Onemedifund Fund Rules

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A INTRODUCTION

A1 Rules Arrangement

1. These rules set out the General Conditions (Fund Rules A to G) and the Schedule of Contribution Rates, Benefits and Specific Conditions applying to the operation of National Health Benefits Australia Pty Ltd.

A2 Health Benefits Fund

1. National Health Benefits Australia Pty Ltd (ACN 122 255 396) is a registered Private Health Insurer, trading as "onemedifund".

2. The Health Benefits Fund is established in accordance with the Constitution of National Health Benefits Australia Pty Ltd.

3. The purpose of the fund is to provide benefits to or on behalf of Policy Holders in accordance with the terms of these Fund Rules.

4. National Health Benefits Australia Pty Ltd may supplement the Fund Rules with Fund Policies that are not inconsistent with the Fund Rules. These Fund Policies include;

    a. Privacy policy
    b. Complaints handling policy
    c. Membership suspension policy

5. All Policy Holders of National Health Benefits Australia Pty Ltd are bound by the Fund Rules as amended from time to time.

A3 Obligations to Insurer

1. A Policy Holder of National Health Benefits Australia Pty Ltd shall provide such information as is reasonably requested from time to time to facilitate the management of the Policy Holder records.

A4 Governing Principles

1. The operation of the fund and the relationship between National Health Benefits Australia Pty Ltd and each Policy Holder is governed by:

    (i) The *Private Health Insurance Act 2007*

    (ii) The *Health Insurance Act 1973*

    (iii) The Fund Rules

    (iv) The Constitution of the company

A5 Use of Funds

1. National Health Benefits Australia Pty Ltd shall:

(i) Keep proper accounts of the moneys received and expended by the Fund and matters in respect of which such receipts and expenditure take place and of the assets, credits and liabilities of the Fund.

(ii) There shall be credited to the Health Benefits Fund the whole of the income paid by Policy Holders and all other income arising out of the carrying on by the company of business as a Registered Private Health Insurer.

(iii) No amount shall be debited to this Fund other than:

a. Payments by the Fund of benefits payable under these rules in respect of Policy Holders to the Fund or dependant children of such Policy Holders;
b. Costs incurred by the Fund in the carrying on of a health insurance or health related business.
c. Costs incurred by the Fund in providing, or arranging to provide Hospital Treatment or General Treatment for Policy Holders, or Policy Holders included in a class of Policy Holders, to that Fund or dependant children of such Policy Holders; or
d. Any amount paid from that Fund to the Health Benefits Risk Equalisation Trust Fund in accordance with a determination of the Trustees under Part 6-7 of the *Private Health Insurance Act, 2007*, and
e. To make investments for the health insurance business or health related business;
f. Such surplus funds as may from time to time be in excess of the absolute needs of the fund as determined by it's Capital Management Plan may be payable as dividends to the shareholder company in accordance with the Constitution.

A6 No Improper Discrimination

1. National Health Benefits Australia Pty Ltd shall ensure that the conduct of the registered health benefits fund shall at all times comply with the community rating provisions of the *Private Health Insurance Act 2007.*

(i) When making decisions in relation to Policy Holders, the fund will, in accordance with the *Private Health Insurance Act 2007* disregard:

i. the suffering by the Policy Holder of a chronic disease, illness or other medical condition;
ii. the gender, race, sexual orientation or religious belief of a person;

iii. except in relation to the calculation of a *Lifetime Health Cover* loading, the age of the Policy Holder;
iv. any other characteristic of a person (including but not just matters such as their occupation of leisure pursuits) that are likely to result in an increased need for hospital treatment or general treatment;
v. the frequency of the rendering of *professional services* to the Policy Holder;
vi. the amount, or extent, of the benefits to which a Policy Holder becomes, or has become, entitled during a period.

A7 Changes to Rules

1. National Health Benefits Australia Pty Ltd may amend the Fund Rules in accordance with the Private Health Insurance Act 2007.

2. National Health Benefits Australia Pty Ltd may in nominated circumstances waive the application of particular Fund Rules at its discretion, provided that the waiver does not result in any breach of any conditions imposed by the Private Health Insurance Act 2007.

3. The waiver of a particular Fund Rule in a given circumstance does not require National Health Benefits Australia Pty Ltd to waive the application of that Fund Rule in any other circumstance.

4. Whenever a Fund Rule is amended; such that a detrimental, material change is made to the scope, level or amount of treatments or benefits payable to a Policy Holder; or the premiums payable by a Policy Holder are increased (other than as an effect of rounding); National Health Benefits Australia Pty Ltd shall, before the change takes effect, take all reasonable steps to directly notify all affected Policy Holders in writing, explaining the change in “Plain English” in accordance with the provisions of the private health insurance Code of Conduct .

5. National Health Benefits Australia Pty Ltd will issue Standard Information Statements (SIS) at least annually in accordance with the Private Health Insurance Act 2007.

6. National Health Benefits Australia Pty Ltd will issue every newly insured person with an up to date copy of the relevant Standard Information Statements, details about what the policy covers and how benefits are provided and identifying the referable health benefits fund when they join.

A8 Dispute Resolution

1. The dispute resolution procedure available to Policy Holders and others shall be included in the Complaints Handling Policy and at all times will comply with the relevant Australian Standard and the private health insurance industry Code of Conduct. The Complaints Handling Policy will be publicised via the fund information brochures and web site and available to any person on request.

2. The Complaints Handling Policy of the Fund shall include escalation provisions to the Private Health Insurance Ombudsman (PHIO) should the internal dispute resolution procedures not resolve the issue. Contact details for PHIO will also be included in the Fund information brochures and on the Fund website.

A9 Notices

1. National Health Benefits Australia Pty Ltd shall send any necessary correspondence to the most recently advised postal address, fax number or email address of the Policy Holder.

2. These Fund Rules are available to Policy Holders upon request.

A10 Winding Up

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

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

3. A further period must be allowed to enable claims to be lodged where such claims arose prior to the date of termination of the fund.

4. When the fund gives notice under Clause A10.1, that notice shall stipulate the termination date. The fund will not entertain any claims arising after that date but, in relation to claims arising prior to the termination date Policy Holders have a period of 12 months from the termination date within which to lodge any outstanding claims.

5. After all claims have been paid and expenses of the fund paid, any surplus then remaining shall revert to ACGHAF Pty Ltd.

6. In winding up the fund and paying all amounts due to Policy Holders, the fund shall observe all requirements of the relevant legislation and any regulations in force applicable at the time in relation to the winding up of a registered private health insurer.

A11 Other

Not Applicable

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

1. The definitions as set out in the *Private Health Insurance Act 2007* shall be read in conjunction with these rules and shall be deemed to be part of these rules and shall have the same meaning as that which is defined in the above Acts.

2. These Rules shall be interpreted so as not to conflict with the Constitution of National Health Benefits Australia Pty Ltd.

3. Any terms used in these Rules and also in the Constitution shall have the same meaning in these Rules as they bear in the Constitution.

4. Unless otherwise specified, the meanings attached to the words and expressions in the *Private Health Insurance Act 2007* shall apply to these Rules.

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

B2 Definitions

1. **'Board'** shall mean the executive body appointed as provided for in Rule 5 of the Constitution of National Health Benefits Australia Pty Ltd.

2. **'Dependant Child'** shall mean and include:-

   (i) who is:
      i. aged under 18; or
      ii. a dependent child who is a full-time student; and

   (ii) who is not aged 25 or over; and

   (iii) who does not have a partner.

   (iv) Such other persons approved by the Board as deemed to be entirely dependent on the Policy Holder.

3. **'Spouse / Partner'** means a person who lives with a relevant person in a marital or defacto relationship.

4. **'Family Relationship'** means a relationship between two persons who are not legally married to each other and live together and consider themselves to be a family.

5. **'Single'** means does not have a spouse or partner.

6. **'Policy'** means a health insurance policy taken out by a Policy Holder to the fund.

7. '**Policy Holder**' of a health benefits fund, means a *holder* of a policy that is referable to the fund.

8. '**Holder**' of an insurance policy, means a person who is insured under the policy and who is not a dependent child.

9. **'The Financial Year'** means the period between 1st July and 30th June the following year.

10. **Applicable Benefits Arrangement** means an applicable benefits arrangement within the meaning of the *National Health Act 1953* as in force before 1 April 2007.

11. **Hospital Purchaser - Provider Agreement** means a private health insurance arrangement as described in Schedule 1 of the *Private health Insurance Act 2007* entered into between National Health Benefits Australia Pty Ltd and a Hospital Facility and as amended from time to time.

12. **Medical Purchaser-Provider Agreement** means a private health insurance arrangement as described in Schedule 1 of the *Private Health Insurance Act 2007* entered into between National Health Benefits Australia Pty Ltd and a Medical Practitioner and as amended from time to time.

13. **Pre-Existing Ailment** means an ailment or illness, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the organisation, existed at any time during the six months preceding the day on which the Policy Holder began contributions to the organisation.

