Part II
Fund Rules relating to see-u by HBF

Important Notes

HBF Fund Rules comprise three parts:

- The rules in Part I directly relate to HBF branded Products and GMF Products;
- The rules in Part II directly relate to see-u by HBF “see-u” Products; and
- The rules in Part III directly relate to QCHF Products.

Unless otherwise stated, nothing in this part of the HBF Fund Rules relates to HBF branded Products and GMF Products or QCHF Products. Persons covered by HBF branded Products and GMF Products are directed to Part I of the HBF Fund Rules. Persons covered by QCHF Products are directed to Part III of the HBF Fund Rules.

Before taking out private health insurance with see-u, you and all Adult Members and Dependants over 18 to be covered on your see-u policy, must read the part of the HBF Fund Rules relevant to your product.

By taking out private health insurance with see-u, you and all other persons on your Membership become Members of our Fund and agree to our HBF Fund Rules as amended from time to time.

We recommend that these HBF Fund Rules (or the part relevant to your product) be read together with the brochures, and product summaries relevant to your cover.

Terms that are defined in section B of these Fund Rules will be capitalised. For example, the term Fund Rules is defined in section B.

Effective 26 August 2024

A INTRODUCTION

A1 Rules Arrangement

A1.1 Application of the Fund Rules
This part of the Fund Rules apply to private health insurance products issued or taken to be issued by HBF under the Brand.

HBF may supplement rules in this part of the Fund Rules with Fund Policies that are not inconsistent with the Fund Rules.

A1.2 Contents of the Fund Rules
This part of the Fund Rules consist of:
- The General Conditions (in Fund Rules A to G); and
- The Schedules (in Fund Rules H to M).

A2 Health Benefits Fund

A2.1 Establishment and Administration of the Fund
HBF is a not-for-profit organisation, incorporated under the *Corporations Act 2001* and is a private health insurer under the Private Health Insurance Legislation.

HBF has established, conducts and administers a Health Benefits Fund (the Fund) which relates to its health insurance business. Since 1 January 2023 private health insurance products issued under the Brand are taken to have been issued by HBF and form part of the Fund administered by HBF. Unless otherwise indicated, nothing in this part of the Fund Rules relates to health insurance products issued by HBF under its own brand or any brand other than the Brand. Persons covered by HBF branded Products or GMF Products are directed to Part I of the Fund Rules. Persons covered by QCHF Products are directed to Part III of the Fund Rules.

A2.2 Purpose of the Fund
A purpose of the Fund is to provide Benefits to, or on behalf of, Policy Holders issued with Products issued under the Brand in accordance with this part of the Fund Rules.

A3 Obligations to Insurer

A person applying to join the Fund through the issue of a Policy shall provide all information reasonably requested by see-u relevant to their Policy or proposed Policy.

Existing Policy Holders shall provide such information as reasonably requested from time to time to facilitate the management of Policy Holder records.

All Policy Holders of Products issued under the Brand are bound by these Fund Rules and Fund Policies as amended from time to time.

A4 Governing Principles

The operation of the Fund is governed by:
- Private Health Insurance Legislation
- *Corporations Act 2001* (the Corporations Act)
- the Constitution
- the HBF Fund Rules
- the Fund Policies.

A5 Use of Funds

A5.1 Income credited to the Fund
see-u shall credit to the Fund:
a) all Premiums paid by Policy Holders; and
b) Any other moneys or income as required by the Private health Insurance Legislation to be credited.

A5.2 Use of Assets
see-u may use the assets of the Fund to:
a) pay Benefits in accordance with these Fund Rules;
b) pay for other liabilities or expenses incurred for the business operations of the Fund;
c) make investments; or
d) Make other distributions, payments or transfers permitted or required under the Private Health Insurance Legislation or Corporations Act.

A5.3 Audit
Accounts and records of the Fund shall be audited in accordance with legislative requirements.

A6 No Improper Discrimination

When making decisions in relation to Policy Holders, the Fund shall at all times comply with the community rating principle within the Private Health Insurance Legislation and not improperly discriminate on the basis of:

- the suffering by a person of a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or
- the gender, race, sexual orientation or a religious belief of a person; or
- the age of the person, except to the extent allowed under the Private Health Insurance Legislation (lifetime health cover); or
- where a person lives, except to the extent allowed under the Private Health Insurance Legislation; or
- any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for Hospital Treatment or General Treatment, or
- the frequency with which a person needs Hospital Treatment or General Treatment; or
- the amount or extent of the Benefits to which a person becomes entitled during a period under a complying health insurance policy, except to the extent allowed under the Private Health Insurance Legislation; or
- Any matter set out in the Private Health Insurance (Complying Product) Rules.

A7 Changes to Rules

A7.1 Amendments to the Fund Rules
The Fund may amend this part of the Fund Rules at any time in a manner consistent with Private Health Insurance Legislation.

A7.2 Overriding Waiver
The Fund may, in writing, waive the application of a particular Fund Rule at its discretion, provided that the waiver does not reduce the relevant Policy Holder's entitlement to Benefits and subject to Private Health Insurance Legislation.

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

A7.3 Notification to Policy Holders
Where the Fund amends, or proposes to amend, these Fund Rules and the amendment would be detrimental to a Policy Holder, see-u will inform the Policy Holder about the change a reasonable time before the change comes into effect, in accordance with the Private Health Insurance Code of Conduct.

Where an amendment to this part of the Fund Rules requires a change to the Private Health Information Statement for a Product, see-u will also provide the Policy Holder of an affected Policy an updated Private Health Information Statement for that Policy as soon as practicable after it has been updated.

A7.4 Premiums
Before increasing premiums, see-u will provide each Policy Holder with a written notice of the increase in accordance with the *Private Health Insurance (Incentives) Rules*.

