation (Amendment) Act* 2018 (Cth) and any rules made under that act;
c) the *Health Insurance Act* 1973 (Cth) and any regulations made under that act;
d) Australian Consumer Law;
e) any conditions imposed, or directions made by, the Minister or the Private Health Insurance Ombudsman (PHIO);
f) these Rules;
g) our Constitution; and
h) TH policies and procedures (that are not inconsistent with these Rules).

The law of New South Wales will apply, and the courts of New South Wales will have jurisdiction in relation to disputes arising between TH and members, and between TH and others who are affected by these Rules regardless of the State or Territory in which the members or affected person resides.

C. Use of Funds

We will:

a) Keep proper accounts and records of the transactions and affairs of the Fund;
b) Maintain adequate control over our assets and liabilities;
c) Arrange for our accounts and records to be audited by a registered company auditor each year;
d) Ensure that all payments from the Fund are correctly made and properly authorised;

e) Only credit the Fund, and draw from the Fund, in a manner which is consistent with the PHI Act.

D. Changes to these Rules

Any Rule may be amended or deleted at any time, in a manner consistent with the PHI Act, the Private Health Insurance Code of Conduct and Australian Consumer Law. If any changes to these Rules have a detrimental impact on you, we will provide at least one Adult member on your Policy (usually the Primary Member) with notice in writing a reasonable time before the changes come into effect. Changes will apply regardless of whether Premiums have been paid in advance. Where a Premium has been paid for a period after a Fund Rule change comes into effect, the Premium payable under the new Rules will be deemed to have been paid for the same period. The Fund Rules that are in force at the date goods / services are provided to you are the Rules that govern the provision of a Benefit for those goods / services.

Where an amendment to the Fund Rules requires a change to the Private Health Insurance Statement relevant to your Policy, we will provide you with an updated statement as soon as possible. You can also request a copy of this statement at any time.

E. Waiver of these Rules

We may waive the application of a Fund Rule at our discretion, provided that the waiver does not materially reduce any member's entitlements to Benefits.

The waiver of a particular Fund Rule on one occasion does not require us to waive the application of that Fund Rule on any other occasion.

F. Dispute resolution

An Insured Member is entitled to make a complaint to the Fund at any time, orally or in writing.

Subject to the provisions of any law, if a dispute arises about any matters relating to the Fund, the complaint will be investigated within a reasonable period of time in accordance with our Complaint Handling and Dispute Resolution Policy and any codes of conduct to which we are a party at that time. The Complaint Handling and Dispute Resolution Policy is available on our website.

Nothing in these Fund Rules prevents an Insured Member from approaching PHIO at any time.

G. Notices

We will send correspondence to the most recently advised postal address, email address or telephone number of the relevant Insured Member, or otherwise make correspondence available on our online membership portal.

When the Primary Member receives correspondence from us regarding the Policy that is not solely to them (such as a notice regarding a detrimental change to the Fund Rules) they must inform all other Insured Members on the Policy of the contents of that notice.

We will, within a reasonable timeframe, forward to any Insured Member one copy of these Rules.

Notices to TH must be sent in writing by post to GPO Box 9812, Sydney NSW 2001 or by email to the email address notified on TH's website at www.teachershealth.com.au.

H. Winding up

In the event of TH ceasing to be registered as a private health insurer under the PHI Act, all Insured Members will be transferred to another registered private health insurers and the health benefits fund shall be terminated in accordance with the requirements of the act and these Fund Rules. All assets of the Fund not required for meeting outstanding liabilities shall be paid to an entity or organisation which has rules prohibiting the distribution of its assets and income to its members.

II. Membership

A. General conditions

Any person who applies for a Policy shall be known as the Primary Member. All persons included in an Application Form that is accepted by TH will be, whilst eligible under these Rules, included as Insured Members within the Policy.

An Insured Member may simultaneously be covered by up to two Hospital and/or Extras Policies or combined Policies, at any level.

B. Eligibility for membership

Unless we determine otherwise, a Primary Member must be aged 18 years or over.

a) TH is a restricted access insurer, as defined in the *Private Health Insurance (Prudential Supervision) Act* 2015 (Cth)(PHIPS Act). The persons set out in Rules II.B.b) and II.B.c) are deemed to be included in TH's restricted access group and are eligible to apply for a Policy.

b) The following persons are Principal Insured:

(i) A person who is, or was, a financial member (including students who are full members) of an employee organisation:

(1) registered or recognised under the *Fair Work (Registered Organisations) Act* 2009 (Cth), including under Schedules 1 or 2 of that act; or

(2) registered as an organisation, being an association of employees under State or Territory legislation in force at the time a membership application is made.

(ii) A person who is a student member of the Queensland Teachers' Union of Employees, the Australian Education Union – Northern Territory branch or the Independent Education Union of Australia – Queensland and Northern Territory branch;

(iii) A person who is, or was, a member of any union and who is, or was an employee or officer of:

(1) a school, university, TAFE, Early Learning Institution, or any other educational institution that is, or was, registered or otherwise licensed or approved under any Commonwealth or State legislation (including support staff); or

(2) a State or Territory Department of Education (or like organisation); or

(3) a State or Territory Board of Studies, Teaching and Educational Standards (or like organisation); or

(4) Australian Education Union New South Wales Teachers Federation (NSWTF) Branch; or
(5) Queensland Teachers' Union of Employees or Queensland Independent Education Union of Employees; or
(6) Australian Education Union or its State or Territory branches and unions affiliated to that union; or
(7) Independent Education Union of Australia (IEU) or its State or Territory branches and unions affiliated to that union; or
(8) Institute of Senior Education Administrators NSW; or
(9) National Tertiary Education Union; or
(10) State School Teachers' Union of WA (SSTUWA); or
(11) Australian Nursing & Midwifery Federation, or a State or Territory branch or affiliated union; or
(12) Teachers Mutual Bank Limited; or
(13) New Law; or
(14) Aware Super Pty Ltd; or
(15) successor organisations.

(iv) A person who is, or was, a member of any union and who is employed as:
(1) A registered nurse;
(2) An enrolled nurse;
(3) A registered midwife;
(4) A nurse practitioner;
(5) A nurse in mental health services;
(6) A psychiatric nurse;
(7) An assistant in nursing or an assistant in midwifery;
(8) A nursing student undergoing training or student nurse or trainee enrolled nurse in Victoria or Tasmania;
(9) Employees, however described or titled, employed to provide or assist in the provision of nursing care or nursing services or both.

(v) Any person who would qualify under items b)(ii) or b)(iii), where no union coverage exists, or existed at the time, for that person.

(vi) A person who was insured with TH or Queensland Teachers' Union Health Fund Limited, immediately before 12 October 2007.

(vii) A person who was insured with Queensland Teachers' Union Health Fund Limited before 1 July 2025.

(viii) A person who is, or becomes, an officer or employee of, or a contractor to, TH and who is, at the time at which they seek to become insured by TH, a financial member of a union, where one exists of which they are eligible to be a member.

c) Any person who pursuant to Rule 7 of the *Private Health Insurance (Registration) Rules* 2017 (No. 2) (Cth) or the PHI Act, is eligible to be an Insured Member of the Fund.

d) TH is prohibited from issuing a complying health insurance policy to a person who does not belong to the restricted access group set out in Rules II.B.b) and II.B.c).

TH will comply with the community rating principles as prescribed in the PHI Act. Subject to the provisions of the act, we will not discriminate between people on the

basis of their health and/or for any other reason that is prohibited under any legislative or regulatory instrument.

C. Dual memberships

A person may not concurrently have a Policy that covers Hospital Treatment with another private health insurer and TH.

Subject to our discretion, a person may not concurrently have a Policy that covers General Treatment with another private health insurer and TH.

A person may be a Primary Member of both TH and another private health insurer, where a Hospital Policy is held with one private health insurer and an Extras Policy is held with the other private health insurer.

However, we may, at our discretion, permit a Primary Member to register as a Dependant, a person already registered as a Dependant on another Policy (whether with TH or another private health insurer) provided that the Primary Member is the parent or guardian of the Dependant and has legal custody of the Dependant.

D. Membership categories

A Primary Member may select one membership category for each Policy. We may offer the following membership categories:

a) Single Membership – one (1) Adult;
b) Single Parent Family Membership – one (1) Adult and at least one (1) Student Dependant or Dependent Child;
c) Couples Membership – the Primary Member and their Partner;
d) Family Membership – the Primary Member, their Partner and at least one (1) Student Dependant or Dependent Child;
e) Extended Family Membership – the Primary Member, their Partner and the Dependants of the Primary Member or their Partner, of which at least one (1) person is a Dependent Non-Student; and
f) Extended Family Membership Single Parent – the Primary Member and the Dependants of the Primary Member or their Partner, of which at least one (1) person is a Dependent Non-Student.

