Fund Rules

of nib health funds limited ABN 83 000 124 381 ("nib") which apply to private health insurance policies sold under the 'nib' and 'GU Health' brands

Effective **1 October 2026**

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A INTRODUCTION

A1 Rules Arrangement

These Rules consist of:

(a) the general conditions (A to G); and

(b) the Schedules (I to M).

A2 Health Benefits Fund

A2.1 Purpose of Fund

The Fund relates solely to nib's Health Insurance Business and its health-related businesses from time to time and its purpose is to provide Benefits to all Members in accordance with these Rules and any other purpose permitted by the Private Health Insurance Act, together with any regulations and rules made pursuant to that Act.

A2.2 Purpose of Rules

These Rules set out:

(a) the requirements for all Members;

(b) the rules regarding payment of Benefits by nib; and

(c) the ways in which nib will conduct the Fund and make decisions regarding all Members.

These Rules apply to nib Policies and GU Health Policies unless a Rule specifies that it only applies to nib Policies or GU Health Policies. These Rules do not apply to:

(d) nib Overseas Student Health Cover Products; or

(e) nib Overseas Visitors Health Cover Products or GU Health Overseas Visitors Health Cover Products.

A3 Obligations to Insurer

A3.1 Disclosure of information

A person applying for any Policy and all Members making a Claim must:

(a) provide all information reasonably required by nib in relation to all Policies; and

(b) give full and complete disclosure on all matters required by nib.

A3.2 Policy Holder must update details

All Policy Holders must inform nib as soon as reasonably possible after a change in all Policy details.

A3.3 Consent of All Members

All Policy Holders:

(a) authorise nib to request and receive personal information from a Provider or any other person in respect of a Claim made under all Policies; and

(b) warrant that in relation to all Policies they have obtained the consent of all Members under that Policy to the authority provided by all Policy Holders in Rule A3.3(a).

A4 Governing Principles

If any provision of these Rules is inconsistent with the Private Health Insurance Act, the *National Health Act 1953* (Cth) or the Health Insurance Act it will be read down or severed to the extent necessary to ensure compliance with those Acts.

A5 Use of Funds

A5.1 Income to be credited to the Fund

nib will credit to the Fund all income arising out of the conduct of its private health insurance and health-related business as required under the Private Health Insurance Act.

A5.2 Limitations on drawings on the Fund

nib will only draw on the Fund in a manner which is not prohibited by the Private Health Insurance Act.

A5.3 Management and Control of the Fund

nib will manage the Fund in accordance with the requirements in the Private Health Insurance Act.

A6 Improper Discrimination

In conducting the Fund and making decisions, nib will not engage in Improper Discrimination and will act in a manner which otherwise complies with the Private Health Insurance Act.

A7 Changes to Rules

A7.1 Amendment

nib may amend these Rules in accordance with the Private Health Insurance Act.

A7.2 Notification of Amendment

(a) Subject to Rule A7.2(b) nib will give all Members who are affected by a change to these Rules reasonable notice of any change to the Rules which is or might be detrimental to the interests of all Members;

(b) Notice under Rule A7.2(a) will:

  (i) be in writing addressed to all Policy Holders who are Members under all Policies;

  (ii) be given before the change takes effect; and

  (iii) explain in plain English the details of the Rule change.

(c) nib will also notify all Members of changes to the Rules in any nib publication generally available to all Members, including any necessary amendments to Private Health Information Statements which arise from the change in the Rules, as soon as practicable after the publication or Private Health Information Statement is updated.

A7.3 Availability of Rules

These Rules are available on nib's websites (www.nib.com.au and www.guhealth.com.au) and a copy will be supplied to a Member on request.

A8 Dispute Resolution

A8.1 Complaints to nib

All Members may make a complaint about any aspect of the Fund or Policies to nib at any time. These complaints may be in the form set out in the current nib complaints policy, including orally or in writing. Complaints will be dealt with by nib in accordance with its then current complaints policy and any codes of conduct to which it is a party at that time and otherwise in a timely and responsible manner.

A8.2 Private Health Insurance Ombudsman

(a) The Private Health Insurance Ombudsman is available to assist all Members with problems they have with their private health insurer or any Provider.

(b) Without limiting a Member's other rights, Members may raise any issue regarding their Policies with the Private Health Insurance Ombudsman at any time.

A9 Notices

nib will send all notices and correspondence to the last mailing address or email address supplied by all Policy Holders.

A10 Winding Up

The Fund may be terminated at any time in accordance with the Private Health Insurance Act.

A11 Other

(a) nib may waive the application of particular Rules (as identified in these Rules) in its discretion, provided the waiver does not reduce the relevant Member's entitlement to Benefits or breach the principle of community rating under the Private Health Insurance Act.

(b) The waiver of a particular Rule in a given circumstance does not require nib to waive the application of that Rule in any other circumstance.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

In these Rules:

(a) Words and phrases commencing with capital letters are defined in Rule B2.

(b) Unless otherwise specified, the definitions in Rule B2 apply throughout the Rules.

(c) Where a word or phrase is defined, its other grammatical forms have a corresponding meaning.

(d) Where not defined, words and expressions are intended to have their ordinary meaning.

(e) Headings are for convenience only and do not affect interpretation.

(f) The singular includes the plural and vice versa.

(g) A reference to any legislation or a provision of legislation includes all amendments, consolidations or replacements and all regulations or instruments issued under it.

(h) A reference to the word 'include' in any form is not a word of limitation.

B2 Definitions

"Accident" means:

(a) for nib Policies**,** an event leading to bodily injury caused solely and directly by violent, accidental, external and visible means and resulting solely, directly and independently of any other cause, unless otherwise defined in the Schedules.

(b) for GU Health Policies, an unplanned and unforeseen event, occurring by chance, and leading to bodily injuries caused solely and directly by an external force or object, but excluding any injuries arising out of surgical procedures, unforeseen illness, drug use and aggravation of an underlying condition or injury.

"Accredited Practitioner" for GU Health Policies means a health practitioner who has obtained appropriate qualifications in a profession within the health industry, and has been accredited by an appropriate industry body or association recognised by nib.

"Acupuncture" or **"Acupuncture Service"** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised by nib as an acupuncturist.

"Acute care" for GU Health Policies means the provision of Treatment for an ailment or disability which cannot be provided by a nursing home;

"Acute medical" for the purpose of Patient classification for GU Health Policies means a Patient of a Private Hospital who has had a surgical procedure which is not classified as surgical or advanced surgical and / or who has had a specified illness as determined by nib.

"ADA Schedule" means the Schedule of Dental Services published by the Australian Dental Association Incorporated;

"Addiction Medicine Specialist" means a specialist (within the meaning of the Health Insurance Act) in relation to addiction medicine.

"Admitted Patient" means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment.

"Adult" means:

(a) for nib Policies, a person insured under a Policy who is not a Child Dependant, Non-Classified Dependant, Student Dependant or Non-Student Dependant; or

(b) for GU Health Policies, a person insured under a Policy who is not a Child Dependant, Non-Classified Dependant or Student Dependant.

"Age-Based Discount Policy" means a Policy identified in the relevant Schedule or Product fact-sheet as providing an age-based discount or a retained age-based discount.

"Ambulance Only Cover" means a Product which provides Benefits for ambulance transport.

“Annual Benefits Limits” or **“Annual Limit”** means the maximum amount of Benefits payable for a specific good or service as set out in the Schedules.

“Annual Service Limit” or **“Service Limit”** means the number of times during any Calendar Year or Membership Year that a Benefit will be paid for a particular Service.

“Antenatal Classes” means General Treatment that is:

(a) approved by nib; and

(b) provided during a class predominantly delivering antenatal services by a Provider who is recognised by nib as a midwife or physiotherapist in private practice; or

(c) provided by an online antenatal course Provider recognised by nib.

“Audiology” means General Treatment that is:

(a) Approved by nib; and

(b) Provided during a consultation by a Provider who is recognised by nib as an audiologist.

“Base rate” means the Premium for a Policy, prior to any applicable discount, Lifetime Health Cover loading or Australian Government Rebate.

“Benefit” means an amount of money payable from a Fund to or on behalf of a Member, in respect of approved expenses incurred by a Member for Treatment, in accordance with the Rules.

“Calendar Year” means the period from 1 January to 31 December.

“Child Dependant” means a person who is not a Policy Holder or Partner and who:

(a) is aged under 18 years of age; and

(b) does not have a Partner; and

(c) includes a Foster Child*

*For the purposes of interpreting the term ‘Child Dependant’, the definition of Foster Child (nib) will be applied to nib Policies, and Foster Child (GU) will be applied to GU Health Policies.

“Chiropractic” or **“Chiropractic Service”** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation by a Provider who is recognised by nib as a chiropractor.

“Claim” means a claim for the payment of Benefits which complies with these Rules.

“Claimable Hospital Expenses” means expenses incurred for Hospital Treatment in respect of which a Benefit is payable.

“Clinical Partners Program” means nib’s program under which participating medical specialists have agreed to perform selected surgical procedures for nib Members with no out-of-pocket expenses, subject to the terms of the Member’s policy (including Benefit coverage and waiting periods). "

“Combined Product” means a Product which includes Benefits for fees and charges for Hospital Treatment and General Treatment.

“Compensation” means an entitlement or a potential entitlement to receive compensation or damages (including a payment in settlement of the claim for compensation or damages) in respect of any Condition.

“Complying Health Insurance Product” has the meaning given in the Private Health Insurance Act and includes any Product which is deemed to be a Complying Health Insurance Product in accordance with the Private Health Insurance Act.

“Condition” includes any illness, injury, ailment, disease or disorder for which Treatment is sought.

“Consultant Psychiatrist” means a medical specialist (within the meaning of the Health Insurance Act) in relation to psychiatry.

“Consultation” means an attendance on a Member by a Provider in a manner approved by nib.

“Contribution Group” means a group of Policy Holders approved by nib for the purposes of Rule D1.4.

“Corporate” means a Product type available to a person who is an employee or member of a company, business, association, charity or other organisation that has an agreement with nib.

“Corporate Group” means an employer sponsored group of employee Members, or group of Members belonging to nib or a particular group, which constitutes a Contribution Group.

“Cosmetic Procedure” for GU Health Policies means any surgery, Treatment or other procedures which are not allocated an item within the Medicare Benefits Schedule issued by the Medicare Benefits Advisory Committee.

“Couples Policy” means a Policy comprising the Policy Holder and their Partner.

“Day Service Limit” means the number of times during any one day that a Benefit will be paid for a particular service or associated item number.

“Default Benefits” or **“Restricted Benefits”** means the Benefits payable pursuant to Schedules 1 to 4 of the *Private Health Insurance (Benefit Requirement) Rules 2011* (Cth) for accommodation and any other amount nib is required to pay under the Private Health Insurance Act.

“Dental Practitioner” means a person registered or licensed to practise as a dental practitioner under a law of a State or Territory that provides for the registration or licensing of dental practitioners or dentists.

“Dental Treatment” or **“Dental Service”** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation by a Provider who is recognised by nib as a Dental Practitioner.

“Dependant” means:

(a) for nib Policies, a Child Dependant, Non-Classified Dependant, Student Dependant or Non-Student Dependant of the Policy Holder or their co-insured Partner; and

(b) for GU Health Policies, Child Dependant, Non-Classified Dependant or Student Dependant of the Policy Holder or their co-insured Partner.

“Dietary” or **“Dietetic Services”** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation by a Provider who is recognised by nib as a dietician or a nutritionist.

“Digital Cognitive Behavioural Therapy (CBT)" means General Treatment that is:

(a) a form of psychological treatment delivered utilising structured programs that are internet-based (also known as iCBT) or computerised (also known as CCBT) and

(b) approved by nib; and

(c) provided by a Digital CBT Provider who is recognised by nib.