14. **Medical Practitioner** means a person as defined in *Health Insurance Act 1973.*

15. **Hospital Facility** means a hospital declared or authorised by the Minister for Health and Ageing as being a hospital under the *Private Health Insurance Act 2007.*

16. **Emergency Benefit** an emergency is a situation where the patient is treated by the medical practitioner within thirty minutes of presentation, and the patient is:

    (i) at risk of serious morbidity or mortality and requiring urgent assessment and resuscitation; or

    (ii) suffering from suspected acute organ or system failure; or

    (iii) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or

    (iv) suffering from a drug overdose, toxic substance or toxin effect; or

    (v) suffering severe pain where the viability or function of a body or organ is suspected to be acutely threatened; or

    (vi) suffering acute significant haemorrhage and requiring urgent assessment and treatment.

17. **Hospital Casemix Protocol** means the Hospital Casemix Protocol as defined in the *Private Health Insurance (Data Provision) rules 2007.*

18. **Episode Duration** in relation to a particular kind of payment made in accordance with an applicable benefits arrangement means the number of days worked out in accordance with the information provided by a hospital facility under the Hospital Casemix Protocol.

19. **Palliative Care** An episode of palliative care occurs when a person's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are

considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

20. **Default Benefit** means the minimum benefit as determined by the Minister for Health that is payable to Policy Holders who are in receipt of treatment for non-emergency conditions in hospital facilities for which no Hospital Purchaser Provider Agreement exists.

21. **Eligible Policy Holder** means a Policy Holder of National Health Benefits Australia Pty Ltd who is treated in a hospital facility which is party to a Hospital Purchaser Provider Agreement.

B3 Other

Not applicable

C MEMBERSHIP

C1 General Conditions of Membership

1. Policy Categories:

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

   (ii) Insured groups for National Health Benefits Australia Pty Ltd shall be:

   (iii) (a) single - only one person

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

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

   (d) family – three or more people (only two of whom are adults, the rest of whom are dependent children)

   (e) family – two or more people (none of whom is an adult, but are dependents of a person who is paying contributions for the policy)

1. Levels of cover
   (i) The insurance policies offered to the insured groups by National Health Benefits Australia Pty Ltd are:
   (a) Hospital Treatment – Covering treatments provided in a recognised hospital, excluding;
   1. Treatment that does not normally require hospital treatment – procedures that do not normally require hospital treatment (Type C Procedures) if no certificate has been given by a medical practitioner stating that the member required hospital treatment;
   2. Treatment provided to a person at an emergency department of a hospital;

3. Treatment provided to a newly-born child whose mother also occupies a bed in the hospital.
4. Treatments that do not have a recognised Medicare benefit schedule number (MBS).

(b) General Treatment – Covering treatments, including hospital substitute and hospital prevention programs, but excluding;
1. Hospital Treatment;
2. Services provided by registered general practitioners and any other services covered by Medicare;
3. Benefits paid in connection with the birth of a baby;
4. Funeral benefits;
5. Disability benefits;
6. Goods or services that are primarily for the purposes of sport, recreation or entertainment other than such treatment which is part of a chronic disease management program or a health management program.

C2 Eligibility for Membership

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

C3 Dependants

1. Dependent children are as defined in section B2.2 of these rules. Dependent children can be covered by any of the family policy options offered by the fund from time to time.

2. Subject to these Fund Rules, a person who ceases to be eligible to be covered as a dependent child of a Policy Holder may become a Policy Holder by choosing a currently available cover and by paying the relevant premium.

3. No additional waiting periods for benefits will apply for such Policy provided that:

    1. The new cover is no higher than the existing cover, and in accordance with S. 78-1 (3) of the *Private Health Insurance Act*.
    2. The person applies for a Policy within two (2) months of ceasing to be a dependent child.

C4 Membership Applications

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

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

3. Once the application to become a Policy Holder has been processed by National Health Benefits Australia Pty Ltd the Policy Holder will receive a new Policy Holder pack that will include Standard Information Statements (SIS). The SIS will also be provided to Policy Holders at least annually and are also available on request.

4. There is no specific requirement for a new Policy Holder to provide proof of their details however, if the Policy Holder changes these details at a later date, an identity check will be undertaken before disclosing any policy information to them in order to comply with the *Privacy Act (1988).*

C5 Duration of Membership

1. The Policy commences on the date the application is lodged with National Health Benefits Australia Pty Ltd or where agreed a date as nominated on the application form.

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

C6 Transfers

1. All health insurance products offered by the fund comply with the Portability Requirements as required under Division 78-1 of the Act. Waiting periods applicable are covered under rule F3.

2. Policy Holders who transfer from another Registered Private Health Insurer within a period of two (2) months from the date to which contributions were paid last, shall be accepted with rights and benefit entitlement not in excess of those pertaining to the policy to which the Policy Holder transfers in this organisation and in accordance with S. 78-1 (3) of the Private Health Insurance Act.

3. On the transfer of a Policy Holder to another Registered Private Health Insurer and upon his/her acceptance of that registered organisation there shall be no further liability on this Fund in respect of such Policy Holder in respect of services incurred after the date of transfer.

4. Where the Policy Holder transfers to another Registered Private Health Insurer a transfer certificate will be provided to the Policy Holder within fourteen days of the cessation of the policy with National Health Benefits Australia Pty Ltd.

5. For those Policy Holders transferring from another Registered Private Health Insurer, National Health Benefits Australia Pty Ltd will require a transfer certificate to be provided by that insurer, otherwise normal waiting periods for that policy will apply.

6. The portability requirements and waiting periods of persons applying for a policy with National Health Benefits Australia Pty Ltd or upgrading from an existing policy are detailed in rules C2.2

C7 Cancellation of Membership

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

2. The period of 30 days during which the Policy Holder may make the determination to cancel their policy will be deemed to be the "cooling off period"

3. A Policy Holder may cancel their Policy entirely

4. A Policy Holder may remove any dependant children from their Policy

5. The Policy Holder or a dependant child aged at least 16 years of age may leave the Policy without the agreement of the Policy Holder, and a dependent child under the age of 16 years of age may leave the Policy with the agreement of the Policy Holder.

6. The actions referred to under clauses C7 3-5 must be authorised in writing and may not have a retrospective effect unless otherwise agreed by National Health Benefits Australia Pty Ltd.

7. Where a Policy has been cancelled National Health Benefits Australia Pty Ltd has the discretion to reinstate the Policy at the request of the Policy Holder with continuity of entitlements, subject to the payment of all relevant premiums.

8. National Health Benefits Australia Pty Ltd has an obligation to refund excess premiums when a Policy ceases only where required to do so by law or where specified in these Fund Rules. The fund may at its discretion refund some or all of the excess premiums after receiving a written request from a former Policy Holder. Such a refund will generally be calculated from the date of receipt of the written request.

C8 Termination of Membership

1. Where in National Health Benefits Australia Pty Ltd's opinion a Policy Holder has obtained an improper advantage for themselves or for any other Policy Holder, National Health Benefits Australia Pty Ltd may terminate the relevant Policy immediately, by written notice, to the Policy Holder.

2. For the purposes of this Fund Rule "improper advantage" means any advantage, monetary or otherwise to which a Policy Holder is not entitled under the Fund Rules.

3. Where a Policy has been terminated under this Fund Rule, National Health Benefits Australia Pty Ltd has discretion to reinstate the Policy at the request of the Policy Holder with continuity of entitlements subject to the payment of all premiums as required under Fund Rule D5.2 (ii).

C9 Temporary Suspension of Membership

1. National Health Benefits Australia Pty Ltd may permit a Policy Holder to temporarily suspend their Policy.

2. A Policy may be suspended for a maximum period of two (2) years while the Policy Holder is absent from Australia due to overseas travel or where the Policy Holder is suffering financial hardship and is in receipt of short term income maintenance paid by Centrelink.

3. A Policy may not be suspended unless the Policy is financial as at the date request for suspension.

4. At the discretion of National Health Benefits Australia Pty Ltd, where a suspension period has been approved a second or follow up period of suspension will not be approved for the same reason where a gap of less than 3 months has applied.

5. A Policy Holder that wishes to suspend their Policy must provide all relevant documentation in support of their application that National Health benefits Australia Pty Ltd may specify.

6. A suspended Policy must be re-activated within one (1) month of the date on which the reason for suspension ceases to apply, or the date on which the maximum suspension period has been reached, whichever is earlier. Where the Policy is re-activated within the required period all previous waiting period served will be deemed to have been served. The only additional waiting periods that can be applied relate specifically to any illness or condition that occurred during the suspension and would normally have been covered by the protocols regarding waiting periods on joining.

7. Where the Policy is not re-activated by the relevant date and has subsequently fallen into arrears, National Health Benefits Australia Pty Ltd may terminate the Policy.

8. All approved periods of suspension will be deemed to satisfy the requirements of the Lifetime Health Cover arrangements in so far that the period of suspension will not be taken into account when calculating any absent days.

9. National Health Benefits Australia Pty Ltd may suspend a Policy Holder's policy where there is reasonable suspicion of inappropriate claims for benefits have been made to provide time for an investigation of such activity to take place. Such suspension shall not be unreasonably undertaken and will not exceed a period of fourteen days.