E. Dependants

We will recognise four types of Dependants as defined below:

a) Dependent Child means a child, Adopted Child, Stepchild or Foster Child of the Primary Member or their Partner, registered with TH, and:
   (i) is aged under eighteen, and
   (ii) does not have a Partner.

   For the purpose of these Fund Rules, references to Dependent Child include Non-Classified Dependent Person.
b) Dependent Non-Student means a child, Adopted Child, Stepchild or Foster Child of the Primary Member or their Partner and:
   (i) is aged between twenty one and thirty one (inclusive),
   (ii) does not have a Partner, and
   (iii) is not receiving full-time education at a school, college or university.
c) Student Dependant means a child, Adopted Child, Stepchild or Foster Child of the relevant Primary Member or their Partner, registered with TH, and:
   (i) is aged between twenty-one and thirty-one (inclusive);

(ii) does not have a Partner;
and is either:
(iii) a full-time student at a school, college, TAFE or university; or
(iv) a registered apprentice or trainee.

d) Non-Classified Dependent Person means a child, Adopted Child, Stepchild or Foster Child of the relevant Primary Member or their Partner and:
(i) is aged between eighteen and twenty (inclusive); and
(ii) does not have a Partner.
For the purpose of these Fund Rules, references to Dependent Child include Non-Classified Dependent Person.

Cover for a Dependent Child or Student Dependant is available on Single Parent Family Memberships or Family Memberships for all policies.
Cover for Dependent Non-Students is only available on Extended Family Memberships and Extended Family Memberships Single Parent.
A person who ceases to be eligible to be covered as a Dependant may become a Primary Member by taking out their own membership. No additional Waiting Periods will apply for such a Policy provided that the new cover is no higher than the existing cover, and the person applies for a Policy within two months of ceasing to be a Dependant.

F. Membership applications
A person wishing to obtain membership must lodge a completed Application Form. Membership will commence on the date the Application Form is processed and the minimum Premium payment is received by us, unless the joining member has nominated a date that is after the date the application is processed (Commencement Date).
TH may refuse to accept an application for a Policy from a person whose Policy was cancelled through the application of Rule II. R.
You have the right to cancel your membership and receive a full refund within a thirty-day cooling off period, provided that you have not made any Claims during that period.

G. Change of membership details
Subject to other Fund Rules the Primary Member must advise of any changes to membership details within one (1) month of the change. If the Primary Member fails to advise us of a change within this period we are not obligated to back-date any changes.
Changes in membership details may include, but are not limited to:
a) Change of name
b) Change of Insured Member's address or contact details
c) Change of bank details
d) A Student Dependant ceases, goes part-time or defers, their course of education
e) A Dependant ceases to be a Dependant
f) Change of status i.e. change of marital or de facto status
g) Change of Australian residency status.

An Insured Member has the right to continue to be an Insured Member after the death of the relevant Primary Member, or the divorce or separation of the Insured Member from the Primary Member, subject to the following conditions:

(i) Premiums are paid according to these Rules;
(ii) each Insured Member covered by the Policy observes the Policy requirements of these Rules and the Constitution; and
(iii) one of the Insured Members becomes the Primary Member.

H. Cooling Off policy

a) Any Primary Member who has not yet made a Claim can cancel their Policy within 30 days of the commencement of the Policy and receive a full refund of any Premiums paid, provided the request to cancel the Policy is:
   (i) made by the Primary Member;
   (ii) received by TH within 30 days of Policy commencement.
b) Any Primary Member who has changed the type of cover or the level of cover on a Policy can cancel the change within 30 days of the commencement of the change and receive a full refund of any additional Premiums paid provided the request to cancel the change is:
   (i) made by the Primary Member;
   (ii) received by TH within 30 days of Policy commencement; and
   (iii) no Claims have been made under the changed Policy.
c) When a Primary Member cancels a Policy or cancels a change to a Policy within the 30-day cooling off period, TH will:
   (i) record the details of any advice or information given;
   (ii) advise the Primary Member of the cancellation of the Policy or the change; and
   (iii) issue a refund of any Premiums paid, or any additional Premium payable, in relation to the change.

I. Adding a Dependent Child to your membership

A newborn child will be deemed to have already served the Waiting Periods served by the Primary Member if:

a) the Primary Member on an existing Single Membership notifies us of the birth of the child and converts to a Single Parent or Family Membership no later than twelve months after the date of birth and pays the additional premiums; or
b) the Primary Member on an existing Single Parent, Couple or Family Membership notifies us of the child's details within twelve months of the date of birth; and
c) Single Parent, Couple or Family Membership Premiums are fully paid from the date of the child's birth.

Where the criteria above are not met, or where a Dependant otherwise enters the care of an Insured Member, cover for the Dependant, including Waiting Periods, will commence:

(i) on the date on which the Primary Member on an existing Single Parent, Couple or Family Membership notifies us of the Dependant's details; or
(ii) on the date on which the Primary Member on an existing Single Membership notifies us on the Dependant's details and converts to a Single Parent or

Family Membership, including payment of the applicable Single Parent or Family Membership Premium.

J. Transferring to our Fund

All policies offered by us comply with the portability requirements of the PHI Act.
If you transfer to TH with a break in coverage of greater than two months between your previous insurer and TH, you will be subject to all applicable Waiting Periods, refer to Rules V. C. and VI.A.
If you transfer from another Fund to TH with a break in coverage of two months or less, we will recognise your previous Waiting Periods served and only apply Waiting Periods to:

a) Any Benefits under the TH Policy that were not provided under the previous Policy;
b) The difference (if any) between the Benefit payable by TH in respect of a Service and that payable by the previous Fund as at the date of Service;
c) The Excess payable under the TH Policy if this is lower than the Excess on the previous Policy;
d) The unexpired portion of any Waiting Periods not fully served under the previous Policy; and
e) The unexpired portion of a Benefit Replacement Period governing the supply or replacement of an appliance, Medical Device or Human Tissue Product. This applies only to General Treatment benefits.

K. Upgrades

A Primary Member or Authorised Person can apply to transfer from one TH Policy to another TH Policy.
Where an Insured Member transfers to another Policy with a higher level of cover, any applicable Waiting Periods must be served before we will pay a Benefit on the new Policy (exceptions may apply under 'lifetime mental health waiver', refer to Rule V.E.). Until the new Waiting Periods are served, Benefits will be paid to the level of the previous cover.

L. Premium payments

You will be required to pay the Premium rate applicable to the Primary Member's State of residence.
Premiums will be subject to the legislated Lifetime Health Cover Loading and Australian Government Rebate on private health insurance.
On your authorisation, Premiums will be deducted from your nominated account.
Premiums are payable in advance from the commencement date of the membership up to the relevant payment period and may be paid fortnightly, monthly, quarterly, half-yearly or yearly. Premiums for Ambulance Cover taken as a separate Policy must be paid on an annual basis.
Premiums are listed in Schedule C and subject to Rule II.N.

We may refuse to accept (including refund any payment accepted in good faith), any payment of Premiums that would cause your period of cover to exceed twelve months in advance of the date of payment.

We may change the Premium payable by you in accordance with the PHI Act. We will provide you with notice in writing prior to any Premium changes. If you have made a payment of Premiums in advance, any Premium change that takes effect during the period in which you have paid in advance will not be enforced against your Policy until your next Premiums fall due (excluding where you change your Policy or reactivate your membership following a temporary Suspension).

If your Premium payments are in Arrears, you will not be entitled to claim any Benefit for treatment received since the Arrears Date unless any Premiums in Arrears are subsequently (and within two months of the Arrears Date) paid in full and payment in advance is received as outlined above.

M. Lifetime Health Cover Loading

We will increase your Premiums by a nominated percentage where required under the Lifetime Health Cover Loading provisions of the PHI Act. The circumstances in which the Lifetime Health Cover Loading applies, ceases to apply and any exemptions, are set out in the act.

N. Australian Government Rebate on private health insurance

Insured Members who are eligible for full Medicare benefits may be entitled to the Rebate subject to prescribed income tiers.

Primary Members can claim the Rebate by:

a) registering to receive the Rebate as a reduced Premium by correctly completing and submitting to TH the relevant form; or
b) claiming via an annual tax return.

