Fund Rules

April 2024

This information is current as of 1 April 2024

This is important information. Please read and retain for future reference.

Latrobe HEALTH SERVICES

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Important notes:

- the *Private Health Insurance Act* requires all registered health funds to have Fund rules
- these rules are the guiding principles and rules of membership under which Latrobe conducts our business
- these rules are supported by the product summaries, member guide, and the Private Health Insurance Statement (PHIS)
- by completing a membership application with Latrobe all persons covered on a membership agree to these Fund rules as amended from time to time.

A Introduction

A1 Rules arrangement

A1.1 Application of Fund Rules

These Fund Rules apply to all private health insurance policies under the Latrobe Health Services (Latrobe) brand.

A1.2 Contents of the Fund Rules

These Fund Rules consist of:

1) the 'Main Rules' (Fund Rules A to G), and
2) the 'Product Specifications" (as detailed in the product summaries).

A2 Health Benefits Fund

A2.1 Conduct of the Fund

Latrobe Health Services Limited (Latrobe) (ABN 94 137 187 010) is a not-for-profit private health insurer trading as Latrobe.

A2.2 Purpose of the Fund

Latrobe Health Services Limited (Latrobe) operates as a health benefits fund for the purposes of health insurance business, to provide benefits to or on behalf of members in accordance with the *Private Health Insurance Act 2007*.

A2.3 Purpose of the Fund Rules

These fund rules govern the arrangements for membership to and benefit payments by, Latrobe, including the obligation and entitlements of fund members and Latrobe in administering the fund.

A2.4 Supporting policy documentation

The Fund may supplement the Fund Rules with policy documents that are consistent with the Fund Rules.

A3 Member obligations to Insurer

A3.1 Principal member's obligations to pay premiums

Each principal member will pay the applicable premiums charged for the principal member's chosen product in the time and manner specified on the policy, in accordance with these rules.

A3.2 Submission of claims

Each claim for benefits from Latrobe made by a member will be made in accordance with these rules, in good faith and based on understanding that a proper entitlement to make the claim exists.

A3.3 Provision of information

All applicants for membership agree to provide Latrobe all the relevant information that is required and requested to complete an application for membership.

This information will include personal details such as, but not limited to residential address, date of birth, Medicare number, status of dependants. The use of this information will be in accordance with *Privacy Act*.

All existing members will, as soon as practicably possible, notify Latrobe of changes to the required information.

A3.4 Binding agreement between Latrobe and all insured persons

All persons included on a policy are bound by these fund rules and associated supporting documentation. The principal member will be responsible for ensuring all persons listed on the membership are aware of, agree to and abide by these documents.

A4 Governing principles

A4.1 Authority

The operation of Latrobe and each member is governed by the laws of Australia including but not limited to:

a) the *Private Health Insurance Act*
b) the *National Health Act*
c) the *Health Insurance Act*
d) the *Privacy Act*
e) the Private Health Insurance Code of Conduct
f) the constitution of Latrobe
g) these Rules; and
h) any policies of Latrobe notified to the member.

A4.2 Inconsistency

Where the *Private Health Insurance Act* is in conflict with these Rules, the *Private Health Insurance Act* takes precedence over these Rules to the extent of the inconsistency.

Where there is no clear conflict between the *Private Health Insurance Act* and these rules, these rules take precedence.

Where any inconsistency occurs between other fund documentation and these rules, these rules take precedence.

A Introduction

A5 Use of Funds

A5.1 Fund credits

Latrobe shall credit to the Fund:

a) all premiums paid in relation to policies
b) the income from investment of assets of the fund and
c) any other moneys or income as required by the Private Health Insurance Legislation to be credited to the Fund.

A5.2 Payments from the Fund

Payments from the Fund may not be made for any purpose other than to:

a) meet the membership liabilities to pay benefits in accordance with these Fund Rules
b) meet other liabilities or expenses incurred for the purposes of the business of the Fund
c) make distributions, investments and for any other purpose allowed under the Private Health Insurance Legislation.

A5.3 Compliance

Latrobe must ensure that the fund complies with the solvency standards and capital adequacy standards of the *Private Health Insurance Act*.

A6 No improper discrimination

A6.1 Community Rating – Prohibition of discrimination

Latrobe will not improperly or illegally discriminate when making decisions in relation to accepting a member or in the payment of benefits, whether under the *Private Health Insurance Act*, or other relevant legislation relating to anti-discrimination.

Specifically the fund will not discriminate on the basis of:

a) any medical condition – acute or chronic
b) a person's gender, race, sexual orientation or religious belief
c) the age of a person, except in relation to the provisions of Lifetime Health Cover, and age-based discounts or any other extent which is permitted by the *Private Health Insurance Act*
d) where a person lives – except where permitted by the *Private Health Insurance Act*
e) any personal characteristic that may increase an individual's need for treatment (occupation or recreation)
f) the frequency with which an individual may need treatment
g) any matter which is prohibited by the *Private Health Insurance Act*.

Notwithstanding the above, Latrobe can determine annual limits to an extras product benefits, but those limits apply without prejudice to all members on the nominated extras product.

Latrobe can also allocate a premium variation for a product based on the State in which the member lives.

A7 Changes to Rules

A7.1 Rule changes

Latrobe may amend the Fund Rules at any time, in a manner consistent with the *Private Health Insurance Act* and required notification periods.

The rules that are in force on the date a service is provided are the rules that govern the provision of the benefit for that service.

Changes to product rules are defined and administered in accordance with the PHI Code of Conduct obligations as amended from time to time.

A7.2 Notification of Rule change

Latrobe will provide notification of any rule changes in accordance with the obligations directed by the PHI Code of Conduct as amended from time to time.

A7.3 Rule waiver

Latrobe may, at the fund's discretion, waive the application of a fund rule, providing it does not reduce any member's entitlement to benefit.

Any waiver of a particular fund rule does not require the fund to waive the application of that or any other fund rule in any other circumstance for that fund member or any other fund member.

Waivers could apply but are not limited to:

i any formalities that apply to membership applications
ii waiting periods
iii eligibility for benefits.

A Introduction

A8 Dispute resolution

A8.1 Private Health Insurance Code of Conduct

Latrobe is a signatory to the industry Code of Conduct and is committed to the provision of best practice service to all members.

A8.2 Member complaints

A member may, at anytime, make a complaint to Latrobe Health Insurance about any aspect of their membership, services or information provided.

Latrobe will take reasonable actions to respond to complaints quickly and efficiently.

Latrobe has a complaint management and resolution process available on the website https://www.latrobehealth.com.au/globalassets/documents/complaint-resolution-process.pdf

A8.3 Other dispute resolution processes

The Commonwealth Ombudsman (the Ombudsman) is available to assist health fund members who have been unable to resolve issues with their Fund.

Nothing in these Fund Rules prevents a member from approaching the Ombudsman at any time.

A9 Notices

A9.1 Correspondence

Latrobe will provide policy documentation to:

i all new principal members

ii all principal members every 12 months

iii principal members who change products

iv any member on request.

Latrobe will send all correspondence addressed to the principal member to the most recently advised address, phone number or email address.

A principal member whom receives written advice from Latrobe regarding the membership that is not specific only to that member, must inform all other members on the membership of the contents of that notice.

A9.2 Availability of Fund Rules to members

These Fund Rules are available for members to view online at Latrobehealth.com.au

A10 Winding up

In the event that Latrobe ceases under the *Private Health Insurance Act*, to be a registered health benefits fund, the fund will be wound up in accordance with the provisions of the Act and the Constitution of Latrobe.

A11 Other

A11.1 Recovery of moneys paid by reason of an error

Latrobe may recover from a member any moneys incorrectly paid to them due to Latrobe's error within two years of the date of the incorrect payment.

This includes errors made by Latrobe due to:

i it relied on a mistaken fact or interpretation of the law or a mixture of both

ii it miscalculated figures

iii it made an administrative or clerical error.

A11.2 Set-off of benefits payable against amounts owed

If a member owes any moneys to Latrobe due to an error by Latrobe or due to inappropriate claiming by the member, Latrobe can recover those amounts by setting it off against any benefits or other moneys payable to the member.

A11.3 Set-off of premiums refundable against amounts owed

If a member owes any moneys to Latrobe due to an error by Latrobe or due to inappropriate claiming by the member, Latrobe can recover those amounts by setting it off against any premiums refundable to the member.

A11.4 Waiver of Rule A11

The Fund may at it's discretion waive the application of all or any part of Rule A11.

B Interpretation and Definitions

B1 Interpretation

In these rules and unless the context suggests otherwise:

a) any reference to a rule should be read and construed as a reference to that rule as in force from time to time;

b) any reference to legislation or government regulation will be read and understood in accordance with that legislation or government regulation as in force from time to time;

c) headings are for convenience only and do not form part of these rules nor do they affect the interpretation of these rules;

d) the singular number includes the plural and vice versa;

e) a reference to one (1) gender includes all other genders;

f) money references are in Australian dollars;

g) the definitions in the dictionary in schedule 1 to the Act shall be read in conjunction with these rules and shall be deemed to be part of these rules and shall have the same meaning as that which is defined in the Act; and

h) a reference to "month" means a calendar month.

B2 Definitions

Unless the context suggests otherwise, the following defined words and phrases will have the meaning set out below:

"Accident" means an unplanned, unintentional, and unexpected event, occurring by chance and caused by external force or object resulting in a physical injury requiring immediate treatment or advice in respect of which benefits are payable under these rules, but excluding:

a) any illness

b) an injury or condition resulting from any complications of treatment or surgery

c) any injury or condition resulting from the effects of alcohol, or drugs of addiction

d) pregnancy

e) the aggravation of an existing physical injury or condition.

"Accommodation" means hospital facilities covered under your applicable policy including meals, bed fees, theatre fees and treatment including nursing care.

"Act" means the *Private Health Insurance Act 2007* and the Private Health Insurance Rules 2007, as amended from time to time.

"Acute Care Certificate" is a certificate in a form approved and required by Latrobe from a medical provider confirming the need for an Admitted Patient to continue to receive acute hospital care. An acute certificate is valid for 30 days and is required after 35 days of continuous hospitalisation.

"Additional Gap Medical Benefits" means the benefits (if any) payable in respect of medical expenses which are in excess of the schedule fee and which otherwise meet the requirements of the Fund's no or known gap membership, provided always that the medical expenses relate to a professional service that:

a) is rendered to a patient, while hospital treatment is provided to that patient in a hospital by a medical practitioner with whom the organisation does not have a medical purchaser provider agreement that applies to that professional service; and

b) is a professional service in respect of which a Medicare benefit is payable.

"Admission" means the period of time when admitted as a patient for a condition or illness into a hospital for treatment until discharged from the hospital/ day facility.

"Admitted Patient" means a person who occupies an approved bed in a hospital for the purpose of hospital treatment and includes:

a) a newly born child who occupies an approved bed in an intensive care facility in a hospital, being a facility approved by the Minister for the purpose of the provision of special care; and

b) where there are two (2) or more newly born children of the same mother in a hospital and those children are not admitted patients of the hospital by virtue of the preceding paragraph – each such child in excess of one (1).

c) an admitted patient does not include an insured person of the staff of the hospital who is receiving treatment in his or her own quarters or a newly born child whose mother also occupies a bed in the hospital.

"Adult" a person who is not a Dependant Child, Dependant Non-Classified, Dependant Student or Non-Student Dependant (previously known as Adult Dependant).

"Allied Health Services" are services such as physiotherapy, occupational therapy, chiropractic, podiatry, optometry, psychology, dietetics and pharmacy (among others).

