RBHS Fund Rules

Effective 15 October 2025

All registered private health insurers are required to have Rules under the Private Health Insurance Legislation.

These Rules set out the general principles and rules of membership under which RBHS conducts its business.

IMPORTANT NOTES

Before taking out private health insurance with the RBHS, you and all other persons to be covered on your Policy must read these Rules.

By taking out private health insurance with the RBHS, you and all the other persons on your Policy become Members of our Fund and agree to our Rules as amended from time to time.

We recommend that these Rules be read together with your Fact Sheet, policy certificate and the brochures relevant to your cover.

Where terms are capitalised in these Rules, they have the meaning given to them as determined in Section B of these Rules.

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A INTRODUCTION

A1 Rules Arrangement

Binding Effect of Rules

These Rules consist of:

(a) the General Conditions (Fund Rules A to G); and

(b) the Schedules of Benefits and Specific Conditions (**Schedules**).

These Rules have effect as a contract between the RBHS and each Member

These Rules apply to all Products and govern the rights and obligations of Members and the RBHS in relation to the Fund.

A2 Health Benefits Fund

A2.1 The RBHS is a registered private health insurer.

A2.2 The RBHS conducts a health benefits fund ("the Fund") for the benefit of persons in the RBHS' restricted access group as defined in the Private Health Insurance Legislation, and detailed in Rule C2.

A2.3 RBHS may supplement the Fund Rules with Fund Policies that are not inconsistent with the Fund Rules. These Fund Policies include:

(i) Privacy policy
(ii) Complaints handling policy

A2.4 Unless otherwise provided for, all matters to be determined in connection with the Fund or its administration will be determined by the Board.

A3 Obligations to Insurer

A3.1 A person applying for admission to the RBHS as a Member will:

(a) comply with the requirements of these Rules; and

(b) provide such information as is reasonably requested to allow the operation of the Policy and advise the RBHS as soon as reasonably possible of changes to that information.

A4 Governing Principles

A4.1 The Fund will be operated according to:

(a) the Private Health Insurance Legislation;

(b) the Health Insurance Act 1973 (as amended);

(c) the National Health Act 1953 (Cth);

(d) the Australian Consumer Law;

(e) these Rules; and

(f) Fund policies

A4.2 The Fund will also operate in accordance with the requirements of the Privacy Act 1988 (as amended) and the Australian Privacy Principles, including taking into account the rights of a person covered under a Policy to have their personal information kept private from other persons covered by that Policy.

A5 Use of Funds

A5.1 The following amounts must be credited to the Fund:

(a) Premiums payable under policies of insurance that are referable to the Fund;

(b) income from the investment of assets of the Fund;

(c) any other money received by the RBHS in connection with its conduct of the Fund;

(d) any other amounts specified in the Private Health Insurance Legislation.

A5.2 The assets of the Fund must not be applied for any purpose other than:

(a) meeting Policy liabilities and other liabilities, or expenses, incurred for the purposes of the business of the Fund as defined in the Private Health Insurance Legislation;

(b) making investments in accordance with the Private Health Insurance Legislation;

(c) any other purpose specified in the Private Health Insurance Legislation.

A6 No Improper Discrimination

A6.1 The RBHS will ensure that the conduct of the Fund will at all times comply with the community rating provisions of the Private Health Insurance Legislation. The RBHS will not take or fail to take any action, make a decision, or have regard or fail to have regard to any matter that would result in the RBHS improperly discriminating between eligible persons who are or wish to be insured by the RBHS.

A6.2 Improper discrimination is discrimination that relates to:

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

(b) the gender, race, sexual orientation or religious belief of a person; or

(c) except in relation to the calculation of Lifetime Health Cover loading and the application of an age-based discount, the age of a person;

(d) where a person lives, except to the extent allowed under the Private Health Insurance Legislation (ie, different Premiums for the same Product based on the State/Territory in which the person resides); or

(e) any other characteristic of a person that is likely to result in an increased need for Hospital Treatment or General Treatment; or

(f) the frequency with which a person needs Hospital Treatment or General Treatment; or

(g) the amount or extent of the Benefits to which a person becomes entitled during a period under a Policy, except to the extent allowed under the Private Health Insurance Legislation (ie, limits for General Treatment).

A6.3 Despite Rule A6.2, discrimination by the RBHS is not improper discrimination to the extent to which the RBHS ensures that the Products are not made available to persons who do not belong to the RBHS's restricted access group as defined in the Private Health Insurance Legislation and detailed in Rule C2.

A7 Changes to Rules

A7.1 The RBHS may alter, vary or amend these Rules in a manner consistent with the Private Health Insurance Legislation and any other law.

A7.2 Where the RBHS amends or proposes to amend a Rule and the amendment is or might be detrimental to the interests of a Member, the RBHS will provide reasonable prior notice of the amendment to the Policy Holders of affected Policies. For the avoidance of doubt, any such notice must comply with the any relevant requirements of the Private Health Insurance Legislation, the Australian Consumer Law and the Private Health Insurance Code of Conduct.

A7.3 Where a Member became entitled to receive a Benefit at a time when a previous Rule applied, the Benefit specified in that earlier Rule will be payable.

A7.4 The RBHS will give a relevant Private Health Insurance Information Statement (**PHIS**) to:

(a) all persons on request;

(b) each Policy Holder at least once every 12 months, or as otherwise required by the Private Health Insurance Legislation;

(c) every new Policy Holder, along with details about what the Policy covers and how Benefits under it are calculated and a statement identifying that the Policy is referable to the Fund operated by RBHS; and

(d) the Policy Holder when a change to these Rules that is or might be detrimental to a Member requires an update to the PHIS for that Member's Product.

A8 Dispute Resolution

A8.1 A Member may make a complaint or notify a dispute about any aspect of his or her Policy at any time.

A8.2 All complaints or disputes should be notified in writing to the RBHS.

A8.3 The RBHS will deal with the complaint or dispute quickly and efficiently and in accordance with the Complaints Policy available to Members and others on the RBHS website.

A8.4 Disputes involving claims will be referred to the Medical Practitioner appointed pursuant to Rule A11.1 or other appropriate expert appointed by the RBHS. If, following receipt of the Medical Practitioner's or expert's advice, the RBHS rejects the claim, the Member will be advised of this outcome.

A8.5 The Commonwealth Ombudsman responsible for private health insurance is available to assist Members who have been unable to resolve disputes. However, the Member should give the RBHS every opportunity to resolve the dispute before going to the Ombudsman.