"Discount Assessment Date" means, in relation to a Policy Holder who is eligible to receive a discount on the Premiums for their nib Policy under rule D3.3, whichever of the following is applicable:

(a) subject to paragraph (c), the date the person became insured under an Age-Based Discount Policy;

(b) if their Age-Based Discount Policy provided a discount under rule D3.3 after the person became insured under that policy - the date the person was first eligible for that discount; or

(c) the person's discount assessment date under their old policy, provided that:

(i) the person transferred to the new policy from their old policy which offered an aged-based discount under the Private Health Insurance Act; and

(ii) continuous Hospital cover was maintained and the new policy is an Age-Based Discount Policy; and

(iii) the person was not a Child Dependant under their old policy.

"Emergency Ambulance Transportation" means:

(a) for nib Policies, ambulance transportation where the ambulance provider describes the transportation as an 'Emergency'. Benefits are not payable for ambulance transportation that is not described by the provider of the services as 'Emergency'; and

(b) for GU Health Policies, emergency ambulance transportation where the account is coded and invoiced as an emergency transportation by a recognised state ambulance authority.

"Emergency hospitalisation" for GU Health Policies means hospitalisation which occurs as a result of a person presenting at a hospital with or at least one of the following conditions or circumstances: significant pain, shock, significant infection, acute trauma, abuse, committable mental illness, significant haemorrhage or threat of haemorrhage, vital sign or mental status change, brought to hospital by police, or brought to hospital by ambulance.

"Employer Funded Plan" means the GU Health Policies for which Premiums are paid fully by the employer of the Policy Holder.

"Essential Medical Care" in respect to travel and accommodation, means where it is necessary for the member to travel in order to receive care or Treatment for a disease, injury illness or condition for which Benefits under the relevant Member's policy are payable. This Benefit excludes travel for routine check-ups, Dental Services, and where the travel is not specifically to manage or prevent a disease, injury illness or condition.

"Excess" means the amount a Policy Holder must pay before a Benefit is paid under a Policy unless otherwise specified in the Schedules.

"Excess Year" for GU Health Policies means the anniversary date from when a member first took out a GU Health Policy with an applicable excess, or changed the excess amount on their GU Health Policy.

"Exercise Physiology" means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised by nib as an exercise physiologist.

"Extended Family Policy" means a Policy with one or more Non-Student Dependants.

"Facility" means a Hospital, or medical facility which substitutes for a Hospital emergency department, excluding General Practitioner clinics.

"Family Groups" means a policy comprising of the Policy Holder and two or more people. For example, a:

(a) Family Policy;

(b) Single Parent Family Policy; or

(c) Extended Family Policy.

"Family Policy" means a Policy comprising the Policy Holder, their Partner and one or more Child Dependants, Non-Classified Dependants and/or Student Dependants.

"Foster Child (nib)" of a Member means, for nib Policies, a foster child registered with nib who is under 21 years of age or is a Student Dependant and who is placed with a person or family to be cared for, usually by local welfare services or by court order, and includes children who are in the care of an extended family member.

"Foster Child (GU)" of a Member means, for GU Health Policies, a foster child registered with nib who is under 21 years of age or is a Student Dependant and who is:

(a) without a Partner;

(b) domiciled with the Member or school, college, university or State ward who has been placed in the care of the Member by court order; and

(c) whose foster parents do not receive an allowance in respect of the child which exceeds the prescribed allowance payable for State wards under the relevant State Act of Parliament.

"Fund" means the health benefits fund established by nib in respect of nib Policies and GU Health Policies.

"GapSure Network" means a program under which participating anaesthetists agree to a reduced or nil out of pocket experience for nib Members for the anaesthetic component of a Hospital admission.

"General Product" means a Product for General Treatment.

"General Treatment" means:

(a) Treatment (including the provision of goods and services) that:

  (i) is intended to manage or prevent a disease, injury or condition; and

  (ii) is not Hospital Treatment; and

(b) any Treatment listed as permissible in the Private Health Insurance (Health Insurance Business) Rules for the purposes of General Treatment; and

(c) despite subsection (a)(ii), General Treatment includes Benefits for Travel and Accommodation relating to Hospital Treatment; and

(d) despite subsections (a), (b) and (c), the following is not General Treatment;

(i) the rendering in Australia of a service for which a Medicare Benefit is payable, unless the Private Health Insurance (Health Insurance Business) Rules provide otherwise;

(ii) any Treatment, listed as not permissible in the Private Health Insurance (Health Insurance Business) Rules for the purposes of General Treatment.

"GU Health Policy" means a health insurance policy issued by nib that is branded as a 'GU Health' health insurance policy except GU Health Overseas Visitors Health Cover.

"Health Insurance Act" means the *Health Insurance Act 1973* (Cth).

"Health Insurance Business" has the meaning given to that term under the Private Health Insurance Act.

"Health Management Services" means, for GU Health Policies, a measure or series of measures undertaken as part of a health management program to ameliorate a specific illness or health condition. The objective is to enable Members to monitor and manage symptoms or signs of illness, manage the impact on lifestyle, emotions and relationships and maintain a positive state of health and wellbeing. The conditions for which approved health management services qualify for Benefits are asthma, cancer, coronary disease, diabetes, mental health, injuries, pregnancy and childbirth, weight management and nutrition. Health Management Services must be intended to have a direct health benefit, and providers are required to meet nib's eligibility criteria to be approved for Benefits.

"Holder" has the meaning given under the Private Health Insurance Act.

"Home Birth" for GU Health Policies means antenatal, delivery and postnatal care rendered by a registered midwife in private practice and may be considered part of an episode of hospitalisation, or hospital-substitute Treatment as outlined in the Schedules.

"Home Support Services and Programs" for GU Health Policies means a program provided by a Provider which supports an approved early discharge from an Acute care Hospital to continue recovery in a home setting.

"Hospital" means a facility for which a declaration under section 121-5(6) of the Private Health Insurance Act is in force.

"Hospital Product" means a Product which includes Benefits for fees and charges for:

(a) some or all Hospital Treatment; and

(b) some or all associated professional services rendered to a Patient receiving Hospital Treatment,

and includes Combined Products.

"Hospital Treatment" means hospital Treatment as defined in section 121-5 of the Private Health Insurance Act.

"Hospital-Substitute Treatments" means General Treatment as defined in section 69-10 of the Private Health Insurance Act.

"**Hypnotherapy Service**" means for GU Health Policies a hypnotherapy service provided by a psychologist registered to provide such services.

"Immunisations" means vaccines that are listed on the National Immunisation Schedule.

"Improper Discrimination" has the meaning given in the Private Health Insurance Act.

"Influenza (flu) Vaccine" means a vaccine that:

(a) is approved by the Therapeutic Goods Administration and entered in the Australia Register of Therapeutic Goods (ARTG) for use in Australia;

(b) is not registered on the Pharmaceutical Benefits Scheme;

(c) is administered via injection to improve the immune response to an influenza (flu) virus;

(d) is supplied and administered by a Provider who is a registered pharmacy in private practice; and

(e) the member is not eligible to claim through the National Immunisation Program.

"Lifestyle Script" in respect to payment of Benefits for health management or chronic disease management programs for GU Health Policies, means a letter from a recognised health professional which recommends that a type of preventative or remedial Treatment be undertaken to manage or prevent the onset of a recognised chronic disease, illness or condition.

"Lifetime Limits" means the maximum amount of Benefits payable for a specific good or service provided to a Member over the lifetime of the Member, as set out in the Schedules.

"Medical Adviser" means a qualified medical practitioner.

"Medical Purchaser-Provider Agreement" means an agreement entered into, between nib and a medical practitioner, as described under section 172-5 of the Private Health Insurance Act and as amended from time to time.

"Medicare Benefits Schedule" means the schedule set by the Commonwealth Government for the purpose of paying Medicare Benefits. **"Medicare Benefits Schedule Fee"** means the amount set under the Medicare Benefits Schedule.

"Medicare Levy Surcharge (MLS)" is a Commonwealth Government initiative to encourage higher income earners to take out Australian health cover. Under Australian taxation law, anyone who holds a Medicare Card or who is entitled to hold a reciprocal Medicare Card and does not have Australian domestic health insurance, may have to pay an additional 1% to 1.5% in tax if their income exceeds the MLS thresholds.

"MediGap Scheme" means nib's schemes to reduce out-of-pocket expenses for Members where general practitioners or specialists charge above the Medicare Benefits Schedule Fee for Hospital Treatment called the 'nib MediGap Scheme' for nib Policies or the 'GU Health Medical Gap Network' for GU Health Policies.

"Member" means any Policy Holder or person (including Adults and Dependants) insured by nib under a Policy.

"Membership Year" means a period of 12 months commencing from the start of a Policy, or from the anniversary of that date.

"Minimum Benefits" means the amount determined by the Minister as described in Rule 4 of the *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth) to be the Minimum Benefit payable under a Hospital Product for a particular Hospital Treatment, being either psychiatric care, rehabilitation or Palliative Care in a Hospital, where no Medicare Benefit is payable for that part of the Treatment.

"Minister" means the Commonwealth Minister or his or her delegate with the powers vested in the Minister by the Private Health Insurance Act.

"Natural Therapies" or **"Therapies"** means General Treatment that is:

(a) not listed as a service in the Private Health Insurance Act for which nib is prohibited from paying Benefits;

(b) approved by nib;

(c) listed as a Natural Therapy or Therapy Treatment in the Schedules; and

(d) provided during a Consultation with a Provider who is recognised by nib as to provide natural therapy Treatment.

"nib" means nib health funds limited (ABN 83 000 124 381).

"nib Agreement Private Hospital" or **"Partner Private Hospital"** means a Hospital with which nib has negotiated a hospital purchaser provider agreement.

"nib Pharmaceutical Schedule" means any list or schedule of pharmaceuticals adopted by nib from time to time for the purpose of determining eligibility for Benefits relating to the supply of Non-PBS Pharmaceuticals.

"nib Policy" means a health insurance policy issued to a Policy Holder by nib, or underwritten by nib, in accordance with these Rules except nib Overseas Student Health Cover, nib Overseas Visitors Health Cover and GU Health Policies.

"nib's First Choice Network" or **"First Choice Network"** means the network of Recognised Providers that have a contracted arrangement with nib to provide Treatment at set or discounted rates.

"Non-Classified Dependant" is a type of Dependant for the purposes of the Private Health Insurance Act, and is a person who is not a Policy Holder or Partner and who:

(a) is aged 18 to 20 (inclusive);

(b) does not have a Partner; and

(c) includes a Foster Child*, legally adopted child or stepchild.

*For the purposes of interpreting the term "Non-Classified Dependant', the definition of Foster Child (nib) will be applied to nib Policies, and Foster Child (GU) will be applied to GU Health Policies.

"Non-First Choice Network" means the Recognised Providers that do not have a contracted arrangement with nib to provide Treatment at set or discounted rates.

"Non-PBS Pharmaceutical" means a pharmaceutical that is not listed on the PBS or is listed on the PBS but is prescribed and dispensed for a purpose outside of the provisions specified by the PBS.

"Non-Student Dependant" for nib Policies is a type of Dependant for the purposes of the Private Health Insurance Act, and is a person who is not a Policy Holder or Partner who:

(a) is aged 21 to 30 (inclusive);

(b) is not receiving full-time education at a school, college or university;

(c) does not have a Partner; and

(d) who the Policy Holder has nominated to stay on the Policy for a fee.

"Nursing Home Type Patient (NHTP)" has the same meaning as in subsection 3(1) of the Health Insurance Act.

“Occupational Therapy” or **“Occupational Therapy Service”** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised by nib to provide occupational therapy Treatment.

“Optical Appliance” or **“Optical Service”** means:

(a) an appliance to correct a sight defect; or

(b) a component of such an appliance,

that has been prescribed during a Consultation with a Provider who is recognised by nib as an Optometrist or an ophthalmologist.