B Interpretation and Definitions

"Age-based discount" means a discount offered on selected hospital policies for persons and/ or their partners aged between 18 and 29. The discount is two per cent for each year that the person is aged under 30, to a maximum of ten per cent. Providing the person remains on an applicable hospital cover, they are entitled to the discount until they turn 41 at which time the discount will decrease at the rate of two per cent per year for up to five years, so that no age-based discounts are available after the age of 45.

"Ambulance" means a registered road vehicle, boat or aircraft operated by an Ambulance Service Provider and equipped for the transport of persons requiring medical attention.

"Ambulance transportation – emergency" is transportation of an unplanned and non-routine nature for the purpose of providing immediate medical attention to a person. The determination of a specific transport as being an emergency is made by the paramedic employed by a recognised Ambulance Service Provider and recorded on the account. It does not include:

- ambulance transport from a hospital to your home, or ambulance transfers between hospitals
- any services which are not operated by the listed recognised Ambulance Service Providers
- any non-emergency services as determined by the recognised Ambulance Service Provider.

"Ambulance Service Provider" means Latrobe Health Services recognises the following providers for the purposes of paying benefits:

- ACT Ambulance Service
- Ambulance Service of NSW
- Ambulance Victoria
- Non-Emergency Patient Transportation NSW
- Queensland Ambulance Service
- South Australia Ambulance Service
- St John Ambulance Service NT
- St John Ambulance Service WA
- Tasmanian Ambulance Service

"Ambulance Subscription" is a membership taken out with a recognised Ambulance Service Provider who participates in a direct membership scheme – Ambulance Victoria, SA Ambulance Service, St John Ambulance Service NT and WA. The services covered by these memberships is defined by the governing ambulance body.

"Annual Limit" means the maximum amount claimable per person in a calendar year, unless otherwise stated.

"Approved Provider" (recognised provider) means a provider of services registered with the appropriate association or organisation to render services to a member and approved by the Latrobe to render services to its members.

"AHPRA" means The Australian Health Practitioner Regulation Agency. AHPRA is responsible for regulating Australia's registered health practitioners.

"APRA" means the Australian Prudential Regulation Authority. APRA is an independent statutory authority that supervises institutions across banking, insurance and superannuation.

"Arrears" means the amount of unpaid premiums whenever the date to which premiums have been paid is earlier than the current date.

"Australian Government rebate" means the private health insurance rebate that helps reduce the cost of health insurance. The rebate you are entitled to depends on your income and age and is indexed annually by the Australian Government.

"Australian Health Service Alliance" (AHSA) means a a service company representing a number of small to medium sized private health insurance funds. AHSA provides a range of services including (but not limited to) management of provider relationships, and negotiation of contracts. Latrobe joined AHSA as a member fund on 01/05/2023.

"Australian Regional Health Group" (ARHG) means a collective of regional health Funds utilised to negotiate hospital purchaser provider agreements with providers and monitor the registration process of relevant general treatment providers. Latrobe was a member of ARHG until 30/04/2023.

"Basic Hospital Cover" means a hospital membership that includes the clinical categories that must be covered by a Basic Hospital product.

"Benefit" means the entitlement due to the principal member in respect of approved expenses incurred in accordance with the terms of these Fund rules.

"Bronze Hospital Cover" means a membership that covers hospital treatment and covers the treatments in all of the clinical categories required for a bronze membership.

"Business Partner" are individual(s), and individuals that are part of separate entities that have an alliance to work together.

B Interpretation and Definitions

"Calendar Year" starts on 1 January and ends on 31 December annually.

"Cancellation Date" means the date on which the written notice of cancellation is received by the Fund or the last date to which premiums were paid.

"Clinical Categories" means a group of hospital treatments where all services within a group must be included.

"Children" means all dependants named on a policy (not including spouse).

"Compensation" means a payment by way of damages or a payment under a scheme of insurance or compensation provided for by law, or any other payment that in the opinion of the Fund is a payment in the nature of compensation or damages.

"Cover" means a defined group of benefits payables under a membership for approved expenses incurred by the insured person.

"Consumables and medical devices" means (consumables) items that require regular replacement (e.g. batteries) to keep a medical device (such as a hearing aid) operational. Many medical devices require consumables.

"Co-payment" means a relatively small amount of money paid by the insured person towards the cost of each day in a private hospital per episode of care.

'Defacto Relationship' means when two people (partners) are not married but are living together as a couple on a genuine domestic basis.

"Dental" means of or relating to the teeth and the work of a dentist.

"Dental Technician (Advanced)" means a person registered or licensed under a law of a State or Territory as a dental technician (advanced).

"Dental Practitioner" means a person in private practice registered by the Australian Dental Association.

"Department" means The Commonwealth Department of Health.

"Dependant" means a person dependant upon the principal member including:

- adult partner (including de facto and same-sex partner)
- own children
- stepchildren
- legally adopted children, and
- children of whom the principal member is the legal guardian who do not have a partner.

"Dependant child" means a dependant person who is aged under 18 years of age who does not have a spouse or partner; or

"Dependant non-classified" means a dependant person who is between the ages of 18 and 20 who does not have a spouse or partner.

"Dependant student" means a dependant person who is between the ages 21 and 31 years, does not have a spouse or partner, is a full-time student at school, college, or university; and may be living away from home.

"Dependant non-student" means a person who is between the ages of 21 and 31 who does not have a spouse or partner and who is no longer a full-time student dependant. These dependants may be working or living away from home.

"Direct debit payment" is a method to make your premium payments automatically depending on your premium frequency. The Direct Debit Customer Service Agreement applies when you pay your premiums by direct debit. You can find this agreement at latrobehealth.com.au

"Elective Surgery" means non-emergency surgery which is medically necessary, but can be delayed for at least 24 hours.

In the public hospital system patients waiting for elective surgery are assessed by their treating medical professional as Category 1, 2 or 3 per the following definitions:

Category 1 – needing treatment within 30 days

Category 2 – needing treatment within 90 days

Category 3 – needing treatment at some point in the next year.

"Emergency" means a situation where the patient presenting at a hospital or other medical facility is assessed using the Australasian Triage Scale as:

Category 1 – immediate treatment

Category 2 - treatment within 10 minutes; or

Category 3 – treatment within 30 minutes.

"Emergency Ambulance" means transportation of an unplanned and non routine nature for the purpose of providing immediate medical attention to a person. Whether the transportation is deemed an emergency is determined by the paramedic and usually recorded on the account

B Interpretation and Definitions

"Episode of Care" means a period of continuous hospital treatment, including readmission within a seven (7) day period for treatment of the same ailment, condition, or illness.

"Excess" means an amount of money paid in a calendar year towards the cost of each hospital episode of care up to an annual maximum before fund benefits are payable.

"Exclusions" means that certain things are deliberately not covered in a particular policy type

"Federation Products" means the products and packages offered by Federation Health which merged with Latrobe in 2005.

"Full Time Student" means an insured person in full-time study at an educational institution recognised by the Fund.

"Gap Medical Benefits" means the benefits (if any) payable in respect of medical expenses which are less than, greater than or equal to the schedule fee, provided always that the medical expenses relate to a professional service that:

a) is rendered to a patient, while hospital treatment is provided to that patient in a hospital by a medical practitioner with whom the organisation does not have a medical purchaser provider agreement that applies to that professional service; and

b) is a professional service in respect of which a Medicare benefit is payable.

"General Medical Practitioner" means a general practitioner as defined in section 3 of the *Health Insurance Act 1973*.

"General Treatment" means treatment (including provision of goods and services) that is intended to manage or prevent a disease, injury or condition and is not "hospital treatment".

"Gold Card" has the same meaning as in s34-15 of the *Private Health Insurance Act*.

"Gold Hospital Cover" means a membership that covers hospital treatment and covers the treatments in all of the clinical categories required for a gold membership.

"Health Benefits Fund" means a Fund as described in s131-10 of the *Private Health Insurance Act*.

"Health Insurance Membership" means a membership that provides specified benefits for hospital and/ or general treatment and meets all requirements under s63-10 of the *Private Health Insurance Act*.

"High-Cost Drugs" means any drugs not listed on the Pharmaceutical Benefits Scheme (PBS) and are not eligible for payment of benefits.

"Hospital" a recognised hospital, private hospital or a hospital as defined under s121-5(5) of the *Private Health Insurance Act*.

"Hospital Purchaser/ Provider Agreement (HPPA Agreement)" means a negotiated agreement entered between the Fund and the hospital for cost of hospital treatment.

"Hospital Treatment" means treatment (including provision of goods and services) that is intended to manage a disease, injury or condition and is provided at a hospital or arranged with the direct involvement of a hospital.

"Informed Financial Consent" means the medical provider advises you of any out-of-pocket costs before your admission. This is called Informed Financial Consent.

"Inpatient services" means services provided to you as an admitted inpatient in a recognised private or public hospital for treatment that is in an included clinical category, has a Medicare item number allocated and a Medicare benefit is payable.

"Insured Person" means a person covered under a principal member's membership with the Fund.

"Insured Person's Year" means a year from the date of commencement of the insured persons membership, or from the anniversary date of the commencement of the insured person.

"Item number" means the unique number attached to each professional service contained in the Medicare Benefits Schedule (MBS). Each item number has a set benefit. For more information see MBS Online.

"Latrobe" means Latrobe Health Services Limited. ABN 94 137 187 010 (otherwise referred to in these rules as "Latrobe" or "the Fund").

"Levels of Cover" means those levels of cover, or any one of them as the context requires, specified in clause C1.2.

"Lifetime Health Cover Loading" means additional premiums payable by an insured person who does not take out an appropriate hospital cover prior to 1 July following their 31st birthday.

"Lifetime limit" means the maximum amount that can be claimed on a selected service in a lifetime, even if cover and funds are changed. This information is included on a clearance certificate.

B Interpretation and Definitions

"Limited benefits" mean that a minimal level of benefit is paid for a specified hospital treatment, or in a non-participating private hospital, or for treatments not covered by Medicare.

"Medical Practitioner" means a person as defined in s3(1) of the *Health Insurance Act 1973* and satisfies the provider eligibility requirements for the payment of Medicare benefits.

"Medical Benefits Schedule" means the Medicare Schedule of Benefits produced by the Department of Health and Ageing to which all fees and benefits relate for inpatient services.

"Medicare Benefit" means the Medicare benefit payable within the meaning of Part II of the *Health Insurance Act 1973* with respect to a professional service.

"Medicare Levy Surcharge" means an extra charge payable by high income earners beyond the standard Medicare Levy if they do not have qualifying private hospital insurance coverage. This charge is assessed as part of an individual or family's annual tax return.

"Medical gap cover" is when Medicare pays 75% of the Medicare Benefit Schedule fee for in-hospital medical charges and Latrobe pays the remaining 25%.

"Member" means any person's, insured person's or dependant's covered on a membership.

"Membership year" means a 12-month period starting on the anniversary of the date that the membership commenced.

"Mental health waiver" means a waiver of the two-month waiting period for an upgrade from 'Restricted services' to 'Included services' for in-hospital psychiatric treatment in accordance with Division 78 of the *Private Health Insurance Act 2007* for an eligible member. The mental health waiver can only be used once in a member's lifetime across any private health insurer.

"Mixed Business Premises" means a premises that provides both health care services and other services that includes but are not limited to retail, beauty, or wellness type services

"Newborn" means a baby less than nine days old.

"New technologies" mean, but are not limited to, medicines, devices, or treatments.

"Non-participating Private Hospital" means a hospital which does not have a hospital purchaser provider agreement with the Fund.

"Non-surgically implanted prostheses" means a replacement body part not surgically implanted.

