



Policy Booklet

March 2021



This Policy Booklet contains our Fund Rules and Policies. These outline the principles on which we operate ACA Health Benefits Fund, as well as your membership entitlements and responsibilities.

It is important that you read this booklet carefully and keep it in a safe place so you can refer to it at any time.

Because we care...

INTRODUCTION3

This covers areas regarding the management of ACA Health Benefits Fund Limited, such as the purpose of the Fund, obligations of policy holders, discrimination, rule changes, dispute resolution, etc.

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INTRODUCTION

Rules Arrangement

These rules shall bind the Fund, all the Policy Holders, and all Insured Persons claiming through them respectively to the same extent as if each person has subscribed his/her name and affixed his/her seal hereto and there were contained in these Rules a covenant on the part of each person to observe the provisions thereof.

A Policy Holder or Insured Person breaching any of the provisions of Fund rules will be considered to have violated the said covenant. The policy or person breaching the provision will be terminated immediately, and the Fund will be discharged from all obligations and liabilities under Fund rules to the respective Insured Persons covered by that policy. Any contributions paid beyond the termination date will be refunded.

Health Benefits Fund

Name

ACA Health Benefits Fund Limited (ACN 128 673 923) ("ACA Health") is a Private Health Insurer and administers a Health Benefits Fund ("the Fund").

Purpose of the Fund

The purpose of the Fund is to provide benefits towards hospital and approved general treatment expenses incurred by the Policy Holders and their dependants.

The Fund is able to engage in health related business or businesses. The manner and extent may be decided by the board.

Provided that;

- (a) Any profit that may accrue to the Fund shall be applied only in promoting the objects of the Fund, and
- (b) The resources of the Fund shall not be used for any payment other than benefits to Policy Holders or their dependants and expenses of management.

Obligations to Fund

A person applying to purchase a policy of the Fund shall:

- Comply with the requirements of the Fund and give full and complete disclosure on all matters required by the Fund.

- The Policy Holders shall inform the Fund of any policy details required in the manner and within the time prescribed in these Rules.
- All Policy Holders and their dependants are bound by the Rules and Policies of the Fund as amended from time to time.

Governing Principles

The operation of the Fund and the relationship between the Fund and each Insured Person is governed by:

- The Private Health Insurance Act 2007 and subordinate legislation.
- The Fund Rules
- The Constitution of ACA Health Benefits Fund Ltd
- The Fund Policies

Use of Funds

Financial Control

ACA Health shall:

- keep proper accounts and records of the transactions and affairs of the Fund;
- ensure that all payments from the Fund are correctly made and properly authorised; and
- maintain adequate control over the assets in the Fund's custody and the incurring of liabilities by the Fund.

Audit

ACA Health will arrange for its accounts and records to be audited by the appointed auditor each year and will comply with the requirements of any law relating to the accounts and the audit of the accounts of the Fund in force at the time.

Income to be credited to the Fund

ACA Health will credit to the Fund all of the premiums paid by Policy Holders and all other income arising from conducting a Health Benefits Fund.

Drawings on the Fund

ACA Health may draw on the Fund only:

- to pay benefits in accordance with these rules;
- to make payments to the Private Health Insurance Risk Equalisation Trust Fund;

- to make investments for the health insurance business; and
- for any purpose directly related to the health insurance business.

No Improper Discrimination

ACA Health will comply with the principle of community rating. ACA Health will not act or fail to act in such a manner as to discriminate between persons except where permitted by the Private Health Insurance Act 2007, any legislative or regulatory instrument or the Fund constitution.

Changes to Rules

ACA Health may amend the rules in accordance with the Private Health Insurance Act.

The Fund will inform Policy Holders of these changes in accordance with the Fund's Detrimental Changes policy. This policy prescribes that where there is a:

(a) significant detrimental change to treatment, hospital benefits and premiums the Fund will:

- provide the affected Policy Holder with a minimum of 60 days notice prior to the effective date of the change;
- make transitional arrangements for persons within a course of treatment for up to 6 months; and
- the change will not affect pre-booked admissions.

(b) detrimental change to treatment, hospital benefits and premiums the fund will:

- provide the affected Policy Holder with a minimum of 30 days notice prior to the effective date of the change;
- make transitional arrangements for persons within a course of treatment for up to 3 months; and
- the change will not affect pre-booked admissions.

(c) significant detrimental change to general (ancillary) treatment benefits and premiums the Fund will:

- provide the affected Policy Holder with a minimum of 30 days notice prior to the effective date of the change; and
- make transitional arrangements for rollover type benefits accumulated in a previous year (such as for Orthodontic and Prosthodontic benefits).

All Policy Holders will receive the Private Health Information Statement (PHIS) relevant to their policy when purchasing the policy as well as when updated or once annually. Private Health Information Statements are available to any person upon request.

Dispute Resolution

An Insured Person may make a complaint to ACA Health at any time. ACA Health will act to respond to all complaints quickly and efficiently, in accordance with the Fund's Complaints Handling policy. Where a dispute is referred to the ACA Health Board of Directors, the decision thereon is final.

The Private Health Insurance Ombudsman is also available to assist Insured Persons with complaints, please refer to page 34.

Notices

All necessary correspondence will be emailed to the email address stored on the policy or where no email address has been supplied it will be sent to the most recently supplied postal address or where no postal address has been supplied, the home address, or telephone number of the Policy Holder. These rules are available to Insured Persons upon request.

Winding Up

Members shall have a right to apply for an investigation of the affairs of the Fund or for the winding up thereof in the manner prescribed by any Act under which the Fund may be registered.

The Fund shall terminate under the terms of the Private Health Insurance Act at any time the Members of ACA Health Benefits Fund Limited resolves that the Fund is no longer necessary or that it is no longer possible to carry on the Fund. In the event of a resolution for dissolution being passed by the Members, the provisions as to the dissolution of the Fund contained in any law or laws in force for the time being under which the Fund may be registered, shall apply. If the Fund be dissolved, all its properties and assets remaining after the payment of outstanding claims, debts and liabilities shall be applied by the Board of Directors, and in compliance with the Constitution.