C10 Other

Not applicable

D CONTRIBUTIONS

D1 Payment of Contributions

1. All Policy Holder contributions are to be paid in advance, at least monthly in accordance with the amounts specified in Schedule K.

2. National Health Benefits Australia Pty Ltd may refuse to accept a payment of premiums or any part thereof that would cause the period of cover to exceed 12 months in advance of the date of payment. Where through any circumstance the period of cover exceeds 12 months from the current date National Health Benefits Australia Pty Ltd may refund the portion of the premiums in excess of 12 months.

3. For those products that cover Ambulance benefits, the contributions shall be reduced for Policy Holders who are prescribed as being exempt from the A.C.T. Ambulance Service Levy or the Health Insurance Levies Act 1982 (NSW). The contributions for such Policy Holders shall be reduced by an amount equal to the prescribed rate of the respective levies.

D2 Contribution Rate Changes

1. National Health Benefits Australia Pty Ltd may change the premiums for any cover in accordance with the requirements set out in the *Private Health Insurance Act 2007* and subject to the Fund Rules D2.2.

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

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

D3 Contribution Discounts

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

D4 Lifetime Health Cover

1. The premiums payable by a Policy Holder will be increased by a nominated percentage where required under the Lifetime Health Cover provisions under the *Private Health Insurance Act 2007.* Any Lifetime Health Cover loading applicable to a Policy Holder shall be removed after ten years of continuous cover. For the purposes of calculating the ten years, permitted days without hospital cover or periods where a person is taken to have hospital cover are disregarded.

2. The amount of contributions payable for hospital cover in respect to an adult who did not have hospital cover on his / her lifetime health cover base day will be increased by an amount worked out as follows:

   (Lifetime health cover age – 30) x 2% x Base rate

   where:

   base rate, for hospital cover, is the amount of premiums that would be payable for the cover if:

   (a)the premiums were not increased under this rule; and

   (b)there was no discount of the kind allowed under subsection 66-5(2) of the Private Health Insurance Act, 2007.

   lifetime health cover age, in relation to an adult who takes out hospital cover after his or her lifetime health cover base day, means the adult's age on the 1 July before the day on which the adult took out the hospital cover.

D5 Arrears in Contributions

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

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

3. A Policy Holder more than two (2) months in arrears with their contributions shall be regarded as un-financial and as having forfeited their right to Policy under the Rules of the Fund. In these circumstances the Policy may be terminated with immediate effect and with written notice to the Policy Holder.

4. National Health Benefits Australia Pty Ltd may review any case and extend the period beyond two (2) months up to twelve (12) months, and/or cancel arrears. The Policy may also be reinstated at the request of the Policy Holder with continuity of entitlements, subject to payment of all relevant premiums and with the authority of National Health Benefits Australia Pty Ltd.

5. Benefits are not payable for treatment provided to a Policy Holder during a period of arrears however this rule may be waived at the discretion of National Health Benefits Australia Pty Ltd.

D6 Other

1. National Health Benefits Australia Pty Ltd may refuse to accept premiums where a third party seeks to pay them on behalf of a Policy Holder where there is evidence of "improper advantage" being gained as a result of such payment.

E BENEFITS

E1 General Conditions

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

2. There shall be established and maintained on and from 1st April, 2007 in the Health Benefits Fund conducted by this organisation a Risk Equalisation account to make payments to the Risk Equalisation Trust Fund as required under section 318-5 of the *Private Health*

E2 Hospital Treatment

1. Policy Holders and their dependant children eligible for benefits shall also be entitled to the Applicable Benefits Arrangements provided by the Hospital Purchaser Provider Agreements. Hospital benefits will only be available for Hospital treatment provided by an authorised Hospital. Hospital and medical benefits will also only be payable for procedures listed in the Medicare Benefits Schedule (MBS).

2. Hospital benefits payable will include:
   i) any part of hospital treatment that is one or more of the following:
      (a) psychiatric care;
      (b) rehabilitation;
      (c) palliative care;
      if the treatment is provided in a hospital and no Medicare benefit is payable for that part of the treatment.

   ii) hospital treatment covered under the policy for which a Medicare benefit is payable.

   iii) if the policy covers hospital-substitute treatment - hospital-substitute treatment covered under the policy for which a Medicare benefit is payable.

   iv) the provision of a prosthesis of a kind listed in the *Private Health Insurance (Prostheses) Rules* in circumstances:
      (a) in which a Medicare benefit is payable; or
      (b) set out in the *Private Health Insurance (Prostheses) Rules* for the purposes of this table item.

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

3. For Hospital Treatment under this rule, benefits are payable to cover all costs that a Policy Holder or eligible dependent child incurs for pharmaceutical benefits dispensed to the Policy Holder or eligible dependent child while they are an admitted patient at the hospital facility with which the Fund has a Hospital Purchaser Provider Agreement.

   (i) The costs that a Policy Holder or eligible dependent child incurs for pharmaceutical benefits are contingent upon whether the Policy Holder or eligible dependent child has reached the Safety Net Threshold under Commonwealth Government Pharmaceutical Benefits Scheme arrangements.

   (ii) A 'pharmaceutical benefit' is defined as any medicine listed in the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing) that is dispensed to the Policy Holder or eligible dependent child.

   (iii) A 'pharmaceutical benefit' referred to in this section of the fund rules must be intrinsic to the hospital treatment provided, clinically indicated and essential for the meeting of satisfactory health outcomes for the Policy Holder or the eligible dependent child. This does not include pharmaceutical benefits that are dispensed where these are not directly related to treatment of the condition or ailment for which they have been admitted.

   (iv) The fund also covers the costs that a Policy Holder incurs for special patient contributions, brand premiums and therapeutic group premiums `listed in the Schedule of Pharmaceutical Benefits that apply to certain pharmaceutical benefits, regardless of whether the Policy Holder or eligible dependent child has reached the Safety Net Threshold under Commonwealth Government Pharmaceutical Benefits Scheme arrangements.

   (v) The fund covers costs for pharmaceutical benefits up to a maximum quantity dispensed. The maximum quantity covered is as listed in the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing) or as recorded on an Authority Prescription Form (and authorised by Medicare Australia where the quantity dispensed is clinically indicated, intrinsic to the hospital treatment provided and essential to the meeting of satisfactory health outcomes for the Policy Holder or the eligible dependent child.

   (vi) Where the cost to a Policy Holder or eligible dependent child for a drug or medicinal preparation listed in the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Ageing) is less than the pharmaceutical benefit co-payment (as determined by the Commonwealth Department of Health and Ageing), these drugs are not considered to be 'pharmaceutical benefits' and are not covered by the fund under this section of the rules.

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

   (i) are rendered to a policy holder or their dependent child while hospital treatment is provided to them in a hospital facility; and

   (ii) are a professional service in respect of which a Medicare benefit is payable;

   Will be at least equal to:

(iii) if the medical expenses incurred in respect of the service are greater than or equal to the Schedule fee (within the meaning of Part II of the Health Insurance Act 1973) in respect of the service—25% of that Schedule fee; or

(iv) if medical expenses incurred in respect of the service are less than that Schedule fee—the amount (if any) by which the medical expenses exceed 75% of that Schedule fee.

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

(v) the service is rendered by or on behalf of a medical practitioner with whom Peoplecare has a Medical Purchaser Provider Agreement that applies to that service; or

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

(vii) the service is rendered by or on behalf of a medical practitioner under the "Access Gap Cover" scheme or any other gap cover scheme approved by the Minister and to which Peoplecare is a party.

5. Hospital benefits payable to nursing home type patients will be paid in accordance with schedule 4 of the *Private Health Insurance (Benefit Requirements) Rules 2007.*

E3 General Treatment

1. The benefits payable in respect to General Treatment and the conditions relevant to those benefits are set out on the Schedules of Contribution Rates, Benefits and Specific Conditions.

2. National Health Benefits Australia Pty Ltd may enter into special arrangements with general treatment providers or groups of providers from time to time to provide benefits for particular general treatment services.

3. General Treatment Benefits can include the provision of goods and services that are intended to manage or prevent a disease, injury or condition that is not hospital treatment.

4. General Treatment does not include:
    1. services for which a Medicare benefit is payable, except as allowable as hospital substitute treatment.
    2. benefits in relation to sport, recreation or entertainment unless they are part of a chronic disease management program or a health management program.

E4 Other

1. National Health Benefits Australia Pty Ltd shall have the power to increase Hospital Treatment and/or Ancillary Treatment benefit payments, make new rules, amend or rescind rules.

2. The Minister for Health and Ageing must approve any premium changes to health insurance policies covered within these rules.

3. National Health Benefits Australia Pty Ltd may pay benefits on an ex-gratia basis, at its discretion.

4. Benefits are not payable for goods or services rendered overseas.

F LIMITATION OF BENEFITS

F1 Co Payments

Not applicable

F2 Excesses

1. An excess is an amount of benefit that a Policy Holder agrees to forego on Hospital Treatment products, in return for a lower premium than would otherwise apply.

