Member Guide.

Product Disclosure Document and Fund Rules

This Member Guide is designed to help *you* understand what *you* will be covered for when *you* take out private health *cover* with Health Partners. It should be read in its entirety and in conjunction with Health Partners individual *cover* details. *We* recommend that *you* always make enquiries with Health Partners before going to hospital or undergoing a new course of *treatment*. This Member Guide is effective 1 October 2025.

HealthPartners

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Private Health Insurance Code of Conduct

Health Partners is a signatory to the Private Health Insurance Code of Conduct. Go to privatehealthcareaustralia.org.au/codeofconduct

This Member Guide contains important information about the general terms of *membership*, Fund Rules and *cover* with Health Partners. It is the *policyholder's* responsibility to understand what is and what is not covered by their health insurance *policy*, therefore this information should be read in its entirety and retained in conjunction with individual *cover* details. This information is correct at time of printing; however, *we* reserve the right to make changes to prices, *cover/benefit* specifications and other conditions relating to Health Partners products, programs and services at any time, with appropriate notice provided to *members* where required. Please contact *us* on 1300 113 113 or visit healthpartners.com.au prior to purchasing any health insurance products to make sure *you* have the latest information available.

Business Rules

Health Partners Limited (ABN 43 128 282 904) (***Health Partners***) conducts its *health insurance business* and *health related business* under these Rules and the *Government Rules*.

All *members* are bound by these Rules, the Health Partners Constitution, and the applicable *Government Rules*.

We recommend *you* read the Rules and all relevant policy documents in their entirety, as they work together to provide the rules associated with *your membership*. Only referring to sub-sections may provide incomplete details when they are not read in totality.

Purposes of the Fund

The purposes of the *Fund* are:

a. to hold the *assets* relating to Health Partners *health insurance business* and the *health related business*;

b. to receive amounts which must or may be credited to the *Fund* under the *Government Rules* in connection with Health Partners *health insurance business* and the *health related business*;

c. to pay *policy* liabilities and other liabilities or expenses incurred in connection with Health Partners *health insurance business* and the *health related business*;

d. to make investments and distributions permitted by the *Government Rules*; and

e. for any other purpose permitted by the *Government Rules*.

Purpose of the Rules

The purpose of these Rules is to set out the rules which relate to the operation of Health Partners *health insurance business* and the *health related business*.

Interpretation and Definitions

Where *you* see a word in *italics* like this, it means the word is defined at the back of this guide in the Definitions and Interpretation section. This will assist *you* in gaining a reasonable understanding of the Rules.

The following applies to the interpretation of these Rules:

a. unless otherwise specified, a term defined in the Private Health Insurance Act has the same meaning in these Rules;

b. if applicable, where a gender is referenced this includes all genders;

c. words in the singular number include the plural and vice versa;

d. a reference to any legislation is taken as a reference to that legislation as amended from time to time; and

e. a reference to a State includes a reference to a Territory.

Business of the Fund

The business of the *Fund* is Health Partners:

a. *health insurance business*; and

b. *health related business*

The dominant purpose of the *Fund* relates to Health Partners *health insurance business*.

Health Related Business

a. Health Partners must conduct the *health related business* for the benefit of *members*.

b. A *member* may use the services of a *health related business* for treatment for which a benefit is provided under their *policy*.

c. Health Partners may provide the optical and dental services of the *health related business* to *persons* who are not *members* provided:

   i. *members* are as far as possible given priority;

   ii. the fee for each service is not less than an appropriate market rate; and

   iii. the predominant purposes for providing services generally to *persons* who are not *members* are to:

      (i) support the *Fund* in operating the *health related business* more efficiently;

      (ii) permit Health Partners to take advantage of economies of scale; and

      (iii) support the more efficient provision of services to *members*.

The Governing Principles

The operation of the *Fund* and the relationship between Health Partners and each *member* is governed by:

a. the Health Partners Constitution

b. the *Government Rules*; and

c. these *Rules*.

If there is any inconsistency between them, to the extent of the inconsistency, the above order of precedence applies.

Membership Information

Here *you'll* find information on *membership* types, *policyholder* requirements, eligibility, how to become a *member*, rules on transferring from another fund and what *you'll* need to provide to become a *member*.

Membership Types

We offer a range of different *membership* types to suit *your* life stage, they include:

a. Single, which comprises of the *policyholder* only;

b. Couple, which comprises only two *adults* who are the *policyholder* and their *partner*;

c. Family, for a *couple* and one or more of *your child dependants* or *student dependants*;

d. Extended Family, for a *couple* and any number of *child dependants* or *student dependants* and at least one *non-student dependant*;

e. Single Parent Family, for one *adult* and at least one or more *child dependants* or *student dependants*;

f. Extended Single Parent Family, for one *adult* and any number of *child dependants* or *student dependants* and at least one *non-student dependant*.

Membership Type is defined by the classifications of *persons* on *your cover*. If there is a change of circumstances to any of the *persons* covered under *your policy*, then it may result in changes to *your membership*. These classifications are *policyholder*, *partner*, *child dependant*, *non-classified dependant*, *student dependant* and *non-student dependant*.

Policyholder

A *policyholder* is the *person* applying for *cover* that will be responsible for ensuring *premium* payments are made. The *policyholder* has full authority over the *membership* and must be 18 years or older. In the case of *child* only policies, if the *policyholder* is under 18, a designated *Responsible Adult* is required. Most correspondence will be addressed to the *policyholder*.

As a *policyholder*, *you* must agree on behalf of the whole *membership* to *our* Privacy Policy and abide by *our Fund* Rules and policies. *You* also agree to let *us* know of any change in circumstances relating to everyone on the *membership*. This is required to be done as soon as possible to ensure the information *we* hold remains correct.

Policyholders can only take out one *Hospital cover* and/or one *Extras cover* under a *membership*. Everyone under the same *membership* will have the same *cover* and must belong to one of *our* defined *membership* types. The only exception to this is for *children* that are held under different *memberships*.

Membership and Treatment Covered

As permitted or required by the *Government Rules*, the types of *treatment* covered by a *membership* include:

a. *hospital treatment*;

b. *hospital treatment* and *general treatment* (also known as extras); or

c. *general treatment* (also known as extras) excluding *hospital-substitute treatment*.

We understand everyone has different needs, so *we* have developed a range of *cover* types to suit *your* needs. *You* can find details of *our cover* types on *our* website, over the phone or in *person* at one of *our* locations.

Membership Eligibility

Membership with Health Partners is open to any *person*, subject to the following conditions:

a. *Person(s)* with a green or blue Medicare card are eligible for *hospital cover* and/or *extras cover* with Health Partners.

b. *Person(s)* with a yellow Medicare card under the Reciprocal Health Care Agreement are only eligible for *extras cover*.

c. Overseas visitors and students are ineligible for private health *cover*, unless the *person* has a yellow Medicare card under the Reciprocal Health Care Agreement. Under this situation they are eligible for *extras cover* only.

Only those listed on the *membership* will be eligible to receive the *benefits* outlined on the *cover* details. However, the Medicare status may impact benefit entitlements. To find out more contact *us*.

Community Rating

Under the *Community Rating* requirement, *we* will not discriminate against *you* in relation to providing *you* with a *Policy*.

In this part improperly discriminating is, except to the extent allowed under the *Government Rules*, discriminating on the grounds of:

a. the *suffering* by a *person* from *chronic disease*, illness or other medical condition or from a disease, illness or medical condition of a particular kind;

b. the gender, race, sexual orientation or religious belief of a *person*;

c. the age of a *person*;

d. where a *person* lives;

e. any other characteristic of a *person* (including not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for *hospital treatment* or *general treatment*;

f. the frequency with which a *person* needs *hospital treatment* or *general treatment*;

g. the amount, or extent, of the *benefits* to which a *member* becomes, or has become, entitled during a period; or

h. any other matter set out in the *Government Rules* for this purpose.

Becoming a Member

All *policyholders* need to complete and submit an application. This can be done:

a. by calling 1300 113 113;

b. online at healthpartners.com.au; or

c. by downloading the application from *our* website, collecting a copy from a Health Partners centre or requesting one to be posted and providing it back to *us*. This can be done by mail to Health Partners, Reply Paid 1493, Adelaide SA 5001, by email to ask@healthpartners.com.au or in person at one of *our* centres.

If the required information is not provided, *we* may do the following until received:

a. withhold approval of an application;

b. refuse to pay *benefits* that *you* may be entitled to under *your* individual *cover*; and

c. suspend payment of *benefits* that *you* may be entitled to under *your* individual *cover*.

Membership Information continued

Transferring from another fund

Transferring couldn't be easier. Just include *your membership* details and *member* number from *your* current Australian health fund with *your* application and *we* will take care of the rest for *you*. Under the *Government Rules we* will also obtain a transfer certificate from *your* old insurer.

And, if *you* switch within 30 days to an *equivalent cover you* will not have to re-serve *your waiting periods*. This rule also applies to *pre-existing conditions*, where *you* have already served *your* 12 month *waiting period* with *your* current Australian health fund provider as long as the *treatment* was not an exclusion or restricted service.

Health Partners will apply the Youth Discount applicable from *your* previous fund providing transfer occurs within 30 days of ceasing to be insured by the other insurer.

The Youth Discount applied for joins after 30 days will be based on *your* age when *you* take out *hospital cover* with *us*.

Membership Commencement

Your membership commences on the date *your* application is lodged and accepted by *us* or the date nominated in *your* application, whichever is the later.

Benefit entitlements will commence once *premiums* are paid and any applicable *waiting periods* are served as outlined in *your* individual *cover*.

Information you receive as a member

We will provide the *policyholder* with:

a. A *Private Health Information Statement* for the *cover* and *membership* type selected; and

b. details of what the *membership* covers and how *benefits* are determined.

Once *your premiums* have been paid as outlined in *your cover* details, *we* will send a *membership* card to the *policyholder* and include a card for *your partner* where applicable, according to *your membership* type. *You* can also request additional cards for any *child dependant* registered and active on *your membership*.

Membership Card Rules

a. *Your membership* card is not transferable;

b. *your membership* card gives *you* on-the-spot *benefits* where HICAPS or HealthPoint electronic payment systems are used;

c. *your membership* card must be presented at *Health Partners participating pharmacies* when *claiming* pharmacy *benefits* and the 20% participating pharmacy discount;

d. if *you* forget *your membership* card *you* will need to pay for *your treatment* in full, obtain an itemised receipt or account from the *provider* and submit *your claim* to *us* for payment. This excludes the 20% participating pharmacy discount – *you* must present *your* card to receive the discount;

e. *Health Partners participating pharmacies* have the authority to confiscate Health Partners' cards and return them to *us* if they suspect misuse by

a customer, for example the card is being used by someone not on the *membership*. In addition, at the time of use they may request *you* produce additional identification to confirm *you* are the cardholder;

f. *your membership* card must not be left with any health care *provider* or other third parties;

g. *your membership* card remains the property of Health Partners;

h. *members* must notify Health Partners if their card is lost or stolen;

i. replacement cards can be requested using the Health Partners app and portal, or by calling 1300 113 113; and

j. *members* must return or destroy their *membership* card if their *membership* is cancelled.

In addition to the above, it is important to know that *benefits* are only paid in accordance to *your* individual *cover* and will only be paid where *your premiums* are not in arrears. Not all *claims* are payable via electronic *claiming*, for example some *claims* for orthodontics. Refer to Benefit Rules for more information.

Cooling-off period

There is a 30 day 'cooling-off period' on all of *our covers*.

So if *you're* a new *member* and decide the *cover* chosen is not right for *you*, *you* can cancel *your membership* and/or *policy* within 30 days and *we* will provide a full refund of any *premiums you* have paid – as long as no *claims* have been made.

If *you're* an existing *member* who has changed *your* level of *cover*, *you* can revert back to *your* previous level of *cover* within 30 days without affecting *your waiting periods*. The difference in *premiums* will be credited to *your* account (if applicable). Should *you* move back to a higher level of *cover*, additional *premiums* will be payable. This does not apply to *members* changing out of a *closed product*, *members* may not transfer back into a product that has been closed.

Where a *claim* has been made during the 30 day cooling-off period, the *membership* and/or *policy* can only be cancelled (or changed) the day after the most recent *claim*. Refunds in *premiums*, if any will be calculated from this date.

Refusal of an application

We have the right to refuse an application for *membership* or *cover* type in any or all of the below situations;

a. fraudulent activity by the proposed *member*;

b. provision of misleading or untrue information;

c. non-disclosure of required information; and

d. unacceptable behaviour or misconduct as determined by *us*.

General information on private health insurance

For general information about private health insurance, see privatehealth.gov.au

Once You're a Member

Now that *you're* a *member*, it's important to know how to make changes, payments and *claim*. *We* have also outlined important rules and conditions related to *your membership* that *you* need to know.

Changing your Membership Type

At Health Partners *we* understand *your* life stage can change, so *you* can change *your membership* type to suit *your* needs. Just simply contact *us* and *we* can help *you* through the process. Changes to *your membership* type will become effective once the request is accepted by *us*.

Below are some of the common changes that *you* might need to make to *your membership*.

Adding a newborn or dependant

Where you are on a *membership* type of Single Parent, Extended Single Parent Family, Family, Extended Family, or, *Couple* on a cover that allows *dependants*. Adding a newborn *dependant* can be done within 12-months of *your child's* date of birth. This will help *you* to avoid *waiting periods* for the *dependant*. *We* will backdate adding the *dependant* to their date of birth. After 12-months, *your dependant* will be added from the day *your* application is accepted by *us* or the date nominated in *your* application, whichever is the later. *Benefit* entitlements will commence once *premiums* are paid and any applicable *waiting periods* are served as outlined in *your* individual *cover* details.

In other circumstances, such as being on a *membership* type of Single, where *your* existing cover does not permit *dependants*, or when adopting or fostering a *child*, adding a *dependant* can be done within 90 days of *your child's* date of birth, or in the event of adoption or fostering, the date of obtaining legal guardianship. This will help *you* to avoid *waiting periods* for the *dependant*. *We* will backdate adding the *dependant* to the relevant date. After 90 days, *your dependant* will be added from the day *your* application is accepted by *us* or the date nominated in *your* application, whichever is the later. *Benefit* entitlements will commence once *premiums* are paid and any applicable *waiting periods* are served as outlined in *your* individual *cover* details.

Adding a *dependant* is done by the person applying for *membership* or the existing *policyholder*. This may result in a change in *membership* type and *premium*, for example, going from *couple* to family. *We* will advise *you* at the time of change any change in *your membership*.

We may request appropriate documentation that verifies *you* (the *policyholder*) have full legal and financial responsibility for the *child/children* being added to a *membership*.

Adding a partner

When adding a *partner*, *waiting periods* will apply (refer to *your* individual *cover* details for more information). The *partner* becomes active on *your membership* on the date *your* application is accepted by *us* or the date nominated in *your* application, whichever is the later. *Benefit* entitlements will commence once *premiums* are paid and any applicable *waiting periods* are served as outlined in *your* individual *cover* details.

Only an authorised person or the existing *policyholder* are able to add a *partner* to the *policy*. This may result in a change in *membership* type and *premium*, for example, going from *single* to *couple*. *We* will advise *you* at the time of amendement any change in *your membership*.

Separated Couples

If *you* have a Couple or Family (including Extended Family) *policy*, and *you* and *your partner* separate, *your partner* will need to be removed from the *policy* and they will need to take out their own *policy*.

Removing a dependant and/or a partner

Removing a *dependant* and/or a *partner* can be done by giving notice to *us* of the change. The removal is effective on the date the notice is accepted by *us* or the date nominated in *your* request, whichever is the later.

Removing a *dependant* is done by the *policyholder*, authorised person or can be done by the *dependant* if they are aged 18 or over. This may result in a change in *membership* type, for example, going from *family* to *couple*.

Removing a *partner* is done by the *policyholder*, authorised person or can be done by the *partner*. This may result in a change in *membership* type, for example, going from *couple* to *single*.