DEFINITIONS

Words and expressions not specified in these Rules will have the same meaning as those which are defined in the Private Health Insurance Act 2007 and the Private Health Insurance Rules 2007. Words in the singular number shall include the plural and words in the plural shall include the singular.

"Application for Membership" means an application to become a Policy Holder of the Fund in the form prescribed.

"Benefit" means any benefit payable in respect of the Policy Holders and Insured Persons of the policy in accordance with these rules.

"Board" means the Board of Directors of the Fund as appointed by the Members of ACA Health Benefits Fund.

"Contributor" in relation to the health benefits fund conducted by the Fund, means a person who pays contributions, or on whose behalf contributions are paid, and includes dependants of a contributor.

"Co-payment" is an amount which a Policy Holder agrees to pay each time a service is provided.

"Chronic Disease Management Program" is a program intended to either reduce complications in a person with a diagnosed chronic disease, or prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease. The program must have a written plan and be coordinated by a Fund approved facilitator.

"Day Hospital Facility" means a hospital facility which does not provide for an overnight admission.

"Dependant" or "Insured Person" means and includes:

- (a) A Policy Holder's spouse or de facto partner;
- (b) A Policy Holder's children under twenty-one (21) years of age who do not have a spouse or de facto partner;
- (c) "Student Dependents" - A child of the Policy Holder who;
 - (i) does not have a spouse or de facto partner;
 - (ii) is a full-time student at a school, college or university;
 - (iii) is twenty-one (21) years or over and under the age of twenty-five (25) years;
 - (iv) is not earning more than \$20,000 gross per annum;
and

(v) has been accepted by the Fund as a "student dependant."

(A statement in respect of Student Dependants must be provided each year by the Policy Holder).

- (d) "Dependent Child Non-Student" - A child of the Policy Holder who;
- (i) does not have a spouse or de facto partner;
 - (ii) is twenty-one (21) years or over and under the age of twenty-five (25) years; and
 - (iii) is not receiving full-time education at a school, college or university.

A Dependent Child Non-Student may only be covered as a dependant on an "extended family policy" (see page 10 for more details).

- (e) Such other persons approved by the Board of Directors as being dependants.

"Detrimental Changes" means any change, other than a significant detrimental change, which affects the benefits or access to benefits under a fund policy.

"Fund" means the ACA Health Benefits Fund.

"Health Management Program" means a program that is intended to improve a person's specific health condition/s.

"Hospital Purchaser-Provider Agreement" (HPPA) means an agreement entered into between ACA Health Benefits Fund and a Hospital or Day Hospital Facility.

"Hospital Substitute Treatment" means general treatment that substitutes for an episode of hospital treatment.

"Medical Practitioner" means a person who is registered or licensed as a medical practitioner under a law of a State or Territory and satisfies the provider eligibility requirements for the payment of Medicare Benefits.

"Medical Purchaser-Provider Agreement" means an agreement entered into between ACA Health Benefits Fund and a Medical Practitioner.

"Member" means a member of the company ACA Health Benefits Fund Limited.

"Partner" means spouse, or a partner in a de facto relationship as defined in Section 4AA of the Family Law Act 1975.

"Person" means a Policy Holder of the Fund or his/her dependant.

"Pre Existing Ailment" means an ailment or illness, the signs or symptoms of which, in the opinion of a medical practitioner appointed by ACA Health Benefits Fund, existed at any time during the six months preceding and including the day on which the person joined ACA Health Benefits Fund or upgraded to a higher level of benefit.

"Product" refers to the type of policy of the Fund which provides entitlement to specified benefits.

"Significant Detrimental Change" means the removal of material benefits or a restriction to benefits for any identified condition, and the addition of material excesses or co-payments or increasing the excesses or co-payments by more than 50%.

"Table" means a table of the policy of the Fund which provides entitlement to specified benefits.

"Year" means a calendar year.

MEMBERSHIP

General Conditions of Membership

- (a) No person shall be accepted as a Policy Holder of the Fund until such time as that person has lodged the required Application Form complete in all details, any associated documents as required by the fund, and the date of birth of all Insured Persons have been verified.
- (b) A Policy Holder shall not be transferred from one category of membership to another, or from one policy to another, until the Policy Holder has informed the Fund in writing of their wish to be so transferred, has furnished such further particulars as the Fund may require and the application to be transferred has been accepted by the Fund.

Categories of Membership

ACA Health offers policies that cover:

- (a) Single Membership
 - only one person
- (b) Single Parent Membership
 - 2 or more people, only one of whom is an adult.
- (b) Family Membership
 - 2 or more people, only 2 of whom are adults; or
 - 2 or more people, none of whom is an adult; or
 - 2 or more people, only one of whom is an adult.

Extended Family Policy

Certain family memberships, as outlined in the summary of available policies below, are eligible to become an extended family policy. This allows a “dependent child non-student” to be covered by the family policy.

The premium payable for a policy that covers a dependent child non-student is 30% higher than the premium payable for a policy in the same product that covers a family without a dependent child non-student.

Summary of Available Policies

- Basic Hospital (BH)
- Basic Hospital plus Complete Ancillary (BHA)
- Basic Hospital plus Ancillary lite (BHA1)
- Bronze Essentials Hospital (BEH)

- Bronze Essentials Hospital plus Complete Ancillary (BEHA)
- Bronze Essentials Hospital plus Ancillary lite (BEHAL)
- Gold Private Hospital (PH)
- Gold Private Hospital Plus Complete Ancillary (PHA)
- Gold Private Hospital Plus Complete Ancillary - Extension (PHAE)
- Gold Private Hospital Plus Ancillary lite (PHAL)
- Gold Private Hospital Plus Ancillary lite - Extension (PHAIE)
- Gold Deluxe Hospital (DH)
- Gold Deluxe Hospital plus Complete Ancillary (DHA)
- Gold Deluxe Hospital plus Complete Ancillary - Extension (DHAE)
- Gold Deluxe Hospital plus Ancillary lite (DHAI)
- Gold Deluxe Hospital plus Ancillary lite - Extension (DHAIE)
- Complete Ancillary (A)
- Ancillary lite (AI)