“Optometrist” means a person registered or licensed as an optometrist or optician under relevant State or Territory laws.

“Orthoptics” or **“Eye Therapy”** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised by nib to provide orthoptics Treatment.

“Orthotics” or **“Orthotic Appliance**” means an appliance to correct a deformity that has been prescribed during a Consultation with a Provider who is recognised by nib as a podiatrist, physiotherapist, chiropractor or osteopath.

“Osteopathy” means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation by a Provider who is recognised by nib as an osteopath.

“Partner” means a person who lives with another person in a marital or de-facto relationship.

“Patient” means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment. This definition:

(a) includes a newborn child who:

  (i) occupies a bed in an intensive care unit; or

  (ii) is the second or subsequent child of a multiple birth; and

(b) excludes:

  (i) any other newborn child whose mother also occupies a bed in the Hospital; and

  (ii) a member of the staff of the Hospital who is receiving Treatment in his or her own quarters.

“PBS” means the Pharmaceutical Benefits Scheme.

“**PBS Pharmaceutical”** means a pharmaceutical that is listed on the PBS and prescribed in accordance with the provisions specified by the PBS.

“Pharmaceutical Benefit” means General Treatment provided in the form of the supply of a medicine or drug that is prescribed and dispensed to the Member in accordance with these Rules (including the Schedules to these Rules).

"Physiotherapy" or **"Physiotherapy Service"** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised by nib as a physiotherapist.

"Podiatry" or **"Podiatry Service"** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised by nib as a podiatrist.

"Policy" means an nib Policy or GU Health Policy.

"Policy Anniversary" means each anniversary of the date when the first Premium in a continuous period of Premiums to the Fund is paid by, or on behalf of, the Policy Holder under the Policy in relation to any Hospital Product.

"Policy Category" means the following groups:

(a) only one person (being the Policy Holder) – a Single Policy;

(b) only two persons who are Adults (one being the Policy Holder) – a Couples Policy;

(c) only one Adult (being the Policy Holder) and at least one Non-Classified Dependant, Child Dependant and/or Student Dependant – a Single Parent Family Policy

(d) only one Adult (being the Policy Holder) and any number of Non-Classified Dependants, Child Dependants and/or Student Dependants and at least one Non-Student Dependant – Extended Family Policy.

(e) only two Adults (one being the Policy Holder) and at least one Non-Classified Dependant, Child Dependant and/or Student Dependant – a Family Policy; and

(f) only two Adults (one being the Policy Holder) and any number of Non-Classified Dependants, Child Dependants and/or Student Dependants and at least one Non-Student Dependant – Extended Family Policy.

"Policy Holder" means a person in whose name an application for a Policy with nib has been accepted.

"Pre-Existing Condition" means:

(a) a member who

  (i) has an ailment, illness or condition; and

  (ii) in the opinion of a Medical Advisor appointed by nib, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy.

(b) in forming an opinion for the purposes of paragraph (a)(ii), the Medical Advisor must have regard to any information in relation to the ailment, illness or condition that the medical practitioner who treated the ailment, illness or condition gives him or her.

(c) if:

  (i) nib replaces a Complying Health Insurance Product with another Complying Health Insurance Product; and

  (ii) a person who was insured under a Policy that was in the replaced Product is transferred by nib to a Policy that is in the replacement Product;

the reference in paragraph (a)(ii) to the day on which the person became insured under the policy is taken to be a reference to the day on which the person became insured under the replaced policy.

"Premium" or **"Contribution"** means an amount of money a Policy Holder is required to pay to nib in respect of a specified period of cover for a Product under a Policy.

"Premium Rate" or **"Contribution Rate"** means the rate of Premiums for a Product set out in the Schedules as amended from time to time in accordance with these Rules.

"Previous Cover" means in respect of a Member who transfers to an nib Complying Health Insurance Product from:

(a) another nib Complying Health Insurance Product, which to avoid doubt includes a GU Health Policy;

(b) a Complying Health Insurance Product of another Australian private health insurer;

(c) a health insurance Product issued in New Zealand by a related entity of nib; or

(d) nib Overseas Student Health Cover, nib Overseas Visitors Health Cover, nib Expatriate Health Insurance, GU Health Overseas Visitors Health Cover or in relation to GU Health Policies only, any other policy issued by an international health insurer recognised at the discretion of nib,

the previous health insurance Product in respect of which premiums were paid by or on behalf of the Member.

"Private Health Information Statement" means a statement about a Product under the Private Health Insurance Act.

"Private Health Insurance Act" means the *Private Health Insurance Act 2007* (Cth) and the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) and includes any regulations and rules made pursuant to those Acts.

"Private Hospital" means a facility for which a declaration under section 121-5(6) of the Private Health Insurance Act is in force where the declaration includes a statement in accordance with section 121-5(8) of the Private Health Insurance Act that the hospital is a private hospital.

"Private Hospital Emergency Department" means a facility for which a declaration under section 121-5(6) of the Private Health Insurance Act is in force where the declaration includes a statement in accordance with section 121-5(8) of the Private Health Insurance Act that the hospital is a private hospital and that private hospital includes an accident and emergency department.

"Private Patient" means a Patient electing to Claim under their Policy for Treatment in a Public or Private Hospital.

"Product" means a defined group of Benefits which are payable to a Member, subject to relevant Rules, for approved expenses incurred by a Member as set out in the Schedules and in respect of which Premiums are payable at the Premium Rates.

"Proper Officer" for GU Health Policies means a senior manager of nib authorised to make operational decisions on behalf of nib and in line with these Rules.

"Psychology and Counselling" or **"Clinical Psychology Service"** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised by nib as to provide psychology and counselling Treatment.

"Public Hospital" means a Hospital declared by the Minister as a public hospital.

"Purchaser-Provider Agreement" means a hospital purchaser-provider agreement or a Medical Purchaser-Provider Agreement between nib and any other Provider.

"Recognised Provider" means:

(a) a Hospital; or

(b) a General Treatment providers who in nib's absolute discretion:

(i) meets and continues to satisfy nib's definition of a Recognised Provider as per nib's Provider Terms and Conditions;

(ii) provides a service recognised by nib under General Treatment for Benefits purposes; and

(iii) satisfies any other criteria reasonably required by nib for nib to pay Benefits for General Treatment

"Restricted Services" means services for which Restricted Benefits are payable.

"Rules" means these Fund Rules as altered or varied from time to time, including all schedules to these rules.

"Schedules" means the schedules of Complying Health Insurance Products attached to these Rules.

"Set Benefits" or **"Fixed Amount"** means a fixed dollar amount that nib pays towards an eligible service or Treatment, which may vary depending on your Cover.

"Single Parent Family Policy" means a Policy comprising the Policy Holder and one or more Child Dependants, Non-Classified Dependants and/or Student Dependants.

"Single Policy" means a Policy comprising the Policy Holder only.

"Speech Therapy" or **"Speech Pathology Service"** means General Treatment that is:

(a) approved by nib; and

(b) provided during a Consultation with a Provider who is recognised nib as a speech therapist.

"Student Dependant"

(a) means for nib Policies, a type of Dependant for the purposes of the Private Health Insurance Act, is a person who is not a Policy Holder or Partner and who:

(i) is aged 21 to 30 (inclusive);

(ii) is receiving full-time education at a school, college or university; and

(iii) does not have a Partner.

(b) means for GU Health Policies, a type of Dependant for the purposes of the Private Health Insurance Act, is a person who is not a Policy Holder or Partner and who:

(i) is aged 21 to 24 (inclusive)

(ii) is receiving full-time education at a school, college or university; and

(iii) does not have a Partner.

"Telehealth" means Treatment provided by any form of technology as an alternative to face-to-face consultations, including videoconferencing, internet and telephone, but excluding the use of technology during a face-to-face consultation.

"Transfer Certificate" means a certificate issued by a registered health insurer, in a form approved under the Private Health Insurance Act, detailing full health insurance cover details and claims histories of a person transferring from the fund operated by that insurer.

"Treatment" means:

(a) in respect of Hospital Products: Hospital Treatment and any other item in respect of which Benefits are payable from a Hospital Product; and

(b) in respect of General Products: services and items for General Treatment for which Benefits are payable under these Rules.

"Unfinancial" for GU Health Policies means where the Policy Holder fails to pay in full all Premiums due to be paid on the due date in respect of a GU Health Policy.

"Waiting Period" means a period of time during which a Policy Holder must continuously hold a Policy for a particular Product before a Member under that Policy has an entitlement to receive a Benefit under that Product.

"Weight Management Medication" means a Non-PBS Pharmaceutical that is specified by nib from time to time as a weight management medication in the nib Pharmaceutical Schedule.

C MEMBERSHIP

C1 General Conditions of Membership

C1.1 Applicable Benefits Arrangements

Members who are covered under the same Policy must:

(a) belong to the same Policy Category; and

(b) have the same Product or Products.

C1.2 Policy Categories

Unless otherwise stated in the Product Schedules, a person may be admitted as a Member of one of the Policy Categories in respect of one of the following Products:

(a) any level of Hospital Product set out in Schedule J;

(b) any level of General Product set out in Schedule I;

(c) any fixed combination of a Hospital Product and a General Product set out in Schedules J and I; or

(d) one of the special Combined Products set out in Schedule J.

C2 Eligibility for Membership

C2.1 Generally

Unless otherwise stated in the Product Schedules, a person is eligible to be a Member.

C2.2 Minimum Age

Unless otherwise approved by nib, a person under 16 is not eligible to be a Policy Holder. Should nib approve an application for a person under 16 to become a Policy Holder, that individual may only obtain a Single Policy.

C2.3 Dual Policies

Paragraph (a) applies to nib Policies only:

(a) A person who is a Member under a health insurance Product offered by a private health insurer other than nib is not eligible to contribute to, or Claim under, an equivalent Product offered by nib.

Paragraph (b) applies to GU Health Policies only:

(b) Unless otherwise expressly permitted by the Private Health Insurance Act, a person shall not be admitted as a Policy Holder or Partner, or continue as a Policy Holder or Partner under a GU Health Policy that covers Hospital Treatment if he or she is covered for Hospital Treatment under a policy referrable to another health insurance fund.

C3 Rights of Policy Holders

Paragraph (a) applies to nib Policies only:

(a) The Policy Holder can nominate a person (e.g. a relative) with 'third party authority' by writing or by calling nib. The person with this authority can make enquiries and operate the nib Policy but cannot change existing direct debit arrangements, or cancel the nib Policy unless permitted by the Policy Holder.

Paragraphs (b) and (c) apply to GU Health Policies only:

(b) In relation to a GU Health Policy, a Policy Holder may, through signing the declaration of GU Health Policy on behalf of a Policy Holder:

  (i) nominate a third party to share equivalent levels of access to GU Health Policy information, and may make changes to the GU Health Policy but cannot cancel the GU Health Policy. If the Policy Holder wishes to give this party access to a Partner not named on the GU Health Policy, they must complete a Third Party Access Authority Form;

  (ii) request a statement of claims made by the Policy Holder and/or any Dependants under the GU Health Policy, (unless eligible Dependants have requested that nib not disclose their personal claims history); and

  (iii) may request that their claims history and or any other personal information including address not be disclosed to any person, including the Partner and any other Dependants.

(c) Members aged 16 and over who are named on a GU Health Family Policy, may request that access to details about their Claims against the GU Health Policy be limited, provided this does not conflict with nib's obligations under any law or statute.

C4 Dependants

Paragraphs (a), (b) and (c) apply to nib Policies only:

(a) A person who ceases to be eligible to be a Dependant under a private health insurance policy with a private health insurer other than nib, may join nib without serving any Waiting Periods (other than the balance of the unexpired waiting period for that Benefit under the policy of private health insurance with the other private health insurer) if:

  (i) the Benefits provided under the new Product are no higher than the Benefits provided under the previous cover; and

  (ii) the person applies for a nib Policy within 59 days of ceasing to be a Dependant under a private health insurance policy with another private health insurer.

