Phoenix Health Fund

Fund Rules

Effective 1 April 2023

Phoenix Health Fund Limited
1800 028 817
phoenixhealthfund.com.au
ABN 93 000 124 863

These Rules apply to Phoenix Health Fund Insurance Covers and should be read in conjunction with the Phoenix Health Member Guide, Product Information Sheets and Government Rules.

Fund Rules Index

(1) Introduction

(1.1) Health Benefits Fund

Phoenix Health Fund Limited (ABN 93 000 124 863) (***Phoenix Health***) is a registered *Private Health Insurer* (PHI) and conducts its health insurance business in accordance with the relevant Government legislation including, but not limited to, the *Private Health Insurance Act 2007* (PHI Act) and the *Private Health Insurance (Prudential Supervision) Act 2015* (PHIPS Act).

The *Health Benefits Fund* is established in accordance with Phoenix Health's *Constitution* in order to carry on health insurance business and issue *Complying Health Insurance Products* referable to the *Fund* - as defined under, and in accordance with the relevant Government Legislation.

The purpose of the *Health Benefits Fund* is to provide *Benefits* to or on behalf of *Insured Persons* in accordance with the terms of these *Fund Rules* (Rules).

All *Insured Persons* are bound by these *Rules*, and the terms and conditions of their applicable *Health Insurance Policies*.

Insured Persons should be familiar with these *Rules* together with the *Phoenix Health* Member Guide, and *Health Insurance Policy* information that is updated from time to time and provided in the applicable *Private Health Information Statements (PHIS)* and *Product Information Sheets*.

(1.2) Fund Rules Arrangement

These *Fund Rules* set out the arrangements for *Membership* of, and the payment of *Benefits*, by the *Fund*.

These *Rules* consist of:

- the 'Main' Rules (sections 1 to 13)
- the Appendixes (sections AP1 to AP2)

If any *Rule* is inconsistent with any legislation, the relevant legislation prevails to the extent of the inconsistency.

(2) Business of the Fund

(2.1) Obligations to Insurer

Obligation to provide required information

A person applying for *Cover* under a *Policy* shall:

- comply with the requirements of these *Rules*;
- give full and complete disclosure on all matters required by the *Fund* in the timeframe and manner prescribed in these *Rules; and*
- inform the *Fund* as soon as reasonably possible after a change in any details that relate to a Health Insurance Policy or any *Insured Person*.

(2.2) Governance of the Fund

The *Fund* may supplement these *Rules* with Governance Policies that are not inconsistent with the *Rules* and relevant Government legislation. These Governance Policies include, but are not limited to the:

- Phoenix Health Privacy Policy,
- Phoenix Health Dispute Resolution Policy.

The operation of the *Fund* and the relationship between *Phoenix Health* and each *Policy Holder* is governed by:

- the Constitution of Phoenix Health (the Constitution)
- these *Rules*
- the governance policies referred to under these *Rules*
- all other applicable laws of the Commonwealth and the *State* or Territory in which the relevant *Policy Holder* resides.

(2.3) Use of Funds

(2.3a) Financial Control

The *Fund* shall:

- keep proper accounts and records of the transactions and affairs of the *Fund*;
- ensure that all payments from the *Fund* are correctly made and properly authorised, and
- maintain adequate control over:
  - the assets in its custody of the *Fund*, and
  - the incurring of liabilities by the *Fund*.

(2.3b) Income to be credited to the Fund

Phoenix Health shall credit to the Fund:

- all *Premiums* paid by *Policy Holders*, and
- such other moneys or income as required in accordance with the relevant Government legislation.

(2.3c) Drawings on the Fund

Phoenix Health may use the assets of the *Fund* only in accordance with and subject to section 28 of the *PHIPS Act* or making a distribution, payment or transfer that may, from time to time, be permitted or which may be required to be paid under the relevant Government legislation.

(2.4) No Improper Discrimination

Community Rating

Phoenix Health will ensure the conduct of the *Fund* shall at all times comply with the community rating provisions of the *PHI Act*.

Phoenix Health must not take or fail to take any action, or in making a decision have regard or fail to have regard to any matter that would result in *Phoenix Health* improperly discriminating between people who are, or wish to be insured under a *Complying Health Insurance Policy* on the basis of any of the following:

- any health-related issues a person may have, i.e. where a person suffers from a chronic health *Condition*, disease or illness, or any other medical *Condition*;
- a person's gender, race, religious belief or sexual orientation;

- any other characteristic of a person (including, but not limited to occupation or leisure pursuits), that may be likely to increase their need for *Treatment*;
- a person's age, except to the extent where the *Fund* is allowed to, or is required to by Part 2-3 of the PHI Act relating to *Lifetime Health Cover* Loading; and or Part 3-3 of the Act and Paragraphs 11B to 11D of the PHI (Reforms) Amendment Rules 2018, relating to Youth Discount incentives;
- the frequency in which a person needs or may need *Treatment*;
- the amount, or extent of the *Benefits* to which a person becomes, or has become, entitled during a period under a *Complying Health Insurance Policy*,
- except to the extent allowed under section 66-15 of the PHI Act.
- where a person resides, except as is permitted by the PHI Act;
- any matter set out in the *Private Health Insurance (Complying Product) Rules* for the purposes of section 55-5(2)(h) of the PHI Act.

(2.5) Changes to the Rules

Amendments to the Fund Rules

The *Fund* may amend the *Fund Rules* in accordance with the PHI Act and other *relevant Government legislation,* and the *Constitution*.

The *Fund* may waive the application of a particular *Rule* at its discretion, provided that by doing so, the *Fund* does not breach any Government legislation to which it is subject.

A waiver does not reduce any entitlement to *Benefits*.

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

Phoenix Health must give notice to all *Policy Holders* of any change to these *Rules*, in which a detrimental change resulted. See Rule 4.5 Correspondence for more on *Notices to Members*.

(2.6) Winding Up

Termination of Fund

In the event of the *Fund* ceasing to be registered under the *PHIPS Act*, the *Fund* shall be dealt with in accordance with the *relevant Government legislation*.

If termination of the *Fund*, pursuant to Division 5 of Part 3 of the *PHIPS Act* occurs, and there are any assets remaining after all *Fund* debts and liabilities have been discharged, those assets must only be dealt with in accordance with the *PHIPS Act*.

(2.7) Persons Appointed to the Fund

(2.7a) Chief Executive Officer (CEO)

The CEO of *Phoenix Health*, unless otherwise determined by the Board of Directors *(Board)*, shall be the person responsible to the *Board* for the administration of the *Fund*, in accordance with and subject to the *Constitution* and these *Rules*.

(2.7b) Medical Practitioner

The *Board* shall be entitled to appoint a Medical Practitioner as a referee and shall be entitled to accept their opinion or report on any *Hospital*, medical or related medical matters as conclusive evidence of the facts to which the opinion or report relates. The *Board* are bound to not disclose any personal information relating to the opinion or report of the appointed Medical Practitioner. The outcomes of any decision will be communicated to the relevant parties by the delegated authority within *Phoenix Health* and in compliance with the *Privacy Act 1988*.

(3) Membership Conditions

(3.1) General Conditions of Membership

All *Insured Persons* under the same *Policy* must belong to the same *Category of Cover*, have the same *Product*, and have the same entitlements to *Benefits*.

Any *Insured Person* may receive a *Benefit* to which that person is entitled under a *Policy*.

Insured Persons may belong to only one *Hospital Cover* and/*or Extras Cover*; or one *Combined Hospital and Extras Cover* per *Policy*, subject to eligibility criteria. Not all *Products* or *Categories of Cover* are available to all *Insured Persons*.

The *Policy Holder* is responsible for ensuring that the *Premiums* are paid in accordance with the terms of the *Policy* and that the *Policy* remains financial at all times.

(3.1a) Multiple Memberships

A *Policy Holder* may not hold more than one *Hospital Cover* and/or one *Extras Cover* with the *Fund*.

An *Insured Person* may be covered under more than one *Policy* with the *Fund at any one time*, subject to approval by the *Fund*.

Where an *Insured Person* is covered by a Health Insurance Policy with another *Fund* at the same time as holding cover with *Phoenix Health*, only one claim per any one *Treatment* may be made and only one limit shall apply per *Insured Person*.

(3.2) Eligibility for Membership

Subject to these *Fund Rules*, any person is entitled to apply to become a *Policy Holder* or to join an *Insured Person*.

(3.2a) Minimum Age of a Policy Holder

Unless otherwise approved by the *Fund*, a person under the age of 16 years is not eligible to be a *Policy Holder*.

(3.2b) State of Residence

A *Policy Holder* may hold a *Product* only in respect of the *Policy Holder's State of Residence*.

(3.3) Membership Applications

An application to become a *Policy Holder*, or to join an *Insured Person* must be made in the form specified by *Phoenix Health*.

Applications for *Policies* must be accompanied by any proof reasonably required and requested by the *Fund* including:

- proof of identity;
- proof of age – such as original birth certificate, current driver's license or current passport;
- any other form of identification as requested by the *Fund*.

The *Fund* may perform *Identity Verification* on application to become a *Policy Holder* or anytime thereafter. All *Insured Persons* may be subject to *Identity Verification.*

The *Fund* may refuse to accept an application until such time as the requested information is provided and verified.

(3.3a) Refusal of Membership Application

The *Fund* may refuse an application, subject to compliance with Rule 2.4 No Improper Discrimination. In the case of an application being refused, the *Applicant*, would be notified of the refusal.

(3.3b) Acceptance of Membership Application

Once the application for *Membership* has been accepted and processed by the *Fund*, the *Policy Holder* will receive *Policy* information, that will include:

- details of what the *Membership* covers;
- the standard *Premium* amount;
- how the *Benefits* are determined;
- the *Product Information Sheet*; and
- the relevant *Private Health Information Statement* (PHIS).

(3.3c) Consent and Authorisation

The *Fund* may conduct activities to confirm the validity of services or goods that have been claimed and activities to detect and prevent fraud. This may include requesting information from the *Insured Person* or the *Recognised Provider*.

By accepting a *Membership*,

- You consent to the *Fund* collecting, using and disclosing information of all *Insured Persons* including personal and health information in accordance with our Privacy Policy and as permitted by the Privacy Act.
- You authorise the *Fund* to obtain information from the *Recognised Provider* for any services claimed including
  - details of the services provided
  - any records relating to the services
- The *Fund* may, at its discretion, request:
  - details if any *Existing Condition*; and
  - details of any actual or potential *Claims* against any third-party regarding illness, ailment, or injury.
- You acknowledge that the *Fund* may use fraud detection systems and advanced analytics including digital intelligence and authentication to prevent and investigate fraud attempts.

(3.4) Duration of Membership

The commencement date of a *Policy* shall be the day the application is lodged with the *Fund*, or the date nominated on the application; whichever is the later.

Membership commences for a *Dependant* on a *Policy* when registration is effective.

The *Policy* will continue until cancellation under Rule 6.1 or termination under Rule 6.2.

(3.4a) Cooling Off

Unless a claim has been made, the *Policy Holder* may, at any time within thirty (30) days of the commencement date of the *Policy*, request the *Fund* to cancel the *Policy* and refund all *Premiums*, and the *Fund* will do so.

(3.5) Transfers

All Health Insurance *Products* offered by the *Fund* comply with the Portability requirements as required under Division 78 of the *PHI Act*. *Waiting Periods* applicable are covered under Rule 8.3.

(3.5a) Transfers to Phoenix Health from Other Health Insurers

When *an Insured Person transfers* from another *Private Health* Insurer, and has a gap in cover of less than thirty (30) days, they will be accepted with rights and *Benefit* entitlement EXCEPT in the following cases, in which *Waiting Periods* would be applied:

- to any *Benefits* that were not covered under their previous *Product*;
- to any increase in *Benefits* or limits on their *Phoenix Health Level of Cover*, compared to their previous *Product*;
- to any portion of *Waiting Periods* that had not been served with their previous Fund;
- to any unexpired portion of a Benefit Replacement Period or limit governing the supply or replacement of an appliance or *Prosthesis.*

If a *Waiting Period* is applied to *an Insured Person* on *Transfer*, *Benefits* are payable at the level of the *Insured Person's* previous cover, or existing cover, whichever is the lesser.

Any claims made by an *Insured Person* in the current *Calendar Year* (or as otherwise stipulated in these Rules and the *Phoenix Health* Member Guide) will be counted towards their *Benefits* and limits used with *Phoenix Health.*

When an *Insured Person Transfers* from another *Private Health Insurer*, and has a gap in cover for more than thirty (30) days, the person will be treated as a new *Insured Person* for all purposes, and full *Waiting Periods* will be applied.

(3.5b) Transfer Certificates

Where an *Insured Person* is *Transferring* from another Registered *Private Health Insurer*, the *Fund* requires a *Transfer Certificate* to be provided by that *Insurer*, otherwise normal *Waiting Periods* will be applied.

For more details on portability requirements and *Waiting Periods* when joining the *Fund*, please see the *Waiting Periods* Rule 8.3.

(3.5c) Transfers internally between Phoenix Health Memberships

Where an *Insured Person Transfers* internally between *Phoenix Health* memberships, regardless of whether they have removed themselves, or whether they have been removed by someone else who is authorised to do so; where they have a gap in cover of less than thirty (30) days, they will be accepted with rights and *Benefit* entitlement EXCEPT in the following cases, in which *Waiting Periods* would be applied:

- to any *Benefits* that were not covered under their previous *Product*;
- to any increase in *Benefits* or limits on their *Phoenix Health Level of Cover*, compared to their previous *Product*;
- to any portion of *Waiting Periods* that had not been served with their previous *Product*;
- to any unexpired portion of a Benefit Replacement Period or limit governing the supply or replacement of an appliance or *Prosthesis.*

If a *Waiting Period* is applied to an *Insured Person* who has *Transferred* to a new Policy from an existing Policy within *Phoenix Health*, then *Benefits* are payable at the level of the *Insured Person*'s previous cover, or existing cover, whichever is the lesser.

