RBHS Fund Rules

A INTRODUCTION

A1 Rules Arrangement

Binding Effect of Rules

These rules set out the General Conditions (Fund Rules A to G) and include the Schedules of Benefits and Specific Conditions applying to the operation of the Reserve Bank Health Society Limited ABN 91 087 648 735 (RBHS). These Rules have effect as a contract between the RBHS, each Member and each person claiming through the RBHS.

The Board may alter, vary or amend these Rules in any manner whatsoever, subject to the Private Health Insurance Act 2007 (as amended) and Rules attaching to the Act by way of Legislative Instrument (the Act). Changes to these Rules that result in a detrimental change to

A2 Health Benefits Fund

A2.1 The RBHS is a registered private health insurer.

A2.2 The RBHS conducts a health benefits fund ("the Fund") for the benefit of persons in the RBHS' restricted access group as defined in the Act, and detailed in Rule C2.

A2.3 Unless otherwise provided for in the Constitution and these Rules, all matters to be determined in connection with the Fund or its administration will be determined by the Board.

A3 Obligations to Insurer

A3.1 A person applying for admission to the RBHS as a Member will:

(a) comply with the requirements of these Rules; and

(b) provide such information as is reasonably requested to allow the operation of the Policy and advise the RBHS as soon as reasonably possible of changes to that information.

A4 Governing Principles

A4.1 The Fund will be operated according to:

(a) the Constitution of the RBHS;

(b) the Private Health Insurance Act 2007 (as amended);

(c) the Health Insurance Act 1973 (as amended);

(d) these Fund Rules.

A4.2 The Fund will also operate in accordance with the requirements of the Privacy Act 1988 (as amended) and the Australian Privacy Principles, including taking into account the rights of a person covered under a Policy to have their personal information kept private from other persons covered by that Policy.

A5 Use of Funds

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

(a) Premiums payable under policies of insurance that are referable to the Fund;

(b) income from the investment of assets of the Fund;

(c) any other money received by the RBHS in connection with its conduct of the Fund;

(d) any other amounts specified in the Act or Constitution.

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

(a) meeting Policy liabilities and other liabilities, or expenses, incurred for the purposes of the business of the Fund as defined in the Act;

(b) making investments in accordance with the Act;

(c) any other purpose specified in the Act or Constitution.

A6 No Improper Discrimination

A6.1 The RBHS will ensure that the conduct of the Fund will at all times comply with the community rating provisions of the Act. The RBHS will not take or fail to take any action, make a decision, or have regard or fail to have regard to any matter that would result in the RBHS improperly discriminating between eligible persons who are or wish to be insured by the RBHS.

A6.2 Improper discrimination is discrimination that relates to

(a) the suffering by a person from a chronic disease, illness or other medical condition; or

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

(c) the age of a person, except to the extent allowed under the Act (Lifetime Health Cover & Aged Based Discount);

(d) where a person lives, except to the extent allowed under s.66-10(2) or s.66-20 of the Act (the state in which the person resides); or

(e) any other characteristic of a person that is likely to result in an increased need for Hospital treatment or General treatment; or

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

(g) the amount or extent of the Benefits to which a person becomes entitled during a period under a Policy, except to the extent allowed under s.66-15 of the Act (general treatment benefit limit usage); or

(h) any matter set out in the Act.

A6.3 Despite Rule A6.2, discrimination by the RBHS is not improper discrimination to the extent to which the RBHS ensures that its Complying Health Insurance Products are not made available to ineligible persons.

A7 Changes to Rules

A7.1 These Rules may from time to time be varied in any way in accordance with the Constitution and the Act, but no variation will reduce the amount of any Benefit already incurred and payable at the date of the Rules variation.

A7.2 The RBHS will give a relevant Private Health Insurance Information Statement to each Member at least once every 12 months, or as otherwise required by the Act.

A7.3 The RBHS will ensure that, if a person asks an officer, employee or agent for information about a complying health insurance product offered by it that:

(a) the person is told about the Private Health Insurance Information Statement for the product that is likely to apply to the person and how to obtain a copy; and

(b) if the person asks for a copy – the person is given an up to date copy of the statement.