(b) A Partner will only have authority to make changes to the nib Policy if nominated by the Policy Holder (**Partner Authority**).

(c) Partner Authority can be removed from the Partner by the Policy Holder at any time.

(d) Dependants can only make enquiries about their own Claim entitlements and Claims history.

Paragraphs (e), (f) and (g) apply to GU Health Policies only:

(e) A person who, within the period of two months immediately prior to the date of making an application for a GU Health Policy was a Dependant under a Member's GU Health Family Policy, may take out a GU Health Policy offering equivalent or lower Benefits to that offered under that GU Health Family Policy without being subject to any unexpired Waiting Periods for Benefits payable under the GU Health Policy.

(f) The Policy Holders' Partner (if named on the GU Health Policy) may:

  (i) access the membership information of all people named on the GU Health Policy;

  (ii) make changes to the membership, including correcting information, adding and deleting the rebate, updating cover choices and adding and deleting Dependants;

  (iii) cancel their own membership on the GU Health Policy

  (iv) request contribution records of the GU Health Policy.

(g) A Partner on a GU Health Family Policy may make changes to the GU Health Policy, but may not cancel the GU Health Policy as set out and agreed in the GU Health Policy application.

C5 Membership Applications

C5.1 Form of Application

(a) Applications for Policies will be in the form required by nib from time to time.

(b) Applications for Policies must be accompanied by any proof of details reasonably required by nib from time to time.

C5.2 Payment of Premiums with Application

Paragraph (a) applies to nib Policies only:

(a) An application for a nib Policy will be accepted by nib only where the Premiums for the minimum period relevant to the applicant as specified by nib from time to time have been paid. nib may waive this Rule in its discretion.

Paragraph (b) applies to GU Health Policies only:

(b) Before it may be accepted by nib, each application for a GU Health Policy must be accompanied by the payment of at least one month's Premium unless the applicant intends to contribute through a payroll deduction scheme, or any other payment included in the application or unless otherwise agreed to by nib.

C5.3 Refusal of Applications

(a) Subject to these Rules and the Private Health Insurance Act, nib may in its discretion refuse an application to join nib as a Member.

(b) If nib refuses an application, nib will provide a reason for the refusal to the applicant.

C5.4 Cooling Off Period

(a) A 30 day cooling off period applies to all Policies. Premiums for new Members are fully refundable if they decide to cancel the Policy within the first 30 days of the commencement of the Policy providing no Claims have been made during that time.

(b) Despite rule C5.4(a), where Claims have been made within the first 30 days of the commencement of the Policy, nib may on a case-by-case basis and in its absolute discretion decide to refund all Premiums where the Member agrees to repay an amount equal to all Benefits received under that Policy.

C5.5 Changes to Cover

Paragraph (a) applies to nib Policies only:

(a) Members who have changed their level of cover under a nib Policy can also revert to the Previous Cover within 30 days with no impact on Waiting Periods providing no Claims have been made during that time. If a Claim is made within 30 days the nib Policy can only be cancelled or changed from the day after the date of service of the Claim.

Paragraph (b) applies to GU Health Policies only:

(b) nib may choose to offer full continuity of Benefits where a Member reinstates or takes out a new GU Health Policy with nib following cancellation of their previous policy within 60 days of cancellation.

C6 Duration of Membership

C6.1 Commencement of Policy

Subject to nib’s acceptance of an application for a Policy, a Policy commences on the date on which an application for the relevant Policy is lodged with nib in accordance with Rule C5 or where nib agrees, such other date nominated in the application.

C6.2 Termination of Policy

A Policy terminates:

(a) on the date it is cancelled by a Policy Holder in accordance with Rule C8; or

(b) on the date the Policy is terminated in accordance with Rule C9.

C7 Transfers

C7.1 Transfers from another private health insurer within 59 or 60 days

Where a person who was insured under a Previous Cover transfers to a nib Complying Health Insurance Product with a break in coverage of 59 days for nib Policies or 60 days for GU Health Policies, or less:

(a) nib may apply all relevant Waiting Periods to any Benefits under the new Product that were not provided under the Previous Cover;

(b) where a Benefit payable by nib under the new Product is higher than that payable under the Previous Cover, the lower Benefit will be paid from nib until the required Waiting Period with nib has been served;

(c) nib may apply all relevant Waiting Periods to the unexpired portions of any Waiting Periods not fully served under the Previous Cover; and

(d) where the Excess on the new Product is lower than the Excess on the Previous Cover, the Excess on the Previous Cover will apply until the unexpired Waiting Period has been served.

C7.2 Transfers from another private health insurer outside 59 or 60 days

Where a person who was insured under a Previous Cover transfers to an nib Complying Health Insurance Product with a break in coverage of more than 59 days for nib Policies, or more than 60 days for GU Health Policies, the person will be treated as a new Member to the extent permitted under the Private Health Insurance Act and nib may apply the Waiting Periods in full.

C7.3 Benefits paid under Previous Cover may be taken into account

Where a person who was insured under a Previous Cover transfers to an nib Complying Health Insurance Product with a break in coverage of 59 days or less for nib Policies or 60 days or less for GU Health Policies nib will take into account any Benefits that have been paid in the relevant Calendar Year or Membership Year under the Previous Cover in calculating Annual Benefits Limits and determining the Benefits payable under the new Product for the remainder of that Calendar Year or Membership Year.

Notwithstanding the above, nib does not take into account previous claims when transferring to or from the DentalPass Product.

C7.4 Transfers to another private health insurer

If a Member transfers to a policy of private health insurance with another private health insurer, nib will provide the Member, or another such person as they nominate with a certificate in accordance with the Private Health Insurance Act.

C7.5 Change in Policy Holder

This rule C7.5 applies to GU Health Policies only:

(a) Where a Policy Holder dies, the Member who is registered under the GU Health Policy as the Partner of that Policy Holder, may continue coverage under a GU Health Policy (either at the single or family rate) that the Member is eligible to hold in his or her own name as Policy Holder with full continuity of Benefits, provided all applicable Waiting Periods have been served by the Partner at such time.

(b) If any dispute between a Policy Holder and his/her Partner results in separation or divorce, nib will keep the agreement first made with the Policy Holder upon joining.

C8 Cancellation of Membership

C8.1 General requirements

Paragraph (a) applies to nib Policies only:

(a) Unless otherwise permitted by nib, any cancellation of a Policy:

(i) must be authorised in writing by the Policy Holder;

(ii) may not have retrospective effect; and

(iii) must be in accordance with other arrangements specified by nib.

Paragraph (b) applies to GU Health Policies only:

(b) The Policy Holder may cancel his or her GU Health Policy at any time with prior written notice to, or as otherwise agreed by, nib. The cancellation will take effect on the day such notice is received by nib or such later date as set out in the notice.

C8.2 Circumstances in which a Policy can be cancelled

(a) Subject to Rule C8.1:

(i) a Policy Holder may cancel their Policy entirely;

(ii) a Policy Holder may remove any Members from their Policy;

(iii) any Member aged at least 16 years of age may leave the Policy; and

(iv) a Child Dependant under the age of 16 years may leave the Policy with the agreement of the Policy Holder.

Paragraph (b) applies to GU Health Policies only:

(b) Where a Member's GU Health Policy forms part of their employer's corporate health plan, their employer (or a broker or agent acting on behalf of the employer) may cancel the Member's GU Health Policy.

C8.3 Refund of Premiums

(a) nib may in its discretion refund any Premiums paid beyond the date of cancellation or termination of a Policy when a Policy is cancelled if requested to do so by the Policy Holder in writing.

Paragraph (b) applies to GU Health Policies only:

(b) Where a Member's GU Health Policy is an Employer Funded Plan, any Premiums refunded under rule C8.3(a) will be refunded to the Member's employer.

C9 Termination of Membership

C9.1 Termination Generally

(a) nib may terminate a Policy:

(i) if a Policy Holder is in arrears for more than 2 months in accordance with Rule D5.2;

(ii) if a Policy Holder fails to reactivate the Policy following a suspension in accordance with Rule C10.9; or

(iii) If the Policy is referable to a Closed Product or Closed Policy Category within an Open Product and nib transfers all the Members covered under that Closed Product or Closed Policy Category to an Open Product.

(b) In Rule C9.1(a)(iii):

(i) Closed Product or Closed Policy Category means a Product or Policy Category which is, or will be, no longer open for new Policy Holders to join; and

(ii) Open Product means a Product which any new Policy Holders may join.

(c) nib will provide any Policy Holders subject to a transfer and termination under Rule C9.1(a)(iii) reasonable prior notice of the transfer and termination.

C9.2 Improper advantage or unacceptable behaviour

nib may, by notice in writing to the Policy Holder, terminate a Policy where, in the opinion of nib:

(a) a Member covered by the Policy has obtained or attempted to obtain an advantage, monetary or otherwise, and whether for the Insured Person or for any other person, to which the Insured Person is not entitled under these Rules;

(b) a Member has engaged in inappropriate behaviour including abuse of staff members of nib; or

(c) the Policy is required to be terminated by law, including to comply with any sanction laws with which nib is required to comply.

C10 Temporary Suspension of Membership

C10.1 Right to Suspend

Paragraphs (a) to (c) apply to nib Policies only:

A Policy Holder may apply to suspend their nib Policy after 12 months since commencement of the nib Policy in the following circumstances:

(a) for a minimum of 2 months and a maximum of 2 years where the Policy Holder is overseas;

(b) for a minimum of 2 months and a maximum of 3 months for financial suspension; or

(c) any other circumstances and for the period that nib may approve from time to time.

Paragraphs (d) to (g) apply to GU Health Policies only:

Subject to Rule C10.2, the following eligibility rules apply to an application for suspension of a GU Health Policy:

(d) must be issued under a Hospital Product or Combined Product. General Product-only GU Health Policies shall not be eligible for suspension of membership;

(e) the GU Health Policy must have been active for at least a continuous period of one month prior to the application being made;

(f) the Policy Holder is departing Australia for a temporary period of time or is unable to pay Premiums due to financial hardship;

(g) the suspension period is for a minimum period of one month and no longer than three years (continuous or accumulative) over the lifetime of the GU Health Policy.

C10.2 nib's discretion

nib may accept or refuse an application for suspension of a Policy in its absolute discretion.

C10.3 Premiums must be paid up to date of suspension

This rule C10.3 applies to nib Policies only:

A Policy may not be suspended unless all Premiums have been paid up to the date of the commencement of the suspension.

C10.4 Documentation

A Policy Holder who applies to suspend or reactivate a Policy must provide all relevant documentation in support of their application reasonably required by nib.

C10.5 Effect of suspension

During the suspension of a Policy:

(a) the Policy Holder is not required to pay Premiums in respect of the Policy; and

(b) any Insured Person covered by the Policy is not entitled to payment of Benefits for services provided during the suspension.

C10.6 Effect of Suspension on Waiting Periods

A period during which a Policy is suspended is not included for the purposes of completing any Waiting Periods that are to be served by a Policy Holder before the Policy Holder is eligible to receive Benefits.

C10.7 Date of Suspension

If an application for suspension is accepted by nib, the suspension will take effect from the date on which the application for suspension is lodged with nib or where nib agrees, such other date nominated in the application.

C10.8 Subsequent Suspensions

Paragraphs (a) and (b) applies to nib Policies only:

(a) A Policy Holder who has previously suspended their nib Policy may only apply for a subsequent suspension where 12 months have elapsed since the reactivation of the nib Policy following a previous suspension; and

(b) nib may waive this Rule in its discretion.