Any claims made by the *Insured Person* in the current *Calendar Year* (or as otherwise stipulated in these *Rules* and the *Phoenix Health* Member Guide) will be counted towards their *Benefits* and limits used with *Phoenix Health* on their new *Product*.

When an *Insured Person Transfers* between memberships internally within *Phoenix Health* and has a gap in cover for more than thirty (30) days, the person will be treated as a new *Insured Person* for all purposes, and full *Waiting Periods* will be applied.

Portability and *Waiting Period* rules do apply and are detailed in Rule 8.3.

The *Fund* may at its discretion reduce or waive any *Waiting Period*. The waiver or reduction of a particular *Waiting Period* has no effect on any other *Waiting Period* or any other *Rule* applicable to the same service.

(4) Membership Rules

(4.1) Cover Changes

A *Policy Holder* may *Transfer* from a table to another table, by applying in the form specified by the *Fund*. The cover change would apply to all *Insured Persons* on that *Policy*.

Where an *Insured Person Transfers* to a different table that is deemed by the *Fund* to be a lower level, any *Benefits* are payable at the level of the new table.

Where an *Insured Person Transfers* to a different table that is deemed by the *Fund* as a higher level, then:

- any higher *Benefits* will be paid at the previous lower *Level of Cover*, until any *Waiting Periods* have been served; and
- any *Benefits* already claimed in the current financial year (or as otherwise stipulated by these *Rules* and the Member Guide), will be counted towards the limits on the new *Level of Cover*;

If the new *Level of Cover* has an *Excess/Co-Payment* that is lesser than that of the previous level, then the *Excess/Co-Payment* applicable to the previous level will be applied until any *Waiting Periods* have been served.

For more details on portability requirements and *Waiting Periods* when *Transferring* between tables within the *Fund*, please see the *Waiting Periods* Rule 8.3.

(4.2) Dependants

(4.2a) Registration of a Dependant

A *Dependant* must be registered on a *Policy* by the *Policy Holder* or a person who has been delegated *Authority* to do so, in the form required by the *Fund*. Registration, is effective from the date the application is received by the *Fund*, or the date written on the application – whichever is the later.

(4.2b) Non-Student Dependants

*Dependant*s aged up to twenty-one (21) (as defined in section AP2.2) can be covered by any of the applicable *Family* and *Single Parent Family* Policies offered by the *Fund*.

(4.2c) Student Dependants

Dependants over the age of twenty-one (21) and under twenty-five (25) can be covered on a *Family* or *Single Parent Policy*, at no extra cost when they are undertaking *Full-time Education*.

The *Dependant* needs to be registered as a *Full-time Student* with the *Fund*, by completion of a form, specified by the *Fund*.

(4.2d) Extended Dependant Cover

Adult Dependants over the age of twenty-one (21) and under twenty-five (25) can remain covered under a *Family* or *Single Parent Policy*, by adding an *Extended Dependant* Cover to the *Policy* for an additional cost.

(4.2e) Removal of Dependant

A *Dependant* may cease to be covered under a *Policy*, by either no longer meeting *Dependant* eligibility requirements, or they may be removed by the *Policy Holder* or a person who has been delegated *Authority*.

A *Dependant* aged over sixteen (16) may elect to remove themselves from the *Family* or *Single Parent Policy* they are covered on.

If a person ceases to be eligible to be covered as a *Dependant* on a *Policy*, they may apply to become a *Policy Holder* of a separate *Phoenix Health Policy* and transfer internally between *Phoenix Health* policies per the transfer rules under Rule (3.5c) *Transfers Internally Between Phoenix Health Memberships*.

(4.3) Temporary Suspension of a Membership

(4.3a) Temporary Suspension of a Membership due to Overseas Travel

A *Policy Holder* may apply for a *Temporary Suspension* of their *Policy* when travelling or residing overseas.

All *Suspensions* must be applied for in the form required by the *Fund*, and must meet the following conditions:

- the *Membership* has been open and financial for at least a period of six (6) months prior to proposed *Suspension* date;
- all *Contributions* are paid up to and including the date of departure;
- the *Membership* must be suspended in full, and all *Insured Persons* covered by the *Policy* must be outside of *Australia* for the entirety of the *Suspension* period;
- *Suspensions* are not available on *Extras Cover* only policies;
- the minimum period of *Suspension* is twenty-one (21) days, and as such the *Insured Person*(s) must be outside of *Australia* for no less than the minimum *Suspension* period;
- the maximum period of *Suspension* is two (2) years, unless extended at the discretion of the *Fund*; and as such the *Insured Person*(s) must be considered outside of *Australia* for this entire period;
- where the reasons for *Suspension* cease to apply, or the maximum period of *Suspension* is reached, the *Policy Holder* must re-activate the *Policy*, in the form required by the *Fund*, within thirty (30) days of their return date. Failure to re-activate within the required period will result in cancellation of the *Policy*, from the *Suspension* date, and all related *Insured Persons* are taken as new for the purposes of these Rules and the relevant Government legislation;
- after re-activation from *Temporary Suspension*, the Membership needs to be active for a further three (3) months before access to an additional *Temporary Suspension* is available;
- *Benefits* are not claimable for the period the *Membership* is suspended;
- any days a *Membership* is suspended, do not count towards the serving of *Waiting Periods*;
- any days the *Membership* is suspended are considered 'not covered' days for taxation purposes, and as such may be subject to the *Medicare Levy Surcharge*. *Policy Holders* should contact the Australian Tax Office (ATO) to see if they will be affected by suspending their *Policy*;

any days the *Membership* is suspended are not considered as 'absent days' for *Lifetime Health Cover* purposes.

(4.3b) Temporary Suspension of a Membership due to Financial Hardship

A *Policy Holder* may apply for a temporary *Suspension* of their *Membership* if they are experiencing financial hardship.

All *Suspensions* must be applied for in the form required by the *Fund*, and will be assessed on a case-by-case basis to meet the following conditions:

- the *Membership* has been open and financial for a period of at least two (2) years prior to proposed *Suspension* date;
- all *Contributions* are paid up to the proposed Suspension date;
- the *Membership* must be suspended in full;
- *Suspension* is not available on *Extras Cover* only policies;
- the maximum period of *Suspension* is twelve (12) months, unless extended at the discretion of the *Fund*;
- where the reasons for *Suspension* cease to apply, or the maximum period of *Suspension* is reached, the *Membership* will be re-instated from the *Suspension* end date, and *Premium* payments recommenced. Failure to recommence *Premium* payments will result in cancellation of the *Policy* from the *Suspension* start date, and all related *Insured Persons* are taken as new for the purposes of these Rules and the applicable Government legislation;
- after re-instatement from *Financial Hardship Suspension*, the *Membership* needs to be active for a further six (6) months before access to apply for additional *Temporary Suspension* is available;
- *Benefits* are not claimable for the period the *Membership* is suspended;
- any days a *Membership* is suspended, do not count towards the serving of *Waiting Periods*;
- any days the *Membership* is suspended are considered 'not covered' days for taxation purposes, and as such may be subject to the *Medicare Levy Surcharge*. *Policy Holders* should contact the Australian Tax Office (ATO) to see if they will be affected by suspending their *Policy*;
- any days the *Membership* is suspended are not considered as 'absent days' for *Lifetime Health Cover* purposes;
- *Temporary Suspension* due to *Financial Hardship* is only available twice in the lifetime of a *Membership* with the *Fund*.
- *Temporary Suspension* due to *Financial Hardship* rules can be amended under special circumstances, at the discretion of the *Fund*.

(4.3c) Temporary Suspension of a Membership by the Fund due to Improper Conduct

Where the *Fund* identifies improper conduct by an *Insured Person*(s), the *Fund* may impose a *Temporary Suspension* of a *Membership*. This is at the sole discretion of the *Fund*, and may include, but is not limited to the following:

- where an *Insured* Person gives false or misleading information for any reason, including, but not limited to; when completing an application, when lodging a claim, or when answering a request for further information from the *Fund*;
- where an *Insured Person* obtains or attempts to obtain any advantage or monetary gain, for themselves or another *Insured Person*, to which they are not entitled;
- where there is a pattern of over-servicing or exploitation to or by an *Insured Person*;
- where there is a pattern of behavior that is deemed by the *Fund* as inappropriate;
- where an *Insured Person* has unreasonably or improperly incurred expenses for Treatment.

Where a *Temporary Suspension* is invoked by the *Fund* due to Improper Conduct, the *Fund*, at its discretion may impose, for a period determined by the *Fund*, the following:

- withhold *Benefits* or refuse *Benefits* to or for the *Insured Person* for the relevant services;
- suspend electronic claiming;

- restitution, on demand, of any monies or property obtained improperly; and
- payment of interest of any amounts obtained improperly, for the period between when paid out of the *Fund*, and when repaid to the *Fund* in full.

(4.4) Dispute Resolution

(4.4a) Member Complaints

In the case of a dispute, an *Insured Person* may contact the *Fund*, at any time.

The *Fund* will investigate and respond to the dispute raised pursuant to this *Rule*, as quickly and efficiently as reasonably possible, in accordance with the *Phoenix Health Dispute Resolution Policy,* which outlines the provisions for the escalation of disputes raised.

The *Dispute Resolution Policy* is publicly available on the *Fund's Website*, or at request.

(4.4b) Commonwealth Ombudsman for PHI

In the case where a dispute is not resolved in accordance with Phoenix Health's *Dispute Resolution Policy*, the dispute may be escalated to the Commonwealth Ombudsman for Private Health Insurance for further review. The *Fund* will liaise with the Ombudsman as is requested to ensure the dispute is resolved.

(4.5) Correspondence

Any correspondence or notice under these *Rules* must be in writing. In most cases, the *Fund* will deliver the correspondence by the *Insured Person's* preferred contact method, however to ensure the correspondence is received, the *Fund* may also send the correspondence by postal letter, email or by hand delivery, where necessary.

(4.5a) Private Health Information Statement (PHIS)

The *Fund* is required by legislation to provide a *Policy Holder* with a *PHIS* when they join the *Fund*, whenever a change to their *Level of Cover* occurs, on request by a member, and once annually.

(4.5b) Lifetime Health Cover Statement

The *Fund* is required by legislation to provide a *Policy Holder* with a *Lifetime Health Cover* Statement once annually, or on request by the *Policy Holder*. This statement must include details of their *Lifetime Health Cover* Loading percentage and how many years they have remaining before their Loading will be removed.

(4.5c) Notice of Detrimental Changes

Where the *Fund* makes a change to these *Rules* and the effect of this change on a *Policy* is or may be detrimental to the interests of an *Insured Person*, *Phoenix Health* will give notice to the *Policy Holder* in writing, detailing the change, a reasonable time prior to the change coming into effect.

(4.6) Contributions

(4.6a) Payment of Contributions

It is the responsibility of the *Policy Holder* to ensure that all *Contributions* are paid in advance (with the exception of *Contributions* paid via payroll, which are paid in arrears), and that payments are up to date at all times.

Contributions must be paid at the rate according to the *Membership* detail, table and *Category*, as agreed upon by the member on joining the *Fund*.

No *Policy* can be paid more than twelve (12) months in advance of the payment date. If a *Contribution* payment made results in a *Membership* being paid further than twelve (12) months in advance, a refund may be issued.

Contributions may be paid to the *Fund* by direct debit, Bpay, cheque or credit card.

Contributions are applied to a *Policy* on a cash basis, meaning any *Government Rebates* or initiatives are applied as at the date of payment.

(4.6b) Changes to Contribution Rates

The *Fund* may at any time, change the *Premium* for any or all Policies in accordance with the requirements set out in the *PHI Act*, and subject to these *Rules*.

(4.6c) Rate Protection

Rate Protection is applied where a yearly *Contribution* is received and processed prior to the rate adjustment date.

In accepting payments in advance, in excess of twelve (12) months, a *Policy Holders* paid to date will not exceed thirty (30) June in any given year. In accordance with Rule 4.6a, where *Contributions* have been accepted in advance, a *Contribution* Rate change made effective during this period will not affect the date to which the *Contributions* have been paid, subject to Rule 4.6d.

(4.6d) When Rate Protection does not apply

Rate Protection does not apply to *Contributions* paid in advance on a *Policy* where any of the following changes are made to a *Policy*:

- a change to a different *Cover Table* or *Policy* Type that would result in a change in *Contributions;*
- a change in the residential Cover *State* of the *Policy* holder that would result in a change in *Contributions*;
- where a *Policy* is re-activated from any form of *Temporary Suspension*.

Where any of these changes to a *Policy* occur, the *Premium* current as at the date of change will apply to the *Policy* from that date.

(4.7) Contribution Discounts

The only discounts provided will be those permitted by section 66-5 of the *PHI* Act.

A total percentage discount may not exceed the percentage specified in the *Private Health Insurance (Complying Product) Rules 2015* as the maximum percentage discount allowed.

(4.8) Arrears in Contributions

A *Policy* is in arrears whenever the date to which *Contributions* have been paid is earlier than the current date, with the exception of *Contributions* paid via payroll payment, or *Policies* that are under *Temporary Suspension*.

Benefits will not be paid whilst a *Policy* is in arrears.

A *Policy Holder* who is in arrears for a period of up to ninety (90) days and pays all such arrears before the end of that period is entitled to retain all *Benefits* of the *Policy* and *Insured Persons may* submit claims for *Benefits* for services rendered during that period.

(4.8a) Termination of Membership due to arrears

If *Contributions* are more than ninety (90) days in arrears, the *Policy* is thereupon terminated from the last date to which the *Contributions* were paid, as stated in Rule 6.2b, without prior written notice to the *Policy Holder*.

Where a *Policy* has been terminated, the *Fund* has the discretion to reinstate the *Policy* at the request of the *Policy Holder* with continuity of entitlements, subject to the payment of all *Contributions* as required by the *Fund Rules*.

