nib health funds limited
ABN 83 000 124 381

Fund Rules

General Conditions
1 March 2017

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A Introduction

A1 Rules Arrangement

These Rules consist of:
(1) the General Conditions (A to G); and
(2) the Schedules (H to M).

A2 Health Benefits Fund

A2.1 Purpose of Fund

The Fund relates solely to nib's private health insurance business and its health-related businesses from time to time and its purpose is to provide Benefits to all Insured Persons in accordance with these Rules and any other purpose permitted by the *Private Health Insurance Act 2007 (Cth),* 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 Insured Persons;
(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 Insured Persons.

Unless specified, these Rules do not apply to:
(a) nib Overseas Student Health Cover products; or
(b) nib Overseas Visitors Health Cover products.

A3 Obligations to Insurer

A3.1 Disclosure of Information

A person applying for all Policy and all Insured Persons 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 Insured Persons

All Policy Holders:
(a) authorises 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) warrants that in relation to all Policies s/he has obtained the consent of all Insured Persons 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 it will be read down or severed to the extent necessary to ensure compliance with the Private Health Insurance Act.

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 Fund

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

A6 No 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 Insured Persons 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 Insured Persons;

(b) Notice under Rule 7.2(a) will:

(i) be in writing addressed to all Policy Holders who are Insured Persons 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 Insured Persons of changes to the Rules in any nib publication generally available to all Insured Persons, including any necessary amendments to Standard Information Statements which arise from the change in the Rules, as soon as practicable after the publication or Standard Information Statement is updated.

A7.3 Availability of Rules

These Rules are available at any nib retail centre and all Insured Persons may read them there on request.

A8 Dispute Resolution

A8.1 Complaints to nib

All Insured Persons may make a complaint about any aspect of all Policies to nib at any time. These complaints may be addressed in writing to the Company Secretary. Complaints will be dealt with by nib in accordance with its then current internal dispute resolution policy and any codes of conduct to which it is a party at that time.

A8.2 Private Health Insurance Ombudsman

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

(b) Without limiting an Insured Person's other rights, all Insured Persons may raise any issue regarding all Policies with the Private Health Insurance Ombudsman at any time.

A9 Notices

nib will send all notices and correspondence to the last address, fax number 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 Insured Person'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 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.

"Acupuncture" 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.

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

"Adult" has the meaning given in the Private Health Insurance Act.

"**Adult Dependent"** means a person who is aged between 21 and up to 25 years and no longer studying full time who can remain on their parents cover as an 'Adult Dependent' for an additional fee determined by nib. The person must be unmarried and not in a de facto relationship.

"All Insured Persons" (all Insured Persons): includes Insured Persons and OSHC Insured Persons (as defined in Schedule L).

"All Policies" (all Policies): includes Policies and OSHC Policies (as defined in Schedule L).

"All Policy Holders" (all Policy Holders): includes Policy Holders and OSHC Policy Holders (as defined in Schedule L).

"Ambulance Product" means a Product which provides Benefits for ambulance transport the details of which are set out in Schedule I.

"Annual Benefits Limits" means the maximum amount of Benefits payable for a specific good or service in a Calendar Year, as set out in the Schedules.

"Benefit" means an amount of money payable from the Fund to or on behalf of an Insured Person, in respect of approved expenses incurred by an Insured Person for Treatment, in accordance with the Rules.

"Benefit Limitation Period" means a period of time during which an Insured Person is entitled to restricted benefits for a particular Condition or Treatment, as set out in the Schedules.

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

"Chiropractic" 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.

"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.

"Consultation" means an attendance on an Insured Person by a Provider in a manner approved by nib.

"Contribution Rates" means the rates specified in Schedule K applicable to Hospital Products, General Treatment Products or Combined Products.

"Continuous Hospitalisation" has the meaning given to it in Rule E2.13.

"Contribution Group" means a group of Policy Holders approved by nib for the purposes of Rule D1.3.

"Couples Policy" means a Policy comprising the Policyholder and their Partner.

"Default Benefits" means the amount determined by the Minister to be the minimum Benefit payable under a Hospital Product for a particular Hospital Treatment in a Hospital which is not an nib Agreement Private Hospital.