A8 Dispute Resolution

A8.1 Complaints
A Policy Holder may make a complaint to see-u at any time.

see-u will endeavour to respond to complaints quickly and efficiently and will not charge a fee for such a service.

A8.2 Private Health Insurance Ombudsman
The Private Health Insurance Ombudsman is available to assist an Insured Person who has been unable to resolve issues with the Fund.

Nothing in these Fund Rules prevents an Insured Person from approaching the Private Health Insurance Ombudsman at any time.

A9 Notices

A9.1 Correspondence
see-u will send any written correspondence to the most recently advised postal address, phone number, fax number or e-mail address of the relevant Policy Holder, except as otherwise agreed.

A9.2 Availability of Rules to Policy Holders
Copies of these Fund Rules are available to Policy Holders upon request.

A10 Winding Up

The Fund may be terminated in accordance with Private Health Insurance Legislation.

A11 Other

This Rule is left intentionally blank.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

The rules in this part of the Fund Rules shall be interpreted so as not to conflict with the Constitution.

Any terms used in this part of the Fund Rules and also in the Constitution shall have the same meaning in this part of the Fund Rules as they bear in the Constitution.

Unless otherwise specified, the meanings attached to the words and expressions in Private Health Insurance Legislation shall apply to this part of the Fund Rules.

Determinations made by the Minister from time to time in relation to the Fund shall be deemed to form part of these Fund Rules and are to be read as part of these Fund Rules.

B2 Definitions

Under this part of the Fund Rules, the following definitions shall apply:

"Access Gap Cover" means arrangements that provide a person with cover issued under the Brand a no Gap or known Gap Benefit in excess of the Medicare Benefits Schedule.

"Accident" means an unforeseen event, occurring by chance and caused by an unintentional and external force or object resulting in involuntary hurt or injury to the body, which requires immediate Treatment. This definition excludes unforeseen Conditions attributable to medical causes.

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

a) includes a new-born Child who:
   i. occupies a bed in a Special Care Unit, or
   ii. is the second or subsequent Child of a multiple birth, but
b) excludes:
   i. any other new-born Child whose mother also occupies a bed in the Hospital, and
   ii. An employee of a Hospital receiving Treatment in their own quarters.

"Adult" means an Insured Person who is not a Dependant Child.

"**Age-based Discount Policy**" has the meaning ascribed to it under Rule 11A of the Private Health Insurance (Complying Product) Rules 2015.

"**Agreement**" means an understanding between a Hospital or a Medical Provider and see-u in which the Hospital or Medical Provider agree to an accepted payment by see-u for monies owed for Treatment to an Insured Person.

"Alternative Therapies" means professional Treatment that is:

a) a General Treatment;
b) approved by see-u; and
c) provided during a Consultation with a practitioner who is recognised by see-u as an alternative health care provider.

"Approved Provider" means a provider of General Treatment (whether the provider is an individual or an organisation) who:

a) is approved and registered by see-u as a provider of relevant treatment, goods or services pursuant to Fund Rule E3 in relation to Products issued under see-u;
b) holds all necessary registrations, licenses or approvals under relevant State or Territory legislation to render the relevant treatment, goods or services including in relation to the premises from which the treatment, goods or services are to be, or are being, provided; and
c) Complies with all other requirements of the Private Health Insurance (Accreditation) Rules.

"Benefit" means in relation to Products issued under see-u the amount of money payable by the Fund to, or on behalf of, an Insured Person to an Approved Provider, Medical Provider or Hospital by the Fund in accordance with the terms of these Fund Rules.

Brand" means
a) from 1 March 2024, see-u by HBF; and
b) prior to 1 March 2024 the Former Brand.

"Child/children" means one of the following:
a) a natural child (including a new-born child)
b) an adopted child
c) a foster child, or
d) A step child (that is a natural, adopted or foster child of the person's partner / spouse).

"Chronic disease" is a disease that has been, or is likely to be, present for at least 6 months, including, but not limited to, asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis and a musculoskeletal condition.

"**Chronic disease management program**" means a program that:

a) is intended to:
   i. reduce complications in a person with a diagnosed chronic disease; or
   ii. prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease; and

b) requires the development of a written plan that:
   i. specifies the allied health service or services and any other goods and services to be provided; and
   ii. specifies the frequency and duration of the provision of those goods and services; and
   iii. specifies the date for review of the plan; and
   iv. has been provided to the patient for consent, and consent is given to the program, before any services under the program are provided; and

c) is coordinated by a person who has accepted responsibility for:
   i. ensuring the services are provided according to the plan; and
   ii. monitoring the patient's compliance with the agreed goals and activities specified in the plan.

"Claim" means a claim for a Benefit under a Product issued under see-u.

"Clinically Relevant" in relation to a procedure or service means one that is:
a) performed or rendered by a Medical Provider or other Approved Provider and
b) generally accepted in the relevant profession as being necessary for the appropriate Treatment of the Patient.

"**Compensation**" means any of the following:
a) a payment made pursuant to a judgment, award or settlement by way of damages;
b) a payment in accordance with a scheme of insurance or compensation provided by a law of the Commonwealth, a State or a Territory; or
c) any other payment that, in the opinion of see-u, is a payment in the nature of compensation or damages.

"**Contribution Group**" means any group of Policy Holders that have been approved by see-u as a belonging to a Contribution Group.

"**Constitution**" means the constitution of HBF.

"**Co-Payment**" means a contribution a Policy Holder agrees to pay towards Hospital Treatment.

"**Corporations Act**" means the *Corporations Act 2001 (Cwth)*.