We will advise the *policyholder* at the time of any change in *your membership*.

Benefit entitlements will cease on the effective date.

Student dependants

If a *dependant* is a full time student aged between 21 and 31 (inclusive), the *policyholder* must complete a Student Dependant Registration form and return it to *us* when they turn 21 and ongoing by the end of February in each year. *We* may require written information in relation to that *person* to ensure that they qualify as a *student dependant*. Please refer to the *student dependant* definition in the Definitions and Interpretation section to see if *your dependant* may qualify.

We hold the right to remove the *student dependant* from the *membership* and adjust the *membership* type accordingly, where the *dependants* no longer fit the definitions outlined in this guide or where the required written information is not received or complete.

The above requirement complies with the *Government Rules*, which does not allow any exceptions.

Non-student dependants

The *policyholder* may have the option to keep a *dependant* who is aged between 21 and 31 (inclusive) and not studying on their policy under a *non-student dependant* definition. Please refer to the *non-student dependant* definition in the Definitions and Interpretation section to see if *your dependant* may qualify.

We hold the right to remove the *non-student dependant* from the *membership* and adjust the *membership* type accordingly, where the *dependants* no longer fit the definitions outlined in this guide.

Membership Changes and the impacts to Premiums and Benefits

A change in *membership* may result in a change to *premiums*.

a. Where the *premium* is higher, the *policyholder* will be responsible for ensuring the required additional *premiums* are paid.

b. Where the *premium* is lower, *we* will re-calculate when *your premiums* are due. Calculations are made in accordance with the *Government Rules*.

Once You're a Member continued

c. Instead of extending the period for which *premiums* are paid, *we* may at *our* discretion refund some or all of the *excess premiums* relating to the period after the change. *We* may deduct an administration charge from any refund.

Payment Rules, Options and Frequency

For payment options, it is the *policyholder's* responsibility to ensure *premiums* are paid in advance as set out in *your* individual *cover*. It is important to understand that where *premiums* become overdue, *your membership* may lapse, meaning *you* will not be able to access the *benefits* as detailed in *your* individual *cover* and *you* may be required to re-serve *your waiting periods*.

The maximum *premium* amount payable is 12 months in advance or up to 31 July in the following year. If *you* exceed the maximum amount permitted, a refund of any additional *premiums* will be processed. Unless as approved by *us*, which is at *our* discretion.

We understand how *you* pay *your premiums* is a personal choice, so *we* have the below options available to *you*.

a. Direct Debit

Direct Debit provides an easy way to manage *your premiums*. *Your* payments can be made from either a nominated bank account or credit card.

Setting up *your* payments through this method entitles *you* to an extra 3% discount on *your premiums*.

Your selected billing date may be the 1st to the 28th of the *month* (does not apply for fortnightly debit frequency).

Your payment frequency can be one of the following:

i. Fortnightly (Fridays only)
ii. Monthly
iii. Quarterly
iv. Half-yearly
v. Yearly

Before establishing a Direct Debit please read and agree to the terms in the Direct Debit Service Agreement. A copy can be found on *our* website healthpartners.com.au

b. Account notice

You can nominate to receive an Account Notice, *we* will post/email this to *you* and *you* can pay using any of the methods below:

i. BPAY;

ii. Australia Post's BillPay service using your Visa or Mastercard. Pay online at www.billpay.com.au, by phone 131 816, or at a Post Office; or

iii. Direct to *us* using Visa, Mastercard, American Express and EFTPOS. This can be done by calling Member Care on 1300 113 113 or in person at any Health Partners centre.

Your payment frequency can be one of the following and the account notice will be sent out before the 15th day of the payment *month*:

i. Monthly;
ii. Quarterly;
iii. Half-yearly; or
iv. Yearly.

c. Payroll

Payroll is linked to *your* pay cycle and is only available for registered groups with *us*. Either contact *your* employer or call *us* for details.

Variation to Premium Rates

We may vary *your premium* rates at any time, in accordance with the *Government Rules*.

Where the *premium* is lower, *we* will re-calculate and extend the time period *your premiums* are due. Calculations are made in accordance with the *Government Rules*.

Premium Discounts

We may offer a discount to eligible *members* in accordance with the *Government Rules*. *We* will advise *you* if a discount can apply to *you*.

Contribution Groups

Health Partners may at its discretion, approve any group of *members* as a *Contribution Group*.

Premium in Arrears

Premiums are considered to be in arrears if a required payment has not been made by the date as set out in *your cover*.

If *your membership* is in arrears, the below rules apply:

a. for *treatment* provided within the arrears period *benefits* are not payable;
b. *we* may deduct from any *benefits* payable to *you* the amount of these arrears;
c. *we* can terminate *your membership* if *premiums* are more than three *months* in arrears, unless the *policyholder* and Health Partners come to an arrangement to recover the amount in arrears; and
d. if a *membership* has been terminated, *we* may (at *our* discretion) reinstate a *membership* upon application by the *policyholder*, subject to the payment of any outstanding *premiums*.

Refunds

We are only required to refund *premiums* where:

a. *we* have stated as part of these *Rules*; or
b. the *Government Rules* require *us* to.

We may, at *our* discretion, refund some or all of the excess *premiums* paid beyond the date of cancellation of a *policy* when:

a. a *policy* is cancelled, and;
b. if a request is made to do so by the *policyholder* in writing.

We may also deduct an administrative charge from any refund at *our* discretion.

Waiting Periods

Different services, *treatments* and goods may have different *waiting periods*, please refer to *your* individual *cover* details for information specific to *you*.

Transferring from another health fund and the impact on waiting periods

If *you* are transferring from another Australian health benefits fund and *you* have served the *waiting period* for an *equivalent cover*, meaning a *policy*

Once You're a Member continued

with the same inclusions and limits, *you* will not need to serve the *waiting periods* again. This rule also applies to *pre-existing conditions*, where *you* have already served *your* 12 *month waiting period* with *your* current Australian health fund *provider*, as long as the *treatment* was not an exclusion or restricted service.

If *you* are transferring to a higher level of *cover*, *waiting periods* will only apply to any additional services, *treatments*, goods and any higher limits. During this time *you* will receive *benefits* aligned to the closest equivalent Health Partners *cover*. *You* will also continue to pay the same *excess* and *co-payments* (where applicable). Limits and *benefits* already *claimed* will count towards any yearly or lifetime limits.

If *you* have only partially served *waiting periods* with *your* previous fund, the remainder of the *waiting period* will be served with *us*. Any loyalty bonuses or accrued entitlements with *your* previous fund are not transferable to Health Partners.

The transfer must occur within 30 days of ceasing to be insured by the other insurer, otherwise all *waiting periods* will apply.

Transferring between covers with us and the impact on waiting periods

If *you're* a current *member* with *us* and change *your* level of *cover*, *waiting periods* apply for any increased *benefits* and limits of *cover*. During this period *you* will receive the same *benefits*. For *hospital cover you* will also pay the same *excess* and *co-payment* as *your* previous level of *cover*, if applicable.

When *you* change *your cover*, *we* will explain to *you* which *benefits you* can *claim* immediately and any *waiting periods* that may apply.

Transferring from your parents' cover and the impact on waiting periods

If *you* were registered as a *dependant* and become a *policyholder* or *partner* to a Health Partners *membership* within 60 days of ceasing to be a *dependant*, *you* will not need to serve *your waiting periods* again. If there is a break in *cover*, no *claims* can be made during the period *you* are not covered.

If *you* are transferring to a higher level of *cover*, *waiting periods* will only apply to any additional *benefits*. During this time *you* will receive the same *benefits you* received on *your* previous *cover* – for a Health Partners *equivalent cover*. *You* will also continue to pay the same *excess* and *co-payments* (if applicable). Limits and *benefits* already *claimed* will count towards yearly and lifetime limits.

Waiting periods for newborns, adopted or fostered children

Waiting periods do not apply to newborns, provided *you* add them to *your membership* within 60 days from their date of birth and any required *premiums* are paid.

Adopted or fostered *children* can also receive immediate *cover* (except for *pre-existing conditions*) provided *you* add them to *your membership* within 60 days of obtaining legal guardianship.

Children adopted from overseas must be eligible for full Medicare benefits before health insurance *benefits* can be paid for *hospital treatment*.

If *you* do not add *your* newborn, adopted or fostered child within the allocated 60 day period, full *waiting periods* will be applied from the date their *cover* commences.

Waiting periods for Gold Card Holders

Waiting periods do not apply to a *person* who:

a. holds a *gold card*;

b. was entitled to *treatment* under a gold card before applying for *insurance*; and

c. applies for *insurance*, no longer than *two months* after ceasing to hold a *gold card*

Waiver of waiting periods

Waiting periods do not apply to *benefits* for *treatment* provided immediately after and related to an *accident* – this applies to *hospital covers* only, not *extras*. *Accidents* must not have occurred within 1 day of *membership* and/or *policy* commencement. When an *accident* has occurred within 1 day of *membership* and/or *policy* commencing, the *accident* rule does not apply and *waiting periods* apply.

We may also at *our* discretion waive or reduce *waiting periods*. In addition, some *covers* may offer *waiting period* waivers, please refer to *your* individual *cover* details for information specific to *you*.

Rules for Pre-existing Conditions and the impact on waiting periods

When *you* take out health insurance, change funds, or change the level of *cover you* have, *you* may have to serve *waiting periods* before *you* are eligible to *claim*. For *pre-existing conditions*, the *waiting period* is 12 *months*.

If it's been less than 12 *months* since *you* joined or upgraded *your cover*, *you* will be required to provide documentation confirming if *you're* being treated for a new condition or if it's pre-existing.

Our members pay *premiums* so that they're covered when an unexpected issue arises. *Waiting periods* for *pre-existing conditions* prevent people from taking up insurance for a short period and taking advantage of funds contributed by genuine *members*.

New and upgrading *members* who do have *pre-existing conditions* can still seek *treatment* for these conditions in a public hospital under Medicare.

The definition of a *pre-existing condition* and the 12 *month* waiting period are outlined in the *Government Rules*.

Additional information about Pre-existing Conditions

As defined by the *Government Rules*, a *pre-existing condition* is any ailment, illness or condition that had signs or symptoms, in the opinion of a *medical practitioner* appointed by *us*, any time during the 6 *months* before *you* joined or upgraded to a higher level of *cover* with *us*.

In the 6 *months* prior to joining or upgrading, a condition is considered pre-existing if any related signs or symptoms were evident to *you*, or would have been evident to a reasonable general practitioner had they been consulted. A doctor may find signs of a condition even if *you* have no symptoms and *you* have not noticed anything wrong. Meaning, the rule could still apply if the condition had not been diagnosed prior to taking out *cover* or upgrading.

The *medical practitioner* appointed by *us* is independent and will review documentation submitted by *you*, applying the best practice guidelines as set out by the Private Health Insurance Ombudsman:

- Considers any information that was provided by the *medical practitioner* who treated the ailment, illness or condition (but is not bound to agree with them);

Once You're a Member continued

- Considers the person's individual circumstances;
- It is not necessary that for the ailment, illness or condition, to have been diagnosed in the 6 *month* period – only that signs or symptoms were, or would have been evident;
- The signs and symptoms should have been reasonably apparent to either *you*, or a reasonable general practitioner had *you* been examined in the 6 *month* period; and
- Is the only person authorised to decide if an ailment, illness or condition is pre-existing.

This does not apply to psychiatric conditions, palliative care and rehabilitation, which have a 2 *month waiting period* even if it is a *pre-existing condition*.

When to contact the Fund

Where *you* have less than 12 *months membership* on *your* current *hospital cover*, contact *us* before *you* are admitted to hospital to find out if the *pre-existing conditions* apply to *you*. Important things to consider:

- *Our* assessment will require 5 working days, subject to the timely receipt and complete documentation from *your* treating *medical practitioner(s)*.
- If *you* proceed with the admission without confirming *benefit* entitlements, *you* will be required to pay all hospital charges and medical charges not covered by Medicare if *we* subsequently determine *your* condition is pre-existing.
- In an emergency, *we* may not have time to determine if *you* are affected by the *pre-existing condition* rule before *your* admission.

Documentation we may require includes:

- Heath Partners Certificate of Medical Attendant form completed and signed by *your* general practitioner (GP) and any specialists *you* consulted.
- Referral letters from *your* GP to specialist/s and doctors notes from any medical appointments.
- Emergency department notes if *you* were treated through a hospital emergency department.
- For injuries resulting from *accidents*, *we* will also need a medical certificate or report from the licensed practitioner *you* saw in the 72 hours following the *accident*.
- Records from a previous general practitioner.
- Correspondence between health professionals, or between hospitals and health professionals.
- Hospital discharge summary statements.
- Hospital inpatient records.
- Results of clinical investigations like blood tests and medical imaging.

What do we do with this documentation?

- *We* will appoint an independent *medical practitioner* to determine whether, in their opinion, there would have been signs or symptoms of the condition evident in the 6 *months* immediately prior to *you* joining *us* or changing *your* level of *hospital cover*.
- If *our* appointed independent *medical practitioner* determines that signs or symptoms would have been evident, then this is considered a *pre-existing condition* under the *Government Rules*.
- Once there is sufficient information and a decision can be made, *we'll* notify *you*.

Health Partners app and portal

The Health Partners app and portal both provide the same set of features and are accessible to any adult with a Health Partners *membership*.

a. The portal is available through the *member* login page at healthpartners.com.au.

b. The app can be freely downloaded from Google Play and the Apple App Store, and accessed on smartphones and tablets.

By providing an email address when applying for cover, *you* will receive instructions in *your* welcome pack on how to register for the digital services. *You* will need to complete the registration process to gain access to both the app and portal.

Benefits

Unless otherwise stated, *your benefits* are per *member* and per calendar year, meaning they reset on 1 January each year. As there are some exceptions, please refer to *your* individual *cover* details for information specific to *you*.

Understanding Benefits and Obtaining a Benefit Quote

There can be thousands of items and service codes linked to *your benefits*, for this reason *we* do not itemise them on *your* individual *cover* details.

To check if a specific item or service is covered, please contact *us* for a *benefit* quote. *You* will need to provide *us* with:

a. *provider* name;

b. *provider* number;

c. item number(s) *you* wish to *claim* as given by *your provider*;

d. the fees charged by *your provider* for each item; and

e. for dental, *we* will require the tooth numbers.

The *benefit* covered can be represented in the following ways:

a. Set Benefit – this is a specified *benefit you* receive back when *you* make a *claim* for that service or item.

b. Benefit Percentage – the amount *you* get back is calculated as a percentage of the fee charged.

c. Maximum amount – *you* can *claim* up to the maximum amount.

d. Number of visits – *you* can *claim* up to the maximum number of visits during the specified period.

e. Loyalty benefit – *benefit* is based on continuous length of *membership*.

The *benefits* can vary, refer to *your* individual *cover* details to see what benefits apply to *you*.

Benefit Rules

Any *benefits we* pay are subject to all of the rules and conditions outlined below.