Paragraph (c) to (e) apply to GU Health Policies only:

(c) The suspension period must not be longer than three years (continuous or accumulative) over the lifetime of a GU Health Policy; and

(d) A Policy Holder who has previously suspended their GU Health Policy may only apply for a subsequent suspension where 30 days have elapsed since the reactivation of the GU Health Policy following a previous suspension; and

(e) nib may waive this Rule in its discretion.

C10.9 Reactivation of Policy

Paragraph (a) applies to nib Policies only:

(a) Where the relevant reason for suspension ceases to apply, or the maximum period of suspension has been reached and:

(i) the Policy Holder applies to nib to reactivate the nib Policy within one month, the Policy Holder will be given continuity of previous coverage under the nib Policy, although no Member covered by the nib Policy will be entitled to payment of Benefits for services provided during the suspension; or

(ii) the Policy Holder applies to nib to reactivate the nib Policy later than one month, the Policy Holder will be considered a new Member for all purposes and relevant Waiting Periods will apply.

Paragraph (b) applies to GU Health Policies only:

(b) A suspended GU Health Policy resumes at the earlier of:

(i) the day after the last day of the suspension period as approved by nib, provided the Policy Holder contacts nib within 30 days of the last day of the suspension period and requests nib to resume the membership; and

(ii) the day the Policy Holder requests nib to resume the membership,

provided the suspension period is no longer than three years.

(c) Where the Member complies in full with the terms and conditions of the suspension and subject to serving any applicable Waiting Periods, the GU Health Policy shall be deemed to resume with continuity of Benefits at the end of the suspension period.

C11 Other

C11.1 Private Health Information Statements

(a) nib will provide a Private Health Information Statement to the Policy Holder on commencement of a Policy with nib and at least once every 12 months.

(b) nib will maintain and make available Private Health Information Statements in accordance with the requirements of the Private Health Insurance Act.

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Payment of Premiums

All Premiums must be paid in advance. The available payment periods are:

Paragraphs (a) to (c) apply to nib Policies only:

(a) for Ambulance Cover – half yearly and yearly;

(b) for DentalPass – yearly;

(c) for all Products other than Ambulance Cover and DentalPass, unless otherwise permitted by nib:

(i) where Premiums are paid to nib by direct debit from a financial institution account or automatically charged to a credit card –fortnightly, monthly, quarterly, half yearly and yearly; or

(ii) where Premiums are paid to nib by payroll deduction – weekly, fortnightly, monthly, quarterly, half yearly and yearly;

(iii) where Premiums are paid by phone, by mail or at an Australia Post Office – monthly, quarterly, half yearly and yearly.

Paragraph (d) applies to GU Health Policies only:

(d) Unless otherwise specified or agreed by nib, Premiums for GU Health Policies shall be payable monthly (or in monthly multiples) in advance.

D1.2 Advance payments

Paragraph (a) applies to nib Policies only:

(a) Premiums for nib Policies cannot be paid more than 13 months in advance of the date of payment.

Paragraph (b) applies to GU Health Policies only:

(b) nib, at its discretion, may not accept Premiums for GU Health Policies for a period exceeding 24 months from the then current paid-to date of the GU Health Policy.

D1.3 Group deductions

This rule D1.3 applies to GU Health Policies only:

(a) where Premiums are made through a group deduction scheme, Premiums shall be payable at least one week in advance.

(b) Premiums may be paid by a Policy Holder or on behalf of a Policy Holder, through a payroll deduction scheme or Corporate Group arranged by nib or by such other arrangements as are authorised by nib from time to time.

(c) Any amounts tendered as Premiums by a health care provider on behalf of a Member other than the Member's Partner or Child Dependant, shall be returned to that Provider if the Member attempts to claim Benefits in respect of services rendered by the Provider who tendered the Premiums.

(d) The Premium rate for a GU Health Policy offered by nib will be the sum of the Premium rates for the Products that comprise that GU Health Policy.

The half yearly, quarterly, monthly and weekly single Premium rates for a GU Health Policy will be the annual Premium rate for that GU Health Policy divided by 2, 4, 12, and 52 respectively. The half yearly, quarterly and monthly single Premium rates will be rounded to the higher of 50c, 20c and 10c respectively and the weekly rates to the higher 5c. nib is currently undertaking system and process changes in order to align premiums across all payment frequencies.

D1.4 Contribution Groups

(a) nib may in its discretion approve any group of Policy Holders as a Contribution Group.

(b) A Contribution Group may include:

(i) employees of a Corporate Group or a particular enterprise or group of enterprises;

(ii) members of any organisation or membership program; or

(iii) Policy Holders who apply for a Policy during a marketing or advertising promotion conducted by nib.

D2 Contribution Rate Changes

D2.1 nib may change Premium Rates

nib may change the Premium Rates for a Product in accordance with the Private Health Insurance Act.

D2.2 Premium Rate changes as a result of changes to Products

Premium rates may change as a result of:

(a) a change in Premiums in line with the Private Health Insurance Act;

(b) a change in Product;

(c) a change in Excess level;

(d) a change in the State of residence; or

(e) a change in Policy Category.

D2.3 Premium Rate Protection

Subject to changes under Rule D2.2, where Premiums are paid by or on behalf of a Policy Holder in advance, a Premium Rate change that takes effect during the period in which that Policy Holder's Premiums have been paid in advance will not take effect until the Policy Holder's next Premiums fall due.

D3 Contribution Discounts

D3.1 Circumstances in which discount payable

nib may discount a Policy Holder's Premium to any Product as follows:

(a) if the Premium is paid through a direct debit from an account at a bank or other financial institution, or by an automatic charge to a credit card;

(b) if nib is not required to pay a levy in respect of a Product under a State or Territory law; or

(c) if the Policy Holder is a member of a Contribution Group; or

(d) if the Policy is an Age-Based Discount Policy.

D3.2 More than one discount

Subject to compliance with the Private Health Insurance Act and restrictions that nib may impose on combinations of discounts from time to time, a Policy Holder is entitled to multiple discounts.

D3.3 Age-Based Discounts

(a) Subject to rule D3.4, where a Policy Holder holds an Age-Based Discount Policy, nib will apply a discount to the Policy Holder's Premiums under this rule D3.3 for each Adult under the Policy who is aged between 18 and 29 inclusive at their Discount Assessment Date.

(b) A Policy Holder's discount under this rule D3.3 will:

(i) continue to apply until the Policy Holder reaches 41 years of age; and

(ii) reduce at the rate of 2% per year after their 41st birthday until no discount applies.

(c) If there are two Adults eligible for an age-based discount under an Aged-Based Discount Policy, the total discount on their Premiums will be an average of each Adult's discount under this rule D3.3.

(d) The discount applied under this rule D3.3 to the Policy Holder's Premium at their Discount Assessment Date is set out in the table below.

Age at Discount Assessment Date	Percentage of discount
18-25 (inclusive)	10%
26	8%
27	6%
28	4%
29	2%

D3.4 Retained Age-Based Discount Policy

If a Policy Holder or an Adult under their Policy:

(a) held an Age-Based Discount Policy within the meaning of the *Private Health Insurance (Complying Product) Rules 2015* (Cth);

(b) transferred to an Age-Based Discount Policy which is specified as a retained Age-Based Discount Policy in the Schedules; and

(c) maintained continuous cover between the cancellation of their old policy and the commencement of their Age-Based Discount Policy;

nib will apply a discount to the Policy Holder's Age-Based Discount Policy equal to the percentage discount they received under their old policy (subject to rule D3.3(b)).

D4 Lifetime Health Cover

D4.1 Premium increases

Premiums payable by a Policy Holder will be increased by a nominated percentage where required under the Lifetime Health Cover provisions of the Private Health Insurance Act.

D4.2 Information

nib will provide information to Policy Holders when required for Lifetime Health Cover purposes in accordance with the Private Health Insurance Act.

D4.3 Continuous cover

nib will stop increasing the amount of premiums payable by a Policy Holder who has held a Hospital Treatment or combined Hospital and General Treatment policy for a continuous period of 10 years that has only been interrupted by permitted days as specified in the Private Health Insurance Act.

D5 Arrears in Contributions

D5.1 When a Policy is in arrears

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.

D5.2 Termination after 2 months in arrears

(a) A Policy which is in arrears for more than two months will automatically terminate.

(b) nib may waive this Rule in its discretion.

D5.3 Less than 2 months in arrears

(a) Where:

  (i) a Policy is in arrears for less than two months; and

  (ii) the Policy Holder pays the amount in arrears within the two months period,

(b) the Policy Holder will be given continuity of coverage under the Policy, and a Member covered by the Policy will be entitled to payment of Benefits for services provided during the arrears period. For the avoidance of doubt, no Benefits will be paid for services rendered to a Member during the period in which the Policy is in arrears until all Premiums in arrears are paid.

D5.4 Arrears consequences under SplitPay or other co-contribution arrangement

This rule D5.4 applies to GU Health Policies only:

Where Premiums for GU Health Policies are paid in accordance with an arrangement for co-contributions to be made by both the Policy Holder and the employer of the Policy Holder, including under the SplitPay arrangement, then, without limiting Rules D5.2 and D5.3, where the GU Health Policy is in arrears, nib may:

(a) where applicable, downgrade the GU Health Policy to the relevant Employer Funded Plan; or

(b) suspend the GU Health Policy for a period as determined by nib.

E BENEFITS

E1 General Conditions

E1.1 Approved goods and services

Benefits are only payable for goods and services permitted under the Private Health Insurance Act.

E1.2 Treatment by Providers

Benefits are only payable where Treatment is provided by an nib Recognised Provider.

E1.3 Services provided by family members

Benefits are not payable under General Products for services rendered by a Provider to themselves, their spouse, de facto Partner or dependants. Where the service includes an invoiced cost of materials, nib may consider payment of Benefits toward the cost of purchase and supply of those materials.

E1.4 Services provided to family members

Benefits are not payable under General Products for services rendered to a Member by their spouse, de facto Partner or Dependant. Where the services include an invoiced cost of materials, nib may consider payment of Benefits towards the cost of purchase and supply of those materials.

E1.5 False or misleading claims

Benefits are not payable if any application or claim submitted to nib contains false or misleading information.

E2 Hospital Treatment

E2.1 Benefits payable according to Schedules

(a) The Benefits payable for Hospital Treatment and the conditions relevant to those Benefits are set out in Schedules J and K.

(b) References to the clinical categories in Schedule J have the meaning given to them in Schedule 5 of the *Private Health Insurance (Complying Product) Rules 2015* (Cth).

E2.2 Same Day Hospital Patients

Benefits for same day Hospital accommodation are payable only where the Member is an Admitted Patient. Same day Benefits are determined by the patient classifications and guidelines issued by the Minister.

E2.3 Hospital Benefits

(a) Where the level of Benefit payable for a service is Default Benefits, then Benefits for services provided by Hospitals are only payable in relation to Hospital accommodation and are not payable in relation to non-accommodation fees (except as required under the Private Health Insurance Act).

(b) If a service received by a Member is:

(i) rendered by an nib Agreement Private Hospital; and

(ii) the Hospital Purchaser Provider Agreement for the nib Agreement Private Hospital covers the level of Benefits paid for that kind of service;

then the amount of Benefits payable is the amount listed in the Hospital Purchaser Provider Agreement for that kind of service.

(c) If a service is received by a Member from a Private Hospital other than in accordance with paragraph (b) above then the amount of Benefits payable is:

(i) the Minimum Benefits for that service, or such higher amount agreed between nib and the Hospital; and

(ii) any higher amount set out in the Schedules.

(d) If a service received by a Member relates to an overnight stay in a Public Hospital, then the amount of Benefits payable is Default Benefits.

E2.4 Medical Services payments while admitted

(a) If a Member receives an inpatient service from a medical practitioner who has a Medical Purchaser Provider Agreement with nib and the agreement deals with the kind of service rendered to the Member then the Benefit payable is the amount specified in the relevant Medical Purchaser Provider Agreement for that service.