    2. The relevant excess is determined each 12 months on a financial year basis.

3. The amount of excess and relevant limits and conditions are as specified in the schedule relevant to the Policy Holders cover.

4. The relevant excess that applies in a public hospital or as a day patient in a private hospital facility is one half of the standard excess that would otherwise apply to a private hospital overnight stay patient.

F3 Waiting Periods

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

   (i) In respect to ambulance services – no waiting period applies

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

   (iii) In respect of any other hospital treatment or general treatment - 2 months, except

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

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

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

      (d) In respect of hearing aids – 24 months

      (e) In respect of hospital treatment or other services related to an obstetric condition - 12 months

      (f) In respect of any ailment, condition or illness, the signs or symptoms of which, existed at any time during the six months preceding the day of joining or upgrading tables – 12 months, except:

         1. psychiatric care – 2 months;

         2. rehabilitation – 2 months;

         3. palliative care – 2 months.

      (g) Persons with an existing hospital Policy that contains restrictions for Psychiatric services and who have served two months waiting period under this restricted cover, may upgrade to full cover for psychiatric services with no waiting periods once per lifetime.

   (iv) for any person who held and was entitled to a treatment under a

      Department of Veteran Affairs Gold Card – no waiting periods

2. For the purposes of the Health Benefits Fund, pre-existing conditions or ailments are as defined in section 75-15 of the *Private Health Insurance Act 2007.*

3. Fund benefits are payable in the case of premature births if the Policy Holder would have completed twelve (12) months on the Policy at the date the birth was due to occur.

4. Dependent children of all Policy Holders who are born after the Policy commences shall be entitled to benefits immediately at birth providing the Policy is at the family rate, as from the date of the birth.

5. National Health Benefits Australia Pty Ltd may at its discretion waive or reduce any Waiting Period.

F4 Exclusions

1. Benefits are not payable when:

   (i) A Policy Holder or dependent child is given treatment without charge.

   (ii) A Policy Holder or dependent child has an entitlement under any Compensation, Third Party or Sports Club Insurance or similar legislation relating thereto.

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

   (iv) The claim benefit is less than $5, although this can be accumulated and submitted with other claims

   (v) A service is provided by a family member, relative, business or practice partner or self

   (vi) Services are provided outside the Commonwealth of Australia, except if the Policy Holder or dependent child is a pre-approved overseas resident

   (vii) The claim is for goods or services that are deemed to be primarily for the purposes of sport, recreation or entertainment

   (viii) The claim is for hospital treatment benefits where the goods or services are for cosmetic purposes and no Medicare benefit is payable

F5 Benefit Limitation Periods

Not Applicable

F6 Restricted Benefits

1. Where general treatment benefits are payable for initial consultations they will be limited to one each financial year, except for physiotherapy services where two initial consultation services will be claimable.

2. Where a Policy Holder, or their dependent child provides a service to a Policy Holder or dependant child, benefits are not payable. In these circumstances a benefit may be payable toward the cost of items provided.

F7 Compensation Damages and Provisional Payment of Claims

1. Fund benefits are not payable under any of the fund hospital policies in respect of expenses incurred for hospital treatment, where a Policy Holder or dependant child has received or established a right to receive a payment by way of compensation or damages (including a payment in settlement of a claim for compensation or damages) under the law that is or was in force in a State or Internal Territory, which, in the opinion of the Fund includes an amount for hospital expenses equivalent to the Fund Benefit that would otherwise be payable.

2. Where the amount of the entitlement for compensation or damages is, in the opinion of the Fund, less than the Fund Benefit that would otherwise be payable under the Health Benefits Fund and/or any hospital policy but for the preceding Rule in respect of the expenses incurred for that hospital treatment, Fund Benefit is payable. The amount of Fund Benefits payable shall not exceed the difference between the amount of Fund Benefit that would otherwise have been payable and the amount of the entitlement for compensation or damages.

3. Where rights have not been determined the Board may, at its discretion and on satisfactory proof of hardship being submitted, make provisional payment of benefits which will be recovered in whole or part when compensation or damages are paid.

F8 Other

Not Applicable

G CLAIMS

G1 General

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

G2 Other

Not Applicable

H1 SCHEDULE HOSPITAL TREATMENT TABLES

H1 1 Table Name or Group of Table Names

1. Private Plus Hospital Table

H1 2 Eligibility

1. In accordance with Rule C2, any natural person whether or not they are eligible for Medicare benefits, is eligible to be a Policy Holder.

H1 3 General Conditions

1. Private Plus Hospital Cover provides comprehensive hospital treatment benefits as a private patient in either a private or public hospital facility. Coverage includes accommodation, theatre fees, medical / medical gap and prostheses benefits for treatment provided while admitted. Services not covered by Medicare are excluded. There are no co-payments or excesses applicable to Private Plus Hospital Cover

H1 4 Hospital Treatment Payments

1. Where a policy holder or their dependant child receives treatment as a private patient in a private hospital or day hospital facility, being patients who are not Nursing Home Type Patients, benefits equivalent to those for public hospital treatment in accordance with the *Private Health Insurance*

(Benefit Requirements) Rules shall be payable, unless the hospital treatment is provided by a hospital that has a Hospital Purchaser Provider Agreement with the fund, in which case the benefits included in the Hospital Purchaser Provider Agreement will be payable.

2. Policy holders and their dependant children eligible for benefits shall also be entitled to the Applicable Benefits Arrangements provided by the Hospital Purchaser Provider Agreements that the fund may have with hospitals from time to time.

H1 5 Medical Services Payments while admitted

1. Medical Services payments while admitted to a hospital will be as provided for in Rule E2.4.

H1 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

1. Pharmaceutical benefits payable while admitted to a hospital will be as provided for in Rule E2.3.

H1 7 Non PBS Pharmaceuticals

1. Pharmaceutical benefits payable while admitted to a hospital will be as provided for in Rule E2.3.

H1 8 Surgically Implanted Prostheses

1. The hospital treatment benefits payable for Surgically Implanted Prostheses and Human Tissue shall be the amount listed in the *Private Health Insurance (Prostheses) Rules* in respect to that item.

H1 9 Nursing Home Type Patients

1. The hospital treatment benefits payable for Nursing Home Type Patients shall be as defined for Nursing Home Type Patients in the *Private Health Insurance (Benefit Requirements) Rules*.

H1 10 Co Payments

Not Applicable

H1 11 Excesses

Not Applicable

H1 12 Benefit Limitation Periods

1. Assisted Reproductive Services: Nil
2. Pregnancy Related Services : Nil
3. Sterilisation and Reversal of Sterilisation: Nil
4. Cardiothoracic: Nil
5. Psychiatric: Nil
6. Rehabilitation: Nil
7. Plastic and Cosmetic Surgery: Nil. Cosmetic surgery is not covered under this Policy.
8. Hip Replacements: Nil
9. Other: Nil

H1 13 Restricted Benefits

1. Assisted Reproductive Services: Nil
2. Pregnancy Related Services: Nil
3. Sterilisation and Reversal of Sterilisation: Nil
4. Cardiothoracic: Nil
5. Psychiatric: Nil
6. Rehabilitation: Nil
7. Plastic and Cosmetic Surgery: Nil. Cosmetic surgery is not covered under this Policy.
8. Hip Replacements: Nil
9. Other: Nil

H1 14 Exclusions

1. Assisted Reproductive Services: Nil
2. Pregnancy Related Services: Nil
3. Sterilisation and Reversal of Sterilisation: Nil
4. Cardiothoracic: Nil
5. Plastic and Cosmetic Surgery: Nil. Cosmetic surgery is not covered under this Policy.
6. Hip Replacements: Nil
7. Other: Services not covered by Medicare are excluded.

H1 15 Loyalty Bonuses

Not Applicable

H1 16 Other Special

Nil

H2 SCHEDULE HOSPITAL TREATMENT TABLES

H2 1 Table Name or Group of Table Names

1. Private Excess 250/500 Hospital Cover

H2 2 Eligibility

1. In accordance with Rule C2, any natural person whether or not they are eligible for Medicare benefits, is eligible to be a Policy Holder.

H2 3 General Conditions

1. Private Excess 250/500 Hospital Cover provides comprehensive hospital treatment benefits as a private patient in either a private or public hospital facility. Coverage includes accommodation, theatre fees, medical / medical-gap and prostheses benefits for treatment provided while admitted. Services not covered by Medicare are excluded. There are no co-payments, but an excess of $250 applies for an overnight hospital admission, or $125 for a day-only procedure. The maximum excess payable on a policy per financial year is $250 for a single policy, and $250 per person covered to a maximum of $500 for a family, single-parent family, or couples policy.
2. Calculation of the excess amount will apply to claims in the order they are processed by the Fund
3. Where a hospitalisation bridges the end of a financial year and part of the next year, the excess amount for the new-year will apply to the first subsequent admission of the new financial year.