Eligibility for Membership

The following persons comprise the Restricted Access Group to whom ACA Health's complying health insurance products are, or will be, made available:

- (a) A person who is, or was, an employee of:
 - an incorporated entity that is affiliated with the Seventh-day Adventist Church in Australia;
 - Avondale College Foundation;
 - Karalundi Aboriginal Education Centre;
 - Mirriwinni Gardens Aboriginal Centre; or
 - Sydney Adventist Hospital Foundation.
- (b) A person who is, or was, a Local Church Officer of any Seventh-Day Adventist Church in Australia.
- (c) A person who is, or was, a literature evangelist, while distributing for Home Health Education Service.
- (d) A person who, by the operation of the Private Health Insurance Act and Rule 6 of the Private Health Insurance Rules 2007 No 2, is taken to belong to the Restricted Access Group.
- (e) A person who is or was a partner, dependant, brother, sister, grandchild or parent of any person mentioned in (a), (b), (c), (d) above.

As ACA Health is registered as a restricted access insurer under the *Private Health Insurance Act 2007*, ACA Health must not:

- (e) Issue a complying health insurance product to a person who does not belong to the Restricted Access Group; and
- (f) Cease to insure a person for the reason that the person has ceased to belong to the Restricted Access Group.

Proof of Eligibility

The Fund may request information from the Policy Holder or their employer at the time of joining the Fund, prior to becoming a Policy Holder, to validate eligibility for membership to the Fund.

Continuation of Membership

A dependant of a Policy Holder, who ceases to qualify as a dependant, may apply for continuation of membership at anytime after they cease to be a dependant. All qualifying and waiting periods will apply unless they make application to join within two months of ceasing membership and maintain financial continuity.

A person eligible for membership may rejoin the fund at any time. All qualifying and waiting periods will apply unless they make an application to join within two months of ceasing membership and maintain financial continuity.

Child Dependants

In the absence of a legally binding determination to the contrary, the Fund shall take direction from the Policy Holder of the policy which covers the child, for all matters and decisions relating to the private health insurance requirements of child dependants.

Membership Applications

Application to become a Policy Holder

A person who is eligible to become a Policy Holder of ACA Health Benefits Fund must apply by:

- (a) Lodging with ACA Health Benefits Fund a completed application in the approved form and accompanied by proof of age and proof of eligibility (where required by the Fund), and
- (b) Payment of the appropriate Contribution.

Non Acceptance of an Application to become a Policy Holder

ACA Health Benefits Fund may refuse any application to become a Policy Holder where the applicant does not satisfy the requirements of the Rules. ACA Health will notify any such applicant in writing.

Commencement of Membership

A Policy commences on:

1. the date on which the application is lodged with ACA Health; or
2. where ACA Health agrees, a later date nominated in the application; or
3. where ACA Health agrees, an earlier date nominated in the application.

Transfers between Memberships

Policy changes within ACA Health

Where a Policy Holder or a dependant wishes to transfer to a different policy they must make an application as outlined in these rules. Where the new policy benefit entitlement differs to the previous policy entitlement, the transferee, during any waiting periods applicable to the new policy will be eligible to receive the benefits of the lesser policy. This is on the proviso that the Policy Holder has served all waiting periods on the previous policy and was eligible for benefits.

Transfers from Other Funds within 2 Months

Contributors who transfer from another health benefit organisation within a period of two months from the date to which contributions were paid to in the other health benefit organisation shall be accepted with rights no less beneficial than those accruing in the previous organisation. This is on the proviso that such benefit entitlements shall not exceed the benefits available under the policy to which the contributor transfers to in ACA Health and that there is financial continuity.

Previous Benefits May be taken into Account

Where a Policy Holder or dependant transfers to another policy within ACA Health or from another fund, any relevant benefits that have been paid in a specified time period under the previous cover may be taken into account in determining the benefits payable under the new cover. 'Any relevant benefits' include but are not limited to, benefits that are subject to calendar, lifetime or other limit or a maximum number of days of hospitalisation.

Cancellation of Membership

A Policy Holder may cancel their policy entirely and may remove any dependants from their policy. The Policy Holder's dependant partner or any dependant aged 16 years of age may leave the policy. Any dependant less than 16 years old may leave the policy with the authorisation of the Policy Holder. All changes to a policy must be received by the Fund and must be in the Fund approved form. All changes to a policy will be effective when received by the fund and may not have retrospective effect. The Fund will supply a transfer certificate within 14 days of the cancellation.

Refunds of Premiums

ACA Health may, at its discretion, refund excess premiums received by the Fund after receiving a written request from a Policy Holder. Any refund will be calculated from the date the written request is received by the fund.

Cooling-off Policy

The Fund will allow any consumer who has not yet made a claim, to cancel their policy and receive a full refund of any premiums paid within a period of 30 days from the commencement date of their policy.

Termination of Membership

Termination of a Policy where an Insured Person Acts Improperly

Where, in the opinion of ACA Health, an Insured Person has obtained or attempted to obtain an improper advantage for themselves or for any other Policy Holder or for any Insured Person, ACA Health may terminate the relevant policy or person on that policy, by written notice to the Policy Holder. 'Improper Advantage' means any advantage, monetary or otherwise, to which an Insured Person is not entitled under the Rules.

Termination of Policy due to Contributions in Arrears

ACA Health may terminate a membership where a Policy Holder is in arrears in their premium payments by 3 months or more.

Non-Payment of Benefits

ACA Health is not obliged to pay benefits if a policy is in arrears or an application form contains false or inaccurate information.

Temporary Suspension of Membership

The Fund may approve the suspension of an entire policy, where a Policy Holder has held the policy for a minimum of 12 months, and completes and returns to the Fund the approved suspension application and associated documents as required by the Fund. Suspension may not have a retrospective effect.