"Nursing home-type patients" means a patient who has been in hospital more than 35 days, no longer requires acute hospital care, cannot live independently at home or be looked after at home, and either cannot be placed in a nursing home or a nursing home place is not available.

"Obstetrics" is a term used to define information or procedures relating to pregnancy and birth.

"Obstetric Condition" means a condition that is listed under Group T4 (Obstetrics) in the Medicare Benefits Schedule.

"Optical" means services related to the provision of glasses, contact lenses, tests and treatments carried out by a registered optometrist or ophthalmologist.

"Orthodontic" means a type of specialist dental treatment carried out by an orthodontist that diagnoses, prevents and corrects mispositioned teeth and jaws and misaligned bite patterns.

"Outpatient attendance" means treatment received in a hospital emergency department where the patient is not admitted to a bed in the hospital.

"Out of Pocket" means the difference between the fund benefit for a treatment or service and the provider's fees and is payable by the member.

"Overseas Treatment" means treatments or appliances provided or sourced from outside of Australia. This includes treatment on cruise ships inside or outside Australian waters.

"Participating Private Hospital" means a hospital which has a hospital purchaser provider agreement with the Fund.

"Pathologist" means a medical practitioner who specialises in the provision of pathology services within the meaning of the *Health Insurance Act 1973*.

"Pharmacy" means prescribed drugs and medicines dispensed by a pharmacist and/ or travel and allergy vaccines dispensed by a pharmacist or doctor.

"PBS" means the Pharmaceutical Benefits Schedule (PBS) that is a list of all the medicines that receive a government subsidy.

"PBS" (non) means a Pharmaceutical that is registered for use in Australia by the Therapeutic Goods Administration (TGA) but has is not on the Pharmaceutical Benefits Schedule (PBS)

B Interpretation and Definitions

"Physiotherapy Class Consultation" means a group of clients are provided with a common intervention simultaneously and in most instances clinical notes are not recorded for each person.

"Physiotherapy Group Consultation" means a small group of clients are provided with different interventions concurrently and generally includes;

a) Pre-intervention assessment
b) Individual designed intervention is provided during the session.
c) Modification of intervention as appropriate occurs during the session
d) Clinical record keeping

"Practitioners in Private Practice" means a practitioner who does not:

a) use any publicly Funded hospital, clinic, health Centre or other such facility, including a facility provided by a municipal authority for, or in connection with, the provision of a general service for which a benefit is claimed under the general table; and
b) receive publicly Funded assistance or support, whether by way of remuneration, subsidy or otherwise, in connection with the provision of the general service.

"Podiatry" is a medical specialty focused on diseases, afflictions and deformities of the foot, ankle and related structures of the lower leg.

"Policy Documentation" is the complete suite of product documents as amended from time to time including but not limited to:

- Product summary
- Member Guide
- Private Health Insurance Statement (PHIS)

"Pre-Existing Condition" means an ailment, illness or condition that, in the opinion of a medical practitioner appointed by the Fund, the signs or symptoms of that ailment, illness or condition existed at any time in the period of six (6) months ending on the day on which the insured person became insured under the membership (s75-15 of the Act).

"Premium" means the financial payment to the Fund, entitling a principal member and dependant(s) to be an insured person of the Fund.

"Principal Member" means the person who signs the application and is responsible for the payment of premiums.

"Private or shared room" in a participating private hospital means you have the choice of a private or shared room when you have a hospital admission. (Private rooms are subject to availability.

"Professional Service or Professional Services" means a professional service or professional services as defined in the *Health Insurance Act 1973*.

"Radiologist" means a medical practitioner who specialises in the provision of radiological services within the meaning of the *Health Insurance Act 1973*.

"Rate Protection" means the payment of premiums for a defined period of time not exceeding 12 months, in advance of a rate increase that will not require any further payments to cover any difference between the advance payment and the new premium rate.

"Recognised Provider" (Approved Provider) means a provider of services registered with the appropriate association or organisation to render services to a member and approved Latrobe to render services to its members.

"Reinstatement Date" means the date from which a membership will be reinstated after cancellation subject to rule C7.8.

"Reinstatement" means that Latrobe may, at its discretion, reinstate a previously cancelled membership at the request of the principal member with continuity of entitlements, subject to the payment of all premiums as required under the fund rules.

"Relevant Change" means a change which is or might be detrimental to the interests of an insured person being to the scope, level or amount of treatment, benefits payable or increases to the premiums payable by an insured person.

"Restricted Benefit" (default benefit, Commonwealth minimum benefits) means benefits payable will be in accordance with the minimum benefit requirements in the Private Health Insurance (Benefit Requirements) Rules as amended from time to time for shared ward accommodation in a public hospital.

"Rule Change" means the changing of these rules by varying or deleting existing rules and by adding new rules.

"Rules" means these rules as amended from time to time.

B Interpretation and Definitions

"Silver Hospital Cover" means a membership that covers hospital treatment and covers the treatments in all of the clinical categories required for a silver membership.

"Simplified and/ or Aggregate Billing Arrangement" means a billing arrangement providing Additional Medical Gap Benefits.

"Specialist Medical Practitioner" means a specialist as defined in Section 3 of the *Health Insurance Act 1973*.

"Spouse or Partner" means a person who lives with the principal member in a marital or de facto relationship.

"Suspension" means the temporary discontinuation of a membership in accordance with rule C9.

"Surgically Implanted Prosthesis" means an artificial substitute for a missing body part that is surgically inserted into the body during a surgical procedure.

"Termination Date" means the date at which the policy is no longer active and benefits are no longer payable.

"TGA" means Therapeutic Goods Administration.

"Transfer Certificate" means a certificate in an approved form providing details of insured persons, membership held, and benefits paid issued under section 99-1 of the *Private Health Insurance Act* to another health insurance fund.

"Transferring Applicant" means a person transferring from another Health Benefits Insurer.

"Two-year claim limitation" means no benefit is payable for any claim submitted two years or more from the date of admission or service provision.

"Waiting Period" means a period during which a member must hold continuous membership under a particular product before the member has entitlement to receive a benefit at the level payable on the product.

C Membership

C1 General conditions of membership

C1.1 Same membership categories and covers

All members under the same membership shall:

a) belong to the same membership category, and

b) have the same cover or covers.

C1.2 Levels of cover

A member, subject to all other fund rules, may have one of the following products:

a) a hospital product and/ or

b) an extras product or

c) a combination of hospital and extras product or

d) a combined package product.

C1.3.1 Insured groups

Members can select one of the following insured groups:

a) only one person – Single

b) two adults and no-one else – Couples

c) two or more people, only one of whom is an adult – Single parent family

d) two or more people, at a least one dependant non-student and any number dependant children, dependant students or non-classified dependant people – Single parent family non-student dependant extension

e) three or more people, only two of whom are adults – Family

f) three or more people, at a least one dependant non-student and any number dependant children, dependant students or non-classified dependant people – Family non-student dependant extension.

C1.3.2 Membership classes

Each membership will be classified by classes aligning to C1.3.1

a) Single – only one person

b) Couples – two adults and no-one else

c) Single parent family – two or more people, only one of whom is an adult

d) Single parent family non-student dependant extension – two or more people, at a least one dependant non-student and any number dependant children, dependant students or non-classified dependant people

e) Family – three or more people, only two of whom are adults

f) Family non-student dependant extension – three or more people, at a least one dependant non-student and any number dependant children, dependant students or non-classified dependant people.

C1.4 Membership authority

The principal member and their spouse have equal responsibility and authority to:

- ensure payment of premiums
- make changes to the membership as required
- submit claims on behalf of all members on the membership
- claim on the membership
- appoint and authorise, in writing, a third party, not a person on the membership to either:
  - i authorise to operate – full access to operate as the principal member
  - ii authorise to make changes and claim, this includes authority to:
    - change Direct Debit/ Credit details
    - add/ remove persons
    - change level of cover
    - submit claims

    does not include authority to:
    - cancel policy
    - obtain a refund
    - transfer ownership
  - iii authorise to enquire only – cannot make any changes to the membership, but can make enquiries on behalf of the principal member, including:
    - direct debit dates and amounts
    - level of cover including exclusions and inclusions
    - information on claim outcome/ status

Any and all dependants on the membership may submit claims on behalf of all members on the membership.

C Membership

C2 Eligibility for membership

C2.1 Membership eligibility

Latrobe offers membership to any person who is seeking a private health insurance product or combination of products.

Latrobe will not refuse membership to an overseas visitor or persons otherwise not eligible for full Medicare benefits on the basis of their residency or Medicare status, however in doing so, Latrobe does not offer a specific cover for this group and large out of pocket costs may result.

Persons under the age of 18, seeking an independent policy, will require a parent or guardian to manage the membership on behalf of the child. This person will be responsible for the maintenance, payment of premiums and notification of any membership change to Latrobe on behalf of the child. The child will be taken to be the insured person who is entitled to receive benefits under the policy.

C2.1.2 Membership category

All persons listed on a membership must have the same product as the principal member.

C3 Dependants

C3.1 Addition to a membership

Dependants, including a spouse can be added to a membership at any time providing the option is available on the product.

If changing from a single membership class:

- the membership class will change as directed by principal member
- will apply from the date the dependant was added
- premiums will adjust to the new membership scale
- all waiting periods will apply to the new dependants.

C3.1.2 Addition of a newborn

A newborn child may be added to a Single Parent Family, Couple or Family membership from the newborn's date of birth provided:

- the application is received by Latrobe before the child's 1st birthday
- prior to any claim for benefits for the child being paid
- only those waiting periods applying to the principal member at that time will apply to the child, provided the membership commenced no later than the child's date of birth
- for the purposes of the application of the Loyal Member excess the newborn will align with the principal member's membership year.

If changing from a single membership class and ensuring that the newborn is covered from birth:

- change to single parent family or family will need to be effective two months prior to the estimated due date
- written confirmation of the expected due date is required
- providing the change to family was attended two months prior to the estimated date of delivery (EDD), the newborn is covered if born prematurely
- premiums will adjust to the new membership scale from the date of change.

C3.2 Dependant types

Dependants are covered on a Family or Single Parent membership as follows:

- spouse/ partner
- dependant child aged 0-17 years
- dependant non-classified aged 18-20 years (not married or in a de facto relationship)
- dependant student aged 21-31 years (not married or in a de facto relationship, is undertaking full time study at a recognised training facility)
- dependant non-student aged 21-31 years (not married or in de facto relationship).

A non-student dependant extension is available on selected products and an additional 25% of premium applies. The non-student dependant extension is available on the following products:

Open products:

- Corporate Gold Hospital Choice Members (CH1)
- Silver Plus 250, 500, SP6
- Silver 250, 500, S6
- Bronze Plus 250, 500, BP6
- Bronze 500, 750
- Healthy Start (ST)
- Premier Families (YFT)

- Premier Singles and Couples (YST)
- Core Complete (PP&P)
- Core Families (YFB)
- Core Essentials (YSB)
- Basic Extras (PF)

Closed products:

- Gold 500
- Bronze 250 *(Closed April 2024)*
- Top Hospital (H3)
- Loyal Members (LM)
- Gold Hospital Choice Members (H1)
- Gold Family Care Top Hospital (K1, K2, K3)
- Gold Hospital $750 (X6)
- Gold Hospital $1000 (X7)
- Premier Extras (PG)
- Premier Family Care Extras (PH)
- Advantage Family Care Extras (PK)

Independent tax advice is recommended.

C3.3 Dependants ceasing eligibility

The principal member must advise if a dependant cease to be eligible to be covered as a dependant in accordance with these Fund Rules.

A dependant student or a dependant non-student will automatically be terminated from a membership upon their 32nd birthday.