Complaints should be directed to the RBHS through either:

- Telephone – 1800 027 299
- Facsimile – 1300 309 704
- Email – info@myrbhs.com.au
- Post – Locked Bag 23, Wollongong DC NSW 2500.

A9 Notices

A9.1 Those Rules requiring direct written notice to a Policy Holder will be satisfied by the RBHS sending that notice to the address last supplied by the Policy Holder, and by the

communication means preference (including electronic) advised by the Policy Holder (mail/email).

A9.2 A Policy Holder who receives written notice from the RBHS regarding their Policy that is not specific only to the Policy Holder, must inform all other Members on the Policy of the contents of that notice.

A10 Winding Up

A10.1 In the event of the RBHS ceasing to be registered under the Private Health Insurance Legislation, the Fund will be dealt with in accordance with the requirements of the Private Health Insurance Legislation.

A10.2 In the event of the winding up of the Fund, all monies not required for meeting outstanding liabilities, contracted payments and other expenses of winding up including the requirements of the Private Health Insurance Legislation, will be utilised in such manner as may be determined by the Board in accordance with the Private Health Insurance Legislation.

A11 Other

A11.1 Medical Practitioner.

The Board is entitled to appoint a Medical Practitioner for the purposes of assessing Pre-existing Conditions.

A11.2 Chief Executive Officer.

The Chief Executive Officer of the RBHS is responsible to the Board for the management and administration of the Fund.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

B1.1 In these Rules, words importing the male gender will include the female gender and words importing the singular or plural number will include the plural or singular number respectively.

B1.2 These Rules are to be interpreted as far as possible in a manner that is consistent with the Private Health Insurance Legislation.

B1.3 The definitions in the Private Health Insurance Legislation as amended will unless otherwise specified in these Rules apply to these Rules.

B2 Definitions

'Accident' means an unforeseen event, occurring by chance and caused by an external force or object, which causes involuntary bodily injury requiring medical treatment in a Hospital within seven (7) days but excludes unforeseen conditions attributable to medical causes.

'Acute Care Certificate' means a certificate required by the RBHS from a Medical Practitioner in a form approved by the RBHS confirming the need for continued acute Hospital care after 35 days of Continuous Hospitalisation.

‘Age-Based Discount’ means a discount which may be applied to Hospital Product Premiums for Members aged between 18 and 29 at the time of purchasing the Hospital Product.

'Agreed Service' means a treatment, good or service that constitutes Hospital Treatment provided by an Agreement Hospital to a Member, which is specified as an agreed service in the Hospital Purchaser Provider Agreement with that Agreement Hospital.

'Agreement Hospital' means a Hospital which:

(a) is subject to a Hospital Purchaser Provider Agreement; or

(b) the RBHS deems to be a participating hospital from time to time.

‘Ambulance Services' means services provided by an Ambulance Service Provider for the transport and/or paramedical treatment of persons requiring medical attention including:

(a) the transport and/or paramedical treatment of persons requiring emergency treatment; and

(b) transport that is requested by the Member’s treating doctor because the Member’s medical condition requires a level of support and medical monitoring in transit that only an Ambulance Service Provider can provide.

'Ambulance Service Provider' includes the following service providers:

(a) ACT Ambulance Service;

(b) Ambulance Service of NSW;

(c) Non-Emergency Patient Transportation NSW;

(d) Ambulance Victoria;

(e) Queensland Ambulance Service;

(f) South Australia Ambulance Service;

(g) St John Ambulance ServiceNT;

(h) St John Ambulance ServiceWA; and

(i) Tasmanian Ambulance Service.

‘Application for Membership’ means an application to become a Member of the RBHS.

'Benefit' means an amount of money or service that may be provided to a Member, or on behalf of or for the benefit of a Member to a Medical Practitioner, Hospital or other provider by the RBHS, in accordance with the terms of a Product and these Rules.

'Board' means the board of directors of the RBHS.

'**Child**' means someone who is under the age of 18 years old.

'Chronic Disease Management Program' means a program approved by the RBHS that is General Treatment and intended to either:

(a) reduce the complications in a person with a diagnosed chronic disease; or

(b) prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

'Combined Hospital and Extras Product' means a Product referred to in Schedule J that includes Benefits towards all or some services defined as General Treatment and as Hospital Treatment through a single Product.

'Compensation' means any of the following:

a. a payment of compensation or damages pursuant to a judgment, award or settlement;
b. a payment in accordance with a scheme of insurance or compensation provided for by Commonwealth or State law (for example, workers compensation insurance);
c. settlement of a claim for damages (with or without admission of liability);
d. a payment for negligence; or
e. any other payment that, in the opinion of the RBHS, is a payment in the nature of compensation or damages.

'Continuous Hospitalisation' means any two (2) periods between which there was no break of more than seven (7) days in the provision of Hospital Treatment. Such Hospital Treatment may have been provided in any Hospital.

'Contribution Group' means a group of Members approved by the RBHS for the purposes of Fund Rule C1.3.

'Default Benefit' means the minimum benefit payable as required in the Private Health Insurance Legislation.

'Dependant' means any child of a Policy Holder or child of a Policy Holder's Partner (including an adopted child, foster child, or child for whom the Policy Holder or Policy Holder's Partner is a legal guardian) who is:

(a) under the age of 18 years without a Partner; or

(b) a Student Dependant.

'**Dependant Person with a Disability**' means a person who is the natural child, adopted child, foster child of, or a child being cared for under a guardianship by, the Policy Holder or the Policy Holder's Partner and:

(i) aged 18 or above; and

(ii) a participant in the National Disability Insurance Scheme.

Non-Classified Dependant Person' means a person who:

(i) Is aged between 18 and 20 (inclusive); and
(ii) Does not have a Partner.

'Non-Student Dependant' means any child of a Policy Holder or child of a Policy Holder's Partner (including an adopted child, foster child, or child for whom the Policy Holder or Policy Holder's Partner is a legal guardian) who is:

a) Aged 18 to 24 (inclusive) who joins as part of a new policy or was formerly a dependent child on a Policy, and
b) Without a Partner, and
c) Not a Student Dependant

'Student Dependant' means any child of a Policy Holder or child of a Policy Holder's Partner (including an adopted child, foster child, step-child or child for whom the Policy Holder or Policy Holder's Partner is a legal guardian) who is:

a) Aged 18 to 24 (inclusive) years, and
b) Without a Partner, and
c) A full-time student at a school, college or university, or are undertaking a traineeship or apprenticeship.