Benefits are only payable where:

a. the *member* is covered for the *treatment claimed*;

b. the *member* has served the *waiting period* for the *treatment claimed* on their *policy*;

c. the *member* has limits remaining. If downgrading *your cover*, any *benefits claimed* on *your* previous *cover* will count towards *your* new lower limits for the same calendar year or period, and in some cases may mean limits are already exceeded for that year and no further *benefits* will apply;

Once You're a Member continued

d. *premiums* on *your policy* are paid up to or in advance of the date of *treatment claimed*;

e. the date of *treatment* is not within a *membership* suspension period on *your policy*; unless as approved by *us*, at *our* discretion.

f. all required supporting documentation is provided, correctly completed and deemed satisfactory and accurate by *us*;

g. *you* have authorised the *benefit claim*;

h. the *benefit claim* is received within two years after the *treatment* date. Please note *benefits* count towards limits for the year in which the *treatment* was provided;

i. the *benefit claim* is for *treatment* provided within *Australia* by persons who satisfy *our recognition criteria*. Although uncommon, there are instances where a previously *recognised provider* may no longer be recognised by *us*. Please contact *us*, to determine if a *provider* is recognised and approved by *us*;

j. the *benefit claim* is for *treatment* that has been provided – *we* will not pay *benefits* where pre-payment was made (including the purchase of any vouchers) for *treatment* not yet provided;

k. the maximum of one consultation per person, per *treatment* type, per day is not exceeded for the following *treatment* types:
Physiotherapy, Chiropractic, Osteopathy, Exercise Physiology, Acupuncture, Massage, Dietary, Podiatry, Psychology, Hypnotherapy, Speech Therapy, Occupational Therapy, Eye Therapy, Chinese Herbalism, Myofascial Release, Myotherapy and Nutritionist;

l. the *treatment claimed* cannot be *claimed* from any other source, including Medicare – *we* may pay a reduced benefit after *you* have *claimed* from another source where *we* are permitted to do so under the *Government Rules*;

m. the *treatment claimed* has been provided to the *member* in person – consultations provided over the telephone or internet will not receive a *benefit* except where included as part of qualifying 'Health Management Programs' or 'Hospital to Home', or unless as approved by *us*, which is at *our* discretion and as set out in these Rules;

n. items are not purchased over the internet or telephone unless *we* have approved this *provider* to supply the items in this manner. Contact *us* prior to purchase to confirm item eligibility and *provider* recognition;

o. required *co-payments* for eligible pharmacy prescriptions are paid for each pharmacy item dispensed. *Benefits* for multiple pack dispensing can vary and multiple *member co-payments* may apply;

p. criteria has been met within Fund Rule 'Transferring from another Fund';

q. criteria has been met within Fund Rule 'Transferring between *covers* with us and the impact on waiting periods';

r. fees for goods *claimed* are not freight or postage charges;

s. *we* believe the billing for *treatment claimed* is reasonable;

t. *treatment* was required and was not provided in an unreasonable, improper or unlawful way. This includes for the intent of monetary gain or other advantage for *yourself* or any other *member*;

u. *treatment claimed* was clinically appropriate and there is no pattern of *over-servicing*;

v. the charge for *treatment claimed* is not lower than the *benefit* that would otherwise have been payable, in this case the *benefit* will be reduced to the amount of the charge;

w. the charge is not higher than what would have been charged to an uninsured *person*, or *person* on a different *cover* for similar *treatment*; and

x. criteria has been met within Fund Rules 'Provisional Payments' and 'Injury Rules and the impact on Claims', for *treatment* that *we* determine may be related to a *claim* for *compensation*.

There are also some additional rules relating to hospital benefits:

a. hospital *benefits* are only payable when *treatment* is provided by an approved hospital, health care organisation or *provider* that meets our *recognition criteria*;

b. where *Hospital Purchaser Provider Agreements* are in place, *benefits* will be paid as set out in the schedules of each agreement;

c. where *Hospital Purchaser Provider Agreements* are not in place, *benefits* will be paid according to *Government Rules*;

d. if *you* are treated as a private *patient* in a public hospital for services included on *your cover*, *we* will pay the default *benefit* as set by the Government for a shared room only. *You* will be required to pay any difference between the *benefit we* pay and the amount the hospital charges. This means *you* may need to pay significant out-of-pocket expenses. At *our* discretion *we* may contribute to some or all of these expenses depending on the services received and location of the public hospital;

e. where *Medical Provider Agreements* are in place, *benefits* will be paid as set out in the schedules of each agreement;

f. where *Medical Provider Agreements* are not in place, *benefits* will be paid according to *Government Rules*;

g. where a medical *provider* has agreed to participate in the *Medical Provider Agreement* referred to as 'Health Partners Access Gap Cover Scheme', *benefits* will be provided to cover the full cost, or all but a specified amount or percentage of the full cost of the medical *provider's* fee;

h. *benefits* are not payable for *hospital treatment* for which no Medicare Benefits are payable, including cosmetic surgery, experimental *treatment* and clinical trials;

i. *hospital cover* does not include *benefits* for the services performed by a dentist. To receive *benefits* for these services, *you* must also hold an eligible *extras cover*, which includes these services.

j. *benefits* are not payable for respite care;

k. *benefits* are not payable for medical costs related to surgical podiatry, unless it is for the *treatment* of Podiatric surgery that is provided by a registered podiatric surgeon and is included in *your cover*;

l. *benefits* are not payable for hospital *treatment* provided by a *medical practitioner* not authorised by the hospital to provide that *treatment*;

m. *benefits* for *nursing home type patients*, will be paid according to *Government Rules*;

n. *benefits* are not payable for emergency department fees;

o. *benefits* are not payable where *you* are considered an *out patient*. An *out patient* is where *treatment* is administered through the below and these are in most instances not be covered by private health insurance. These services may be *claimable* in part or in full through Medicare if *you* have an eligible Medicare card.

   i. Emergency departments;

   ii. *Treatment* rooms;

   iii. *Out patient* clinics;

   iv. Specialist *consultations*;

   v. Lab tests and scans; and

   vi. Any other hospital services that do not require *you* to be admitted to hospital as an in-*patient* (including *type 'C' procedures*, as detailed in the *Government Rules*).

p. At *our* discretion, *we* pay for incidental costs associated with a public hospital, where *your hospital cover* is not being used. This could include the cost of TV rental, local phone call and car parking during *your* stay.

Hospital conditions that impact on your hospital benefits:

a. in calculating *benefits* for hospital accommodation, the day of admission will be counted as a day for *benefit* purposes and the day of discharge will not be counted as a day for *benefit* purposes, unless it is the day of admission;

b. multiple procedures – if *you* undergo more than one operative procedure during the one theatre admission, the procedure with the highest fee in the Medicare Benefits Schedule determines *your* classification subject to the rules for continuous hospital;

c. subsequent procedure – if *you* undergo a subsequent operative procedure during the same period of hospitalisation:

   i. and *your* procedure results in a higher classification, the classification increases from the date of the procedure; and

   ii. where the procedure would otherwise have resulted in *you* moving to a lower classification, the classification is unchanged; and

d. continuous hospital stay greater than 35 days – if *you* are hospitalised continuously for a period of more than 35 days, *you* will be automatically classified as a *nursing home type patient* and *your benefits* will be reduced to the minimum default *benefits* for *nursing home type patients* according to *Government Rules*. The n*ursing home type patient* classification will not apply if a *medical practitioner* responsible for *your* care in hospital provides *us* with certification that *you* require ongoing *acute care hospital treatment*, including the details of the condition(s) requiring *treatment* and the *treatment* to be provided.

Where the *benefit* rules and conditions are not met, the *benefit claim* may be refused, suspended, withheld or reduced.

Injury Rules and the impact on Claims

In this rule:

a. **Claim** means a reference to a demand or action (other than a *claim* for *Fund benefits*).

b. **Injury** includes any condition, ailment or injury for which *benefits* would, or may otherwise be,

payable by *us* for expenses incurred in relation to its *treatment*.

A reference to a *member* receiving *compensation* includes:

a. *compensation* paid to another person at the direction of the *member*; and

b. *compensation* paid to another *member* on the same *membership* in connection with an *injury* suffered by the *member*.

If *you* have the right to receive *compensation* to an injury *you* must:

a. inform *us* as soon as *you* know or suspect that such a right exists;

b. inform *us* of any decision to claim *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 *our* reasonable satisfaction;

e. keep *us* informed of the progress of the claim for *compensation*;

f. inform *us* immediately upon the determination or settlement of the claim for *compensation*; and

g. upon settlement supply *us*, if requested, copies of all related settlement documentation and/or associated medical information in relation to the claim for *compensation* and damages.

Withholding Payment of Benefits relating to Injury

Subject to Fund Rule 'Benefits for Expenses subsequent to Compensation', where *you* appear to have a right to make a claim for *compensation* in respect of an injury but that right has not been established, *we* may withhold payment of *benefits* in respect of expenses incurred in relation to that injury.

Provisional Payments

Where a claim for *compensation* in respect of an injury is in the process of being made, or has been made and remains unfinalised, *we* may in *our* absolute discretion make a provisional payment of *benefits* in respect of expenses incurred in relation to the injury.

In exercising *our* discretion, *we* may consider factors such as unemployment or financial hardship or any other factors that *we* consider relevant.

A provisional payment is conditional upon *you* signing a legally binding undertaking and authority supplied by *us*, that contains an agreement by *you*, in consideration for the payment:

a. to comply with the Injury Rules as outlined in this document;

b. that the provisional payment is bound by these Fund Rules;

c. to disclose to *us*, on request, all matters pertaining to the progress of the claim and details of any determination made or any settlement reached in respect of the claim;

d. to repay *us* the full amount of the provisional payment as a debt immediately repayable upon the determination or settlement of the claim, whether or not the terms of such a settlement specify that the sum of money paid under the settlement relates to expenses past or future for which *Fund benefits* are otherwise payable; and

e. that *we* have specified rights of subrogation whereby *we* acquire all rights and remedies of *you* in relation to the claim.

Once You're a Member continued

Where Benefits have been paid by Health Partners

Subject to Fund Rule 'Requirement to Repay Benefits may be Waived' where:

i. *we* have paid *benefits*, whether by way of provisional payments or otherwise, in relation to an injury; and

ii. *you* have received *compensation* in respect of that injury;

you must repay *us* the full amount *we* have paid in relation to the injury, upon the determination or settlement of the claim for *compensation*.

Rights of Health Partners

If *you* make a claim for *compensation* in relation to an injury and fail to:

a. comply with any obligation as outlined in the Injury Rules or the rules relating to 'Where Benefits have been paid by Health Partners'; or

b. include in *your* claim for *compensation* any payments of *benefits* by *us* in relation to an injury, *we* may without prejudice to *our* rights (including our broader subrogation rights) in *our* absolute discretion take any action permitted by law to:

   i. assume that all expenses in relation to the injury have been met from the *compensation* payable or received pursuant to the claim; and/or

   ii. pursue *you* for repayment of all *benefits* paid by *us* in relation to the injury; and/or

   iii. assume legal rights in respect of all or any parts of claim.

Claim Abandoned

Where:

a. *you* have or may have a right to make a claim for compensation in respect of an injury; and

b. *we* have reasonably determined that *you* have abandoned or chosen not to pursue the claim;

benefits are payable (subject to other Fund Rules) if *you* sign a legally binding undertaking supplied by *us* and agree, in consideration for the payment of *benefits*, not to pursue the claim.

Requirement to Repay Benefits may be waived

Where in respect of a claim for *compensation* in relation to an injury:

a. *you* have complied with the Injury Rules outlined in this document; and

b. *we* have given prior consent to the settlement of the claim for an amount that is less than the total *benefits* paid or which would otherwise have been payable by *us*;

we may at *our* absolute discretion and subject to any conditions that *we* consider appropriate, determine that *you* need not repay any part or the full amount of the *benefits* paid by *us* in respect of the injury.

Benefits for Expenses subsequent to Compensation

We may, in *our* 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 subject of a claim for *compensation*; and

b. that the 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.

Other Insurance

For the avoidance of doubt, *you* are not entitled to *benefits* for as much of the expenses as the *member* is entitled to recover under another *insurance policy* or would have been entitled but for this *insurance*. *You* must first *claim* under that *insurance policy*. This applies whether the other *insurance policy* provides full or partial coverage.

Benefits payable in accordance with these Rules will not exceed 100% of the fee charged for *treatment*, less any amounts recoverable from any other source.

Limits

Unless otherwise stated, *your benefit* limits are calculated per *member* and per calendar year, meaning they reset on 1 January each year. As there are some exceptions, please refer to *your* individual *cover* details for information specific to *you*.

Where a limit applies, it can either be a:

a. Annual limit – this is the maximum amount of *benefits claimable* in a calendar year for that service or item;

b. Lifetime limit – the total amount *you* can *claim* in *your* lifetime across all health funds (for example, orthodontics). Once *you* reach the limit, no further *benefits* will apply in future;

c. Combined limit – one limit across more than one service, as opposed to a single limit for one service. This provides flexibility for *you* to use the limit on the service that is more important to *you*, but provides security to know *you* still have *cover* just in case *you* need it; or

d. Sub-limit – is part of (rather than in addition to) an overall limit. It indicates the total amount *claimable* for that particular service/item within an overall limit.

Claiming

How to claim

Policyholders and *partners* with Delegation of Authority are able to view and submit *claims* for anybody on their *membership*. *Partners* without Delegation of Authority can view and submit *claims* for themselves and minor *dependants* on their *membership*. *Dependants* (other than *partners*) can only view or submit their own *claims*.

When it comes to *claiming*, choose the option that best suits *you*.

a. Online

Claims can be submitted in a few easy steps via the Health Partners portal at healthpartners.com.au, or the Health Partners app. With no paperwork or hassle, most *benefits* are generally paid within two to five business days of *your* claims being submitted.

b. On-the-spot

In most cases *your claim* can be processed on-the-spot whenever *you* visit a *provider* that utilises electronic *claiming* (such as HICAPS or HealthPoint). Simply present *your membership* card at the time of service and *you* will only have the gap to pay — or nothing at all, depending on *your* level of *cover* and available limit.

Once You're a Member continued

c. Post/Email

Claim forms are available on *our* website, at *our* centres and upon request. Once the form is completed (with itemised accounts attached), *you* can mail it freepost to:

Health Partners Claims
Reply Paid 1493
Adelaide SA 5001

Or email it to:
ask@healthpartners.com.au

If *you* prefer, submit *your claims* in person at any Health Partners centre. Please note that over- the-counter cash *claiming* is not available.

Required information to include with your claim

Your claim must include an account and receipt from the *provider*. The account and receipt must include:

a. the *provider's* name, ABN, *provider* number and address;
b. the *patient's* full name and address;
c. the date of service;
d. the description of the service including item numbers (if applicable);
e. the amount charged;
f. any amounts already paid;
g. any other information that Health Partners may reasonably request;
h. it must appear on the *provider's* letterhead or include the *provider's* official stamp; and
i. any *claim* for hospital *treatment* expenses shall also be accompanied by a certificate of hospitalisation in a form approved by *us*.

By submitting a *claim* for *benefits*, *you* authorise *us* to contact the *provider* to clarify or obtain further information about the *claim*.

We may request a certificate from the *person* who provided the *treatment* relating to any matter which *we* determine is relevant to consideration of *your claim*, including:

a. the precise nature of the *patient's* illness, injury or condition;
b. the precise nature of the services or *treatment* provided;
c. whether the *patient's* condition needed the use of medical, nursing, pathological, radiological and other diagnostic services, operating theatre, recovery room and anaesthetic facilities available at the premises;
d. the period the *patient* was hospitalised; and
e. any other information appropriate to the circumstances of the *claim*.

Where *we* request such information direct from the *person* who provided the *treatment*, *you* will, if required, authorise the *person* to make the information available direct to Health Partners for use by *us* or relevant government body.

Refusing, Suspending, Withholding or Reducing Payment of a Claim or Benefit

We have the right to refuse, suspend, withhold or reduce a payment *claim* if *our benefit* rules and conditions are not satisfied.

At our discretion *we* also have the right to refuse, suspend, withhold or reduce a *benefit claim* where the *treatment* was provided to *you* by a family member/relative or business partner.

Subrogation of Rights in a Claim

a. If a *person*, in *our* opinion, incorrectly charges a *member* for a service for which a *benefit* is payable, *we* may in the name of the *member* take or defend any action in connection with the charge, including an action to recover money overpaid.

b. For this purpose *you* must do all acts and sign all documents that *we* require.

c. If *you* fail to do this *we* may withhold *benefits* or not pay *benefits* for this service.

Payment of a Claim

By default, *claim* payments will be paid to the *policyholder*, or to the *provider* if the account is unpaid.

For *claims* made by a *policyholder's partner* or *dependant* (over the age of 18) for themselves, the payment can be made directly to them if requested by them at the time of *claiming*.

If an account for a *claim* is paid by a person other than the *policyholder* or *member*, Health Partners does not need to pay or require the *policyholder* or *member* to pay, that *person*.