"**Cosmetic Surgery**" means surgical procedures:
a) listed in the Plastic and Reconstructive Section (Subgroup13) of the Medicare Benefits Schedule that:
   i. are not Clinically Relevant; or
   ii. do not meet the eligibility conditions for the payment of Medicare Benefits; or
b) of a plastic or reconstructive nature that are not listed in the Medicare Benefits Schedule.

"**Dependant Child**" means a Child of a Policy Holder that is:
a) less than 23 years of age;
b) does not have a partner / spouse; and
c) Is substantially maintained and supported by a Policy Holder.

Or is:
a) aged 23 to less than 25 years of age;
b) a full-time student at a recognised school, college, tertiary institution or university; and

c) does not have a partner / spouse; and
d) is substantially maintained and supported by a Policy Holder.

"**Excess**" means an amount of money a Policy Holder agrees to pay towards Hospital Treatment before Benefits are payable.

"Former Brand" means CUA Health

"**Fund**" means the health benefits fund conducted by HBF in accordance with Private Health Insurance Legislation.

"**Fund Policy**" means a policy relating to the operation of the Fund by HBF which supplements the Fund Rules that are amended from time to time.

"**Fund Rules**" means the rules in part II of the HBF Fund Rules relating to Policies issued under the Brand.

"**General Treatment**" means treatment, including the provision of goods and services, that is:
a) intended to manage or prevent a disease, injury or condition; and
b) is not Hospital Treatment, but includes Hospital-Substitute Treatment; and
c) is not excluded from being 'general treatment' under Private Health Insurance Legislation.

"HBF" means HBF Health Limited ABN 11 126 884 786.

"**HBF Fund Rules**" means these rules relating to the operation of the Fund by HBF, which for clarity comprises rules in Part I relating to HBF branded Products and GMF Products, rules in Part II relating to see-u Products, and rules in Part III relating to QCHF Products.

"Health management program" means a program that is intended to ameliorate a person's specific health condition or conditions approved by see-u in relation to Policies issued under see-u and provided by a Medical Provider or an Approved Provider.

"Hospital" means a facility which the Minister has declared a hospital under Private Health Insurance Legislation.

"**Hospital Product**" means a Product offered by the Brand which covers Hospital Treatment.

"**Hospital-Substitute Treatment**" means General Treatment that:
a) substitutes for an episode of Hospital Treatment; and
b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and
c) Is not specified in the *Private Health Insurance (Complying Product) Rules* as a treatment that is excluded from this definition.

"Hospital Treatment" shall mean treatment (including the provision of goods and services) that:
a) is intended to manage a disease, injury or condition; and 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
b) either:
    i. is provided at a Hospital; or
    ii. Is provided, or arranged, with the direct involvement of a Hospital.

"Insured Person" means in relation to a Policy issued under the Brand a Policy Holder or a Dependant Child covered by a Policy in accordance with these Rules.

"**Maximum Benefit Limit**" or "**Lifetime Limit**" means the amount determined by see-u or another private health insurer at which no further benefits shall be payable for that person for services.

"Medical Practitioner" means a person as defined in sub-section 3(1) of the *Health Insurance Act 1973 (Cth)*.

"Medical Provider" means a person who:
a) is registered or licensed as a Medical Practitioner under a law of a State or Territory;
b) satisfies the provider eligibility requirements for the payment of Medicare benefits; and
c) Complies with all other requirements of the *Private Health Insurance (Accreditation) Rules*.

"Medicare Benefit" means a Medicare benefit under Part II of the *Health Insurance Act 1973 (Cth)*.

“Mental Health Upgrade” means the waiver of the two month waiting period on Psychiatric Services for an upgrade to a higher level of hospital cover for an eligible member. This can only be used once in a Member’s lifetime across any Private Health Insurer in accordance with Division 78 of the Act.

“Minister” means the Minister for Health in the Commonwealth Government.

“Nursing Home Type Patient” means a nursing-home type patient as defined in the *Private Health Insurance (Benefit Requirements) Rules*.

“Nursing Home Type Patient Benefit” means the Benefit determined by the Minister for any Hospital Treatment provided to a person while they are a Nursing Home Type Patient.

“**Out-of-pocket**” means the difference between the Benefit for a particular treatment and the provider’s fees.

“Premium” means an amount of money a Policy Holder is required to pay to see-u for a specified period under their Policy.

“Prescribed List” means the list of medical devices and human tissue products as approved by the Minster under the Private Health Insurance (Medical Devices and Human Tissue Products) Rules (No. 1) 2024 (Cth), as amended from time to time.

“Private Health Insurance Act” means the Private Health Insurance Act 2007 (Cth).

“Private Health Insurance Legislation” means the Private Health Insurance Act, Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and their regulations, rules and other instruments under them and consolidations, amendments, re-enactments or replacements of any of them.

“Policy Holder” means a person who is insured under the Policy and who is not a Dependant Child.

“Policy” means a complying health insurance policy within the meaning of Private Health Insurance Legislation issued under the Brand.

“Pre-Existing Condition” is an ailment or illness or condition the signs or symptoms of which a Medical Practitioner appointed by see-u considers, after examining information furnished by the Insured Person’s Medical Practitioner who treated the ailment or illness, and other material relevant to the Claim for Benefits, were in existence (as opposed to in evidence) at any time during the six months ending on the day and time the Insured Person commenced with see-u or upgraded to a higher level of Cover.

“Private Practice” is a practice operated on an independent and self-supporting basis either as a sole, partnership or group practice but not under an agreement with, or the subsidy by, another party for the provision of accommodation, facilities or services. Practitioners in practice at a public hospital or any other type or class of publicly funded facility do not normally meet the guidelines applicable to Private Practice.

“Private Room” is a room designed and equipped specifically for the care of one patient. Charges at the private room rate may be levied where placement in a private room is at the discretion and choice of the Insured Person and not for medical or nursing convenience.