TH will send a statement to the Primary Member in respect of each prescribed person in accordance with *the Private Health Insurance (Incentives) Rules* 2012 (No.2) (Cth).

O. Temporary Suspension of your membership

We may permit a Primary Member or Authorised Person to suspend their membership while travelling overseas or due to unexpected financial difficulties outside of your control. Any Suspension will apply to all Insured Members covered by the Policy.

Temporary Suspension of membership will be granted, subject to Suspension guidelines established by TH from time to time, if the reason for Suspension is:

a) the temporary absence from Australia of the Primary Member or a relevant Insured Member;
b) leave of absence without pay of the Primary Member or a relevant Insured Member from their place of employment; or
c) financial hardship,

for a period exceeding two months.

For temporary absence from Australia, the temporary Suspension period may not exceed thirty-six months. For leave of absence without pay and financial hardship, the temporary Suspension may not exceed twelve months.

Services provided to an Insured Member during a period of Suspension of the Policy will not be eligible for Benefits. Any new Waiting Periods may be pro-rated to the period of Suspension at the discretion of TH.

All Policy entitlements, other than Benefits, under a suspended Policy will remain unchanged during the period of Suspension. Any period of Suspension will not be counted towards Accrued Benefit Entitlements.

Policies suspended on one or more occasions for the reason of financial hardship for an aggregate total of three years within a five year period are not eligible for Suspension again for the same reason.

If a suspended Policy is recommenced within one calendar month after the expiry of the Suspension period or other agreed recommencement date, no additional Waiting Periods will be imposed under the Policy.

P. Policy migration

We may at any time mandate the closure of a particular Policy. This will involve the compulsory migration of your cover from the closing Policy to another open Policy. Should this occur you will be provided with written notice in advance of the date of effect and the full details of the nominated substitute Policy (which may provide cover for a greater or lesser range of treatment). Where the transfer is to a Policy which provides higher Benefits that the closing Policy, the unserved Waiting Period will apply to the additional Benefit and the lower Benefit will be paid during the unserved Waiting Period.

You will have the option of changing to another open Policy of your choice or to the nominated substitute Policy.

Q. Cancellation of your membership

We will permit:

a) the Primary Member to cancel their Policy entirely;
b) the Primary Member to remove any Insured Member or Dependants from their Policy;
c) any Insured Member aged at least 18 years of age to leave the Policy; and
d) any Insured Member aged under 18 years of age to leave the Policy with the agreement of the Primary Member or Authorised Person.

Unless otherwise permitted by us, the above actions must be notified to us in writing and may not have retrospective effect.

If you transfer to a new Fund and a request is made to TH for a transfer certificate, we will provide the certificate within 14 days.

Once you cancel your membership, we will not be liable to pay any Benefits in respect of goods/services obtained by you after the date of cancellation. If a Primary Member terminates a Policy during the course of a Hospital admission, TH will only pay Benefits up to the day before the termination of the Policy becomes effective.

If any excess Premium exist when a membership is cancelled, we will refund these to the Primary Member. Refunds will only be paid to the same account that the payment originated from. However, if a member owes any monies due to an error, fraudulent activity or inappropriate claiming, we may recover the amount due by setting it off against any Premiums paid in advance of the date of cancellation.

R. Termination of your membership

We may terminate your membership on written notice if:

a) your Premium payments are more than two months in Arrears;
b) any Insured Member has committed or, in the opinion of TH, attempted to commit fraud upon TH, has made a material misrepresentation (including by omission), or provided false or misleading information;
c) we believe that you have brought our business into disrepute;
d) you have acted in a way that could be reasonably construed as inappropriate to one of our employees, providers or other members;
e) you materially or repeatedly breach these Fund Rules;
f) it comes to our attention that you do not and never have, met the restricted eligibility criteria for membership; or
g) at our discretion, if an Insured Member on the Policy is concurrently an Insured Member of another health benefits fund under a Policy which duplicates, in whole or in part, Benefits under the Policy.

In the event of fraud, any Premiums paid in advance of the date of membership termination, may be first applied by TH to offset the cost of the erroneous payment, with TH being only liable to the Primary Member of the cancelled Policy of any balance remaining.

Reinstatement of membership (including continuity of entitlement or otherwise) is at our discretion.

S. Membership Authority

We will permit a Primary Member to request that another person (e.g. Partner or a third party) be treated as authorised to operate the Policy as though they are the Primary Member. The authority provided by the Primary Member does not permit cancellation of the membership and may be withdrawn by them at any time, by notification to us.

On receiving documentary evidence, we will treat the holder of a Power of Attorney or Guardianship Order as authorised to operate the Policy as though they are the Primary Member.

III. Health Service Providers

A. Recognised Providers

We will pay Benefits in accordance with the relevant Policy schedule in these Rules only where treatment is provided by a Recognised Provider.

We recognise the following providers:

a) Hospitals,
b) Medical Practitioners,
c) General Treatment providers who:
   (i) are in Private Practice; and

(ii) satisfy all applicable criteria for each class of Service or treatment, including legislative requirements such as the *Private Health Insurance (Accreditation) Rules* 2011 (Cth); and
(iii) hold an active Medicare Provider Number for each location they engage in Private Practice; and
(iv) hold an active Australian Regional Health Group (ARHG) Provider Number, which has been registered with each location they engage in Private Practice; and
(v) are approved by us in our absolute discretion.

Where we have reasonable grounds to believe that a provider does not meet the above criteria, we will revoke electronic claiming access and decline to pay Benefits in respect of any Claim.

Further requirements are set out in the General Treatment Provider Guidelines available on our website.

B. De-recognised Providers

We may, at our discretion, ban providers from being a TH Recognised Provider where:

a) they fail to comply with reasonable requests for further information to validate a Claim;
b) we believe that they have obtained or attempted to obtain an improper advantage for themselves / their practice or an Insured Member;
c) they have been involved in any (attempted) fraudulent, negligent or criminal act in relation to our business;
d) they materially or repeatedly breach any of these Fund Rules or the General Treatment Provider Guidelines;
e) we believe that they have brought our business into disrepute;
f) they have acted in a way that could reasonably be construed as inappropriate to one of our employees, providers or Insured Members; or
g) they have been suspended or expelled by their relevant professional board or association.

Further requirements are set out in the General Treatment Provider Guidelines available on our website.

C. Health Centres

We own and operate Health Centres that provide dental, optical and other services. Benefits available to Insured Members of the Fund depend on the level of cover held by the Insured Member. A schedule of fees is agreed and reviewed annually between the Health Centre and the Fund.

D. Preferred Providers

We may enter into a special arrangement with other General Treatment providers, or a group of such Recognised Providers, to provide Benefits for particular General Treatment. An arrangement may appoint the Recognised Provider as a preferred provider.

We make no representation or undertaking as to the quality of Service of a preferred provider.

E. Agreements with Medical Practitioners and Hospitals

We may enter into an agreement with a Medical Practitioner or group of Medical Practitioners, or a Hospital or a group of Hospitals, under which any of the following items, or any combination of the following items, are to remain fixed throughout the term of the agreement:

a) the total charge of any treatment,
b) the Benefit payable by us, and
c) any out-of-pocket expenses payable by the Insured Member.

The amount payable by an Insured Member receiving treatment from a Medical Practitioner or Hospital under an agreement or arrangement with us must not vary according to the frequency with which the Recognised Provider treats an Insured Member.

Benefits under Access Gap Cover Scheme arrangements with Medical Practitioners are payable subject to the following conditions:

d) a Medical Practitioner who provides Services under a known Access Gap Cover Scheme shall give the Insured Member written Informed Financial Consent advice;
e) if possible, the advice should be given before any treatment is provided or as soon as practicable and the recipient of the advice must acknowledge they have received the advice; and
f) a Medical Practitioner who provides Services under a known Access Gap Cover Scheme or a No Access Gap Cover Scheme shall give the Insured Member written advice of any financial interest the Medical Practitioner may have in products or Services recommended or provided to the Insured Member.

IV. Benefits

We will pay eligible Benefits in accordance with the relevant Policy schedule in these Rules. If the PHI Act requires us to provide a particular Benefit that is not provided for by these Rules, we will provide the Benefit on the minimum terms required by law.
To ensure the correct payment of a Benefit, we may request information from an Insured Person or a Health Care Provider prior to, or after the payment of a Benefit.

A Benefit is not payable to the Insured Member in respect of a Service that has been provided through a Purchaser Provider Agreement between TH and the Health Care Provider.

Benefits are calculated based on the date the cost was incurred and will not exceed 100% of the cost to the Insured Member of any services for which Benefits are payable.