(b) If:

(i) a Member receives an inpatient service from a medical practitioner which is not subject to paragraph (a) above; and

(ii) the medical practitioner has opted to be covered by the nib MediGap Scheme, Clinical Partners Program or GapSure Network in relation to the rendering of that service to that Member;

then the amount of Benefit payable is the amount agreed between nib and the medical practitioner under the nib MediGap Scheme, Clinical Partners Program or GapSure Network for that service.

(c) In any other case, if a Member receives an inpatient service from a medical practitioner, then the Benefit payable is the lower of:

(i) the balance of the medical practitioner's fee for the service, after a payment of Medicare Benefit for the services is received;

(ii) 25% of the Medicare Benefits Schedule Fee for that service; or

(iii) any other amount set out in the Schedules.

E2.5 Surgically Implanted Prostheses

If a Member receives a non-cosmetic surgically implanted prosthesis approved by the Department of Health, Disability and Ageing as part of receiving an inpatient service at a Hospital, then the Benefit for that prosthesis is the lower of:

(a) the cost of the prosthesis; and

(b) the Minimum Benefit for that prosthesis as determined by the Minister.

E2.6 Patient Classifications

(a) Subject to any arrangements set out in a hospital purchaser provider agreement between nib and a nib Agreement Private Hospital, Benefits for accommodation in Private Hospitals are payable according to the classification of the patient as set out in these Rules.

(b) Capitalised terms in rules E2.7 to E2.11 and rule E2.14 have the meaning given to them in the *Private Health Insurance (Benefit Requirements) Rules 2011* (Cth) or Schedule 3 of the *Private Health Insurance (Complying Product) Rules 2015* (Cth), as applicable.

E2.7 Surgical and Advanced Surgical Patients

Subject to these Rules, the Benefits payable for Surgical and Advanced Surgical classifications apply:

(a) from the date of admission, where the operative procedure is performed on the first or second day of admission; or

(b) from the date of the procedure, where the operative procedure is performed on the third day of admission or later.

E2.8 Obstetric Patients

(a) The Obstetric classification applies only where childbirth occurs following the mother's admission to a Hospital.

(b) Where labour resulting in childbirth commenced before admission, the Obstetric classification applies from the date of admission.

(c) Where labour commenced after admission, the Obstetric classification applies from the earliest of:

  (i) the date on which labour commenced, or

  (ii) the date on which an obstetric procedure took place, or

  (iii) any other date that nib may in its absolute discretion specify.

E2.9 Rehabilitation Patients

(a) Benefits for Rehabilitation Patients are payable subject to the following conditions:

  (i) Treatment must be supported by a Rehabilitation Certificate; and

  (ii) a further Rehabilitation Certificate is required:

    (1) for each period specified in any certificate where Treatment as a Rehabilitation Patient beyond 35 days is provided, and

    (2) for any subsequent readmission as a Rehabilitation Patient that does not constitute a Continuous Period of Hospitalisation.

(b) For the purposes of this Rule E2.9, a **"Rehabilitation Certificate"** means a certificate in a form approved by nib and indicates the patient is in need of Rehabilitation Treatment.

E2.10 Psychiatric Patients

(a) Benefits for Psychiatric Patients are payable subject to the following conditions:

  (i) Treatment must be supported by a Psychiatric Care Certificate; and

  (ii) a further Psychiatric Care Certificate is required:

(1) for each period specified in any certificate where Treatment as a Psychiatric Patient beyond 35 days is provided, and

(2) for any subsequent readmission as a Psychiatric Patient that does not constitute a Continuous Period of Hospitalisation.

(b) Psychiatric care Benefits are not payable for any patient under the custodial care of a State or Territory.

(c) For the purposes of this Rule E2.10, a **"Psychiatric Care Certificate"** means a certificate in a form approved by nib and indicates the patient is in need of Hospital Psychiatric Services.

E2.11 Multiple Treatments

Subject to the provisions of the Private Health Insurance Act relating to the payment of Benefits for Associated Treatments for Complications, Associated Unplanned Treatments and common and support Treatments, where a patient undergoes more than one type of Hospital Treatment during a Hospital Admission, nib will only cover accommodation, theatre fees and procedures related to the covered Treatment performed as part of that Admission. If one or some Hospital Treatments are covered as a Restricted Service, nib will pay Restricted Benefits toward any part of the costs associated with that Treatment. If one or some Hospital Treatments are excluded, no Benefits will be paid toward any part of the costs associated with the excluded Treatment.

E2.12 Subsequent Procedures

Where a patient undergoes a subsequent operative procedure during the same period of hospitalisation:

(a) where the procedure results in the patient having a higher classification, the patient's classification increases from the date of the procedure, and

(b) where the procedure would otherwise have resulted in the patient moving to a lower classification, the patient's classification is unchanged until day 15.

E2.13 Continuous Period of Hospitalisation

Where a Patient is discharged, and within 7 days is admitted to the same or a different Hospital, the two admissions are regarded as forming one Continuous Period of Hospitalisation.

E2.14 Medical Purchaser Provider Agreements and Hospital Purchaser Provider Agreements

nib may enter into an agreement with:

(a) a medical practitioner or group of medical practitioners; or

(b) a Hospital or group of Hospitals,

under which any of the following items, or any combination of the following items, are to remain fixed throughout the term of the agreement:

(c) the total charge for any Treatment (excluding paramedical services);

(d) the Benefit payable by nib; and

(e) any out of pocket expenses payable by the Member.

E2.15 Pharmaceuticals provided in Hospitals

(a) Where a Hospital Product includes Benefits for PBS medications the Benefit will meet the full cost of the PBS pharmaceutical if it is directly related to the Treatment for which the Member was admitted.

(b) The full cost referred to in (a) includes the patient co-payment, and any special or patient contribution, brand premium or therapeutic premium otherwise payable by the patient under the PBS; and

(c) Benefits for non-PBS medications supplied to Members are payable in accordance with the agreement with the Hospital if:

    (i) the Benefit is specifically included in the agreement with the Hospital; and

    (ii) the pharmaceutical is directly related to the Treatment for which the Insured person is admitted.

(d) The Benefits described in rule E2.15(a) – (c) are only payable for Pharmaceutical items that are:

    (i) approved by the Therapeutic Goods Administration Council for use in Australia;

    (ii) listed in the Poisons Schedule; and

    (iii) where the item is intrinsic to the patient's episode of care.

E2.16 Accidental Injury Benefit

If a Member is entitled to the Accidental Injury Benefit under a Policy, Benefits are payable under the following conditions:

(a) the Member must present to a medical practitioner (e.g. a general practitioner) or Hospital/Facility within 72 hours of the Accident* (documentation may be required as proof); and

(b) any subsequent Treatment will be covered for the 90 days following the date of the Accident* only; and

(c) all Hospital Treatment must be related to injuries sustained in the Accident* and must be provided in a Hospital (not a doctor's surgery) as an Admitted Patient.

*Relevant definition of 'Accident' will be applied for nib Policies and GU Health Policies.

E2.17 Travel and Accommodation

Where a policy provides Cover for Travel and Accommodation in respect of Hospital Treatment as outlined in Schedule J, and subject to any express conditions contained in Schedule J, Benefits are payable subject to the following conditions:

(a) Travel and Accommodation must be for the purpose of Essential Medical Care;

(b) a Benefit must be payable in respect of the associated Hospital Treatment;

(c) the Member's residential address must be greater than 100-kilometres from the registered address of the Hospital where the Treatment is provided, with the distance and associated Benefit calculated based on the most direct route as determined by nib;

(d) Benefits for travel expenses are payable only in respect of the person receiving Treatment;

(e) For travel benefits to be payable, documentation must be provided confirming the related expenses incurred;

(f) for the person receiving Treatment, Benefits for accommodation are limited to the night before admission and the night of discharge;

(g) for a carer, Benefits for accommodation are limited to the first night of admission, plus the night before admission and the night of discharge;

(h) the accommodation booking must be under the name of the Patient or a carer, unless otherwise approved by nib;

(i) Benefits paid in respect of a carer are paid under the available Benefits of the Member's policy; and

(j) per admission Benefit limits apply, as specified in Schedule J.

For nib Policies:

(a) for accommodation Benefits to be payable, an invoice must be provided confirming accommodation details, date of stay and the amount paid for the stay.

(b) Where no claim is made for accommodation, a Benefit remains payable for travel expenses incurred by the person receiving the Treatment.

(c) For a Benefit to be payable in respect to a carer, the person receiving Treatment must provide confirmation from the admitting doctor that they require a carer to accompany them.

(d) No Benefit is payable for travel expenses incurred by a carer, unless the carer travels separately from the Member who is receiving Treatment.

E2.18 Private Midwifery

For nib Policies, where a policy provides Cover for Private Midwifery in respect of Hospital Treatment as outlined in Schedule J, and subject to any express conditions contained in Schedule J, Benefits are payable subject to the following conditions:

(a) The Benefit is being used towards a registered midwife in private practice present at a Home Birth delivery; and

(b) Valid MBS item numbers are not raised; and

(c) No Benefit has been paid or is payable by Medicare.

(d) If the Member is admitted as a Private Patient, Benefits are payable for Treatment provided by a registered midwife in private practice in an nib Agreement Private Hospital in accordance with Clause E2.4 of the General Conditions.

E2.19 In-Hospital Carer Benefit

For nib Policies, where a policy provides Cover for In-Hospital Carer Benefit in respect of Hospital Treatment as outlined in Schedule J, and subject to any express conditions contained in Schedule J, Benefits are payable subject to the following conditions:

(a) A Benefit is payable under the Member's Policy towards the cost of Hospital accommodation and meals for a Partner, family member or caretaker of the admitted Member; and

(b) The Member is admitted as a Private Patient; and

(c) The Partner, family member or caretaker stays overnight with the Member in onsite Hospital facilities; and

(d) The Partner, family member or caretaker submits an overnight accommodation invoice; and

(e) Benefits for overnight Hospital accommodation are paid before meals; and

(f) Meals are purchased from a Patient meal menu or from the Hospital cafeteria.

E2.20 Private Emergency Department Benefit

For nib Policies, where a Policy provides Cover for a Private Emergency Department Benefit in respect of Hospital Treatment as outlined in Schedule J, and subject to any express conditions contained in Schedule J, Benefits are payable for a Private Emergency Department admission fee subject to the following conditions:

E2.21 The Member attends a Private Hospital Emergency Department and is admitted as an in-patient as a result of their attendance; and

E2.22 The Member pays an admission fee upfront; and

E2.23 The Member provides nib with an invoice detailing the admission fee charged.

Benefits are not payable under the Private Emergency Department Benefit for medical services, diagnostic imaging, pathology services or any other charge incurred.

E2.24 Antenatal Classes in Hospital

For nib Policies, where a policy provides cover for Antenatal Classes in Hospital in respect of Hospital Treatment as outlined in Schedule J, and subject to any express conditions contained in Schedule J, Benefits are payable subject to the following conditions:

(a) The member attends an Antenatal Class performed in Hospital; and

(b) The Hospital is a nib Recognised Provider; and

(c) The member provides nib with an invoice detailing the cost of the class.

E2.25 Miscellaneous

This rule E2.18 applies to GU Health Policies only:

(a) Where a Claim is made for Benefits in respect of a person who has been a Patient in an nib Agreement Private Hospital, then notwithstanding any other provision of these Rules, a fixed daily maximum patient moiety may apply if specified in the Schedules.

(b) nib may, after receiving evidence from the Medical Adviser, exercise a discretion to extend the payment of Hospital Benefits beyond the maximum periods specified in this Rule in individual cases.