A7.4 If a proposed change to these Rules:

(a) is or might be detrimental to a Member; and

(b) will require an update to the Standard Information Statement relevant to the Member, the RBHS will ensure that the Member:

(i) is informed of the proposed change a reasonable time before the change takes effect; and

(ii) is given the relevant updated Standard Information Statement as soon as practicable after the statement is updated.

A7.5 If a proposed change to these Rules is or might be detrimental to a Member, but will not require an update to the Standard Information Statement relevant to the Member, the RBHS will ensure that the Member is informed of the proposed change a reasonable time before the change takes effect.

A8 Dispute Resolution

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

A8.2 All complaints or disputes should be notified in writing to the RBHS.

A8.3 The RBHS will deal with the complaint or dispute quickly and efficiently and in terms of the Complaints Policy available to members on the RBHS website.

A8.4 Disputes involving claims will be referred to the Medical Practitioner appointed pursuant to Rule A11.1 or other appropriate expert appointed by the RBHS. If, following receipt of the Medical Practitioner's or expert's advice, the RBHS rejects the claim, the Member will be advised of this outcome.

A8.5 The Ombudsman responsible for private health insurance is available to assist Members who have been unable to resolve disputes. However, the Member should give the RBHS every opportunity to resolve the dispute before going to the Ombudsman.

Complaints should be directed to the RBHS through either:

- Telephone – 1800 027 299
- Facsimile – 1300 309 704
- Email – info@myrbhs.com.au
- Post – Locked Bag 23, Wollongong DC NSW 2500.

A9 Notices

A9.1 Those Rules requiring direct written notice to a Member will be satisfied by the RBHS sending that notice to the address last supplied by the Member, and by the communication means preference (including electronic) advised by the Member (mail / facsimile / email).

A10 Winding Up

A10.1 In the event of the RBHS ceasing to be registered under the Act, the Fund will be dealt with in accordance with the requirements of the Act.

A10.2 In the event of the winding up of the Fund all monies not required for meeting outstanding liabilities, contracted payments and other expenses of winding up including the requirements of the Act, will be utilised in such manner as may be determined by the Board in accordance with the Constitution and the Act.

A11 Other

A11.1 Medical Practitioner.

The Board is entitled to appoint a Medical Practitioner as a referee, and is entitled to accept his or her opinion or report on any hospital, medical or related medical matters as conclusive evidence of the facts to which the opinion or report relates. Subject to Rule A8.4 the Board is not bound to disclose the contents of the opinion or report to any person.

A11.2 Chief Executive Officer.

The Chief Executive Officer of the RBHS is responsible to the Board for the management and administration of the Fund in accordance with the Constitution, these Rules, and other directions provided by the Board from time to time.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

B1.1 In these Rules, words importing the male gender will include the female gender and words importing the singular or plural number will include the plural or singular number respectively.

B1.2 The definitions in the Private Health Insurance Act 2007 as amended and the Health Insurance Act 1973 as amended will unless otherwise specified in these Rules apply to these Rules.

B2 Definitions

“Act” means the Private Health Insurance Act 2007 (Cth) (as amended) and Rules attaching to the Act by way of Legislative Instrument.

“Age-Based Discount” means a discount which may be applied to an eligible person as defined in the Private Health Insurance (Complying Product) Rules.

“Application for Membership” means an application to become a Member of the RBHS.

"Benefit" means any benefit payable by the RBHS in accordance with these Rules.

"Board" means the board of directors of the RBHS. “Complying Health Insurance Policy” is an insurance policy that meets:

a) the community rating requirements in Division 66 of the Act; and

b) the coverage requirements in Division 66 of the Act; and

c) if the Policy covers Hospital treatment – the benefit requirements in Division 72; and

d) the waiting period requirements in Division 75; and

e) the portability requirements in Division 78; and

f) the quality assurance requirements in Division 81; and

g) any requirements set out in the Private Health Insurance (Complying Product) Rules for the purposes of this paragraph.

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

"Constitution" means the constitution of the Reserve Bank Health Society Limited.

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

"Dependant" means any child of a Member or child of a Member’s Partner (including an adopted child, foster child, or child for whom the Member or Member’s Partner is a legal guardian) who is:

(a) under the age of 18 years without a partner; or

(b) a person who is defined as a Student Dependant

"Fund" means the health benefits fund conducted by the RBHS pursuant to the Act.