A student declaration is required on an annual basis to confirm continued eligibility as a student dependant, if this is not received nor a request to upgrade of cover to adult dependant policy the dependants cover will cease.

Subject to these Fund Rules, a person who within 30 day of ceasing to be an eligible dependant may commence their own cover, either on the same product they were on or on any other open product. Waiting periods will apply to any upgrade in cover.

C4 Membership applications

C4.1 Form of application

Applications for membership to Latrobe must be in the form required by Latrobe. This application can be completed by:

a) telephone
b) online
c) in person
d) or any other means approved by Latrobe.

C4.2 Application acceptance

An application will be accepted by Latrobe once all application documents are competed and the initial payment of the premium required from the applicant is received by Latrobe and funds have cleared.

Following this acceptance, Latrobe will provide the members' with a Welcome Pack that includes:

a) full set of membership documents – product summary, member guide, PHIS
b) a membership card for each adult and any dependants as requested
c) details of how to access online member services and the Member App.

C4.3 Refusal of applications

Latrobe may reject any application for admission to the Fund when:

a) an application does not comply with these rules
b) to any applicant who has supplied incorrect, misleading or false information in support of an application
c) as a member including where the applicant was a former member of Latrobe whose membership was cancelled under Fund Rule C6 Termination of membership
d) any and all refusal of application, Latrobe will provide a statement of reasons for refusal.

Latrobe will not reject any membership application for reasons described as improper discrimination/ breach of community rating under the *Private Health Insurance Act.*

C5 Duration of membership

C5.1 Commencement of membership:

a) a membership with Latrobe commences on the date on which the application is lodged; or
b) a later date as nominated by the applicant on the application form.

And the application has been accepted in accordance to C4.2.

C5.2 Termination of membership:

A membership continues:

a) until the date the principal member, spouse or authorised third party notifies Latrobe that they wish to cancel the membership under C5.3, or Latrobe notifies that the membership has been terminated under C6; or

b) a date as nominated by the principal member.

C5.3 Cooling off period

A principal member who has not yet made any claim for benefits on the membership and who terminates that membership within a period of 30 days from the start date of the membership ('cooling off period') is entitled to receive a full refund of any premium paid.

Any refund made will be refunded to the account from which the original payment was taken.

C5.4 Cancellation:

a) a principal member or spouse may cancel the membership

b) a principal member may remove any dependants including their spouse from the membership

c) a spouse may not remove the principal member from the membership unless by consent from the principle membership or death

d) the principal member, spouse or a dependant aged at least 18 years of age may remove themselves from the membership

e) any request for cancellation is effective from the date of request or an agreed future date

f) where the spouse has been removed by the principal member the fund will take all reasonable and practicable steps to notify the spouse, the fund is not liable in the event that any notifications are undeliverable.

C5.5 Entitlement to refund of premiums

If the membership is cancelled before the date on which the next premium is due any premiums paid in advance of the termination date will be reimbursed.

Where a refund is owing following the death of a principal member, Latrobe will refund any premiums paid in respect of the period after the cancellation date to the Estate of the principal member.

Any refund made will be refunded to the account from which the regular payment was taken.

C5.6 Transfer certificates

A transfer certificate will be provided in the approved form within fourteen (14) days of:

a) cancellation of membership of the principal member; or

b) receipt of request from a new insurer on behalf of the principal member.

C5.7 Reinstatement of cancelled membership

Where a membership has been cancelled under these Fund Rules, Latrobe may, at its discretion, reinstate the membership at the request of the principal member with continuity of entitlements, subject to the payment of all premiums as required under these Fund Rules.

C5.8 Temporary suspension of membership

C5.8.1 Types of suspensions

A membership may be temporarily suspended and resumed without having to re-serve waiting periods for the following reasons:

a) hardship due to:
   i unemployment
   ii illness
   iii death of family member

b) overseas travel

c) natural disaster:
   i first responders, including Victorian CFA, NSW Rural Fire Service and State Emergency Services
   ii hardship arrangements for members impacted by bushfires, floods and other disasters – reference to Natural Disaster Guidelines

d) any other reason at the discretion of Latrobe.

C5.8.2 Suspension conditions

A membership may be temporarily suspended with the following conditions:

Hardship

- the membership has been active with Latrobe for at least 12 months
- for an initial mandatory period of three months – no reactivation can be made during this period
- extensions in three month increments with total period not exceeding 12 months
- maximum 12 months suspension in a lifetime of membership
- greater than six months since the last period of suspension, for the same reason.

Overseas Travel

- the membership has been active with Latrobe for at least 12 months
- for a period of between two weeks and 24 months
- suspension must be arranged prior to member leaving Australia
- greater than six months since the last period of suspension, for the same reason.

C5.8.2 Effect of suspension

During the suspension of a membership:

- the principal member is not required to pay premiums in respect of the membership; and
- any member that is suspended is not entitled to payment of benefits for services provided during the suspension
- the period of a suspended membership will not be taken into account for the purposes of lifetime health cover calculations
- the period of a suspended membership will not count towards any applicable Loyalty Bonus
- periods of suspension do not count towards waiting periods. Therefore, the balance of all outstanding waiting periods must be served upon reactivation of membership
- a principal member with two different types of cover (i.e. a hospital product and general treatment product) may not suspend one cover without also suspending the other
- suspensions can apply to the entire membership or individual members as required
- Medicare levy surcharge applies during a suspension period.

C5.8.3 Reactivation of membership

Hardship

Memberships will be automatically reactivated at the completion of the three month mandatory period. If a hardship extension is required it is the responsibility of the principal member to contact the fund 14 days prior to the expiry of the suspension period.

Overseas Suspension

Memberships will be automatically reactivated based on the date provided by the member. If the reactivation date changes whilst overseas it is the principal member's responsibility to inform Latrobe.

Latrobe requires that international travel documents be supplied to support reactivation following overseas suspension, these include but are not limited to:

- international movement records
- boarding passes
- passport stamps that confirm date of re entry to Australia
- official travel itinerary.

C6 Transfers

C6.1 General

Transfer from other Funds

Subject to all other Rules, members of another registered health benefits fund may apply to transfer to Latrobe within a period of thirty (30) days from the date to which contributions were last paid and may be accepted from the date the application is received by Latrobe.

C6.2 Transfers from another Fund outside thirty (30) days

Where a former member of another private health insurer joins Latrobe with a gap in cover of more than 30 days Latrobe will treat the person as a new member for all purposes, including all waiting period application.

C6.3 Transfers from another Fund within thirty (30) days

Where a person who was insured under another health insurer with a previous cover, transfers to a Latrobe product with a break in coverage of 30 days or less, Latrobe will:

a) recognise waiting periods served under the old product for hospital or extras treatment when the previous fund product provides equivalent cover

b) apply the balance of waiting periods not served with the previous fund to the new Latrobe product cover

c) apply all relevant waiting periods to any benefits under the new Latrobe product that were not provided under the previous fund's product cover

d) in the case of an upgrade to a Latrobe product with a higher benefit payable, the lower benefit that would have been paid by the previous fund will be paid until all waiting periods have been served for the new Latrobe product

e) any excess or co payment paid under the previous fund product cover is not recognised

f) any extra benefits paid under the previous fund product will contribute towards the annual limits on the new Latrobe extras product

g) apply all waiting periods for both hospital and extras products if a gap of 31 days or more exists between the date last paid on the previous fund product and the first payment paid on the new Latrobe product.

C6.4 Transfer from an International Health Insurer cover within thirty (30 days) of returning to Australia

Where a person who was insured under an internationally recognised health insurer cover and supplies international movement records transfers to Latrobe product within 30 days or less of returning to Australia, Latrobe will:

a) recognise waiting periods served under the old product for hospital or extras treatment when the previous fund product provides equivalent cover

b) apply the balance of waiting periods not served with the previous fund to the new Latrobe product cover

c) apply all relevant waiting periods to any benefits under the new Latrobe product that were not provided under the previous fund's product cover

d) in the case of an upgrade to a Latrobe product with a higher benefit payable, apply the lower benefit payable under the previous fund cover until the required waiting period has been served for the new Latrobe product

e) any excess or co payment paid under the previous fund product cover is not recognised

f) any extra benefits paid under the previous fund product will contribute towards the annual limits on the new Latrobe extras product

g) apply all waiting periods for both hospital and extras products if a gap of 31 days or more exists between the date last paid on the previous fund product and the first payment paid on the new Latrobe product.

C6.5 Gold card holders

Waiting periods will not apply to any insured person who:

a) held a gold card, or was entitled to treatment under a gold card, before applying for the insurance; and

b) applies for the insurance no longer than two (2) months after they ceased to hold, or be entitled under, the gold card.

C6.6 Upgrades of policies within the Fund

Where a principal member transfers from one (1) principal member category or level of cover to another principal member category or level of cover within the Fund then:

a) benefits payable will be paid at the level applicable to the earlier membership or the new membership whichever is the lesser, until any applicable waiting periods relevant to the new membership have been served; and

b) any entitlements to benefits will be assessed after allowing for benefits already paid or payable prior to the change in membership; and

c) any co-payment or excess applicable will be assessed after allowing for any co payment or excess paid under their previous membership.

C6.7 Waiver

Latrobe may at its discretion waive the application of all or any part of rule C6.

C7 Termination of membership

C7.1 Termination generally

Latrobe may terminate the membership of any principal member or terminate a member from a membership (with or without advanced written notice) on any of the following grounds:

a) the application for the membership is discovered to have been incomplete or inaccurate in a material respect

b) the membership is in arrears for a period of more than two months.

C7.2 Termination for breach

Termination of membership where member acts improperly Latrobe may, by notice in writing to the principal member, terminate the membership of any principal member or terminate a member from a membership where, in the opinion of Latrobe:

a) any member had committed or attempted to commit fraud upon Latrobe
b) any member materially or repeatedly breached any of these Fund Rules or any other term or condition of membership
c) any member included in the membership has behaved inappropriately towards Latrobe staff, providers or other members.

C7.3 Notice of termination for breach

If the membership is terminated in accordance with rule 7.2, then the Fund may give notice in writing to the principal member immediately terminating the membership and that of any of the principal member's dependants.

C7.4 Right to notice and premiums – significant detrimental changes

If the Fund terminates a principal member's membership and that of any dependants under rule C8.1, then the Fund must:

a) give the principal member not less than 60 days notice in writing of the reason for termination without being under any obligation to give such notice to the principal dependants; and
b) if requested by the principal member, refund to the principal member any premiums paid in advance of the termination date.

C7.5 Member entitlements on termination

Unless Fund Rule 7.1.a or 7.1.b apply:

a) all benefits and entitlements continue to apply until the effective date of termination; and
b) the principal member will be entitled to a pro-rata refund of any premium paid for any period beyond the date of termination.

C7.6 No rights to benefits

Once the membership is terminated the members will not have any right to claim benefits from Latrobe after the date of termination comes into affect.

C7.7 Waiver of rule C7

The Fund may at it's discretion waive the application of all or any part of Rule C7.

C8 Other

C8.1 Closed products

Latrobe, may at its discretion decide to remove a product from sale from a specified date. Latrobe may:

a) transfer each affected insured person to the nearest equivalent membership offered by the Fund and premiums paid in advance will be applied as premiums for the new membership at the appropriate rate for the new membership or
b) allow those members to continue holding policies under that product
c) a person cannot take out or transfer to a closed product unless:
    i the person is a dependant or partner of a person that holds a closed product membership and they wish to join the members membership
    ii the person is a spouse or dependant on the closed product and wishes to transfer to their own membership.
    iii the person who holds a closed product and wishes to transfer to a different excess option within the same type of closed product.