(c) Interstate hospitalisation Benefits will be payable in accordance with the Benefits pertaining to the State in which the hospitalisation occurred irrespective of the State in which the Premiums are paid.

E3 General Treatment

E3.1 Benefits for General Treatment

(a) The Benefits payable in respect of General Treatment and the conditions relevant to those Benefits are set out in Schedules I, J and M.

(b) Benefits for General Treatment consultations will only be payable in accordance with the schedules to these General Conditions and on the basis of one consultation per patient, per practitioner, per day provided by a Recognised Provider at the time that person provided the Treatment and:

(i) on premises registered with us, unless we otherwise approve or;

(ii) by way of Telehealth, where provision of the relevant General Treatment has been approved by nib to be provided by way of Telehealth.

(c) Benefits for Dental Services are payable only in respect of approved procedures or services performed by a registered dentist, oral health therapist, dental therapist, dental hygienist or dental prosthetist in private practice or employed by a registered health insurer. Benefits for DentalPass will only be payable when provided by a Dental Practitioner who is an nib Recognised Provider and participating in nib's First Choice Network .

(d) Benefits will only be payable in respect of charges made for services rendered by General Treatment Providers who are recognised by nib. nib may at its discretion require a General Treatment Provider to complete a declaration concerning their private practice status, in the form prescribed by nib from time to time, prior to payment of Benefits.

(e) For all services covered under a General Product, the percentage stated in these Rules is applicable to the receipted cost, which may be limited to a charge recognised by nib.

(f) A GU Health Policy cannot be issued under a General Product only, it must be issued under a Hospital Product or Combined Product as outlined in Schedules J of these Rules.

(g) General Treatment Benefits are not payable:

(i) for services provided as part of Hospital Treatment;

(ii) where Medicare, a Commonwealth Government authority or third party provides a benefit;

(iii) for services delivered as a group class or consultation unless specifically included in the Schedules;

(iv) where a benefit replacement period applies and the Member has already claimed a Benefit in that period; or

(v) for Treatments or healthcare services required under a Member's employment, life insurance or part of a visa or residency application.

(vi) where nib has chosen to cease its recognition of a Recognised Provider for reasons including, but not limited to, where they no longer meet nib's recognition criteria or the agreement governing the relationship between nib and a Recognised Provider comes to an end.

E3.2 Benefits for Ambulance Transportation

(a) Ambulance Benefits are only payable for an ambulance service within Australia that is:

(i) provided by a State or Territory Ambulance Service; and

(ii) not ambulance transport that is excluded pursuant to paragraph (b); and

(iii) defined by the relevant service provider as Emergency Ambulance Transportation.

(b) Ambulance Benefits are not payable for ambulance transport provided where the Members are covered by a State Government ambulance scheme.

(c) Ambulance Benefits cover the charge incurred where an ambulance is called to attend an emergency but on arriving is no longer required.

(d) Benefits are not payable for non-Emergency Ambulance Transportation or Treatment, e.g. transportation to a General Practitioner clinic or from a Hospital to a residence.

(e) Benefits are not payable for ambulance transport between Hospitals unless the transfer is required as a result of the existing Hospital not specialising in the Treatment required.

Paragraph (f) applies to GU Health Policies only:

(f) Ambulance Benefits are not payable for:

(i) transport between Hospitals (unless classified as Emergency Ambulance Transportation and not covered by a Hospital) or required after discharge from a Hospital;

(ii) transport from a Member's home, nursing home or Hospital for ongoing medical Treatment (including chemotherapy and dialysis) unless certified as medically-necessary and the Member has full ambulance cover; or

(iii) ambulance subscriptions.

E4 Hospital-Substitute Treatment

Paragraph (a) applies to nib Policies only:

(a) Unless stated otherwise in Schedule J, and to the extent permitted by the Private Health Insurance Act, Benefits for Hospital-Substitute Treatment are payable:

(i) in accordance with the Benefits payable for included services as specified in Schedule J; and

(ii) when approved by nib.

Paragraphs (b) applies to GU Health Policies only:

(b) To the extent permitted by the Private Health Insurance Act, Benefits for Hospital-Substitute Treatment are payable for selected Products as specified in Schedule J.

E5 Other

E5.1 Ex Gratia Payments

nib may pay Benefits on an ex gratia basis at its discretion.

E5.2 Treatment Outside Australia

(a) No Benefits are payable for Treatment (including goods) provided to a member from outside Australia.

(b) No Benefits are payable for Treatment (including goods) provided to a member while the member is outside of Australia.

F LIMITATION OF BENEFITS

F1 Co Payments

The amount of and conditions regarding co-payments are set out in the Schedules.

F2 Excesses

F2.1 Generally

(a) An Excess is the amount of a Benefit that a Policy Holder agrees to pay towards Claimable Hospital Expenses in return for a lower Premium Rate than would otherwise apply to the Product.

(b) If an Excess applies to a Policy and unless otherwise specified in the Schedules, the Excess is only payable if a Member covered by the Policy claims a Benefit for the Claimable Hospital Expense.

(c) The amount of the Excess and relevant limits and conditions which apply to each Product are specified in the Schedule relevant to that Product.

F3 Waiting Periods

F3.1 Independence of Waiting Periods

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

F3.2 Waiver of Waiting Periods

(a) nib may, to the extent permitted by the Private Health Insurance Act, waive or reduce any one or more Waiting Period in its discretion.

(b) A waiver of a Waiting Period has no effect on any other Waiting Period, any Excess or any other Rule applicable to the same service.

(c) The commencement date of any waiver of a Waiting Period shall be determined by nib.

F3.3 Waiting Periods – Hospital Products

(a) The following Waiting Periods apply to Benefits payable under Hospital Products for the services shown (where relevant to the Member's Product):

(i) Ambulance transportation: 1 day

(ii) Accidental Injury Benefit: 1 day

(iii) Other services, except those listed below: 2 months for nib Policies

(iv) rehabilitation or palliative care (whether or not a Pre-Existing Condition): 2 months

(v) In relation to psychiatric Treatment (whether or not a Pre-Existing Condition): 2 months*

(vi) Pre-Existing Conditions: 12 months

(vii) Obstetric conditions: 12 months

(viii) Private Midwifery: 12 months for nib Policies

*The Mental Health Waiver allows Members to upgrade their Hospital cover and waive the standard 2 month Waiting Period to access full Benefits for Psychiatric Treatment. The Mental Health Waiver is only available to Members who have held Hospital cover for at least the previous 2 months, have not previously used their waiver with nib or any other fund, have been admitted to a Hospital and is under the care of an Addiction Medicine Specialist or Consultant Psychiatrist. Members who have held Hospital cover for less than 2 months may elect to serve a

reduced Waiting Period of 2 months minus the length of time that the Member held Hospital cover. This Waiver or reduction can only be accessed once in a Member's lifetime.

Members who are eligible to receive the Mental Health Waiver may backdate their cover change to access full Benefits beginning on their date of admission, provided they contact nib on or before the fifth business day after their date of admission.

(b) Immediate cover is provided under a Policy for newborns if an Adult under the Policy notifies nib of the birth and requests the newborn become a Member under the Policy:

(i) within 2 months after the newborn's birth, where the parent/guardian upgrades from an existing Single or Couples Policy;

(ii) if the newborn is to be added to a Family Policy or a Single Parent Family Policy that was active at the newborn's date of birth:

(1) for nib Policies, within 24 months after the newborn's birth; or

(2) for GU Health Policies, within 12 months after the newborn's birth,

(c) Immediate cover means:

(i) for nib Policies, that the newborn is eligible for the level of cover that applied to the longest serving parent at the newborn's date of birth, subject to any unexpired Waiting Periods not served by that parent; and

(ii) for GU Health Policies, that the newborn is eligible for the level of cover that applied to the longest serving parent at the newborn's date of birth and will not have to serve any Waiting Periods.

(d) Where nib is advised within these periods, the newborn will be added from their date of birth. If nib is notified of the newborn's birth after these periods, normal Waiting Periods apply.

F3.4 Pre-Existing Conditions

nib may refuse to pay or reduce Benefits in respect of a Pre-Existing Condition that is the subject of Treatment within the first 12 months of a Policy of any Product.

F3.5 Waiting Periods – Ancillary Products

Paragraph (a) applies to nib Policies only:

(a) Unless otherwise specified in Schedules I or J, the following Waiting Periods apply to Benefits under General Products for General Treatment shown below (where relevant to the Member's Product):

No.	Item	Waiting period
(i)	Ambulance transportation	1 day
(ii)	All services and items except those listed below	2 months
(iii)	Optical appliances and repairs	6 months
(iv)	Healthier Lifestyle	6 months
(v)	Removal of wisdom teeth and oral surgery	12 months

No.	Item	Waiting period
(vi)	Periodontic surgical, root therapy & endodontic services by a dentist not registered as a specialist	12 months
(vii)	Dentures, denture maintenance/repairs & other prosthodontic services	12 months
(viii)	Dental specialty services, dental prosthetic services, inlays, onlays, facings, orthodontia, periodontia, endodontia & oral surgery	12 months
(ix)	Non-specialty orthodontia	12 months
(x)	Midwifery services	12 months
(xi)	Health aids	12 months
(xii)	Hearing aids / Speech processors	36 months

Paragraphs (b), (c) and (d) apply to GU Health Policies only:

12 month Waiting Periods

(b) Where a GU Health Policy offers Benefits for the services listed below (subject to any conditions noted hereunder and in the relevant Schedules), there shall be a 12 month Waiting Period from the commencement date of coverage under the GU Health Policy or date of transfer from another registered health insurer in respect of the Member for:

(i) Major Dental Services (including Crowns and Bridge, Prosthodontic and Orthodontic Dental Services, Periodontia and Endodontia);

(ii) Artificial Aids and Appliances (including Asthma Pumps/Nebulisers, Blood Glucose Monitors T.E.N.S. pain management machines, C.P.A.P. airway pumps etc);

(iii) Hearing Aids;

(iv) Non-Surgical Prosthesis;

(v) Surgically implanted Prosthesis;

(vi) Pregnancy, pregnancy and birth related services; and

(vii) Elective cosmetic or reconstructive surgery.

6 month Waiting Periods

(c) Where a Policy offers Benefits for the services listed below (subject to any conditions noted hereunder and in the relevant Schedules), there shall be a 6 month Waiting Period from the commencement date of coverage under the Policy or date of transfer from another registered health insurer in respect of the Member for:

(i) Health Management Services; and

(ii) Optical for selected Products specified in the Schedules.

2 month Waiting Periods

(d) For selected Products specified in the Schedules a 2 month Waiting Period applies to General Treatment services.

F3.6 Payment of Benefits

Benefits are only payable for Treatment provided after the expiration of the relevant Waiting Period.

F3.7 No Waiting Period applies to Gold Card Holders

Where a Member joins within 2 months of ceasing entitlements to a Gold Card under the *Veterans' Entitlements Act 1986* (Cth), that Member will not be subject to any Waiting Periods as described in this Rule F3 in respect of Hospital or General Treatment.

F4 Exclusions

F4.1 Exclusions – All Products

No Benefits are payable for services excluded from a Product.