“General Treatment” is defined under S.121-10 of the Act and is treatment, including the provisions of goods & services, that is not Hospital Treatment and is intended to manage or prevent a disease, injury, or condition.

"Hospital" means a declared hospital as defined in the Act and includes a Private Hospital or a Day Hospital Facility.

"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 the RBHS and a Hospital Facility and as amended from time to time.

“Hospital Treatment” is defined under S.121-5 of the Act and is treatment, including the provision of goods & services, provided while admitted to a Hospital, or provided or arranged with the direct involvement of a Hospital.

“Hospital Policy” means a policy of a Hospital insurance that provides Benefits prescribed in Schedule H.

“Medical Gap” means the difference, if any, between the cost of a professional service and the combined Medicare Benefit and Fund Benefit.

"Medical Practitioner" means a person who:

a) is registered or licensed as a medical practitioner under the law of a State or territory of Australia; and who
b) satisfies the eligibility requirements for the payment of Medicare Benefits.

"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 the RBHS and a Medical Practitioner and as amended from time to time.

"Medicare Benefit" means a Medicare Benefit under Part II of the Health Insurance Act 1973.

"Member" means a person who is:

a) a Policy Holder, and
b) the Principal Person insured on that Policy; and
c) the person whose name is entered in the register of members under S. 168 & 169 of the *Corporations Act (2001)*

"Nursing-Home Type Patient" has the same meaning as in the *Private Health Insurance (Benefit Requirements) Rules.*

“Non-Student Dependant” means any child of a Member or child of a Member’s Partner (including an adopted child, foster child, or child for whom the Member or Member’s Partner is a legal guardian) who is:

a) Aged 18 to 24 (inclusive) years who was formerly a dependent child on the policy, and
b) Without a partner, and
c) Not a Student Dependant

“Partner” means a person who is living with the Member as their Partner on a domestic basis whether or not legally married to that other person.

“Policy” means a Hospital Policy (specified in Schedule H) or a General Treatment Policy (specified in Schedule I) that provides an entitlement to Benefits under these Rules.

“Policy Holder” has the same meaning as in the Act, and is a person who is insured under a Policy who is not a Dependant.

“Pre-Existing Condition” means an ailment, illness or condition, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by the RBHS, existed at any time during the six months preceding the day on which the Member became insured under the relevant Policy. In forming the opinion the Medical Practitioner must have regard to any information in relation to the ailment, illness or condition that the Medical Practitioner who treated the ailment, illness or condition gives him or her.

“Premium” means a premium as defined in the Act whether paid by or on behalf of a Principal insured to be eligible for Benefits under a Policy.

“Principal insured” means the person in whose name the Policy is registered with the RBHS.

“Private Hospital” has the same meaning as in the Act.

"Rules" means these rules of the Fund as amended from time to time.

"RBHS" means the Reserve Bank Health Society Limited.

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

"Student Dependant” means any child of a Member or child of a Member’s Partner (including an adopted child, foster child, or child for whom the Member or Member’s Partner is a legal guardian) who is:

a) Aged 18 to 24 (inclusive) years, and

b) Without a partner, and
c) They are a full-time student at a school, college or university, or are undertaking a traineeship or apprenticeship.

“Waiting Period” means the period that applies to a person for a Benefit under a Policy being the period:

a) starting at the time the person becomes insured under the Policy; and

b) ending at the time specified in the Policy and in rule F3 to these Rules;

during which the person is not entitled to the Benefit.

B3 Other

C MEMBERSHIP

C1 General Conditions of Membership

C.1.1 Insured Groups

Policies may be offered to the following insured groups:

(a) only one person;

(b) 2 adults and no-one else;

(c) 2 or more people, none of whom is an adult and any number of Dependants;

(d) 2 or more people, only one of whom is an adult and any number of Dependants;

(e) 2 or more people, only one of whom is an adult, at least one of whom is a Non-Student Dependant and any number Dependants

(f) 3 or more people, only 2 of whom are adults and any number of Dependants;

(f) 3 or more people, only two of whom are adults, only one of whom is a Non-Student Dependant and any number of Dependants;

(g) 3 or more people, only 2 of whom are adults, at least one of whom is a Dependant Person with a Disability, and any number of Dependants and Non-Student Dependants

The RBHS recognises the following classes of people in the insured groups:

(a) adults;
(b) Dependants as defined in Rule B2;
(c) Non-Student Dependants as defined in Rule B2
(d) Dependant Persons with a Disability as defined in Rule B2

C1.2 Levels of Cover

The RBHS offers Policies to Members comprising:

(a) specified treatments that are Hospital treatment in a recognised Hospital, but excluding:
(i) Treatment that does not normally require hospital treatment;

(ii) Treatment provided to a person at an emergency department of a hospital;

(iv) 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).”