Criteria and Time Limits

The Fund may permit the suspension of a policy in the following circumstances and conditions:

- (a) Where a Policy Holder is moving overseas to work for the Seventh-day Adventist Church in an employed or volunteer basis. The minimum period of suspension is 12 weeks and no maximum time limit will be imposed.
- (b) Where a Policy Holder is leaving Australia for overseas travel or to work other than for the Seventh-Day Adventist Church, the minimum period of suspension is 12 weeks. A maximum period of suspension is 2 years.
- (c) Financial Hardship is being experienced by a Policy Holder. Financial hardship is defined as being on a Government short term income support payment paid by Centrelink including Youth, Jobsearch, Newstart & Sickness Allowances. A maximum period of suspension of up to 2 years may be allowed – but only while the Policy Holder/spouse continues to receive the allowance. Periods beyond this will count towards “leave of absence” under the Lifetime Health Cover Legislation.

A membership may not be suspended unless the premiums have been paid to the date of departure or date of commencement of any income support payment.

Arrangements during Suspension

- (a) The date suspension becomes effective will generally be:
 - The date of departure from Australia for overseas travel or work.
 - The date a Policy Holder/spouse becomes eligible for an income support payment from Centrelink.
 - The date of the suspension application if this date is after the date a Policy Holder becomes eligible to suspend.
- (b) No contributions are due or payable during the period of suspension.
- (c) A Policy Holder, spouse, or dependants, are unable to make claims on the Fund for services performed during the period of suspension.

- (d) No Waiting periods will apply on recommencement of the membership if all waiting periods were served at the time of suspension.
- (e) The period of suspension will not normally count as part of the two year Leave of Absence allowed under Lifetime Health Cover Legislation. (See Rule 26) (Applies only to Hospital Cover).
- (f) A Policy Holder retains his/her “certified age”, under Lifetime Health Cover that applied at the commencement of suspension.
- (g) Suspension will apply to all a whole membership and all components of cover. For example Hospital and Ancillary cover if taken together.
- (h) A Policy Holder is only able to suspend their membership once in any 1 calendar year period –and not within 6 months of any previous suspension.
- (i) Suspension does not count towards satisfaction of waiting periods or for calculating membership duration.
- (j) Natural children born outside of Australia and children legally adopted (approved for membership) during a period of suspension will be covered at the time of recommencement providing all waiting periods were served by the Policy Holder at the time of suspension.
- (k) Any injury, ailment, condition or illness arising during a period of suspension (which on the evidence did not exist at the time of suspension) may have a 12 month waiting period apply at the time of recommencement of membership. All decisions will be made in conjunction with the Fund’s medical advisor. The provisions of this clause apply to pregnancy and to legally adopted children.

Reactivation to Occur Within One Month

Recommencement of membership after a period of suspension will apply from the day of return to Australia or Centrelink benefits cease. If notification occurs more than 1 month after this time a new membership may be required with waiting periods applied.

Documentation to be Provided

Proof of departure and return dates (boarding passes, tickets, passport entries etc.) are required. Under financial hardship provisions copies of Centrelink letters are required.

CONTRIBUTIONS

Payment of Contributions

Premiums Payable for each Policy

Premiums payable for each policy or cover type are set out in the 'Price Guide'. Lifetime health cover loadings may apply. Please refer to page 18.

Contribution Groups

A Contribution Group may include, but is not restricted to:

- (a) employees of a particular business enterprise or group of enterprises; or
- (b) Policy Holders who pay their contributions in a certain way.

Timing and Methods of Premium payments

Premium payments are the responsibility of the individual Policy Holder and are payable at least one month in advance, except those paying by payroll deduction.

Where the Policy Holder elects to:

- (a) have their premiums deducted from their salary, wages or retirement benefits, these will be remitted to ACA Health in arrears by the employer payroll office. To establish this method of payment the Policy Holder must complete the payroll authority on the application form and lodge this form with the fund through their participating pay office. This service is offered to the employee by their employer and may not be available to all Policy Holders.
- (b) Have their premiums deducted from their bank account by direct debit or charged to their credit card. To establish this method of payment the Policy Holder must complete the direct debit authority or the credit card authorisation on the application form and lodge this form with the Fund. This method is available for monthly, quarterly and yearly payment periods.
- (c) Those Policy Holders not electing one of the methods above can pay by cash, cheque or credit card. All premiums must be paid at least one month in advance. The fund reserves the right to delay or decline benefit payments where premium payments are not paid at least one month in advance.

Contribution Rate Changes

Premiums May be Changed

ACA Health may change the premiums for any cover in accordance with the requirements set out in the Private Health Insurance Act 2007, and subject to these Rules.

Rate Protection

Subject to the rules below, where premiums have been accepted in advance, a premium change that takes effect during the advance period will not affect the date to which premiums have been paid. The new rate applies when the next contribution or premium payment is due.

When Rate Protection Does Not Apply

- (a) Where a policy is not paid in advance of the date the premium rate change is effective.
- (b) Where a cover change occurs, or a suspended policy is reactivated, the premium current as at the date of the cover change or reactivation applies to the policy from that date.
- (c) For the purposes of this Fund Rule 'cover change' includes:
 - the addition or removal of a cover component (inc. Rebate election)
 - a change in the level of existing cover
 - a change of policy category resulting in a change in premiums.

Contribution Discounts

ACA Health does not offer premium discounts.

Lifetime Health Cover

Lifetime Health Cover Loadings

Persons taking hospital policies pay 2% more for each year they are over 30 years old, to a maximum of 70% and for a maximum of 10 years. Ancillary only policies are not affected.

Persons born on or before 1 July, 1934 will not have to pay more. All existing members as at 1/7/2000 were credited with a certified age of 30 and will attract the base rate premium for as long as they maintain their hospital policy.

Please refer to the Department of Health website www.health.gov.au for full details of minimum period of membership, periods of absence, periods of suspension, special provisions for refugees and Australians overseas and LHC loading removal.