(5) Government Initiatives

(5.1) Australian Government Rebate

The Australian Government Rebate on Private Health Insurance is an amount the Government will contribute towards a *Policy Holder's* health insurance *Premiums*, dependent on age and income, in accordance with the *PHI Act*.

If a *Policy Holder* elects to receive the Rebate, they will receive their nominated Rebate Tier percentage as a reduction in their *Premiums*.

(5.2) Lifetime Health Cover

The *Premiums* payable by a *Policy Holder* will be increased by a nominated percentage where required under the *Lifetime Health Cover* provisions in the *PHI Act*.

Any *Lifetime Health Cover* loading applied to a *Policy* will be removed after ten (10) continuous years of holding *Hospital Cover*, in accordance with the provisions in the *PHI Act*.

(5.2a) Norfolk Island Residents

Effective 1 July 2016, Norfolk Island residents who are aged over thirty-one (31) will have a twelve (12) month grace period to purchase health insurance without incurring a *Lifetime Health Cover* loading. If they purchase from or after 1 July 2017, a loading will apply.

For other residents, all other *Lifetime Health Cover* provisions under the *PHI Act* will apply.

(5.3) Youth Discounts

The *Premiums* payable by a *Policy Holder* will be reduced by a nominated percentage in accordance with the Private Health Insurance (Reforms) Amendment Rules 2018 (paragraphs 11B to 11D).

Aged Based Discounts are applied when a *Policy Holder* and/or a *Policy Holders Partner* commence *Hospital Cover* for the first time between eighteen (18) and twenty-nine (29) years of age and nominate a *Level of Cover* that attracts an Age Based Discount.

The percentage discount is applied in accordance with the Amendment Rules, will be applied whilst the *Insured Person*(s) remain on the eligible level of *Hospital Cover*, and will begin to decrease at 2% following the age of forty (40) and will continue to decrease at 2% per year until it is entirely removed.

Application of Youth Discount on a particular *Level of Cover* is completely at the *Fund's* discretion and is not a requirement under the *PHI Act.*

(6) Cessation of Membership

(6.1) Cancellation by Member

Unless otherwise permitted by the *Fund* any cancellation:

- must be requested in writing, or in the form specified by the *Fund*;
- may not have retrospective effect;
- must be in accordance with these *Fund Rules*; and
- must be in accordance with any other arrangements specified by the *Fund*.

A *Policy Holder* may cancel a *Policy* in its entirety.

A *Policy Holder*, or another *Insured Person* covered by the same *Policy,* who has been granted *Authority*, may request to remove any *Insured Person* from their *Policy*, however *Phoenix Health* must give written notice to any Person over the age of sixteen (16) years who has been removed, advising that *Benefits* entitlements under the *Policy* have ended from that date, and that if they do not commence a new *Policy* within thirty (30) days of their removal date, their entitlements to *Benefits* and *Waiting Periods* served will cease, and they will be considered as a new *Insured Person* for all purposes, and they may be impacted by *Lifetime Health Cover and Medicare Levy Surcharges*.

An *Insured Person who is a Dependant* over the age of sixteen (16) years may request to remove themselves from the *Policy* they are listed on.

Unless otherwise permitted by the *Fund*, a *Dependant* under sixteen (16) years of age, may only remove themselves from the *Policy* they are listed on, with the written approval from the *Policy Holder* or an *Insured Person, on the same Policy,* who has been delegated *Authority*.

Where a third-party has been granted and holds Power of Attorney of the *Policy Holder*, they may request to remove any *Insured Person* from the *Policy*, or cancel the *Policy* on behalf of the *Policy Holder*.

Where it is found that a claim has been made with a date of service after the date of cancellation requested, the *Policy* will be cancelled the day after the date of service of the claim made; or the *Fund* will request a refund of the *Benefit* paid on the claim, the claim will be reversed from the system, and the *Policy* cancelled from the requested date.

If a *Policy* is cancelled, *Phoenix Health* at its discretion can re-instate the *Policy* at the request of the *Policy Holder*. Continuity of entitlements is subject to payment of all outstanding *Contributions*, as detailed in Rule 4.8.

Where the Fund is notified of a *Policy Holder's* death, their *Policy* will be cancelled from the day following their date of

death, as detailed in their Death Certificate. Any refund of *Contributions* will be paid to the Deceased Estate by cheque, to the *Policy Holder's* address recorded on their *Policy*, unless otherwise advised by a third-party who holds Power of Attorney and provides a copy of these Power of Attorney Documents to the *Fund*.

(6.1a) Refunds of Premiums

Subject to these *Fund Rules*, and the *PHI Act, Phoenix Health* may, at its discretion refund some, or all *Contributions* paid in advance of the cancellation date, when a *Policy* ceases. Such a refund will be calculated from the day following the date (receipt by *Phoenix Health*) of the request for cancellation.

As detailed in Rule 6.1, if a claim has been made, with a date of service after the requested cancellation date, the *Policy* will be cancelled from the day after the date of service of the claim, and any refund will be calculated from the date of cancellation; or the *Fund* will request a refund of the *Benefit* paid on the claim, the claim will be reversed from the system, and the *Policy* cancelled from the requested date, and the refund calculated from the cancellation date.

The *Fund* must refund all *Contributions* if an *Insured Person* has not claimed under a *Membership* and the *Policy Holder* has cancelled the *Membership* by giving notice to *Phoenix Health* within thirty (30) days from its commencement date.

Phoenix Health may also deduct an administrative charge from a refund, at its discretion.

All refunds for *Premiums* will be processed to the credit card or bank account used for payment of those *Premiums.*

(6.2) Termination of Membership by the Fund

If the *Fund* terminates a *Policy* due to any of the reasons in this Rule, or for any other reason, it shall:

- provide the *Policy Holder* with written notification, including a reason for the termination, and
- at its discretion, refund any *Contributions* paid in advance, as at the date of termination.

(6.2a) Termination due to Improper Conduct

Where the *Fund* identifies improper conduct by an *Insured Person*, they may Terminate a *Membership*. This is at the sole discretion of the *Fund*, and may include, but is not limited to the following:

- where an *Insured Person* gives false or misleading information for any reason, including, but not limited to; when completing an application, when lodging a claim, or when answering a request for further information from the Fund;
- where an *Insured Person* obtains or attempts to obtain any advantage or monetary gain, for themselves or another *Insured Person*, to which they are not entitled;
- where there is a pattern of over-servicing or exploitation to or by an *Insured Person*;
- where there is a pattern of behavior that is deemed by the *Fund* as inappropriate;
- any *Insured Person* included on the *Membership* has, in the opinion of the *Fund*, behaved inappropriately towards *Fund* staff, providers or other members;
- where an *Insured Person* has unreasonably or improperly incurred expenses for *Treatment*.

Phoenix Health reserves its rights to take other action to protect the *Fund* or preserve its position, in addition to, or instead of termination of the *Policy*. Action that may be taken includes, but is not limited to:

- suspend electronic claiming;
- restitution, on demand, of any monies or property obtained improperly; and
- payment of interest of any amounts obtained improperly, for the period between when paid out of the *Fund*, and when repaid to the *Fund* in full;
- instituting civil proceedings to restrain conduct from continuing or to recover damages suffered and legal costs incurred.

The *Fund* reserves the right to notify the relevant authorities.

(6.2b) Termination due to arrears

The *Fund* may terminate a *Policy* where the payment of *Contributions* is in arrears of more than ninety (90) days. More information about Termination due to arrears can be found in Rule 4.8.

(7) General Conditions for Claiming of Benefits

(7.1) General Conditions

(7.1a) Benefit Reductions

Where a *Benefit* is payable, the *Fund* may reduce the *Benefit* in the following circumstances:

- where the amount paid for a service is lower than the *Benefit* that would otherwise have been payable, the *Fund* shall reduce the *Benefit* to that amount paid;
- where the *Treatment* was provided free of charge to the *Insured Person*;
- where the *Insured Person* has *Transferred* to the *Fund* and previously claimed for the *Treatment*;
- where moneys are payable from more than one source for the same service, the *Fund* may reduce its *Benefit* such that the total amount payable from all sources does not exceed the amount charged;
- in determining entitlements to *Extras Cover Benefits* in respect of a period, the *Fund* will have regard to the amount of *Benefits* for that kind of *Treatment* already claimed by the *Insured Person* in respect to that period;
- where, in the opinion of the *Fund*, the charge is higher than the Provider's usual charge for the service, the *Fund* may, at its discretion, open an investigation into the Claim;
- where the Provider's account has been incompletely, incorrectly, or inappropriately itemised;
- where the service is subject to *Waiting Periods* or other limitation which has not been served in full.

(7.1b) Benefits Rendered Outside of Australia

Phoenix Health will not pay any *Benefit* for services received or supplied outside of *Australia*.

(7.1c) Telephone and Internet Consultations

Except where permitted by these *Rules*, *Benefits* are only payable for services performed in person.

(7.1d) Multiple Services

Where multiple services are rendered by the same provider, on the same day for the same *Condition, Benefits* will only be payable for the first service. In some instances, the *Fund* will pay multiple services for *Chronic Conditions* where the service is provided both am/pm. This is at the discretion of the *Fund*, and further information may be requested.

(7.1e) Benefit Liability where Incorrect Information Provided

Benefits are not payable if an application or claim contains false or misleading information.

(7.2) General Conditions for Provider Recognition

(7.2a) Treatment to be Provided by Recognised Providers

Benefits are payable only where *Treatment* is provided by a *Recognised Provider* at the time of *Treatment*.

(7.2b) No Benefit Payable where Provider does not meet Accreditation Requirements

The *Fund* will not pay any *Benefit* for *Treatment* or services provided by a person who does not meet the standards required from time to time by any *Private Health Insurance (Accreditation) Rules 2011* or the *Fund Rules*.

(7.2c) Recognised Providers Who Cease to Meet Recognition Requirements

If the *Fund* finds or believes a *Recognised Provider* ceases to meet *Recognition Criteria*, or in the opinion of the *Fund*, has committed or participated in any fraudulent activity in relation to the provision of *Treatment*, it may:

- refuse to pay *Benefits* in respect of any claim; and
- suspend or cancel the provider's recognition for the purpose of paying *Benefits*

(7.2d) Aberrant or Inappropriate Services and/or Billing Practices

If in the opinion of the *Fund*, a *Recognised Provider* has committed or participated in any inappropriate billing, aberrant or fraudulent activity in relation to provision of a service, the *Fund* may refuse to pay a *Benefit* or may suspend or cancel the provider's recognition with the *Fund*.

(7.2e) Providers Treating Family Members, Business Partners or Family of Business Partners

Benefits will not be payable by the *Fund* for *Treatment* rendered by a provider to:

- the Provider's Partner, *Dependant* or immediate family member
- the Provider's business partner, or an immediate family member of the business partner.

The *Fund* at its discretion may pay *Benefits* in the following cases:

- where it is satisfied that the charge is raised as a legally enforceable debt, or
- in respect of the invoiced cost of materials required in connection with any *Treatment.*

(7.2f) Phoenix Health Fund General Treatment Billing Standards (Standards)

General Treatment Providers must comply with the *Phoenix Health Billing Standards* available at phoenixhealthfund.com.au/pdf/general-treatment-billing-standards.pdf

(7.3) Hospital Treatment Conditions

Persons covered under a *Policy*, eligible for *Benefits*, shall be entitled to the applicable *Benefit* Arrangements provided by the *Hospital Purchaser Provider Agreement (HPPA*).

Subject to these *Rules*, *Benefits* payable are those specified in the relevant *Schedules* when an *Insured Person* is charged for *Treatment* provided in a *Contracted Hospital* or when a *Treatment* is provided through an *Access Gap* Cover Scheme. For *Treatment* provided at a Hospital that is not a *Contracted Hospital*, *Phoenix Health* will pay *Benefits* that are at least the equivalent to the *Default Benefit*.

Hospital and medical *Benefits* will also only be payable for procedures listed in the *Medicare Benefits Schedule (MBS).*

Hospital Treatment Benefits will not be paid where:

- a *Treatment* does not normally require *Hospital Treatment* and no certificate has been given by a Medical Practitioner stating that the Patient required *Hospital Treatment*;
- *Treatment* has been provided to a person at an emergency department of a *Hospital*;
- the *Treatment* has been provided to a newly-born child whose mother also occupies a bed in the *Hospital*;
- a Treatment does not have a recognised Medicare Benefit Schedule number;
- *a Treatment* has a General Treatment item number.

(7.3a) Medical Benefits

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

- are rendered to a person covered while *Hospital Treatment* is provided to them in a *Hospital* facility; and
- are a professional service in respect of which a *Medicare Benefit* is payable;

Will be at least equal to:

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

The amount of *Benefit* payable will not exceed the amount referred to above, unless:

- the service is rendered by or on behalf of a Medical Practitioner with whom the *Fund* has an *Agreement* that applies to that service; or

- the service is rendered in a *Contracted Hospital*; or the service is rendered under the *Access Gap* Cover scheme.

(7.3b) Hospital Benefits Payable

Hospital Benefits payable will include:

- *Hospital Treatment* covered under the *Policy* for which a *Medicare Benefit* is payable.
- Any part of *Hospital Treatment* that is one or more of the following:
  - *Psychiatric care*
  - *Rehabilitation*
  - *Palliative Care*
- if the *Treatment* is provided in a *Hospital* and no *Medicare Benefit* is payable for that part of the *Treatment*;
- *Hospital Substitute Treatment*, where covered under the *Policy*, for which a *Medicare Benefit* is payable;
- any Treatment for which the *Private Health Insurance (Benefit Requirements) Rules 2011* specify there must be a Benefit.

No *Benefit* is payable for Pharmaceuticals (whether or not PBS Medication) provided as part of discharge from a *Hospital Treatment* unless specified in the relevant *Schedule.*

(7.3c) Same-Day Patients

Benefits for *Day Treatment* (or *Day Procedure*) *Hospital* accommodation are payable only where the *Insured Person* is an *Admitted Patient*.