'Ex-Gratia' means providing a payment for a service or good that is not covered by the relevant Policy or an extension of a Benefit or limit to that entitled under the relevant Policy.

'**Extras Product'** means a Product referred to in Schedule I which includes Benefits towards services that constitute General Treatment only.

'Fund' means the health benefits fund conducted by the RBHS pursuant to the Private Health Insurance Legislation.

'General Treatment' means treatment (including the provisions of goods and services) that is not Hospital Treatment and is intended to manage or prevent a disease, injury or condition.

'Hospital' means a facility which is declared by the Minister for Health and Aged Care as being a hospital under the Private Health Insurance Legislation.

'Hospital Purchaser-Provider Agreement' means an agreement entered into between the RBHS and a Hospital (or Hospital operator) and as amended from time to time.

'Hospital Treatment' is treatment, 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; and
includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance Legislation as "hospital treatment".

'Hospital Product' means a Product referred to in the Schedule H which includes Benefits towards services that constitute Hospital Treatment only.

'Medical Gap' means the difference, if any, between the cost of a professional service and the combined Medicare Benefit and Benefit paid by the RBHS.

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

'Medical Purchaser-Provider Agreement' means an agreement entered into, between the RBHS and a Medical Practitioner, as described under section 172-5 (1) of the *Private Health Insurance Act* 2007 (Cth) and as amended from time to time.

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

'Member' means a Policy Holder, Policy Holder's Partner, Dependant and Non-Student Dependant.

'Minister' means the Commonwealth Minister for Health and Aged Care.

"Nursing-Home Type Patient" has the same meaning as in Schedule 4 of the *Private Health Insurance (Benefit Requirements) Rules* (Cth).

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

'Non-Agreed Service' means a treatment, good or service that constitutes Hospital Treatment provided by an Agreement Hospital to a Member which is not an Agreed Service.

'Out-of-pocket' means the difference between the Benefit for a particular treatment and the Hospital's or other provider's fees for that treatment.

'Palliative Care' means Hospital care provided to a person when a person's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

'Partner' means a person who is living with the Policy Holder on a domestic basis whether or not legally married to the Policy Holder.

'Policy' means a health insurance policy issued by the RBHS covering Hospital Treatment and/or General Treatment taken out by a Policy Holder.

'Policy Holder' means the person in whose name an application for a Policy has been accepted and who is responsible for Premium payments.

'Pre-Existing Condition' means an ailment, illness or condition of a Member, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by the RBHS, existed at any time during the six months preceding the day on which the Member became insured under the relevant Policy. In forming the opinion the Medical Practitioner must have regard to any information in relation to the ailment, illness or condition that the Medical Practitioner who treated the ailment, illness or condition gives him or her.

'Premium' means the amount payable by a Policy Holder in respect of their Policy.

'Prescribed List' means the list of medical devices and human tissue products in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules (Cth), as amended from time to time.

'Private Health Insurance Legislation' means the *Private Health Insurance Act* 2007 (Cth), *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.

'Private Practice' means a professional practice (whether sole, partnership or group) that is self-supporting. This means that its accommodation, facilities and services are not provided or subsidised by another party (as is the case with a public hospital or publicly funded facility) but through the leveraging of fees directly to recipients of treatment, goods or services.

'Product' means a collection of insurance policies issued by the RBHS:

d) that cover the same treatments; and
e) that provide Benefits that are worked out in the same manner; and
f) whose other terms and conditions are the same as each other.

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

(a) holds all necessary registrations, licences or approvals under relevant State or Territory legislation to render the relevant General Treatment, goods and services including in relation to the premises from which the treatment, goods or services are to be, or are being, provided;
(b) complies with all other requirements of the Private Health Insurance (Accreditation) Rules; and
(c) is registered with or otherwise approved or recognised by the RBHS as a provider of relevant treatment, goods or services pursuant to Fund Rule E3.

'Restricted Benefit' means the Default Benefit that applies to a service or treatment under a Hospital Product.

'Rolling Year' means the 12-month period that begins from the date a Benefit is first claimed.

'Rules' means these rules of the Fund as amended from time to time.

'RBHS' means the Reserve Bank Health Society Limited.

'Transfer Certificate' means a certificate provided by a private health insurer, in a form approved under the Private Health Insurance Legislation, setting out health insurance cover details and claims histories of a person transferring from that private health insurer and meeting the required criteria as detailed in the Private Health Insurance Legislation.

'Waiting Period' means the period during which a Member must hold continuous cover under a particular Policy before the Member has an entitlement to receive a Benefit at the level payable on that Policy.

C MEMBERSHIP

C1 General Conditions of Membership

C.1.1 Insured Groups

For the purpose of this section, an adult is defined as someone who is not a dependant.

Policies may be offered to the following insured groups:

(a) only one person, over the age of 16;

(b) 2 adults and no-one else;

(c) 2 or more people, none of whom is an adult and the rest of whom are Dependants;

(d) 2 or more people, only one of whom is an adult and any number of Dependants;

(e) 2 or more people, only one of whom is an adult, at least one of whom is a Non-Student Dependant and any number Dependants

(f) 3 or more people, only 2 of whom are adults and any number of Dependants;

(f) 3 or more people, only two of whom are adults, only one of whom is a Non-Student Dependant and any number of Dependants;

(g) 3 or more people, only 2 of whom are adults, at least one of whom is a Dependant Person with a Disability, and any number of Dependants and Non-Student Dependants.

The RBHS recognises the following classes of people in the insured groups:

(a) adults;
(b) Dependants as defined in Rule B2;
(c) Non-Student Dependants as defined in Rule B2
(d) Dependant Persons with a Disability as defined in Rule B2

C1.2 Levels of Cover

The RBHS offers Products to Members comprising:

(a) Hospital Products;
(b) Extras Products;
(c) any combination of a Hospital Product and Extras Product allowed to be purchased concurrently in the Schedules; or
(d) a Combined Hospital and Extras Product.

C1.3 Authorisation

The Policy holder may authorise in writing or other means approved by the RBHS, another person to operate the Policy as if that person is the Policy Holder. This authorisation may be withdrawn at any time by the Policy Holder by providing notice to the RBHS.