C8.2 Product Rationalisation

Latrobe may at is discretion migrate or move a member from an existing closed product to another product as part of product rationalisation activities

D Contributions

D1 Contributions

D1.1 Payment of premiums

Premiums payable for each cover are determined by Latrobe (in accordance, where applicable, with the Act).

The amount of premiums payable for a membership may be impacted by eligibility for the Australian Government Rebate, and the Lifetime Health Cover loading on private health insurance.

D1.2 Premiums payable in advance

Membership premiums must be paid in advance. The maximum advance payment available is 12 months from the current paid date.

If a membership's financial date (date paid to) is in exceeds of 12 months in advance, Latrobe may, at its discretion, refund the premiums in excess of the 12 months.

D1.3 Payment method and frequency

Premiums are payable by:

- direct debit bank account or credit card on a weekly, fortnightly, monthly, quarterly, half yearly or yearly frequency
- billing notices – Bpay, billpay, credit card on a monthly, quarterly, half yearly and yearly
- payroll as governed by a Corporate Partnership agreement.

D1.4 Changes to membership cover

Where changes are made to a membership cover, any premiums paid in advance of the date of change will be credited to the new level of cover at the premium rate applicable to the new cover.

D1.5 Premium rate applicable to state of residence

The premium rate payable is the applicable rate for the State in which the principal member resides.

D1.6 Premium rate applicable to membership classes

The premium rate payable is based on the membership classes defined in C1.3.2:

a) Single
b) Couple – 100% above single rate
c) Family – 100% above single rate
d) Family non-student dependant – 25% above family rate
e) Single Parent Family – 50% above single rate
f) Single Parent Family non-student dependant – 75% above single rate

D2 Premium rate changes

D2.1 Procedure for rate change

Latrobe may vary the premiums for any product in accordance with these Fund Rules and any requirements set out in the *Private Health Insurance Act*.

D2.2 Premium rates may change as a result of:

a) a change in premiums in line with the *Private Health Insurance Act*
b) a change in product
c) a change in excess level
d) a change in the state of residence
e) a change in policy category.

Any changes in premium rates imposed by Latrobe will require a notice period the complies with the PHI Code of Conduct obligations as amended from time to tome. In the case of a significant detrimental change that will be 60 days.

D2.3 Rate protection

A principal member who has paid their premiums in advance of the rate increase, outlined in D2.2a) will not be required to make any further payments in order to cover any difference between their advance payment and the new premium rate until the next premium is due.

D3 Premium discounts

D3.1 Contribution Groups

The Fund may at its discretion approve any group of persons as a 'contribution group'.

D3.2 Discount on premiums

The Fund at its discretion may apply discounts of up to 12% per annum in addition to any aged-based discount, in accordance with the PHI Act and the Latrobe Discount Policy.

D3.3 Discount application

All discounts are applied in accordance to Latrobe's Private Health Insurance Discount policy as amended time to time.

D Contributions

D3.4 Age-based discounts:

a) an age-based discount may be offered on hospital cover to principal members or their partner aged 18 to 29 when they first purchase a membership that attracts an age-based discount in accordance with the Private Health Insurance (complying product) Rules

b) age-based discount start at 10% for members aged 18-25 and decrease by 2% each year to age 29

c) a membership that covers more than one adult requires the amount of discount in premiums to be calculated by averaging the discounted premiums applicable to each member

d) the aged-based discount will continue to receive the discount until the age of 41 whilst they remain on a product with age-based discount applied. After age 41 the discount will be removed at a rate of 2% per year until the age of 45

e) age-based discount applies to specific products and as amended from time to time, currently applies to:

Gold 500
Top Hospital (H3)
Loyal Members (LM)
Gold Hospital Choice Members (H1)
Corporate Gold Hospital Choice Members (CH1)
Top Hospital Co-payment (H2)
Gold Hospital $750 (X6)
Gold Hospital $1000 (X7)
Bronze 250, 500, 750
Bronze Plus 250, 500, BP6
Silver 250, 500, S6
Silver Plus 250, 500, SP6
Healthy Start ST

- any age-based discount is transferable from another fund providing no greater than 30 days gap in cover has elapsed
- if a member suspends, in accordance with the suspension rules, the age-based discount will not be impacted when the suspension finishes
- if a person terminates their cover and then rejoins, any prior age-based discount will be null and the age-based discount will apply in accordance with the age at the time of the rejoin
- any premium reduction provided as age-based discounts is excluded from the calculation of the maximum percentage discount specified in the Private Health Insurance (complying product) Rules
- Application of an age-based discount will be in accordance with the Private Health Insurance (Reforms) Amendment Rules 2018 Part 2A paragraph 11C.

D4 Lifetime Health Cover

D4.1 Lifetime Health Cover application

Latrobe must increase the hospital product premiums applying to an adult if:

a) the adult was not covered by a hospital product on their Lifetime Health Cover Base Day; or

b) the adult ceases to be covered by a hospital product after their Lifetime Health Cover Base Day.

D4.2 Certified age of entry

Any increase in premiums under this rule must be calculated based on the adult's Lifetime Health Cover Age, in accordance with Division 34 of the *Private Health Insurance Act*. At a time determined by the Act Latrobe must stop increasing the premiums.

D4.3 Loading not to apply

The premiums must not increase when:

a) the member purchased a hospital product prior to their 31st birthday

b) the member purchased a hospital product prior to 1 July 2000

c) the member was born on or before 1 July 1934; or

d) the member had turned 31 on or before 1 July 2000 and was overseas on 1 July 2000

e) the member is an Australian citizen or permanent resident and was overseas on the 1st July following their 31st birthday, and their 31st birthday falls after 1 July 2000 and they return to Australia and purchase hospital cover by the first anniversary of the day of their return to Australia that greater than 90 days. International movement records (IMR) will be required to validate.

D Contributions

f) the member is the subject of a determination (with effect immediately before 1 April 2007) under clause 10 of the Schedule 2 of the *National Health Act 1953*. That is an arrangement/ determination made by the Minister.

All aspects of Lifetime Health cover administered in accordance with the *Private Health Insurance Act 2007* Part 2-3 Lifetime Health Cover.

D4.4 Lifetime Health Cover loading

The premium payable:

a) increases by 2% of the base for each year that the member's Lifetime Health Cover age is over 30 years up to a maximum of 70% of the base rate; and

b) the premium increases by 2% each year the member is not covered by a hospital product. This is calculated in accordance with section 34-5 of the *Private Health Insurance Act 2007*.

D4.5 Lifetime Health Cover loading for couples

Where the membership covers a principal member and a spouse the amount of increased premiums is calculated by averaging the increased premiums applicable to each member. This is calculated in accordance with section 37-20 of the *Private Health Insurance Act 2007*.

D4.6 Lifetime Health Cover and age-based discount on the same membership

When a membership has both a member eligible for age-based discount and a member with a Lifetime Health Cover loading, the applicable rate will be applied to each member's component of the premium and together calculates the applicable premium.

D4.7 Removal of Lifetime Health Cover loading:

a) any loading applied to premiums will be removed once 10 years (3,652.5 days) of continuous cover has been served

b) this does not include the counting of permitted days without hospital cover

c) may recommence if hospital cover is subsequently ceased, refer D4.8

d) lifetime Health cover years are transferable from fund as part of portability requirements.

D4.8 Continuity of cover

Lifetime Health Cover is preserved during a period in which a member ceases to have a hospital product for:

a) permitted days without hospital cover for a cumulative period of 1,094 days

b) once 1,094 days are exceeded and hospital cover has not be resumed a 2% loading of the base premium recommences for every year without hospital cover (excluding the 1,094 permitted days)

c) this is on top of any previous loading

d) the loading will apply for a 10 year (3,652.5 days) period.

D5 Arrears in contributions

D5.1 Payment not made by due date

A membership is considered to be in arrears if the date the membership is paid up to is before the current date and there is no payment pending.

D5.2 Cover during arrears

Benefits are not payable for treatment provided to a member when the membership is in arrears.

D5.4 Payment of arrears outstanding less than 60 days

A principal member whose premiums are outstanding for less than 60 days may pay the total of all premiums in arrears. Once that payment has been made the right to claim benefits will be reinstated for the principal member and all dependants listed on the membership.

D5.5 Maximum period of arrears

A membership will be terminated when the arrears in premiums reaches 60 days.

When a period of arrears exceeds 60 days, the Fund will issue a notice of termination, with immediate effect.

At Latrobe's discretion, a membership may be reinstated, without penalty, if payment in full is received within 14 days of receiving the termination notice. After this date waiting periods will need to be re-served. Latrobe may impose, at their discretion, any such condition as deemed appropriate prior to agreeing to any reinstatement.

E Benefits

E1 General conditions

E1.1 Provider recognition requirements

Benefits are only payable where a treatment is provided by a recognised provider.

a) Hospital provider:
   - registered hospital with a Commonwealth Department of Health allocated Provider Number
   - licensed in the relevant State or Territory

b) Medical provider:
   - Medicare registered and allocated provider number for the appropriate practice location
   - applicable AHPRA registration
   - is in independent private practice – that is not an employee/ salaried member of the hospital in which service was provided

c) Extras provider
   - modalities recognised by Medicare are Medicare registered and allocated provider number for the appropriate practice location
   - applicable AHPRA registration for modalities
   - modalities not registered with Medicare are required to be registered through the Australian Regional Health Group (ARHG) Alternative Therapy process
   - is in independent private practice.

Any extras provider providing services in a mixed business premises must be able to demonstrate that minimum quality standards are being met these include but are not limited to

a) infection control, and hygiene procedures and protocols are in place where invasive techniques are used

b) premises (patient reception, waiting rooms, toilet facilities, workrooms etc) that meet minimum physical standards and expectations and all state, territory and local council laws

c) clinical notes taken at each consultation, that are written in English, and maintaining and stored in a confidential and secure environment in accordance with the Privacy Act and any other relevant legislation

d) informed clinical consent (either written or verbal) obtained from patients for any procedural treatment offered

e) informed financial consent (either written or verbal) obtained from patients before commencing treatment.

E1.2 Providers not meeting the provider recognition requirements

The Fund may:

a) decline to pay benefits in respect of any claim submitted by a provider that does not meet the recognition requirement

b) suspend or cancel the provider's recognition for purpose of paying benefits where it has reasonable grounds to believe that:
   i a hospital has ceased to meet the definition as set out in these rules; or
   ii a medical provider has ceased to meet the Medicare or AHPRA requirements
   iii an extras provider has ceased to meet any recognition requirements
   iv provider has ceased to be in independent private practice
   v a recognised provider has, in the opinion of the fund, committed in any fraudulent activity in relation to the provision of a service to a member
   vi a recognised provider does not meet the standards required from time to time by any Private Health Insurance (Accreditation) Rules or rules of the Fund that may be in force.

E1.3 Providers treating themselves, family members, and business partners and family

Benefits are not payable by Latrobe for treatment rendered by a provider to:

a) the provider's partner, dependants, or business partner; or

b) the partner or a dependants of any business partner of the provider

c) Family members of the provider and any business partner including: brother/sister, husband/ wife, children, parents, grandparents and grandchildren, or

d) the provider themselves.

e) any other person not independant from the practice including but not limited to employees, contractors, locuums and their families

E Benefits

E1.4 Benefits application

Benefits are payable only on services that are included on the membership cover and that comply with these rules. Any and all information must be supplied to support the validity of such a claim. This information must be provided on official provider documentation and may include but is not limited to:

a) invoice
b) receipts
c) treatment plans
d) prescriptions
e) medical/ patient records and clinical notes.