(7.3d) Nursing Home Type Patients

Benefits for *Nursing Home Type Patients* will be paid in accordance with Schedule 4 of the *Private Health Insurance (Benefit Requirements) Rules 2011* for the duration of the classification as a *Nursing Home Type Patient*. A *Nursing Home Type Patient* must make a contribution to their care as declared by the *Minister*. The *Fund* may request an *Acute Care* Certificate and any additional supporting information from the medical record before *Benefits* are payable.

(7.3e) Continuous Hospitalisation

Where an *Admitted Patient* is discharged, and within seven (7) days is admitted to a different *Hospital* for the same or a related *Condition*, the two (2) admissions are regarded as forming one (1) period of Continuous Hospitalisation, and *Benefits* at the advanced surgical, surgical or obstetric levels are payable in respect of the later admission only if an appropriate procedure is rendered following that admission.

(7.3f) Counting of Admitted Days

The day on which an *Insured Person* became an *Admitted Patient* and the day of discharge are counted as one day for the purpose of assessing *Benefits* payable.

Days spent in a special unit (such as an intensive care, critical care, coronary care, or high dependency nursing care unit) do not interrupt the counting of days in relation to the patient classification on entering the unit. To avoid doubt, *Benefits* payable upon discharge from the special unit will be paid at the classification applicable upon entering the unit, after taking into account any days spent in the unit.

(7.3g) Patient Classification Principles

Benefits for accommodation in a *Private Hospital* are payable according to the classification of the *Admitted Patient*.

Patients are classified in accordance with the guidelines issued by the Department of Health. The classifications are:

- Surgical
- Advanced Surgical
- Obstetric
- Other (Medical)
- Psychiatric Care, and
- Rehabilitation.

The *Fund* may permit further sub-classifications of *Admitted Patients* where not inconsistent with these guidelines.

(7.3h) Patient Classification: Surgical and Advanced Surgical Patients

Subject to Rule 7.3b, the Benefit payable under the surgical and advanced surgical classifications applies:

- from the date of admission, where the operative procedure is performed on the first or second day of admission; or
- from the date of the procedure, where the operative procedure is performed on the third day of admission or later.

(7.3i) Patient Classification: Obstetric Patients

The obstetric classification applies only where childbirth occurs following the mother's admission to a *Hospital*. Where labour resulting in childbirth commenced before admission, the obstetric classification applies from the date of admission.

Where labour commenced after admission, the obstetric classification applies from the earliest of:

- the date on which labour commenced; or
- the date on which an obstetric procedure took place, or
- any other date that the Fund may at its absolute discretion specify.

(7.3j) Patient Classification: Psychiatric Care Patients

Psychiatric Care Patient means a patient who is admitted, or an outpatient receiving *Treatment* for a *Psychiatric Condition* as defined in the Australian Refined Diagnosis Related Groups Definitions Manual.

Benefits for *Psychiatric Care Patients* are payable subject to the following *Conditions*:

- *Psychiatric Treatment* in a *Private Hospital* must be provided as part of an approved Psychiatric Program;
- *Treatment* must be supported by an *Acute Care* Certificate in the form approved by the *Fund*, for the period specified up to a maximum of thirty-five (35) days; and
- A separate *Acute Care* Certificate is required for any subsequent readmission as a *Psychiatric Care Patient* that does not constitute *Continuous Hospitalisation*;

Psychiatric Care Benefits are not payable for any patient under the custodial care of a *State or Territory*.

(7.3k) Patient Classification: Rehabilitation Patients

Rehabilitation Patient means a patient who is admitted, or an outpatient receiving *Treatment* for a *Rehabilitation Condition* as defined in the Australian Refined Diagnosis Related Groups Definitions Manual.

Benefits for *Rehabilitation Patients* are payable subject to the following *Conditions*:

- Rehabilitation Treatment in a Private Hospital must be provided as part of an approved Rehabilitation Program;
- Treatment must be supported by an Acute Care Certificate in the form approved by the Fund, for the period specified up to a maximum of thirty-five (35) days; and
- a separate Acute Care Certificate is required for any subsequent readmission as a Rehabilitation Patient that does not constitute Continuous Hospitalisation.

(7.3l) Patient Classification: Multiple Procedures

- Subject to these *Rules*, where a Patient undergoes more than one operative procedure during the one theatre admission, the procedure with the highest fee in the *Medicare Benefits Schedule* determines the Patient's classification.

(7.3m) Patient Classification: Subsequent Procedures

Where a Patient undergoes a subsequent operative procedure during the same period of Hospitalisation:

- where the procedure results in the Patient having a higher classification, the Patient's classification increases from the date of the procedure; and
- where the procedure would otherwise have resulted in the Patient moving to a lower classification, the Patient's classification is unchanged.

(7.3n) Hospital Pharmaceuticals

Pharmaceutical Benefits Scheme (PBS) Pharmaceuticals

- Where an Insured Person is admitted for Hospital Treatment,
  a Benefit will be available on any PBS Pharmaceuticals and pharmaceutical supplies, directly relating to the Treatment for the Condition in which they have been admitted to Hospital for.

Non-PBS Pharmaceuticals

Where an *Insured Person* is admitted for *Hospital Treatment*, a *Benefit* will be available on any Non-*PBS* Pharmaceuticals supplied to them, directly relating to the *Treatment* for the *Condition* in which they have been admitted to Hospital for.

Where a Non-PBS Pharmaceutical exceeds $1000 per dose, the Hospital may contact the *Fund* to seek authorisation.

Discharge Pharmaceuticals

No *Benefit* is available towards the cost of any Pharmaceuticals or Medications supplied on discharge from a *Hospital Treatment*.

(7.4) Extras Cover Conditions

Benefits for *Extras Cover* (or *General Treatment*) services will be paid up to any limit per period that applies to the specific cover an *Insured Person* holds.

Extras Cover Benefits can include the provision of goods and services that are intended to manage or prevent a *Condition* that is not *Hospital Treatment*.

Benefits for *Extras Cover* services will only be paid where they are provided by a *Provider Recognised* by and registered with the *Fund*.

Benefits will not be paid on services rendered by a Provider not recognised by the *Fund* at the time of service.

It is at the sole discretion of the *Fund* to determine if someone becomes, or remains a *Recognised Provider*, and for which *Treatments Benefits* are payable for.

(7.4a) Arrangements with General Treatment Providers

The *Fund* may enter into special arrangements with *General Treatment* providers or groups of providers from time to time to provide *Benefits* for particular *Extras Cover* services. Where these arrangements exist, details will be made available to *Policy Holders*.

(7.4b) Items not considered General Treatment

General Treatment (or *Extras Cover*) does not include *Benefits* for:

- services for which a *Medicare Benefit* is payable, except as allowable as *Hospital Substitute Treatment*;
- *Benefits* considered to be in relation to sport, recreation or entertainment unless they are part of a *Chronic Disease* management program or a Health Management Program, as confirmed by a Medical Practitioner and approved by the *Fund*.

(7.4c) General Treatment Benefits Not Payable

General Treatment (or Extras Cover) Benefits are not payable:

- where the service is for a *Hospital Treatment*;
- where the services are provided by registered general practitioners and any other services covered by *Medicare*;
- where the services are in connection with the birth of a baby;
- for Funeral *Benefits* (except in relation to Rules 7.4d and 13.2s);
- for Disability *Benefits*;
- the goods or services 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;
- for goods or services rendered outside of Australia;
- where Treatments are experimental;
- where *Treatments* involve a pharmaceutical clinical trial.

(7.4d) Funeral Benefit Coverage

The *Fund* has previously offered funeral Benefits as part of a health insurance *Policy*.

This *Benefit* was removed, effective 30 Nov 2007.

Nothing in this *Rule* affects the rights of any person to a *Funeral Benefit*, where that entitlement arose prior to 30 November 2007.

Any entitlement that is preserved under this rule cannot be altered, redeemed or exchanged for other *Benefits* or any other entitlement.

(8) Limitation of Benefits

(8.1) Excess

An *Excess* is an amount on a *Hospital Cover* that is to be paid on admission to *Hospital* by the *Insured Person*.

Excesses are payable once per *Insured Person* per *Calendar Year*, however does not apply to *Dependants* listed on the *Membership*.

Any *Hospital Benefit* payments are made after the Excess has been applied to the admission.

For individual cover details, including *Excess* levels, refer to *Product Information Sheet* for the applicable cover, the *Member Guide* or the *Phoenix Health Fund Website*.

(8.2) Co-Payment

A *Co-Payment* is an amount on a *Hospital Cover* that is paid in addition to the *Excess*.

Co-Payments are payable once per admission (unless otherwise stipulated in the *Product Information Sheet*) to *Hospital* and do not apply to day surgery admissions or *Dependants* listed on the *Membership*.

Any *Hospital Benefit* payments are made after the *Excess* and *Co-Payment* has been applied to the admission.

For individual cover details, including *Excess* and *Co-Payment* levels, refer to *Product Information Sheet* for the applicable cover, the *Member Guide* or the *Phoenix Health Fund Website.*

(8.3) Waiting Periods

Benefits are not payable during a *Waiting Period*.

An *Insured Person* must hold *Membership* continuously for the *Waiting Period* at the level of cover before the *Insured Person* can receive the *Benefits* at that level of cover.

Where more than one *Waiting Period* applies to a *Benefit*, each *Waiting Period* is served independently of and concurrently with any other.

The *Fund* may at its discretion reduce or waive any *Waiting Period*. The waiver or reduction of a particular *Waiting Period* has no effect on any other *Waiting Period* or any other Rule applicable to the same service.

(8.3a) Waiting Periods for Hospital Treatment

A two (2) month *Waiting Period* applies to all services in these Rules, considered to be *Hospital Treatment*, except for the following services:

Pregnancy and Birth	**12 months**
Pre-Existing Conditions *Excluding Hospital Psychiatric services, Rehabilitation and Palliative Care*	**12 months**
Hospital Psychiatric services, Rehabilitation and Palliative Care *Regardless of whether they are pre-existing or not*	**2 months**
Hospital Care programs	**2 months**

In respect of the *Clinical Category* Pregnancy and Birth, *Benefits* are not payable for any *Treatment* during the twelve (12) month *Waiting Period*, with the exception of the delivery of the child where the estimated date of delivery falls outside of the twelve (12) month *Waiting Period*.

The *Fund* requires confirmation of the expected delivery date in writing by the treating Obstetrician.

(8.3b) Psychiatric Upgrade Waiver

Effective 1 April 2018, the Government introduced mandatory *Psychiatric Upgrade Waiver* rules.

Where an *Insured Person* has completed serving the general two (2) month *Waiting Period* for *Psychiatric Treatment* on a *Policy* that provides *Restricted Cover*, an *Insured Person* may upgrade to a cover that provides full cover, where available, without having to serve any additional *Waiting Periods* on the upgrade for that *Treatment*.

The *Psychiatric Upgrade Waiver* is available once per person for the insured lifetime. The waiver does not apply to any *Excess* or *Co-Payment* changes that may apply on upgrading cover. All other *Waiting Periods* still apply.

A *Psychiatric Upgrade Waiver* is transferrable between funds and will be recognised on a *Transfer Certificate*.

Phoenix Health don't currently offer an open level of *Cover* that provides un-restricted *Benefits* for Hospital Psychiatric Services for this waiver to be used.

(8.3c) Waiting Periods for Extras Cover

A two (2) month *Waiting Period* applies to all services in these Rules, considered to be *General Treatment* or *Extras Cover*, except for the following services:

Optical	**6 months**
Major Dental and Endodontics **Orthodontics**	**12 months**
Hearing Aids	**12 months**
Non-surgically implanted Prosthesis or Devices & Aids to Recovery	**12 months**

(8.3d) Other Waiting Periods

Accidents	**No waiting period**
Ambulance services	**1 day**

(8.3e) Waiting Periods for Newborns and Adopted and Foster children

A *Waiting Period* will not apply to a newborn child of an *Insured Person* under a *Family Policy* or a *Single Parent Policy* if the newborn is added to the *Policy* within sixty (60) days of the date of birth.

Adopted or foster children can be added to a *Family Policy* or a *Single Parent Policy* by supplying the *Fund* supporting documentation in the form required by the *Fund*. When the child is added to a *Family Policy* or a *Single Parent Policy* within sixty (60) days of legal guardianship date, the *Fund* may waive the child's *Waiting Periods* dependant on the Policy in which the child is being added.

For *Hospital* only *Policies* the standard two (2) month *Hospital Waiting Period* will be waived. *Pre-Existing Conditions* will still be subject to the standard twelve (12) month *Waiting Period*.

For combined *Hospital* and *Extras Policies* the standard two (2) month *Hospital* and *Extras Waiting Period* will be waived. Six (6) and twelve (12) month *Extras Treatment Waiting Periods* will still be applied on *Pre-Existing Conditions* will still be subject to the standard twelve (12) month *Waiting Period*.

For *Extras* only *Policies* no *Waiting Periods* will be waived, and standard new *Member Waiting Periods* will apply.

Supporting documentation must show the *Policy Holder's* parental responsibility for the child and the date this order came into effect, and can include a letter from the Department of Family and Community Services, Court Order from Children's or Family Court, Centrelink communication confirming that support payments are received by the member.

The *Fund* may at its discretion reduce or waive any *Waiting Period*. The waiver or reduction of a particular *Waiting Period* has no effect on any other *Waiting Period* or any other Rule applicable to the same service.

(8.3f) Gold Card Holders

Where an *Insured Person* has held or was entitled to *Treatment* under a Gold Card before applying for the Insurance *Policy/ Cover* and has not been without the Gold Card entitlements for more than sixty (60) days, then a *Waiting Period* will not be applied on joining. Proof of the Gold Card entitlements may be requested by the *Fund*.

(8.3g) Other Waiting Period Information

For New Members to the *Fund*, current *Insured Persons* changing their level of cover or *Members Transferring* between policies, refer Rule 3.5 and 4.2e.