(b) specified treatments that are General Treatment, including hospital substitute and hospital prevention programs, but excluding;
(i) Hospital Treatment;

(ii) Services provided by registered general practitioners and any other services covered by Medicare;

(iii) Funeral benefits;

(iv) Disability benefits;

(v) 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

C2.1 The following persons are eligible for membership of the RBHS:

(a) any person who is, or was, an employee of the Reserve Bank of Australia or Note Printing Australia Limited;

(b) the Partners and Dependants (as defined in Rule B2) of any person described in paragraph (a) of this sub rule.

(c) the former Partners and adult children of any persons described in Paragraph (a) of this sub rule.

(d) Any other person deemed to form part of the restricted access group as defined in the Private Health Insurance (Registration) Rules.

C2.2 Subject to these Rules, persons who have retired from the Reserve Bank of Australia or Note Printing Australia Limited employment, or widowed Partners of Members who have died, may be admitted as Members.

C3 Dependants

C3.1 Dependants and Non-Student Dependant are defined in Rule B2.

C3.2 The following applies in regard to adding a Dependant to a Policy:

1. If there is no impact on premiums resulting from adding a Dependant – there is no limit of time during which the member needs to add a Dependant to a Policy (e.g. a newborn); waiting periods would not apply per existing Rule F3.
2. If there is an impact on premiums resulting from adding a Dependant –
   a) A Member can add a child up to 3 months after birth / adoption with no resulting backdating of premiums; waiting periods would not apply per existing Rule F3.
   b) A Member can add a child beyond 3 months of birth / adoption, but resulting premium changes would need to be backdated, with a maximum of 12 months. Waiting periods would not apply per existing Rule F3.

C3.3 The following applies in regard to adding a Dependant Child Non Student to a Policy:

1. A dependent child non-student can remain on a policy, on which they were formerly a dependent child, up to age 24 for an additional premium (with the exception of C1.1.1.(g) Insured Group) .

C3.4 The following applies in regard to adding a Dependant Person with a Disability to a Policy:

1. A Dependant Person with a Disability can remain on a policy, on which they were formerly a dependant child indefinitely or until they no longer meet the definition of Dependant Person with a Disability

C4 Membership Applications

C4.1 An application to become a Member will be made on the application form specified by the RBHS, signed by the person who will be the Member, and accompanied by such additional information as required to process the application.

C5 Duration of Membership

C5.1 Provided that the first Premium has been paid, the commencement date of a Policy will be the date the application is lodged with RBHS or where agreed a date as nominated on the application form.

C5.2 A Policy will continue while Premiums continue to be paid until cancellation by the Member or cancellation by the RBHS in accordance with these Rules.

C6 Transfers

C6.1 Policy Holders who transfer from another Registered Private Health Insurer within a period of two (2) months from the date to which contributions were paid last, will be accepted with rights and benefit entitlement not in excess of those pertaining to the

RBHS policy to which the Policy Holder transfers in accordance with S. 78-1 (3) of the Act.

C6.2 On the transfer of a Policy Holder to another Registered Private Health Insurer there will be no further liability on the RBHS in respect of that Policy Holder for services incurred after the date of transfer.

C6.3 Where the Policy Holder transfers to another Registered Private Health Insurer, the RBHS will provide a transfer certificate to the Policy Holder within fourteen days of the cessation of the policy.

C6.4 For those Policy Holders transferring from another Registered Private Health Insurer, RBHS will require a transfer certificate to be provided by that insurer, otherwise normal waiting periods for the Policy will apply.

C6.5 The portability requirements and waiting periods of persons applying for a Policy with the RBHS, or upgrading from an existing policy are detailed in Rule F3.

C7 Cancellation of Membership

C7.1 A Principal insured may:

(a) cancel his or her Policy:

(b) add or remove a Partner or Dependants from his or her Policy.