"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" 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.

"Dependent Child" means a person who is not a Policy Holder or spouse/partner and who:
(a) is aged under 21 years of age; and
(b) does not have a Partner,

"Dietary" 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.

"Excess" means the amount a Policy Holder elects to pay for Claimable Hospital Expenses before a Benefit is paid unless otherwise specified in the Schedules.

"Excess Premiums" means any Premiums paid beyond the date of cancellation or termination of the Policy and referred to in Rule C7.3 and Rule C8.3.

"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 Adult Dependants.

"Family Groups" means a policy comprising of the Policy holder and two or more people. For example:
(a) Family Policy
(b) Single Parent Family Policy
(c) Extended Family Policy

"Family Policy" means a Policy comprising the Policyholder, their partner and one or more Dependent Children.

"Fund" means the health benefits fund established by nib.

"General Product" means a Product for General Treatment.

"General Treatment" means Treatment (including the provision of goods or services) that:
(a) is intended to manage or prevent a Condition; and
(b) is not Hospital Treatment,
which is permissible under the Private Health Insurance Act and in respect of which Benefits are payable under these Rules.

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

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

"Hospital" means a facility for which a declaration under section 121-5(60) 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.

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

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

"Insured Person" means any Policy Holder or Holder (including Adults and Dependent Children) insured by nib under a Policy.

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

"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 Federal 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 gap cover scheme described in Rule E2.14.

"MIMS" is information on Australian prescription medicines that is used by health care providers.

"Minimum Benefits" means the amount determined by the Minister as described in Rule 4 of the *Private Health Insurance (Benefit Requirements) Rules 2011* 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 federal Minister or his or her delegate with the powers vested in the Minister by the Private Health Insurance Act.

"Natural Therapies" means General Treatment that is:
(a) approved by nib;
(b) listed as a Natural Therapy treatment in the Schedules; and
(c) provided during a Consultation with a Provider who is recognised by nib as to provide natural therapy treatment.

"Naturopathy" 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 naturopath.

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

"Occupational 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 occupational therapy treatment.

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

"Optical Appliance" 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.

"Orthotics" 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.

"Orthoptics" 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.

"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 new born child who:
    (i) occupies a bed in a Special Care Unit; or
    (ii) is the second or subsequent child of a multiple birth; and
(b) excludes:
    (i) any other new born 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.

"Physiotherapy" 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" 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 a policy of private health insurance between a Policy Holder and nib in accordance with these Rules.

"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) two Insured Persons who are Adults (and no-one else) – a Couples Policy;
(c) two or more Insured Persons, none of whom is an Adult;
(d) two or more Insured Persons, only one of whom is an Adult – a Single Parent Family Policy;
(e) three or more Insured Persons, only two of whom are Adults – a Family Policy; and
(f) three or more Insured Persons, at least three of whom are Adults – an Extended Family Policy

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

"Pre-Existing Ailment" means a Condition, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by nib were exhibited:
(a) in the case of a Policy Holder, at any time during the 6 months prior to the commencement of the Policy (or in the case of an Insured Person added to or covered under an existing Policy at any time during the 6 months prior to them being added to the Policy);
(b) in the case of an upgrade from one Hospital Product to another Hospital Product that provides higher Benefits for Hospital Treatment, at any time during the 6 months prior to the Policy Holder paying Premiums for the upgraded Hospital Product (a change to a lower Excess constitutes an upgrade); or
(c) in the case of a Policy in financial suspension, at any time during the suspension period.
nib's Medical Practitioner will examine relevant information (including information supplied by the Policy Holder's or Insured Person's Medical Practitioner) to determine if the Condition is a Pre-Existing Ailment.

"Premium" 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" 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 Customer who transfers to an nib Complying Health Insurance Product from:
(a) another nib Complying Health Insurance Product;
(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 or nib overseas visitor cover,
the previous health insurance product in respect of which premiums were paid by or on behalf of the Customer.

"Private Health Insurance Act" means the Private Health Insurance Act 2007 (Cth) and includes any regulations and rules made pursuant to that Act.