(8.4) Exclusions

Benefits stated as excluded within each Policy.

The *Fund* may exclude *Benefits* as detailed in the associated cover's *Product Information Sheet*, Private Health Information Statements and the *Member Guide*.

(8.5) Restrictions

Benefits stated as restrictions within each Policy.

The *Fund* may restrict *Benefits* as detailed in the associated cover's *Product Information Sheet*, Private Health Information Statements and *Member Guide*.

A *Benefit* equivalent to minimum *Default Benefit* determined by the Government Rules may be applicable.

(8.6) Benefit Limitation Periods

The *Fund* does not have any Benefit Limitation Periods on any of its Policies.

(8.7) Pre-Existing Condition Assessment by Medical Practitioner

If an *Insured Person* applies to the *Fund* for cover for a *Condition* they do not consider to be *Pre-Existing (excluding Psychiatric, Rehabilitation and Palliative Care Treatments* as explained in Rule 8.3b), as is defined in section (AP2.2) of these *Rules*, within their applicable *Waiting Periods*, the *Fund* will:

- require the *Insured Person* to supply the *Fund* with completed documentation, in the form required by the *Fund*, from their treating General Practitioner and Treating Specialist;
- appoint an independent Medical or other Practitioner to determine whether or not the *Condition* is considered *Pre-Existing*.

They shall take into account:

- information provided by the practitioners who treated the *Insured Person* in the six (6) months prior to them taking out the cover; and
- any other material the *Fund* deem relevant to the claim.

The *Fund* will assume that a *Condition* is a *Pre-Existing Condition* until the *Insured Person* authorises the release of information referred to in these *Rules* and provides it to the *Fund*.

(8.8) Compensation Damages and Provisional Payment of Claims

Benefits are not payable where an *Insured Person* has received or established a right to receive *Compensation* which, in the opinion of the *Fund*, includes an amount for expenses equivalent to the *Benefit* that would otherwise be payable. This includes expenses incurred after the *Insured Person* has received any *Compensation*.

Where the amount of *Compensation* is, in the opinion of the *Fund*, less than the *Benefit* that would otherwise be payable but for the preceding Rule in respect of the expenses incurred for that *Treatment*, a *Benefit* is payable. The amount of the *Benefit* payable shall not exceed the difference between the amount of the *Benefit* that would otherwise have been payable and the amount of entitlement for *Compensation*.

(8.8a) Obligations of an Insured Person

An *Insured Person* who has a right, or may have a right to receive *Compensation* for, or in relation to an injury must:

- inform the *Fund* as soon as the *Policy Holder* knows or suspects that this right exists;
- inform the *Fund* of any decision to claim *Compensation*;
- include in any *Health Benefits Claim* the full amount of all expenses;
- take all reasonable steps to pursue the *Compensation Claim*;
- keep the *Fund* informed of the progress of the *Compensation Claim*; and
- inform the *Fund* immediately upon the determination or settlement of a *Compensation Claim*.

(8.8b) Withholding of Payment by the Fund

The *Fund* may withhold payment of *Benefits* if it appears that an *Insured Person* may have a right to receive *Compensation* until such time as it is determined, to the satisfaction of the *Fund*, whether that right exists.

(8.8c) Provisional Payments

The *Fund* may make a provisional payment of *Benefits* whilst a *Compensation Claim* is in progress. In this case the *Fund* will consider relevant factors including unemployment or financial hardship. A provisional benefits payment is conditional upon the *Policy Holder* signing a legally binding document supplied by the *Fund* that contains an *Agreement* by the *Insured Person* (and where relevant, the *Policy Holder*) to:

- comply with and be bound by these Rules;
- disclose to the *Fund*, on request, all matters relating to the progress of the *Compensation Claim* and details of any determination made or any settlement reached in respect of the *Compensation Claim*;
- repay to the *Fund* the full amount of the provisional payment immediately upon settlement of the *Compensation Claim*, regardless of whether the terms of the settlement specify that *Compensation* relates to expenses past or future for which *Benefits* are otherwise payable, and
- acknowledge that the *Fund* has specified rights of subrogation whereby the *Fund* acquires all rights and remedies of the *Insured Person* in relation to the *Compensation Claim*.

An *Insured Person* must repay any provisional payments upon settlement of a *Compensation Claim*. This *Rule* applies regardless of whether the settlement includes the full amount of the provisional payment or whether the terms of the settlement specifies that *Compensation* relates to expenses which *Benefits* are otherwise payable, or whether the *Insured Person* or the *Policy Holder* has complied with their obligations under these *Rules*.

(8.8d) Rights of the Fund

If an *Insured Person* makes a *Health Benefits Claim* and fails to comply with any obligation in this Rule, or include in their *Health Benefits Claim* any payments of *Benefits*, the *Fund* may, without prejudice to any of its rights, take any legal action to:

- ensure that all *Benefit* payments are repaid from any *Compensation*;
- pursue the *Insured Person* for repayment of all *Benefits*; or
- assume the legal rights of the *Insured Person* or the *Policy Holder* in respect of all or any parts of the Claim.

(8.8e) Claim Abandoned

When an *Insured Person* is, or may be, eligible for a *Compensation Claim* but has abandoned or chosen not to pursue it, *Benefits* are payable only when the *Insured Person* has signed a legally binding document agreeing not to pursue the *Compensation Claim* in relation to the *Benefit* payments.

(8.8f) Right to Waive Repayment of Benefits

The *Fund* may waive any *Benefit* repayments. For this consideration to be made the *Insured Person* must have complied with this Rule and the *Fund* must have given its prior written consent if the *Compensation* settlement received is less than the total *Benefits* paid.

(8.8g) Benefits Subsequent to Compensation

The *Fund* may pay *Benefits* if expenses are the result of complications arising from a *Compensation Claim* or for *Treatment* of an injury related to a *Compensation Claim*, only if the *Compensation Claim* had been the subject of a settlement and where medical evidence supports that those expenses could not have been reasonably anticipated at the time of the determination of settlement.

An *Insured Person* is not entitled to *Benefits* for any expenses they are entitled to recover under another *Insurance Policy, such as* workers compensation. The *Insured Person* must first claim any entitlements under that Insurance *Policy*, regardless of whether the other *Insurance Policy* provides full or partial cover.

(8.9) Accident Cover

If an *Insured Person* is hospitalised as a result of an *Accident*, and is within their applicable *Waiting Periods*, or holds a *Level of Hospital Cover* that has exclusions, the *Fund* will waive any mandatory *Waiting Period* for that *Condition* and *Benefits* will be payable for a *Private Hospital Admission*, regardless of whether the service is excluded on the *Insured Person's Level of Cover* or not.

If the *Insured Person's Level of Cover* has an *Excess/Co-Payment*, the *Excess/Co-Payment* will not be waived and will be applied to the *Admission*.

For *Benefits* to be assessed and payable under Accident Cover, the Insured Person must:

- report within 24 hours of the *Accident* or injury to an emergency facility, or where an emergency facility is geographically not available, an authorised medical clinic for assessment by a registered Medical Practitioner;
- submit the report from the emergency facility assessment by the treating Medical Practitioner to the *Fund*;
- provide the *Fund* with any other supporting documentation, as requested.

All *Treatment* relating to the *Accident* or injury must be initiated within thirty (30) days and completed within ninety (90) days of the *Accident* for *Benefits* to be paid under *Accident Cover*. *Waiting Periods* will not be waived, and *Accident Cover Benefits* are not payable:

- where the *Insured Person* is admitted to a *Public Hospital* for *Treatment* as the result of an *Accident*
- where the causing event of the *Accident* or injury occurred outside of Australia
- towards *Conditions* relating to:
  - a Pre-Existing Condition
  - pregnancy
  - drug and alcohol use
  - illegal activities
  - a surgical procedure, or any Condition resulting from a surgical procedure.
- Where *Benefits* are claimable through *Compensation or Damages*, as detailed in section (8.8) of these *Rules*; or through another source or third-party *Insurance Policy*, such as workers compensation.

(9) Claims

(9.1) Requirements for Claims

Claims for *Benefit*s must be made in a manner approved by the *Fund*.

Claims for *Benefits* must be supported by accounts and receipts on the Provider's letterhead or showing the Provider's official stamp, and the following information:

- the invoice number;
- the business name and ABN/ACN
- the Provider's name, provider number and address;
- the Patient's full name and address;
- the date of Treatment;
- the description of the Treatment including item numbers;
- the amount charged; and
- any other information that the Fund may reasonably request.

If a claim is received, and is not accompanied by the above supporting documentation, or the *Insured Person* has not correctly filled in the Claim Form or has not met any of the requirements of these Rules, the *Fund* may withhold or suspend payment of *Benefits.*

Benefits will, by default, be paid to the *Policy Holder*, unless otherwise requested by an *Insured Person* who has the *Authority* to do so.

The *Fund* may request a doctor's certificate from the person or facility providing the services relating to any matter which, in the opinion of the *Fund* requires consideration for the claim. This could include but is not limited to details of a Patients injury or illness, *Treatment* provided, length of *Treatment* or the results of any tests performed.

Any Claim for expenses for *Treatment in Hospital* are required to be accompanied by a certificate of hospitalisation form, approved by the *Fund*.

(9.2) Claims Become Property of the Fund

Unless otherwise agreed by the *Fund*, all documents submitted in connection with a claim become the property of the *Fund.*

(9.3) Claims to be Lodged Within 2 Years

Claims need to be lodged for assessment within two (2) years of the *Treatment* date.

Benefits are not payable where a claim is lodged more than two (2) years after the date of *Treatment*.

(9.4) Manner of Benefit Payment

The *Fund* may pay *Benefits* by electronic funds transfer, cheque or any other method of payment that the Fund determines and advises *Policy Holders.*

(10) Other

(10.1) Overpayments

Overpayments can be made by the *Fund* to a *Policy Holder*, either through an error in completing a claim, or an error in processing a claim.

If an overpayment is made, the *Policy Holder* is liable to repay the amount of the overpayment to the *Fund* on demand. The *Fund* has the right to deduct from any money it owes to a *Policy Holder* any money due to the *Fund* on any account.

(10.2) Audit activities

The *Fund* undertakes audit activities in order to protect *Policy Holders* and *Fund* assets and manage costs. The *Fund* may contact the *Policy Holder* to request information about particular *Treatments,* or request copies of documents or other assistance. A *Policy Holder's* co-operation with these requests is critical to the proper and effective management of the *Fund* and it is a mandatory requirement for a *Policy Holder* to provide all reasonable assistance that may be requested by the *Fund*.

The *Fund* may request information from the Provider in accordance with 3.3c of the *Fund Rules*.

(11) Levels of Cover

- The table to the right outlines the Levels of Cover available and closed for purchase and includes the Cover names (including previous table name), codes, Excess options and type of cover available.
- For individual cover details, including Benefits available and pricing, refer to Product Information Sheets for the applicable cover, the Member Guide or the Phoenix Health Fund Website.

State	Code
NSW	**N**
ACT	**A**
VIC	**V**
QLD	**Q**
SA	**S**
WA	**W**
NT	**D**
TAS	**T**

(11.1) Hospital Covers

Effective 1 April 2019, Government reforms introduced compulsory *Clinical Categories*, which define the classification of Gold, Silver, Bronze and Basic Hospital Covers.

Clinical Categories stipulate Hospital Treatments that must be covered, as a minimum, under an insurer's Hospital Covers, as follows:

Hospital Treatment Product Tiers – Gold, Silver, Bronze and Basic				
Hospital treatments by clinical category	**Basic**	**Bronze**	**Silver**	**Gold**
Rehabilitation	✓R	✓R	✓R	✓
Hospital psychiatric services	✓R	✓R	✓R	✓
Palliative care	✓R	✓R	✓R	✓
Brain and nervous system	RCP	✓	✓	✓
Eye (not cataracts)	RCP	✓	✓	✓
Ear, nose and throat	RCP	✓	✓	✓
Tonsils, adenoids and grommets	RCP	✓	✓	✓
Bone, joint and muscle	RCP	✓	✓	✓
Joint reconstructions	RCP	✓	✓	✓
Kidney and bladder	RCP	✓	✓	✓
Male reproductive system	RCP	✓	✓	✓
Digestive system	RCP	✓	✓	✓
Hernia and appendix	RCP	✓	✓	✓
Gastrointestinal endoscopy	RCP	✓	✓	✓
Gynaecology	RCP	✓	✓	✓
Miscarriage and termination of pregnancy	RCP	✓	✓	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	RCP	✓	✓	✓
Pain management	RCP	✓	✓	✓
Skin	RCP	✓	✓	✓
Breast surgery (medically necessary)	RCP	✓	✓	✓

Diabetes management (excluding insulin pumps)	RCP	✓	✓	✓
Heart and vascular system	RCP		✓	✓
Lung and chest	RCP		✓	✓
Blood	RCP		✓	✓
Back, neck and spine	RCP		✓	✓
Plastic and reconstructive surgery (medically necessary)	RCP		✓	✓
Dental surgery	RCP		✓	✓
Podiatric surgery (provided by a registered podiatric surgeon)	RCP		✓	✓
Implantation of hearing devices	RCP		✓	✓
Cataracts	RCP			✓
Joint replacements	RCP			✓
Dialysis for chronic kidney failure	RCP			✓
Pregnancy and birth	RCP			✓
Assisted reproductive services	RCP			✓
Weight loss surgery	RCP			✓
Insulin pumps	RCP			✓
Pain management with device	RCP			✓
Sleep studies	RCP			✓

LEGEND

✓	Indicates the clinical category is a minimum requirement of the product tier. The clinical category must be covered on an unrestricted basis.
✓R	Indicates the clinical category is a minimum requirement of the product tier. The clinical category may be offered on a restricted cover basis in Basic, Bronze and Silver product tiers only.
RCP	*Restricted cover permitted.* Indicates the clinical category is not a minimum requirement of the product tier. Insurers may choose to offer these as additional clinical categories on a restricted or unrestricted basis.
	A blank cell indicates that the clinical category is not a minimum requirement of the product tier. Insurers may choose to offer these as additional clinical categories, however it must be on an unrestricted basis.