Lifetime Health Cover Period of Absence

- (a) Policy Holders can lapse their cover for a cumulative period of 1094 days (2 years and 364 days) over their lifetime without affecting their premium.
- (b) After a total of 1094 days absence, a 2% loading will be applied to their premium for each additional 365 days of absence.
- (c) Policy Holders are allowed only one cumulative total of 1094 days lapse of hospital policy during their lifetime.
- (d) "Permitted Days without Hospital Cover" – If a Policy Holder or Insured Person moves overseas for more than 12 months and does not return to Australia for more than 90 consecutive days at any one time, the Policy Holder or Insured Person will not incur a lifetime health cover penalty for this period. Days overseas will not count towards absence days and no increased lifetime health cover levy will be applied for this period. The person must provide proof for this provision to apply (Australian Government Department of Immigration and Citizenship – Movements Record).
- (e) The fund is not responsible for any costs that may be associated with the provision of proof mentioned above.

Arrears in Contributions

Policies in Arrears

A policy (other than a suspended Membership) is 'in arrears' or in a 'period of arrears' whenever the date to which a premium has been paid is earlier than the current date.

Treatment During Arrears

- (a) Benefits are not payable for treatment provided to an Insured Person during a period of arrears. ACA Health may waive this Fund Rule at its discretion.
- (b) A Policy Holder who is in arrears for a period of two months and pays such arrears before the end of that period is entitled to regain an entitlement to benefits for services rendered during that period.

Maximum Period of Arrears

A Policy Holder whose contributions are more than three months in arrears shall be deemed no longer to be a Policy Holder. ACA Health may terminate the policy immediately without written notice to the Policy Holder.

BENEFITS

General Conditions

Benefit Reductions

Health Fund benefits payable under Fund policies shall not exceed the fees and/or charges raised for any treatment and/or services rendered:

- (a) after taking into account benefits claimable from any other source; and
- (b) where, in the opinion of the Fund, the charge is higher than the provider's usual charge for the service.

No Benefit Payable for Providers Treating Family Members, Business Partners and Family

Health Fund benefits are not payable for treatment rendered by a provider to:

- (a) the provider's spouse, partner, dependants or business partner; or
- (b) the business partner's spouse, partner, or dependants.

The Fund may at its discretion pay benefits in these instances, where:

- (a) it is satisfied that the charge is raised as a legally enforceable debt; or
- (b) in respect of the invoiced cost of materials required in connection with any treatment.

Provider Recognition

Health Fund benefits are payable under Fund policies only where treatment is provided by recognised providers. A provider is recognised where:

- (a) It is a hospital as advised by the Department of Health; or
- (b) It is a medical practitioner who satisfies the provider eligibility requirements for the payment of Medicare Benefits; or
- (c) It is a General Treatment provider who is:
 - Relevantly qualified;
 - Registered with the appropriate State Registration Board or Association, or where an alternative therapy provider, recognised by the Australian Regional Health Group; and
 - Approved by ACA Health Benefits Fund in its absolute discretion.

Where a Provider Fails to Meet or Ceases to Meet Provider Recognition Requirements

Where the Fund has reasonable grounds to believe that a provider fails to meet or no longer meets the provider recognition criteria, ACA Health Benefits Fund may decline to pay benefits provided by that provider and may cancel the providers recognised status for paying benefits.

Benefit Assessment

The Fund may request additional information from an Insured Person or their health service provider prior to or after the disbursement of benefits. The information requested will relate directly to a claim or a request for approval of a future benefit to be paid to the Policy Holder or their health service provider. Such information may include but not be limited to:

- Prescriptions
- Treatment plans
- Medical/Patient records
- Treatment schedule
- Invoices
- Receipts

Benefit Repayment to the Fund

The Fund may seek a refund of the benefits paid where:

- (a) A claim was incorrectly assessed;
- (b) A claim was paid after the termination date of the policy or person insured on the policy;
- (c) A claim contains false or misleading information; or
- (d) Information is received after the claim has been paid which establishes that the benefit should not have been paid.

Exclusion of Benefit

Benefits are not payable where:

- (a) The treatment or service occurred within waiting periods;
- (b) The treatment or service occurred during a period where the policy was in arrears;
- (c) There was no charge for the treatment or service;
- (d) Where the membership application form or claim form contains false or misleading information;
- (e) The treatment or service was for sport, recreation or entertainment (except as part of an approved chronic disease management program or a health management program);

- (f) Any other circumstance referred to in the “Exclusions” section on page 27; or
- (g) A benefit has already been paid for a treatment or service performed on the same day.

Hospital Treatment

Hospital Treatment Benefits

The benefits payable for hospital treatment are for admitted patients or where a benefit is specified under a Hospital Purchaser Provider Agreement with that hospital and are paid as set out in the relevant product rule.

For **surgical patients**, a period no greater than three nights pre-operative care will be considered in approved private hospitals. An exception to this rule may be made if a Medical Arbitrator appointed by the Fund determines that a particular surgical procedure requires a longer pre-operative period.

For **obstetric patients**, benefits will be paid for patients in approved private hospitals for one day prior to the day the patient commences labour, including induction of labour. An exception to this rule may be made if a Medical Arbitrator appointed by the Fund considers that a longer hospitalisation period prior to the commencement of labour was justified.

For **nursing home-type patients**, benefits will be paid at the private hospital level for 7 days only, thereafter the nursing home-type benefits will apply. In extreme cases, up to 7 additional days may be considered upon application to Fund management.

Patient Classification

Benefits for accommodation in Private Hospitals are payable in accordance with the classification of the patient. Patients are classified in line with the guidelines issued by the Department of Health.

Patient Classification: Benefit Calculation

- (a) The day of admission into hospital and the day of discharge from hospital shall be regarded as one benefit day.
- (b) Where a patient undergoes more than one operative procedure during one theatre admission, the procedure with the highest fee in the Medical Benefits Schedule determines the patient classification.

- (c) The patient classification of the procedure applies to the patient from when the procedure is performed.
- (d) For additional guidance the fund will follow the guidelines issued by the Department of Health.

Accommodation Benefits in a Public Hospital

Accommodation benefits payable in a recognised public hospital will be 100% benefit of the daily bed rate as set out by the relevant State Health Authority.

