Membership Terms and Conditions

westfund Health Insurance

Please read this document carefully and retain it for future reference.
These Terms and Conditions should be read in conjunction with the Policy Summary relevant to you. Please refer to Westfund's registered Fund Rules at **www.westfund.com.au/terms-conditions** or by calling Westfund on 1300 937 838.

A7 Changes to Rules

A7.1 The Fund may vary, delete or add to Westfund's Fund Rules at any time in accordance with the PHI Act with effect as set out in the relevant notice, whether or not Premiums have been paid in advance. Changes to rules apply to all Members immediately regardless of a Member's paid to date.
A7.3 The rules of the Fund that are in force at the date of the provision of a service for which a Fund Benefit under Westfund's Fund Rules is provided, are the rules which shall govern the provision of that Fund Benefit. If a Benefit is claimed for a service that occurred before the commencement of Westfund's Fund Rules and the Member was entitled to a Benefit under the previous rules then the Benefit payable shall be in accordance with the previous rules.

C MEMBERSHIP

C1 General Conditions of Membership

C1.1 Members shall have the right to obtain from Westfund, the Benefits and/or services as provided under Westfund's Fund Rules.
C1.2 All Members under the same Policy shall belong to the same Insured Group, and have the same Policy.
C1.3 There are eight types of Insured Group representing Policies Westfund may choose to offer from time to time:
• Only one person referred to as a Single Policy
• Only two Adults referred to as a Couple Policy
• Only one Adult and at least one Dependant Child or Non Classified Dependant referred to as a Sole Parent Family Policy
• Two Adults and at least one Dependant Child or Non Classified Dependant referred to as a Family Policy
• Only one Adult and at least one Adult Dependant and any number of Dependant Children and/or Non-Classified Dependants referred to as an Adult Dependant Sole Parent Family Policy
• Two Adults and at least one Adult and any number of Dependant Children and/or Non-Classified Dependants referred to as an Adult Dependant Family Policy
• Only one Adult and at least one Adult Disability Dependant and any number of Adult Dependants, Dependant Children and/or Non-Classified Dependants referred to as an Adult Disability Dependant Sole Parent Family Policy
• Two Adults and at least one Adult Disability Dependant and any number of Adult Dependants, Dependant Children and/or Non-Classified Dependants referred to as an Adult Disability Dependant Family Policy.
C1.4 A Member may contribute to any of the following Policies offered by Westfund in the Member's State of Residence:
• any one Policy set out in Schedule J that provides Hospital Treatment
• any one Policy set out in Schedule I that provides General Treatment but not including Hospital-Substitute Treatment
• any combination of a Hospital Treatment Policy and General Treatment Policy (that may include Hospital-Substitute Treatment) set out in Schedules I and J
• any one Policy set out in Schedule J that provides both Hospital Treatment and General Treatment (which may include Hospital-Substitute Treatment).

C2 Eligibility for Membership

C2.1 Subject to Westfund's Fund Rules any person who is 18 years of age or more is entitled to apply in his or her own right as a Primary Member. Persons aged 14 to 17 years (inclusive) will be considered on a case by case basis.
C2.2 Any person who applies for a Policy shall be known as the Primary Member. The Primary Member may also apply to cover his or her Partner or Dependants. A Primary Member may not receive Benefits in respect of any person other than the Primary Member unless that person is registered on the Policy as a Dependant.
C2.3 A person may not concurrently have a Policy that covers Hospital Treatment with the health benefits fund of another private health insurer and Westfund.
C2.4 Subject to Westfund's discretion a person may not concurrently have a Policy that covers General Treatment with the health benefits fund of another private health insurer and Westfund.
C2.5 A person may be a Member of Westfund and a policy holder with another health benefits fund of another private health insurer, where a Hospital Treatment Policy is held with one private health insurer and a General Treatment Policy is held with the other private health insurer.

C3 Dependants

C3.1 A Primary Member may register their Partner and/or Dependant on an appropriate Policy other than a Policy for an Insured Group of one person.
C3.2 A newborn child of a Member will be covered if they are added to an eligible Policy (refer Rule C1.3) within three months of birth. In this case, continuity of cover applies to the newborn child. The child must be added prior to making a claim.
C3.3 Westfund, at its discretion, may allow a Primary Member to register as a Dependant, a person already registered as a Dependant on another Policy (even if with another health benefits fund), provided that the Primary Member is the parent or guardian.
C3.4 A person who ceases to be a Dependant (even if with another private health insurer) may join Westfund as a Primary Member without any additional Waiting Periods provided the new Policy does not provide a higher level of Benefits. Where the new Policy provides a higher level of Benefit, Waiting Periods will apply to the difference in Benefits.
C3.5 If a person was a Member (even if with the health benefits fund of another private health insurer) immediately prior to becoming a Dependant on a different Policy, the person's Policy will be regarded as continuous.

C4 Membership Applications

C4.1 A person may apply to be a Member by:
a) Completing the specified application form, or
b) Completing an application online and providing an online acknowledgement and acceptance of the terms and conditions of membership, or
c) Completing an application over the phone and providing a recorded acknowledgement and acceptance of the terms and conditions of membership, and by providing any additional information relevant to the application requested by Westfund.
By making an application pursuant to paragraphs (a), (b) or (c) the applicant agrees that, in respect of any application or claim form signed by the applicant or another person covered under the relevant Policy and permitted by Westfund's Fund Rules, the signing of the form constitutes consent given by the signatory of the form (and if the form is not signed by the applicant, an undertaking by the applicant to procure such consent) in favour of the Hospital or other relevant authorities authorising them to supply any information to Westfund or its agent.
C4.2 The applicant must be the person who will be the Primary Member unless an application is being submitted by an agent approved by Westfund on behalf of the applicant.
C4.3 An applicant who intends to pay his or her Premiums by direct debit must accompany his or her application with a payment equivalent to at least:
• one week in the case of weekly direct debit
• one fortnight in the case of fortnightly direct debit
• one month in the case of monthly direct debit
• one year in the case of yearly direct debit for Ambulance members.
C4.4 Applicants who intend to pay their Premiums directly (over the counter/mail/BPAY) or through a payroll group must provide at least one month's Premium with their application. In the case of Ambulance Members, they must pay one year's Premium.
C4.5 Westfund will not refuse any Policy application on the ground of any of the matters set out in Rule A6.1 of Westfund's Fund Rules.
C4.6 If Westfund has exercised its rights to terminate a Policy, Westfund shall have the right to refuse an application for a Policy from a former Member who has been terminated.

Membership Terms and Conditions

C4.7 Where an application is refused, Westfund shall provide a reason for the refusal.
C4.8 The Partner of a Primary Member may deal with Westfund in respect of all other matters concerning the Policy except for the addition or subtraction of a Dependant and the change of Policy. The Primary Member may provide his or her Partner with these additional powers by granting spousal authority via written authorisation or by recorded acknowledgement over the telephone.
C4.9 Westfund may require proof of identity, age, and previous health cover at the time of an initial application for a Policy and at the time of any application to change the Policy or Dependants.
C4.10 Westfund will inform any person enquiring in relation to Complying Health Insurance Products about Private Health Information Statements and how to obtain a copy. Westfund will provide a copy of the relevant statement if the person so requests.
C4.11 Westfund will provide an up to date copy of the relevant Private Health Information Statement when an Adult first becomes insured. This statement will be provided to the Primary Member.