“**Product**” has the meaning set out in subsection 63-5(2) of the PHI Act.

"Psychiatric" or "**Rehabilitation**" patient classifications and the accreditation of particular treatment programs shall be a matter for see-u who will make reference to the guidelines provided by the Royal Australian & New Zealand College of Psychiatrists and the Australian College of Rehabilitation Medicine.

“QCHF” means HBF trading as Queensland Country Health Fund and Territory Health Fund.

“QCHF Brands” means Queensland Country Health Fund and Territory Health Fund.

“QCHF Products” are products issued under the QCHF Brands, which for clarity are administered in accordance with the rules in Part III of the Fund Rules.

“Risk Equalisation Trust Fund” means the Private Health Insurance Risk Equalisation Trust Fund continued in existence under Part 6-7 of the Act.

“Risk factors for chronic disease” include, but are not limited to:

a) lifestyle risk factors, including, but not limited to, smoking, physical inactivity, poor nutrition or alcohol misuse; and

b) biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; and
c) family history of a chronic disease.

"see-u" is HBF trading as see-u by HBF.

"**Waiting Period**" is a period of time a Policy Holder must serve on a Cover before benefits are payable. Benefits are not payable for goods and services obtained during a Waiting Period and are further detailed in Fund Rule F3.

B3 Other

This Rule is left intentionally blank.

C MEMBERSHIP

C1 General Conditions of Membership

C1.1 Policy Categories
see-u may from time to time offer the following Policy categories:

- Single Policy - Only one Adult
- Single Parent Policy – Two or more people (only one of whom is an Adult the rest of whom are Dependant Children)
- Family Policy, incorporating the following insured groups:
    - 2 Adults (and no-one else);
    - 2 or more people, none of whom is an Adult;
    - 3 or more people, only 2 of whom are Adults.

The classes of people in the insured groups are Adults and Dependant Children as defined in Section B2 of these Rules.

C1.2 Levels of Cover
A person may be admitted as a Policy Holder in one of the Policy categories in respect of one of the following Products:

- Any one level of Hospital Product
- Any one level of General Treatment Product
- Any combination of one level of Hospital Product and one level of General Treatment Product within the scope of product rules as defined in Schedules
- Any other Product determined by see-u from time to time.

All Insured Persons under the same Policy shall:

- Belong to the same Policy category, and
- Have the same level of Product or Products.

C2 Eligibility for Membership

Subject to these Fund Rules, any person is eligible to be a Policy Holder of any see-u Product.

A person may not be covered by a see-u Policy if that person has an equivalent or corresponding policy with another private health insurer.

C3 Dependants

C3.1 Dependants of Policy Holders
A Dependant Child, as defined in section B2 of this part of the Fund Rules, shall be eligible for cover under a Single Parent Policy or a Family Policy as defined in section C1 of these Fund Rules.

C3.2 Dependants Previously Insured
A person who ceases to be a Dependant Child of a Policy Holder of see-u or a policy holder of any other private health insurer may join see-u as a Policy Holder. If the application is made within two (2) months of ceasing to be a Dependant Child, no waiting periods will be applied except:

I. The balance of a waiting period not served under the previous Policy;
II. The difference in coverage of treatment between the Policies.

C4 Membership Applications

C4.1 Application to Join
An eligible person as defined in section C2 of these Fund Rules may make an application to become a Policy Holder in writing, by telephone or by any other oral or electronic means approved by see-u.

All relevant information reasonably requested by see-u in order to establish and maintain a Policy must be supplied by the applicant.

C4.2 Acceptance of Application to Join
An application to join the Fund will only be accepted by see-u when the relevant Premium required from the applicant is received by see-u, as specified in Rule D1.

Upon acceptance of an application to join the Fund, see-u will provide one Policy Holder with:
a) the relevant, up to date Private Health Information Statement; and
b) Details of what the Policy covers and relevant Benefits limits.

C4.3 Non-Acceptance of Application to Join
see-u may refuse an application to join an Insured Person, including as a Policy Holder or as a Dependant, where the applicant does not comply with these Fund Rules.

see-u must not refuse to join an Insured Person under a Policy if to do so would result in Improper Discrimination as described in A6 of these Fund Rules.

C4.4 Reinstatement of cancelled Policy
If a Policy has been cancelled, see-u has the absolute discretion to re-instate the Policy at the request of the Policy Holder. Continuity of Benefit entitlements will be subject to the payment of all outstanding Premiums in accordance with Fund Rules D5.

C5 Duration of Membership

C5.1 Commencement Date
Policies shall commence on:
a) the date the application is accepted by see-u; or
b) where see-u agrees, a later commencement date nominated in the application; or
c) Where see-u agrees, in its absolute discretion, an earlier date of no greater than two months as nominated in the application.

A newborn Dependant Child may be added to a Single Parent, Couple or Family Policy from its date of birth provided the application is received by see-u within 12 Months of the date of birth. No waiting periods will apply to the child, providing the Policy commenced no later than the Child's date of birth.

A newborn Dependant Child may be added to a Single Policy from its date of birth and no waiting periods will apply to the child provided that:
a) the Policy commenced no later than the Child's date of birth;
b) the application is received by see-u within 2 Months of the date of birth; and
c) the Policy Category is amended to Family or Single Parent, as agreed.

A Dependant Child that is added to a Single Policy, Single Parent, Couple or Family Policy more than 12 Months after the date of birth will be added from the date of application.

C5.2 End Date
A Policy continues until the date the Policy Holder notifies see-u in writing that the Policy Holder wishes to cease the Policy under rule C7, or see-u notifies the Policy Holder that the Policy has ceased under rule C8.