(11.1a) Phoenix Health Hospital Covers available for purchase to new and existing members

	SILVER PLUS CATEGORY						SILVER CATEGORY		
Scale	Silver Plus Advantage Hospital Cover			Silver Plus Content Hospital			Silver Everyday Hospital		
Excess	250	500	750	250	500	750	250	500	750
Single	SSE250	SSE500	SSE750	SSC250	SSC500	SSC750	SEH250	SEH500	SEH750
Family	FSE250	FSE500	FSE750	FSC250	FSC500	FSC750	FEH250	FEH500	FEH750
Couple	CSE250	CSE500	CSE750	CSC250	CSC500	CSC750	CEH250	CEH500	CEH750
Single Parent	PSE250	PSE500	PSE750	PSC250	PSC500	PSC750	PEH250	PEH500	PEH750
Extended Family	XFSE250	XFSE500	XFSE750	XFSC250	XFSC500	XFSC750	XFEH250	XFEH500	XFEH750
Extended Single Parent	XPSE250	XPSE500	XPSE750	XPSC250	XPSC500	XPSC750	XPEH250	XPEH500	XPEH750

Silver Plus Advantage Hospital – change of name from Silver Plus Essentials (2019) and Top Hospital Essentials (pre 2018).

Silver Plus Content Hospital – new to market from 1 October 2020.

	BRONZE PLUS CATEGORY						BRONZE CATEGORY		
Scale	Bronze Plus Care Hospital (previously Bronze Plus Hospital with Heart)			Bronze Plus Essentials Hospital (previously Basic Plus Simple Start Hospital)			Bronze Hospital (new to market 1 October 2020)		
Excess	250	500	750	250	500	750	250	500	750
Single	SPH250	SPH500	SPH750	SSS250	SSS500	SSS750	SB250	SB500	SB750
Family	FPH250	FPH500	FPH750	FSS250	FSS500	FSS750	FB250	FB500	FB750
Couple	CPH250	CPH500	CPH750	CSS250	CSS500	CSS750	CB250	CB500	CB750
Single Parent	PPH250	PPH500	PPH750	PSS250	PSS500	PSS750	PB250	PB500	PB750
Extended Family	XFPH250	XFPH500	XFPH750	XFSS250	XFSS500	XFSS750	XFB250	XFB500	XFB750
Extended Single Parent	XPPH250	XPPH500	XPPH750	XPSS250	XPSS500	XPSS750	XPB250	XPB500	XPB750

Bronze Plus Care Hospital – change name from Bronze Plus Hospital with Heart from 1 Oct 2020.

Bronze Plus Essentials Hospital – changed name from Basic Plus Simple Start Hospital and became available to Family, Single Parent, Extended Family and Extended Single Parent from 1 Oct 2020.

(11.1b) Phoenix Health Hospital covers closed for purchase to new and existing members

	GOLD CATEGORY				
Scale	**Gold Classic Cover**	**Gold Complete Hospital**			
Excess	**Nil**	**Nil**	**250**	**500**	**750**
Single	SGCA	SGT	SGT250	SGT500	SGT750
Family	FGCA	FGT	FGT250	FGT500	FGT750
Couple	CGCA	CGT	CGT250	CGT500	CGT750
Single Parent	PGCA	PGT	PGT250	PGT500	PGT750
Extended Family	XFGCA	XFGT	XFGT250	XFGT500	XFGT750
Extended Single Parent	XPGCA	XPGT	XPGT250	XPGT500	XPGT750

Gold Classic Cover – change of name from Top Cover Combined (2019).
Gold Complete Hospital – change of name from Gold Top Hospital (1 April 2020)
Gold Complete Hospital Nil Excess & 250 Excess Closed from 1 April 2020.
Gold Complete Hospital 500 & 750 Excess Closed from 1 October 2020.

	BRONZE PLUS CATEGORY				
Scale	**Bronze Plus Starter Hospital Cover**		**Bronze Plus Mid Hospital Cover**		
Excess	**250**	**500**	**250**	**500**	**750**
Single	SBS250	SBS500	SBM250	SBM500	SBM750
Family	FBS250	FBS500	FBM250	FBM500	FBM750
Couple	CBS250	CBS500	CBM250	CBM500	CBM750
Single Parent	PBS250	PBS500	PBM250	PBM500	PBM750
Extended Family	XFBS250	XFBS500	XFBM250	XFBM500	XFBM750
Extended Single Parent	XPBS250	XPBS500	XPBM250	XPBM500	XPBM750

Bronze Plus Starter Hospital – change of name from Basic Hospital (1 April 2019)
Bronze Plus Mid Hospital – change of name from Mid Hospital (1 April 2019)

	BASIC PLUS CATEGORY
Scale	**Public Basic Hospital** CLOSED
Excess	**Nil**
Single	SPB
Family	FPB
Couple	CPB
Single Parent	n/a
Extended Family	n/a
Extended Single Parent	n/a

(11.2) Combined/ Packaged Hospital and Extras Covers

(11.2a) Phoenix Health Combined Hospital and Extras Packaged Covers available for purchase to new and existing members

None currently available for purchase

(11.2b) Phoenix Health Combined Hospital and Extras Packaged Covers closed for purchase to new and existing members

	GOLD CATEGORY	
Scale	**Gold Value Combined Cover**	
Excess	**250**	**500**
Single	SGV250	SGV500
Family	FGV250	FGV500
Couple	CGV250	CGV500
Single Parent	PGV250	PGV500
Extended Family	XFGV250	XFGV500
Extended Single Parent	XPGV250	XPGV500

	BRONZE PLUS CATEGORY		
Scale	**Bronze Plus YoungSavers Cover**		
Excess	**250**	**500**	**750**
Single	SBYS250	SBYS500	SBYS750
Family	n/a	FBYF500†	n/a
Couple	CBYS250	CBYS500	CBYS750
Single Parent	n/a	PBYF500^	n/a
Extended Family	n/a	n/a	n/a
Extended Single Parent	n/a	n/a	n/a

† FBYF500 Family not for sale ^ PBYF500 Single Parent not for sale

	BASIC PLUS CATEGORY
Scale	**Public Basic Plus Hospital & Classic Ancillary**
Excess	**Nil**
Single	SPBA
Family	FPBA
Couple	CPBA
Single Parent	n/a
Extended Family	n/a
Extended Single Parent	n/a

(11.3) Extras Covers

(11.3a) Phoenix Health Extras Covers open for purchase to new and existing members as a standalone product, or paired with a Phoenix Health Hospital Cover

	Kick Start Extras 50
Single	SE50
Family	FE50
Couple	CE50
Single Parent	PE50
Extended Family	n/a
Extended Single Parent	n/a

*Effective 24 Oct 21 Everyday Extras 60 - Single, Couple, Family, Single Parent are closed for sale as a standalone product.

(11.3b) Phoenix Health Extras Covers open for purchase to new and existing members paired with a Phoenix Health Hospital Cover only

	Everyday Extras 60	Kick Start Extras 50
Single	E60*	-
Family	E60*	-
Couple	E60*	-
Single Parent	E60*	-
Extended Family	E60ˆ	E50ˆ
Extended Single Parent	E60ˆ	E50ˆ

*Effective 24 October 2021 Everyday Extras 60 - Single, Couple, Family and Single Parent - are only available for purchase in conjunction with a Phoenix Health Hospital cover. Kick Start Extras 50 is only available for purchase as an Extended Family or Extended Single Parent cover, when paired with a Phoenix Health Hospital Cover.

(11.3c) Phoenix Health Extras covers closed for purchase to new and existing members

	Classic Ancillary	Top Extras	Mid Extras	Base Extras	First Start Extras	Complete Extras 70	Everyday Extras 60
		Closed 1/4/20	*Closed 1/4/20*	*Closed 1/4/20*	*Closed 1/4/20*	*Closed 1/11/22*	*Standalone closed 24/10/21*
Single	A	TA	MA	BA	SA	E70	E60
Family	A	TA	MA	BA	–	E70	E60
Couple	A	TA	MA	BA	SA	E70	E60
Single Parent	A	TA	MA	BA	–	E70	E60
Extended Family	A	TA	MA	BA	–	E70	-
Extended Single Parent	A	TA	MA	BA	–	E70	-

Classic Ancillary is also the Extras Cover component of Gold Classic Cover (closed) and Public Basic Hospital Cover (closed)

First Start Extras was open 1/4/19 to 31/3/20 and was available for purchase as a standalone, or in conjunction with a Phoenix Health Hospital cover.

Complete Extras 70 was available for purchase as a standalone product from 1 April 2019 to 24 October 2021. Effective 24 October 2021 it was available for purchase in conjunction with a Phoenix Health Hospital cover only. Complete Extras 70 was closed for purchase from 1 November 2022.

Everyday Extras 60 was available for purchase as a standalone product from 1 April 2019 to 24 October 2021(still available for purchase in conjunction with Phoenix Health hospital cover).

(12) Hospital Cover Conditions

Note: this section of The Rules relates to all stand-alone Hospital Covers, and the Hospital component of Combined/ Packaged Hospital and Extras Covers and are subject to all eligibility criteria within these Rules.

For individual cover details, including *Benefits* available and pricing, refer to *Product Information Sheets* for the applicable cover, the *Member Guide* or the *Phoenix Health Fund Website*.

(12.1) General Conditions

Refer Rule 7.3 for General *Hospital Treatment* Conditions.

(12.2) Hospital Treatment

(12.2a) Hospital Treatment in a Private Hospital

If the *Hospital* has an *Agreement* with *Phoenix Health*, *Benefits* are payable in accordance with that *Agreement* which may fully cover the cost of *Treatment* and accommodation.

If the *Hospital* does not have an *Agreement* with *Phoenix Health*, *Benefits* payable shall be in accordance with the minimum *Benefits* requirements in the *Private Health Insurance (Benefit Requirements) Rules* 2007 as amended from time to time.

(12.2b) Hospital Treatment in a Public Hospital

Benefits for *Public Hospital Treatment* and accommodation shall be in accordance with the minimum *Benefit* requirements in the *Private Health Insurance (Benefit Requirements) Rules 2007*, as amended from time to time, for shared or private award accommodation.

(12.2c) Approved Outreach Services

Benefits are payable for services provided to non-admitted patients by a *Hospital* with a *Hospital Agreement* with *Phoenix Health*.

(12.3) Medical Services Payments while admitted

All medical services payments will be paid subject to the conditions and eligibility requirements in these Rules.

Medicare pays a *Benefit* of 75% of the *Commonwealth Medical Benefits Schedule (CMBS)* fee.

Where the charge for the service is less than the *CMBS* fee, *Fund Benefits* for the gap after allowing for the *Medicare* payment will be an amount equal to:

- 25% of the CMBS fee; or
- if the medical expenses incurred in respect of the professional services are less than the CMBS fee – the amount (if any) by which the medical expenses exceed 75% of that CMBS fee.

Where the charge for the service is greater than the *CMBS* fee, the *Fund* will pay a *Benefit* above the *CMBS* fee where the Medical Practitioner chooses to participate and bill under the *Access Gap Scheme*. The *Benefit* will vary according to the *Access* Gap *Scheme* of *Benefits*.

(12.4) Prosthesis

(12.4a) Surgically Implanted Prosthesis

Surgically Implanted Prosthesis are paid in accordance with Government legislation *Private Health Insurance (Prostheses) Rules 2019*.

(12.4b) Non-surgically Implanted Prosthesis

Non-surgically Implanted Prosthesis are paid in accordance with the Government legislation *Private Health Insurance (Prostheses) Rules 2019*.

(12.5) Hospital Assistance Package

Effective 1 April 2019, as a part of the Government Reforms, the *Fund* will pay a *Benefit* on travel and accommodation for rural members under select *Hospital* and *Combined Covers*.

Where an *Insured Person* is required to travel over three hundred (300) kilometres return for medical *Treatment*, a *Benefit* for travel expenses can be claimed. An additional *Benefit* towards accommodation for the *Partner/Spouse* or parent listed on the *Policy* is claimable.

For individual cover details, including *Benefits* relating to Hospital Assistance Package and eligibility requirements, refer to *Product Information Sheets* for the applicable cover, the *Member Guide* or the *Phoenix Health Fund Website*.

(12.6) Ambulance

All levels of *Phoenix Health* Hospital Cover provide full, unlimited cover for all *Medically Necessary Ambulance* transport and *Treatment* across *Australia* – including road, air and sea.

Medically Necessary under Rule 12.6, means on-site treatment or transport to the closest *Hospital* or Emergency Department for treatment of an acute *Medical Condition* or *Accident*.

It is at the absolute discretion of the *Fund* to determine what is considered *Medically Necessary* in relation to *Ambulance*.

Benefits are not payable on transfers between *Hospitals*.

Benefits are not payable on *Ambulance* services where a *Patient* is being transported interstate, where treatment is not required.

Payment of *Benefits* outside of these *Rules* are at the absolute discretion of the *Fund*.

In the case in which an *Ambulance* service is claimable or subsidised through another source, including charitable or *State or Territory Ambulance* subscriptions or *Compensable Claims*; and/or where the subscription has been paid by the fund, the service must be claimed through this other source in the first instance.

(13) Extras Cover Conditions

Note: this section of The Rules relates to all stand-alone Extras (or General Treatment) Covers, and the Extras Treatment component of Combined/ Packaged Hospital and Extras Covers and are subject to all eligibility criteria within these Rules.

All extras cover benefit rules should be read in conjunction with Rule 7.4 for *Extras Treatment* Conditions, the *Phoenix Health Member Guide, Phoenix Health website, Private Health Information Statements, and the Product Information Sheets* for specific *Benefit* details.

(13.2a) Dental

Benefits for Dental services include General Dental, *Major Dental*, Endodontics and Orthodontics and are payable when provided by a *Registered Provider*.