Latrobe will not be liable for any costs associated with the supply of information to validate a claim:

- an insured person will only be eligible to claim a benefit for a service/ treatment that has occurred. No benefits will be paid in advance of the service date
- an insured person will only be eligible to claim a benefit for a service/ treatment when the membership has premiums up to date. No benefits are payable for terminated or suspended memberships.
- benefits are not payable for any goods or services sourced outside Australia
- benefits are not payable for any goods sourced online
- benefits are not payable for any services that are not provided as part of a "face-to-face" consultation unless provided under rule E4.2
- benefits may be reduced where the charge is lower than the benefit that would otherwise have been payable, the benefit shall be reduced to the amount of the charge
- benefits are not payable where incorrect or incomplete information has been provided
- benefits that are claimable from a compensable source for the same service, Latrobe, at its own discretion may provide a benefit to a member in advance of the compensable funding being finalised. Benefits paid by Latrobe in this circumstance must be refunded to Latrobe once the compensable funding is confirmed and settlement finalised. In the event that the compensable funding is less than the benefit payable Latrobe will undertake to accept the reimbursement as payment in full and not seek retribution for the difference
- benefits are not payable for any service or treatment that is in the opinion of the fund be considered experimental or not within the clinical category of the membership.

E2 Hospital Treatment

E2.1 General

Hospital treatment is (including the provision of goods and services) that:

a) is intended to manage a disease, injury or condition; and
b) is provided to a person:
   i by a person who is authorised by a hospital to provide the treatment; or
   ii under the management or control of such a person; and
c) either
   i is provided at a hospital; or
   ii is provided, or arranged, with the direct involvement of a hospital.
d) no benefits are payable if the member does not have a hospital cover product
e) benefits are payable according to the Act and the associated Private Health Insurance Rules as amended from time to time
f) benefits for same day hospital accommodation are payable only where a member is an admitted patient and the admission meets the criteria for an admitted patient episode including but not limited to:
   i admitting Medicare Benefit Schedule (MBS) is on the automatic admit list as amended from time to time
   ii is not in an emergency department
   iii a short stay unit admission that is clinically required for continuous active management, documented care plan, at least half hourly vital observations and full documentation of care provided in the clinical record. Awaiting test results, discharge medication or transport does not fulfill this criteria
   iv provision of an appropriately completed type C certification.

E2.2 Participating/ contracted private hospitals

Subject to any excess applicable, the benefits provided will fully cover charges for accommodation and theatre fees at any

participating private hospital for the defined clinical categories of the principal members cover.

E2.3 Non-participating/ non-contracted private hospitals

The benefits payable in respect of an insured person are as follows:

- an amount of money equal to the benefits paid for the cost of a shared ward in a public hospital, known as the Commonwealth Default rate/ Minimum Benefit as amended from time to time; or
- an amount of money equal to the benefits paid for the cost of single room accommodation in a public hospital, as defined in E2.4
- an amount of money against the cost of the use of operating theatre, recovery room or labour ward in a private hospital
- an amount of money where an insured person occupies an approved intensive care unit, with a limit of five (5) days per period of hospitalisation. This limit may be extended beyond 5 days on Fund approval and certification by a medical intensivist.

The level of benefits are as determined by either:

- the Funds non-participating private hospital schedules (Victoria) and (other States) as amended from time to time; or
- second tier default benefits:
  - being a benefit that is at least the minimum level set from time to time by the Private Health Insurance (Benefit Requirements) Rules (Schedule 5)
  - for treatment provided in a private hospital that is specified in Schedule 5 with which the fund does not have a HPPA
  - the minimum benefit payable to a facility for episodes of hospital treatment between 1 September of any year (first year) and 31 August the next year that is qualified and listed in Schedule 5 and that does not have a HPPA is not less than 85% of the average charge for the equivalent episode of hospital treatment under the HPPA's in force on 1 August of the first year with comparable facilities in the state.

In a non-participating private hospital, no benefits are payable for consumables, allied health services or any other services charged by the treating hospital that are not outlined above.

E2.4 Public hospitals:

a) Shared room accommodation

Benefits payable shall be in accordance with the minimum benefit requirements as set out in the Private Health Insurance (Benefit Requirements) Rules and amended from time to time

b) Single Room accommodation

The benefit payable will be equal to the shared room minimum benefit requirements as set out in the Private Health Insurance (Benefit Requirements) Rules and amended from time to time plus an additional amount of up to $80.00

c) Theatre Benefits

No theatre benefits are payable in a public hospital.

E2.5 Patient classification general principles:

- benefits for accommodation are payable according to the classification of the patient
- patients are classified in accordance with the guidelines issued by the Department of Health (Commonwealth) and based on the benefit requirement rules as amended from time to time. These patient classification are:
  - Surgical
  - Advanced Surgical
  - Obstetric
  - Other (medical)
  - Psychiatric care
  - Palliative care
- Rehabilitation
  - hospital accommodation benefits

The calculation of benefits for overnight hospital accommodation have the following principles applied:

- the member has a membership that includes cover for the clinical category associated with the condition requiring admission
- an admitted day is counted from 12.01am to 11.59pm
- day of admission is counted as a full day regardless of admission time
- day of discharge is not counted as a day regardless of discharge time

- a period of hospitalisation is considered continuous unless there is a full seven days break between hospital stays or the two periods are not related to each other – this includes admission to other hospitals, public and private
- the applicable surgical patient category applies from the day prior to surgery, if the member is admitted prior to this the prior days are categorised at the applicable medical category
- a surgical/ advanced surgical patient category is determined by the surgical item that has the highest schedule fee
- if a member requires subsequent surgical intervention during a continuous stay:
  - i if the subsequent surgical item has a higher classification the patient classification will increase and the day count will recommence
  - ii if the subsequent surgical item has the same or lower classification the patient's classification will remain unchanged and the day count will not recommence
- higher benefits are payable for admission to critical care facilities outlined and approved at participating/ contracted private hospitals at a rate determined in the agreement and accompanied by documentation required under the terms of the HPPA
- no critical care defined benefits are payable in a public hospital
- any days spent in a critical care unit are included in the continuous day count
- a medical patient category is determined if the episode is not related to a surgical procedure that has a surgical category assigned, an obstetric category, a psychiatric category, or a rehabilitation category and is determined by the highest classification of the ICD 1O code being actively treated during the episode
- a psychiatric category is determined by an admission for the treatment of a psychiatric condition as defined by the allocation of a psychiatric ICD 10 code
- a psychiatric category benefit is payable at facilities that have a fund approved psychiatric program otherwise a medical classification rate is payable
- Latrobe may require the provision of certification to support the psychiatric classification
- no benefits are payable when a patient is under the custodial care of a state or territory including any person subject to a compulsory Mental Health Treatment Order
- a rehabilitation category is determined by an admission for the treatment of a rehabilitation condition as defined by the allocation of a rehabilitation ICD 10 code for the purpose of restoring function as is provided in accordance with the Guidelines for Rehabilitation Services as amended from time to time
- a rehabilitation category benefit is payable at facilities that have a fund approved rehabilitation program otherwise a medical classification rate is payable
- Latrobe will require the provision of certification to support the rehabilitation classification
- all benefits are payable in regards to benefit requirement rules, the Act and Department of Health guidelines as amended from time to time
- admission greater than 35 days continuous admission will be payable at the Nursing Home type patient rate as determined by the Commonwealth from time to time and a daily co-payment may be payable, unless:
- a valid continuing acute care certificate is provided after an initial 35 days of continuous hospitalisation and then at 30 days intervals thereafter for any acute care benefits to continue to be paid. Latrobe may require the provision of additional information, to support the ongoing acute care status.

E2.6 Theatre benefits

The calculation of benefits for theatre fees have the following principles applied:

- the member has a membership that includes cover for the clinical category associated with the condition requiring admission
- the applicable theatre fee is determined by the surgical item that has the highest schedule fee
- multiple procedure rule as defined by Medicare is applied
- theatre bandings are applied in accordance the national theatre banding list as amended from time to time
- no theatre benefits are payable in a public hospital
- theatre fees are only payable for MBS recognised surgical items.

E Benefits

E2.8 Prosthesis benefits

Benefits are payable for Prosthesis in accordance with the *Private Health Insurance Act* specifically:

- that the item is listed on the current Commonwealth Prosthesis listing
- the item has a current Australian Register Therapeutic Goods listing (ARTG) and is being used in accordance with the ARTG registered indications
- associated with a surgical MBS item number for which a theatre benefit is payable
- payable at the listed price, that is the full cost of a no gap item or an amount equal to the minimum benefit for a gap permitted item
- prosthesis implanted at a public hospital will be paid as listed on the Prosthesis listing at the public hospital listed price
- Latrobe may, at it's own discretion, require the provision of documentation to support the payment of prosthesis benefits.

E2.9 Emerging technology, treatments and non-listed prosthesis and exceptional drug funding

Benefits are not payable in respect of emerging technology or treatments, non-listed prosthesis and exceptional drugs and these will not be covered unless required by the Act or the Rules or unless the Fund in its absolute discretion determines otherwise.

E2.10 Non-Medicare Benefit Schedule listed procedures

Limited benefits are payable for non-Medicare Benefit Schedule listed procedures such as cosmetic and podiatric surgery. These are limited to Day Band 1 and Theatre Band 1 rates in the HPPA for a participating/ contracted private hospital, the 2nd tier rates or Day Band 1 only at a public hospital.

E2.11 Consumables

All consumables including by not limited to single use equipment, devices, disposables or dressing materials such as laparoscopic and robotic consumables are considered to be included in the theatre and accommodation benefits and no separate benefit will be paid by Latrobe unless specified by a current Hospital Provider Agreement.

E2.12 Inpatient pharmacy benefits:

a) pharmaceuticals – including high cost non-PBS, that have been commenced as part of treatment the member was admitted for are included in the accommodation benefit payable to the hospital

b) pharmaceuticals that predate admission or are supplied as discharge medication are not covered

c) experimental (including under clinical trial), high cost non-PBS and any off label use of TGA approved pharmaceuticals are not covered

d) no benefit is payable for any pharmaceuticals in a non-participating/ contracted or public hospital.

E2.13 Exceptional drug funding of high cost non-PBS

The cost of non-PBS Pharmaceuticals is included in the accommodation costs the Fund will pay that an insured person incurs while admitted to a participating private hospital. Additional Exceptional Drug Funding may be paid in accordance with the Schedule C of the HPPA currently in place with the relevant participating private hospital. To be considered for this benefit, the non-PBS pharmaceuticals must be intrinsic and directly related to the conditional ailment for which the insured person was admitted, be clinically indicated and supported by level three evidence, used in accordance with manufacturers guidelines, have TGA approval and not be in clinical trial phase.

Any requests for exceptional drug funding will be assessed on an individual basis in accordance with the Fund's exceptional drug funding guidelines. Approval is granted at the fund's discretion. The insured person may be subject to out of pocket costs associated with the administration of non-PBS Pharmaceuticals.

E2.14 Supported discharge

Benefits are payable for the cost of providing services to support members to be discharged from hospital to home.

Eligibility requires:

- replacement of inpatient bed days
- coordination between the treating clinical team and Latrobe
- time limited to a maximum of six weeks post discharge
- must, at the least, be cost neutral to continued inpatient stay.

E2.15 Private midwife

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries, for the attendance at a birth in a registered hospital by a registered midwife in private practice, who is not employed by the hospital.

E2.16 Emergency ambulance

Benefits are payable under a hospital product for emergency ambulance transportation by a recognised ambulance provider on the following products:

Open products:

- Corporate Gold Hospital Choice Members (CH1)
- Silver Plus 250, 500, SP6
- Silver 250, 500, S6
- Bronze Plus 250, 500, BP6
- Bronze 500, 750
- Healthy Start (ST)

Closed products:

- Gold 500
- Bronze 250
- Loyal Members (LM)
- Gold Hospital Choice Members (H1)
- Gold Hospital $750 (X6)
- Gold Hospital $1000 (X7)

These entitlements are:

- unlimited emergency transports per calendar year
- waiting period of 1 day.