C6 Transfers

C6.1 Transfers from another private health insurer within two months
Policy Holder or Dependant Child who transfers from another private health insurer within a period of two months from the date to which premiums were last paid shall be accepted as a Policy Holder or Dependant Child to the nearest equivalent Product operated by see-u at an equivalent level of benefits, without Waiting Periods, except:
a) for services not covered by the previous policy
b) the unexpired portions of any Waiting Periods not fully served under the previous policy; and
c) for Benefits greater than those payable under the previous policy.

Transferees from another private health insurer who have reached a Maximum Benefit Limit or Lifetime Limit entitlement for specialist dental services with that insurer shall be required to serve a waiting period of 12 months for Major Dental and Orthodontics services under General Treatment Tables of these Fund Rules.

see-u will commence the Policy from the day after cessation with the other insurer and the Policy Holder or Dependant Child will be required to pay Premiums from that date.

C6.2 Transfers between products within the Fund
Where a Policy Holder transfers Products, and through such transfer, the level of cover and/or benefit entitlements is upgraded or increased, the Policy Holder will be subject to the applicable Waiting Periods before being eligible for benefits at the upgraded or increased level.

Where a Policy Holder transfers to a Product with a higher Benefit, see-u will pay Benefits at the previous Product level for treatment or services provided during the Waiting Periods applicable to the new Product.

Where a Policy Holder transfers to a Product with a lower Benefit, see-u will pay Benefits at the new Product level for treatment or services provided from the date of transfer.

If a higher excess or higher co-payment applied on the previous Product, the higher excess or higher co-payment will continue to apply for a Benefit for Hospital Treatment or Hospital-Substitute Treatment to a Policy Holder that transfers Products for a period no longer than the maximum allowable Waiting Periods.

C6.3 Previous Benefits will be taken into account
Subject to other Fund Rules, where a Policy Holder transfers from another Private Health Insurer or to a different Product within the Fund, any relevant Benefits that have been paid in a specified time period under the previous Policy may be taken into account in determining the Benefits payable under the new Policy.

'Any relevant Benefits' include, but are not limited to, Benefits that are subject to an annual or other limit or a maximum number of days of hospitalisation.

C6.4 Transfers without continuity of coverage
When a Policy Holder or Dependant Child transfers from another private health insurer to see-u with a break in coverage of two (2) months or more in between, see-u may treat that person as a new Policy Holder for all purposes, including the application of all relevant Waiting Periods, except those relating to Lifetime Health Cover as specified at rule D4.

C7 Cancellation of Membership

A Policy Holder must authorise cancellation of a Policy or cessation of a Product under their Policy for any Insured Persons as defined in these Rules.

A transfer certificate in the approved form will be provided within 14 days:
- To the person if that person ceases to be a Policy Holder,
- To the new insurer upon request.

C8 Termination of Membership

C8.1 Termination of Policy in arrears
A Policy Holder whose Premiums are more than two (2) months in arrears shall be deemed to be no longer a Policy Holder, provided however that see-u may at its absolute discretion allow for arrears to be paid and the Policy continuity maintained.

C8.2 Termination of Policy where a Policy Holder acts improperly
see-u may elect to terminate a Policy, in whole or in part, on notice to the Policy Holder or an Insured Person, including, without limitation, if, in see-u's reasonable opinion the Policy Holder and/or an Insured Person has been involved in any act to gain an improper advantage, and/or any fraudulent, negligent and/or criminal act in relation to the operation of the Fund and/or see-u.

C9 Temporary Suspension of Membership

C9.1 Absence from Australia
Policy Holders who have held a Policy with see-u for more than 12 months may apply in writing requesting suspension of a Policy for periods in excess of two months and no more than three years in situations of absence from Australia.

The Policy Holder must provide overseas travel documents to verify departure and return dates from Australia.

The Policy Holder must make an application for suspension for an absence from Australia prior to the date of departure. Suspensions for absences from Australia take effect from the day after departure.

If the Policy has not been terminated, the Policy will recommence with the applicable Premium payments due and payable upon the return date from overseas travel.

If the Policy Holder has identified their proposed date of return on or before the date of departure, then see-u will require that the Policy Holder notify see-u of this date and the Policy will automatically recommence from the identified date of return. The Policy Holder must pay the relevant Premium to confirm the recommencement of the Policy.

C9.2 No benefits payable during suspension
No benefits are payable for treatment during a period of suspension. Waiting Periods that were applicable to the Policy Holder at the start of suspension continue to apply on resumption of the Policy Holder.

Periods of suspension do not count towards the serving of Waiting Periods.

C10 Other

This Rule is left intentionally blank.

D CONTRIBUTIONS

D1 Payment of Contributions

Premiums payable for each Product are set out in Schedule K of these Fund Rules. Policy Holders of see-u must pay Premiums in advance, in the agreed frequency (being weekly, fortnightly, monthly, quarterly, six monthly or yearly). Premiums may be paid up to twelve months in advance.

Premiums may differ based on the State or Territory in which the Policy Holder permanently resides.

D2 Contribution Rate Changes

see-u may amend the Premiums that apply to its Products in accordance with Private Health Insurance Legislation.

Amendments to Premiums will be advised to Policy Holders in accordance with Private Health Insurance Legislation.

Subject to Rule D1, Premiums which have been paid in advance may not be affected by rate changes until a new payment period commences.

D3 Contribution Discounts

see-u may from time to time apply a discount up to the maximum discount allowed under Private Health Insurance Legislation.

D4 Lifetime Health Cover

Lifetime Health Cover loadings will be applied to Premiums in accordance with Private Health Insurance Legislation.

D5 Arrears in Contributions

Whenever the date to which Premiums have been paid passes, other than a Policy that has been suspended in accordance with Rule C9, the Policy will be in arrears.