C5 Duration of Membership

C5.1 Provided that the first Premium has been paid, the commencement date of a Policy shall be the later of:
• the day the Policy application is accepted by Westfund; or
• the date nominated by the applicant and accepted by Westfund;
except that in the case of transferring members, an earlier date may be agreed at the discretion of Westfund being a date up to 2 months prior to the date the application is received for the purposes of maintaining continuity of cover.
C5.2 A Policy will continue while Premiums continue to be paid until cancellation by the Primary Member, Partner with spousal authority or cancellation by Westfund due to failure of a Member to observe Westfund's Fund Rules.
C5.3 In respect of Policy review period (cooling off period), new Members and Members who have transferred to another Westfund Policy are entitled to a review period of 30 days from the date the Policy or the changed Policy commences.
Primary Members who decide during this review period that they do not want the Policy or want to change it in any way, will either be refunded their Premiums or transferred to a more appropriate Policy effective from the original date of application.
If a Primary Member chooses to change to a Policy with greater Benefits from the original date of application he or she will be required to pay any difference in Premiums from that date and will be subject to Waiting Periods associated with the higher level of cover.
The review period does not apply if a Member makes a claim in respect of the 30-day review period.

C6 Transfers

C6.1 When a Member of another private health insurer Transfers to Westfund with a gap in Policy of thirty (30) days or less:
- Westfund may apply all relevant Waiting Periods to any Benefits under the Westfund Policy that were not provided under the previous policy;
- the unexpired portions of any Waiting Periods not fully served under the previous policy will apply;
- where the Benefits that would have been provided under the previous policy are lower than the Benefits payable by Westfund, the lower Benefits will apply for the relevant Waiting Period;
- where the previous policy carried a higher Excess or Co-Payment, the difference between any Excess or Co-Payment payable under the previous policy and the new Policy will apply for the relevant Waiting Period.

This Rule C6.1 is subject to Rule F3.5.
C6.2 When a Member of another private health insurer Transfers to Westfund with a gap in Policy of more than thirty (30) days, Westfund will treat the Member as a new Member and will apply any relevant Waiting Periods in full.
C6.3 Where a Westfund Member Transfers to another Westfund Policy he or she shall be treated as a Transfer from the health benefits fund of another private health insurer in relation to the application of Waiting Periods.
C6.4 Where a Member Transfers from the health benefits fund of another private health insurer or to a different Westfund Policy, any Benefits that have been paid that were subject to an annual or other limits under the previous policy may be taken into account in determining the Benefits payable under the new Policy.
C6.5 Incremental Benefits or Benefit limits paid in relation to the policy held at the health benefits fund of the previous insurer or with Westfund may be taken into account when determining any incremental Benefit or Benefit limit where the increment requires an accrued term of a specific Policy.
C6.6 A Waiting Period will not apply to a Policy that covers a person who holds a gold card or was entitled to treatment under a gold card (as defined in the PHI Act) or to members of the Australian Defence Force or people in Antarctica who have health cover provided as part of their employment.
C6.7 Westfund will provide in the approved form and within the period set out in the Private Health Insurance (Complying Product) Rules a Transfer certificate where a person ceases to be insured with Westfund.
C6.8 Westfund will request in the approved form and within the period set out in the Private Health Insurance (Complying Product) Rules a Transfer certificate from a person's previous insurer where this has not been provided within 7 days of the person becoming insured by Westfund.

C7 Cancellation of Membership

C7.1 A Primary Member or a Partner with spousal authority may:
• cancel the Policy;
• remove Dependants from the Policy.
C7.2 Westfund will refund Premiums paid in advance when a Policy ceases only where required to do so by law or where specified in Westfund's Fund Rules. Westfund may at its discretion upon written request refund Premiums paid in advance from the date of receipt of that request and after allowing an appropriate administrative charge.
C7.3 A Dependant aged at least 16 years of age may leave the Policy. A Dependant under 16 years of age may leave the Policy with the agreement of the Primary Member. Westfund will notify a change of this nature in writing to the Primary Member and the Dependant.
C7.4 A request to cancel a Policy must be in writing, in person or by recorded confirmation.
C7.5 The date of cessation of a Policy will be the later of the date requested by the Member or the date of receipt by Westfund of the relevant communication from the Member except that in the case of Transferring Members, an earlier date may be agreed at the discretion of Westfund being a date up to 2 months prior to the date the cancellation request is received for the purposes of avoiding overlap of cover.
C7.6 A Primary Member who has been given rate protection due to his or her Premiums being paid in advance and who cancels his or her Policy before the end of the period paid in advance will lose his or her rate protection.

C8 Termination of Membership

C8.1 Westfund shall not have the right to terminate the Policy of any Member on the ground of any of the matters set out in Rule A6.1 of Westfund's Fund Rules.
C8.2 Westfund shall have the right to terminate the Policy of a Member from the date of notification to that Member, if any Member in that Policy has, in the opinion of Westfund, committed or attempted to commit fraud upon Westfund. Any Premiums paid in advance of the date of cancellation of the Policy may be first applied by Westfund to offset the cost of the fraud or attempted fraud, with Westfund being only liable to the Member of the cancelled Policy for any balance remaining.

Membership Terms and Conditions

C8.3 Westfund shall have the right to terminate the Policy of a Member if the application for the Policy for that Member contained inaccurate or incomplete information in a material respect and such right may be effected from the date such Policy commenced. "Material" means that Westfund could have made a different decision if provided with accurate and/or complete information.
C8.4 Westfund shall have the right to terminate a Policy if any Member with a Hospital Treatment Policy concurrently has a Hospital Treatment Policy with the health benefits fund of another private health insurer.
C8.5 Where permitted by law, Westfund may terminate a Policy in circumstances other than those specified at C8.2, C8.3 or C8.4. In these circumstances Westfund will communicate with the Primary Member advising of the reason for the termination and provide the Primary Member with at least one month's notice of the date of the termination.
C8.6 Westfund 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 the Member.
C8.7 Where Premiums are more than two months in arrears the Policy is terminated except at the discretion of Westfund. The Member remains liable for unpaid Premiums.
C8.8 Where a Policy has been terminated for non-payment of Premiums, the Member must complete a new application. Westfund may at its discretion and subject to payment of the Premium arrears, agree to waive Waiting Periods and reinstate any accumulated Benefit entitlements.
C8.9 Westfund will notify the Primary Member in writing where the Policy has been or will be terminated.
C8.10 A Member can be terminated from a Policy due to death under the following circumstances:
• If the termination is requested by an existing Spouse on the same Policy that has been granted spousal authority
• If the termination is requested by a person with power of attorney (power of attorney documentation to be supplied)
• If a Death Certificate is supplied
• In the event that any of the above circumstances cannot be met, Westfund may terminate a Member from a Policy due to death after receiving appropriate documentation as determined by Westfund.