"Private Hospital" means a Hospital.

"Private Patient" means a Patient classified as such in accordance with Rule E2.4.

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

"Professional Attention" means:
(a) medical or surgical treatment by or under the supervision of a medical practitioner; or
(b) obstetric treatment by or under the supervision of a medical practitioner or a registered nurse with obstetric qualifications; or
(c) Dental Treatment by or under the supervision of a Dental Practitioner.

"Provider" means:
(a) Hospitals; and

(b) General Treatment providers that:
  (i) are registered or hold a licence under relevant State or Territory legislation to provide the General Treatment sought;
  (ii) are professionally qualified, or a member of a professional body recognised by nib;
  (iii) are in private practice; and
  (iv) satisfy any other criteria reasonably required by nib for nib to pay Benefits for General Treatment provided by the provider.

"Psychiatric Patient" means a Patient classified as such in accordance with Rule E2.4.

"Psychology and Counselling" 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.

"Rehabilitation Patient" means a Patient classified as such in accordance with Rule E2.4.

"Restricted Benefits" means the lower level of Benefits payable for some services under a Product as set out in the Schedules.

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

"Rules" means these rules as altered or varied from time to time.

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

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

"Single Parent Family Policy" means a Policy comprising the Policy Holder and one or more Dependent Children.

"Special Care Unit" means a unit of a Hospital approved by nib for the purpose of providing special care, and includes facilities such as intensive care units, critical care units, coronary care units and high dependency nursing care units.

"Speech Therapy" 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.

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

"Student Dependent" means a person who is not a Policy Holder or spouse/partner and who:
(a) is aged 21 to 24;
(b) is engaged in full time study; and
(c) does not have a partner

"Treatment" means:
(a) in respect of Hospital Products: Hospital Treatment, Professional Attention 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.

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

C Membership

C1 General Conditions of Membership

C1.1 Applicable Benefits Arrangements

Insured Persons 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

A person may be admitted as an Insured Person of one of the Policy Categories in respect of one of the following Products:
(a) Any level of Hospital Product set out in Schedule H;
(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 H and I; or
(d) One of the special combined Hospital and General 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 an Insured Person.

C2.2 Minimum Age of Contributors

Unless otherwise approved by nib, a person under 16 is not eligible to be a Policy Holder.

C2.3 Dual Policies

A person who is an Insured Person 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.

C3 Dependants

A person who ceases to be eligible to be a Dependent Child or a dependent child under a policy of private health insurance 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:

(a) the Benefits provided under the new Product are no higher than the benefits provided under the Previous Cover; and

(b) the person applies for Policy within 59 days of ceasing to be a Dependent Child or a dependent child under a policy of private health insurance with another private health insurer.

C4 Membership Applications

C4.1 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.

C4.2 Payment of Contribution with Application

(a) An application for a Policy will be accepted by nib only where the Premiums for the minimum period relevant to the applicant have been paid.

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

C4.3 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 an Insured Person.
(b) If nib refuses an application, nib will provide a reason for the refusal to the applicant.

C5 Duration of Membership

C5.1 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 C4 or where nib agrees, such other date nominated in the application.

C5.2 Termination of Policy

A Policy terminates:
(a) on the date it is cancelled by a Policy Holder in accordance with Rule C7; or
(b) on the date the Policy is terminated in accordance with Rule C8.

C6 Transfers

C6.1 Transfers from another private health insurer within 59 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 59 days 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 the Fund under the new Product is higher than that payable under the Previous Cover, the lower benefit will be paid from the Fund until the required Waiting Period with the Fund 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) nib may apply all relevant Waiting Periods to the unexpired portion of a Benefit Limitation Period or limit governing the supply or replacement of an appliance or Prosthesis.

6.2 Transfers from another private health insurer outside 59 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, the person will be treated as a new Insured Person to the extent permitted under the Private Health Insurance Act and nib may apply the Waiting Periods in full.

C6.3 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, nib may take into account any benefits that have been paid in the relevant Calendar 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.