Benefits are not payable for Treatment provided to an Insured Person during a period of arrears.

A Policy Holder whose Premiums are less than two (2) months in arrears and pays such arrears before the end of that period is entitled to services rendered during that period.

A Policy Holder whose Premiums are more than two (2) months in arrears shall be deemed to be no longer a Policy Holder, provided however that see-u may at its absolute discretion allow for arrears to be paid and the Policy continuity maintained.

D6 Other

This Rule is left intentionally blank.

E BENEFITS

E1 General Conditions

E1.1 Benefits Available
Details of Benefits available under each Product are set out in the relevant Schedule of these Fund Rules.

E1.2 Reduction in Benefits Payable
see-u will not pay Benefits that exceed the actual charge for treatment, goods or services received by the Policy Holder.

The Benefit payable may be reduced in the following circumstances:
- Where the amount paid by a Policy Holder for treatment is lower than the Benefit payable, the Benefit will be reduced to the amount paid;
- Where money is payable from more than one source for the same treatment, see-u may reduce its Benefit so that the total money payable from all sources does not exceed the amount charged; and
- Where in the opinion of see-u the charge is higher than the provider's usual charge for the treatment, good or service, in which case see-u may assess the claim as if the provider's usual charge had applied.

E1.3 Benefits Not Payable
Benefits are not payable:
- For treatment, goods or services provided to a Policy Holder during the Waiting Period;
- During a period for which the Premiums have not been paid (other than in the conditions specified in Fund Rule D5);
- For treatment or services or an item where the expense was incurred by the employer of the Policy Holder or if the Policy Holder obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at see-u's discretion;
- Where the provider is not a Hospital, Medical Provider or Approved Provider at the time the treatment, goods or services were provided to the Policy Holder;
- Where the Policy Holder has received, or established a right to receive, Compensation for treatment, goods or services;
- Where the Policy Holder has received, or has the right to receive, and to the extent the Policy Holder has received, or has the right to receive, payment (in full or in part) for the treatment, goods or services from a third party including:
    - Another Private Health Insurer; or
    - In the case of General Treatment, through publicly available funding;
- For treatments, goods or services provided outside of Australia or by a provider without an ABN;
- If false or misleading information is provided in respect of the treatment, goods or services;
- Where the Medical Provider or Approved Provider:
    - at the time the treatment, good or service was provided, has ceased to be engaged in Private Practice; or
    - does not provide the treatment, good or service while engaging in Private Practice; or
    - provides the treatment, good or service from the premises of a Public Hospital, or premises made available to the Medical Provider or Approved Provider from the operator of a Public Hospital, or an entity authorised or allowed by the operator of a Public Hospital to make the premises available to the Approved Provider, unless otherwise agreed to by see-u at its absolute discretion
- For a procedure which is:
    - not covered by Medicare;
    - Cosmetic Surgery, except where the procedure is Clinically Relevant;
    - experimental; or
    - relates to clinical trial pharmaceuticals.
- For outpatient services: that is, services provided to patients who are not Admitted Patients, unless otherwise specified by see-u;
- For treatment provided to a person at an Emergency Department.
- For benefits in relation to sport, recreation or entertainment unless they are part of a chronic disease management or a health management program approved by see-u.
- For General Treatment, services for which a Medicare benefit is payable, except as allowable as hospital substitute treatment or Private Health Insurance Legislation..
- Under Hospital Product, Benefits for Treatment that does not normally require Hospital Treatment.
- For Treatment provided to a newborn child whose mother occupies a bed in the hospital, except where the newborn child is classified as a patient under Section 3 of the Health Insurance Act 1973.
- For treatments or services provided by a family member.

E2 Hospital Treatment

E2.1 Hospital Benefits payable according to Agreements
Benefits are only payable I respect of Hospital Treatment provided by a person authorised by a Hospital to provide Hospital Treatment.

Benefits in respect of the Hospital Treatment shall be payable in accordance with level of Benefits payable under the Hospital Product as selected by the Policy Holder and will be determined in accordance with the relevant Hospital Agreement.

E2.2 Non-contract Hospitals
For Treatment provided in a non-contract Hospital, see-u will pay Benefits that at a minimum are the amounts specified in the *Private Health Insurance (Benefit Requirements) Rules 2011 (Cth)*.

E2.3 Pharmaceuticals provided during Hospital Treatment
Where the cost to an Insured Person for a PBS item is less than the pharmaceutical benefit co-payment (as determined by the Department of Health), these drugs are not covered by see-u under this section of the Fund Rules.

Where pharmaceuticals are provided as part of a Treatment under a Hospital Agreement, the cost so covered includes the whole of the amount that, but for the Arrangement, would be the cost to the Insured Person of pharmaceutical benefits dispensed to the Insured Person while the Insured Person is an Admitted Patient at the Hospital.

To be eligible for the Benefit, the pharmaceutical item must be:
- Intrinsic to the Hospital Treatment;
- Clinically indicated;
- Essential for the meeting of satisfactory health outcomes for the Policy Holder;
- Directly related to treatment of the condition or ailment for which the Policy Holder was admitted;
- A non-experimental drug or compound item;
- Provided by the Hospital during the Hospital admission and not provided upon discharge; and
- The reason for admission to Hospital was not solely for the administration of the pharmaceutical item.

E2.4 Coverage Requirements
Each Policy that covers Hospital Treatment shall cover any part of Hospital Treatment that is psychiatric care, rehabilitation or palliative care if the Hospital Treatment is provided in a Hospital and no Medicare benefit is payable for that part of the Hospital Treatment.