Coverage of In-Hospital Pharmacy - Gold Deluxe Hospital Only

Benefits are payable to cover costs that an eligible Insured Person incurs for pharmaceutical benefits dispensed to them while he / she is an admitted patient at the hospital or day hospital facility with which the Fund has a Hospital Purchaser Provider Arrangement. The costs that an Insured Person incurs for pharmaceutical benefits are contingent upon whether the Insured Person has reached the Safety Net Threshold under Commonwealth Government Pharmaceutical Benefits Scheme arrangements.

A 'pharmaceutical benefit' is defined as any medicine listed in the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health) that is dispensed to the Insured Person.

A 'pharmaceutical benefit' referred to in this section of the Fund rules must be intrinsic to the hospital treatment provided, clinically indicated and essential for the meeting of satisfactory health outcomes for the Insured Person. It does not include pharmaceutical benefits dispensed that are not directly related to treatment of the condition or ailment for which they have been admitted.

The Fund also covers the costs that an Insured Person incurs for special patient contributions, brand premiums and therapeutic group premiums listed in the Schedule of Pharmaceutical Benefits that apply to certain pharmaceutical benefits, regardless of whether the Insured Person has reached the Safety Net Threshold under Commonwealth Government Pharmaceutical Benefits Scheme arrangements.

The Fund covers costs for pharmaceutical benefits up to a maximum quantity dispensed. The maximum quantity covered is as listed in the Schedule of Pharmaceutical Benefits, or as recorded on an Authority Prescription Form (and authorised by Medicare Australia) where the quantity dispensed is clinically indicated, intrinsic to the hospital treatment provided and essential to the meeting of satisfactory health outcomes for the Insured Person.

Where the cost to an Insured Person for a drug or medicinal preparation listed in the Schedule of Pharmaceutical Benefits is less than the pharmaceutical benefit co-payment (determined by the Commonwealth Department of Health), these drugs are not considered to be 'pharmaceutical benefits' and are not covered by the Fund under this section of the rules.

General (Ancillary) Treatment

The benefits payable for General Treatment services and the conditions that apply to the payment of these benefits are set out in the General Treatment product guides.

From July 1, 2000 any benefit claims for ancillary health care or paramedical services not exempt from GST will need to be submitted with a "tax invoice" which has GST shown separately on all accounts or state that GST was included.

Other

Ex Gratia Benefits

ACA Health Benefits Fund may pay benefits on an ex-gratia basis, at its discretion.

Overseas Treatments and Products

ACA Health Benefits Fund does not pay benefits for products and treatments provided or purchased from countries outside of Australia. This includes international websites without an Australian Business Number (ABN).

LIMITATION OF BENEFITS

Co-payments

A Co payment is an amount per service or day which a Policy Holder agrees to forgo in return for a lower premium than would otherwise apply. A member co-payment applies to the Private Hospital Cover (PH) and where Private Hospital Cover is combined with any General Treatment covers.

Excesses

The Bronze Essentials Hospital Cover is the only product that has an excess.

Waiting Periods

Waiting Periods: General Treatment Policies

The following waiting periods apply to benefits under General Treatment covers for the services shown (where relevant to the Policy Holder's cover) and are not eligible for a later claim:

- (a) All services and items, except those listed below – 2 months
- (b) Optical services – 4 months
- (c) Orthodontic services – 9 months
- (d) Dental services and appliances – 9 months
- (e) Maternity related services and appliances – 12 months
- (f) Medically prescribed health appliances – 12 months
- (g) Foot orthoses and surgical shoes – 12 months
- (h) Hearing aids – 12 months
- (i) Pre-existing conditions – 12 months

Waiting Periods: Hospital Policies

The following waiting periods apply to benefits under Hospital covers for the services shown (where relevant to the Policy Holder's cover) and are not eligible for a later claim:

- (a) All services – 2 months
- (b) Obstetric related services – 12 months
- (c) Treatment for Pre-Existing Ailments – 12 months
- (d) Hospital treatment or hospital-substitute treatment for psychiatric care, rehabilitation or palliative care (whether or not considered a pre-existing ailment) – 2 months

A waiting period does not apply to an Insured Person who held a gold card or was entitled to be treated under a gold card.

Waiting Periods: Changes to Policies

A Policy Holder or Insured Person changing policies shall not be eligible to receive any increased benefit associated with the new policy until all waiting periods described in the Rules above have been served following the first payment of contributions at the new rate. However, during the above waiting period, benefits will be payable at the rate applicable to the previous policy from which the Policy Holder or Insured Person transferred. This is on the proviso that they were eligible for benefits under the previous policy, and that the level of benefits of the previous policy do not exceed that of the current policy.

Pre-Existing Ailment or Condition (PEA)

Pre-existing ailment means an ailment or illness for which the signs or symptoms, in the opinion of the Medical Adviser or other relevant health care practitioner appointed by the Fund to give advice on such matters, existed at any time during the six months preceding, or on the day of, the commencement of contributions for the policy, or change to a policy with a higher cover. Benefits shall not be payable for a period of 12 months from the commencement of contributions. If changing to a policy with a higher level of cover, benefits will only be payable at the lower level of cover for a period of 12 months if a pre-existing condition exists at that time.

PEA: Information from Treating Practitioner(s)

ACA Health may suspend consideration of a claim or reject payment of benefits on a claim until such time as;

- (a) the Insured Person (or Policy Holder where appropriate) authorises the release of the information required by the Fund appointed Medical Advisor to form an opinion; and
- (b) this information has been provided to the fund.

PEA Waiting Period Not to Apply Where the Fund Alters the Cover

Where ACA Health has changed the terms of a policy type, any higher or additional benefit now available to existing Insured Persons of the cover are not subject to an additional Pre-Existing Ailment waiting period.

This Fund Rule has no effect on any other waiting period or condition that applies to a newly available benefit.

PEA Waiting Period Not to Apply

ACA Health may at its discretion waive or reduce any waiting period.

The waiver or reduction of a waiting period has no effect on:

- any other waiting period;
- any benefit limitation period; or
- any other Fund Rule applicable to the same service.