C9 Temporary Suspension of Membership

C9.1.1 Westfund may allow suspension of a Policy or Member on grounds other than those listed in C9.2, C9.3, C9.4 for such periods and subject to such criteria as it, in its absolute discretion, allows.
C9.1.2 Any Policy (excluding Ambulance) is eligible for suspension.
C9.1.3 A Member listed on a Policy (excluding Ambulance) is eligible for suspension.
C9.1.4 Health services provided during a suspension of a Policy or Member shall not be eligible for Benefits.
C9.1.5 A suspension of a Policy or Member shall not qualify for the purpose of completing any Waiting Periods or Claimable Periods that are to be served by a Member before the Member is eligible to receive Benefits.
C9.1.6 A minimum of six months must elapse from the end of the previous suspension period for the same suspension reason.
C9.1.7 Continuity of the Policy for the purposes of Lifetime Health Cover is subject to the provisions of section D5 of Westfund's Fund Rules.
C9.1.8 Westfund may suspend a Policy or Member upon application by the Primary Member or Spouse/Partner with spousal authority.
C9.1.9 If any criteria set out in C9.2, C9.3 or C9.4 or determined under C9.1 are not met, Westfund will terminate the Policy or Member. Westfund at its discretion may allow reinstatement of the Policy or Member if all above mentioned criteria are met.
C9.2 Overseas Suspension
C9.2.1 Suspension of a Policy or Member may be granted by Westfund if the reason for the suspension is the temporary absence from Australia for more than two months and no more than 24 months provided that Premiums are paid from the date of return to Australia.
C9.2.2 A Policy will not be suspended unless paid to the suspension commencement date.
C9.2.3 Proof of departure such as a boarding pass, itinerary or airline ticket must accompany the Overseas Travel Suspension Form prior to leaving Australia.
C9.2.4 If a Policy or Member is leaving Australia within 6 months of a previous suspension period, proof of departure and the Overseas Travel Suspension Form must be supplied prior to leaving Australia; however the suspension commencement date must be 6 months from the end of the previous suspension period.
C9.2.5 A Policy or Member must be reinstated from the date of return to Australia. Reinstatement must be within one month of returning to Australia and proof of entry such as a boarding pass, itinerary or airline ticket must be supplied.
C9.3 Forced Retrenchment Suspension
C9.3.1 Westfund may suspend a Policy or Member (excluding a Dependant) who has had 3 continuous years of membership at the date of application for the Forced Retrenchment Suspension.
C9.3.2 Suspension of a Policy or Member may be granted by Westfund only if the following conditions have been met by the Member who has applied for the Forced Retrenchment Suspension:
• The Member is currently unemployed and has been unemployed for more than seven (7) consecutive days
• The Member's unemployment was a result of forced retrenchment and not caused by a voluntary act
• The Spouse/Partner of the Member, who has applied for the Forced Retrenchment Suspension, earns no more than the National Minimum Wage (Fair Work Commission) plus 30% per week
• The Member's employment, at the time of retrenchment, was within Australia
• Where the Member was self-employed, then the business must have been either legally declared bankrupt or have been placed into involuntary liquidation
• Where the Member's engagement was entered into on a "contractor" type arrangement, the forced retrenchment was not a result of a contract expiring. If the contractor is forced into retrenchment during the period of the contract and he or she satisfies all other criteria in C9.3 then he or she may be eligible for the suspension.
C9.3.3 The initial application for suspension due to forced retrenchment must be made within 3 months of the last day of paid employment.
C9.3.4 The Forced Retrenchment Suspension is applied from the date as declared on the Forced Retrenchment Suspension Form and is valid for one (1) calendar month or until such time that the criteria set out in C9.3.2 are no longer met, up to a maximum of six (6) consecutive calendar months.
C9.4 Protected Industrial Action Suspension
C9.4.1 Westfund may suspend a Policy or Member (excluding a Dependant) who has had 3 continuous years of membership at the date of application for the Protected Industrial Action suspension.
C9.4.2 Suspension of a Policy or Member may be granted by Westfund only if the following conditions have been met by the Member who has applied for the Protected Industrial Action suspension:
• The Member's union has been taking Protected Industrial Action for more than seven (7) consecutive days
• The Member's engagement, at time of Protected Industrial Action, was within Australia
• The Spouse/Partner of the Member, who has applied for the Protected Industrial Action suspension, earns no more than the National Minimum Wage (Fair Work Commission) plus 30% per week
• Where the Member's engagement was entered into on a "contractor" type arrangement, Protected Industrial Action was not a result of a contract expiring. If Protected Industrial Action is undertaken during the period of the contract and he or she satisfies all other criteria in C9.4 then he or she may be eligible for the suspension.

Membership Terms and Conditions

C9.4.3 The initial application for suspension due to Protected Industrial Action must be made within 3 months of the last day of paid work.
C9.4.4 A Protected Industrial Action suspension may be granted provided the Protected Industrial Action Suspension Form is supported by written confirmation from the Member's union that the Member is unable to work due to Protected Industrial Action. The written confirmation is effective for the period of Protected Industrial Action or one (1) week from the date of the written confirmation, whichever is longer. The written confirmation may be renewed, and the suspension may be extended for successive periods of one (1) week to a maximum of six (6) consecutive calendar months.

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Premiums payable for each Policy are set out in Westfund's Rates Schedule. A membership quotation is available on request.
D1.2 Westfund may, at its discretion, approve any group of Members as a Contribution Group.
D1.3 A Member must pay Premiums at the rate for the chosen Insured Group and Policy. Premiums may be paid by a Member or on behalf of a Member by an agent approved by Westfund.
D1.4 Any Premiums paid by a Recognised Provider on behalf of a Member other than the Provider's Spouse, Partner or Dependant shall be returned to that provider if the Member attempts to claim Benefits for services rendered by the provider. The Member's Premium status will be adjusted accordingly.
D1.5 All Premiums must be paid in advance, but a Policy cannot be more than 18 months Premiums in advance in total.
D1.6 An amount received as a Premium for a particular Policy shall be applied first in payment of any arrears of Premiums and then applied in respect of future periods.
D1.7 Premiums may vary between States. A Member will be required to pay the Premium for the State in which he or she resides as advised to Westfund. If a Member changes his or her State of Residence, the Premium for that new State or Territory will apply from the date of the change of residence.
D1.8 Any refund of Premiums received will be limited to the period of 2 years prior to the date of the receipt by Westfund of written notification of the circumstances which would render a Member or Dependant ineligible to receive Benefits. This circumstance may arise for example where a Member concurrently held equivalent Policies with two private health insurers. A Member would be ineligible for a refund if a Benefit has been paid under the Policy.