H2 4 Hospital Treatment Payments

1. Where a policy holder or their dependant child receives treatment as a private patient in a private hospital or day hospital facility, being patients who are not Nursing Home Type Patients, benefits equivalent to those for public hospital treatment in accordance with the *Private Health Insurance (Benefit Requirements) Rules* shall be payable, unless the hospital treatment is provided by a hospital that has a Hospital Purchaser Provider Agreement with the fund, in which case the benefits included in the Hospital Purchaser Provider Agreement will be payable.

   ii) Policy holders and their dependant children eligible for benefits shall also be entitled to the Applicable Benefits Arrangements provided by the Hospital Purchaser Provider Agreements that the fund may have with hospitals from time to time.

2) Policy Holders and their dependant children eligible for benefits shall also be entitled to the Applicable Benefits Arrangements provided by the Hospital Purchaser - Provider Agreements as current from time to time.

   i) Hospital treatment benefits payable under this policy shall be made after deducting the relevant excess as noted in Rule H2.11.

H2 5 Medical Services Payments while admitted

i) Medical Services payments while admitted to a hospital will be as provided for in Rule E2.4.

H2 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

1. Pharmaceutical benefits payable while admitted to a hospital will be as provided for in Rule E2.3.

H2 7 Non PBS Pharmaceuticals

1. Pharmaceutical benefits payable while admitted to a hospital will be as provided for in Rule E2.3.

H2 8 Surgically Implanted Prostheses

1. The hospital treatment benefits payable for Surgically Implanted Prostheses and Human Tissue shall be the amount listed in the *Private Health Insurance (Prostheses) Rules* in respect to that item.

H2 9 Nursing Home Type Patients

1. The hospital treatment benefits payable for Nursing Home Type Patients shall be as defined for Nursing Home Type Patients in the *Private Health Insurance (Benefit Requirements) Rules*.

H2 10 Co Payments

1. Not Applicable

H2 11 Excesses

1. The maximum excess payable for an overnight hospital admission is two hundred and fifty ($250) dollars for a single person policy, or two hundred and fifty ($250) dollars for each policy holder or dependent child covered under a family, single-parent, or couples policy each financial year. The maximum excess payable for a financial year is two hundred and fifty ($250) dollars for a single policy, or five hundred ($500) dollars for a family, single-parent, or couples policy.

H2 12 Benefit Limitation Periods

1. Assisted Reproductive Services: Nil
2. Pregnancy Related Services : Nil
3. Sterilisation and Reversal of Sterilisation: Nil
4. Cardiothoracic: Nil
5. Psychiatric: Nil
6. Rehabilitation: Nil
7. Plastic and Cosmetic Surgery: Nil. Cosmetic surgery is not covered under this Policy.
8. Hip Replacements: Nil
9. Other: Nil

H2 13 Restricted Benefits

1. Assisted Reproductive Services: Nil
2. Pregnancy Related Services: Nil
3. Sterilisation and Reversal of Sterilisation: Nil
4. Cardiothoracic: Nil
5. Psychiatric: Nil
6. Rehabilitation: Nil
7. Plastic and Cosmetic Surgery: Nil. Cosmetic surgery is not covered under this Policy.
8. Hip Replacements: Nil
9. Other: Nil

H2 14 Exclusions

1. Assisted Reproductive Services: Nil
2. Pregnancy Related Services: Nil
3. Sterilisation and Reversal of Sterilisation: Nil
4. Cardiothoracic: Nil
5. Plastic and Cosmetic Surgery: Nil. Cosmetic surgery is not covered under this Policy.
6. Hip Replacements: Nil
7. Other: Services not covered by Medicare are excluded.

H2 15 Loyalty Bonuses

Not Applicable

H2 16 Other Special

Nil

I1 SCHEDULE GENERAL TREATMENT TABLES

I1 1 Table Name or Group of Table Names

1. Extras Plus Cover

I1 2 Eligibility

1. In accordance with Rule C2, any natural person whether or not they are eligible for Medicare benefits, is eligible to be a Policy Holder. Extras plus cover can only be taken by a Policy Holder in conjunction with an eligible hospital cover. onemedifund does not allow the sale of general treatment tables without taking hospital cover.

I1 3 General Conditions

1. Benefits for Ancillary Plus services will generally be paid on a per person basis with an annual limit for benefits applying each financial year unless otherwise identified in the Fund Rules i.e. the period 1 July to 30 June.

I1 4 Loyalty Bonuses

1. Loyalty bonus benefits apply to Dental and Optical services as defined in Fund Rules I1 5 3 (i) (b), I1 5 3 (ii) (b), I1 5 3 (iii) (b) and I1 6 4 where the Policy for the Ancillary Plus product has been continuous for a period of not less than 5 years.

I1 5 Dental

1. Services performed by Licensed Advanced Dental Technicians and Dental Prosthetists registered under *Health Practitioner Regulation National Law* will attract the same benefits as Registered Dental Practitioners.

2. Benefits will be limited to the cost or the benefit including service type limits where dental restrictions apply, as shown in the National Health Benefits Australia Pty Ltd Schedule of Dental Services applicable at the date of service, whichever is the lesser.

3. Dental Restrictions

i) Crowns/Bridgework

(a) The maximum benefits payable per person per financial year shall be an amount of one thousand ($1,000) dollars.

(b) The maximum benefit payable per person each financial year shall be increased to one thousand five hundred ($1,500) dollars provided that the policy holder has completed five (5) years of continuous cover with the fund in the Ancillary Plus Cover.

ii) Orthodontia

(a) The maximum lifetime benefit payable shall be an amount of two thousand one hundred ($2,100) dollars per person. Benefits are payable at eighty (80%) percent of the cost of each account subject to the limits defined above.

(b) The maximum lifetime benefit payable shall be increased to two thousand six hundred ($2,600) provided that the policy holder has completed five (5) years of continuous cover with the fund in the Ancillary Plus Cover.

iii) Prosthodontics (Dentures)

(a) The maximum benefits payable per person per financial year shall be an amount of six hundred and fifty ($650) dollars.

(b) The maximum benefit payable per person each financial year shall be increased to eight hundred ($800) dollars provided that the policy holder has completed five (5) years of continuous cover with the fund in the Ancillary Plus Cover.

iv) Implants

(a) The maximum benefits payable per person per financial year shall be an amount of one thousand ($1,000) dollars.

I1 6 Optical

1. Spectacles / Spectacle Repairs / Contact Lenses

   When prescribed by a registered Optometrist or a Registered Ophthalmic Surgeon a benefit will be paid equivalent to the cost of spectacles, spectacle repairs and/or contact lenses to a maximum amount of two hundred and seventy five ($275) dollars per person per financial year.

2. The prescription, account and receipt of payment is to be submitted to the Fund on request and benefits shall only be payable where a sight correction or adjustment to the lens is shown on the prescription form.

I1 7 Physiotherapy

1. Physiotherapy - A benefit of sixty ($60) dollars for the Initial Consultation and forty ($40) dollars for each subsequent consultation up to ten (10), fifty ($50) dollars for extended consultation and thirty ($30) dollars for each subsequent consultation from eleven onwards (11+) with a registered Physiotherapist applies.

2. Orthoptics - A benefit of ninety ($90) dollars for the Initial Consultation and seventy five ($75) dollars for each subsequent consultation up to ten (10), and fifty five ($55) dollars for each subsequent consultation from eleven to twenty (11-20) with a registered Orthoptist applies.

3. A maximum of two (2) Physiotherapy Initial Consultation benefits are payable.

4. The maximum benefits for Physiotherapy services shall be five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy.

5. The maximum benefits for Orthoptic services shall be five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy.

6. A maximum overall benefit limit of five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Physiotherapy, Orthoptic and Occupational Therapy sections.

7. A maximum overall benefit limit of five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Physiotherapy, Orthoptic, Occupational Therapy and Hydrotherapy sections.

I1 8 Chiropractic

1. Chiropractic/Osteopathic - A benefit of thirty five ($35) dollars for the Initial Consultation and twenty five ($25) dollars for each subsequent consultation up to ten (10), and fifteen ($15) dollars for each subsequent consultation from eleven to twenty (11-20) with a registered Chiropractor/Osteopath applies.

2. A benefit of 80% of the cost of Chiropractic X-Rays applies with a maximum benefit paid of one hundred and fifteen ($115) dollars per person and two hundred and thirty ($230) dollars per family, single parent or couple policy per financial year.

3. A maximum of one (1) Chiropractic Initial Consultation benefit is payable.

4. The maximum benefits for Chiropractic / Osteopathy services shall be four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy.

5. A maximum overall benefit limit of four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies and Dietetic sections.

6. A maximum overall benefit limit of seven hundred and fifty ($750) dollars per person and one thousand five hundred ($1,500) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies, Dietetic, Chiropractic X Rays and Orthotic sections.

I1 9 Non PBS Pharmaceuticals

1. Policy Holders and their dependant children shall be entitled to receive a benefit for prescriptions other than Pharmaceutical Benefits Scheme (PBS) items, contraceptives, or items normally available without a doctor's prescription.