E2.5* Surgically Implanted *Medical Devices and Human Tissue Products
Benefits are payable for medical devices and human tissue products on the Prescribed List, surgically implanted during a medical procedure provided by a Hospital in the following circumstances:
- The medical device or human tissue product is provided as part of an episode of Hospital Treatment or hospital-substitute treatment; and
- A Medicare benefit is payable in respect of the professional service associated with the provision of the medical device or human tissue product, or the provision of the medical device or human tissue product is associated with podiatric treatment by an accredited podiatrist; and
- The person to whom the medical device or human tissue product is provided is a Policy Holder or Dependant Child under the Policy; and
- The person is covered by the Policy (wholly or partly) in respect of the episode of Hospital Treatment, hospital-substitute treatment or the professional service.

E2.6 Nursing Home Type Patients
see-u will pay the Nursing Home Type Patient Benefit for a Policy Holder while they are classified as a Nursing Home Type Patient.

E2.7 Admission and Discharge Days
The date of admission to Hospital will be included in the period for which a claim may be made, but the date of discharge from Hospital will not be included.

E2.8 Medical Gap Cover
Where a Policy Holder is admitted as a Private Patient and incurs a fee for a medical service rendered as part of Hospital Treatment that has an MBS item number, the Benefit paid:

I. Where the provider charges less than the MBS, is the difference between 75% of the MBS fee and the amount charged by the provider; or
II. Where the provider charges the MBS fee or more, is 25% of the MBS fee.

Where the Medical Provider has an Agreement as part of see-u's Access Gap Cover scheme, an additional Medical Gap Benefit may be payable.

Members may still need to pay an Out-of-pocket for medical services rendered as part of Hospital Treatment.

Access Gap Cover is available under any Hospital Product.

E3 General Treatment

E3.1 Benefits Payable
The Benefits payable in respect of General Treatment Services, and the conditions relevant to those Benefits, are set out in the associated Schedules.

Benefits for Dental Treatment are payable in accordance with the schedule of dental benefits maintained by see-u.

Benefits are not payable for General Treatment unless the provider is an Approved Provider. see-u has absolute discretion to approve or not approve a provider as an Approved Provider under these Fund Rules.

The amount of benefits payable shall not exceed the cost of a professional service, treatment, appliance or other expense in respect of which benefits are payable after taking into account benefits payable from any other source.

The Benefits payable under each Product shall be the same for all policies selecting that Product.

E3.2 Pharmaceuticals
Where the cost to a Policy Holder for a non PBS item is less than the pharmaceutical benefit co-payment, these pharmaceuticals are not covered by see-u.

E3.3 Hospital Substitute Treatment
Hospital Substitute Treatment Benefits will be paid as specified in the relevant Agreement.

E3.4 Limitations of General Treatment Benefits
As determined from time to time by see-u, the General Treatment Benefits specified in the Schedule may be subject to limitations of frequency of treatment for particular items and/or combinations of items, which may be provided at the same time or within particular periods.

E4 Other

Ex gratia payments may be paid at the discretion of see-u in respect of claims that would not otherwise attract benefits under these Fund Rules.

Where a Policy Holder receives Treatment outside their State of residence, Benefits applicable to the State or Territory where the Treatment was provided are payable.

F LIMITATION OF BENEFITS

F1 Co Payments

Policy Holders may choose a Policy that covers Hospital Treatment that requires a Co-payment be made.

The amount of Co-payment and relevant limits and conditions are specified in the relevant Product Schedule.

Co-Payments are not payable in relation to Hospital Treatment for Dependant Children.

F2 Excesses

Policy Holders may choose a Policy that covers Hospital Treatment that includes an Excess. The amount of Excess and relevant limits and conditions are specified in the relevant Product Schedules.

F3 Waiting Periods

The Waiting Periods to be served before a Benefit may be paid shall be:

a) From one day after the date of joining for Accidents occurring after joining, and for Ambulance services.
b) Twelve months in respect to a matter related to an obstetric condition.
c) Twelve months in respect to a matter related to a pre-existing condition.
d) Two months in respect of hospital or hospital-substitute treatment for psychiatric, rehabilitation and palliative care (whether or not for a pre-existing condition).
e) Twelve months from the date of joining in respect to a matter related to benefits for Wisdom Teeth, Crowns and Bridges, Dentures, Orthodontic, Periodontic, Endodontic, Veneers, Podiatry Related Aids, Orthotic Appliance, Prostheses benefits and see-u approved appliances.
f) Twelve or twenty four months from the date of joining for benefits for Hearing Aids depending on product.
g) Six months from date of joining in respect to a matter related to benefits for Optical services and Wellness Benefits
h) Two months from the date of joining for all other services.
i) As defined in (a) to (h) for Policy Holders who up-grade to a higher level of Product. During the respective Waiting Period, the Policy Holder or dependant's existing level of cover at the time of up-grade is used to pay any applicable benefit.
j) Waiting Periods do not apply to a Policy that covers a person who held a gold card or was entitled to treatment under a gold card.
k) Waiting Periods do not apply to newborn children, provided they are added to a Family or Single Parent Policy with effect from their date of birth.

see-u shall have at its discretion the right to waive or reduce any Waiting Period applying to any of the Products operated by see-u provided that such waiver or reduction does not contravene any of the provisions of Private Health Insurance Legislation.

F4 Exclusions

Unless otherwise stated in these Rules, there are no total exclusions applicable to any types of Hospital Treatment on any of see-u's Hospital Products for Clinically Relevant treatment.

F5 Benefit Limitation Periods

This Rule is left intentionally blank.

F6 Restricted Benefits

A Product may restrict Benefits for Hospital Treatment as detailed in the associated Schedules to these Rules.