A. Ex-Gratia Payments

We may, at our discretion, make Ex-Gratia Payment to Insured Members who have incurred exceptional expenses.

B. Benefit reductions

Benefits may be reduced in the following circumstances:

a) Where the amount payable by an Insured Member is lower than the Benefit that would otherwise have been payable, the Benefit shall be reduced to the amount payable.
b) Where a Benefit is claimable from another source for the same Service, we may reduce our Benefit so that the total from all sources does not exceed the amount payable. E.g. Government subsidies or separate insurance policies.
c) Where in our reasonable opinion, the charge is higher than the Health Care Provider's usual charge for the Service, we may assess the Claim as if the Health Care Provider's usual charge had applied.

d) Where the Insured Member owes any monies to us as a result of prior fraudulent activity or inappropriate claiming, we may offset this debt against any Benefit payable.

C. Benefit exclusions

We will not pay Benefits where:

a) Treatments or Services were conducted during an Insured Member's Waiting Period including where the condition is identified as a Pre-Existing Condition.
b) the Insured Member has reached their available annual limit for the General Treatment.
c) The same treatments or Services are claimed under more than one Policy.
d) Treatments or Services were provided more than two years prior to the Claim.
e) A fee was not charged for the Service or treatment.
f) The Insured Member is unable to provide a valid receipt for payment.
g) The costs of the treatment or Service were not incurred by the Insured Member.
h) Treatment has not yet been provided, including but not limited to, payments made in advance and charges raised for non-attendance or late cancellations.
i) Treatment occurred when the Premium payments were in Arrears (subject to Rule II.L.).
j) Treatment occurred during a period of temporary Suspension of the membership.
k) Treatment does not meet the terms and conditions specified in these Rules or in any legislative instrument.
l) Treatment is excluded from the relevant Policy schedule to these Rules.
m) Services were not received face-to-face, with the exception of:
    (i) Telepsychology services provided by a registered psychologist, a recognised counsellor or an Accredited Mental Health Social Worker;
    (ii) Speech therapy;
    (iii) Dietetic services;
    (iv) Lactation Nursing;
    (v) Physiotherapy and exercise physiology services;
    (vi) Occupational therapy; and
    (vii) Podiatry; and
    (viii) Digital Mental Health Support.
n) For Nursing Home Treatment or the cost of care and accommodation in aged care within the meaning of the *Aged Care Act* 1997 (Cth).
o) A medical Service has been provided as a non-admitted patient (other than Hospital-Substitute Treatment).

p) A procedure performed in a Hospital is not covered by Medicare or is an elective procedure not considered to be medically necessary, e.g. cosmetic surgery.
q) A General Treatment is covered by Medicare.
r) Treatment was provided in an emergency department.
s) For Hospital and General Treatment received or goods purchased overseas including items sourced over the internet.
t) Goods are considered to be consumable supplies.
u) Services primarily take the form of sport, recreation or entertainment and are not part of an approved Healthy Lifestyle Program or chronic disease management program.
v) Treatment was, in the reasonable opinion of a Medical Adviser appointed by us, unnecessary or excessive.
w) Services were not provided by a Recognised Provider.
x) Treatment is of an experimental nature.
y) Pharmaceuticals are prescribed for the purposes of contraception or for cosmetic purposes or are vitamin supplements (subject to Rule VI.V.).
z) Services were provided to an Insured Member as a result of an Accident for which they have received compensation or damages, or there is the right to receive compensation from other insurance or another third party that includes an amount equivalent to the Benefit (see below).

aa) The Insured Member fails to authorise us to obtain further information from the Health Care Provider to validate the Claim, e.g. clinical notes.

bb) The Insured Member or Health Care Provider has made a material misrepresentation (including by omission) or gives inaccurate or misleading information relevant to the Claim.
cc) The Insured Member provides services as a Health Care Provider: (i) to themselves, (ii) to anyone insured on the same Policy as themselves or their Partner or their Dependants, (iii) to the Insured Member's business partner/associate or anyone insured on the business partner's/associate's Policy or their spouse/Partner or their Dependants.
dd) The Insured Member does not meet the eligibility criteria set out in Rule II.B.
ee) A Dependant was not notified to and accepted by TH.

D. Compensation or damages

We will not pay a Benefit for Hospital Treatment or General Treatment where an entitlement exists, or may exist, for compensation or damages. However:

a) Where the amount of the entitlement for compensation or damages is, in our opinion, less than the Benefit that would otherwise be payable for the expenses incurred for that treatment the difference will be payable;
b) Where a right to receive compensation has not been determined or the Claim is still being finalised, we may in our absolute discretion, grant the provisional payment of a Benefit;
c) Claims for work related injuries must be submitted directly to the relevant compensation regulator in your State or Territory (or otherwise directly to your employer's insurer if the organisation self-insures). In the event that your workers' compensation claim is denied, Benefits may be payable by TH on

submission of fully itemised accounts/receipts with a copy of the determination stating that there is no entitlement to workers' compensation Benefits.

Where an Insured Member has or might have an entitlement for compensation or damages they must:

d) Advise us of a potential Claim as soon as they are aware that a Claim may exist;
e) Keep us informed about all decisions regarding the compensation claim;
f) Ensure the full amount of expenses (including future expenses where applicable) are claimed; and
g) Advise us when the case is settled or a decision is reached and ensure we are refunded all associated costs (including any provisional Benefits already paid).

E. Lifetime Limits

Lifetime limits apply to an Insured Member and are not tied to the duration of a Policy.

Where a Benefit is subject to a lifetime limit, Benefits paid on a previous level of cover or with other health funds will count towards the lifetime limit with us.

V. Hospital Treatment

Private Hospitals

At contracted Hospitals (refer to Rule III.E.), where a Hospital Purchaser Provider Agreement (HPPA) is in place, we will pay the contracted Benefit for any treatment covered by your Policy (including theatre, accommodation and services in accordance with the PHI Act less any applicable Excess).

If we do not have a HPPA in place with the Hospital ('non-agreement Hospitals'), we will pay only the Second-Tier Default Benefit or a Minimum Default Benefit less any applicable Excess. This may result in the Insured Member incurring greater out of pocket costs.

Public Hospitals

When the Insured Member elects to be treated as a private patient at a Public Hospital, we will pay the Minimum Default Benefit for that treatment less any applicable Excess.

Any amount in excess of these Benefits may be charged directly to the Insured Member provided that the Hospital first obtains Informed Financial Consent.

Where the Insured Member is eligible for Boarder Fees at a public hospital, the Benefit is $30 per night with a yearly cap of $200 per person.

All Hospitals

All Hospital Policies will also provide entitlement to Benefits for Inpatient treatment as follows:

a) Where there is an Access Gap Cover Scheme in place, a Benefit of the amount agreed above the Medicare Benefits Schedule Fee.

b) For interstate hospitalisation, Benefits will be payable in accordance with the Benefits set by TH for the State in which the hospitalisation occurred irrespective of the State in which Premiums are paid.
c) In relation to Hospital Treatment and Hospital-Substitute Treatment:
    (i) where the incurred medical expense is equal to or more than the Medicare Benefits Schedule Fee, a Benefit of 25% of that MBS Fee is payable; and
    (ii) where the medical expense is less than the Medicare Benefits Schedule Fee, a Benefit equal to the difference between 75% of the MBS Fee and the amount charged.
d) However, no Benefit is payable for Hospital-Substitute Treatment if a Medicare benefit of at least 85% of the Medicare Benefits Schedule Fee is able to be claimed for that treatment.
e) For Hospital Pharmaceuticals, a Benefit of 100% of the cost to the patient in accordance with the HPPA.
f) For Inpatient non-cosmetic surgically implanted Medical Devices or Human Tissue Products approved by the Department of Health, Disability and Ageing, the minimum Benefit specified for the Medical Device or Human Tissue Product in the Prescribed List of Medical Devices and Human Tissue Products.
g) For Emergency Ambulance services where the Insured Member is not otherwise covered, 100% of the cost of such services.
h) Where there is a Medical Purchaser Provider Agreement (MPPA) or Practitioner Agreement within an HPPA in place, a Benefit of the amount agreed above the Medicare Benefits Schedule Fee.
i) Benefits for anaesthetic services will be paid at a rate equal to the Benefit TH would pay under the Access Gap Cover Scheme if the anaesthetist had an agreement with TH or at a rate equal to 25% of the Medicare Benefits Schedule Fee if no agreement exists.
j) In relation to Inpatient podiatric surgery, Benefits for accommodation, theatre fees and implanted Medical Devices and Human Tissue Products will be paid at a rate equal to the amount of Benefit that would have been paid had the surgery been rendered by an orthopaedic surgeon in accordance with the Hospital Policy of the patient.
k) For psychiatric care, rehabilitation and/or palliative care provided in a Hospital where no Medicare benefit is payable, the Minimum Default Benefit for that treatment will be payable.
l) Where TH has an agreement or arrangement with a particular Health Care Provider (other than a Medical Practitioner), all Hospital Treatment or Hospital-Substitute Treatment provided to Insured Members under the same type of Policy will be charged at the same amount.