C6.4 Transfers to another private health insurer

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

C7 Cancellation of Membership

C7.1 General requirements

Unless otherwise permitted by nib, any cancellation of a Policy:
(a) must be authorised in writing by the Policy Holder;
(b) may not have retrospective effect; and
(c) must be in accordance with other arrangements specified by nib.

C7.2 Circumstances in which a Policy can be cancelled

Subject to Rule C7.1:
(a) a Policy Holder may cancel their Policy entirely;
(b) a Policy Holder may remove any Insured Person from their Policy;
(c) any Insured Person aged at least 16 years of age may leave the Policy; and
(d) a Dependant Child under the age of 16 years may leave the Policy with the agreement of the Policy Holder.

C7.3 Refund of Premiums

nib may in its discretion refund any Excess Premiums when a Policy is cancelled if requested to do so by the Policy Holder in writing.

C8 Termination of Membership

C8.1 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 C9.10(b); or

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

(b) In Rule C8.1(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 C8.1(a)(iii) reasonable prior notice of the transfer and termination.

C8.2 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) an Insured Person 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; or
(b) an Insured Person has engaged in inappropriate behaviour including abuse of staff members of nib.

C8.3 Refund of Premiums

nib may in its discretion refund any Excess Premiums when a Policy is terminated if requested to do so by the Policy Holder in writing.

C9 Temporary Suspension of Membership

C9.1 Right to Suspend

A Policy Holder may apply to suspend their Policy after 12 months since commencement of the 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.

C9.2 nib's discretion

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

C9.3 Premiums must be paid up to date of suspension

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

C9.4 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.

C9.5 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.
(c) Should an equivalent level of cover not have been held for the entire period of suspension, the waiting period for Pre-Existing Conditions will apply for Hospital Treatment.

C9.6 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.

C9.7 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.

C9.8 Subsequent Suspensions

(a) A Policy Holder who has previously suspended their Policy may only apply for a subsequent suspension where 12 months have elapsed since the reactivation of the Policy following a previous suspension; and
(b) nib may waive this Rule in its discretion.

C9.9 Reactivation of Policy

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

(a) the Policy Holder applies to nib to reactivate the Policy within 1 month, subject to Rule 9.5 c) the Policy Holder will be given continuity of previous coverage under the Policy, although no Insured Person covered by the Policy will be entitled to payment of Benefits for services provided during the suspension ; or

(b) the Policy Holder applies to nib to reactivate the Policy later than 1 month, the Policy Holder will be considered a new Insured Person for all purposes and relevant Waiting Periods will apply.

C10 Other

C10.1 Standard Information Statements

(a) nib will provide a Standard 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 Standard 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:

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

(b) for all Products other than Ambulance Cover, 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 at an nib retail centre, by Phone Pay, by mail or at an Australia Post Office – monthly, quarterly, half yearly and yearly.

D1.2 Maximum period for payment in advance

Premiums cannot be paid more than 13 months in advance of the date of payment.

D1.3 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 particular enterprise or group of enterprises;
- (ii) members of any organisation; 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 Health 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.

D3.2 More than one payment circumstance

A Policy Holder is entitled to multiple discounts for the following combinations:
(a) D3.1 (a) and D3.1 (b) or
(b) D3.1 (b) and D3.1 (c)

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 if required in accordance with the Lifetime Health Cover provisions of the Private Health Insurance Act.

D5 Arrears in Contributions

D5.1 When is a Policy 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,
the Policy Holder will be given continuity of coverage under the Policy, and an Insured Person covered by the Policy will be entitled to payment of Benefits for services provided during the arrears period.

(b) For the avoidance of doubt, no Benefits will be paid for services rendered to a Insured Person during the period in which the Policy is in arrears until all Premiums in arrears are paid.

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 a Provider.

E1.3 Services provided by family members

Benefits are not payable for services other than wholesale material costs involved in the provision of the service rendered by a Provider to:
(a) the Provider's spouse, de facto partner, dependents, family members or business partner; or
(b) the spouse, de facto partner, dependents or family members of the Provider's business partner.