C1.4 Contribution Groups

RBHS may, at its discretion, approve any group of Members as a contribution group.

C2 Eligibility for Membership

C2.1 The following persons are eligible to be a Member of the Fund:

(a) any person who is, or was, an employee of the Reserve Bank of Australia or Note Printing Australia Limited;

(b) the Partners, Dependants, Non-Student Dependants and Dependant Persons with a Disability of any person described in paragraph (a) of this sub rule;

(c) the former Partners and adult children of any person described in paragraph (a) of this sub rule; and

(d) any other person deemed to form part of the restricted access group as defined in the Private Health Insurance Legislation.

C2.2 Subject to these Rules, persons who have retired from the Reserve Bank of Australia or Note Printing Australia Limited employment, or widowed Partners of former Policy Holders who have died, may be admitted as Members.

C2.3 The RBHS will not permit a person to be a Member of the Fund if they do not meet the eligibility requirements in this Rule C2.

C3 Dependants

C3.1 Dependants and Non-Student Dependants are defined in Fund Rule B2.

C3.2 The following applies in regard to adding a Dependant to a Policy:

1. If there is no impact on Premiums resulting from adding a Dependant – there is no limit of time during which the Policy Holder needs to add a Dependant to a Policy (e.g. a newborn); Waiting Periods would not apply per existing Rule F3.
2. If there is an impact on premiums resulting from adding a Dependant –
   a) A Member can add a child to a Policy but resulting Premium changes would need to be backdated, within a maximum of 12 months of birth/adoption. Waiting Periods would not apply per existing Rule F3.

C3.3 The following applies in regard to adding a Non-Student Dependant to a Policy:

1. A Non-Student Dependent can join as part of a new policy or remain on a Policy, on which they were formerly a Dependent, up to age 24 for an additional Premium (with the exception of C1.1.1.(g) insured group for which an additional Premium is not payable).

C3.4 The following applies in regard to adding a Dependant Person with a Disability to a Policy:

1. A Dependant Person with a Disability can remain on a Policy, on which they were formerly a Dependant, indefinitely or until they no longer meet the definition of Dependant Person with a Disability.

C4 Membership Applications

C4.1 An application to become a Member will be made on the application form specified by the RBHS, signed by the person who will be the Policy Holder, and accompanied by such additional information as required to process the application.

C4.2 The person applying for a Policy must make full, true and proper disclosure in the application form as to all matters referred to therein.

C4.3 RBHS may, acting reasonably, reject any application to become a Policy Holder, including where the applicant was a former Member whose Policy was cancelled under these Fund

Rules. RBHS will not reject any application for reasons described as improper discrimination under the Private Health Insurance Legislation.

C5 Duration of Membership

C5.1 Provided that the first Premium has been paid, the commencement date of a Policy will be the date the application is lodged with RBHS or the date nominated on the application form and agreed to by the RBHS.

C5.2 A Policy will continue while Premiums continue to be paid until cancellation or termination by the Member or cancellation or termination by the RBHS in accordance with these Rules.

C6 Transfers

C6.1 Transfers from another private health insurer within two (2) months

Where a member of another private health insurer transfers to The RBHS within two (2) months of the date the member ceased to be covered by the other private health insurer under a policy (**Previous Cover**), and a Transfer Certificate is provided to RBHS:

(i) The RBHS may, at its discretion, recognise a period of cover under the Previous Cover in determining maximum entitlements for Benefits for General Treatment under the new Policy;

(ii) the Member will not be required to serve waiting periods except:

(a) for services not covered by the Previous Cover;

(b) the unexpired portions of any waiting periods not fully served under the Previous Cover; and

(c) for Benefits greater than those payable under the Previous Cover;

(iii) any relevant Benefits that have been paid within a specified time period under the Previous Cover for General Treatment may be taken into account by RBHS in determining Benefits payable under the new Policy for General Treatment;

(iv) where the Previous Cover had an excess, that excess will be applied to the new Policy during any applicable waiting periods; and

(v) RBHS will not take into account any agreements between the other private health insurer and any provider for the purposes of calculating the level of Benefits covered under the Previous Cover.

C6.2 Transfers from another private health insurer outside two (2) months

Where a person who was insured under a Previous Cover transfers to The RBHS more than two (2) months after the member ceased to be covered under the Previous Cover, the person will be treated as a new Member to the extent permitted under the Private Health Insurance Legislation and RBHS may apply any applicable waiting periods in full.

C6.3 Transfers between Products

(i) A Member may apply to transfer from any Product to any other Product and the RBHS reserves the right (subject to this part of the Fund Rules) to either approve or refuse the application.

(ii) Claims for Benefits for treatment or services provided during membership under the previous Product will be paid under the previous Product.

(iii) Where a Member transfers to a Product with a higher level of Benefits:

(a) The RBHS will pay Benefits at the level of the previous Product for treatment or services provided during any waiting period applicable to the new Product;

(b) the Member will not be required to serve waiting periods except:

i) for services not covered by the previous Product;

ii) the unexpired portions of any waiting periods not fully served under the previous Product; and

iii) where the Benefit limits under the new Product are greater than those that were payable under the previous Product;

(iv) Where a Member transfers to a Product with a lower level of Benefits, RBHS will pay Benefits at the level of the new Product for treatment or services provided during membership under the new Product.

(v) Any relevant Benefits that have been paid within a specified time period for General Treatment under the previous Product may be taken into account by RBHS in determining Benefits payable for General Treatment under the new Product.

C6.4 Transfers to another private health insurer

If a Member transfers to a policy of private health insurance with another private health insurer, The RBHS will provide the Policy Holder, or another such person as they nominate, with a Transfer Certificate.

C7 Cancellation of Membership

C7.1 A Policy Holder may:

(a) Cancel his or her Policy;

(b) Add or remove a Partner or any Dependant, Non-Student Dependant or Dependant Person with a Disability from his or her Policy.

C7.2 The Partner or a dependant aged at least 16 years of age may leave the Policy without the agreement of the Policy Holder, and a dependant under the age of 16 years of age may leave the Policy with the agreement of a Policy Holder.

C7.3 Premium refunds will be given to a Policy Holder who has paid Premiums in advance and who wishes to cease a Policy before the paid-to date. Any refund will be calculated from the date of cancellation of the Policy.

C7.3 A request to cancel a Policy must be in writing.