2. Benefits shall be payable at 100% of the charge after deducting the standard Pharmaceutical Benefits Scheme (PBS) amount from the cost of the prescription with a maximum benefit of sixty-five ($65) dollars per prescription.

3. Benefits in respect of impotence and HRT compounded drugs shall be payable at fifty (50%) percent of the cost to a maximum of three hundred ($300) dollars per person per financial year.

4. The maximum benefits for Non PBS Pharmaceutical items shall be five hundred ($500) dollars per person and one thousand ($1,000) dollars per family, single parent or couple policy.

I1 10 Podiatry

1. A benefit of thirty-five ($35) dollars for the Initial Consultation and twenty-five (25) dollars for each subsequent consultation up to ten (10), and fifteen ($15) dollars for each subsequent consultation from eleven to twenty (11-20) with a registered Podiatrist applies.

2. A maximum of one (1) Podiatry Initial Consultation benefit is payable.

3. The maximum benefits for Podiatry services shall be four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy.

4. A maximum overall benefit limit of four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy per financial year shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies and Dietetic sections.

5. A maximum overall benefit limit of seven hundred and fifty ($750) dollars per person and one thousand five hundred ($1,500) dollars per family, single parent or couple policy per financial year

shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies, Dietetic, Chiropractic X Rays and Orthotic sections.

I1 11 Psychology and Counselling

1. A benefit of eighty (80) percent of the cost for consultations up to a maximum of one hundred and twenty ($120) dollars for the initial assessment and eighty ($80) dollars for each subsequent attendance with a Hypnotherapist registered with the fund or a Psychologist who is operating in private practice and is registered with the appropriate authority in the respective State or Territory.

2. A maximum of one (1) Psychology and Counselling Initial Consultation benefit is payable.

3. The maximum benefits shall be five hundred ($500) dollars per person and six hundred and fifty ($650) dollars per family, single parent or couple policy.

I1 12 Alternative Therapies

1. Benefits for Alternative Therapies are included under Natural Therapies Fund Rule I1 13.

I1 13 Natural Therapies

1. For the purposes of this section, “Natural Therapies” includes :

   - Myotherapy
   - Homeopathy
   - Naturopathy
   - Remedial Therapy & Massage (including Shiatsu)
   - Chinese Herbal Medicine – consultation only
   - Wester Herbal Medicine - consultation only

   The following treatments not claimable under Natural Therapies :

   - Alexander Technique
   - Bowen Therapy
   - Feldenkrais
   - Iridology
   - Kinesiology
   - Pilates
   - Reflexology
   - Rolfing
   - Nutrition
   - Ultralite.

2. A benefit of forty ($40) dollars for the Initial Consultation and thirty ($30) dollars for each subsequent consultation up to ten (10), and twenty ($20) dollars for each subsequent consultation from eleven to twenty (11-20) applies for recognised services with a Natural Therapist that is registered with the fund

3. A maximum of one (1) Natural Therapy Initial Consultation benefit is payable.

4. The maximum benefits for Natural Therapy services shall be four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy.

5. A maximum overall benefit limit of four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies and Dietetic sections.

6. A maximum overall benefit limit of seven hundred and fifty ($750) dollars per person and one thousand five hundred ($1,500) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies, Dietetic, Chiropractic X Rays and Orthotic sections.

I1 14 Speech Therapy

1. A benefit of up to eighty (80%) percent of the cost of each treatment will be paid.

2. The maximum benefits payable for Speech Therapy services shall be eight hundred ($800) dollars per person per financial year.

I1 15 Orthotics

1. A benefit of eighty (80%) percent of the cost for Orthotic services / supplies provided by a registered Podiatrist applies.

2. The benefit payable for Orthotics shall be restricted so that a benefit is payable once each two financial years for policy holders and their dependent children.

3. The maximum benefits each financial year for Orthotic services / supplies shall be two hundred and fifty ($250) dollars per person and five hundred ($500) dollars per family, single parent or couple policy.

4. A maximum overall benefit limit of seven hundred and fifty ($750) dollars per person and one thousand five hundred ($1,500) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies, Dietetic, Chiropractic X Rays and Orthotic sections.

I1 16 Dietetics

1. A benefit of thirty-five ($35) dollars for the Initial Consultation and twenty-five ($25) dollars for each subsequent consultation up to ten (10), and fifteen ($15) dollars for each subsequent consultation from eleven to twenty (11-20) with a registered Dietician applies.

2. A maximum of one (1) Dietetic Initial Consultation benefit is payable.

3. The maximum benefits for Dietetic services shall be four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy.

4. A maximum overall benefit limit of four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies and Dietetic sections.

5. A maximum overall benefit limit of seven hundred and fifty ($750) dollars per person and one thousand five hundred ($1,500) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies, Dietetic, Chiropractic X Rays and Orthotic sections.

I1 17 Occupational Therapy

1. A benefit of sixty ($60) dollars for the Initial Consultation, forty ($40) dollars for each subsequent consultation and thirty ($30) dollars for each subsequent consultation from eleven onwards with a registered Occupational Therapist applies.

2. A maximum of one (1) Occupational Therapy Initial Consultation benefit is payable.

3. The maximum benefits for Occupational Therapy services shall be five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy.

4. A maximum overall benefit limit of five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Physiotherapy, Orthoptic and Occupational Therapy sections.

5. A maximum overall benefit limit of five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Physiotherapy, Orthoptic, Occupational Therapy and Hydrotherapy sections.

I1 18 Naturopathy

1. Benefits for Naturopathy services are included under Natural Therapies Rule I1 13.

I1 19 Acupuncture

1. A benefit of thirty-five ($35) dollars for the Initial Consultation and twenty-five ($25) dollars for each subsequent consultation up to ten (10), and fifteen ($15) dollars for each subsequent consultation from eleven to twenty (11-20) with a registered Acupuncturist applies.

2. A maximum of one (1) Acupuncture Initial Consultation benefit is payable.

3. The maximum benefits for Acupuncture services shall be four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy.

4. A maximum overall benefit limit of four hundred and thirty five ($435) dollars per person and eight hundred and seventy ($870) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies and Dietetic sections.

5. A maximum overall benefit limit of seven hundred and fifty ($750) dollars per person and one thousand five hundred ($1500) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Acupuncture, Osteopathy, Podiatry, Natural Therapies, Dietetic, Chiropractic X Rays and Orthotic sections.

I1 20 Other Therapies

1. Hydrotherapy – A benefit of eighty (80%) percent of the cost up to a maximum of fifteen ($15) dollars per visit shall be payable for Hydrotherapy services provided under the care and direction of a registered Physiotherapist.

2. The maximum benefits for Hydrotherapy services shall be two hundred ($200) dollars per person and four hundred ($400) dollars per family, single parent or couple policy.

3. A maximum overall benefit limit of five hundred and fifty ($550) dollars per person and one thousand one hundred ($1,100) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Physiotherapy, Orthoptic, Occupational Therapy and Hydrotherapy sections.

4. Ante-Post Natal Physiotherapy/Classes - A benefit of eighty (80%) percent shall be payable for Ante-Post Natal Physiotherapy classes with a registered Physiotherapist, an approved Midwife or other approved program up to a maximum of one hundred and fifty ($150) dollars each financial year.

I1 21 Non Surgically Implanted Prostheses and Appliances

1. Benefits shall be paid for surgical equipment and health aids as specified below:

2. The maximum benefits payable per person per financial year shall be based on continuous and completed years on the Ancillary Plus Cover as shown below:

Year 1	$400 payable at fifty (50%) percent of the cost of service
Year 2	$625 payable at fifty (50%) percent of the cost of service
Year 3	$750 payable at sixty (60%) percent of the cost of service

Year 4	$875 payable at seventy (70%) percent of the cost of service
Year 5+	$1000 payable at eighty (80%) percent of the cost of service

3. For specific items as noted below the maximum benefits shall be:

Glucometers	Max $130 and 1 item each 3 financial years
Peakflow meters	Max $ 50 and 1 item each 3 financial years
TENS machines	Max $200 and 1 item each 3 financial years
BP monitors	Max $150 and 1 item each 3 financial years
Nebulisers	Max $160 and 1 item each 3 financial years
CPAP machines	Max $800 and 1 item each 3 financial years
Insulin Pump Consumables	Max $200 and 1 item each financial year
Leg Calipers	Max $200 and 1 item each financial year
Orthopaedic Shoes	Max $200 and 1 item each financial year
Synvisc	Max $355 and 2 courses each financial year
Wigs	Max $200 and 1 item each financial year
Other Equipment	Max $200 each claim
Therapy Appliances	Max $150 each claim

4. “Other Equipment” includes :

- Back braces
- Bath board
- Bed wetting alarm (including rental)
- Breast Prostheses
- Breath-a-tec or Volumatic
- Commode (toilet chair)
- CPAP disposables (replacement only)
- Crutches – hire or purchase
- Diabetic disposables
- Fibreglass cast
- Grab rails
- Incontinence Pads
- Knee braces – only after reconstructive surgery

- Oxygen concentrator disposables (replacement only)
- Over Toilet Aids (commode)
- Pressure garments (Jobst suits)
- Second skin
- Surgical Stockings (surgery, elderly but not for travel)
- Walkers
- Walking Sticks – hire / purchase
- Wheelchair – hire / purchase
- Magnifier – Royal Blind Society

5. Claims for benefits for surgical appliances other than those detailed in this rule would be at the discretion of the Directors.