D2 Contribution Rate Changes

D2.1 Westfund has the right to change Premiums in accordance with the requirements of the PHI Act.
D2.2 Westfund will advise the Primary Member in writing of the new Premiums before they take effect in accordance with the requirements of the PHI Act.
D2.3 In respect of changed Premiums, where a Member's Premiums are paid in advance, Westfund will apply the new Premiums from the date to which those Premiums are paid in advance.
D2.4 A Member who has been given rate protection due to his or her Premiums being paid in advance and who cancels his or her Policy before the end of the period paid in advance will lose his or her rate protection and his or her Policy period will be adjusted accordingly.

D3 Contribution Discounts

D3.1 The only discounts provided will be those permitted as set out in section 66-5 of the PHI Act. The maximum percentage discount allowed is 12% per annum.
D3.2 The discount for a Policy is the difference between the full Premium and the net Premium and is calculated in accordance with the Private Health Insurance (Complying Product) Rules. The full Premium for a Policy is the Premium without any reductions due to circumstances as set out in section 66-5 of the PHI Act.
D3.3 Westfund may offer to all eligible Members in a Contribution Group a discount which:
(i) is also available for that reason under every Policy in the product;
(ii) is determined at the same time as Westfund's Premium changes are determined;
(iii) subject to (i) above, is offered on such conditions as are determined by Westfund;
(iv) is certified by Westfund's Appointed Actuary as being prudent and equitable;
(v) applies from the date and for the period specified by Westfund.

D4 Age-Based Discounts

D4.1 The Fund may operate the Age-Based Discount arrangement referred to in section 66-5(3)(ea) of the PHI Act. An insurance Policy must not provide an Age-Based Discount unless;
(a) the Policy covers:
(i) Hospital Treatment; or
(ii) Hospital Treatment and General Treatment; and
(b) the discount will be a reduction in the amount that would otherwise be payable by the person for the Policy, equal to the dollar amount calculated in accordance with the PHI Act; and
(c) the discount will apply to each person insured under the Policy who, on the Discount Assessment Date for the person:
(i) was within one or more ranges of ages, between 18 and 29 (inclusive), that are specified in the Policy as eligible for the discount; and
(ii) was not a Dependant under the Policy; and
(d) while Age-Based Discounts are available under the Policy, the discount will continue to apply until it is reduced to zero in relation to each such person insured under the Policy; and
(e) the Policy states whether it is a Retained Age-Based Discount Policy.
D4.2 A person's base percentage is calculated using the formula as set out in the PHI Act and corresponds to the person's age at the Discount Assessment Date:

Person's age at Discount Assessment Date	Percentage
18 or older, but under 26	10%
26	8%
27	6%
28	4%
29	2%

D4.3 Once an eligible person turns 41 years of age; the Age-Based Discount will be removed incrementally as set out in the PHI Act; as per the below table:

If, for that period, the person is aged:	the person's percentage for the period is:
18 or older, but under 41	the person's base percentage
41	the person's base percentage minus 2 percentage points
42	the person's base percentage minus 4 percentage points
43	the person's base percentage minus 6 percentage points
44	the person's base percentage minus 8 percentage points
45 or older	zero

D5 Lifetime Health Cover

D5.1 The Fund shall operate the Lifetime Health Cover (LHC) arrangements in accordance with the PHI Act. Without limiting the foregoing:
• The Fund is required to charge different Premiums for Hospital Policies depending on the age at which a person first takes out a Policy which covers Hospital Treatment and the continuity of such coverage;
• A person who joins a health fund earlier in life and maintains a Policy which covers Hospital Treatment pays a lower Premium than someone who joins later in life due to Lifetime Health Cover loading;

Membership Terms and Conditions

• From 1 July 2000, Premiums for people taking out a Hospital Policy after turning 30 years of age must include a loading of 2 per cent on the Base Rate Premium for the person's Hospital Policy each year his or her Lifetime Health Cover Age exceeds 30 years. The maximum loading is 70 per cent of the Base Rate Premium for the Member's Hospital Policy;
• Where a Hospital Policy covers more than one Adult, the amount of any increase in the Premium due to the application of Lifetime Health Cover loading is calculated using the averaging method in section 37-20 of the PHI Act;
• Premium increases stop after 10 years continuous cover (not counting any Permitted Days Without Hospital Cover), but may start again if the Member ceases to have a Policy which covers Hospital Treatment as specified in the PHI Act. Lifetime Health Cover recognises continuous cover even if the Member has had a Policy which covers Hospital Treatment from more than one health fund;
• Continuity for the purposes of Lifetime Health Cover is preserved during a period in which the Member ceases to have a Policy which covers Hospital Treatment for a cumulative period of 1,094 days or otherwise in accordance with the PHI Act (known as Permitted Days Without Hospital Cover). However, after exceeding 1,094 Permitted Days Without Hospital Cover, a person must pay an additional loading of 2% of the Base Rate Premium for every year without Hospital cover (excluding Permitted Days Without Hospital Cover) on top of any previous loading. If a person takes out a Hospital Policy again after exceeding 1,094 Permitted Days Without Hospital Cover, the person must re-serve 10 years of continuous Hospital cover before Premiums stop increasing.
• People born on or before 1 July 1934 are not affected by Lifetime Health Cover. If people in this age group take out a Hospital Policy at any time in the future they will pay the Base Rate Premium, with no loading for late entry.

D6 Arrears in Contributions

D6.1 If a Member has not made a Premium payment prior to the 'paid to' date, then that Member shall be regarded as being in arrears.
D6.2 If a Member is less than two months in arrears, the Member may pay all Premiums in respect of the period in arrears and the Member will then be eligible for Benefits in respect of that period.
D6.3 When a Member is more than two months Premiums in arrears then his or her Policy shall be terminated from the last 'paid to' date of the Policy except at the discretion of Westfund.
D6.4 No Benefits shall be paid for services rendered to a Member during the period in which his Policy is in arrears until the arrears in Premiums are paid.

D7 Other

D7.1 Some Policies provide for waiver of Premiums for financial hardship. Where this is provided in a Policy, the circumstances, terms and conditions are as follows.
D7.2 Hardship Provision
D7.2.1 Westfund may allow upon application by the Primary Member or Spouse/Partner who is covered by the same Westfund Policy, who has had 3 continuous years of membership at the date of application for the hardship provision. Payment of Premiums may be delayed by up to 6 months under this hardship provision where application has been received by Westfund within two (2) months of the Policy's "paid to" date being in arrears.
D7.2.2 If a Policy is in arrears on a Hospital (Schedule J) or combined Hospital and General Treatment Policy (Schedule J) because of being temporarily unable to work due to illness or other incapacity, strikes, lockouts or any other hardship provision agreed to by Westfund and provided that the Member undertakes in writing that, after he or she resumes work, Premiums will be paid weekly, at double the weekly rate, until such arrears are repaid, then notwithstanding other rules to the contrary, and at the discretion of Westfund, Benefits for any Member on the Policy shall continue to be paid while the Policy is in arrears, but for not more than six (6) months after the "paid to" date. Payment of Benefits is conditional on the Member, who has applied for the hardship provision, having furnished such evidence as Westfund requires as to his or her good faith in the making to the undertaking.