C7.4 The date of cancellation of a Policy will be the later of the date requested by the Policy Holder or the date of receipt by the RBHS of the request to cancel a Policy from the Policy Holder.

C7.5 A Policy Holder may cancel his or her Policy within 30 days of becoming a Policy Holder and be provided with a full refund of Premiums paid, provided there have been no Benefits paid or payable on the Policy. If a Member has made a claim against the relevant Policy during this period, the Policy Holder may cancel their Policy during this period but will only be entitled to a refund of excess Premiums when the Policy ceases. Any refund will be calculated from the date of cancellation of the Policy.

C8 Termination of Membership

C8.1 The RBHS has no right to terminate the Policy of any Member on the ground of any of the matters set out in Rule A6.

C8.2 The RBHS has the right to terminate a Policy from the date of notification to the Policy Holder, if any Member on that Policy has, in the reasonable opinion of the RBHS, committed or attempted to commit fraud upon the RBHS. Any Premiums paid in advance of the date of termination of the Policy may be first applied by the RBHS to offset the cost of the fraud or attempted fraud, with the RBHS only being liable to the Policy Holder of the cancelled Policy for any balance remaining.

C8.3 The RBHS has the right to terminate a Policy if the application for the Policy contained inaccurate or incomplete information in a material respect, and such right may be effected from the date the Policy commenced. “Material” means that the RBHS could have made a different decision if provided with accurate and/or complete information. The RBHS will refund any Premiums paid in advance as at the date of the termination but may deduct an appropriate amount from the refund for administrative expenses associated with processing the termination and any amounts wrongfully paid to or on behalf of any Member of the Policy.

C8.4 The RBHS may terminate a Policy where Premiums are unpaid more than two months in arrears. The Policy Holder remains liable for unpaid Premiums.

C8.5 Where a Policy has been terminated for non-payment of Premiums, should the Member wish to rejoin the RBHS they must complete a new application. The RBHS may, at its discretion and subject to payment of the Premium arrears, agree to waive Waiting Periods and reinstate any accumulated Benefit entitlements.

C8.6 The RBHS will notify a Policy Holder in writing where the Policy has been terminated.

C8.7 The termination or cancellation of a Policy under Rules C7 or C8 will not affect the right of the RBHS to recover from a former Member any monies payable or otherwise owing by that Member to the Fund.

C9 Temporary Suspension of Membership

C9.1 The RBHS may suspend a Policy upon application by the Policy Holder for the following two reasons subject to the applicable requirements specified below being met:

a) Temporary Absence from Australia - for more than three months and no more than 40 months by every Member on that Policy. The Policy must be resumed within one month of returning to Australia by any Member on the Policy, and Premiums are paid from the date of return to Australia or;

b) Financial Hardship - The maximum suspension period for financial hardship is 12 months. To be eligible for further suspensions, the Policy Holder must hold

continuous, active cover for at least 12 months and provide documentation to support the suspension (e.g. proof of short-term income support).

Long-term income support (e.g. aged or disability pension) is not sufficient to support membership suspension.

C9.3 Hospital Treatment or General Treatment provided during a period of suspension of a Policy are not eligible for Benefits.

C9.4 A period of suspension of a Policy does not:

i. qualify for the purpose of completing any Waiting Periods that are to be served by a Member before the Member is eligible to receive Benefits. Any outstanding Waiting Periods must be served upon resumption of the Policy.

ii. qualify for serving a period of time, where a Benefit limit is defined in these Rules with reference to a period of time, or period of time before the maximum Benefit is payable. Any remaining periods must be served upon resumption of the Policy.

	Overseas Travel	**Financial Hardship (Centrelink Assistance)**
Requirements	• All suspensions are at the RBHS's absolute discretion to allow or not • A Policy cannot be suspended in the first 12 months of membership • Must have a Hospital Product (no Extras Product only) • Must be paid up to date at date of request • If a policy is reactivated before the maximum reactivation date, the Member will not be able to suspend the policy again until they have held and maintained their Policy for the required period as outlined under 'Maximum Period' for each suspension type.	
	• Must be overseas full time for at least 3 months	• Policy Holder or Partner on short term unemployment benefit from Centrelink.
Maximum period	• 40 months • individual consideration for longer suspensions may be considered only for long term absences where	• Maximum 12 months • After 6 month's suspension, must reactivate and have at least 6 months of

	Overseas Travel	Financial Hardship (Centrelink Assistance)
	Policy Holder or a person on the Policy is working overseas. • After reactivation, must have at least 3 months of premiums paid before any more suspensions will be considered.	premiums paid before any more suspensions will be considered.
Documentation required	Proof of leaving/arrival date in Australia: • Boarding pass • Passport • Copy of ticket	• Proof of Centrelink benefits
Effective Date of Suspension	• Where the suspension has been approved, it will be effective from the date specified by the Member for a future date, or where no date is specified, the date the suspension was applied for, unless an earlier date is agreed by the Fund.	
Effect of Suspension	• No Benefits for services provided during the period of suspension will be payable by the Fund • Periods of suspension will not count as Lifetime Health Cover absent days. Any absence beyond an approved suspension period will be treated as "days without hospital cover" for the purposes of Lifetime Health Cover. • The period of suspension will not count towards any unserved waiting periods.	
Reactivating	• Within 1 month of returning to Australia OR • Within 1 month of maximum (2 years). (whichever's earlier)	• Within 1 month of the cessation of Centrelink benefits OR • Within 1 month of maximum suspension (6 months) (whichever's earlier)
Waiting periods	• When policy is reactivated within the prescribed rules, the RBHS will recognise all previous waiting periods already served. Any outstanding waiting periods must be served upon resumption of the Policy.	
Termination	• If policy is not reactivated by the agreed date and is in arrears, the RBHS may terminate the Policy on providing notice to the Policy Holder.	

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Subject to Rules D3 and D4, the rates of Premiums payable by a Policy Holder are set out in the Private Health Information Statement for the Policy Holder's Product, State/Territory of residence and insured group available at www.privatehealth.gov.au, or by contacting the Fund directly.

Premiums payable by the Policy Holder will be paid by payroll group deduction, direct debit, or such other means as approved by the Board from time to time.

The RBHS has a policy of ensuring Policy Holders who pay Premiums in advance will have their Premium rate protected for the term of that advance payment, or 12 months, whichever is the lesser. For Premiums paid in advance beyond 12 months, the paid to date of Premiums will be altered in line with any movement in the rate of Premiums payable by adjusting the period of advance payment.