6. Details of appliances and supporting documents should be submitted with the claim.

I1 22 Hearing Aids

1. A benefit of eighty (80%) percent of the cost up to one thousand five hundred ($1,500) dollars shall be payable per person towards the cost of a hearing aid.

2. The benefits will be restricted to one thousand five hundred ($1,500) dollars each five (5) years per policy holder and each of his/her dependant children.

I1 23 Prevention Health Management

A benefit of one hundred (100%) per cent of the cost of services provided to policy holders and their dependent children will be paid for the following items:

- Approved fitness and exercise classes;
- Membership fees for fitness / sporting activities;
- Equipment and programs used for health improvement/maintenance;
- Stress management;
- Health programs for weight control, quit smoking, managing alcohol, or similar.
- Health assessment or screening services, including blood pressure, cholesterol and blood sugar testing (where not covered by Medicare).

The maximum benefits payable per financial year will be one hundred and fifty dollars ($150) per person to a maximum limit of three hundred dollars ($300) per family, single parent or couple policy, and one hundred and fifty dollars ($150) per single policy.

Benefits shall be payable only where the goods or services are part of a health management program approved by the fund or are rendered on the advice of a health professional approved by the fund and such treatment is intended to prevent or ameliorate a specific health condition or conditions. Goods or services that are primarily for the purpose of sport, recreation or entertainment are not eligible for benefits.

I1 24 Ambulance Transportation

1. Benefits payable are 100% reimbursement of the cost of service, irrespective of distance travelled within the Commonwealth of Australia. There is no annual claim limit on ambulance services and there is no waiting period. No benefit is payable for Ambulance subscriptions or state based ambulance levies or Ambulance costs that are covered under Government legislation or other compensable sources.

2. Full cost of taxi service as arranged by the Fund with the consent of the policy holder for transport to and from hospitals or surgeries for recurring treatment only where an ambulance would normally be used.

I1 25 Accident Cover

Not Applicable

I1 26 Accidental Death Funeral Expenses

1. A benefit of up to one thousand two hundred ($1,200) dollars shall be payable on presentation of a death certificate applicable to a policy holder or one of his/her eligible dependant children up to and including 30 June 2008.

2. From 1 July 2008, this benefit shall cease and no longer be payable

I1 27 Other Special

1. Home Nursing - A benefit of up to eighty (80%) percent of the cost up to a maximum of forty five ($45) dollars for each visit up to a maximum of ninety ($90) dollars in any one day for home nursing visits by a registered nurse approved by the Fund. The maximum benefits shall be one thousand ($1,000) dollars per person per financial year.

2. Midwifery - A benefit of up to eighty (80%) percent of the cost up to a maximum of one thousand one hundred ($1,100) dollars. Where a midwifery benefit is payable the benefit will be deemed to be part of the overall benefit limit applicable to Home Nursing services.

3. Laser Eye Surgery - A benefit of up to eighty (80%) percent of the cost will be paid with a limit of five hundred ($500) dollars per eye each two (2) financial years.

4. Travel Expenses - A benefit of twenty (20) cents per kilometre shall be paid where the policy holder or a dependant child is hospitalised more than two hundred (200) kilometres from the policy holder's home address (four hundred [400] kilometre round trip). The benefit shall be payable once only per admission to hospital and the maximum benefits payable will be one hundred ($100) dollars per single policy and two hundred ($200) dollars per family, single parent or couple policy.

5. Non Smoking Items – A benefit of 100% of the charge after deducting the standard sum of thirty ($30) dollars per claim issued in respect of non-smoking supplies shall be payable up to a maximum of eighty ($80) dollars.

6. Allergy Treatments - A benefit of up to eighty (80%) percent of the cost of Allergy treatments/supplies shall be payable. A maximum benefit of one hundred ($100) dollars shall apply per person per financial year.

I2 SCHEDULE GENERAL TREATMENT TABLES

I2 1 Table Name or Group of Table Names

1. Basic Extras Cover

I2 2 Eligibility

1. In accordance with Rule C2, any natural person whether or not they are eligible for Medicare benefits, is eligible to be a Policy Holder. Extras plus cover can only be taken by a Policy Holder in conjunction with an eligible hospital cover. onemedifund does not allow the sale of general treatment tables without taking hospital cover.

I2 3 General Conditions

1. Benefits for Basic Ancillary services will generally be paid on a per person basis with an annual limit for benefits applying each financial year unless otherwise identified in the Fund Rules i.e. the period 1 July to 30 June.

2. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person shall apply for any combination of services covered under the Chiropractic / Osteopathy, Acupuncture, Natural Therapies and Podiatry sections.

3. A maximum overall benefit limit of seven hundred ($700) dollars per family, single parent or couple policy shall apply for any combination of services covered under the Chiropractic, Osteopathy, Acupuncture, Natural Therapies and Podiatry sections.

I2 4 Loyalty Bonuses

Not Applicable

I2 5 Dental

1. General Dental - includes ADA recognised item numbers for diagnostic, preventative, extractions, oral surgery, restorations and endodontic services. Benefits shall be paid at 75% of the charge for those services.

2. A maximum overall benefit limit of five hundred and fifty ($550) dollars per person shall apply.

3. Dental benefits are payable where the account from the dentist includes ADA recognised item numbers and tooth identification.

I2 6 Optical

1. Spectacles / Spectacle Repairs / Contact Lenses

   When prescribed by a registered Optometrist or a Registered Opthalmic Surgeon a benefit will be paid equivalent to the cost of spectacles, spectacle repairs and/or contact lenses to a maximum amount of one hundred and eighty ($180) dollars per person per financial year.

2. The prescription, account and receipt of payment is to submitted to the Fund and benefits shall only be payable where a sight correction or adjustment to the lens is shown on the prescription form.

I2 7 Physiotherapy

1. A benefit of 75% of the charge for consultations with a registered Physiotherapist will be paid for the policy holders and their dependent children.

2. A maximum overall benefit limit per financial year of three hundred and fifty ($350) dollars per person and seven hundred ($700) dollars per family, single parent or couple policy shall apply.

I2 8 Chiropractic

1. A benefit of 75% of the charge for consultations with a registered Chiropractor (including Chiropractic x-rays) or Osteopath recognised by the fund will be paid for the policy holders and their dependent children.

2. A maximum overall benefit limit per financial year of three hundred and fifty ($350) dollars per person and seven hundred ($700) dollars per family, single parent or couple policy shall apply.

3. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person and seven hundred ($700) dollars per family, single parent or couple policy each financial year shall apply for any combination of services covered under Complementary Therapies including Chiropractic, Acupuncture, Osteopathic, Podiatry, Natural Therapy and Remedial Massage sections.

I2 9 Non PBS Pharmaceuticals

1. Policy holders and their dependent children shall be entitled to receive a benefit for prescriptions other than Pharmaceutical Benefit Scheme items, contraceptives, or items normally available without a doctor's prescription.

2. Benefits shall be payable at 75% of the charge after deducting the standard Pharmaceutical Benefits Scheme (PBS) amount from the cost of the service with a maximum benefit of fifty ($50) dollars per prescription.

3. A maximum overall benefit limit of five hundred ($500) dollars per person and one thousand ($1,000) dollars per family, single parent or couple policy shall apply.

I2 10 Podiatry

1. A benefit of 75% of the charge for consultations with a registered Podiatrist recognised by the fund will be paid.

2. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person and seven hundred ($700) per family, single parent or couple policy shall apply.
3. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person and seven hundred ($700) dollars per family, single parent or couple policy each financial year shall apply for any combination of services covered under Complementary Therapies including Chiropractic, Acupuncture, Osteopathic, Podiatry, Natural Therapy and Remedial Massage sections

I2 11 Psychology and Counselling

Not Applicable

I2 12 Alternative Therapies

1. Benefits for Alternative Therapies are included under Natural Therapies Fund Rule I2 13

I2 13 Natural Therapies

1. For the purposes of this section, “Natural Therapies” includes :

    - Myotherapy
    - Homeopathy
    - Naturopathy
    - Remedial Therapy & Massage (including Shiatsu)
    - Chinese Herbal Medicine – consultation only
    - Wester Herbal Medicine - consultation only

    The following treatments not claimable under Natural Therapies :

    - Alexander Technique
    - Bowen Therapy
    - Feldenkrais
    - Iridology
    - Kinesiology
    - Pilates
    - Reflexology
    - Rolfing
    - Nutrition
    - Ultralite.

2. A benefit of 75% of the charge for consultations with a registered Natural Therapist recognised by the fund will be paid.

3. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person and seven hundred ($700) per family, single parent or couple policy shall apply.

4. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person and seven hundred ($700) dollars per family, single parent or couple policy each financial year shall apply for any combination of services covered under Complementary Therapies including Chiropractic, Acupuncture, Osteopathic, Podiatry, Natural Therapy and Remedial Massage sections.

I2 14 Speech Therapy

1. Not Applicable

I2 15 Orthotics

1. Not Applicable

I2 16 Dietetics

1. Not Applicable

I2 17 Occupational Therapy

1. Not Applicable

I2 18 Naturopathy

1. Benefits for Naturopathy are included under Natural Therapies Fund Rule I2 13

I2 19 Acupuncture

1. A benefit of 75% of the charge for consultations with a registered Acupuncturist recognised by the fund will be paid.

2. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person and seven hundred ($700) per family, single parent or couple policy shall apply.

3. A maximum overall benefit limit of three hundred and fifty ($350) dollars per person and seven hundred ($700) dollars per family, single parent or couple policy each financial year shall apply for any combination of services covered under Complementary Therapies including Chiropractic, Acupuncture, Osteopathic, Podiatry, Natural Therapy and Remedial Massage sections.

I2 20 Other Therapies

Not Applicable

I2 21 Non Surgically Implanted Prostheses and Appliances

Not Applicable

I2 22 Hearing Aids

Not Applicable

I2 23 Prevention Health Management

A benefit of seventy five (75%) per cent of the cost of services provided to policy holders and their dependent children will be paid for the following items:

- Approved fitness and exercise classes;
- Membership fees for fitness / sporting activities;

- Equipment and programs used for health improvement/maintenance;
- Stress management;
- Health programs for weight control, quit smoking, managing alcohol, or similar.
- Health assessment or screening services, including blood pressure, cholesterol and blood sugar testing (where not covered by Medicare).

The maximum benefits payable per financial year will be one hundred dollars ($100) per person to a maximum limit of two hundred dollars ($200) per family, single parent or couple policy, and one hundred and fifty dollars ($100) per single policy.

Benefits shall be payable only where the goods or services are part of a health management program approved by the fund or are rendered on the advice of a health professional approved by the fund and such treatment is intended to prevent or ameliorate a specific health condition or conditions. Goods or services that are primarily for the purpose of sport, recreation or entertainment are not eligible for benefits.

I2 24 Ambulance Transportation

1. Benefits payable are 100% reimbursement of the cost of service, irrespective of distance travelled within the Commonwealth of Australia. There is no annual claim limit on ambulance services and there is no waiting period. No benefit is payable for Ambulance subscriptions or state based ambulance levies or Ambulance costs that are covered under Government legislation or other compensable sources.

I2 25 Accident Cover

Not Applicable

I2 26 Accidental Death Funeral Expenses

Not Applicable

I2 27 Other Special

Not Applicable

I3 SCHEDULE GENERAL TREATMENT TABLES

I3 1 Table Name or Group of Table Names

Ambulance Only

I3 2 Eligibility

In accordance with Rule C2, any natural person whether or not they are eligible for Medicare benefits, is eligible to be a Policy Holder. This product is specifically created for bolt on to Hospital only products.

I3 3 General Conditions

I3 4 Loyalty Bonuses

I3 5 Dental

I3 6 Optical

I3 7 Physiotherapy

I3 8 Chiropractic

I3 9 Non PBS Pharmaceuticals

I3 10 Podiatry

I3 11 Psychology and Counselling

I3 12 Alternative Therapies

I3 13 Natural Therapies

I3 14 Speech Therapy

I3 15 Orthotics

I3 16 Dietetics

I3 17 Occupational Therapy

I3 18 Naturopathy

I3 19 Acupuncture

I3 20 Other Therapies

I3 21 Non Surgically Implanted Prostheses and Appliances

I3 22 Hearing Aids

I3 23 Prevention Health Management

I3 24 Ambulance Transportation

Benefits payable are 100% reimbursement of the cost of service, irrespective of distance travelled within the Commonwealth of Australia. There is no annual claim limit on ambulance services and there is no waiting period. No benefit is payable for Ambulance subscriptions or state based ambulance levies or Ambulance costs that are covered under Government legislation or other compensable sources.

I3 25 Accident Cover

I3 26 Accidental Death Funeral Expenses

I3 27 Other Special

K SCHEDULE CONTRIBUTION RATE

K1 Contribution Rate

The standard gross contribution rates for coverage under each policy from 1st April 2018 are:

PRODUCT NAME	PRODUCT TYPE	INSURED GROUP	HOSPITAL CLASS	GENERAL CLASS	Product Sub Group	Product Price $ per month
Private Plus Hospital No Excess	Combined	Single	Top		A - Only one person	$226.50
Private Plus Hospital No Excess	Combined	Couple	Top		B - 2 adults and no-one else	$453.00
Private Plus Hospital No Excess	Combined	Family	Top		E - 3 or more people, only 2 of whom are adults	$453.00
Private Plus Hospital No Excess	Combined	Single,Parent,Family	Top		D - 2 or more people, only one of whom is an adult	$453.00
Private Plus Hospital 250/500 Excess	Combined	Single	Top		A - Only one person	$206.50
Private Plus Hospital 250/500 Excess	Combined	Couple	Top		B - 2 adults and no-one else	$413.00
Private Plus Hospital 250/500 Excess	Combined	Family	Top		E - 3 or more people, only 2 of whom are adults	$413.00
Private Plus Hospital 250/500 Excess	Combined	Single,Parent,Family	Top		D - 2 or more people, only one of whom is an adult	$413.00
Extras Plus	General	Single		Comprehensive	A - Only one person	$85.53
Extras Plus	General	Couple		Comprehensive	B - 2 adults and no-one else	$171.06
Extras Plus	General	Family		Comprehensive	E - 3 or more people, only 2 of whom are adults	$171.06
Extras Plus	General	Single,Parent,Family		Comprehensive	D - 2 or more people, only one of whom is an adult	$171.06
Basic Extras	General	Single		Budget	A - Only one person	$50.54
Basic Extras	General	Couple		Budget	B - 2 adults and no-one else	$101.08
Basic Extras	General	Family		Budget	E - 3 or more people, only 2 of whom are adults	$101.08
Basic Extras	General	Single,Parent,Family		Budget	D - 2 or more people, only one of whom is an adult	$101.08
Private Plus Hospital No Excess & Extras Plus	Combined	Single	Top	Comprehensive	A - Only one person	$312.03
Private Plus Hospital No Excess & Extras Plus	Combined	Couple	Top	Comprehensive	B - 2 adults and no-one else	$624.06
Private Plus Hospital No Excess & Extras Plus	Combined	Family	Top	Comprehensive	E - 3 or more people, only 2 of whom are adults	$624.06
Private Plus Hospital No Excess & Extras	Combined	Single,Parent,Family	Top	Comprehensive	D - 2 or more people, only one	$624.06

Plus					of whom is an adult	
Private Plus Hospital No Excess & Basic Extras	Combined	Single	Top	Budget	A - Only one person	$277.04
Private Plus Hospital No Excess & Basic Extras	Combined	Couple	Top	Budget	B - 2 adults and no-one else	$554.08
Private Plus Hospital No Excess & Basic Extras	Combined	Family	Top	Budget	E - 3 or more people, only 2 of whom are adults	$554.08
Private Plus Hospital No Excess & Basic Extras	Combined	Single,Parent,Family	Top	Budget	D - 2 or more people, only one of whom is an adult	$554.08
Private Plus Hospital 250/500 Excess & Extras Plus	Combined	Single	Top	Comprehensive	A - Only one person	$292.03
Private Plus Hospital 250/500 Excess & Extras Plus	Combined	Couple	Top	Comprehensive	B - 2 adults and no-one else	$584.06
Private Plus Hospital 250/500 Excess & Extras Plus	Combined	Family	Top	Comprehensive	E - 3 or more people, only 2 of whom are adults	$584.06
Private Plus Hospital 250/500 Excess & Extras Plus	Combined	Single,Parent,Family	Top	Comprehensive	D - 2 or more people, only one of whom is an adult	$584.06
Private Plus Hospital 250/500 Excess & Basic Extras	Combined	Single	Top	Budget	A - Only one person	$257.04
Private Plus Hospital 250/500 Excess & Basic Extras	Combined	Couple	Top	Budget	B - 2 adults and no-one else	$514.08
Private Plus Hospital 250/500 Excess & Basic Extras	Combined	Family	Top	Budget	E - 3 or more people, only 2 of whom are adults	$514.08
Private Plus Hospital 250/500 Excess & Basic Extras	Combined	Single,Parent,Family	Top	Budget	D - 2 or more people, only one of whom is an adult	$514.08

Note 1 – The Contributions Rates shown are those excluding the impacts of the Government Rebate on Private Health Insurance or any effect of Lifetime Health Cover loadings applicable to the Private Plus and Private Plus Excess 250/500 Hospital Covers. A national pricing policy applies in that the contribution rates do not differ by state of residence of the policy holder.

L SCHEDULE OVERSEAS

L1 Overseas

Not Applicable

M SCHEDULE OTHER

M1 Other

Not Applicable