C7.2 Premium refunds will be given to a Principal insured who has paid Premiums in advance and who wishes to cease a Policy before the paid-to date up to no more than three (3) months for general termination requests and no more than twelve (12) months for deceased estates.

C7.3 A request to cancel a Policy must be in writing.

C7.4 The date of cessation of a Policy will be the later of the date requested by the Member or the date of receipt by the RBHS of the request to cancel a Policy from the Principal insured.

C7.5 A new Principal insured may cancel his or her Policy within 30 days of becoming a Policy Holder and be provided with a full refund of Premiums paid, provided there have been no Benefits paid or payable on the Policy.

C8 Termination of Membership

C8.1 The RBHS has no right to terminate the Policy of any Member on the ground of any of the matters set out in Rule A6.

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

C8.3 The RBHS has the right to terminate the Policy of a Member if the application for the Policy for that Member contained inaccurate or incomplete information in a material respect, and such right may be effected from the date the Policy commenced. "Material" means that the RBHS could have made a different decision if provided with accurate and/or complete information. The RBHS will refund any Premiums paid in advance as at the date of the termination but may deduct an appropriate amount from the refund for administrative expenses associated with processing the termination and any amounts wrongfully paid to or on behalf of the Member.

C8.4 The RBHS will terminate the Policy of a Member where Premiums are unpaid more than two months in arrears, except at the discretion of the RBHS. The Member remains liable for unpaid Premiums.

C8.5 Where a Policy has been terminated for non-payment of Premiums, should the Member wish to rejoin the RBHS they must complete a new application. The RBHS may, at its discretion and subject to payment of the Premium arrears, agree to waive Waiting Periods and reinstate any accumulated Benefit entitlements.

C8.6 The RBHS will notify a Member in writing where the Policy has been terminated.

C9 Temporary Suspension of Membership

C9.1 The RBHS may suspend a Policy upon application by the Member.

C9.2 The RBHS will allow the temporary suspension of a Policy in the following circumstances:

a) Temporary Absence from Australia - for more than three months and no more than 40 months by every person covered by that Policy. The Policy must be resumed within one month of returning to Australia by any person covered by the Policy, and Premiums are paid from the date of return to Australia or;

b) Financial Hardship - The maximum suspension period for financial hardship will be 12 months. To be eligible for further suspensions, you must hold continuous, active

cover for at least 12 months and provide documentation to support the suspension (e.g. proof of short-term income support).

Long-term income support (e.g. aged or disability pension) is not sufficient to support membership suspension.

C9.3 Services provided during a period of suspension of a Policy are not eligible for Benefits.

C9.4 A period of suspension of a Policy does not:

i. qualify for the purpose of completing any Waiting Periods that are to be served by a Member before the Member is eligible to receive Benefits.

ii. qualify for serving a period of time, where a Benefit limit is defined in these Rules with reference to a period of time, or period of time before the maximum Benefit is payable.

C10 Other

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Subject to this Rule the rates of Premiums payable by a Member are set out in the Private Health Information Statement for their level of cover available at www.privatehealth.gov.au, or by contacting the Fund directly.

Premiums payable by the Member will be paid by payroll group deduction, direct debit, or such other means as approved by the Board from time to time.

The RBHS has a policy of ensuring members who pay Premiums in advance will have their Premium rate protected for the term of that advance payment, or 12 months, whichever is the lesser. For Premiums paid in advance beyond 12 months, the paid to date of Premiums will be altered in line with any movement in the rate of premiums payable by adjusting the period of advance payment.

D2 Contribution Rate Changes

D2.1 The RBHS has the right to change Premiums in accordance with the requirements of the Act.

D2.2 The RBHS will advise Members in writing of the new Premium rates before they take effect.

D3 Contribution Discounts

D3.1 The only discounts provided will be those permitted by the s. 66-5 of the Act. A total percentage discount may not exceed the percentage specified in the Private Health Insurance (Complying Product) Rules as the maximum percentage discount allowed.

D4 Lifetime Health Cover

D4.1 The premiums payable by a Member will be increased by a nominated percentage where required under the Lifetime Health Cover provisions of the Act. Any Lifetime Health Cover loading applicable to a Policy will be removed after ten years of continuous cover from the date the loading is added. For the purposes of calculating the ten years, permitted days without hospital cover and periods of Policy suspension are disregarded.