Please note *benefits* cannot be paid into a credit card account.

Benefit payments are deposited by direct credit directly into *your* preferred bank account (or a cheque is provided if required, subject to availability). Simply supply *your* bank account details on *your membership* application, on the Member Claim form or any time via a Benefit Payments form.

It is the responsibility of the *member* to provide accurate and up to date bank account information.

Health Partners accepts no liability for payments made to an incorrect bank account, should this result from the *member* having provided incorrect bank account details.

You only need to supply the details for a direct credit once — the next time *you* submit a *claim* (either through our app, online or a claim form), simply tick the "direct credit" box and *we* will transfer *your benefit* to that same account.

Once direct credit payments have been processed, a Remittance Statement will be sent to *you* outlining the *benefits* paid.

Claims Security

All private health insurers are run according to the same strict solvency, capital adequacy and governance standards set out by the Australian Government, so *you* can feel secure when it comes time to *claim*.

We are regulated by the Australian Prudential Regulation Authority (APRA) and have Board approved strategies in place to assist in complying with our obligations under the Governance, Capital and Risk Management standards.

Suspensions

Overseas Travel Suspension

At *our* discretion *we* may approve suspending *your membership* or *policy* for the period of time *you* are absent from *Australia*.

Your initial application for suspension for travel will only be considered where *you've* held continuous *membership* for at least one *month* and all *premiums* are paid to the date of departure. The minimum duration is three weeks to a maximum of two years.

Once reactivated for a duration no less than three

months, a further suspension may be available at *our* discretion for a minimum duration of three weeks to a maximum of two years.

Over the life of the *membership*, suspending *your membership* for travel reasons cannot exceed a maximum of four years per event.

Where the reasons for suspension cease to apply, or the maximum period of suspension is reached the *policyholder* must reactivate the *membership* within one *month*.

Otherwise the *membership* and its related *members* are taken to be new for the purposes of these Rules and the *Government Rules*.

Your suspension commences the day after *you* leave *Australia*.

Prior to suspending, *you* will be required to comply with any requirements, as determined by *us* and comply with all rules and conditions.

Financial Hardship Suspension

At *our* discretion *we* may approve suspending *your membership* or *policy* for the period of time *you* are experiencing financial hardship.

Your initial application for suspension for financial hardship will only be considered where *you've* held continuous *membership* for at least six *months*. The duration is only while *you're* experiencing financial hardship and cannot exceed 12 *months*, unless approved by *us*, which is at *our* discretion.

Over the life of the *membership*, suspending *your membership* for financial hardship reasons cannot exceed an accumulative time of two years, unless approved by *us*, which is at *our* discretion.

Your suspension period commences on the day after the period ends for which *premiums* are paid or when suspended under 'Other' suspension rules unless otherwise approved by *us*. Prior to suspension, *you* will be required to comply with any requirements, as determined by *us* and comply with all relevant *rules* and conditions.

Other Suspensions

We may at *our* discretion suspend a *membership* for any reason *we* see fit, for the terms and time period determined by *us*.

Rules for Suspensions

For the duration of any suspended *membership*, the below rules apply:

a. no *benefits* are payable, unless approved by *us*, which is at *our* discretion;
b. the period of suspension does not count towards any *waiting period* or *loyalty bonuses*; and
c. a suspension is subject to the conditions, if any, which *we* may impose from time to time.

Loyalty Benefits and Length of Membership Rules

The below rules apply when calculating length of *membership* to be eligible for loyalty bonuses:

a. each *member* must achieve the minimum length of *membership* on their *cover* to be eligible to receive any loyalty *benefits* available on *your cover*;
b. *your* length of *membership* transfers with *you* between Health Partners equivalent *covers*, without breaking the continuous length of *membership* count;
c. if *you* have terminated *your membership* and re-join *us* at another point in time, for the purpose

of loyalty *benefits*, *your* length of *membership* will restart at the time *you* re-join *us*;

d. the start date is when *your membership* has been processed and is financial, meaning the required *premium* amount has been received as outlined in *your cover* details;

e. Health Partners do not recognise length of membership in another fund for the purposes of loyalty *benefits*; and

f. where an approved suspension of *membership* occurs, the below rules will apply:

   i. the period of suspension will not count for the purposes of loyalty *benefits*; and

   ii. the length of *membership* prior to the suspension will be included in any length of *membership* after the *membership* is reactivated.

Loyalty *benefits* do not apply on all *covers*. Please refer to *your* individual *cover* details for information specific to *you*.

Moving Interstate

Premiums and some *benefits* may vary slightly from state to state. If *you* are moving interstate, *you* will need to advise *us* of *your* new address within 14 days. *We* will then make the required changes and provide *you* with notice of any updates to *your premiums* and *benefits*.

Delegation of Authority

Delegation of Authority is automatically provided to any *partner* of the *membership* at the time of joining. This can be revoked at the request of the *policyholder* at any stage.

The *policyholder* can also give Delegation of Authority to anyone over the age of 18, even if they are not listed on the *membership*. Anyone who holds the Delegation of Authority can manage most aspects of the *membership*, including:

a. updating personal details (e.g. address, phone number);

b. changing the level of *cover*;

c. changing the payment method;

d. adding or removing a *dependant*;

e. adding or removing a *partner;*

f. suspending and reactivating the *membership*;

g. submitting *claims* on behalf of any *member* on the *membership*;

h. make general enquiries about the *membership*, including dental and optical appointments; and

i. access personal health information such as medical details or conditions regarding other *members* covered on that *membership*.

This authorisation does not allow the nominated *person* to:

a. cancel the *membership*;

b. change the status of the *policyholder*;

c. nominate further delegated authorities; and

d. access or change passwords for the *policyholder's* Health Partners app and portal account.

Any changes to the Delegation of Authority can be made by the *policyholder* at any time by contacting *us*.

Where other forms of legal authority apply, for example Power of Attorney, *you* will need to provide a copy of the document. This will enable *us* to determine what levels of authority apply.

Once You're a Member continued

Substitute Decision-makers

Designated Substitute Decision-makers can be nominated by the *policyholder* or by someone that holds an Advance Care Directive (including the Power of Attorney designation), an administration or guardianship order, from a relevant judicial body. Supporting documentation will be required at the time of adding a Substitute Decision-maker.

This enables them to make decisions on behalf of individuals who cannot do this for themselves. Substitute Decision-makers have all the functions held by someone with Delegation of Authority, plus:

a. cancel the *membership*;
b. change the status of the *policyholder*; and
c. operate the policyholder's Health Partners app or portal account.

Responsible Adult

A *Responsible Adult* is required for all *child* only memberships. Health Partners require relevant documents confirming authority for the child (e.g. Birth Certificate, Guardianship Document, Power of Attorney) along with a completed Responsible Person Authority form (available upon request from Health Partners).

Cancellation of Membership and/or Policy

You will need to provide *your* request for cancellation in writing, unless otherwise agreed by *us*.

Cancelling *your membership* and/or *policy* can be done by either:

a. removing *yourself* from a *membership* and/or *policy*, but other *members* remain; or
b. cancelling the entire *membership* and/or *policy*, so all parties to the *membership* and/or *policy* are also cancelled (this can only be done by the *policyholder*).

The date of cancellation will be effective from:

- the date requested in writing - the *policy* must be paid up to the requested date, if not the cancellation date will revert to the date the *policy* is paid up to; or
- the date the cancellation request was received, where no date was provided; or
- the date following a *member* becoming deceased.

Where a *claim* has occurred after the requested cancellation date, the cancellation will not be effective until the day following the *claimed* service.

The *policyholder* may cancel the *membership* and/or *policy* provided no *member* has *claimed* under the *membership* and/or *policy*. This applies to any new *member* taking out *cover* or existing *members* taking out new *cover* with *us*. Cooling-off and/or notice periods may apply, refer to the Cooling-off period section of this Member Guide for more details.

A *policyholder* that terminates their *membership* and/or *policy* can apply to reinstate their *membership* and/or policy with *us* without re-serving *waiting periods*. The request must be accepted by *us* and done within 30 days of the date of termination.

If the product is no longer available for new business, *you* will be reinstated to an equivalent product, *waiting periods* will apply to any additional *benefits*. During this time *you* will receive the same *benefits*

you received on *your* previous *cover*. *You* will also continue to pay the same *excess* and *co-payments* (if applicable). Limits and *benefits* already *claimed* will count towards yearly and lifetime limits.

Improper Conduct

We may terminate or suspend a *membership*, or remove a *member* from a *membership* if in *our* opinion;

a. a *member* gives misleading or untrue information to *us* for any reason including in an application, when making a *claim* or answering a request for further information;
b. a *member* obtains or attempts to obtain any monetary or other advantage for themselves or for anyone else, which they or the other *person* is not entitled to; or
c. there is a pattern of *over-servicing* to a *member* or any other form of abuse by or for a *member*.

Transfer Certificate

In the event a *membership* is cancelled, *we* will provide *you* with a certificate as required by the *Government Rules*.

Notices and Changes to Rules

We may vary *our* Fund Rules at any time and will provide the required notice in line with the *Government Rules*.

We will provide an *adult member* with reasonable notice of the change where the change is considered to be detrimental to *your* interest. This applies to:

a. the scope, level or amounts of *benefits* payable to *you*; or
b. increases in *premium* rates (other than as an effect of rounding); or
c. decreases to the *treatment* included in *your cover*.

We will also provide an *adult member* with notice if the change:

a. positively varies the scope, level or amount of *benefits* payable to *you*; or
b. decreases the *premium* rates (other than as an effect of rounding); or
c. increases the *treatment* included in *your cover*.

We may also provide notice of changes by:

a. publishing the change in:
    i. a Health Partners publication distributed generally to *members*; or
    ii. a newspaper circulating generally in South Australia; or
b. by including the change in the *Private Health Information Statement* given to an *adult* every 12 *months*.

Private Health Information Statements

a. Health Partners must give an *adult* under each *membership* a copy of the *Private Health Information Statement* for the relevant *policy*:
    i. when the *person* is first insured;
    ii. at least once every 12 *months*; and
    iii. if a change to these Rules is or might be detrimental to the interests of a *member*, as soon as practicable following the change.
b. Health Partners must provide an up-to-date copy of a *Private Health Information Statement* to anyone who requests a copy.

Australian Government Initiatives

The Rebate

The Australian Government Rebate on Private Health Insurance was introduced as a financial incentive to help Australians afford private health *cover*. The rebate depends on *your* age, is income-tested and applies to all Health Partners products.
For more information on the rebate, go to healthpartners.com.au/health-insurance/rebate

Claiming the rebate

You may claim the rebate as a reduction in *your premiums* by nominating a rebate tier. Alternatively, *you* can claim the rebate via *your* tax return.

Please note that if *you* have a Lifetime Health Cover (LHC) loading, the rebate is not claimable on the LHC component of *your* private health *cover premiums*.

Nominating a rebate tier

The *policyholder* may determine the Rebate Tier. Nominate the tier appropriate to *your* circumstances when *you* join by calling *our* Member Care at 1300 113 113.

After completing the join process, *you* may update an existing tier at any time by contacting *us* or by using the Health Partners portal at healthpartners.com.au, or via the Health Partners app.

As *we* are not permitted to advise *you* on which rebate tier to select, if *you* are unsure, *we* recommend *you* contact *your* tax agent.

The income thresholds are subject to change and are determined by the Federal Government.

For more information please visit:

- healthpartners.com.au/health-insurance/rebate
- privatehealth.gov.au
- ato.gov.au

Lifetime Health Cover

Lifetime Health Cover (LHC) is a government initiative designed to encourage *you* to purchase and maintain *private patient* hospital insurance *cover* earlier in life.

If *you* have not taken out and maintained *private hospital* health insurance from the year *you* turn 31, *you* will pay a 2% LHC loading on top of *your premium* for every year *you* are aged over 30 if *you* decide to take out *hospital cover* later in life.

For example, if *you* wait until *you* are 40 years old *you* could pay an extra 20% on the cost of *your hospital cover*. If *you* wait until *you* are 50 years old, *you* could pay 40% more. The maximum LHC loading that can be applied is 70%.

LHC loading is not paid by all people. To avoid incurring an LHC loading, residents of *Australia* must ensure they hold an appropriate level of *private patient hospital cover* before they reach their LHC 'base day'.

For many people, LHC base day is 1 July following their 31st birthday, but this can change depending on personal circumstances.

LHC loadings apply only to *private patient hospital cover* – they do not apply to *general treatment cover* (also known as ancillary or *extras cover*).

The *premium* payable by a *policyholder* will be increased by an amount, if any, required by the Lifetime Health Cover provisions in the *Government Rules*.

For more information, visit privatehealth.gov.au

Certified age

In most cases, *your* certified age is the age on the 1st of July before the day on which *you* first took out private *hospital cover*. This is used to calculate *your* LHC loading. The minimum certified age is 30.

If *you* know *your* certified age, use the Certified Age table to determine the loading that may apply to *you*. For *couples* and families, look up the loading for each *partner*, add the loadings together and divide by two.

Certified age	LHC loading
30	0%
31	2%
32	4%
33	6%
34	8%
35	10%
36	12%
37	14%
38	16%
39	18%
40	20%
41	22%
42	24%
43	26%
44	28%
45	30%
46	32%
47	34%

Certified age	LHC loading
48	36%
49	38%
50	40%
51	42%
52	44%
53	46%
54	48%
55	50%
56	52%
57	54%
58	56%
59	58%
60	60%
61	62%
62	64%
63	66%
64	68%
65	70% (max)

Exceptions

You may be eligible for an exemption to the LHC loading if:

- *you* were born on or before 1 July 1934;
- *you* have been living overseas since 1 July following *your* 31st birthday or since 1 July 2000;
- *you* have migrated to *Australia* and became eligible for Medicare benefits in the last 12 *months*;
- *you* hold or have held a Gold Card; or
- *you* are an active member of the Australian Defence Force.

Permitted days

Permitted days are the number of days *you* are able to drop *your hospital cover* without affecting *your* loading. *You* can drop *your hospital cover* for a cumulative period of 1,094 days (i.e. 3 years less 1 day). Once *you* have used these permitted days without *hospital cover*, a 2% loading will apply for each year or part year *you* are without *hospital cover*.

You can drop *your cover* without using permitted days and without affecting *your* loading when:

- *you* have suspended *your membership* with *us*; and
- *you* are overseas for at least 12 *months*. *You* can return to *Australia* for visits of up to 90 days at a time and still be considered as being overseas.

Please be aware that if *you* do drop *your hospital cover*, *you* will need to re-serve hospital *waiting periods* upon re-joining.

Australian Government Initiatives continued

Removal of LHC

We will remove *your* LHC loading after *you* have completed 10 years of continuous *cover* with one or more health funds, as outlined in the *Government Rules*.

Please note that although *you* can break up *your* 10 years of continuous *cover* with any of the permitted periods without *hospital cover*, the breaks in *cover* do not count towards the 10 years.

You should also note that if *you* use up *your* full 1,094 permitted days, the continuity of *your* 10-year period of *cover* is broken. If *you* re-join *hospital cover* after exceeding the 1,094 days, *you* will have to pay an increased loading and *you* will have to restart *your* 10 years of continuous *cover* from the date of re-joining.

Youth Discount

The Youth Discount is an initiative designed by the Australian Government that allows Private Health Insurers to offer an aged based discount on *hospital cover* for 18 to 29 year olds. This does not apply to *dependants* on family *covers*.

This discount is completely voluntary, meaning insurers aren't obligated to give the discount.

We have applied the discount to all hospital products for new and existing members from 1 April 2019.

Here are the maximum discounts by age that *we* will automatically apply to *your membership*:

Your age when you take out hospital cover	Your discount
18-25	10%
26	8%
27	6%
28	4%
29	2%

Once *you* have *your* age-based discount, it will stay in place until *you* turn 41 years old, unless otherwise notified by *us*. Calculations are based on the formula outlined in the *Government Rules*.

Health Partners will apply the Youth Discount applicable from *your* previous fund providing transfer occurs within 30 days of ceasing to be insured by the other insurer.