D2 Contribution Rate Changes

D2.1 The RBHS has the right to change Premiums in accordance with the requirements set out in the Private Health Insurance Legislation.

D2.2 The RBHS will advise Policy Holders in writing of the new Premium rates before they take effect as set out in these Rules and required by Private Health Insurance Legislation.

D3 Contribution Discounts

D3.1 The only discounts to Premiums provided by the RBHS will be those permitted by the Private Health Insurance Legislation, including in relation to Members of a Contribution Group. The total percentage discount to Premiums for a Policy may not exceed the percentage specified in the Private Health Insurance (Complying Product) Rules (Cth) as the maximum percentage discount allowed.

D4 Lifetime Health Cover

D4.1 The Premiums payable by a Member will be increased by a nominated percentage where required under the Lifetime Health Cover provisions of the Private Health Insurance Legislation. Any Lifetime Health Cover loading applicable to a Policy will be removed after ten years of continuous cover from the date the loading is added. For the purposes of calculating the ten years, permitted days without hospital cover and periods of Policy suspension are disregarded.

D5 Arrears in Contributions

D5.1 If a Policy Holder has not made a Premium payment prior to the ‘paid to’ date, then that Policy will be regarded as being in arrears.

D5.2 If a Policy is less than two months in arrears, the Policy Holder may pay all Premiums in respect of the period in arrears and the Members of the relevant Policy will then be eligible for Benefits in respect of that period.

D5.3 When a Policy is more than two months in arrears then the Policy may be terminated by the RBHS from the last 'paid to' date of the Policy by written notice to the Policy Holder.

D5.4 No Benefits will be paid for eligible Hospital Treatment and/or General Treatment rendered to a Member during the period in which his or her Policy is in arrears until the arrears in Premiums are paid and accepted by RBHS.

D6 Other

D6.1. Policy Holders are required to pay the Premium rate applicable to the State/Territory of residence in which they reside.

E BENEFITS

E1 General Conditions

E1.1 RBHS will pay Benefits to Members out of the Fund in accordance with the terms and conditions of the Product referable to the Member's Policy and the Fund Rules. Benefits are payable from the date of joining the RBHS for eligible Hospital Treatment and/or General Treatment expenses incurred on or after that date that are covered by the Member's Policy, provided the Policy premiums are not in arrears at the date of the treatment to which the expense relates, and any applicable Waiting Periods have been served.

E1.2. Details of Benefits payable under each Product are set out in Schedules to these Rules.

E1.3 Benefits are not payable for a treatment that does not meet the requirements of the Private Health Insurance Legislation.

E1.4 Benefits are not payable where the services are provided by an immediate family member, relative, business or practice partner, or self.

E1.5 Maximum Benefits payable will be as set out in these Rules, and will not exceed the charge for the goods or services to which the Benefit relates, after taking into account benefits paid from any other source.

E1.6 RBHS will only pay Benefits for General Treatment where it is provided by or on behalf of a Recognised Provider. For the avoidance of doubt, RBHS will not pay Benefits for treatment provided by someone who was not a Recognised Provider at the time that person provided the treatment.

RBHS will determine, acting reasonably, if someone becomes or remains a Recognised Provider and for which of their treatments RBHS will pay Benefits. RBHS may choose to "de-recognise" someone from being a Recognised Provider for reasons including, but not limited to, fraudulent behaviour or if the agreement governing the relationship between RBHS and that person comes to an end.

E2 Hospital Treatment

E2.1 A Member paying Premiums for a Policy set out in the Schedules to these Rules will, subject to these Rules, be entitled to Benefits towards Hospital Treatment.

E2.2 Benefits will only be payable towards Hospital Treatment provided by a Hospital or other facilities as permitted by the Private Health Insurance Legislation.

E.2.3 Benefits will only be payable towards Hospital Treatment listed in the Medicare Benefits Schedule (MBS) except in relation to the clinical category “Podiatric Surgery (provided by a registered podiatric surgeon)”, provided that such treatment is covered by the Policy.

E2.4 Benefits payable towards Hospital Treatment and/or Hospital-Substitute Treatment will include:

1. any part of Hospital Treatment that is one or more of the following:
   (a) psychiatric care;
   (b) rehabilitation;
   (c) palliative care,
   if the treatment is provided in a Hospital and no Medicare Benefit is payable for that part of the treatment;

2. Hospital Treatment or Hospital-Substitute Treatment covered by the Policy that is the provision of a medical device or human tissue product of a kind listed in the *Private Health Insurance (Medical Decides and Human Tissue Products) Rules* in circumstances:

a. in which a Medicare benefit is payable and, if those Rules set out conditions that must be satisfied in relation to the provision of the medical device or human tissue product in those circumstances, those conditions are satisfied; or

b. as set out in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for the purposes of this item and, if those Rules set out conditions that must be satisfied in relation to the provision of the medical device or human tissue product in those circumstances, those conditions are satisfied;

3. Benefits towards pharmaceutical items dispensed to a Member while they are an admitted patient at a Hospital with which the RBHS has a Hospital Purchaser Provider Agreement. The pharmaceutical item must be intrinsic to the Hospital Treatment provided, clinically indicated and essential for the meeting of satisfactory health outcomes. This does not include pharmaceuticals that are dispensed where these are not directly related to treatment of the condition or ailment for which they have been admitted;

4. Benefits in respect of professional services that:

a. are rendered to a Member while Hospital Treatment is provided to them in a Hospital; and

b. are a professional service in respect of which a Medicare Benefit is payable. Such Benefits will be at least equal to:

c. if the medical expenses incurred in respect of the service are greater than or equal to the Schedule fee (within the meaning of Part II of the *Health Insurance Act 1973*) in respect of the service – 25% of that Schedule fee; or

d. if medical expenses incurred in respect of the service are less than that Schedule fee— the amount (if any) by which the medical expenses exceed 75% of that Schedule fee.

The amount of the Benefit payable will not exceed the amount referred to in subparagraph (c) or (d) (whichever is applicable) unless:

i. the service is rendered by or on behalf of a Medical Practitioner has a Medical Purchaser Provider Agreement with the RBHS that applies to that service; or

ii. the service is rendered by or on behalf of a Medical Practitioner who has a practitioner agreement with the Hospital that applies to the service; or

iii. the service is rendered by or on behalf of a Medical Practitioner who is covered under the "Access Gap Cover" scheme or other approved gap cover scheme with the RBHS.