E BENEFITS

E1 General Conditions

E1.1 Westfund offers health Benefit entitlements to its Members in accordance with the chosen Policy and the rules in force and the Benefits payable at the date on which the service was provided, subject to any applicable limits.
E1.2 Benefits are only payable for:
a) Hospital Treatment, and/or
b) General Treatment.
E1.3 Westfund may request any medical or other evidence, which it considers necessary to determine eligibility for Benefits.
E1.4 Benefits are only payable where services or appliances are provided by a Recognised Provider.
E1.5 Westfund has no liability to a Member for negligence, losses, costs, damages, suits or actions arising through the provision of services to any Member by any Recognised Provider.
E1.6 The following conditions apply to all Benefits:
•Benefits are only payable for services rendered by providers who are recognised by Westfund and in private practice (Recognised Provider); as per the Private Health Insurance (Accreditation) Rules. Recognition by Westfund is for Benefit payment purposes only and is not to be construed as any recommendation of the qualifications and services provided by a provider;
•Benefits shall not be payable for services which occurred earlier than 24 months before the lodgement of a valid claim;
•Benefits must not exceed 100% of the documented cost to the Member of any service or item for which Benefits are payable;
•Where monies are payable from more than one source for a service, Westfund may limit the Benefit so that the amount payable from all sources does not exceed the amount charged;
•Benefits are not payable in respect of services or treatment performed by a Recognised Provider to a Member where Premiums in respect of that Member have been paid, or contributed to, by that Recognised Provider;
•General Treatment Benefits are not payable for services or treatment performed or recommended by a Recognised Provider to the provider's business partner, or to the Spouse, Partner, parents or Dependants of the provider;
•Benefits are not payable in respect of Dependants of Dependants registered on a Policy.
E1.7 Westfund may, in lieu of Benefits, provide services or appliances to a Member or Dependants.
E1.8 Where Benefits are determined as a percentage of the receipted cost of a service and the receipted cost of a service appears excessive, Westfund has the right to determine the Benefit from the Usual, Customary and Reasonable Charge it determines for that service.
E1.9 In the event that a Benefit has been erroneously paid (claim was not properly payable under Westfund's Fund Rules) then Westfund shall be entitled to recover any such amount or deduct the amount from any other Benefits payable in respect of the Policy or any Premiums paid in advance.
E1.10 Notwithstanding Westfund's Fund Rules, Westfund shall have the right to relax any particular term or condition in specific instances and Westfund shall also have the right to provide, without prejudice, an ex gratia payment.
E1.11 Benefits are only payable for treatments, health care goods and services provided in Australia.
E1.12 Waiting Periods are as detailed in Part F3 of Westfund's Fund Rules.
E1.13 Other conditions relating to Benefits, Limitation of Benefits and Claims are detailed in Parts E, F and G of Westfund's Fund Rules.

E2 Hospital Treatment

E2.1 Hospital Benefits are payable in relation to the cost of Hospital Treatment.
E2.2 Hospital Treatment Benefits provided in Policies set out in Schedules J excludes:
• treatment which involves a procedure that has an item number that is specified in clause 8 of Schedule 3 of the Private Health Insurance (Benefit Requirements) Rules, if no certificate for that procedure has been provided under clause 7 of that Schedule;

Membership Terms and Conditions

•treatment provided to a person at an emergency department of a Hospital;
•treatment provided to a person who is not a patient within the meaning of that word in paragraph (b) of the definition of 'patient' in subsection 3(1) of the Health Insurance Act 1973 ('patient' does not include a newly born child whose mother also occupies a bed in the Hospital except in certain specified circumstances);
•treatment which is part of a Chronic Disease Management Program that is intended to delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease;
•the cost of care and accommodation in an aged care service (within the meaning of the Aged Care Act 1997);
•a charge for a pharmaceutical benefit supplied under Part VII of the National Health Act 1953, unless the circumstances of the charge are covered by section 92B of that Act;
•any other treatment specified in the Private Health Insurance (Complying Product) Rules as a treatment for which Benefits must not be provided.
E2.3 Westfund will pay Benefits for Hospital Treatment at least equivalent to the following:
•The amount detailed in the Private Health Insurance (Benefit Requirements) Rules as the minimum Benefit for Hospital Treatment that is psychiatric, rehabilitation, and palliative care if the treatment is provided in a Hospital and no Medicare Benefit is payable for that part of the treatment
•Up to 25% of the MBS Fee for Hospital Treatment covered under the Policy for which a Medicare Benefit is payable
•The amount detailed in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules as the minimum Benefit where a medical device or human tissue product is provided in circumstances in which a Medicare Benefit is payable or in other circumstances set out in those Rules;
• Up to 100% of the fee for PBS Items that are administered according to PBS approved indications during an Admitted Episode of Care.
E2.4 Westfund may enter a Contract with a Hospital or a group of Hospitals for Hospital Treatment. Contracts specify the total charge for any Hospital Treatment and the Benefit payable. The Member's entitlement to a Benefit in a contracted Hospital is determined in accordance with the terms of the Contract and the Policy. A list of contracted Hospitals is available to Members on our website: www.westfund.com.au.
E2.5 Benefits for Hospital Treatment provided in a private Hospital which does not have a Contract with Westfund are payable at the minimum and second tier Default Benefits as applicable, determined under the Private Health Insurance (Benefit Requirements) Rules.
E2.6 Westfund will also pay on some Hospital Treatment Policies, all or part of the fee that is above the MBS fee in cases where the medical practitioner either has a Contract with Westfund or participates in Westfund's Access Gap Scheme arrangements.
E2.7 For the purposes of determining the level of Benefit paid for Hospital Treatment, unless otherwise specified, where a Member is readmitted, the Hospital Treatment is regarded as a continuation of the preceding admission where there is a related reason for the readmission.
E2.8 In determining the Benefit payable where a daily Benefit is paid for services provided by the Hospital, the day of discharge and the day of admission are counted as one day.
E2.9 Where a patient is designated a Nursing-Home Type Patient, Benefits shall be limited to the current amounts determined under the Private Health Insurance (Benefit Requirements) Rules.
E2.10 Physiotherapy is covered in some Contracts with Hospitals. In Contracts where physiotherapy is not covered, Westfund will pay a Benefit in accordance with the specific product rules.
E2.11 For Medical Treatment in Hospital, Medicare pays a Benefit of 75% of the MBS fee for Professional Services.
E2.12 For Medical Treatment in Hospital, Westfund will pay a Benefit of 25% of the MBS fee for Professional Services.
E2.13 Where the charge for the Professional Service is less than the MBS fee, Westfund will pay a Benefit equal to the amount by which the charge exceeds 75% of that MBS fee.
E2.14 Westfund shall have the right to dispute any claim for Benefits in respect of Professional Services or Hospital Treatment.
In the event Westfund disputes a claim for Professional Services or Hospital Treatment, the Fund may at its absolute discretion refer the claim to its Medical Adviser.
The Medical Adviser's fees shall be paid by the Fund. If, following the advice of the Medical Adviser, Westfund decides not to pay the Benefits, this advice shall also be made available to the Member.
E2.15 Accommodation Benefit
E2.15.1 An Accommodation Benefit is payable for costs incurred as the result of boarding at a Hospital or nearby motel by the patient or one Member covered by the same Westfund Policy. Benefits are paid for the night before admission, for the nights during the hospitalisation and the night of discharge; where there is a corresponding hospitalisation record on the Members Policy. This Benefit is not claimable for the patient while admitted.
E2.15.2 The Accommodation Benefit is an uncapped Benefit payable per Policy per Calendar Year. A higher Benefit is payable for the first four nights claimed per Policy. All subsequent nights claimed will be paid at a lower nightly rate per Policy.
E2.15.3 To be eligible for the Accommodation Benefit the Member must be admitted as a private patient.
E2.16 Inpatient Travel Benefit
E2.16.1 An Inpatient Travel Benefit is payable for travel expenses incurred by a Member when receiving inpatient medical specialist services, where there is a corresponding hospitalisation record on the Members Policy.
E2.16.2 Benefits will be paid on a grouped kilometre basis, in excess of 150 kilometres round trip from the Member's home locality to the locality of the hospitalisation. This benefit is not available if transport is provided by Ambulance or Non-Emergency Patient Transport.
E2.16.3 This Benefit is limited to one service per Member per episode of hospitalisation.
E2.16.4 To be eligible for the Inpatient Travel Benefit the Member must be admitted as a private patient.
E2.16.5 The following limits apply to Benefits for inpatient travel expenses:

Distance Travelled	Benefit
0 - 149km	Nil
150km - 200km	$40
201km - 250km	$50
251km - 300km	$60
301km - 350km	$70
351km - 400km	$80
401km - 450km	$90
451km +	$100

E3 General Treatment

E3.1 The Benefits payable in respect of General Treatment, and the conditions relevant to those Benefits, are set out in Schedules I and J.
E3.2 General Treatment provided in Policies set out in Schedules I and J excludes:
1. Services for which a Medicare Benefit is payable except:
a) The professional medical therapeutic services identified in Groups T1 to T11 of the Health Insurance (General Medical Services Table) Regulation that are:
•items in the table without the symbol (H); or
•not stated in the item to be services that are to be performed in a Hospital for the Medicare Benefit to be payable; and
b) oral and maxillofacial services set out in Groups O1 to O11 of the Health Insurance (General Medical Services Table) Regulation that are:
•items in the table without the symbol (H); or
•not stated in the item to be services that are to be performed in a Hospital for the Medicare Benefit to be payable; and
c) the associated services in the:
•Health Insurance (Pathology Services Table) Regulations; and
•Health Insurance (Diagnostic Imaging Services Table)

Membership Terms and Conditions

Regulation, that are integral to the provision of the services specified in paragraphs (a) and (b) but only when any of the services in the above classes are provided as part of Hospital-Substitute Treatment.
2. Treatment which primarily takes the form of sport, recreation or entertainment, other than such treatment which is part of a Chronic Disease Management Program or a Health Management Program where the program has been approved by Westfund.
3. Treatment which is Excluded Natural Therapy Treatment.
4. Benefits paid in connection with the birth of a baby, funeral benefits, and disability Benefits, other than where Members were entitled to these Benefits as at the commencement of the PHI Act, i.e. funeral benefit prior to 1 April 2007.
E3.3 Some Policies may incorporate Hospital-Substitute Treatment. For these Policies, Westfund will pay:
•Up to 25% of the MBS fee for Hospital-Substitute Treatment covered under the Policy for which a Medicare Benefit is payable, provided a Medicare Benefit of 85% or more of the MBS fee is not payable for the treatment (in which case no Benefit is payable)
•the amount detailed in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules as the minimum Benefit where a medical device or human tissue product is provided in circumstances where a Medicare Benefit is payable or in other circumstances set out in those Rules.
E3.4 Westfund may make Chronic Disease Management Programs and other Health Management Programs available to Members under one or more Policies from time to time. Benefits payable in respect of Chronic Disease Management Programs and other Health Management Programs are subject to the Member meeting any applicable enrolment or eligibility criteria specified by Westfund from time to time. A Lifetime Limit per Member applies to Chronic Disease Management Programs.
E3.5 Benefits for General Treatment are only payable where the service or item is provided by a Recognised Provider of General Treatment.
E3.6 Westfund may Contract with Recognised Providers of General Treatment. The Benefits that apply within these Contracts may differ from those shown in Westfund's Fund Rules.
E3.7 Westfund may declare that a provider is no longer a Recognised Provider in the event that the provider fails to adhere to any requirements set down by Westfund.
E3.8 Benefits payable in respect of General Treatment will be the lesser of:
•the actual charge; or
•the Benefit payable under Westfund's Fund Rules for the service or item.
E3.9 Unless Westfund considers there are justifiable circumstances; a Member may only receive Benefits for one service or appliance per day per Recognised Provider. Exceptions to this rule are:
•Chiropractic where a Member may receive Benefits for one x-ray and a general consultation per day per Recognised Provider.
•Podiatry where a Member may receive Benefits for a diagnostic service (item numbers 101 - 118, 142 - 148) and a general consultation per day per Recognised Provider.
E3.10 Dental Benefits
E3.10.1 Dental Benefits are payable as per Westfund's Dental Schedules. A Benefit quotation is available on request.
E3.10.2 Where Benefits are available for dental services or appliances, Benefits are only payable when the services or appliances are not considered excessive or unnecessary for the wellbeing of the Member by Westfund's Dental Expert and where they are primarily non-cosmetic.
E3.10.3 Westfund shall have the right to dispute any claim for Benefits in respect of dental treatment. In the event Westfund disputes a claim for dental treatment, it may appoint a Dental Expert to examine the Member who received the dental treatment and/or any records deemed by the Dental Expert to be relevant to verify the claim. Westfund shall notify the Member in writing of the disputed claim and advise the Member of the Dental Expert appointed. The Dental Expert's fees shall be paid by Westfund.
E3.10.4 The Dental Expert shall be at liberty, should they think fit, to satisfy himself or herself as to all matters in relation to the claim and provide advice to Westfund.
The Member is required to provide to the Dental Expert all documents and records that the Dental Expert may reasonably request in relation to the claim. Westfund shall pay all reasonable expenses of the Member in attending an examination by the Dental Expert.
In the event that the Member after being requested by Westfund fails, within a reasonable period of time, to attend the Dental Expert appointed by Westfund or fails or refuses to provide documents or records requested by the Dental Expert, Westfund may refuse payment of Benefits for all dental services associated with the claim.
E3.10.5 No Benefits for Orthodontic are payable until a service has been provided. Where a Member pays in advance of the service, Benefits will be paid progressively against certification of work completed by a Recognised Provider. Benefits will be paid up to the full value of work completed and invoiced within the Benefit limit entitlement (items 825 – 882).
E3.10.6 Benefits for Orthodontic items: Dental Retainers (items 811, 821, 823 and 824) are payable for a maximum of two services per item per Member per Calendar Year. These items are paid at set Item Limits and are not included in the Orthodontic Lifetime Limit.
E3.11 Optical Benefits
E3.11.1 Optical Benefits (other than sunglass Benefit) are only payable for sight correction. This includes Irlen lenses, specially tinted for dyslexia,when provided by a Recognised Provider.
E3.11.2 No Benefits available for tinting, coatings or add-ons.
E3.11.3 A sunglass Benefit is payable for sunglasses purchased through Westfund Care Centres and selected Optical Provider of Choice providers. This Benefit is available only for non-prescription "off the shelf" sunglasses. This Benefit can be used for fit overs.
E3.11.4 A Laser Eye Surgery Benefit is payable for Lasik, ASLA and Smile procedures and must be performed by an Ophthalmologist recognised as a specialist under the Health Insurance Act 1973.
E3.12 Consultations
E3.12.1 Benefits for all services are only payable for one on one Consultations (in person, video and telecommunication). Exceptions to this rule are:
•Antenatal Classes, Exercise Physiology, Physiotherapy, Dietetics/ Nutrition, Occupational Therapy, Clinical Psychology, Counselling, Speech Therapy and Benefits listed under Health Management Programs. These services can be provided in a group setting by a Recognised Provider.
E3.13 Non PBS Pharmaceuticals
E3.13.1 A Pharmaceutical Benefit for a prescription, Vaccination or injection is payable on an item that is prescribed or administered by a medical practitioner, must be a Schedule 4 or Schedule 8 item (per the Poisons Standard). Where the Non PBS Pharmaceutical is provided by a pharmacy the receipt must detail the pharmacy prescription number.
E3.13.2 A Pharmaceutical Benefit is only payable on the amount over the standard Pharmaceutical Benefit Scheme (PBS) co-payment charge. This is re-set each year, effective 1st January.
E3.13.3 Pharmaceutical Benefits for prescriptions, Vaccinations and injections are not payable for:
•PBS Items supplied under the PBS;
•medicinal preparations where not prescribed or administered by a medical practitioner;
•experimental and clinical trial pharmaceuticals;
•contraceptives, anabolic steroids or cosmetic injections (e.g. Botox) unless prescribed specifically for the treatment of a medical illness;
•items which have not been approved for sale in Australia by the authorities that regulate the sale of pharmaceuticals (TGA). This includes items that have been supplied under Special Access Scheme.
E3.14 Health Aids and Appliances
E3.14.1 Refer to Rule G – Claims for the following Benefits require a letter of recommendation or Health Management Declaration Claim Form from a Medicare Registered Practitioner to validate Benefits payable. A letter of recommendation or Health Management Declaration Claim Form is not required when Health Aids and Appliances are provided by or purchased from a Medicare Registered Practitioner.