The Youth Discount applied for joins after 30 days will be *your* age when *you* take out *hospital cover* with *us*.

All *you* have to do is keep *your hospital cover* with Health Partners. If *you* upgrade or downgrade *your hospital cover your* discount will still stay in place. Once *you* turn 41, *your* discount will then gradually phase out at 2% each year.

For more information refer to health.gov.au.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a surcharge imposed on people who earn above a certain income and who do not have applicable private *hospital cover*. The level of surcharge depends on *your* level of income for MLS purposes and is payable in addition to the standard Medicare Levy. It may apply for any period during which *you* suspend *your hospital cover*; for example, if *you* suspend *your cover* for overseas travel.

The Medicare Levy Surcharge table will help *you* determine if the MLS may apply to *you*.

For more information, including when the levy applies, levy percentages and surcharge thresholds, please visit ato.gov.au or call the Australian Taxation Office on 13 28 61.

What you need to know about your extras cover

With *extras cover*, *you* can *claim* for a range of services that generally aren't covered by Medicare and that aren't covered by *hospital cover.* The level of *extras cover you* choose will determine whether *you* are covered for a particular service.

Details on the services included with each *cover* can be found in individual *cover* details or on the Health Partners website. Any conditions mentioned below need to be read in conjunction with the *Benefit* Rules.

Membership Types

The below *membership* types are available for those products listed:

Product	Membership Type
Base Extras	Single
Good Extras	Couple
Better Extras	Single Parent
Best Extras	Extended Single Parent Family
Growing Family Extras	Family
	Extended Family
Combined Good Extras*	Single
Combined Better Extras*	Couple
Combined Best Extras*	Single Parent
Combined Growing Family Extras*	Extended Single Parent Family
	Family
	Extended Family

*This *cover* is only available when combined with a Health Partners hospital product on the same *membership*. If *you* cancel *your hospital cover* with *us*, *you* will default back to the equivalent standalone product.

If *your* product does not appear in the list it could be a *closed product* (not available to new *members*). Please refer to Closed Products section for further details.

Maximum Treatment

Benefits are limited to one *consultation* per *member*, per *provider*, per day for the same services, unless *we* approve additional *consultations*, which is at *our* discretion or unless stated on *your* individual *cover*.

Dental is the exception, allowing multiple *consultations* on the same day where a referral and *treatment* is required.

Ambulance Cover

Ambulance conditions are the same for *extras cover* and *hospital cover* - refer to pg 43 for details.

Dental (including General, Major, Endodontics & Periodontics)

We will pay a *benefit* where *treatment* or services are provided by a *person* who meets our *recognition criteria*. If *treatment* takes place in South Australia, different *benefits* apply for Health Partners Dental versus *Health Partners participating dentist* versus *recognised providers*.

Please refer to *your* individual *cover* details to see what *benefits* apply to *you*.

Optical

We will pay a *benefit* where *treatment* or services are provided by a *person* who meets our *recognition criteria*. If *you* reside in South Australia, different *benefits* apply for Health Partners Optical versus *recognised providers*. Please refer to *your* individual *cover* details to see what *benefits* apply to *you*.

Benefits include prescription frames, lenses & contact

lenses. Prescription lens add-on items are limited to one item per lens, with the exception of lens hard coating and hardening. No *benefits* are payable for contact lens tinting or contact lens consumables.

General eye tests are bulk-billed through Medicare and subject to eligibility and Medicare conditions.

Some specialised eye tests and scans are not covered by Medicare and may incur costs. *Your* optometrist will advise *you* if this is the case.

Orthodontics

We will pay a *benefit* where *treatment* or services are provided by a *person* who meets *our recognition criteria*. *Benefits* are only payable where *treatment* has commenced. At *our* discretion *we* may request a *treatment* plan to support orthodontic *benefit claiming*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Physiotherapy

We will pay a *benefit* where *treatment* is provided by a *person* who meets *our recognition criteria* for the *treatment* of a diagnosed clinical condition. If *you* reside in South Australia, different *benefits* apply when *treatment* is provided by a *Health Partners participating physiotherapist* versus a *recognised provider*.

Treatment for any excluded natural therapy, as outlined in the *Government Rules* will not receive a *benefit*, unless the *treatment* forms part of an exercise-based intervention program prescribed by a health professional and is specific to *you*. Any *treatment*, including group sessions and classes, must be preceded by an individual assessment for a current health problem. Services will be considered excluded Natural Therapy *treatments* if they are in any way advertised, promoted or invoiced as such.

For the purposes of *benefit* entitlements, any individual *treatment* will be regarded as subsequent consultations unless otherwise defined on *your* individual *cover* details.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Chiropractic, Osteopathic and Exercise Physiology

We will pay a *benefit* where *treatment* is provided by a *person* who meets our *recognition criteria* for the *treatment* of a diagnosed medical condition. Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Pharmacy

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

PBS Prescription

We will pay a *benefit* for:

- Pharmaceutical Benefits Scheme *(PBS)* listed prescriptions that do not attract a government subsidy.
- *PBS* Authority scripts, where written for quantities as intended per *PBS* maximum quantities and repeat rules.

What you need to know about your extras cover continued

They must be dispensed at a pharmacy which is a *Health Partners participating pharmacy*. *We* will pay a *benefit* for the above prescriptions that are above the *co-payment* specified on *your* individual *cover*, and up to *your* limits.

We will not pay a *benefit* for *PBS* prescriptions, where the prescription is dispensed for a greater quantity than the maximum quantity specified in the *PBS*.

Private and Compounding Prescriptions

A private and compounding prescription is defined as a prescription that:

a. is not listed on the *PBS*, and;

b. is a medicine classified as Schedule 4 (S4), Schedule 8 (S8) or a recordable Schedule 3 (S3). For compounded medicines, at least one ingredient must be classified as an S4 or S8.

Medicines are classified under the Poisons Standard (Standard for the Uniform Scheduling of Medicines and Poisons), with recordable requirements regulated commonly by state government legislation. If *you* are unsure what classification *your* prescribed medicine is *we* encourage *you* to speak to *your* prescriber or pharmacist.

We will pay a *benefit,* up to a fixed amount, for each private or compounded prescription that cost more than the *co-payment* specified on *your* individual *cover*, up to *your* limit.

In certain circumstances, some *PBS* authority prescriptions can be written as a private prescription. In these cases, *benefits* will be paid under the same conditions as a private and compounding prescription.

All *claimable* prescriptions must be dispensed at a pharmacy which is a *Health Partners participating pharmacy* or for *members* covered with National Extras who cannot access a *Health Partners participating pharmacy*, at their local pharmacy that meets *our recognition criteria*.

Refer to *your* individual *cover* details for the *benefits* applicable to *you* .

Benefits do not apply for the below:

a. where the prescription costs less than the *co-payment* amount;

b. if the prescription is dispensed for a greater quantity than the manufacturer's largest listed pack size specified;

c. where the items are purchased using online telehealth prescription subscription services; and

d. items that are on *our* exclusion list, which is at *our* discretion and may change from time to time. Please refer to www.healthpartners.com.au/pharmacy-benefits.

Vaccination

We will pay *benefits* for selected vaccinations recognised by Health Partners, but only when they are provided by:

a. *Health Partners participating pharmacy* or for *members* covered with National Extras who cannot access a *Health Partners participating pharmacy*, at their local pharmacy that meets *our recognition criteria*;

b. a *medical practitioner*; or

c. an approved vaccination provider that meets *our recognition criteria*.

We will pay a *benefit,* up to a fixed amount, for each

of these vaccinations that are above the *co-payment* specified on *your* individual *cover*, up to *your* limit.

We will not pay *benefits* for *members* who may be eligible for Government funded vaccines, such as those available under the National Immunisation Program (NIP) or state funded programs.

We will not pay *benefits* for any out-of-pocket costs associated with consultation or administration fees from any *provider*.

Hormone and Allergen Implant

We will pay *benefits* for prescriptions recognised by Health Partners and supplied by a *medical practitioner*. The same conditions and rules apply to those detailed for private prescriptions.

IVF Associated Drugs

We will pay *benefits* for prescriptions approved by Health Partners prior to a hospital admission for the purpose of In Vitro Fertilisation *treatment*. The same conditions and rules apply to those detailed above for private prescriptions.

Pharmacy Discount

The pharmacy discount is provided by *Health Partners participating pharmacies*. Discounts, terms and conditions may change from time to time. Please refer to www.healthpartners.com.au/pharmacy-benefits.

Podiatry

We will pay a *benefit* where *treatment* is provided by a *person* who meets our *recognition criteria* for the *treatment* of a diagnosed clinical condition.

Benefits for 'in-rooms' surgical podiatry procedures are payable only when the *provider* is a Fellow of the Australian College of Podiatric Surgeons and the procedure is not performed in a hospital. This *benefit* is subject to the *Government Rules* for Surgical Podiatry.

Extras cover does not include *benefits* payable for inpatient hospital procedures. To receive *benefits* for these services, *you* must also hold an eligible *hospital cover*, which includes these services. Large out-of-pocket costs could still apply.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Orthotics

Benefits for approved orthotics are payable only when supplied and fitted by a recognised Orthotist or custom made, supplied and fitted by a recognised Podiatrist.

Psychology

We will pay a *benefit* where *treatment* is provided by a *person* who meets our *recognition criteria* for the *treatment* of a diagnosed clinical condition. *Benefits* are not payable for counselling or any other *treatment* not provided by a Health Partners recognised psychologist.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Other Therapies

We will pay a *benefit* where *treatment* is provided for Hypnotherapy, Acupuncture, Massage, Dietitian, Speech Therapy, Occupational Therapy, Eye Therapy and inclusions under Natural Therapies (Wellness

What you need to know about your extras cover continued

add-on product). *Benefits* are only payable when performed by a *person* who meets our *recognition criteria*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Aids and Appliances

A health appliance is an item prescribed by a medical or health practitioner such as *your* doctor, physiotherapist or other specialist to help treat a particular medical condition or to compensate for reduced functionality. Like health aids, if included on *your* level of *cover*, some additional information will be required with each *claim you* make.

Hearing Aids

You will need to provide evidence of the clinical need for this device from an Audiologist, Ear, Nose and Throat Specialist or other Medical Specialist, if requested by *us*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Asthmatic Spray Appliance, Blood Glucose Monitoring Machine or Blood Pressure Machine

You will receive a *benefit* where there is a medical need and as recommended by a *medical practitioner*. At *our* discretion, *we* may ask the *medical practitioner* to satisfy the *recognition criteria* and provide any supporting documentation with *your benefit claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Sleep Apnoea Machine

You will need to provide satisfactory evidence from a *medical practitioner* or accredited Sleep and Respiratory Physician and include this with *your benefit claim*. *You* can purchase the Sleep Apnoea Machine using a reputable Australian online retailer with a valid ABN. The item must be TGA approved.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Low Vision Optical Magnification Aids

You may be required to provide supporting documentation from a GP or Optometrist/ Ophthalmologist, confirming *your* condition and requirement for Low Vision Optical Magnification Aids. In addition to the above, *you* will need to include a purchase receipt with *your claim*. General daily living aids are not covered.

The Low Vision Optical Magnification Aids must be purchased from one of the below in order to receive a *benefit*:

a. registered Optical store;

b. the Royal Society for the Blind of SA (RSB); or

c. *medical practitioner*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Circulation Booster

To receive a *benefit, you* will need to include with *your claim* the receipt for a Circulation Booster appliance and where requested from *us*, supporting documentation from a *medical practitioner* recommending the appliance. The Circulation Booster appliance must be purchased from a:

a. surgical medical *provider*;

b. pharmacy;

c. *medical practitioner*; or

d. Health Partners *recognised provider*.

This is not eligible on all *covers*, please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Royal District Nursing Service (RDNS)

You will receive a *benefit* for Royal District Nursing Service (RDNS), when the service is provided by a registered nurse who satisfies the *recognition criteria*. The service must be for management of an illness, injury or condition which does not require admission to a hospital, and is not *hospital-substitute treatment*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Healthier Living

Healthier Living benefits are designed to support *members* who are looking to improve the way they manage their health condition(s) and overall wellness.

Weight Management Program

You will receive a *benefit* as detailed on *your* individual *cover*. *You* will need to provide evidence that the program has been approved by *your medical practitioner*, if requested by *us*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Bowel Cancer Screening

You will receive a *benefit* towards the cost of bowel cancer screening at a *Health Partners participating pharmacy* or a *provider* who meets our *recognition criteria*. To *claim* the benefit, *you* will need to include the receipt and supporting documentation that confirms *your* test is finalised along with *your claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Mole Check Body Scan

You will receive a *benefit* towards a full or part body scan where a *Medicare rebate* is not applicable. It must be performed by a:

a. Qualified Dermatologist;

b. GP with qualifications in Primary Care Dermatology or Skin Cancer Medicine; or

c. Registered Nurse or Melanographer who undertakes the examination but results are diagnosed by the Specialist GP or Dermatologist.

To *claim* the *benefit*, *you* will need to submit the receipt as proof of completion. This needs to be included with *your claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Diabetes Association Membership

You will receive a *benefit* for membership to the diabetes association. This must be in the State *you* reside in. *You* will need to provide confirmation of diabetes diagnosis from *your medical practitioner,* if requested by *us*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Medically Necessary Gym & Fitness Programs

You will receive a *benefit* for approved gym or fitness programs where it is required and designed to treat or relieve a specific health condition or conditions.

What you need to know about your extras cover continued

The program must be supported by an approval form signed by a recognised *medical practitioner*, Physiotherapist, Exercise Physiologist, Chiropractor or Osteopath. The signed form must confirm the specific health condition or conditions being managed, the recommendation is valid for a period of 2 years unless otherwise advised.

No *benefits* payable if used for general fitness and for selected wellness treatments.

To *claim* the *benefit*, *you* will need to include the form with *your claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Post-natal Lactation Consultation

Where a *Medicare rebate* is not applicable, *you* will receive a *benefit* for *consultations*. The *consultation* must be provided by a registered, qualified specialist midwife who is an International Board Certified Lactation Consultant (IBCLC).

To *claim* the *benefit*, *you* will need to include an itemised invoice for *treatment* with *your claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Agreements and General Treatment Providers

Health Partners may enter into a special arrangement with a *person* who provides *general treatment* or a group of such *providers*, to provide *benefits* for particular *general treatment* services. *Providers* who enter into any such arrangements must at all times comply with the terms and conditions set out in the Health Partners General Treatment Recognition Policy.

The *benefits* that apply under these arrangements may differ from, and will take precedence over, those shown in *our* product schedules.

What you need to know about your hospital cover

Membership Types

The below *membership* types are available for those products listed:

Product	Membership Type
Gold Hospital Advantage	Single
Silver Hospital Plus Advantage	Couple
Silver Hospital Plus Lite	Single Parent
Bronze Hospital Plus	Extended Single Parent Family
Basic Hospital Plus	Family
	Extended Family

If *your* product does not appear in the list it could be a *closed product* (not available for new *members*). Please refer to Closed Products section for further details.

Any conditions mentioned in the following sections need to be read in conjunction with the Benefit Rules.

Costs covered under your hospital cover

We pay *benefits* to contribute towards the cost of *your* medical expenses when *you* are admitted to hospital as an 'in-patient'. *Benefits* do not apply if *you* are treated by a hospital as an *out patient*.

You need to be formally admitted into a hospital or approved private day hospital by a doctor, for a stay to be considered 'in-patient'. This includes admissions for day procedures and overnight stays. Hospitals and private day hospitals sometimes perform minor day procedures that would not normally require hospital admission, which are classed as '*out patient*' *treatment*. Care *you* receive in a hospital emergency department is also *out patient treatment*.

You may choose to be admitted to a *private hospital*. Health Partners has contracts known as *hospital purchaser-provider agreements* with most *private hospitals* in *Australia*, which help to reduce *your* out-of-pocket expenses. If *you* are admitted to a *private hospital* that *we* do not have a *hospital purchaser-provider agreement* with, *you* may experience higher out-of-pocket costs.