All Benefits payable from all Hospital Policies will be reduced to the Minimum Default Benefit on the expiration of 35 days continuous hospitalisation as a patient, when the patient will thereafter be classified as a Nursing-Home Type Patient.

No Benefit is payable for Services under Hospital or combined Policies for which no Medicare benefit is payable.

A. Clinical categories

The Department of Health, Disability and Ageing has developed a list of standard clinical categories which each Policy must be structured around. Schedule A sets out the clinical categories covered by each TH Hospital and combined Hospital and Extras Policy.
For a detailed description of the services / treatments / health conditions included in each clinical category please refer to:
https://www.health.gov.au/resources/collections/private-health-insurance-clinical-category-and-procedure-type

B. Policy coverage
For each Hospital Policy, a clinical category will be:
a) Included – Benefits will be paid according to the HPPA, at a Second-Tier rate for eligible private Hospitals or at the Minimum Default Benefit rate for all other Private Hospitals and any Public Hospitals.
b) Excluded – no Benefits will be payable for any Hospital Treatment aligned to that clinical category (including accommodation, theatre, medical, Medical Device and Human Tissue Product charges).
c) Restricted – Benefits will be paid at the Minimum Default Benefit rate for all Private and Public Hospitals.

C. Waiting periods
Where relevant to the Primary Member's cover, the following Waiting Periods apply for each Insured Member (subject to Rule II.K. and II.L.).

1 day	Emergency Ambulance transportation
2 months	Hospital Treatment or Hospital-Substitute Treatment that is hospital psychiatric services, rehabilitation or palliative care (whether or not for a Pre-Existing Condition) Any other Benefit for Hospital Treatment or Hospital-Substitute Treatment not mentioned elsewhere in this table.
9 months	Pregnancy and birth services
12 months	Hospital Treatment or Hospital-Substitute Treatment for a Pre-Existing Condition

Certain Insured Members may be eligible for a one-off exemption from the Waiting Period for psychiatric care, subject to meeting the relevant criteria specified in the *Private Health Insurance (Complying Product) Rules* 2015 (Cth) as amended from time to time.

D. Pre-Existing Conditions
Unless we determine otherwise, you will not be entitled to Benefits for any ailment, illness or condition where signs or symptoms of which, in the opinion of the Medical Adviser appointed by TH, existed at any time during the six (6) months ending on the day on which the person became insured under the relevant Policy or upgraded to a higher level of cover.

Whether a Pre-Existing Condition exists will be determined taking into account information provided by your own Medical Practitioner and any other material the appointed Medical Adviser believes is relevant to the Claim.

It is not necessary for you to be aware or have a diagnosis of an ailment for it to be considered pre-existing.

This Rule applies for the first 12 months after your commencement date or your transfer to a Policy that offers an increased or additional Benefit.

The Pre-Existing Condition rule does not apply for psychiatric, rehabilitation or palliative care/services.

E. Lifetime mental health waiver

In accordance with Rule 9A of the P*rivate Health Insurance (Complying Product) Rules* 2015 (Cth), the two-month Waiting Period imposed under Rule V.C. in relation to a Benefit for Hospital Treatment that is referred psychiatric treatment, will be waived if we are notified of an intention to upgrade cover under this Rule.

The lifetime mental health waiver is available to an Adult or Dependant ("the Nominating Patient") who has a financial membership under a complying health insurance policy in the following circumstances:

a) The Nominating Patient, their authorised representative, or guardian (if the Nominating Patient is a Dependent Child), notifies us within 5 working days (starting on the day the person is admitted to Hospital), that they wish to access the lifetime mental health waiver;
b) The Nominating Patient is a current financial member of a Policy under which Benefits for Hospital Treatment that is psychiatric care are restricted (the Previous Policy);
c) The Nominating Patient agrees to upgrade their Policy to a TH Policy under which Benefits for Hospital Treatment that is psychiatric care are not restricted, including payment of the relevant Premium for at least the duration of their admission for referred psychiatric treatment under the lifetime mental health waiver provisions;
d) The Nominating Patient is admitted to Hospital under the care of a consultant psychiatrist or addiction specialist; and
e) The Nominating Patient has not previously in their lifetime utilised the TH lifetime mental health waiver provisions, or any equivalent upgrade provisions under any other complying health insurance policy issued by another Fund.

We will require written evidence of:

f) Financial membership of the Nominating Patient's current Policy (if transferring from another Fund);
g) A referral by a consultant psychiatrist for admission to Hospital for treatment is psychiatric care, made at or before the time of admission.

If the Nominating Patient was previously on a level of cover that is subject to an Excess, the Excess provisions of the previous Policy will apply for the first two

months of any upgrade, including an upgrade under the lifetime mental health waiver.

If the Nominating Patient has not fully served Waiting Periods relevant to hospital psychiatric services on the Previous Policy at the time of their upgrade under the lifetime mental health waiver, this unexpired Waiting Period will be applied to the upgraded Policy.

F. Surgically implanted Medical Devices and Human Tissue Products
We will pay Benefits for a range of Medical Devices and Human Tissue Products (as approved by the relevant statutory body) that are provided as part of an episode of eligible Hospital Treatment for which an Insured Member has cover.

Clinical choice remains a matter between the Medical Practitioner and the patient. If a Medical Practitioner considers that a gap-permitted Medical Device or Human Tissue Product is the most clinically suitable for a patient, the Medical Practitioner should provide appropriate clinical and financial information so that the patient may give Informed Financial Consent before the procedure proceeds.

G. Pharmaceuticals
Medications listed on the government PBS supplied to an admitted patient of a Hospital and directly related to the treatment of the condition for which the Insured Member was admitted, will be eligible for a Benefit as defined in the relevant HPPA.

Subject to Rule III.A., Benefits for non-PBS medications supplied to an admitted patient of a Hospital are payable in accordance with the HPPA only if the Benefit is specifically included in the agreement with the Hospital.

If we do not have a HPPA with the treating Hospital, we will not pay any Benefit for any Pharmaceuticals that are not included in the accommodation charge.

Pharmaceutical Benefits are not payable under this Rule if the Insured Member is treated for services which are excluded or subject to an unexpired Waiting Period on their Policy.

H. Dental surgery in Hospital
For dental surgery performed by a dentist rather than a Medical Practitioner, we only pay benefits towards Hospital charges. If the surgery is performed by a Medical Practitioner and Medicare benefits are payable, we will pay Benefits towards the Hospital and medical charges.
Treatment charges may be covered under your ancillary cover.

I. Podiatric surgery in Hospital
For podiatric surgery, we pay a Benefit towards the Hospital charges only. The surgeon’s fees are not payable by Medicare or claimable under your Hospital Policy.

J. Nursing Home Type Patients

Benefits are payable in accordance with the definitions of Nursing Home Type Patient as prescribed under the PHI Act. Benefits will be reduced to the Nursing Home Type Patient Rate for Nursing Home Type Patients.

K. Excess

A Primary Member may choose whether to have an Excess on the Policy or not. The Excess options available for each Hospital Policy is specified in Schedule A.

An Excess is applied once per Adult, per Calendar Year. Any Excess must be paid by the Insured Member before we will pay a Benefit for Hospital Treatment. The Excess amount will apply to Claims in the order they are processed by us.

The Hospital Excess is waived for Dependants.

Reducing your Excess is considered to be upgrading your membership. We will charge your previous Excess within the first two months of the upgrade, including for Adults who are upgrading their level of cover by joining/re-joining as a Dependant on a Family membership.

Where a hospitalisation bridges a Calendar Year and part of the next year, the Excess for the second Calendar Year will apply to the first subsequent admission of the second Calendar Year.

Any Excess is applied in both Public and Private Hospitals.

L. Travel and accommodation Benefit

If required treatment for a serious medical or dental condition requiring specialist services is not available within 100 km of the Insured Member's home address, and the Insured Member will be required to travel a return distance of at least 200 km, a Benefit may be payable towards the costs of travel and accommodation.
Where travel relates to an attendance at the TUH Health Hub a Benefit may be payable where the return distance is at least 300 km.