5. if the Policy covers Hospital-Substitute Treatment - Hospital-Substitute Treatment covered under the Policy for which a Medicare benefit is payable;

6. if covered under the Policy, podiatric surgery (provided by a registered podiatric surgeon); and

7. any treatment for which the *Private Health Insurance (Benefit Requirements) Rules* specify there must be a Benefit.

E3 General Treatment

E3.1 The Benefits payable with respect to General Treatment and the conditions relevant to those Benefits are set out in the Schedules of these Rules.

E3.2 The RBHS may enter into special arrangements with General Treatment providers or groups of providers from time to time to provide Benefits for particular General Treatment services.

E3.3 General Treatment does not include:

1. services for which a Medicare Benefit is payable, except as allowable as Hospital Substitute Treatment; and

2. sport, recreation or entertainment unless they are part of a chronic disease management program or a health management program.

E4 Other

E.4.1 The RBHS may make payments on an Ex-Gratia basis, at its discretion.

E4.2 Notwithstanding anything to the contrary in these Rules, in respect of any Product, the RBHS will not pay Benefits towards treatment or a person supplying treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules.

E4.3 RBHS may recover from a Member any moneys incorrectly paid to them due to error within 2 years of the date of the incorrect payment. This includes errors made by RBHS because:
(a) it relied on a mistaken fact or interpretation of the law or a mixture of both;
(b) it miscalculated figures; or
(c) it made an administrative or clerical error.

If a Member owes any moneys to RBHS due to an error by RBHS or due to inappropriate claiming by the Member, the Member must pay the debt within 30 days of receiving a request from RBHS. If the Member does not pay within 30 days, RBHS can recover those amounts by setting them off against any Benefits payable to the Member or from any other moneys refundable to the Member.

F LIMITATION OF BENEFITS

F1 Co Payments

F1.1 Not Applicable.

F2 Excesses

F2.1 Not Applicable.

F3 Waiting Periods

F3.1 A Policy Holder who transfers from another private health insurer will be required to serve Waiting Periods as set out in this Rule, unless they have served equivalent waiting periods on an equivalent level of cover with their previous insurer.

F3.2 Subject to the portability requirements under the Private Health Insurance Legislation and Rule F3.1 & F3.2, any eligible person who elects to become a Member who has not had at least equivalent cover with another private health insurer and served equivalent waiting periods, may join the RBHS but will be subject to the following Waiting Periods:

(a) two months for all Hospital Treatment Benefits including palliative care, rehabilitation and psychiatric treatment;

(b) twelve months for Hospital Treatment benefits relating to pregnancy and birth ;

(c) twelve months for any Pre-Existing Condition related to Hospital Treatment, except for palliative care, rehabilitation, and psychiatric treatment;

(d) persons with a Policy covering Hospital Treatment that contains Restricted Benefits for psychiatric services and who have served the two month Waiting Period, may upgrade their cover for psychiatric services with no waiting periods once per lifetime.

(e) for any General Treatment Benefits on items:

a. with a maximum entitlement limit period of one (1) year as provided by these Rules – two months;

b. with a maximum entitlement limit period of two (2) or more years as provided by these Rules, and subject to Rule F5 – twelve (12) months.

F3.3 Dependants, Non-Student Dependants and Dependants with a Disability who are added to a Policy as a result of being newborn, adopted, fostered or cared for under legal guardianship are not subject to any Waiting Period. Waiting Periods and conditions set out in Rule F3.1 and F3.3 apply to a new Partner and their Dependants, Non-Student Dependants and Dependants with a Disability added to a Policy.

F3.4 Full Premiums will be payable by Members during any Waiting Period being served, and such Members will not be eligible for any Benefits until such Waiting Period has expired.

F4 Exclusions

F4.1 Notwithstanding any other provision of these Rules, Benefits are not payable under a Policy for:

(i) A Member is given treatment without charge;

(ii) A Member has received, or has the right to receive, payment for the treatment, goods or services from a third party, including another Registered Private Health Insurer, an employer or sports club Insurance;

(iii) A Member has received, or established a right to receive, Compensation for treatment, goods or services;

(iv) A claim is submitted for optical appliances not requiring sight correction e.g. sunglasses

(v) The Benefit is less than $5, although this can be accumulated and submitted with other claims

(vi) Treatment is rendered by a provider to:

(a) the provider's Partner, Dependants or business partner;

(b) family members of the provider and the provider's business partner including wife/husband, brother/sister, children, parents, grandparents and grandchildren;

(c) the provider themselves; or

(d) any other person not independent from the provider's practice;

(vii) the provider is not a Hospital, Medical Practitioner or Recognised Provider at the time the treatment, goods or services were provided to the Member;

(viii) the Recognised Provider:

(a) at the time the treatment, good or service was provided, has ceased to be engaged in Private Practice; or

(b) does not provide the treatment, good or service while engaging in Private Practice;

(ix) Services are provided outside the Commonwealth of Australia

(x) A claim is for goods or services that are deemed to be primarily for the purposes of sport, recreation or entertainment (unless provided as part of a chronic disease management program or health management program approved by RBHS).

(xi) A claim is for Hospital Treatment where the goods or services are for cosmetic purposes and no Medicare benefit is payable.

(xii) A claim is in respect of an Excluded Service.

(xiii) A claim is in respect of services or treatment rendered during a waiting period.

(xiv) A claim is submitted for a service which occurred while the Policy was suspended or in arrears.

(xv) A claim is for treatment that is experimental or involves a clinical trial

(xvi) A claim relates to experimental drugs that are not listed on the Pharmaceutical Benefits Scheme or are not approved by the Therapeutic Goods Administration for the use in the specific condition

(xvii) An application form or claim form contains false, inaccurate or misleading information.

F5 Maximum entitlement limits

F5.1 For General Treatment Benefits with a maximum entitlement limit period of two (2) or more years:

(a) after the twelve-month Waiting Period has elapsed, Benefits will accrue up to the specified annual limit on a yearly basis until the maximum entitlement limit has been reached.

F6 Restricted Benefits

F6.1 Further Benefit restrictions may apply as noted in Schedule H below for specific products.

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Subject to Fund Rule F7 5, Benefits are not payable for treatment, goods or services for which the Member has received (or is entitled to receive) Compensation in respect of that treatment, good or service.