If the *hospital treatment you* require is included in *your cover*, *we* will pay *benefits* for the following during *your* hospital admission:

a. hospital accommodation;

b. treating specialist(s)/doctors' fees;

c. theatre fees;

d. intensive care;

e. dressings and other medical consumables;

f. diagnostic tests;

g. an extensive range of government-recognised surgically implanted medical devices and human tissue products;

h. pharmaceutical prescription *benefits* relating to *your* admission, refer to Pharmaceutical conditions for details;

i. *we* also cover allied health services provided during *your* admission, such as dental, physiotherapy and dietetics where they are included in *our* agreement with the hospital (*hospital purchaser-provider agreement*) or according to *your* level of *extras cover*, if held; and

j. other additional services, depending on *your* individual *cover*.

What you need to know about your hospital cover continued

We also support *you* before and after *your* hospital admission with a range of support programs such as Hospital to Home.

Any *benefits* payable are subject to the rules and conditions as detailed in Benefit Rules in the Once You're a Member section of this guide. Inclusions also vary between *covers*, for this reason please refer to *your* individual *cover* details for the inclusions specific to *you*.

Before going to hospital

Our 'Going to Hospital' brochure will provide *you* with everything *you* need to know. This includes important information *you* should know about out-of-pocket costs.

Excess

An *excess* is the amount *you* agree to pay towards *your* hospital accommodation. An *excess* assists in lowering *your* annual *premiums*, helping to keep *your cover* affordable.

An *excess* is payable by *you* for an overnight or same day hospital admission. It is paid to the approved hospital at the commencement of the admission.

You only pay the *excess* amount per rolling year. Where there is more than one *person* on a *membership*, there is a maximum of two *excesses* per *membership*, per rolling year. A rolling year is defined as 12 *months* from the commencement of the first day of any admission to an approved hospital.

Please refer to *your* individual *cover* to see if an *excess* applies to *you* and any additional rules.

Co-payment

A *co-payment* is the daily amount *you* agree to pay towards *your* hospital accommodation. *Co-payments* are payable by *you* for an overnight or same day hospital admission.

You must pay the daily *co-payment* amount each time *you* go to hospital, but only to the maximum amount per rolling year. The *co-payment* is limited to a maximum of 5 days per person to a maximum of 10 days per *membership*, per rolling year. A rolling year is defined as 12 *months* from the commencement of the first day of any admission to an approved hospital.

They are paid to the approved hospital at the commencement of the admission. Please refer to *your* individual *cover* details to see if a *co-payment* applies to *you. Your* individual *cover* will also provide the daily amount payment, the maximum *you* will be required to pay and when the amount may not be payable.

If *you* have an *excess* on *your* individual *cover* this will be required in addition to the *co-payment*, unless otherwise stated in *your cover*.

Restricted Benefits

Restricted *benefits* may apply to *your hospital treatment*, which means *you* are only covered for minimum *benefits*, as determined by the *Government Rules*. This can lead to large out-of-pocket expenses.

In addition, where a *Medicare rebate* does not apply for *hospital treatment* that is included in *your cover*, *benefits* paid are in accordance with the default payment schedule as determined by *Government*

Rules. This may result in large out-of-pocket expenses and limits may apply.

Please refer to *your* individual *cover* details to see if restricted *benefits* apply to *you*.

Restricted Hospital Psychiatric Services

Restricted Hospital Psychiatric Services means *you* are only covered for minimum *benefits*, as determined by the *Government Rules*. This can lead to large out-of-pocket-expenses. *You* have the ability to upgrade to a product that includes this service, without serving a *waiting period* to access the higher *benefits*. *You* can only do this once and only when *you* have already completed an initial two *months* of *membership* on any level of *hospital cover*. *You* will still need to serve *waiting periods* for the additional inclusions on *your* upgraded policy, meaning those conditions that were excluded on *your* current *cover*.

This *waiting period* exemption only applies to the higher *benefits* paid under the *policy you* upgrade to, but does not apply to a change in *excess* or *co-payment*. If *your* new *policy* has a lower *excess* or *co-payment* than *your* old *policy*, *you* will be required to pay the higher *excess* required under *your* old *policy* until the standard *excess waiting period* of two *months* has expired.

Please refer to *your* individual *cover* details to see if restricted *benefits* for psychiatric services apply to *you*.

Ambulance Cover

At *our* discretion, *we* may allow *you* to use *your* Ambulance *benefit* to *claim* for a subscription to a state ambulance service. In these cases, this will be taken as **full use** of *your* annual ambulance *benefit*.

Health Partners Ambulance Cover includes road and air ambulance transports from the place where *you* are initially treated, to the nearest hospital or other emergency healthcare facility that can provide the necessary medical *treatment*.

Health Partners does not pay ambulance *benefits* for:

- Transport to home or nursing home;
- Transport to and from medical appointments;
- Air transport on or off cruise ships;
- Ambulance services covered by the state; and
- Ambulance services that could be funded by any other source.

There are three types of ambulance services — non-emergency ambulance, emergency ambulance and unlimited emergency ambulance as defined by Health Partners.

a. Non-emergency ambulance

If this is included in *your cover*, *you* will be covered for the cost of any transport to hospital required on medical grounds that is classified as non-emergency (excluding clinic-car type transport).

b. Emergency ambulance

Emergency ambulance covers the cost of service required on medical grounds (excluding clinic-car type transport) that is deemed or classed as 'emergency' only (emergency classification determined by approved ambulance *provider*). Additionally, *you* will be covered for *treatment* where no transport is required. This will count towards *your* annual limit. This definition does not apply to unlimited emergency ambulance.

What you need to know about your hospital cover continued

c. Unlimited emergency ambulance

Unlimited emergency ambulance as defined by Health Partners, is for an unplanned event where there is a serious threat to *your* health, as a result of an *accident*, serious medical event or trauma, and immediate medical *treatment* is needed. Transport costs are covered from the place where *you* are initially treated, to the nearest hospital that can provide the necessary emergency medical *treatment*. This includes *treatment* where no transport is provided. It also includes transport between hospitals only where the required emergency care could not be provided at the transferring hospital.

Where *you* have both *hospital* and *extras cover* and each provide separate ambulance *cover*, both are applicable. The limit per service remains at $20,000 per *person*, unless unlimited emergency ambulance forms part of *your cover*.

Holding private health insurance does not restrict *you* from purchasing a separate ambulance subscription in *your* state of residence, which is recommended if *you* require full ambulance *cover*.

Benefits and limits vary by *cover*, please refer to *your* individual *cover* details to see what *benefits* apply to *you*.

Accident Cover

Accident Cover is not the same as the *accident* definition detailed in the 'Definitions & Interpretation' section at the back of the guide. Accident Cover is a feature attached to certain *covers* only, refer to *your* individual *cover* details to see if this applies to *you*.

Accident Cover provides *you* with protection for the clinical categories that are exclusions on *your* policy. Meaning, *you* will receive the highest level of *cover*, even for hospital procedures and services that are listed as exclusions, if *you* require *treatment* as a result of an accident (as defined by *us*). Accident Cover does not apply for hospital procedures and *treatment* types that are included on *your* policy. Refer to the *accident* definition to see if *waiting periods* apply.

For the purpose of Accident Cover, an accident is defined as an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or damage to the Insured Person's body that has occurred in Australia. It must result in the need for *hospital treatment* from a registered *Medical Practitioner* (other than anyone on the same *Policy*) within 24 hours of the event, and if needed, any further *treatment* within 90 days of the event.

Accidents must not have occurred within 1 day of *membership* commencement. This also excludes any condition resulting from surgical procedures, pregnancy, drug use, alcohol use, illegal activity, aggravation of an underlying condition or injury or pre-existing conditions. When an accident has occurred within 1 day of membership commencing and does not satisfy the definition, Accident Cover does not apply. This means *waiting periods* apply for the inclusions on *your* individual *cover* details. This also means that only the inclusions will apply as detailed on *your* individual *cover* details.

Benefits are payable where the above definition has been satisfied, an Accident Information Form has been completed and the *claim* has been pre-approved.

Pharmaceutical Benefits

PBS government subsidised prescriptions

You will receive the full cost for *PBS* government subsidised prescriptions. The *benefit* only applies where the prescription is for *treatment* directly related to the reason for *your* hospital admission, and dispensed either while *you* are an in-patient or supplied on discharge.

The full cost referred to above includes *your co-payment*, and any special or *member* contribution, brand *premium* or therapeutic group *premium* otherwise payable by *you* under the *PBS*.

This *benefit* is not included on all *covers*, please refer to *your* individual *cover* details to see if *benefits* apply to *you* and any applicable limits.

Non-PBS government subsidised prescriptions

You will receive *benefits* for Health Partners approved drugs or medicinal preparations not listed on the *PBS*. The *benefit* only applies where the prescription is TGA approved for the condition for which *you* were admitted for *hospital treatment*, and dispensed either while *you* are an in-patient or supplied on discharge. *Benefits* will not be paid where the cost is covered under a *Hospital Purchaser-Provider Agreement*.

This *benefit* is not included on all *covers*, please refer to *your* individual *cover* details to see if *benefits* apply to *you* and any applicable limits.

Surgically Implanted Medical Devices and Human Tissue Product

Surgically implanted medical devices and human tissue products are pieces of equipment that are surgically implanted into the body during a hospital procedure, to replace or assist a bodily function.

For all items on the Australian Government's Prescribed List of Medical Devices and Human Tissue Products produced and published according to *Government Rules*, the *benefit we* pay will be 100% of the amount referred to as the 'minimum benefit' for each item. If the fee charged for an item is less than the 'minimum benefit', the *benefit* paid will be equal to the fee charged.

For surgically implanted medical devices and human tissue products that are ordered by a *medical practitioner* in private practice, but not listed on the Australian Government's Prescribed List of Medical Devices and Human Tissue Products, a *benefit* is payable on certain *covers*. Please refer to *your* individual *cover* details to see if *benefits* apply to *you* and any applicable limits.

The *benefit* only applies for surgically implanted medical devices and human tissue products when the devices are:

a. supplied during hospital admission;

b. successfully implanted and deployed during the approved procedure;

c. TGA approved; and

d. associated with an approved Medical Benefit Scheme (MBS) procedure, where a *Medicare rebate* applies.

What you need to know about your hospital cover continued

Non-Surgically Implanted Medical Devices and Human Tissue Products

Non-surgically implanted medical devices and human tissue products are items that replace or assist a normal bodily function following related *hospital treatment* or for other diagnosed diseases when supported by a letter from a *medical practitioner*.

Benefits apply for prosthetic garments following mastectomy, artificial eyes and limbs, wigs, erectile dysfunction prostheses, and punctal plugs. *Benefits* do not cover any associated freight charges and are only applied to fees after any eligible discounts, government payments or subsidies have been deducted.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Aids for Recovery

You will receive *benefits* for the purchase or hire of recovery aids for *treatment* up to six *months* following hospital admission. The *benefit* only applies where the item has been recommended by a registered *medical practitioner* or physiotherapist, with the purpose of assisting recovery and related to the hospital admission. Items could include braces, splints, moon boots, crutches, wheelchair and bed pulley.

Additional items covered under this *benefit* that do not require prior hospital admission are compression garments for lymphoedema, oscillating positive expiratory pressure devices, pregnancy compression garments, spica cast or abduction brace for infant hip dysplasia, viscosupplementation injections for osteoarthritis and devices prescribed by an orthopaedic surgeon for recovery from acute injury, e.g. CAM walkers, moon boots and zimmer splints.

You will need to provide an invoice from a *recognised* or *participating provider* and submit it with *your benefit claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Compression Garments

You will receive *benefits* for the purchase of compression garments when an invoice is provided by a *recognised* agency or pharmacy and the item has been recommended by a registered *medical practitioner*, physiotherapist or occupational therapist. The item must be required for the management of a specific medical condition. Items could include pregnancy shorts, lymphoedema garments, surgical and pressure stockings.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Hip Safety Kit

You will receive *benefits* for the purchase of a hip safety kit if *you* have been diagnosed with osteoporosis or *you* have been assessed as at risk of hip fracture by a registered *medical practitioner*. *You* will need to provide an invoice from a *recognised* agency or pharmacy and submit it with *your claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Insulin Pumps

For an insulin pump to be covered as an inpatient, *you* need to be admitted to hospital. The doctor responsible for *your* admission will be required to certify the reason why *you* require a hospital admission. On applicable *covers*, an *excess* and *co-payments* will apply for these admissions, refer to *your* individual *cover* details for more information. In many instances, the provision of an insulin pump does not require the patient to be admitted to hospital, and instead the insulin pump is supplied and fitted as an *out patient*.

Benefits are only payable for a replacement Insulin Pump once a current pump's warranty has expired, and only where clinically needed. *We* will not pay *benefits* solely at the expiration of warranty where the device is still functioning properly. Supporting documentation will need to be provided and our required form completed by an accredited Diabetes Educator or Endocrinologist.

Replacement Speech/Sound Processors

Benefits are only payable for a non-surgically implanted replacement speech/sound processor once a current processor's warranty has expired and replacement is clinically necessary. Supporting documentation and our required form, completed by an accredited Audiologist or Medical Specialist, must be submitted with *your claim*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you* and for details on any applicable limits.

Surgical Podiatry

Benefits for surgical podiatry procedures are payable only when the *provider* is a registered podiatric surgeon who holds specialist registration in the specialty of podiatric surgery and meets *our recognition criteria. Benefits* cover:

a. accommodation; and

b. the cost of a medical device or human tissue product as listed in the Australian Government's Prescribed List of Medical Devices and Human Tissue Products, as in force from time to time.

Hospital cover does not cover the *benefits* payable for services performed by a Podiatric Surgeon. To receive *benefits* for these services, *you* must also hold an eligible *extras cover*, which includes these services. Large out-of-pocket costs could still apply.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Health Management Programs

Health Management programs are only available where an agreement is in place with a registered health care organisation and if it's included in *your* individual *cover*.

Health Coaching

If *you* are suffering from *chronic disease*, complex health or mental health issues and *we* determine that *you* require ongoing medical support, *you* will be entitled to register for a *Health Coaching* program. 100% *benefit* will be paid. This is a telephone-based

What you need to know about your hospital cover continued

information and support line, providing *you* support with self-management of these health conditions.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Asthma Foundation Membership

You will receive a *benefit* for membership to Asthma Australia Ltd in the State *you* reside if *you* have a supporting letter from a *medical practitioner* confirming *you* are diagnosed with asthma.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Bone Density Test

Where a *Medicare rebate* is not applicable, *you* will receive a *benefit* for a Dual Energy X-ray Absorptiometry (DEXA) scan performed by a Medicare recognised radiologist. They must hold a Location Specific Provider Number (LSPN).

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Diabetes Education

You will receive a *benefit* for *consultations* with a *recognised* diabetes educator (credentialed by the Australian Diabetes Educators Association) for *members* diagnosed with Type 2 Diabetes. *You* must have a referral by a *medical practitioner* or specialist. The *consultation* must be in person and *you* must not be an admitted *patient* of a hospital at the time of *consultation*.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Home Sleep Studies

You will receive *benefit* for sleep studies performed in *your* home if *you* have satisfactory evidence from a *medical practitioner* and if performed by one of *our preferred* providers.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Home Nursing

A *benefit* will be payable for *home nursing* services:

a. When *treatment* is provided by a registered nurse who satisfies the *recognition criteria*; and

b. Where that *treatment* is for an illness or injury which would otherwise require admission; and

c. *Treatment* of the kind provided in an approved hospital with the agreed *benefit* inclusions as detailed in *your* individual *cover*.

This is considered to be a *hospital substitute treatment*, meaning the rules as set-out in the *Government Rules* apply.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you* and applicable limits.

Home Birth

You will receive a *benefit* for pre-natal and post-natal *treatment* provided at home, if provided by a registered midwife who satisfies the *recognition criteria*. *Benefits* are not payable for:

a. Home birth services and hospital services provided on the same day;

b. Pre and post-natal services if *you* plan to have *your child* in a hospital; or

c. Any midwife services provided in a hospital.