Orthodontics have a Lifetime limit, which is *Transferrable* between funds.

(13.2b) Optical

Benefits for Optical include the purchase of custom prescription glasses and sunglasses, including frame and single and multi-vision frames, as well as contact lenses.

No *Benefit* is payable on non-prescription sunglasses, where no sight correction is needed.

Benefits are only payable on a frame where a prescription lenses is being fitted at the same time.

(13.2c) Physiotherapy

Benefits for Physiotherapy are payable when provided by a *Registered Provider*.

(13.2d) Chiropractic & Osteopathic

Benefits for Chiropractic & Osteopathic are payable when provided by a *Registered Provider*.

(13.2e) Non-PBS Pharmaceuticals

Benefits are payable on approved Pharmaceutical prescriptions, not already subsidised by the *PBS.*

This includes vaccinations purchased and administered by a General Practitioner or Travel Doctor. Doctors appointment and administration fees are not claimable.

The *Extras Co-Payment* for the current PBS patient contribution amount ($30.00 from 1 January 2023), will be applied prior to the *Phoenix Health Benefit* being assessed.

(13.2f) Podiatry

Benefits for Podiatry are payable when provided by a *Recognised Provider*.

(13.2g) Orthotics

Orthotic *Benefits* are payable on custom made Orthotic devices, when purchased from a registered Orthotist or Podiatrist.

(13.2h) Psychology and Hypnotherapy

Psychology *Benefits* are payable for services provided by a registered Clinical Psychologist, in private practice.

Hypnotherapy *Benefits* are payable for services provided by a registered Clinical Hypnotherapist, in private practice.

Health Fund Benefits do not apply to services which attract a *Medicare* rebate, or have a *Medicare* Item Number.

Counselling and Psychotherapy services are not eligible for a *Benefit*.

(13.2i) Alternative & Natural Therapies

Remedial Massage

Remedial Massage *Benefits* are available when provided by *Recognised Providers* included in the Australian Regional Health Group (ARHG) Alternative Therapists Registration Database.

Alternative & Natural Therapies not covered under Government Reform Changes

Effective 01 Apr 2019 Government Reform changes called for the removal of Alternative & Natural Therapies from *Extras Covers*.

Private Health Insurers can no longer cover the following *Treatments* under a *Complying Health Insurance Product*:

- Alexander Technique
- Bowen Therapy
- Feldenkrais
- Iridology
- Naturopathy
- Reflexology
- Shiatsu
- Western Herbal Medicine
- Aromatherapy
- Buteyko
- Homeopathy
- Kinesiology
- Pilates
- Rolfing
- Tai Chi
- Yoga

(13.2j) Speech Therapy

Benefits for Speech Therapy are payable when provided by a *Registered Provider*.

(13.2k) Dietetics

Dietetic *Benefits* are payable for services rendered by a registered Dietician, who is also a member of The Australian Association of Dieticians.

(13.2l) Occupational Therapy

Benefits for Occupational Therapy are payable when provided by a *Registered Provider*.

(13.2m) Acupuncture

Benefits for Acupuncture are payable when provided by a *Registered Provider*.

(13.2n) Orthoptic Therapies

Benefits for Orthoptic Therapies are payable when provided by a *Registered Provider*.

(13.2o) Midwifery

Benefits are payable for Ante-Natal and Post-Natal Classes and Confinement Delivery, for services rendered by a registered Provider.

Benefit for Confinement Delivery not available if a medical practitioner is required to intervene and take over the delivery.

(13.2p) Aids to Recovery

Benefits are payable towards approved Aids and Appliances which assist in the recovery of an *Insured Person* after a surgery or aid an *Insured Person* who suffers from a *Chronic Condition*.

If not claimable through any other source, Aids to recovery *Benefits* are claimable for, but not limited to, the following:

- Blood Glucose monitors
- Blood Pressure monitors
- Nebulisers
- CPAP Machines (machine and replacement masks only)
- Braces and splints
- Circulation booster
- Toilet seat raiser
- Compression garments and bras
- Moon Boot
- Tens Machines
- Wigs

Payment of *Benefits* towards other Aids to Recovery is at the discretion of the *Fund*.

A claim for *Benefit* must be accompanied by a referral from Medical Practitioner, outlining the need for the aid or appliance, or a recent related hospital admission.

No *Benefits* are available for:

- rent or hire of an aid or appliance
- repairs of an aid or appliance
- second-hand goods
- the purchase of consumables
- medical reporting on the aid or appliance
- any other parts to be used with the approved aid or appliance.

(13.2q) Hearing Aids

Hearing Aid *Benefits* will be paid up to annual limits.

Where bilateral hearing loss is demonstrated a *Benefit* is payable for a second appliance, up to corresponding yearly/ 3 yearly/ 5 yearly limits.

Limit two (2) appliances every five (5) years.

No *Benefit* is available for batteries.

(13.2r) Healthy Lifestyle

Benefits are payable towards approved services and programs designed to manage a specific health condition as recommended by a doctor or health professional and are categorised as follows:

Health Education

Health Education *Benefits* are available for approved programs and providers, including:

- Weight Management programs provided by an approved provider
- Asthma management programs provided by an accredited Asthma educator or an Asthma Foundation affiliated provider
- Diabetes classes provided by Diabetes Australia or a provider registered with Australian Diabetes Educators Association
- Quit Smoking courses with Quit Smoking, Smokenders and organisations registered in Australia who charge a fee.

*Benefit*s are payable on the program/*Consult* only and do not apply to food, supplements, consumables or laser therapies associated with the program.

Health Screening

Benefits are available for approved Health Screening diagnostic testing, that do not attract a *Medicare* rebate, or have a *Medicare* Item Number.

If not claimable through any other source, *Health Screening Benefits* are claimable for, but not limited to the following, up to annual limits:

- Blood Pressure tests
- Bone Density testing
- Bowel Cancer test kits
- Cholesterol tests
- Hearing tests
- Mammograms
- Cervical Screenings
- Optical Coherence Tomography (OCT) scans
- Retinal Photography
- Skin checks

Payment of *Benefits* towards other Diagnostic tests is at the discretion of the *Fund*.

Health Management

Benefits are payable towards approved programs designed and recommended by a health care professional, for the purpose of managing a chronic health condition, when the Claim is accompanied by a Healthy Lifestyle Treatment Plan Form completed by a treating Doctor, and can include:

- Gym Memberships
- Swimming Lessons

A claim for *Benefit* must be accompanied by a Healthy Lifestyle Treatment Plan, completed by a Doctor, outlining the need for the Health Program.

Benefits are not payable for services that are for sports, recreation or entertainment, or for gym shoes or sports equipment.

Swimming Lessons Benefits are available for swimming classes provided by an AUSTSWIM or Swim Australia *Recognised* Swim Centre.

(13.2s) Accidental Death Funeral Expenses

Refer to Rule 7.4d for eligibility requirements.

Funeral *Benefits* are payable to eligible *Insured Persons*.

A *Benefit* of up to $1,300 for funeral costs for the *Policy Holder* and *Dependants* upon presentation of a death certificate.

(13.2t) Travel and Accommodation

Travel & Accommodation *Benefits* are payable to eligible *Insured Persons* who hold stand-alone Top *Extras Cover*.

Single travel *Benefit* payable for patient and/or accompanying family member, towards travel expenses and overnight accommodation, where return distance is at least 200km.

Where an *Insured Person* holds *Hospital* and *Extras Cover, Travel and Accommodation Benefits* will be paid under the *Hospital* component of their cover, and in accordance with the *Benefits* payable under their *Hospital* cover. Refer section 12.5 for more details.

(13.2u) Ambulance

All levels of *Phoenix Health Extras Treatment* Cover provide cover for all *Medically Necessary Ambulance* transport and *Treatment* across *Australia* – including road, air and sea (see individual *Private Health Information Statements* for specific *Benefit* details)

Medically Necessary under Rule 13.2u, means on-site treatment or transport to the closest *Hospital* or Emergency Department for treatment of an acute *Medical Condition* or *Accident*.

It is at the absolute discretion of the *Fund* to determine what is considered *Medically Necessary* in relation to *Ambulance*.

Benefits are not payable on transfers between *Hospitals*.

Benefits are not payable on *Ambulance* services where a *Patient* is being transported interstate, where treatment is not required.

Payment of *Benefits* outside of these *Rules* are at the absolute discretion of the *Fund*.

In the case in which an *Ambulance* service is claimable through another source, including *State or Territory Ambulance* subscriptions; and or where the subscription has been paid by the *Fund*, the service must be claimed through this other source in the first instance.

Appendix 1: Schedules

Please refer to the *Phoenix Health Member Guide, Phoenix Health website, Private Health Information Statements, and the Product Information Sheets* for specific *Benefit* details.

Appendix 2: Interpretation & Definitions

The *Fund Rules* are written using 'plain English'.

Words or expressions in *Initial Capital Italics* are defined in Appendix 2 and are intended to be interpreted accordingly.

(AP2.1) Interpretation

In these *Fund Rules*, and any *Fund Policies* unless excluded, the following rules of interpretation apply:

- These Fund Rules are to be interpreted in a manner that is consistent with the relevant Government legislation, in particular the PHI Act;
- words denoting one gender include the other genders;
- words denoting the singular include the plural, and vice versa;
- where not defined, words are meant to have their ordinary meaning;
- subject to the definition of 'State of Residence', reference to a State or Territory;
- a reference to any legislation or legislative provision are taken as reference to legislation as amended from time to time;
- a reference to a document (including these Rules) is to that document as varied, novated, ratified or replaced from time to time;

(AP2.2) Definitions

In these Rules, unless the context requires otherwise, definitions are as follows:

Access Gap Scheme means the *Fund's* approved *Medical Benefits Scheme* that provides a 'no gap' or 'known gap' *Benefit* for the payment of *Medical Benefits* in excess of the *Medicare Benefits Schedule*.

Accident means an unplanned or unforeseen event, occurring by chance and caused by an unintentional external source resulting in bodily injury that requires immediate *Hospital Treatment* but excludes unforeseen *Conditions* attributable to medical causes.

Acute Care Certificate means a certificate in a form approved by the *Fund* certifying that an *Admitted Patient* is in need of *Acute Care*.

Admitted Patient means a person who is admitted to *Hospital* for the purpose of *Hospital Treatment*. This definition:

(i) includes a newborn child who:

- occupies a bed in a Special Care Unit; or
- is the second or subsequent child of a multiple birth, but

(ii) excludes:

- any other newborn child whose mother also occupies a bed in the *Hospital*, and
- an employee of a *Hospital* receiving *Treatment* in their own quarters.

Adult Dependant – see *Dependant*

Agreement means an *Agreement*, arrangement or understanding entered into between a *Hospital* or a Medical Practitioner and the *Fund*, under which the *Hospital* or Medical Practitioner agrees to an accepted payment *by Phoenix Health* for money owed for *Treatment* of an *Insured Person*.

Ambulance means a road vehicle, boat or aircraft operated by a service approved by the *Fund* and equipped for the transport or paramedical *Treatment* of a person requiring medical attention.

Applicant means someone who applies to *Phoenix Health* to become a *Policy Holder*, or to join a health insurance *Policy* or *Membership* as an *Insured Person*.

Australia means the *States and Territories* collectively.

Australian Educational Institution means:

- a secondary school or secondary college delivering a curriculum accredited by a *State or Territory* authority;
- a publicly funded tertiary institution, private sector tertiary institution, not for profit tertiary institution, Australian branch of an overseas university, or other higher education provider, registered by TEQSA as a higher education institution, which course is accredited by TEQSA; or
- a Registered Training Organisation providing vocational education and training.

Authority can be granted by the *Policy Holder* to any listed Member, over the age of sixteen (16), allowing the person to access the *Policy* on their behalf. *Authority* does not permit anyone other than the *Policy Holder* to cancel a *Policy*.

Benefit means the amount of money paid from the *Fund* under a *Policy* in respect of the costs of *Treatment* of an *Insured Person* in accordance with these *Fund Rules*.

Calendar Year means the period between 1 January and 31 December.

Category of Cover means a *Complying Health Insurance Product* in the following:

- Single Cover: insures only one Insured Person, being the Policy Holder.
- Couple Cover: insures the Policy Holder and their Partner.
- Family Cover: insures the Policy Holder, the Policy Holder's Partner, and at least one Dependant.
- Single Parent Family Cover: insures the Policy Holder and at least one Dependant.

Chronic Disease means a disease that has been, or is likely to be, present for at least six (6) months including, but not limited to, asthma, cancer, cardiovascular illness, diabetes, a mental health *Condition*, arthritis and a musculoskeletal *Condition*.

Clinical Category defines the classification of Gold, Silver, Bronze and Basic Hospital Covers, as per *Government Rules*.

Code of Conduct is a self-regulatory and voluntary code, designed to promote informed and transparent relationships between *Private Health Insurers*, consumers, agents, brokers and corporate partners. *Phoenix Health Fund* is proudly a signature to the *Private Health Insurance Code of Conduct*.

Compensation means:

- a payment of *Compensation* or damages pursuant to a judgment, award or settlement;
- a payment in accordance with a scheme of insurance or *Compensation* provided for by Commonwealth or *State or Territory* law (for example, *Workers Compensation* insurance) other than a payment of *Fund Benefits*;
- settlement of a claim for damages or a claim under any scheme referred to in 2 (with or without admission of liability);
- a payment in settlement of a professional negligence damages claim in relation to payment claims in 1, 2 or 3, regardless of liability; or
- any other payment that in the *Fund's* opinion is a payment in the nature of *Compensation* or damages.

Compensation Claim means a claim made to a general insurer or workers compensation insurer in relation to an incident where the *Insured Person* may be entitled to a compensation payment.