Membership Terms and Conditions

Documentation is valid for lifetime of Policy:
•Artificial Limbs
•Cardiac Monitors
•Compression Garments/Devices
•Devices for Sleep Apnoea and diagnosed snoring
• INR Monitor
• Low Vision Aids
•Mammary Prostheses and Brassieres (no letter required if a hospitalisation for a mastectomy is on Westfund's system)
•Oximeter
•Oxygen and Oxygen Accessories
•Repairs to Devices (no letter required if initial purchase is recorded with Westfund)
•Respiratory Aids
•TENS Machine
•Wigs (no letter required if a hospitalisation for a medical condition is on Westfund's system)
Documentation is valid for one Calendar Year:
•Braces
•Burns Suit
•Mobility Aids
•Orthopaedic Boots
•Orthotics
E3.14.2 To be eligible for an Orthotic Benefit, orthotic items must be specifically made (custom made) or molded (preformed) for the Member and be for the support, alignment, prevention or correction of deformities of the feet. Benefits for orthotic models/impressions are eligible to be claimed to a maximum of two services per Calendar Year per Member (items 301-305).
E3.14.3 To be eligible for an Orthopaedic Boots Benefit, the orthopaedic boots must be individually made (custom made) for the Member and be for the correction of an abnormality.
E3.14.4 To be eligible for a Brace Benefit the brace must contain a solid support stabilizer component.
E3.14.5 To be eligible for a Compression Garment/Device Benefit, the compression garment/device or anti-embolism garment/device must be purchased as a consequence of a diagnosed health condition.
E3.14.6 To be eligible for Benefits for repairs to listed health aids and appliances the claim for the repairs must be accompanied with a letter of recommendation or Health Management Declaration Claim Form from a Medicare Registered Practitioner stipulating the need for the device. A letter of recommendation or Health Management Declaration Claim Form is not required if the device being repaired has been previously claimed with Westfund. The warranty period for the device must have lapsed to be eligible for this Benefit.
E3.15 Prevention and Health Management Benefits
E3.15.1 Benefits for membership or class fees with a fitness or aquatic centre are only payable where:
•the membership or class is required to enable the Member to undertake a Health Management Program for the treatment of a specific health condition or conditions; and
•the Health Management Program has been recommended to the Member by a Medicare Registered Practitioner who is treating the Member for the specific health condition or conditions; and
•all documentation required by Westfund has been provided to Westfund; and
•the provider must be a Recognised Provider as per Westfund's Recognition Criteria.
E3.15.2 Vitamin Benefits are payable for vitamins and minerals listed with Therapeutic Goods Administration (TGA Approved) and approved by Westfund.
Vitamins and minerals must fulfil the following criteria;
•Vitamins must be any vitamin A-K or minerals must be iron, potassium, calcium, magnesium or zinc;
•Administered orally or intravenously;
•Intended to aid in a specific vitamin or mineral dietary deficiency;
•Excludes body building, weight loss, meal replacement or any consumable food or drink product;
• Excludes Schedule 4 and Schedule 8 (per the Poisons Standard) item/drugs;
• Excludes PBS items supplied under the PBS.
E3.15.3 Benefits for Weight Loss Programs are payable only for joining or membership fees.
E3.15.4 For the purpose of chronic disease association fees Benefits, the chronic disease association must be either:
•Alzheimer's Australia
•Arthritis Australia
•Asthma Foundation
•Coeliac Association
•Crohn's and Colitis Australia
•Diabetes Australia
•Lupus Association of Australia
•MedicAlert Foundation
•Multiple Sclerosis (MS) Australia
•Myasthenia Gravis Associations
•National Association of People with HIV Australia (NAPWHA)
•Parkinson's Australia
•Stoma Associations (Ostomy, Colostomy)
E3.15.5 For the purpose of preventative health tests Benefits; the tests must not be Medicare claimable and be one of the following tests:
•Bone density test
•Bowel testing kit
•Calcium score
•Chronic disease health screen
•Mammogram
•Mole scan
•Thin prep pap test
E3.15.6 For the purpose of ear and eye preventative checks Benefits, the tests must not be Medicare claimable and be one of the following tests:
•Audiology Test
•Eye Health Test
E3.15.7 Omega 3 Benefits are payable for Omega 3 listed with Therapeutic Goods Administration (TGA Approved) and approved by Westfund. Omega 3 must contain the following active ingredients:
•Omega 3; or
•Fish Oil; or
•Krill Oil.
E3.15.8 Probiotic Benefits are payable for Probiotics listed with Therapeutic Goods Administration (TGA Approved) and approved by Westfund. Probiotics must contain the following active ingredients:
•Lactobacillus; or
•Bifidobacterium; or
•Streptococcus Thermophilus.
E3.16 Funeral Expenses
E3.16.1 A funeral Benefit of $1,750 per Member is available for Members who held any Policy (excluding Ambulance only cover) prior to 1st April 2007 and have maintained continuous Westfund membership (excluding Ambulance only cover).
E3.16.2 Members who have downgraded to Ambulance only cover within this period (1st April 2007 – present) are not eligible for the Benefit.
E3.16.3 Members who have terminated their Westfund membership and re-joined the Fund at a later date are not eligible for the Benefit.
E3.16.4 Members who were born after 1st April 2007 are not eligible for the Benefit.
E3.17 Outpatient Travel Benefit
E3.17.1 An Outpatient Travel Benefit is payable for travel expenses incurred by a Member to attend outpatient medical specialist services when referred by a Medicare Registered Practitioner. The provider must be a recognised specialist as per Westfund's Recognition Criteria.
E3.17.2 An Outpatient Travel Benefit will only be paid for medical specialist services where:
• in the case of an outpatient service, a Medicare item number is billed for that service;
• in the case of a Specialist Dentist, a dental consultation item number is billed for that service.