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Definitions

In Fund Rule F7:

- A reference to a claim (other than a Claim for Benefits) includes a reference to a demand or action
- A reference to an injury includes a Condition (including an ailment or injury) for which Benefits would or may otherwise be, payable by see-u for expenses incurred in relation to its Treatment, and
- A reference to a Policy Holder receiving Compensation includes:
  - Compensation paid to another person at the direction of the Insured Person, and
  - Compensation paid to another Insured Person on the same Policy Holder in connection with an injury suffered by the Insured Person.

F7.2 Obligations of an Insured Person

Subject to Fund Rule F7.8, an Insured Person who has, or may have, a right to receive Compensation in relation to an injury, must:

- Inform see-u as soon as the Insured Person knows or suspects that such a right exists;
- Inform see-u of any decision of the Insured Person to claim for Compensation;
- Include in any claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable;
- Take all reasonable steps to pursue the claim for Compensation to see-u's reasonable satisfaction;
- Keep see-u informed of and updated as to the progress of the claim for Compensation; and
- Inform see-u immediately upon the determination or settlement of the claim for Compensation.

F7.3 Entitlement to Benefits for an injury

Subject to Fund Rule F7.5, and unless otherwise permitted under this Fund Rule, Benefits are not payable for expenses incurred in relation to an injury where the Insured Person has received, or may be entitled to receive, Compensation in respect of that injury.

The expenses referred to above include expenses incurred after the Insured Person has received any Compensation.

F7.4 see-u may withhold payment

Subject to Fund Rule F7.10, where an Insured Person appears to have a right to make a claim for Compensation in respect of an injury but that right has not been established, see-u may withhold payment of Benefits in respect of expenses incurred in relation to that injury.

F7.5 Provisional Payments

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

In exercising its discretion, see-u may consider factors such as unemployment or financial hardship or any other factors that it considers relevant.

A provisional payment is conditional upon the Insured Person signing a legally binding undertaking and acknowledgment supplied by see-u, that contains an agreement by the Insured Person, in consideration for the payment:

- to comply with Fund Rule F7.2;
- that it is bound by these Rules;
- to disclose to see-u on request, all matters pertaining to the progress of the claim and details of any determination made or any settlement reached in respect of the claim;
- to repay to see-u the full amount of the provisional payment as a debt immediately repayable upon the award or settlement of the claim, whether or not the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future for which Fund Benefits are otherwise payable; and
- That see-u has specified rights of subrogation whereby see-u acquires all rights and remedies of the Insured Person in relation to the claim.

F7.6 Where Benefits have been paid by see-u

- Subject to Fund Rule F7.9, where:
  - see-u has paid Benefits, whether by way of provisional payments or otherwise, in relation to an injury, and
  - the Insured Person receives Compensation in respect of that injury, the Insured Person must repay to see-u the amount that see-u paid in relation to the injury up to the amount of Compensation, upon the determination or settlement of the claim for Compensation.
- This Fund Rule applies whether or not:
  - the determination or settlement sum includes the full amount that see-u paid, or
  - the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future in respect of which Benefits are otherwise payable, or
  - the relevant Insured Person complied with their obligations under Rule F7.2.

F7.7 Rights of see-u
If an Insured Person makes a claim for Compensation in relation to an injury and fails to:

- comply with any obligation in Rules F7.2 or F7.6, or
- include in their claim for Compensation any payments of Benefits by see-u in relation to an injury, see-u may, without prejudice to its rights (including its broader subrogation rights) in its absolute discretion take any action permitted by law to:
    - assume that all expenses in relation to the injury have been met from the Compensation payable or received pursuant to the claim, and/or
    - pursue the Insured Person for repayment of all Benefits paid by see-u in relation to the injury, and/or
    - Assume the legal rights of the Insured Person in respect of all or any parts of the claim.

F7.8 Claim Abandoned
Where an Insured Person has or may have a right to make a claim for Compensation in respect of an injury, and where see-u reasonably determines that the Insured Person has abandoned or chosen not to pursue the claim, Benefits are payable (subject to other Rules) if the Insured Person signs a legally-binding undertaking supplied by see-u by which the Insured Person agrees, in consideration for the payment of Benefits, not to pursue the claim.

F7.9 Requirement to Repay Benefits may be waived
Where, in respect of an Insured Person's claim for Compensation in relation to an injury:

- The Insured Person has complied with Fund Rule F7.2, and
- see-u 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 see-u, see-u may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the Insured Person need not repay any part or the full amount of the Benefits paid by see-u in respect of the injury.

F7.10 Benefits for Expenses Subsequent to Compensation
see-u may, in its absolute discretion, pay Benefits where:

- expenses have been incurred as a result of:
    - a complication arising from an injury that was the subject of a claim for Compensation, or
    - the provision of service or item for Treatment of an injury that was the subject of a claim for Compensation, and
- that claim has been the subject of a determination or settlement, and
- There is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

F8 Other

This Rule is left intentionally blank.

G CLAIMS

G1 General

Applications for the payment of Benefits shall be in the manner determined by see-u and may include by paper form, electronically or in person. Claims must be lodged with see-u within 24 calendar months of the date of the service.

see-u may, in its discretion, extend the time for the lodgement of Claims beyond 24 calendar months if it deems that non-payment of Benefits would cause hardship to the Policy Holder.

A Policy Holder shall furnish such other evidence as required and advised by see-u.

see-u may keep copies of documents submitted in connection with a Claim to the extent required to assess the Claim.

The Policy Holder authorises see-u to contact any Hospital and/or Medical Provider for clarification of details and information necessary to assist in the verification of any Claim pertaining to the Policy Holder or Insured Person. see-u is further authorised to withhold Benefits payable until the details requested by see-u is provided by the Hospital and/or Medical Provider or Approved Provider.

G2 Other

see-u may authorise a Policy Holder to delegate to another person the right to Claim Benefits to which the Policy Holder or Insured Person may be entitled.