E1.4 False or misleading claims

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

E2 Hospital Treatments

E2.1 Benefits payable according to Schedules

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

E2.2 Same Day Hospital Patients

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

E2.3 Not Used

E2.4 Patient Classifications

(a) Benefits for accommodation in Private Hospitals are payable according to the classification of the patient.

(b) Patients are classified in accordance with the guidelines issued by the Minister. The classifications are:
(i) Surgical;
(ii) Advanced Surgical;

(iii) Obstetric;
(iv) Other (Medical);
(v) Psychiatric Care, and
(vi) Rehabilitation.

(c) nib may permit further sub-classifications of patients where not inconsistent with the Minister's Guidelines.

E2.5 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.

E2.6 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.

(d) nib has discretion to pay Benefits additional to those provided in Rule E2.6(b) and (c).

E2.7 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 Continuous Hospitalisation.

(b) For the purposes of this Rule, a Rehabilitation Certificate means a certificate in a form approved by nib that the patient is in need of a special rehabilitation program to recover from an Acute Catastrophic Illness or Injury.

E2.8 Psychiatric Care Patients

(a) Benefits for Psychiatric Care patients are payable subject to the following conditions:
(i) Treatment must be supported by a Psychiatric Care Certificate
(ii) A further Psychiatric Care Certificate is required:
(1) for each period specified in any certificate where Treatment as a Psychiatric Care patient beyond 35 days is provided, and
(2) for any subsequent readmission as a Psychiatric Care patient that does not constitute Continuous Hospitalisation;

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

(c) For the purposes of this Rule, a Psychiatric Care Certificate means a certificate in a form approved by nib that the patient is in need of a special program of acute psychiatric care.

E2.9 Counting of Days

(a) The day on which a person became an Admitted Patient and the day of discharge are counted as one day for the purpose of assessing Benefits payable.

(b) Days spent in a Special Care Unit do not interrupt the counting of days in relation to the patient classification on entering the Special Care Unit. For the avoidance of doubt, Benefits payable upon discharge from the Special Care Unit will be paid at the classification applicable upon entering the Special Care Unit, after taking into account any days spent in the Special Care Unit.

E2.10 Multiple Procedures

Subject to the Rules, where a patient undergoes more than one operative procedure during the one theatre admission, or on the one day, the procedure with the highest fee in the Medicare Benefits Schedule determines the patient's classification.

E2.11 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.

E2.12 Special Care Units

The higher Benefits for patients of Special Care Units are payable only for periods during which the patient occupies a bed in a facility approved by nib for this purpose.

E2.13 Continuous Hospitalisation

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

(b) Where the Hospitals are different, Benefits at the Advanced Surgical, Surgical or Obstetric levels are payable in respect of the later admission only if an appropriate procedure is rendered following that admission.

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,
    (i) under which any of the following items, or any combination of the following items, are to remain fixed throughout the term of the agreement:
    (ii) the total charge for any Treatment (excluding paramedical services);
    (iii) the Benefit payable by nib; and
    (iv) any out of pocket expenses payable by the Customer.

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 pharmaceutical if it is directly related to the Treatment for which the Insured Person 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 Pharmaceutical Benefits Scheme; and

(c) Benefits for non-PBS medications supplied to Insured Persons 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 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) published within the MIMS schedule; and
  (iii) where the item is intrinsic to the patient's episode of care.

(e) No Benefits are payable for:
  (i) contraceptive drugs;
  (ii) drugs issued for the sole purpose of use at home;
  (iii) ward drugs;
  (iv) pharmacy items charged in a public hospital;

(f) Any agreement under a hospital purchaser provider agreement may override this Rule.

E3 General Treatments

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

E4 Other

E4.1 Ex Gratia Payments

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

E4.2 Treatment Outside Australia

No Benefits are payable for treatment (including goods) provided outside 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 an Insured Person 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 Benefit Limitation Period 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 Insured Person's Product):

(i)	Accidental Injury	1 day
(ii)	Other services, except those listed below	2 months
(iii)	Psychiatric, Rehabilitation or palliative care (whether or not a Pre-Existing Ailment)	2 months
(iv)	Pre-Existing Ailments/Conditions	12 months
(v)	Obstetric conditions	12 months

(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 an Insured Person under the Policy:
- (i) within 2 months after the newborn's birth, where the parent/guardian upgrades from an existing Single or Couples Policy; or
- (ii) within 24 months after the newborn's birth, 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.