(a) Unless expressly provided for in these Rules and subject to nib's obligation to pay Benefits under the Private Health Insurance Act, Benefits are not payable under Products:

(i) for Claims which relate to services rendered while a Policy is in arrears or while the Policy is suspended;

(ii) for Claims which relate to Treatment or goods rendered outside Australia;

(iii) where the Member is entitled or may be entitled to Compensation or any amounts because the Member is covered by workers compensation, public liability insurance, general insurance or other health insurance;

(iv) for Claims which relate to Treatment rendered by a provider who is not approved as a Provider by nib;

(v) for pharmaceuticals that are available under the PBS and are provided to Members upon being discharged from a Hospital, or for pharmaceuticals that are available under the PBS which are not directly associated or essential to the Member's admission to a Hospital;

(vi) where an application form or a claim form submitted to nib contains false, or misleading information;

(vii) for services rendered in a nursing home;

(viii) where moneys are payable from another source;

(ix) where the Treatment is otherwise excluded by the operation of a Rule;

(x) for luxury room charges;

(xi) for personal in-hospital expenses such as pay TV, internet, non-local phone calls, newspapers, broader fees, meals for visitors and any other personal expenses charged to Members;

(xii) for respite care where a Member is deemed a Nursing Home Type Patient (except where a Benefit is payable as listed under the Private Health Insurance Act);

(xiii) for special nursing, including where a Member's private nurse is not employed by a Hospital;

(xiv) for experimental and/or Treatment not covered by Medicare;

(xv) the gap on Commonwealth Government approved prostheses; or

(xvi) for Treatment in a Hospital where a Member is not an Admitted Patient, including hospital emergency departments, outpatient consultations in a doctor's room or consultations with a nurse.

Paragraph (b) applies to nib Policies only:

(b) Unless expressly provided for in these Rules and subject to nib's obligation to pay Benefits under the Private Health Insurance Act, Benefits are not payable under Products for:

(i) oral contraceptives;

(ii) private room accommodation for a same day procedure;

(iii) take home items;

(iv) autologous blood collection and storage; or

(v) procedures normally performed in a doctors' surgery.

Paragraphs (c) and (d) apply to GU Health Policies only:

(c) Unless expressly provided for in these Rules and subject to nib's obligation to pay Benefits under the Private Health Insurance Act, Benefits are not payable under Products for:

(i) admission or booking fees charged by the Hospital or specialist;

(ii) medical fees for Treatment not listed under the Medicare Benefits Schedule, except for Psychiatric Treatment, rehabilitation and palliative care;

(iii) circumstances where a Member chooses their own allied health provider (such as a chiropractor, dietician or psychologist) rather than the Hospital's practitioner for services that form part of their Hospital Treatment; or

(iv) storage and transportation of eggs and similar in vitro fertilisation expenses.

(d) Notwithstanding any other provision of these Rules or subject to nib's obligation to pay Benefits under the Private Health Insurance Act, nib shall have no liability in respect of a Member.

(i) for any Claim in respect of services or Treatment rendered on or after the date on which a membership became Unfinancial;

(ii) for any Claim in respect of services or Treatment rendered to a Member as a Patient of a Hospital associated with the Department of Defence Industry or Veterans Affairs, or by any practitioner acting on behalf of any Naval, Military, Veterans Affairs or Air Service Authority, unless the Patient is a civilian and not entitled to Treatment without charge;

(iii) for any Claim for General Treatment Benefits in respect of services rendered at a recognised Public Hospital by one of its salaried employees, where such employee has established a practice within or directly associated with that Hospital and raises charges in his own name;

(iv) for any Claim in excess of fees charged or where no charge is made;

(v) for any claim where a service was rendered outside of Australia;

(vi) for any Claim in respect of services or Treatment rendered that primarily takes the form of sport, recreation or entertainment;

(vii) for any Claim where the service is not considered Health Insurance Business as prescribed under the Private Health Insurance Act; and

(viii) where a Member has:

(1) failed to make full and complete disclosure as to all matters relied upon in support of, or relevant to, a claim for Benefits; or

(2) provided in support of any Claim for Benefits information which is false, inaccurate or misleading, whether or not such information is contained in a claim form, given orally or provided in any other manner whatsoever; or

(3) failed to provide such information or medical evidence in respect of a claim as may be required by the Proper Officer; or

(4) failed to provide a signed authority authorising the obtaining of medical evidence concerning the Member from a medical or para-medical practitioner of the Member as required by the Proper Officer.

F5 Restricted Benefits

(a) The services for which Restricted Benefits are payable are set out in the Schedules.

F6 Compensation Damages and Provisional Payment of Claims

This rule F6 applies to nib Policies only:

F6.1 Interpretation

In this section:

(a) A reference to a claim (other than a Claim for Benefits) includes a reference to a demand or action;

(b) A reference to an injury includes a Condition (including an ailment or injury) for which Benefits would or may otherwise be payable by nib for expenses incurred in its Treatment; and

(c) A reference to a Member receiving Compensation includes:

(i) Compensation paid to another person at the direction of the Member; and

(ii) Compensation paid to another Member on the same Policy in connection with an injury suffered by the Member.

F6.2 Insured Person's Obligations if entitled to Compensation

Subject to the following, a Member who has, or may have, a right to receive Compensation in relation to an injury, must:

(a) inform nib as soon as the Member knows or suspects that such a right exists;

(b) inform nib of any decision of the Member to claim for Compensation;

(c) include in any claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable;

(d) take all reasonable steps to pursue the claim for Compensation to nib's reasonable satisfaction;

(e) keep nib informed of and updated as to the progress of the claim for Compensation;

(f) inform nib immediately upon the determination or settlement of the claim for Compensation; and

(g) repay nib any Benefits paid in respect of the injury.

F6.3 Entitlement to Benefits

Subject to these Rules, Benefits are not payable for expenses incurred (including after the Insured Person has received any Compensation) in relation to an injury where the Member has received, or may be entitled to receive, Compensation in respect of that injury.

F6.4 nib's rights to withhold payment of Benefits

Where nib reasonably forms the view that a Member has or may have a right to make a claim for Compensation in respect of an injury, but that right has not been established, nib may withhold payment of Benefits for expenses incurred in relation to that injury.

F6.5 Provisional payment of Benefits

(a) Where a claim for Compensation in respect of an injury is in the process of being made, or has been made and remains unfinalised, nib may in its absolute discretion make a provisional payment of Benefits in respect of expenses incurred in relation to the injury.

(b) In exercising its discretion, nib may consider factors such as unemployment or financial hardship or any other factors that it considers relevant.

F6.6 Payment of Benefits

nib may, in its absolute discretion, pay Benefits where:

(a) expenses have been incurred as a result of:

  (i) a complication arising from an injury that was the subject of a claim for Compensation; or

  (ii) the provision of service or item for Treatment of an injury that was the subject of a claim for Compensation; and

(b) that claim has been the subject of a determination or settlement; and

(c) there is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

F7 Compensation Damages and Provisional Payment of Claims

This rule F7 applies to GU Health Policies only:

Benefits are not payable in respect of a service that has been rendered to a Member if the expenses in respect of that service were incurred by the employer of that Member or if the Member to whom that service was rendered, obtained that service in connection with, or in conjunction with, employment or application for employment or an industrial undertaking or profession or a life insurance examination or the like.

Benefits are not payable in respect of services provided to a Member as a result of an Accident for which there has been established the right of recourse to receive compensation which includes an amount equivalent to the Benefit. When a Benefit has been paid and the Member subsequently obtains compensation equivalent to the whole or part of that Benefit, nib has the right of recovery.

F7.1 Where Benefits shall not be payable

Benefits shall not be payable for a claim in respect of expenses incurred for any condition, illness or injury:

(a) where a Member has made any claim or application or instituted any proceedings under any law of the Commonwealth, any State or internal Territory seeking damages or Compensation in respect of that condition, illness or injury; or

(b) where a Member has sustained such condition, illness or injury in circumstances where the Member is in the opinion of the Proper Officer entitled to make a claim or application or institute proceedings under any law of the Commonwealth, any State or internal Territory seeking damages or Compensation in respect of that condition, illness or injury; or

(c) where the Member has received in respect of that condition, illness or injury any payment of any Compensation or damages pursuant to any judgment, award, settlement or agreement whether or not any such judgment, award, settlement or agreement excludes or purports to exclude expenses in respect of any Benefits which may be provided under these Rules.

F7.2 Where Benefits may be available

Where the amount of entitlement of a Member for Compensation or damages is in the opinion of nib less than the Benefits which would otherwise be payable under these Rules, nib may in its absolute discretion determine to pay Benefits for the Member concerned in such amount as nib may decide, but not in any event exceeding the difference between the amount of the Benefits otherwise payable and the amount of the entitlement for Compensation, damages or settlement.

F7.3 Irrevocable Authority

Where nib is of the opinion that a condition, illness or injury is one which may give rise to a claim for Compensation or damages, or where Benefits have been paid which relate to such a claim, nib at its absolute discretion may require that before payment or further payment of Benefits is made, the Member in respect of whom the Benefits are otherwise payable shall sign an irrevocable undertaking and authority in favour of nib, in a form acceptable to nib, pursuant to which the Member undertakes to make such a claim for Compensation or damages and to include in any such claim all Hospital, paramedical and related expenses in respect of which Benefits otherwise are or may be payable by nib, not to withdraw the claim for such expenses, to prosecute the claim with all diligence, to disclose to nib and its legal advisers all matters relevant to the prosecution of the said claim and to notify nib forthwith upon payment of the claim or any part thereof and directs that from the proceeds of any such claim there is first deducted and paid to nib by way of reimbursement, an amount equal to the amount of Benefits paid by nib in respect of such condition, illness or injury.

F7.4 Establishing Member's right

Where in respect of a Claim for Benefits it appears to nib that a Member may be entitled to receive a payment by way of Compensation or damages but the Member has not established his or her right to that payment, Benefits are not payable. The Member shall be required to establish his or her right to receive payment by way of Compensation or damages before the claim may be considered by nib. Should it be established that the Member has no right to payment by way of Compensation or damages, then the relevant Benefits shall be payable.

Where a Member establishes his or her right to a payment by way of Compensation or damages and accepts a settlement, whether or not such settlement is later approved by a duly constituted Court or Tribunal, and where the terms of such settlement specify that the sum of money paid under the

settlement does not relate to expenses past or future in respect of which Benefits from nib are otherwise payable, or where the Member abandons or compromises any part of the claim so that such expenses are excluded, then Benefits are not payable.

G CLAIMS

G1 General

G1.1 Requirements for Claims

(a) Claims for Benefits must:

(i) be made in a manner approved by nib; and

(ii) be supported by Provider invoices and/or receipts on the Provider's letterhead or showing the Provider's official stamp, and showing the following information:

(1) the Provider's name, provider number and address;

(2) the Patient's full name and address;

(3) the date of service;

(4) the description of the service;

(5) the amount(s) charged for the service in Australian Dollars ($AUD);

(6) that the amount(s) charged for the service have been paid in full; and

(7) any other information that nib may reasonably request.

G1.2 Claims become property of nib

This rule G1.2 applies to nib Policies only:

Unless otherwise agreed by nib, all documents submitted in connection with a Claim become the property of nib.

G1.3 Time limit on Claims

(a) Benefits are not payable where a Claim is lodged more than 2 years after the date on which the service is provided (except as required under the Private Health Insurance Act).

(b) nib may waive this rule in its discretion.

G2 Other

G2.1 Agents

nib may authorise a Member to delegate to another person the right to Claim or assign Benefits to which the Member may be entitled.

G2.2 Method of Payment of Benefits

nib may pay Benefits by electronic funds transfer to a bank account with an Australian recognised banking provider in accordance with arrangements it determines from time to time.

G2.3 Recovery of Benefits

nib may recover any Benefit paid to a Member (including their agents, executors, administrators, and assigns) or to a Provider on their behalf, where nib notifies the Member of the error within 24 months of the date of payment, and the Benefit was paid as a result of any of the following:

(a) Incorrect information supplied on the Member's application form, claiming form or any other official nib form;

(b) Incorrect information supplied or claimed by a Provider;

(c) The provision of clinically unnecessary or excessive Treatment;

(d) Incorrect information regarding a claim that is identified by nib;

(e) An error of an administrative or clerical nature;

(f) Any mistake of fact or of law or of mixed fact or law;

(g) An error of omission or calculation.

Without limiting any other rights or remedies available, nib may offset and deduct any amount recoverable under this Rule from any monies otherwise payable to the Member, either now or in the future.