Benefits are not payable if a membership is covered by an applicable state or territory ambulance scheme (including informal reciprocal arrangements) or third party scheme.

E2.17 Autologous blood collection

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the donation of a member's own blood prior to an elective surgical or medical procedure for reinfusion.

E3 Additional medical benefits

Additional gap medical benefits

An additional gap medical benefit (if any) is payable for members with a hospital product for services that are included in the clinical category of that product.

E3.1 Specialist medical practitioner

An additional 25% of the Medicare schedule fee:

a) when informed financial consent has been provided to the member; and

b) the invoice is submitted directly to Latrobe for payment through the Simplified Billing process

OR

An additional 20% of the Medicare Schedule Fee:

a) when informed financial consent has been provided to the member; and

b) the invoice is billed to the member as a patient claim.

E3.2 A general medical practitioner

An additional 16% of the Medicare schedule fee:

a) when informed financial consent has been provided to the member; and

b) the invoice is submitted directly to Latrobe for payment through the Simplified Billing process

OR

An additional 13% of the Medicare schedule fee:

a) when informed financial consent has been provided to the member; and

b) the invoice is billed to the member as a patient claim.

E3.3 Pathology/ radiology services

An additional 6% of the Medicare schedule fee:

a) when practicable, otherwise implied informed financial consent has been provided to the member; and

b) the invoice is submitted directly to Latrobe for payment through the Simplified Billing process

OR

An additional 3% of the Medicare schedule fee:

a) when practicable, otherwise implied, informed financial consent has been provided to the member; and

b) the invoice is billed to the member as a patient claim.

E.3.4 No provision of Informed Financial

When informed financial consent cannot be determined Latrobe will pay an amount equivalent to the difference between the Medicare benefit payable and the schedule fee.

E3.5 Individual medical provider purchasing agreements

Latrobe, at it's discretion may enter into individual Medical Provider Purchasing Agreements (MPPA), where this applies the benefits will be paid directly in accordance with the signed MPPA document.

E4 General treatment

E4.1 Payment of benefits

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries with a maximum benefit payable on specific services or a combined range of services:

a) per person, per insured persons year or calendar year; and/ or

b) per membership, per insured persons year or calendar year.

E4.2 Telehealth service provision

Benefits are payable for services facilitated by telehealth technology for the following general treatment modalities:

- physiotherapy
- dietetics
- speech pathology
- podiatry
- psychology
- occupational therapy
- exercise physiology

Services provided facilitated by telehealth technology will be payable in accordance with the benefits and limits defined for each service and product.

E4.3 Non-surgically implanted prosthesis, health appliances and health management/ screening programs (breast screening, bone density testing and mole mapping) and lymphodema garments (including pregnancy specific)

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries.

The payment of benefits for these items require:

- supporting documentation from treating doctor or recognised general treatment provider
- supply from within Australia
- not supplied online
- supporting documentation, proof of purchase.

Health appliances are payable in accordance with the level of cover as defined by product specification and product summaries and may include some or all of the following:

- blood glucose monitor
- CPAP machine including replacement tubing and mask
- air compressor pumps
- nebulisers
- asthma Spacers
- peak flow metre
- TENS machine
- crutches
- braces (knee)
- splints (finger, hand, wrist, arm, elbow)
- cam boot
- wheelchair hire

Benefits are not payable for the repair or maintenance of any health appliances.

E4.4 Visiting nurse

Visiting nurse services must be provided by a registered nurse employed by an approved private practice. Benefits are payable, in accordance with level of cover as defined by product specification and product summaries.

E4.5 Orthodontics:

- Orthodontic treatment is any service provided with a Dental Schedule item number in the 800-899 range
- Orthodontia has a lifetime limit and an annual limit
- lifetime limit applies across all funds and will not refresh upon transfer to another fund
- all orthodontic claims require the submission of an Orthodontic Treatment Plan completed by the treating orthodontist
- benefits are paid over a 3 year period as defined on the product summary
- if a product applies a stepped benefit this is determined by tenure of membership on the product. The year of tenure in which the orthodontic treatment commences determines the annual benefit payable for the entire course of treatment

- if a product applies a fixed benefit, this amount is payable each year for a maximum of 3 years
- no benefit is payable on a course of orthodontic treatment if the course is commenced within the waiting period
- if a member changes products (that has orthodontic cover) during the course of treatment, benefits will be payable in accordance with the product that applied at the commencement of treatment
- all orthodontic treatment must be provided face-to-face by a Medicare registered dental practitioner.

E4.6 Emergency ambulance

Benefits are payable under an extras cover for emergency ambulance transportation by a recognised ambulance provider on the following products:

- Premier Families (YFT)
- Premier Extras (PG)
- Premier Singles and Couples (YST)
- Core Complete (PP&P)
- Core Families (YFB)
- Core Essentials (YSB)
- Basic Extras (PF)

These entitlements are:

- unlimited emergency transports per calendar year
- waiting period of 1 day
- benefits are not payable if a membership is covered by an applicable state or territory ambulance scheme (including informal reciprocal arrangements) or third party scheme.

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries towards the cost of an ambulance subscriptions paid to an authorised ambulance service provider

E4.7 Non-PBS pharmaceuticals

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the cost of non-PBS Pharmaceuticals as specified in the *National Health Act*. The benefit is calculated on the charge after the Commonwealth determined co-payment has been deducted.

The PBS co-payment contribution is not applied to Federation products.

This only applies to:

- pharmaceuticals that are approved by the Therapeutic Goods Administration (TGA)
- pharmaceuticals that are not listed on the Pharmaceutical Benefits Schedule (PBS)
- pharmaceuticals that are a prescription only (category S4 or S8)
- pharmaceuticals that are not a compound medication
- pharmaceuticals that are not a contraceptive
- pharmaceuticals that are provided with an official pharmacy receipt that includes:
  - full medication name and dose
  - full name of person script is for
  - dispense date
  - price paid
  - declaration of whether it is a private script or PBS script.
- non PBS vaccinations - including but not limited to HPV and travel vaccines
- separate benefits for HPV vaccine Gardasil 9 and travel vaccinations are payable, in accordance with level of cover as defined by product specification and product summaries for some products.
- all vaccines require an official invoice and receipt that includes:
  - full name of vaccine and dose
  - full name of person vaccine is for
  - administration date
  - price paid

  the invoice can be supplied as either an official pharmacy receipt or on the official receipt from the treating Doctor.

E4.8 Allergy management

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the cost of:

- Skin Prick Test – for diagnosis of allergy response – requires medical documentation to support claim
- EpiPen – requires medical documentation to support claim and only payable if supplied as a non-PBS script
- Immunotherapy – preventative treatment for allergic reactions – requires medical documentation to support claim.

E Benefits

E4.9 Medical gases

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the cost of the supply of medical air and oxygen:

- requires medical documentation to support claim
- no benefit is payable if the medical air/ oxygen is provided through a third party funder such as but not limited to National Disability Insurance Scheme, or any other government funding programs
- benefit will be payable whilst awaiting assessment and funding of a government funded program
- requires invoices and receipts from an authorised medical equipment supplier that is Australian based
- cannot be purchased through an online retailer.

E4.10 Smoking cessation

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the cost of:

- Nicotine Replacement Therapy – gum, patches, sprays, inhalers or lozenges – requires medical documentation to support claim and an official receipt, cannot be purchased online
- QUIT Smoking Program – completion of a recognised QUIT smoking program – requires proof of completion of program.

E4.11 School accident top up

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the cost of additional extras services required following a dependant's accident at school:

- requires medical documentation to support claim
- services are not claimable through a third party compensation source.

E4.12 Accident top up

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the cost of additional extras services required following a dependant's accident at school:

- requires medical documentation to support claim
- services are not claimable through a third party compensation source.

E4.13 Benefit Bonus (previously known as loyalty bonus)

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for each year of membership:

- must be combined with a hospital product for a minimum of 6 months
- bonus accumulates each year on the anniversary of joining the eligible product combination, defined:
  - redeemable against any service on the applicable product.
  - personal and membership limits apply
  - benefit bonus is not redeemable for cash
  - any accumulated bonus expires on cancellation of eligible product

E4.14 Travel for outpatient specialist appointments

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for cost associated with travel to a specialist medical appointment or out patient procedure that is not available locally.

Requires:

- greater than 200km return travel
- statement of attendance from a doctor or
- copy of a Medicare statement
- copy of doctors account
- copy of a completed form for a state based travel and accommodation subsidy scheme
- does not include travel related to hospitalisations, dental or extras services or IVF treatment.

E4.15 Baby sleep consultations

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for out of hospital support provided by a certified sleep consultant for infants up to 24 months.

E4.16 Australian Breast Feeding Association

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for the annual membership to the Australian Breast Feeding Association.

E Benefits

E4.17 Antenatal and postnatal classes

Benefits are payable, in accordance with level of cover as defined by product specification and product summaries for consultations, classes and birthing courses provided by a qualified and registered midwife.

E4.18 Individual general treatment provider agreements

Latrobe, at it's discretion may enter into individual General Treatment Provider Purchasing Agreements, where this applies the benefits will be paid directly in accordance with the signed agreement document.

E4.19 Physiotherapy Group Therapy

Benefits are payable, in accordance with the level of cover as defined by product specification and product summaries for group physiotherapy sessions. These sessions will require individual design, assessment, review and individual clinical records to be maintained.

E4.20 Physiotherapy Classes

No benefits are payable for physiotherapy services provided in a class environment.

F Limitation of Benefits

F1 Co-payments

F1.1 Obligation to make co-payments

Co-payments may apply to a cover. Where a co-payment applies, the amount of the co-payment and any applicable conditions will be specified in the relevant product summary.

Any co-payment applicable to a product will be applied before any hospital benefit is payable.

A PBS equivalent co-payment is applied before any benefit is paid for a pharmaceutical item.

F2 Excesses

The amount of the excess and relevant limits and conditions are specified in the product summary.

Any excess applicable to a product will be applied before any hospital benefit is payable. Excesses apply either per calendar year or membership year as outlined in the product summary.

F3 Waiting periods

Waiting periods will apply to:

- new memberships (previously uninsured)
- additions to a membership (previously uninsured); and
- existing memberships and transfers to Latrobe from another private health insurer where the level of cover and/ or benefit entitlement is upgraded or increased (including by reducing the excess payable) and/ or where the waiting periods have not been completed
- existing memberships and transfers to Latrobe from another private health insurer where the level of cover and/ or benefit entitlement is upgraded or increased (including by reducing the excess payable) and waiting periods have been completed, waiting periods will apply only to the upgrade benefit entitlement. Waiting periods will not apply to any entitlements provided under the previous cover.

Waiting periods will not apply to any insured person who:

- existing memberships and transfers to Latrobe from another private health insurer where the level of cover and/ or benefit entitlement is equivalent (including by reducing the excess payable) and all waiting periods been completed and is no longer than 30 days between covers
- held a gold card, or was entitled to treatment under a gold card, before applying for insurance, and is no longer than 60 days between covers.

F3.1 Hospital membership waiting periods

The following waiting periods apply to a benefit for hospital treatment or hospital-substitute treatment(where relevant to the principal member's product):

a) obstetrics related services – 12 months

b) treatment for pre-existing conditions – 12 months

c) all rehabilitation and palliative care regardless of whether it is a pre-existing condition – two months

d) psychiatric treatment – two months. Mental Health Waiver is available for upgrading members once in a lifetime in accordance with the Private Health Insurance (complying product) Rules 2015 after the initial two-month wait has been served.

e) all other services – two months

f) newborns – two months only if changing from a single membership class. To ensure that the newborn is covered from birth, the membership must be upgraded to a family two months prior to estimated due date.