D5 Arrears in Contributions

D5.1 If a Member has not made a Premium payment prior to the 'paid to' date, then that Member will be regarded as being in arrears.

D5.2 If a Member is less than two months in arrears, the Member may pay all Premiums in respect of the period in arrears and the Member will then be eligible for Benefits in respect of that period.

D5.3 When a Member is more than two months Premium payments in arrears then his or her Policy will be terminated from the last 'paid to' date of the Policy except at the discretion of the RBHS.

D5.4 No Benefits will be paid for services rendered to a Member during the period in which his or her Policy is in arrears until the arrears in Premiums are paid.

D6 Other

E BENEFITS

E1 General Conditions

E1.1 Members are entitled to all classes of Benefits contained in these Rules from the date of joining the RBHS for expenses incurred on or after that date, provided the Policy premiums are not in arrears at the date of the service to which the expense relates, and any applicable Waiting Periods have been served. Benefits payable will comprise rebates set out in Schedules H and I to these Rules against actual expenses incurred by the Member in respect of persons covered under the Member's Policy.

E1.2 Benefits are not payable for a treatment that does not meet the requirements of the Act.

E1.3 Benefits are not payable where the services are provided by an immediate family member, business or practice partner, or self.

E1.4.1 Maximum Benefits payable will be as set out in these Rules, and will not exceed the charge for the goods or services to which the benefit relates. At the absolute discretion of the Board, such maximum Benefits payable under a Policy may be exceeded if a special request is submitted to the Board and approved by the Board.

E2 Hospital Treatment

E2.1 A Member paying Premiums for a Policy set out in Schedule H to these Rules will, subject to these Rules, be entitled to Benefits for Hospital Treatment.

E2.2 Policy Holders and their Dependants eligible for Hospital benefits are also entitled to the Applicable Benefits Arrangements provided by the Hospital Purchaser Provider Agreements. Hospital benefits will only be available for Hospital Treatment provided by a declared Hospital. Hospital and medical benefits will also only be payable for procedures listed in the Medicare Benefits Schedule (MBS).

E2.3 Hospital benefits payable will include:

1. the provision of a prosthesis listed in the Private Health Insurance (Prostheses) Rules in circumstances:

a. in which a Medicare benefit is payable; or

b. as set out in the Private Health Insurance (Prostheses) Rules for the purposes of this item.

2. pharmaceutical benefits for items dispensed to a Policy Holder or Dependants while they are an admitted patient at a Hospital with which the RBHS has a Hospital Purchaser Provider Agreement. The Pharmaceutical item must be intrinsic to the Hospital Treatment provided, clinically indicated and essential for the meeting of satisfactory health outcomes. This does not include pharmaceuticals that are dispensed where these are not directly related to treatment of the condition or ailment for which they have been admitted.

3. medical services payments payable in respect of professional services that:

a. are rendered to a Policy Holder or their Dependents while Hospital Treatment is provided to them in a hospital facility; and

b. are a professional service in respect of which a Medicare benefit is payable;

c. up to 25% of the Schedule fee (within the meaning of Part II of the Health Insurance Act 1973) in respect of the service.

d. the amount of benefit payable will not exceed the amount referred to in subparagraph (c) unless:

i. the medical practitioner has a Medical Purchaser Provider Agreement with the RBHS; or

ii. the medical practitioner has a practitioner agreement with the Hospital; or

iii. the medical practitioner is covered under the “Access Gap Cover” scheme or other approved gap cover scheme with the RBHS.

4. any treatment for which the Private Health Insurance (Benefit Requirements) Rules specify there must be a benefit.

E3 General Treatment

E3.1 The benefits payable in respect to General Treatment and the conditions relevant to those benefits are set out on Schedule I of these Rules.

E3.2 The RBHS 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.

E3.3 Benefits payable for General Treatment will, after taking into account benefits paid from any other source, not exceed the maximum charges raised for any goods or service rendered.

E3.4 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.

E3.5 General Treatment does not include:

1. services for which a Medicare benefit is payable, except as allowable as hospital substitute treatment;

2. 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

E4.1 RBHS has the power to increase Hospital Treatment and/or General Treatment benefit payments, make new rules, amend or rescind rules.