M. Emergency Ambulance Benefit

Emergency Ambulance means an ambulance service provided by a State Government ambulance service (or a private ambulance service substituted for a State Government ambulance service) or a private ambulance service recognised by TH. Benefits may be payable where the Insured Member is transported directly to a Hospital or treated at the scene due to a medical emergency and excludes transportation to hospital for the routine management of an ongoing medical condition or inter-Hospital transfers (other than emergency transfers).

A benefit may also be payable towards Non-Emergency Ambulance transport. Non-Emergency Ambulance means an ambulance service provided by a State Government Ambulance Service or by a private ambulance service recognised by TH, for:

a) a call out or attendance by an ambulance where no transport occurs;
b) admission to a Hospital from home where transport is deemed medically necessary;

c) discharge from Hospital to home where transport is deemed medically necessary, and does not include inter-hospital transfers.

All medically necessary ambulance transport must be supported by a letter from the treating doctor explaining the medical requirement for ambulance transport.
Medically necessary ambulance transport is classified as:

(i) patient requiring stretcher transport, is not able to travel in a normal seated position or has impaired cognitive function; and
(ii) patient requiring active management or monitoring while in transit.

A Waiting Period of one (1) day applies to Emergency Ambulance Benefits. Refer to Rule V.C.

N. Hospital-Substitute Treatment

All Hospital and combined Hospital and Extras Policies will provide Benefits for Hospital-Substitute Treatment provided by an approved Medical Practitioner in relation to treatment within eligible clinical categories.

O. Member Health Programs

Member Health Programs provide access to Benefits for programs such as Chronic Disease Management (including Care Coordination), hospital in the home and other health management programs as approved by us from time to time.
Eligibility for Member Health Programs will be determined at our discretion and considered on an individual basis with regard to clinical need and the requirement of relevant private health insurance legislation and rules.

VI. General Treatment

The Benefits payable for General Treatment are listed in Schedule B.

A. Waiting periods

Where relevant to the Primary Member's cover the following Waiting Periods apply for each Insured Member (subject to Rules II.K. and II.L.):

24 months	Wheelchair Benefits
12 months	Non-surgically implanted Medical Devices and Human Tissue Products Major Dental treatment and orthodontia Hearing aids CPAP Machine, CPAP Accessories
6 months	Optical Services Healthy Lifestyle Programs
2 months	All other services

Additional Waiting Periods apply depending on your level of cover.

B. Limits

Unless otherwise stated, limits listed in Schedule B are per person, per Calendar Year and may vary according to your Years of Continuous Membership while insured on the same Policy (or similar Policy as determined by us).

C. Same day treatments
Where you have more than one (1) General Treatment Consultation on any one day for the same type of service, treatment for the same condition, or treatment from the same Medical Practitioner, Benefits will be paid in line with internal guidelines.

D. Telehealth services
Benefits are payable where the following services are delivered by telephone or video Consultations. All other services, other than Digital Mental Health Support, are currently eligible to receive Benefits only when delivered in-person.
Telehealth Claims must be submitted directly to us and are not claimable via provider-submitted electronic claiming channels such as HICAPS.
Eligible Telehealth Services:

a) Telepsychology services provided by a registered psychologist, a recognised counsellor or an Accredited Mental Health Social Worker;
b) Speech therapy;
c) Dietetic services;
d) Lactation Nursing;
e) Physiotherapy and exercise physiology services;
f) Occupational therapy; and
g) Podiatry.

All Service conditions listed below and Benefit limits listed in Schedule B apply to telehealth services.

Specific services

E. Acupuncture
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for Acupuncture Services as listed in Schedule B are payable where provided by a Recognised Provider (refer to Rule III.A.).
Limit of one initial Consultation per person, per Calendar Year.

F. Ante-natal / post-natal classes
Refer to Schedule B for a list of relevant annual limits and sub-limits in addition to the below.
Benefits for ante-natal / post-natal classes as listed in Schedule B are claimable per person, up to the annual sublimit. Ante-natal / post-natal classes have to be provided by a Recognised Provider.

G. Audiology Service
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for Audiology Services as listed in Schedule B, are payable where provided by a Recognised Provider (refer to Rule III.A.).

H. Chiropractic (including chiropractic x-ray)

Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for chiropractic services as listed in Schedule B are payable when provided by a registered Chiropractor who is a Recognised Provider.

I. Dental Services
Refer to Schedule B for a list of relevant annual limits and sub-limits in addition to the below.
Dental Benefits will be provided only in respect of procedures or services recommended by the Australian Dental Association. Details of the services for which Benefits are payable and the levels of Benefit prescribed are available on request. Dental Services have to be provided by a Recognised Provider such as a dentist, dental prosthetist or orthodontist.

We may negotiate separate fees per Service with internal and external dental preferred providers; however, the Benefit limits listed in Schedule B still apply.

Lifetime limits apply to orthodontic treatment. Orthodontic Benefits paid on previous levels of cover or with other health funds will count towards the lifetime limit.

J. Dietetic services
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for dietetic services as listed in Schedule B are payable where provided by a Recognised Provider.

K. Eye therapy – orthoptics
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for orthoptics as listed in Schedule B are payable where provided by a Recognised Provider.

L. Aids & appliances
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.

M. Healthy Lifestyle
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.

Benefits for prevention health management services and Healthy Lifestyle Programs may include Gym Membership, hydrotherapy, health screening / preventative screening services, disease management subscriptions/memberships, weight management, flu vaccination, yoga and pilates.

Prevention health management Benefits must be intended to ameliorate an Insured Member’s specific health condition.

For weight management programs, Gym Membership and Healthy Eating Activity and Lifestyle (HEAL) program, we require a valid Healthy Lifestyle Program form completed by the Insured Member's Medical Practitioner outlining the nature of the proposed program and how this will treat or prevent a chronic health condition.

Health screening services available vary based on your Extras Policy.

Benefits are only payable where not claimable from any other source of funding.

N. Hearing aids
Hearing aid refers to a device for personal use that amplifies sound to allow improved hearing. Refer to Schedule B for a list of relevant annual limits and sub-limits in addition to the below.
Hearing aid Benefit limits apply per person over a three-year period. Benefits for hearing aids and their repair as listed in Schedule B are only payable when ordered by a Medical Practitioner or appropriate medical specialist.

O. Home Nursing Service & Lactation Nursing
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for Home Nursing Services as listed in Schedule B, are only payable when provided by a Recognised Provider.
Benefits for Lactation Nursing as listed in Schedule B, are only payable when provided by a Recognised Provider.

P. Remedial massage / myotherapy
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for myotherapy and remedial massage services as listed in Schedule B, are only payable where provided by a Recognised Provider (refer to Rule III.A.).

Q. Occupational therapy
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for occupational therapy as listed in Schedule B, are payable where provided by a registered occupational therapist who is a Recognised Provider.
Limit of one initial Consultation per person, per Calendar Year.

R. Orthotics
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for orthotics as listed in Schedule B, are payable where ordered and supplied by a Recognised Provider.
No Benefit will be paid for orthopaedic shoes that have not been individually custom made from a mould specific to the Insured Member.

S. Optical

Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for Optical Services as listed in Schedule B, are payable when:

a) Prescribed by a Recognised Provider; and
b) Where sight correction or adjustment to the lens is clearly shown on the prescription form.

Benefits are not payable for non-prescription sunglasses or for additional lens treatments such as tinting, hard coating or transitional.

The date the appliance was ordered is used to calculate the Benefit payable.

T. Osteopathy

Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for Osteopathic Services as listed in Schedule B, are payable when provided by a Recognised Provider.
Limit of one initial Consultation per Insured Member, per Calendar Year.

U. Pharmaceuticals

Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for Pharmaceuticals are payable after deduction of the current PBS contribution, on private prescription items (S4 or above) that:

a) Have been prescribed by a Recognised Provider; and
b) Have been supplied by a registered pharmacist in Private Practice or a Medical Practitioner; and
c) Can only be supplied on prescription under applicable State law, but does not include a substance which:
   (i) Is available under the PBS in any formulation, presentation, strength or pack size, with or without repeat dispensing, regardless of whether such availability is subject to the Specified Purpose, Authority Required, Pensioner Concession or Special Patient Premium conditions of that scheme; or
   (ii) Was prescribed in the absence of illness or disease or for enhancement of sporting or employment performance.
d) Have been approved by the Therapeutic Goods Administration Division of the Department of Health, Disability and Ageing.
e) Not prescribed for the sole or primary purpose of contraception (for Benefits to be payable, a letter may be required from the Medical Practitioner to verify that this item is otherwise medically necessary).