Exclusions

Unless expressly provided for in these Rules, benefits are not payable:

- (a) for claims for services rendered while premiums are in arrears or the policy is suspended;
- (b) where an entitlement exists, or may exist, to compensation and or damages;
- (c) for claims for treatment rendered by a provider other than a recognised provider;
- (d) for claims on services in any period during which the Policy Holder or Insured Person is not qualified to be a Policy Holder under these rules;
- (e) for claims for services rendered outside Australia or for items purchased or hired from overseas suppliers unless otherwise provided for in these rules;
- (f) any item without Therapeutic Goods Administration approval;
- (g) for cosmetic surgery unless prior approval has been granted by the Board of Directors;
- (h) for any claims for services occurring during waiting periods;
- (i) where an application form or claim form contains false or inaccurate information;
- (j) for services provided in a nursing home;
- (k) where the treatment is otherwise excluded by the operation of a Rule;
- (l) for any costs incurred where not specifically provided for under a benefit contained in the product selected;
- (m) for claims for services or treatments incurred prior to 24 calendar months before receipt of the claim in the office of the Fund. Compensation or damages cases that are lost in court by the Policy Holder or Insured Person have no time limit; or
- (o) for claims for services or treatments provided in countries outside of Australia.

Restricted Benefits

Benefits are not payable for the professional services of registered Podiatric surgeons.

Compensation Damages and Provisional Payment of Claims

- (a) Fund benefits are not payable under any Fund policy in respect of expenses incurred for hospital or general treatment where a person has received or established a right to receive a payment by way of compensation or damages (including a payment in settlement of a claim for compensation or damages) under the law that is or was in force in a State or Internal Territory, which, in the opinion of the Fund, includes an amount for hospital or other expenses equivalent to the Fund benefit that would otherwise be payable under the policy.
- (b) Where the amount of the entitlement for compensation or damages is, in the opinion of the Fund, less than the Fund benefit that would otherwise be payable under the policy but for the preceding rule in respect of the expenses incurred for that hospital treatment, Fund benefits are payable. The amount of Fund benefit payable shall not exceed the difference between the amount of Fund benefit that would otherwise have been payable and the amount of the entitlement for compensation or damages.

CLAIMING

General

Claims

All claims must be submitted to the Fund, by the Policy Holder or authorised benefit recipient;

- (a) on the prescribed claim form; and
- (b) supported by the scans of or original invoice and/or receipt on the provider's letterhead or showing the provider's official stamp, and showing the following:
 - The provider name, provider number and address;
 - The provider's qualifications;
 - The date of service;
 - The description of the service provided;
 - The patients full name and address;
 - The amount(s) charged; and
 - Any other information as may be reasonably required by ACA Health.

Where a claim has been made electronically, the provider and the Insured Person agree to provide any information in relation to the claim, in the form and within the time frames requested by the Fund. Any failure to cooperate with the Fund may result in the Fund requesting that the benefit paid in relation to the claim be repaid to the Fund.

Documents Remain the Property of the Fund

All documents submitted in connection with a claim or an audit of an electronic claim becomes the property of the Fund, unless otherwise agreed by the fund.

Claim to be Lodged within 24 months

Benefits will not be paid on expenses incurred prior to twenty-four whole calendar months before receipt of the claim in the office of the Fund. Compensation or damages cases that are lost in court by the contributor have no time limit.

Other

Policy Holder is the Claimant

All claims must be submitted by the Policy Holder unless the Policy Holder has made arrangements in writing for Insured Persons to claim independently on the policy, making them an Authorised Benefit Recipient. Where arrangements have been made to allow an Insured Person to claim

independently, this arrangement will continue until the Fund has been informed in writing, by the Policy Holder that the arrangement is to cease.

Payment of Claims to Policy Holders

ACA Health will pay benefits, for paid claims against a policy, to the Policy Holder unless the Policy Holder has provided permission to the Fund to pay the benefits to another person. This can be done by electing that an Insured Person be eligible to receive benefits with respect for services relating to claims for themselves, or by electing a third party by indicating this each time on the claim form. Where arrangements have been made to allow an Insured Person to receive benefits on their claims independently, this arrangement will continue until the Fund has been informed in writing, by the Policy Holder that the arrangement is to cease.

Manner of Benefit Payment

- (a) ACA Health may pay benefits by cheque or electronic funds transfer in accordance with arrangements it determines from time to time.
- (b) ACA Health will endeavour to pay benefits to Policy Holders either by cheque or electronic funds transfer in accordance with the election made on the claim form, however where the Fund is unable to be certain of the banking information supplied, ACA Health will produce a cheque.
- (c) Where incorrect payment details have been provided by the claimant (Policy Holder or Insured Person) the claimant is responsible for all costs associated with the recovery of the payment. Where the claimant is unwilling to pay the cost to recover the amounts paid by the Fund in satisfaction of the claim, the claimant's benefit entitlement in relation to the claim is considered extinguished by the health fund.

CONSUMER POLICIES

Privacy Policy

ACA Health is committed to maintaining the privacy of individuals whose personal information we collect in accordance with the National Privacy Principles (NPPs) and the Privacy Act. The Fund is bound by the NPPs, however as a non-profit organisation certain exemptions under the Privacy Act may apply.

Our policies on the management of personal and sensitive information in accordance with the terms of National Privacy Principle (“NPP”) number 5.1, are set out below.

Why ACA Health Collects Information

The Fund collects personal information about Insured Persons not only when they join the Fund, but from time to time during their membership, and on leaving membership.

The personal information collected either by, or on behalf of the Fund, will only be used for the purposes of administering the Fund, including the determination of entitlement to benefits, the calculation and payment of those benefits and the collection of contributions together with related regulatory requirements such as member communication and reporting.

The Fund, and its delegates, will only use the personal information collected for the purposes outlined above. The Fund will *not* use information collected for any other purpose, unless the individual gives his or her consent. A Policy Holder providing information about dependants will be responsible for making dependants aware that personal information has been provided for the purposes outlined above.

What Information is collected and how is it used?

The Fund engages various service providers to assist in the tasks involved in managing the Fund. Those providers include:

- Hospital and Medical Contracting Suppliers;
- Auditors;
- Insurers; and
- Software Systems Suppliers and Consultants.

The Fund undertakes to contact each provider and obtain:

- reassurances that they comply with the legislation; and
- a copy of their Privacy Policy.