Complying Health Insurance Product means an insurance *Policy* that meets:

- Community Rating requirements; and
- Coverage Requirements; and
- if the *Policy* covers *Hospital Treatment, Benefit* Requirements; and
- *Waiting Period* requirements; and
- *Portability* Requirements; and
- Quality Assurance Requirements; and
- Any other requirements as set out in the Private Health Insurance (Complying Product) Rules.

Condition means any actual or perceived state of health for which *Treatment* is sought and includes but is not limited to states variously described as: abnormality, ailment, disability, disease, disorder, health problem, illness, impairment, impediment, infirmity, injury, malady, sickness or unwellness.

Consultation means an attendance by a relevant provider, on and in the physical presence of, a Patient, or as otherwise approved in writing by the *Fund*.

Constitution means *Constitution* of *Phoenix Health Fund Limited*.

Contracted Hospital means a *Hospital* with which there is *an Agreement* in place.

Contribution (also referred to as *Premium*) means the money (in the amount approved by the *Minister*) a *Policy Holder* is required to pay to *Phoenix Health* in exchange for a specified period of Cover under a *Policy*.

Contribution Group means a *Premium* payment group.

Cover (also referred to as *Product)* means a defined group of *Benefits* payable, subject to these *Fund Rules*, in respect of approved expenses incurred by an *Insured Person*.

Co-Payment means an amount that a *Policy Holder* must contribute towards the cost of any *Hospital Treatment* of an *Insured Person* during a *Calendar Year* in addition to the *Excess* in accordance with the *Policy*. The *Co-Payment* is a daily amount paid in addition to the *Excess* and is paid by the *Policy Holder* and subtracted from any *Benefit* which payable.

Day Procedure (also referred to as *Day Treatment*) means a procedure for which a person is admitted to *Hospital* for *Treatment* and discharged prior to midnight on the same day.

Default Benefit means the minimum *Benefit* as determined by the *Minister* payable under a *Policy* for a particular *Hospital Treatment*.

Dependant means a person who is not married or living in a de facto relationship and is one of the following:

- aged under twenty-one (21) who lives with, or is dependant for support on, the *Policy Holder (Non-Student Dependent)*;
- who has reached the age of twenty-one (21) but is under the age of twenty-five (25) and is registered as receiving *Full-time Education (Student Dependent)*; or
- who has reached the age of twenty-one (21) but is under the age of twenty-five (25), who lives with, or is dependant for support on the *Policy Holder* and is not registered as receiving *Full-time Education (Adult Dependant)*

Equivalent Cover means a *Cover* offered by the *Fund* or another *Complying Health Insurance Policy* offered by a *Private Health Insurer* which the *Fund* considers to be *Equivalent* to a *Cover* held by or sought to be acquired by a person applying to become a *Policy Holder*.

Excess means an amount that a *Policy Holder* must contribute towards the cost of any *Hospital Treatment* of an *Insured Person* during a *Calendar Year* in accordance with the *Policy*. The *Excess* is paid by the *Policy Holder* and subtracted from any *Benefit* which payable.

Extras Cover (also known as *Ancillary or General Treatment*) means a service or *Treatment* that is not *Hospital Treatment*. For example, physiotherapy, dental and optical *Treatment*.

Extras Co-payment means an amount that a *Policy Holder* must contribute towards the cost of *General Treatment* of an *Insured Person* during a *Calendar Year* in accordance with the *Policy*.

Full-time Education means a course of study in which the *Dependant* is registered with the *Educational Institution* as a *Full-Time Student*.

Fund means the Health Benefits *Fund* conducted by *Phoenix Health Fund Limited* pursuant to these *Fund Rules,* unless the context refers to the *Health Benefits Fund* of another *Private Health Insurer*.

General Treatment (also known as *Ancillary or Extras Cover*) means a service or *Treatment* that is not *Hospital Treatment*. For example, physiotherapy, dental and optical *Treatment*.

Health Benefits Claim means a claim made to *Phoenix Health* by an *Insured Person* in relation to a benefit an *Insured Person* is entitled to under a health insurance *Policy*

Hospital Co-payment means an amount that a *Policy Holder* must contribute towards the cost of *Hospital Treatment* of an *Insured Member*, payable in respect of each day the *Insured Person* is an *Admitted Patient* in accordance with the *Policy*, separate and in addition to any Excess.

Hospital Substitute Treatment means *Treatment* that:

- is a substitution for admission to a Hospital for *Hospital Treatment* as defined in the Act;
- is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or any other goods or services intended to treat, manage or prevent a disease, injury or Condition; and
- is not excluded by the Private Health Insurance (Complying Product) Rules 2015.

Hospital Treatment includes:

- Hospital accommodation and nursing care; and
- the provision of a *Prosthesis* listed in the Schedule of the *Private Health Insurance (Prostheses) Rules 2016 (No. 1)* in circumstances:
  - in which a *Medicare Benefit* is payable; or
  - set out in the *Private Health Insurance (Prostheses) Rules* for the purposes of this item.

Identity Verification means confirming the identity of the *Insured Persons* through internal systems and third parties with whom we have retained for the purposes of verifying your identity.

Insured Person means a person who is Covered under the terms of a *Policy* and includes the *Policy Holder*.

Lifetime Health Cover (LHC) means the scheme under Part 2-3 of the *PHI Act*.

Major Dental Treatment includes, but is not limited to, crowns, bridgework, complete dentures, partial dentures, prosthodontics services, implant procedures, periodontics, oral surgery and oral appliances for sleep apnoea.

Medically Necessary in relation to *Ambulance* transport means transportation by *Ambulance* that is necessary as, due to the Patient's *Condition*, the Patient could not be transported by any other means. It does not include transportation for out-patient services, transfers between *Hospitals* or transport interstate where *Treatment* is not required.

Medicare Benefits Schedule (MBS or Commonwealth Medicare Benefits Schedule (CMBS)) means the *'Medicare Benefits Schedule'* published by the Commonwealth Department of Health and contains all items payable, all regulations and rules of interpretation for those items, that describe services for which *Medicare Benefits* are payable and, without limitation, includes each of the Health

Insurance (General Medical Service Table) Regulations, the Health Insurance (Pathology Services Table) Regulations and the Health Insurance (Diagnostic Imaging Services Table) Regulations.

Membership has the same meaning as *Policy*.

Member Guide means the Product Disclosure Statement published by *Phoenix Health.* The *Member Guide* should be read in conjunction with the *Product Information Sheets.*

Minister means the Commonwealth *Minister* of the Crown allocated portfolio responsibility for the *PHI Laws*, or that person's authorised delegate.

Non-Student Dependant – see *Dependant*

Nursing Home Type Patient means an *Admitted Patient* who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding thirty-five (35) days, as defined in Schedule 4 of the *Private Health Insurance (Benefit Requirements) Rules*.

Palliative Care means *Treatment* of a person whose *Condition* has progressed beyond the stage where curative *Treatment* is effective and attainable or who chooses not to pursue curative *Treatment*, which *Treatment* provides relief of suffering and enhancement of quality of life for the person. Interventions such as radiotherapy, chemotherapy, and surgery may be considered part of the *Palliative Care* if undertaken specifically to provide symptomatic relief.

Partner means a person who is not related by family to and is living with another person on a *bona fide* domestic basis as a couple whether or not legally married to that other person.

Pharmaceutical Benefits Scheme (PBS) means the Commonwealth scheme for the payment by the Commonwealth of Pharmaceutical *Benefits* detailed in Part VII of the *National Health Act 1953.*

PBS Pharmaceuticals means any pharmaceutical listed in the Schedule of *Pharmaceutical Benefits* and prescribed in accordance with the *Pharmaceutical Benefits Scheme* that is directly related to the *Treatment* provided, clinically indicated and essential for the meeting of satisfactory health outcomes.

PHI Act means the *Private Health Insurance Act 2007 (Cth)* and, where the context requires, includes any Private Health Insurance Rules made by the *Minister* or by the Private Health Insurance Council, of that Act.

PHI Laws means each of the *Health Insurance Act 1973*, the *PHI Act*, the *PHIPS Act* and the *National Health Act 1953*.

Phoenix Health or *Phoenix* means *Phoenix Health Fund Limited* (ABN 93 000 124 863).

Policy (also referred to as *Membership*) means a *Complying Health Insurance Product* referable to the *Fund* through the payment of *Contributions* in accordance with these *Fund Rules*.

Policy Holder means:

- the named principal Insured Person on a Policy, who is responsible for the payment of Premiums and to whom Benefits are paid, unless Phoenix Health is otherwise notified, and includes that person's legal personal representative or lawful attorney; or
- if the Insured Person referred to in the above paragraph dies or no longer has legal capacity, in the absence of any written notice from the legal personal representative of that person, the next named Insured Person is the Policy Holder.

Pre-Existing Condition (*PEC* (also referred to as *Pre-Existing Ailment PEA*)) means a *Condition*, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by the *Fund*, existed (irrespective of whether or not those signs or symptoms were apparent or should have been apparent to the person) at any time during the six (6) months preceding the day on which the person became insured under the *Policy*. In forming the opinion, the Medical Practitioner must have regard to any information in relation to the *Condition* that the Medical Practitioner who treated the *Condition* (if any) provides in response to a reasonable request.

Premium (also referred to as *Contribution*) means the money (in the amount approved by the *Minister*) a *Policy Holder* is required to pay to *Phoenix Health* in exchange for a specified period of Cover under a *Policy*.

Private Health Information Statement (*PHIS,* also previously known as *Standard Information Statement or SIS*) means the standardised statement required by the Government for all *Private Health Insurance Policies* sold in Australia and provides only a summary of the key product features. All *PHIS* are available to consumers at privatehealth.gov.au

Private Health Insurer means an organisation registered under the *Supervision Act*.

Private Hospital means a Hospital declared by the *Minister* under the *PHI Act* to be a *Private Hospital*.

Private Patient means an *Admitted Patient* in a *Private Hospital* who is not a *Public Patient*.

Product (also referred to as *Cover)* means a defined group of *Benefits* payable, subject to these *Fund Rules*, in respect of approved expenses incurred by an *Insured Person*.

Product Information Sheet (previously referred to as Cover Information Statements) means documentation published by *Phoenix Health* containing information on *Benefits* and *Limits*, specific to each *Product*. *Product Information Sheets* should be read in conjunction with the *Phoenix Health Member Guide* and are publicly available on the *Fund's Website*.

Prosthesis means:

- in relation to a Hospital Cover: any item on the Federal Government's Prostheses Schedule, which for the purpose of these Fund Rules, is the schedule approved by the Minister under the Private Health Insurance (Prostheses) Rules, and

- in relation to Extras Cover: an external appliance or device approved by the Fund normally associated with a physical replacement of some part of the human body that is no longer performing in the manner in which it is supposed to.

Psychiatric Patient means a Patient undergoing *Treatment in Hospital* under the supervision of a Psychiatrist who is a *Recognised Provider*, and the *Treatment* program has been approved by the *Fund*.

Public Hospital means a Hospital declared by the *Minister* under the *PHI Act* to be a *Public Hospital*.

Public Patient means an *Insured Person* who has been admitted to a *Public Hospital* for *Treatment* without charge.

Recognised Provider means a Hospital or any other provider of *Treatment* (who is in Independent Private Practice) and who satisfies the *Recognition Criteria*.

*Recognition Crit**eria*** means the conditions set by Phoenix Health in its absolute discretion for the recognition of providers including:

- meeting all professional qualifications or membership of professional bodies required to lawfully provide the relevant clinical services in Australia, including registration with the relevant Board or professional association (where applicable);
- registration, or being licensed under relevant State or Territory laws, including the Health Practitioner Regulation National Law (as in force in the relevant State and Territory in Australia);
- satisfying all appliable standards required of equipment and facilities and the training of staff; and
- any other matter determined by the Fund as necessary or desirable.

Rehabilitation Patient means a Patient undergoing *Treatment* in a *Private Hospital* under the supervision of a specialist in rehabilitation medicine who is a *Recognised Provider* and the *Treatment* program has been approved by the *Fund*.

Restricted Service means a service or *Treatment* in respect of which the *Benefit* payable under a *Policy* is the relevant Minimum *Benefit*.

State or Territory means each of the Australian Capital Territory (ACT), New South Wales (NSW), Northern Territory (NT), Queensland (QLD), South Australia (SA), Tasmania (TAS), Victoria (VIC) and Western Australia (WA).

State of Residence means the *State or Territory* in which the *Policy Holder* resides.

Supervision Act means the *Private Health Insurance (Prudential Supervision) Act 2015.*

Suspension means the temporary discontinuation of Cover in accordance with these *Fund Rules*.

Transfer means a *Transfer* of an *Insured Person* from another *Private Health Insurer's Fund* to the *Fund* with a break in Cover no longer than that specified in these Rules; or a change of Cover by an *Insured Person* within the *Fund.*

Transfer Certificate (also known as a *Clearance Certificate*), serves as a record of a person's health insurance cover. The certificate confirms type of cover, level of cover, join and cancellation dates, *LHC* entry dates and history of recent claims.

Treatment means the management in the application of medicine, therapies, procedures or surgeries given to a person to treat or ameliorate the effect of a *Condition*, but excluding any service not provided personally by or under the direct supervision of a *Recognised Provider.*

Waiting Period (also referred to as *Waits*) means the continuous period that applies to an *Insured Person* for a *Benefit* under a *Policy* being the period:

- starting at the time the person becomes insured under the Policy; and
- ending at the time specified in the Policy, during which the person is not entitled to the Benefit.

Website means the *Website* published by or with the authority of *Phoenix Health*, at or under the domain name **phoenixhealthfund.com.au.**

These Rules apply to **Phoenix Health Fund** Insurance Covers and any other branded Health Insurance covers underwritten by **Phoenix Health Fund**. These Rules should be read in conjunction with the **Phoenix Health Fund** Member Guide, Product Information Statements and Government Rules.
These Rules were last updated 1 April 2023.

Phoenix Health Fund
1800 028 817
enquiries@phoenixhealthfund.com.au
PO Box 156 Newcastle NSW 2300
phoenixhealthfund.com.au