F LIMITATION OF BENEFITS

F1 Co Payments

F1.1 Not Applicable.

F2 Excesses

F2.1 Not Applicable.

F3 Waiting Periods

F3.1 A Policy Holder who transfers from another private health insurer will be required to serve Waiting Periods as set out in this Rule, unless they have served equivalent waiting periods on an equivalent level of cover with their previous insurer.

F3.2 With the exception of any Pre-Existing Condition related to hospital treatment, any eligible person who elects to become a Member has 30 days, from the date of becoming eligible, to join the RBHS without incurring the Waiting Periods set out in part F3.3 of this Rule.

F3.3 Subject to the portability requirements under the Act and Rule F3.1 & F3.2, any eligible person who elects to become a Policy Holder who has not had at least equivalent cover with another private health insurer, may join the RBHS but will be subject to the following Waiting Periods:

(a) two months for all Hospital Treatment Benefits including palliative care, rehabilitation and psychiatric treatment;

(b) twelve months for Hospital Treatment benefits relating to pregnancy and birth ;

(c) twelve months for any Pre-Existing Condition related to hospital treatment,

except for palliative care, rehabilitation, and psychiatric treatment;

(d) 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.

(e) for any General Treatment Benefits on items:

a. with a maximum entitlement limit period of one (1) year as provided by these Rules – two months waiting period;

b. with a maximum entitlement limit period of two (2) or more years as provided by these Rules, and subject to Rule F5 – twelve (12) months waiting period.

F3.4 Dependants who are added to a Policy as a result of being newborn, adopted, fostered or cared for under legal guardianship are not subject to any Waiting Period. Waiting Periods and conditions set out in Rule F3.1 and F3.3 apply to a new Spouse/Partner and their Dependants added to a Policy.

F3.5 Full Premiums will be payable by the Member during any Waiting Period being served, and neither the Member (nor the Partner or Dependants of that Member) will be eligible for any Benefits until such Waiting Period has expired.

F3.6 The Board may at its absolute discretion waive any Waiting Period, or part of a Waiting Period, in respect of specific expenses or circumstances.

F4 Exclusions

F4.1 The following are excluded from Benefits under a Policy:

(a) Cosmetic surgery not covered by Medicare;

(b) Any hospital treatment not covered by Medicare;
(i) This does not apply to the clinical category “Podiatric surgery (provided by a registered podiatric surgeon).”

(c) Treatments, goods or services provided overseas.

F5 Benefit Limitation Periods

F5.1 For General Treatment Benefits with a maximum entitlement limit period of two (2) or more years:

(a) after the twelve month Waiting Period has elapsed, benefits with maximum limit entitlement periods of two, three and five years will be paid in subsequent years on a pro-rata basis;

(b) regardless of any Waiting Periods, once the full maximum entitlement limit has been exhausted, no further benefits will be payable until a further two, three or five years (as applicable) have been served.

F6 Restricted Benefits

F6.1 No Benefit under any Policy is payable for a medical service for which a Medicare Benefit was payable on the date of the service, unless rendered to a person whilst a patient in a Hospital.

F6.2 Further benefit restrictions may apply as noted in the Hospital Schedule H below for specific products.

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Benefits are not payable for expenses incurred for Hospital or General treatment where a Policy Holder or Dependant 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).

F7.2 A Benefit is payable if the entitlement for compensation or damages is, in the opinion of the RBHS, less than the Benefit that would otherwise be payable under a Policy. The amount of Benefit payable will not exceed the difference between the amount of Benefit that would otherwise have been payable and the amount of the entitlement for compensation or damages.

F7.3 The Board at its absolute discretion may agree to the payment of Benefits for compensable claims in cases where the compensation has not yet been paid,or an entitlement to compensation has not yet been established. In such cases the RBHS will

require the Member to engage in an agreement whereby the RBHS will be reimbursed for claims paid when the case has been settled. In such circumstances, the principles in Rule F7.1 & F7.2 will apply to calculate the amount of the reimbursement.

F8 Other

Nil.

G CLAIMS

G1 General

G1.1 All claims upon the RBHS must be submitted in the form prescribed, and include accounts, receipts and prescriptions, or other evidence the RBHS may require to allow assessment of the claim.

G1.2 To be eligible for Benefits claims must be submitted within two (2) years of the date of service.

G2 Other

Nil.