This is considered to be a *hospital substitute treatment* program, meaning the rules as set out in the *Government Rules* apply.

Please refer to *your* individual *cover* details to see if *benefits* apply to *you*.

Hospital to Home

For details on what is included in *our* Hospital to Home program, refer to *our* 'Going to Hospital' brochure.

Hospital Guide

Hospital Guide helps *you* navigate through *your* hospital journey with the ultimate goal of getting *you* home sooner. There is no cost to *you* and the option is available under all Health Partners *Hospital covers*.

You will need to qualify for the service by contacting *us* so *we* can assess *your* individual situation. If extra care or support is required, *we'll* refer *you* for a personalised care program that's developed and tailored to *your* health condition or procedure.

Hospital in the Home

This program is designed to make *your* transition from hospital to home easier. There is no cost to *you* and the option is available under all Health Partners *Hospital covers*.

Once *you* contact *us*, *we* will refer *you* to *our recognised provider* for assessment. The services are only available if *you* meet *our* qualifying criteria. If extra care or support is required *we'll* refer *you* for a personalised care program that's developed and tailored to *your* health condition or procedure.

This is considered to be a *hospital substitute treatment* program, meaning the rules as set out in the *Government Rules* apply.

Rehabilitation in the Home

A great alternative to in-hospital rehab. There is no cost and the option is available under all Health Partners *Hospital covers*. *You* will need to qualify for the service by contacting *us* so *we* can assess *your* individual situation. If extra care or support is required, *we'll* refer *you* for a personalised care program that's developed and tailored to *your* health condition or procedure.

This is considered to be a *hospital substitute treatment* program, meaning the rules as set out in the *Government Rules* apply.

Closed Products

The below products are no longer available to new *members*. If *you* are on one of these *covers you* may retain *your cover*, unless otherwise notified. To remain on the *cover, you* need to have continuous and unchanged *cover*. This also means, *you* cannot leave and return to this *cover*. If changes are requested due to unforeseen circumstances, approval is at *our* discretion.

Product	Applicable Membership Type		Effective Date
Classic Hospital Gold 25 **Classic Hospital Gold 50** **Classic Hospital Gold 500** **Classic Hospital Gold 250** **Classic Hospital Silver Plus**	Single Couple Single Parent	Extended Single Parent Family Family Extended Family	1 April 2017
Classic Hospital Gold	Single Couple Single Parent	Extended Single Parent Family Family Extended Family	1 April 2019
Classic Hospital Bronze Plus	Single Couple	Single Parent Family	1 April 2019
Starter Extras **Standard Extras** **Top Extras** **Natural Therapies**	Single Couple Single Parent	Extended Single Parent Family Family Extended Family	3 February 2020
National Extras	Single Couple Single Parent	Extended Single Parent Family Family Extended Family	1 July 2020
Gold Hospital **Silver Hospital Plus**	Single Couple Single Parent	Extended Single Parent Family Family Extended Family	29 July 2021

Privacy Policy

Health Partners is committed to providing quality and affordable health care services in a way which meets *your* needs. *We* understand and value *our* relationship with *you* and *our* obligation to protect the personal information *you* entrust to *us*, whether *you* are a *member* or not. In accordance with privacy legislation, *we* comply with the Australian Privacy Principles (APPs) in the *Privacy Act 1988* (Cth) (Privacy Act) in relation to *our* handling of *your* personal information.

The following is a summary of *our* Privacy Policy. If *you* would like to know more about how *your* privacy is protected, *you* may view a full copy of the Health Partners Privacy Policy at *our* website or by contacting *us*.

Your personal information

The type of personal information *we* hold about *you* depends on the nature of *your* relationship with *us* and the extent to which *you* have utilised *our* services. Such information includes *your* name, address, age, *dependants*, contact details (including telephone and mobile numbers and email addresses). Certain financial information may also be collected from time to time, including bank account and credit card details, Medicare numbers and details about *your premium* payments and *claims* history.

We may also hold information concerning *your* employer if *you* have elected to pay *premiums* via a payroll deduction scheme. Sensitive information about *you* (including health information) may also be collected from time to time. All sensitive information will be collected in accordance with Health Partners Privacy Policy or as otherwise prescribed by the APPs.

If your personal information is not provided

If *you* do not provide *us* with all of the information *we* request, *we* may be unable to provide *you* with the products or services *you* require.

How we use your personal information

The primary purpose of the collection of *your* personal information is to enable *us* to provide health *benefits* and services to *you* and to fulfil *our* legal obligations as a registered private health insurer. To ensure that *we* can effectively provide *you* with the quality of health *benefits* and other services that *you* expect, *we* will use *your* personal information for:

- *Claims* processing and administration;
- Product development, marketing and research purposes (including social media marketing and Google) to improve and extend our range of services to *you*;
- Information technology requirements and systems maintenance;
- Investigating and resolving complaints about the provision of services by *us* (or organisations associated with *us*);
- Direct marketing initiatives in accordance with the APPs; or
- Compliance with any legislative and regulatory provisions.

You may contact *us* at any time to indicate *you* do not wish to receive direct marketing information from *us*.

When we disclose your personal information

We may disclose *your* personal information to *our* agents, contractors or service *providers* who act or provide their professional services on *our* behalf. The identity of these agents, contractors and service *providers* may change from time to time. In general, the types of *persons* and organisations *your* information may be disclosed to include:

- Federal and State health authorities, and government agencies including Medicare Australia;
- The Private Health Insurance Administration Council;

Privacy Policy continued

- The Australian Prudential Regulation Authority (APRA);
- Health service *providers* including hospitals, doctors, specialists and other medical and related professionals;
- Other service *providers* providing services associated with *your* health and wellbeing;
- *Our* outsourced contracted service providers, including:
  - payment systems operators,
  - mail houses,
  - recruitment organisations, and
  - research providers;
- *Your* employer (if part of a payroll deduction scheme);
- Third party social media sites that provide marketing services;
- Other parties to whom *we* are permitted, authorised or required by law or the APPs to disclose *your* personal information; and
- Health Management and Support Programs. *We* may use *your* personal information (including sensitive information) to offer these programs and services to *you*. *We*, or someone acting on *our* behalf, may contact *you* to offer *you* a specific health management or support program.

Cross-Border Disclosure of Information

Health Partners may disclose *your* personal information to third party organisations who provide services to *us*, or on behalf of *us*, including hosting, data processing, and other outsourced services. These service providers may be located outside of *Australia*, in places including the United States, United Kingdom, Europe, Singapore, and New Zealand, in which case, *your* personal information may be transferred outside of *Australia*.

We confirm that Health Partners will only disclose personal or sensitive information to overseas recipients in accordance with the Privacy Act including:

- where disclosure is required or authorised by Australian law; or
- where *we* reasonably believe that the recipient is subject to a law that has the effect of protecting the information in a way that is consistent with the Privacy Act and there are mechanisms for *you* to access or take action to enforce that protection.

We will not disclose *your* information outside of *Australia* in any other circumstances.

Any law that requires the particular information to be collected

Health Partners is required under Commonwealth and State health legislation to collect, store and disclose certain personal information about individuals from time to time. The *Private Health Insurance Act 2007* (Cth), for instance, requires *us* to collect certain sensitive information as a condition of registration as a registered private health insurer.

You can access your personal information

You may request access to the personal or sensitive information that *we* hold about *you* at any time (although under the APPs some requests may be denied in certain circumstances). All requests should be made by writing to *us*, or by contacting Member Care.

For verification purposes, *we* may ask *you* to complete a personal information access request form, and *we* may also charge an administrative fee for this service (the amount of which will be advised at the time of *your* request).

Your responsibilities

It is a condition of *membership* that *you* ensure that every *person* on *your membership* is aware of the Health Partners Privacy Policy.

Dispute Resolution

If *you* have any issues or concerns regarding *your membership*, *we* encourage *you* to contact *us*. *We* have a Dispute Resolution Process to ensure *your* feedback is heard, addressed and responded to in a timely manner.

Your personal information is handled in accordance with *our* Privacy Policy.

Step 1

Provide your feedback by:

Calling
1300 113 113

Emailing
ask@healthpartners.com.au

Mailing
Health Partners
Reply Paid 1493
Adelaide SA 5001

In person at one of *our* locations.

So that *we* can provide a response as quickly as possible, *we* ask that *you* provide:

- Any supporting documentation
- *Your membership* details
- Details on what *you* require from *us* to help resolve the matter

Step 2

We will promptly respond to *you* and endeavour to resolve any issues or concerns in accordance with *our* Dispute Resolution Process and *our* Member Care Charter.

Step 3

Is only required if *you* are not satisfied with the resolution provided in Step 2 and wish to escalate the matter.

Provide *your* feedback by contacting *our* Manager Customer Relations:

Calling
1300 113 113

Emailing
complaints@healthpartners.com.au

Mailing
Manager Customer Relations
Health Partners
Reply Paid 1493
Adelaide SA 5001

Step 4

The Manager Customer Relations will promptly respond to *you* and endeavour to resolve any issues or concerns in accordance with *our* Dispute Resolution Process.

If, after this, *you* are still not satisfied with the outcome, *we* may refer the matter to the Chief Customer Officer.

Dispute Resolution continued

Step 5

Is only required if *you* are not satisfied with the resolution provided in Step 4 and wish to escalate the matter.

If *you* feel that *your* issue is still unresolved or that the complaint was not dealt with fairly, *we* encourage *you* to seek an external review. Depending on the nature of *your* complaint, *we* would suggest that *you* contact the following departments for free and independent advice:

Optical and Dental related general service disputes

This is used where an explanation, apology, refund, compensation, access to *your* health records, a change in policy at the place of health service for **Optical** and **Dental** only.

Provide *your* feedback to Health and Community Services Complaints Commissioner (HCSCC):

Call
(08) 8226 8666 or 1800 232 007

(Toll free from Country SA landline)
Available Mon-Fri 9.00am to 5.00pm

Email
info@hcscc.sa.gov.au

Mail
HCSCC
PO Box 199
Rundle Mall SA 5000

Internet
hcscc.sa.gov.au

Optical and Dental related disputes regarding practitioners and their conduct

This is used where *you* believe a Health Partners Optical and/or Dental practitioner is placing the public at risk, they are performing their duties in an unsafe way, or *you* are concerned about a practitioner's ability to make safe judgments because of their health.

Provide *your* feedback to Australian Health Practitioner Regulation Agency (AHPRA):

Call
1300 419 495

Available Mon-Fri 9.00am to 5.00pm

Email
ahpra.gov.au/About-AHPRA/Contact-Us/Make-an-Enquiry

Mail
AHPRA
GPO Box 9958
Adelaide SA 5001

In Person
Level 11, 80 Grenfell Street
Adelaide SA 5000

Internet
ahpra.gov.au

For all remaining Membership and Fund Related disputes

This is used for all other concerns that relate to *your* membership with *us* or matters relating to Health Partners where the concern has not been resolved, to seek an external review.

Call
1300 362 072

(select option 4 for Private Health Insurance during business hours)

Internet
To make a complaint, contact the Commonwealth Ombudsman at ombudsman.gov.au

For general information about private health insurance, see privatehealth.gov.au

Member Care Charter

At Health Partners, *we're* committed to doing health right. That means great value health *cover*, and great customer service – so much so that *we've* been awarded Canstar's 'Most Satisfied Customers' for six years running.

Our Member Charter and Service Standards outline the service *you* can expect when *you* become a Health Partners *member*.

We're here to help

Your health is *our* priority, and *we* know that in challenging times personal support can make all the difference. That's why when *you* call Health Partners, *you'll* always talk to a real person who will work to understand *your* needs and make the process as easy as possible.

If *you* prefer, *you* can also choose to contact *us* via the webchat located on *our* website. These options will only be available to *you* during business hours, available on *our* website.

In addition, *we* also offer options to manage and understand *your cover* 24/7 via *our* website, app or portal.

Inclusion and respect

When *you* deal with Health Partners, *you* will always be treated fairly. *We'll* inform *you* of *your* rights and obligations as a *member*. *We're* committed to respect, diversity and inclusion, and *we* will not discriminate based on *your* culture, race, gender, sexuality, age, disability or religion.

Working with you

Despite *our* best efforts there may be times *you* disagree with a decision *we've* made. *We* take *your* concerns and complaints seriously, and always work to find a solution. *You* can learn more about *our* dispute resolution process on page 53.

Always aiming for better

By measuring *member* satisfaction each year and responding to *your* feedback, *we're* ensuring *our member* services are always given the highest priority.

We'll make sure *you're* kept informed of any new or updated products or services and provide *our* staff with the necessary skills and training required.

Our Service Standards

Standard	We will
Friendly	Deliver *you* genuine service with a smile and make sure everyone feels welcome.
Helpful	Do the hard work for *you* whenever *we* can and will communicate with *you* proactively.
Knowledgeable	Give *you* expert advice and if *we* don't know the answer to something, *we* will find out.
Transparent	Always be honest and open when *you* ask *us* a question and will provide information, especially around costs, to *you* upfront.
Understanding	Listen to *you* to make sure *we* understand *your* needs and can tailor solutions for *you*.
Responsive	Respond quickly to *your* enquiries and will promptly process any changes *you* require. *We'll* personally answer 80% of calls within 30 seconds. *We'll* also respond to *your* correspondence within 2 working days and process *your claims* within 5 working days.
Confidential	Ensure *your* privacy and confidentiality at all times.
Accurate	Keep *your* records and information up to date and accurate.
Accessible	Ensure *our* services are for everyone and *our* locations are easy to use, sign-posted, comfortable and clean.
Reciprocate	*We* ask that *you* treat *our* staff as *you* would like to be treated - with courtesy, honesty and respect at all times.

Use of Monies

Credits to the Fund

Health Partners must credit to the *Fund*:

a. all the *assets* of the Health Partners *Fund* as of the day this *Fund* is established;

b. all *premiums* paid under *memberships*;

c. all amounts received in connection with its conduct of the business of the *Fund*;

d. any amount borrowed for the business of the *Fund*; and

e. all other amounts required by the *Government Rules* to be paid to the *Fund*.

Debits from the Fund

Health Partners may only apply the assets of the *Fund* for:

a. meeting *policy* liabilities;

b. meeting other liabilities or expenses of the business of the *Fund* including liabilities or expenses:

   i. incurred in providing, or arranging to provide, professional medical services, *hospital treatment*, *out patient* services or other related health services for *members*;

   ii. which are treated for a restructure or arrangement approved under the *Government Rules* as *policy* liabilities or other liabilities incurred for the purposes of the *Fund*; or

   iii. incurred in operating the *health insurance business* and the *health related business*;

c. making investments in accordance with the *Government Rules*;

d. providing a mortgage or charge in accordance with the *Government Rules*;

e. transfer to another Health Partners Fund in accordance with the *Government Rules*;

f. transfer to a *fund* of another private health insurer in accordance with the *Government Rules* where the *insurance* policies that are **referable** to the *Fund* become referable to the *Fund* of the other private health insurer; or

g. any of the other purposes in the *Government Rules*.

Winding Up

Termination of the Fund

a. Health Partners may only terminate the *Fund* under and in accordance with the *Government Rules*.

b. Health Partners must comply with the *Government Rules* that relate to termination of the *Fund* including:

   i. not entering into *insurance* policies referable to the *Fund* after termination is approved;

   ii. giving notice to *members* stating the day from which it will not renew *insurance* policies referable to the *Fund*;

   iii. not renewing these *insurance* policies after this time; and

   iv. paying the assets remaining after termination is complete in accordance with the *Government Rules*.

Definitions and Interpretation

Where *you* see a word in italics *like this*, it means the word is defined in this section. This will assist *you* in gaining a reasonable understanding of the Rules.