V. Physiotherapy / exercise physiology / hydrotherapy

Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for physiotherapy / exercise physiology / hydrotherapy as listed in Schedule B are payable when provided by registered physiotherapists or exercise physiologists who is a Recognised Provider:

a) The provider is acting within their usual scope of practice;

b) Group Therapy or Classes are preceded by a Consultation with a registered physiotherapist or exercise physiologist in order to diagnose and plan treatment;
c) Group Therapy or Classes are part of an individual treatment plan to treat or prevent injury or to manage a chronic disease;
d) Preceding Consultations and Group Therapy or Classes are provided at the same practice; and
e) Clinical notes are documented by the provider relevant to individual participants for each Consultation including Group Therapy or Classes.

General wellness exercise-based group physiotherapy or exercise physiology services are not eligible for a Benefit.

Limit of one initial Consultation per person, per Calendar Year.

Conditions on same-day treatments apply. Refer to Rule V.C.

W. Podiatry
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Limit of one initial Consultation per person per, Calendar Year.

X. Psychology
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for Psychology and Counselling Services as listed in Schedule B are payable where provided by a Recognised Provider (refer to Rule III.A.).
A sub-limit as listed in Schedule B applies to Digital Mental Health Support programs provided by This Way Up.
Limit of one initial Consultation and one psychology/psychometric assessment per person, per Calendar Year.

Y. Refractive laser eye surgery
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits as listed in Schedule B for refractive eye surgery are payable if the treatment is provided by a Recognised Provider.

Z. Speech therapy
Refer to Schedule B for a list of relevant annual limits and sub limits in addition to the below.
Benefits for speech therapy services as listed in Schedule B are payable where provided by a registered speech therapist who is a Recognised Provider.
Limit of one initial Consultation per person, per Calendar Year.

VII. Claims

A. Form
All Claims must be submitted with invoices or receipts. Insured Members must retain all original invoices or receipts for a period of twelve (12) months after submission of the Claim.

Invoices or receipts should be on the Recognised Provider's official account or letterhead or on a receipt stamped with an official provider stamp, be an accurate representation of the treatment episode and include:

a) Recognised Provider's full name, their association name and number or Medicare Provider Number, practice address and preferred contact details (must be included as part of the provider letterhead or stamp and not hand written);
b) Recognised Provider's company, trading name, ABN and/or ACN (as applicable);
c) Patient's full name and address;
d) Date of service(s) and where the service(s) took place;
e) Itemisation, description of cost of the service(s);
f) Date the invoice or receipt was issued;
g) Details of amounts paid and outstanding balances; and
h) The words "duplicate" or "copy" on any duplicate invoices issued or where the document provided is a quote, it should be marked as a "quote" or "estimate".

Invoices or receipts must be generated by the Recognised Provider, templated documents that are populated by the Insured Member will not be accepted. Cash register dockets, copies of credit card or bank statements, e-commerce marketplace receipts and gift vouchers are not acceptable documents for making Claims.

B. Submitting your Claim

Claims may be made electronically at the Recognised Provider (if available), submitted via the mobile app, via online member services or at a member care counter.

Claims must be submitted within two years of the date of service.

C. Assessing your Claim

The Insured Member must provide us with accurate and complete information and advise us of any issue that may affect a Claim.

We may request additional information from you, your Medical Practitioner or your Health Care Provider in support of a Claim prior to or after the payment of a Benefit. This may include requesting copies of clinical documentation for our review. We do not pay additional fees or charges for the provision of this information. If you do not provide this information, instruct your Medical Practitioner not to provide this information, or we are otherwise unable to obtain this information from your Medical Practitioner, we may refuse to pay a Benefit in relation to that Claim and/or future Claims for goods or services delivered by the same Medical Practitioner.

D. Paying your Claim

We will pay your valid Claims by electronic funds transfer or any other method of payment prescribed by us from time to time. When making an electronic funds transfer, we will utilise the account details of the Primary Member, unless you request an alternative arrangement. It is the Insured Member's responsibility to ensure we have the correct account details prior to submitting a Claim. We will not accept any responsibility for locating or repaying lost funds if you have given us incorrect details or fail to update your details with us.

E. Reimbursement of Claims

We may seek to have a Claim reimbursed to us if:

a) The Claim was incorrectly assessed;
b) An overpayment has occurred;
c) The Claim was found to contain a material misrepresentation (including by omission) or false or misleading information;
d) The Policy is in Arrears;
e) The Claim was paid after termination of the Policy; or
f) Information is received by us that the Benefit should not have been paid (refer to Rule IV.D.).

VIII. Interpretations and Definitions

A. Interpretations

a) Unless expressed to the contrary, these Rules shall be interpreted so as not to conflict with the TH Constitution. 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.
b) Unless otherwise specified:
   (i) an expression or meaning that deals with a matter dealt with by a particular provision of the Law, has the same meaning as in that provision of the Law; and
   (ii) the Rules must be read as subject to any requirements under the PHI Act and any other act regulating or affecting the regulation of the Fund.
c) Words importing the singular number include the plural number and vice versa. Words importing the masculine gender include the feminine gender and vice versa.

B. Definitions

Access Gap Cover Scheme means arrangements with specific medical specialists where TH pays Benefits for Inpatient medical services above the Medicare Benefits Schedule Fee to eliminate or reduce out-of-pocket expenses for the Insured Member.

Accident means an injury to the body inflicted as a result of unintentional, unexpected actions or events caused by an external force or object, which occurred in Australia after joining the Fund and serving the 2-month Waiting Period, that requires, within 7 days of the Accident, treatment by a recognised Medical Practitioner, or Dentist, but excludes pregnancy. Benefits are payable for the initial Inpatient Hospital Treatment for injuries resulting from the Accident, as well as ongoing Inpatient Hospital Treatment where the services are provided within 180 days of the date of the Accident and which form part of the initial course of treatment covered by the Fund. Accident cover is only available under StarterPak (Basic Plus). Refer to Schedule B.

Accredited Mental Health Social Workers are registered providers with Services Australia. They have been assessed on behalf of the Commonwealth Government by the Australian Association of Social Workers (AASW) as having specialist mental health expertise.

Accrued Benefit Entitlements means a Benefit that accrues to an Insured Member in relation to certain Years of Continuous Membership under one Policy with TH.

Adopted Child means a legally adopted Dependent Child or Dependent Non-Student.

Adult does not include a Dependent Child, Dependent Non-Student or Student Dependant.

Ambulance Cover means the General Treatment Benefit for which maximum Benefits are prescribed in Schedule B.

Ambulance Services means attendance or attendance and transport by an ambulance for emergency treatment. Emergency is defined as an event that is unplanned, non-routine, and which requires immediate medical attention.

Application Form means an application for a Policy made by a person who will become the Primary Member, in such form as TH determines from time to time.

APRA means the Australian Prudential Regulation Authority.

Arrears means a period during which Policy Premiums are not paid to the current date.

Arrears Date means that date on which a Policy becomes unfinancial. This date will be equal to the date on which the first missed premium payment was due.

Australian Government Rebate on private health insurance or **Rebate** means the incentive rebate offered by the Federal Government to reduce Premiums of private health insurers. The Rebate is offered to encourage permanent residents, interim and reciprocal Medicare card holders in Australia to take out private health insurance. It applies to both Hospital and Extras Policies.

Authorised Person means an insured person authorised by the Primary Member in accordance with Rule II.S.

Benefit means an amount of money payable under these Rules and includes access to a Service to be provided directly to the Insured Member in lieu of a payment.

Benefit Replacement Period means a continuous period of time that must elapse between any two purchases of the same type of item before Benefits are payable in respect of the later purchase.

Boarder Fees means the fee charged by a Public Hospital for accommodation of an individual, which is considered part of General Treatment rather than Hospital Treatment since the benefit only applies where, in the opinion of a Medical Practitioner, it is necessary for the care and management of a disease, injury or condition of an Insured Member who is undergoing Inpatient treatment that the individual stay overnight at the Public Hospital with the Insured Member.

Broader Health Cover means the private health insurance that covers services that prevent, are part of, or substitute for hospitalisation, including chronic disease

management programs, hospital in the home, transitional care and rehabilitation in the home.

Calendar Year means the 12-month period commencing 1 January and ending 31 December.