F7.2 A reference to a Member receiving Compensation includes:

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

(ii) Compensation paid to another Member on the same Policy in connection with a treatment, good or service received by the Member.

F7.3 A Member who has, or may have, a right to Compensation in respect of a treatment, good or service received, must:

(i) to the extent permitted by law, inform RBHS as soon as the Member knows or suspects that such a right exists;

(ii) to the extent permitted by law, inform RBHS of any decision of the Member to claim for Compensation;

(iii) where reasonable to do so, include in any claims for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable by RBHS including any allocation for future medical expenses and the treatments and services relating to those expenses;

(iv) where requested by RBHS, identify any and all treatment, goods or services the subject of, or potential subject of, a Compensation claim for which Benefits have been or may be paid;

(v) take all reasonable steps to pursue the claim for Compensation;

(vi) to the extent permitted by law, keep RBHS informed of and updated as to the progress of the claim for Compensation;

(vii) to the extent permitted by law, provide to RBHS all documents and information in relation to injuries sustained or conditions suffered for which Benefits were paid or may be payable and any claim for Compensation (including details of the insurer

or statutory body responsible for paying Compensation) which will enable RBHS to assess the likelihood of recovering any or all Benefits paid;

(viii) authorise RBHS to disclose to the Member's legal advisers any and all information held by RBHS which reasonably relates to the claim for Compensation; and

(ix) to the extent permitted by law, inform RBHS immediately upon the determination or settlement of a claim for Compensation or the establishment of a right to receive Compensation and provide a copy of the settlement or award and if not evident from the settlement or award, an explanation of how Compensation has been allocated.

F7.4 Where the amount of the Compensation is less than the Benefits that would otherwise be payable (if Fund Rule F7 1 did not apply), then Benefits are payable in an amount equal to the difference between the amount of Benefits that would otherwise have been payable and the amount of the entitlement for Compensation.

F7.5 When a Member has not yet received, or established a right to receive, Compensation, and RBHS reasonably believes there may be a right to make a claim for Compensation, RBHS may, at its discretion, pay Benefits provided the Policy Holder signs for provisional payment in the form approved for this purpose by RBHS from time to time. In these circumstances, the Member agrees to make the claim for Compensation on the following conditions:

(i) the Member must not withdraw the claim for RBHS's expenses;

(ii) the Member must disclose (and authorise the Member's legal advisers to disclose) to RBHS, and keep RBHS informed of, all matters relevant to the progress of the claim for Compensation in a timely manner including the time and place of all settlement or other negotiations or hearings in relation to the claim for Compensation;

(iii) from the Compensation, the amount that RBHS paid in Benefits for the treatment, goods or services will be deducted and reimbursed to RBHS and will be a debt immediately repayable to RBHS upon the award or settlement of the claim and the

Member must authorise the Member's legal adviser to pay that debt from the proceeds of any award or settlement following a claim for Compensation; and

(iv) RBHS has specified rights of subrogation whereby RBHS acquires all rights and remedies of the Member in relation to the recovery of the amount that RBHS paid in Benefits.

F7.6 RBHS will pay Benefits where RBHS is satisfied that the Member has no right to payment for Compensation.

F7.7 Where a Member receives (or establishes a right to receive) payment for Compensation and:

(i) by the terms of the settlement or award it is expressed or implied that the sum of money to be paid excludes or limits the expenses for which RBHS has paid Benefits; or

(ii) the Member abandons or compromises any part of the Member's claim so that such expenses are excluded or limited

RBHS may decline to pay the Benefits which are excluded or limited and any Benefits paid to that extent may be recovered by RBHS from the Member as a debt immediately repayable to RBHS.

F7.8 Where:

(i) RBHS has paid Benefits, whether by way of provisional payments in accordance with Fund Rule F7 5 or otherwise, in relation to a treatment, good or service; and

(ii) the Member has received Compensation in respect of that treatment, good or service,

the Member must, unless otherwise agreed, repay to RBHS the amount that RBHS paid in relation to the treatment, good or service up to the amount of Compensation, upon the determination or settlement of the claim for Compensation and RBHS may set off any

amount payable by RBHS to the Member under this part of the Fund Rules against any amount payable by the Member to RBHS under this part of the Fund Rules.

This Fund Rule applies whether or not:

(i) the determination or settlement sum includes the full amount that RBHS paid; or

(ii) the Member complied with their obligations under Fund Rule F7 2.

F7.9 The disclosure of a document or information in accordance with these Fund Rules is not a waiver of, or disclosure of any intention to waive, confidentiality or privilege existing over the document or information.

F7.10 If a Member makes a claim for Compensation in respect of a treatment, good or service received and fails to:

(i) comply with any obligation in Fund Rule F7; or

(ii) unreasonably include in their claim for Compensation any payments of Benefits by RBHS in relation to a treatment, good or service,

F7.11 RBHS may, without prejudice to its rights (including its broader subrogation rights) in its discretion take any action permitted by law to:

(i) assume that all expenses in relation to the treatment, good or service have been met from the Compensation payable or received pursuant to the claim; and/or

(ii) pursue the Member for repayment of all Benefits paid by RBHS in relation to the treatment, good or service; and/or

(iii) assume the legal rights of the Member in respect of recovery of the amount that RBHS paid in Benefits.

F8 Other

Nil.

G CLAIMS

G1 General

Applications for Benefits must be made in the manner determined by RBHS from time to time, which may include by paper form, electronically or in person. Where forms are required by RBHS, they must be fully completed, including the Member's details and a signed authority for RBHS to request information from the provider as required.

Claims may only be made by a Member or authorised person.

Benefits are only payable after treatment has been provided.

G2 Claims Must Be Accompanied By Required Information

The account for the treatment to be claimed must be received by RBHS and must note the treatment provided (descriptions and item numbers), the dates of the treatment, the patient's name, provider details and the fees charged and paid. RBHS may require further information for validation of a claim from time to time.

Any hand-written alterations to a printed account or receipt are not acceptable. Where an account or receipt requires amendment, a new copy must be issued.

RBHS may, in its discretion, waive some or all of these requirements for claims submitted electronically.

All documents submitted in connection with a claim become the property of RBHS.

G3 Time Limit for Lodgement of Claims

Benefits are not payable where a claim is submitted more than twenty-four (24) months after the date of service.

G4 Manner of Benefit payment

RBHS pays Benefits by electronic funds transfer only.