Interpretation

In these Rules:

- words and phrases written in *italics* are defined in Definitions;
- unless otherwise specified, the 'Definitions' apply throughout the Rules;
- where a word or phrase is defined, its other grammatical forms have a corresponding meaning;
- where not defined, words and expressions are intended to have their ordinary meaning, unless otherwise defined in the Government Rules;
- the singular includes the plural and vice versa;
- a gender includes the other genders;
- a reference to the word 'include' in any form is not a word of limitation; and
- a reference to any legislation includes all amendments to it and any legislation enacted in substitution for it and all statutory instruments and rules issued under it and in force.

Definitions

In these Rules:

Accident means an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or damage to the Insured Person's body that has occurred in *Australia*. It must result in the need for medical advice or *treatment* from a registered Medical Practitioner (other than anyone on the same Policy) within 72 hours of the event, and if needed, any further *treatment* within 180 days of the event. Accidents must not have occurred within 1 day of membership commencement. When an accident has occurred within 1 day of *membership* commencing the accident rule does not apply and *waiting periods* apply. This definition is separate to the definition within Accident Cover.

Acute care means *hospital treatment* where the primary clinical purpose or *treatment* goal is to, manage labour (obstetric), cure illness or provide definitive *treatment* of injury, perform surgery, relieve symptoms of illness or injury (excluding palliative care), reduce the severity of an illness or injury, protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function, or to perform diagnostic or therapeutic procedures.

Adult means a *person* who is not a *child dependant, non-student dependant, student dependant* or *non-classified dependant.*

Asset means a resource with economic value that Health Partners owns or controls.

Australia includes the six States, the Australian Capital Territory (ACT), the Northern Territory (NT), the Territory of Cocos (Keeling) Islands, the Territory of Christmas Island and Norfolk Island.

Benefit means an amount payable by Health Partners to or for a *member*, in respect of expenses incurred by a *member* for *treatment*, in accordance with the terms and conditions of these Rules.

Board means the Board of Directors of Health Partners.

Child means:

a. a natural *child*;
b. an adopted *child*;
c. a foster *child*;

d. a step-*child* (that is a natural, adopted or foster *child* of the *policyholder's partner*); and
e. another *child* deemed by Health Partners to be in full care and the responsibility of the *policyholder*.

See also *child dependant*.

Child dependant means a *person* who:
a. is aged under 18;
b. is not married or living in a de facto relationship; and
c. is a *child* of the *policyholder* or *child* of the *policyholder's partner.*

See also *non-classified dependant*.

Chronic disease means an illness "that is prolonged in duration, does not often resolve spontaneously, and is rarely cured completely".
Features common to most *chronic diseases* include:
a. complex causality, with multiple factors leading to their onset;
b. a long development period, for which there may be no symptoms;
c. a prolonged course of illness, perhaps leading to other health complications; and
d. associated functional impairment or disability.

Claim means a *claim* for *Fund benefits*.

Closed Cover/Policy/Product is one which is no longer available for sale, but which continues to cover existing *members* still on it. Current *members* on these levels of *cover* may retain their *cover* whilst the *membership* remains continuous and unchanged. If they leave the *cover* at any time after its closure, either by choice, change of circumstances or by becoming unfinancial (*membership* payments have not remained up to date), they cannot re-join it.

Community Rating
Community Rating means, in compliance with the *Government Rules*, the principle of *community rating* that prevents private health insurers from discriminating between people on the basis of their health or for any other reason described in the *Government Rules*.

Compensation means a monetary reimbursement an injured party receives to help make reparations after an injury.

Complying Health Insurance Product means an insurance *policy* that meets:
a. *Community rating* requirements;
b. Coverage requirements;
c. If the *policy* covers *hospital treatment*, *benefit* requirements;
d. *Waiting period* requirements;
e. Portability requirements;
f. Quality Assurance requirements; and
g. Any other requirements as set out in the Private Health Insurance (Complying Product) Rules.

Consultation means an attendance by a relevant *provider* on, and in the physical presence of, a *patient* or as otherwise approved by Health Partners.

Contribution see *Premium*.

Contribution Group means a group of *members* approved under these Fund Rules.

Co-payment means the amount a *member* agrees to pay each time a service is provided.

Couple means for *you* and *your partner*.

Cover (also referred to as *policy*) means a defined group of *benefits* payable under these Rules for expenses incurred by the *member*.

Dependant means a *person* who is:
a. a *child dependant*; or
b. a *non-student dependant*; or
c. a *student dependant*; or
d. a *non*-classified *dependant*.

Definitions and Interpretation continued

Equivalent cover means a level of *cover* offered by another fund which Health Partners considers to be equivalent to a level of *cover* offered by Health Partners.

Excess means an amount that a *member* agrees to pay towards the cost of *hospital treatment*, in exchange for lower *premiums*.

Extras Cover see *general treatment*.

Fund means the health *benefits* fund established by Health Partners and governed by these Rules.

General treatment means *treatment* (including the provision of goods and services by a *provider* who meets our *recognition criteria*) that is intended to manage or prevent disease, injury or condition, and is not *hospital treatment* but may or may not include *hospital substitute treatment* program as defined in the *Private Health Insurance Act 2007*. Also referred to as *Extras Cover* or *Ancillary Cover*.

Government Rules means *Private Health Insurance Act 2007* and the Private Health Insurance Rules made under that Act, the *Health Insurance Act 1973* and the rules made under that Act, as well as the *National Disability Insurance Scheme Act 2013*.

Group scheme means a scheme under which Health Partners and the employer of a *member* agree that the employer will deduct from amounts payable to the *member* at the *member's* direction, *premiums* due to Health Partners and pay the same to Health Partners.

Health Coaching (formerly "Chronic disease management program") means a program that is intended to either reduce complications in a *person* with a diagnosed *chronic disease* or prevent or delay the onset of *chronic disease* for a *person* with identified risk factors for *chronic disease* and which complies with the *Government Rules*.

Health insurance business in compliance with the definition under the *Government Rules*, means Health Partners' *health insurance business* of undertaking liability relating to the *hospital treatment* and/or *general treatment* of its *members*, by way of *insurance*.

Health Partners participating dentist means the network of participating dentists who have entered into an agreement with Health Partners.

Health Partners participating pharmacies means the network of pharmacies who have entered into an agreement with Health Partners.

Health Partners participating physiotherapist means the network of participating physiotherapists who have entered into an agreement with Health Partners.

Health Partners Provider includes Health Partners Dental, Health Partners Optical, *Health Partners participating pharmacies, Health Partners participating physiotherapists* and *Health Partners participating dentists.*

Health related business in compliance with the definition under the *Government Rules*, means Health Partners' *health related businesses* of:

a. providing optical and dental services and goods;
b. undertaking liability, by way of *insurance*, to indemnify people who are ineligible for Medicare for costs associated with providing *treatment*, goods or services, that are provided to those people in *Australia* and are provided to manage or prevent diseases, *injuries* or conditions; and
c. providing a financial service to assist people insured under *complying health insurance products* to meet the costs associated with *treatment*, goods or services that are provided to manage or prevent diseases, *injuries* or conditions.

Home nursing means nursing in a home by a registered nurse who meets the *recognition criteria* and where the *treatment* is not *hospital treatment*.

Hospital cover means a *membership* which covers some or all *hospital treatment*.

Hospital Purchaser-Provider Agreement means an agreement between Health Partners and a private hospital or private day hospital, where Health Partners must pay and that hospital must accept a schedule of agreed prices in full payment for *hospital treatment* provided to Health Partners' *members* covered for this *treatment*.

Hospital substitute treatment means *treatment* that substitutes for an episode of *hospital treatment*, and is *general treatment* and is any of, or any combination of, nursing, medical, surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology, or goods and services intended to manage disease, injury or condition as defined in the *Private Health Insurance Act 2007*.

Hospital treatment means *treatment* (including the provision of goods and services) that is intended to manage disease, injury or condition, where that *treatment* is provided by a *person* who is authorised by a hospital to provide that *treatment* or, a *person* under the control of such a *person*; and is provided at a hospital or in direct control of a hospital, as defined in the *Private Health Insurance Act 2007*.

Medical practitioner means a *person* who is registered or licensed as a *medical practitioner* under an Australian law and who satisfies the *provider* eligibility requirements for the payment of Medicare *benefits*.

Medical provider agreement means a contract between Health Partners and *medical practitioners* that allows *us* to pay *benefits* in excess of the Medicare Benefits Schedule fees for those practitioners' services.

Medicare Rebate means a payment made to an eligible *person* under the Australian Government's Medicare Scheme.

Member means each insured *person* being the *policyholder, partner* and each of their *dependants* who are registered under these Rules and for the avoidance of doubt.

Membership means one or more *members* covered under the same *policy* or policies.

Month or **Monthly** means a calendar *month*.

National Disability Insurance Scheme has the same meaning as in section 9 of the *National Disability Insurance Scheme Act 2013.*

Non-classified dependant means a *person* who:

a. is aged between 18 and 20 (inclusive);
b. is not married or living in a de facto relationship; and
c. is a *child* of the *policyholder* or *child* of the *policyholder's partner*.

For the purpose of these Rules references to *child dependant* include *non-classified dependant*.

Non-student dependant means a *person* who:

a. is aged between 21 and 31 (inclusive);
b. is not receiving full-time education at a school, college or university recognised by *us*;
c. is not married or living in a de facto relationship;
d. is a *child* of the *policyholder* or *child* of the *policyholder's partner;* and
e. is insured under an Extended Family Membership or Extended Single Parent Family Membership.

Definitions and Interpretation continued

Nursing home type patient is defined in *Government Rules* and means a *patient* in hospital who has been provided with accommodation and nursing care for a continuous period exceeding 35 days and is then receiving accommodation and nursing care as an end in itself.

Out patient means a *patient* of a hospital who is not an admitted *patient*, with the exception of qualifying day procedures and *treatments*.

Over-servicing is when treatment is provided, and when viewed objectively, is over and above what can be clinically justified, or where there is no justification for that care at all.

Participant has the same meaning as in section 9 of the *National Disability Insurance Scheme Act 2013*.

Partner in relation to a *policyholder* means a *person* who:

a. is married to the *policyholder*; or

b. is a de facto spouse of the *policyholder*; and

c. lives together with the *policyholder* on a genuine domestic basis as a *couple*.

Patient means a *person* receiving or registered to receive *treatment*.

PBS means the Australian Government's Pharmaceutical Benefits Scheme

Person includes a firm, a body corporate, an unincorporated association or any authority; a reference to a *person* includes its executors, administrators, successors and permitted assigns.

Person with a disability means a *participant* in the *National Disability Insurance Scheme*.

Policy means a *complying health insurance product* detailing the terms and conditions of that product.

Policyholder means a *person* who is responsible for the *membership* and the payment of *premiums*.

Pre-existing condition as defined by the *Government Rules*, a *pre-existing condition* is any ailment, illness or condition that had signs or symptoms, in the opinion of a *medical practitioner* appointed by *us*, any time during the 6 *months* before *you* joined or upgraded to a higher level of *cover* with *us*.

In the 6 *months* prior to joining or upgrading, a condition is considered pre-existing if any related signs or symptoms were evident to *you*, or would have been evident to a reasonable general practitioner had they been consulted. A doctor may find signs of a condition even if *you* have no symptoms and *you* have not noticed anything wrong. Meaning, the rule could still apply if the condition had not been diagnosed prior to taking out *cover* or upgrading.

Premium means the amount a *policyholder* is required to pay for a specified period of *cover*.

Private Health Information Statement means a statement that is provided by Health Partners that provides a summary of a *complying health insurance product's* key features and *premium* as defined in the *Government Rules*.

Private hospital means a *hospital* that is approved as a *private hospital* under an Australian law or any other hospital recognised by Health Partners as a *private hospital*.

Private patient means a *person* who is admitted to a public or *private hospital* as an *acute care patient* and who is not a *public patient*.

Provider means:

a. a *person* who provides goods or services as, or as part of, *hospital treatment* or *general treatment*; or

b. a *person* who manufactures or supplies goods provided as, or as part of, *hospital treatment* or *general treatment*.

Public patient means a *person* who is admitted to a *public hospital* and who receives *treatment* as a Medicare patient without charge.

Recognised provider means a *provider* of healthcare, *treatment* or services who meets our *recognition criteria* and whose business is neither a *Health Partners health related business* nor do they have a contract with Health Partners for the provision of healthcare, *treatment* or services.

Recognition criteria means the following conditions apply to a *person* who is a *provider* of *treatment* that *we* will pay *benefits* for:

a. the *person* is registered, or holds a licence, under any relevant State or Territory legislation to render *treatment* for which recognition is sought;
b. the *person* is professionally qualified or a member of a professional body recognised by Health Partners;
c. the *person* maintains comprehensive and accurate *patient* records that are made at the time of *treatment*, or as soon as practicable after, that clearly identify the *patient* and the *treatment* provided, and are written in English and understandable by a third party;
d. the *person* provides facilities that meet the standards determined or recognised by Health Partners and the *Government Rules*; and
e. the *person* fulfils the other criteria that Health Partners considers reasonable and appropriate from time to time.

Resolution policy means Health Partners policy for resolving disputes with *members* determined by the *Board* from time to time.

Responsible Adult has the same meaning as a Private Health Insurance Incentive Beneficiary (PHIIB) as defined in the *Government Rules*.

Single means for yourself only (including *responsible adult*).

Student dependant means a *person* who:

a. is aged between 21 and 31 (inclusive);
b. is receiving full-time education at a school, college or university recognised by *us*;
c. is not married or living in a de facto relationship; and
d. is a *child* of the *policyholder* or *child* of the *policyholder's partner.*

Treatment means health or medical *treatment* to manage, prevent or alleviate a condition, disease or injury by the provision of either or both of a good or service.

Waiting Period means a specific period after a new *cover* has commenced during which *benefits* are not payable or *benefits* are only payable as per the entitlements of a previous *cover* or *policy* for *treatment* received.

We/Us/Our means Health Partners.

You/Your means the *member* and/or *policyholder*.

Where to find us

Find our most up-to-date location list on our website at healthpartners.com.au/provider-search

Health Partners Administration

Registered office

Adelaide

Level 3, 101 Pirie Street, Adelaide SA 5000

Phone 1300 113 113
Fax (08) 8113 2259
Web healthpartners.com.au

Health Partners Optical

Adelaide

101 Pirie Street, Adelaide SA 5000
Phone 1300 115 115

Flinders Park

288 Grange Road, Flinders Park SA 5025
Phone 1300 115 115

Goodwood

92 King William Road, Goodwood SA 5034
Phone 1300 116 116

Modbury

27 Smart Road, Modbury SA 5092
Phone 1300 127 127

Morphett Vale

118-120 Main South Road, Morphett Vale SA 5162
Phone 1300 191 191

Mount Barker

7 Morphett Street, Mount Barker SA 5251
Phone 1300 115 115

Health Partners Member Care

Phone 1300 113 113
Fax (08) 8113 2259
Email ask@healthpartners.com.au
Web healthpartners.com.au

Adelaide

101 Pirie Street, Adelaide SA 5000

Flinders Park

288 Grange Road, Flinders Park SA 5025

Modbury

27 Smart Road, Modbury SA 5092

Morphett Vale

118-120 Main South Road, Morphett Vale SA 5162

Mount Barker

7 Morphett Street, Mount Barker SA 5251

Health Partners Dental

Phone 1300 114 114

Adelaide

Level 1, 101 Pirie Street, Adelaide SA 5000

Flinders Park

288 Grange Road, Flinders Park SA 5025

Highgate

1/445-449 Fullarton Road, Highgate SA 5063

Modbury

Level 1, 27 Smart Road, Modbury SA 5092

Morphett Vale

118-120 Main South Road, Morphett Vale SA 5162

Mount Barker

7 Morphett Street, Mount Barker SA 5251

Notes

Notes continued

1300 113 113 (SA)
1800 182 322 (regional or interstate)

Visit **healthpartners.com.au**

Health Partners is a registered private health insurer since 1937. All information in this brochure is effective 1 October 2025, v2.1. Health Partners Ltd ABN 43 128 282 904

HealthPartners