(c) Immediate cover means that the newborn is eligible for the level of cover that applied to the longest serving parent at the newborn's date of birth.

(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 Ailments

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

F3.5 Waiting Periods – Ancillary Products

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 Insured Person's Product):

(a)	Approved ambulance transport	1 day
(b)	All services and items except those listed below	2 months
(c)	Optical appliances and repairs	6 months
(d)	Healthier Lifestyle	6 months

(e)	Removal of wisdom teeth and oral surgery	12 months
(f)	Periodontic surgical, root therapy and endodontic services by a dentist not registered as a specialist	12 months
(g)	Dentures, denture maintenance/repairs and other prosthodontic services	12 months
(h)	Dental specialty services, dental prosthetic services, inlays, onlays, facings, orthodontia, periodontia, endodontia and oral surgery	12 months
(i)	Non-specialty orthodontia	12 months
(j)	Midwifery services	12 months
(k)	Artificial aids	12 months
(l)	Hearing aids	36 months

F3.6 Payment of Benefits

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

F4 Exclusions

F4.1 Exclusions –All Products

Unless expressly provided for in these Rules, Benefits are not payable under Products:

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

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

(c) where the Insured Person is entitled or may be entitled to Compensation;

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

(e) for pharmaceuticals that are available under the PBS;

(f) for oral contraceptives;

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

(h) where the service is provided exclusively or primarily for the care or Treatment of a mentally disabled person who is not a Private Patient in a Hospital;

(i) for services rendered in a nursing home;

(j) where moneys are payable from another source;

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

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

(m) for luxury room charges;

(n) for respite care;

(o) for take home items;

(p) for experimental and/or treatment not covered by Medicare;

(q) for autologous blood collection and storage;

(r) for procedures normally performed in a doctors surgery;

(s) for private hospital emergency or outpatients fees; or

(t) for special nursing.

F5 Benefit Limitation Periods

The services for which Benefit Limitation Periods apply and the relevant conditions for such services during the Benefit Limitation Period are set out below and in the Schedules.

A Benefit Limitation Period will not apply where an Insured Person transfers to a product with a Benefit Limitation Period from either another nib Hospital product or another hospital product with another private health insurer.

Benefit Limitation Periods do not apply in the event of an Accident to an Insured Person.

F6 Restricted Benefits

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

F7 Compensation Damages and Provisional Payment of Claims

F7.1 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 an Insured Person receiving Compensation includes:

  (i) Compensation paid to another person at the direction of the Insured Person; and
  (ii) Compensation paid to another Insured Person on the same Policy in connection with an injury suffered by the Insured Person.

F7.2 Insured Person's Obligations if entitled to Compensation

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

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

(b) inform nib of any decision of the Insured Person 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.

F7.3 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 Insured Person has received, or may be entitled to receive, Compensation in respect of that injury.

F7.4 nib's rights to withhold payment of Benefits

Where nib reasonably forms the view that an Insured Person 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.

F7.5 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.

F7.6 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.

G Claims

G1 General

G1.1 Requirements for Claims

Claims for Benefits must:
(a) be made in a manner approved by nib; and
(b) be supported by accounts and/or receipts on the Provider's letterhead or showing the Provider's official stamp, and showing the following information:
  (i) the Provider's name, provider number and address;
  (ii) the Patient's full name and address;
  (iii) the date of service;
  (iv) the description of the service;
  (v) the amount(s) charged; and
  (v) any other information that nib may reasonably request.

G1.2 Claims become property of nib

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.

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

G2 Other

G2.1 Agents

nib may authorise an Insured Person to delegate to another person the right to Claim or assign Benefits to which the Insured Person may be entitled.

G2.2 Method of Payment of Benefits

nib may pay Benefits by cash, cheque or electronic funds transfer in accordance with arrangements it determines from time to time.

[End of General Conditions]