In order to be able to administer the Fund, key personal information about Insured Persons is collected and stored.

Such information includes:

- Name;
- Address;
- Date of birth;
- Gender;
- Contact telephone numbers;
- Dependants details as above and relationship to the Policy Holder; and
- Bank account details or credit card details for direct debit.

In particular, the Fund uses the information to provide all relevant administration services, which include:

- Recording contributions;
- Retaining membership records; and
- The payment of benefits.

With respect to Medicare Australia matters, the Fund stores the Medicare number of Insured Persons for the purpose of making direct claims on Medicare Australia on behalf of the Insured Person who has received in-hospital services under our Access Gap Cover scheme as well as applying for the Federal Government 30% rebate on private health insurance.

“Sensitive” Information

Special rules apply to “sensitive” information which includes “health information”. For example, with respect to Pre-Existing Ailments/Conditions, the Fund will need to collect a variety of information, which might include details as to Insured Person’s medical conditions (including medical reports), and the like. The information collected will be used to determine eligibility to benefits during the first 12 months of membership or at the time of an upgrade to a higher level of cover. The Fund will provide Insured Persons with further information in that regard when they are asked to provide health information.

Disclosure of Information

The Fund will only disclose personal information where directly necessary to perform its services outlined above. The Fund will *not* otherwise disclose any personal information that has been collected unless:

- Express consent is given by the individual affected; or
- Law requires disclosure.

The Fund undertakes to Insured Persons not to disclose sensitive information without their consent. For dependants age 14 and over consent will be necessary. For dependants under 14, discretion will be used by the Fund in determining if disclosure will be made to the Policy Holder.

Access by Individuals to Information Collected

Individuals will have access to their own personal information collected by the Fund and are able to notify the Fund of any corrections which need to be made. The Fund will only grant access by an individual to personal information where the individual's identity has been confirmed by the Fund through appropriate identification procedures.

Security of Information

Personal information collected by the Fund may only be accessed by Fund employees, agents and delegates. Given that the Fund outsources various functions, the security of the interface with those providers is critical, and the Fund has addressed this issue. Each service provider is responsible for taking reasonable precautions to protect the security of personal information it holds.

Questions or complaints about the Fund's privacy policy and practices may be directed to:

Privacy Officer 1300 368 390
ACA Health Benefits Fund info@acahealth.com.au
Locked Bag 2014
Wahroonga NSW 2076

Complaints Policy

We are keen to hear from you to be able to improve our service. This could be through feedback you give us or through a complaint you make. A complaint is an opportunity for the staff and management to find out about when you believe we are not doing well and use that information to improve the products and service we provide to our members.

Definition of complaint

A complaint is when you let us know that you are unhappy with something about our product or service, and you want some specific result from your complaint. Because we need to contact you about the result, a complaint cannot be anonymous.

If you want to remain anonymous but want to let us know how you think we could do better, please send us your suggestions.

How and where to complain

You can provide your feedback by talking to us (face to face or over the phone), or in writing.

What happens with your complaint?

All complainants will be dealt with fairly, equitably and with respect and dignity. We will also try to resolve complaints to the satisfaction of the complainant in the shortest time possible.

ACA Health

1300 368 390

Locked Bag 2014

info@acahealth.com.au

Wahroonga NSW 2076

Complainants and other people who provide information will not be disadvantaged in any way as a result of making a complaint. If you wish, we will discuss what we can do to make sure you are still comfortable using our products and services after you have made a complaint.

All information provided will be kept confidential between you and ACA Health. All documentation will be distributed within the Fund on a "need to know" basis only. We will keep notes about your complaint for statistical and analytical purposes.

When you make a complaint, it would be helpful if you said what you want as a result of your complaint. This could be a review of a decision not to pay a benefit, an apology, or a change in the way we do things.

Our Customer Service Team will work to resolve your complaint as soon as possible. If they are unable to resolve the problem or you are unhappy with the outcome, your complaint may be escalated to our Complaints Officer (ACA Health Manager).

Our Complaints Officer will acknowledge the receipt of your complaint and aim to resolve the problem within 2-3 weeks, but if it takes longer you will receive weekly updates. At the end of the process we will tell you the outcome of your complaint in writing. If you are not happy with the outcome of your complaint, you can take it to the ACA Health Board of Directors.

To make a complaint, contact the Commonwealth Ombudsman at www.ombudsman.gov.au or call 1300 362 072.

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

The Ombudsman's office may ask you whether you have attempted to resolve the conflict directly with the Fund.

Private Health Insurance Code of Conduct

The Private Health Insurance Code of Conduct has been developed by the private health insurance industry with the aim of ensuring Funds provide clear information and transparency in relationships with consumers.

ACA Health is a signatory to the Code of Conduct, promising that we will:

- Work towards improving the standards of practice and service in the private health insurance industry;
- Provide information to you in plain language;
- Promote better informed decisions about our private health insurance products and services by;
 - ensuring that policy documentation is full and complete;
 - providing clear explanations of the contents of the policy documentation when asked by you; and
 - ensuring that persons providing information on health insurance are appropriately trained.
- Provide information to you on your rights and obligations under your relationship with ACA Health, including information on the PHI Code of Conduct; and
- Provide you with easy access to our internal dispute resolution procedures, which will be undertaken in a fair and reasonable manner, and advise your rights to take an issue to an external body such as the Commonwealth Ombudsman.



Note:

A copy of the Private Health Insurance code of conduct is available online at www.privatehealthcareaustralia.org.au/codeofconduct/

Rates Paid to Non-contracted Hospitals

ACA Health will pay the Federal Government Default Benefit where the hospital is not eligible for the second tier and does not have a "Hospital Purchaser - Provider Agreement" with the Fund. Out of pocket gaps may apply.

Please check with the Fund and hospital prior to admission.





ACA Health Benefits Fund
is a restricted member, registered
Health Fund operated by
ACA Health Benefits Fund Limited.

Information in this brochure was
correct at time of printing. Changes
may occur by Board of Directors
actions. The operation of the Fund is
governed by the Fund Rules.

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