Claim means a formal request for benefit payable in accordance with the Fund Rules and Constitution.

Class in respect of physiotherapy, exercise physiology or chiropractor services is the class-based provision of a common intervention to a number of clients simultaneously. A class participant must be individually assessed by a physiotherapist, exercise physiologist or chiropractor (as applicable) prior to participation. The physiotherapist, exercise physiologist or chiropractor must be in attendance for the duration of the class.

Commencement Date in relation to a membership is defined in Rule II.F.

Compression Garments means compression garments used for the treatment of lymphoedema or the treatment of vascular conditions or to minimise scarring following burns or prescribed post-surgery. It does not include sports compression garments used to improve performance or post-exercise recovery. Claim must be supported by a written request from a medical professional prescribing the use of a garment for a specific condition and compression based on the needs of the patient.

Consultation means an attendance by a Recognised Provider on a one to one basis, exclusive of all other. The Recognised Provider must be in attendance and must remain accessible during the entire course of the Consultation and treatment.

Dependant is defined in Rule II.E.

Digital Mental Health Support refers to digital mental health support programs provided by This Way Up. Refer to Rule VI.X.

Excess means an amount of a benefit that is foregone, in return for a lower premium than would otherwise apply. Refer to Rule V.K.

Extras Policy means a Policy that provides Benefits for General Treatment as prescribed in Schedule B.

Foster Child means a Dependant who is a State ward placed in the care of a Primary Member or their Partner by court order or formal arrangement.

Fund means the health benefits fund conducted by TH.

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

Group Therapy in respect of a physiotherapy, exercise physiology, chiropractor or occupational therapy is when a small group of clients are provided with medically

necessary treatment through differentiated interventions concurrently. Group interventions are characterised by the following features:

a) Individual pre-intervention assessment by a Recognised Provider;
b) individually designed intervention provided and re-assessed during the Consultation; and
c) clinical record keeping.

The Recognised Provider remains in attendance for the duration of the session.

Gym Membership means standalone gym membership provided by a Recognised Provider undertaken as part of a health management program intended to ameliorate a specific health condition or conditions on the recommendation of a Health Care Provider.

Health Care Provider means a person who provides goods or services as, or as part of, Hospital Treatment or General Treatment, or a person who manufactures or supplies goods provided as, or as part of, Hospital Treatment or General Treatment.

Healthy Lifestyle Programs means weight loss programs, stop smoking courses, stress management courses and other activities approved by TH and provided by a Recognised Provider.

Home Nursing Service means essential home nursing of an Insured Member provided by a Recognised Provider.

Hospital means a hospital as defined by the PHI Act.

Hospital Pharmaceuticals means any drug or medicinal preparation listed in the PBS that is dispensed to a hospital patient and is part of the episode of care of the Hospital Treatment provided.

Hospital Policy means a Policy that provides Benefits for Hospital Treatment as prescribed in Schedule A.

Hospital-Substitute Treatment has the same meaning as in the PHI Act.

Hospital Treatment has the same meaning as in the PHI Act.

HPPA means Hospital Purchaser Provider Agreement which is an agreement between a health benefits fund and a Hospital or day Hospital facility relating to fees for the provision of Hospital Treatment.

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

Inpatient means a patient who is formally admitted to a Hospital but excludes an emergency department attendance.

Insured Member means a person who is covered by a Policy and is entitled by these Rules to Benefits and includes the Primary Member.

Lactation Nursing means Services provided by lactation nurses who are Recognised Providers.

Major Dental refers to more complex dental procedures and includes periodontics, endodontics, occlusal therapy, oral surgery, prosthodontics, inlays, onlays, bridges, crowns, dentures and tooth bleaching.

Medical Adviser means a qualified Medical Practitioner appointed by TH to give technical advice on clinical matters.

Medical Devices and Human Tissue Products refer to products defined in the Prescribed List of Medical Devices and Human Tissue Products as published by the Department of Health, Disability and Ageing, and updated from time to time.

Medical Practitioner means a medical practitioner within the meaning of the *Health Insurance Act 1973* (Cth).

Medicare means Australia's health care system established under the *Human Services (Medicare) Act 1973* (Cth).

Medicare Benefits Schedule Fee or **MBS Fee** means the fee set by the Federal Government for medical services that are listed in the Medicare Benefits Schedule Book published by the Department of Health, Disability and Ageing, and includes any updates and supplements to the schedule.

Minimum Default Benefit means the minimum Hospital Benefit prescribed by the Minister from time to time as prescribed under the *Private Health Insurance (Benefit Requirements) Rules* 2011 (Cth).

Minister means the Minister (or their delegate) administering the PHI Act.

Medical Purchaser Provider Agreement or **MPPA** means an agreement between a Health Benefits Fund and Medical Practitioners relating to fees for the provision of medical services.

Natural Therapies means Remedial Massage, Myotherapy, Chinese herbal medicine and Acupuncture Services provided by a Recognised Provider.

Nursing Home Treatment means any medical or medical-related treatment provided by a Recognised Provider to an Insured Member in a nursing home.

Nursing Home Type Patient means a person who has been admitted as an Inpatient for a period of continuous hospitalisation exceeding 35 days and there is no longer a certified requirement for acute care.

Nursing Home Type Patient Rate means the minimum Hospital Benefit for Nursing Home Type Patients prescribed by the Minister from time to time under the *Private Health Insurance (Benefit Requirements) Rules* 2011 (Cth).

Partner means a person married to or living in a de-facto relationship with another person.

Pharmaceutical Benefits Scheme or **PBS** means, in relation to drugs or medicines, the Commonwealth Pharmaceutical Benefits Scheme listed pharmaceuticals.

Policy means a complying health insurance policy as defined in the PHI Act, which is issued by TH.

Practitioner Agreement means an agreement between a Hospital or Day Hospital Facility and a Medical Practitioner for the provision of medical services at the Hospital or facility.

Pre-Existing Condition is described in Rule V.D.

Premium means the insurance premium or contribution payable by the Primary Member under the Policy as determined by TH from time to time, in accordance with these Rules.

Primary Member means the Insured Member who has legal responsibility for the membership and for ensuring that Premiums are kept up to date.

Private Health Insurance Statement has the same meaning as in the PHI Act.

Private Hospital means a Hospital that has been declared by the Minister to be a Private Hospital.

Public Hospital means a Hospital that has been declared by the Minister to be a Public Hospital.

Pregnancy Compression Garments are used both pre- and postpartum to reduce swelling, provide relief of pain associated with pregnancy & assist in postpartum recovery. This includes both recovery shorts and leggings that are TGA approved. Pregnancy active wear such as sports-related or body enhancing garments are not included. Claim must be supported by a written request from a medical professional prescribing the use of a garment during and after pregnancy.

Private Practice means a professional practice that is self-supporting principally through fees received from patients and whose accommodation, facilities and services are not provided or subsidised by another party such as a Public Hospital or publicly funded facility.

Private Room (in a Hospital) refers to:

a) a purpose-built room;
b) which holds one single sized bed;
c) has facilities for no more than a single admitted patient; and
d) includes a private ensuite.

Psychology Services means psychological assessment, treatment or group therapy sessions, counselling and other Services provided by a psychologist, recognised counsellor or an Accredited Mental Health Social Worker who is a Recognised Provider.

Purchaser Provider Agreement means an HPPA or MPPA and includes a purchaser-provider agreement between TH and any Health Care Provider.

Recognised Provider is defined in Rule III.A.

Second-Tier has the meaning set out in the *Private Health Insurance (Benefit Requirements) Rules* 2011 (Cth).

Service means a treatment, Consultation or approved item including Broader Health Cover provided personally by a Recognised Provider, or under the direct supervision of a Recognised Provider or Hospital, for which TH pays a Benefit under these Rules.

State means a State or a Territory of Australia.

Stepchild means a child of the Insured Member's Partner by a previous union.

Surgical Shoes means shoes that must be custom made by a surgical shoe maker, prescribed by a podiatrist or medical practitioner.

Surgical Stockings means stockings obtained on the recommendation of a Medical Practitioner following surgery.

Suspension means the temporary discontinuation of membership in accordance with these Rules.

TH means Teachers Federation Health Limited.

This Way Up is a digital mental health support platform offering evidence-based online programs and tools to help individuals manage anxiety, depression, and related conditions**.** It is the only digital mental health support platform currently recognised by TH.

Waiting Period is defined in Rules V.C. and VI.A.

Years of Continuous Membership means a period during which an Insured Member maintains membership of the Fund with no break in Premium payments of date or effect between product changes (if any).