F3.2 PEC: Information from treating practitioners:

1) the Fund may appoint a medical or other relevant practitioner to determine whether or not a condition for which treatment has been provided and benefits have been claimed is a pre-existing condition

2) a practitioner appointed under (1) shall take into account:
   a) information provided by the practitioner(s) who treated the member in the six months prior to their becoming a member or changing their cover, and
   b) any other material that the Fund considers is relevant to the claim.

3) the Fund may suspend consideration of a claim until such time as:
   a) the member authorises the release of the information referred to in (2); and
   b) this information has been provided to the Fund.

4) the fund will not be responsible for any costs associated with the provision of this material.

F Limitation of Benefits

F3.3 General membership waiting periods

The following general membership waiting periods will apply:

Service	Membership: PG, PP, P, PF, ST, YST, YFT, YSB, YFB	Membership: PH, PK, PM, PC, PS, E, D, BA	Membership: PV	Membership: MA, IA, PA, AP, EE
Major Dental	12	12	12	12
Orthodontic	12	12	12	12
Non-surgically implanted prostheses	12	12	12	12
Blood Glucose Monitor	12	12	12	36
Hearing Aids	12	12	12	36
Nebulisers	12	12	12	36
C-PAP Machines	12	12	12	36
Optical	6	12	6	2
Acupuncture	2	2	2	6
General Dental treatment	2	3	2	2
Mouthguards	General Dental waiting period applies – General Dental Item D151			
Blood Pressure Monitor	N/ A	N/ A	12	36
Excimer Laser Surgery	N/ A	N/ A	N/ A	12
Home Services	N/ A	N/ A	N/ A	12
Accident top up	12	N/ A	N/ A	N/ A
Loyalty Bonus	6	N/ A	N/ A	N/ A
Health Appliances	12	N/ A	N/ A	N/ A
All other Services	2	2	2	2

Key

Open products:

PP/P Core Complete Extras
PF Basic Extras
YST Premier Singles and Couples
YFT Premier Families Extras
YSB Core Essential Extras
YFB Core Family Extras

Closed products:

PG Premier Extras *(closed 1/11/2022)*
PH Premier Family Care Extras
PK Advantage Family Care Extras
PM Senior Extras
PC Couples Extras
PS Singles Extras
D Dental Extras
BA Primary Extras
PV Top Extras
MA Maximum Ancillary
IA Intermediate Ancillary
PA Proactive Package
AP Active Package
EE Economically Effective Package

F Limitation of Benefits

F3.4 Accident waiver of rule

Latrobe may at its discretion waive the one day and two month waiting period for treatment required as the result of an accident occurring within that waiting period.

F4 Exclusions

F4.1 Exclusion of benefits

Benefits are not payable for:

a) treatment or service occurring within waiting periods

b) any treatment or service during a period where contributions are in arrears or the membership is suspended

c) any treatment or service for which no fee was charged

d) treatment for which is provided at no cost or subsidised under a Commonwealth or state government act or program and for which the member is eligible

e) treatment or services where the expense was incurred by the member's employer or that was required to be incurred for the purposes of employment or life insurance (but not limited to) assessments

f) if the claim contains false, misleading or fraudulent information

g) any treatment, service or item provided or purchased overseas

h) any pharmaceuticals that are available under the Pharmaceutical Benefits Scheme (PBS)

i) for any treatment or service provided more than two years ago

j) medical treatment provided to a member who is an outpatient

k) services or treatment rendered by a practitioner not in private practice, or does not hold appropriate registration, that is Medicare registration for those modalities recognised by Medicare (allied health professionals and medical practitioners). Alternative therapy registration for other general treatment providers

l) foot orthotics by any provider who is not a podiatrist or orthotist.

F4.2 Clinical category exclusions

Exclusions will apply in accordance with the standard clinical categories of Silver or Bronze tier products except where the membership explicitly includes a clinical category. All exclusions are outlined in the product summary.

F6 Restricted benefits

Restricted benefits will apply in accordance with the standard clinical categories of Silver or Bronze tier products except where the membership explicitly includes a clinical category. All exclusions are outlined in the product summary.

F7 Compensation damages and provisional payment of claims

F7.1 Application of this rule:

a) a reference to a "Claim" includes a claim, demand, action, proceeding, litigation, judgment or award other than a claim for benefits

b) a reference to an "injury" includes a condition, ailment or injury for which benefits would or may otherwise be, payable by Latrobe for expenses incurred in relation to its treatment; and

c) a reference to a member receiving compensation includes:

   i compensation paid to another person at the direction of the member; and

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

F7.2 Obligations of a member

Member who has, or may have, a right to receive compensation in relation to an injury, must:

a) inform Latrobe as soon as the member knows or suspects that such a right exists

b) inform Latrobe of any decision of the member to claim for compensation

c) include in any claim for compensation the full amount of all expenses for which benefits are or would otherwise be payable

d) take all reasonable steps to pursue the claim for compensation to Latrobe's satisfaction

e) keep Latrobe informed and updated as to the progress of the claim for compensation; and

f) inform Latrobe immediately upon the determination or settlement of the claim for compensation.

F7.3 Entitlement of benefits for an injury

a) benefits are not payable for expenses incurred in relation to the injury where the member has received, or may be entitled to receive, compensation in respect of that injury

b) the expenses referred to in Fund Rule F7.3a) include expenses incurred after the member has received any compensation.

F7.4 Latrobe may provisionally withhold payment

Where a member appears to have a right to make a claim for compensation in respect of an injury but that right has not been established, Latrobe may, at its discretion, elect not to assess a claim for benefits in respect of expenses incurred in relation to that injury until the member has taken all reasonable steps to pursue enquiries in relation to the claim for compensation to Latrobe's satisfaction.

F7.5 Provisional payments

Where a benefit is claimable from a compensable source for the same service, Latrobe, at its own discretion may provide a benefit to a member in advance of the compensable funding being finalised.

F7.6 Where benefits have been paid by Latrobe

Benefits paid by Latrobe in this circumstance must be refunded to Latrobe once the compensable funding is confirmed and settlement finalised. In the event that the compensable funding is less than the benefit payable Latrobe will undertake to accept the reimbursement as payment in full and not seek retribution for the difference.

F7.7 Rights of Latrobe

If a member makes a claim for compensation in relation to an injury and fails to:

a) comply with any obligation in Fund Rule F7.2 or F7.6; or

b) include in their claim for compensation any payments of benefits by Latrobe in relation to any injury, Latrobe may, without prejudice to its rights (including its broader subrogation rights) in its 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 for compensation; and/ or

ii pursue the member for repayment of all benefits paid by Latrobe into the injury; and/ or

iii assume the legal rights of the member in respect of all or any parts of the claim for compensation.

F7.8 Claim abandoned where:

a) a member has or may have a right to make a claim for compensation in respect of an injury, and

b) Latrobe reasonably determines that the member has abandoned or chosen not to pursue that claim, benefits are payable (subject to other Fund Rules) if the member signs a legally-binding undertaking supplied by Latrobe by which the member agrees, in consideration for the payment of benefits, not to pursue that claim.

F7.9 Requirements to repay benefits may be waived

Where, in respect of a member's claim for compensation in relation to an injury:

a) the member has complied with Fund Rule F7.2, and

b) Latrobe has 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 Latrobe, Latrobe may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the member need not repay any part, or the full amount of the benefits paid by Latrobe in respect of that injury.

F Limitation of Benefits

F7.10 Benefits for expenses subsequent to compensation

Latrobe may, in its absolute discretion, pay benefits where:

a) expenses have been incurred as a result of:
   i a complication arising from an injury that was the subject of a claim for compensation; or
   ii the provision of a service or item for treatment of an injury that was the subject of a claim for compensation; and
b) that claim has been the subject of a determination or settlement; and
c) there is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

F7.11 Future medical expenses

a) where it is anticipated that a member has future medical needs in relation to an injury, the member must use reasonable endeavors to procure an award or settlement of a claim for compensation that includes a specified allocation for future medical expenses
b) on request by Latrobe, a member must provide evidence to Latrobe to establish whether a determination or settlement of a claim for compensation includes an allocation for future medical expenses
c) where a determination or settlement of a claim for compensation includes an allocation for future medical expenses in relation to an injury:
   i the member must use that allocation to pay for treatment of that injury
   ii the Fund may refuse to pay benefits for treatment relating to that injury until the allocation is exhausted
   iii the member must keep and provide to Latrobe evidence to establish that the allocation has been exhausted on expenses for treatment of that injury; and
   iv if the member cannot provide such evidence, or the allocation has been exhausted on expenses other than for treatment of that injury, Latrobe may refuse to pay benefits for treatment relating to that injury.
d) where a member has complied with their obligations in Fund Rule F7.11a) but a determination or settlement of a claim for compensation does not include a specified allocation for future medical expenses, Latrobe may in its absolute discretion agree to pay benefits for treatment rendered after the determination or settlement in relation to the relevant injury.

F7.12 Cancellation/ termination of membership

A member's obligations under these Fund Rules continue despite any termination or cancellation of membership.

F7.13 Waiver of F7

Latrobe may at its discretion waive the application of all or any part of rule F7.

G Claims

G1 General

G1.1 Eligibility to claim benefits

A member and their dependants are only able to claim benefits for treatment or services when:

- the treatment or service is included in the applicable product summary
- the membership is active and financial
- all applicable waiting periods have been served
- in accordance with the fund rules detailed in this document.

G1.2 Lodging claims

Claims for benefits must be submitted:

- in person at a member hub or branch
- by ordinary mail
- electronically by either mobile app or online
- electronically through a third party mechanism such as but not limited to ECLIPSE, HICAPs
- at a date after the date of service, no claim can be submitted prior to the service being delivered.

Claims for benefits must be submitted with supporting documentation of account/ receipt on official provider letterhead or official provider stamp and including the following information:

- the provider's full name, provider number, qualification and address
- the patient's full name and address and health fund membership number
- date of service
- description of service
- tooth numbers for dental services
- amount charged
- any amount member paid
- any other information as required and amended by the fund from time to time
- all documents submitted to Latrobe become the property of Latrobe and will not be returned.

G1.3 Time limit on claims

Any claim for benefits are required to be made within two years of date of service.

Claims that are subject to contract requirements such as but not limited to hospital, medical or general treatment provider agreements will require submission of claims within the time limit defined in the agreement.

G1.4 Rejection and resubmission of claims

Where a claim for benefits does not comply with the requirement outlined, the claim will be rejected. This same claim may be resubmitted and accepted if all requirements are met with the resubmission.

G1.6 Payment of benefits

Where a claim for benefits has been validated, then benefits will be paid by the fund:

a) by direct credit to the member's nominated bank account when proof of payment of service fee is validated by the submitted claim documentation

b) by direct credit to the provider's nominated bank account when proof of payment of service fee is not validated by the submitted claim documentation and the fee has not been paid by the member.

G1.7 Waiver of rule G1

The Fund may at its discretion waive the application of all or any part of rule G1.

G2 Other

Latrobe may at its discretion waive the application of all or any part of these rules providing it does not reduce a member's entitlements, contravene any legislative requirement under the PHI Act or any PHI Code of Conduct obligation.

Latrobe
HEALTH SERVICES

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This is important information. Please read and retain for future reference.

The information contained in this brochure is current at the time of issue and replaces all previously published material.