Membership Terms and Conditions

E3.17.3 Where a Member is not billed for a medical service (e.g. post-operative consultation), a letter of attendance from the medical specialist is required.
E3.17.4 Benefits will be paid on a grouped kilometre basis, in excess of 150 kilometres round trip from the Member's home locality to the locality of the consultation. This Benefit is limited to one service per Member per day.
E3.17.5 The following limits apply to Benefits for outpatient travel expenses:

Distance Travelled	Benefit
0 - 149km	Nil
150km - 200km	$20
201km - 250km	$25
251km - 300km	$30
301km - 350km	$40
351km - 400km	$50
401km - 450km	$60
451km +	$70

F1 Co-Payments
F1.1 A Co-Payment may be required under particular Policies where detailed in Schedule J.
F1.2 A Co-Payment may also be required where the Member has transferred from a Policy with the health benefits fund of another private health insurer that applies Co-Payments and a Waiting Period still applies to his or her Policy.

F2 Excesses
F2.1 An Excess may be required under particular Policies where detailed in Schedule J.
F2.2 An Excess may also be required where the Member has Transferred from a Policy with the health benefits fund of another private health insurer that applies Excesses and a Waiting Period still applies to his or her Policy.
F2.3 If the Hospital admission fee is less than the Excess payable on the Policy for a Member for their first admission, the balance of the Excess shall be applied to any subsequent admissions within the same Calendar Year; up to the value of their Excess.

F3 Waiting Periods
F3.1 Benefits are not payable in respect of services provided to a Member during a Waiting Period.
F3.2 Refer to Rule C6 Transfers, when a Member of another private health insurer Transfers to Westfund.
F3.3 Waiting Periods do not apply to a newborn child of a Member that has served all Waiting Periods. Any Waiting Periods that remain for a Member at the time of birth will apply to a newborn child. A newborn child of a Member will be covered if they have been added to an eligible Policy (refer Rule C3.2) within three months of birth. A child added to a Policy three months after their birth date will be subject to all Waiting Periods.
F3.4 A Waiting Period will not apply to a Policy that covers a person who held a gold card or was entitled to treatment under a gold card (as defined in the PHI Act) or to members of the Australian Defence Force or people in Antarctica who have health cover provided as part of their employment.
F3.5 The following Waiting Periods apply to Benefits payable for Hospital Treatment, Hospital-Substitute Treatment and Chronic Disease Management Programs:

Accident-related hospitalisation	1 day
Hospital psychiatric services, Palliative care and Rehabilitation	2 months
Pregnancy and birth	12 months
Treatment of a Pre-existing Condition (excluding Hospital Psychiatric services, Palliative care and Rehabilitation	12 months
All other treatments (not listed above)	2 months
Accomodation Benefit, Inpatient Travel Benefit	12 months
Chronic Disease Management Programs	12 months

The following Waiting Periods apply to Benefits payable for General Treatment:

Emergency Ambulance Transport 1 day	1 day
Non-Emergency Patient Transport, General Dental, Optical (excluding Laser Eye Surgery), Other Therapies (Excluding Surgical Tratment by a Podiatrist), Prescriptions, Vaccinations, Injections, Prevention and Health Management (excluding Antenatal Classes)	2 months
Major Dental, Orthodontic, Dental Top Up, Surgical Treatment by a Podiatrist, Antenatal Classes, Health Aids and Appliances (excluding Hearing Aids and Accessories, FM Systems), Outpatient Travel Benefit	12 months
Laser Eye Surgery, Hearing Aids and Accessories, FM Systems	36 months

F3.6 A Member who has held a policy with Hospital cover (whether as a member of Westfund or another private health insurer) and upgrades to a Policy which includes psychiatric treatment may elect to waive the 2 month Waiting Period that applies to psychiatric treatment upon upgrade. If the Member has held Hospital cover for at least 2 months, the Waiting Period is waived. If the Member has held Hospital cover for less than 2 months, the Waiting Period will be 2 months less the period during which the Member held Hospital cover under the previous policy. This waiver can only be accessed once in a Member's lifetime; as specified in the Private Health Insurance (Complying Product) Rules.

F4 Exclusions
F4.1 Some procedures may be excluded under particular Policies where detailed in Schedules I&J.

F5 Restricted Benefits
F5.1 Restricted Benefits may apply under particular Policies where detailed in Schedules I&J.

F6 Compensation Damages and Provisional Payment of Claims
F6.1 The following conditions apply to Benefits in respect of compensable services:
•Benefits are not payable in respect of services provided to a Member as a result of an Accident, illness, injury, condition or other incident for which there exists in the opinion of Westfund, a right to claim compensation from a third party or authority at law or under any insurance or arrangement or for which the Member has personally received a payment or consideration in settlement of a claim for compensation or damages however the settlement is described, including payments by way of ex gratia and/or non-disclosed settlement.
•In circumstances in which the preceding paragraph applies, and Westfund makes an ex gratia payment, the Member shall repay to Westfund any such ex gratia payment, and interest at no more than the Commonwealth Bank's 90 day bill rate at the relevant time, where the Member subsequently becomes entitled to receive a payment or consideration in settlement of a claim for compensation or damages (howsoever described). The liability of the Member to repay shall apply regardless of whether the Member continues to be a Member of Westfund.
•Where the Member receives, or becomes entitled to receive, a lesser amount than the sum of ex gratia payments made by Westfund, then the Member's liability to repay to Westfund shall be limited to such lesser amount.
•In addition to any other terms or conditions which Westfund may apply under this rule, the Member shall provide:
•an undertaking in a form approved by Westfund to repay to Westfund the amount of the ex gratia payment;

Membership Terms and Conditions

•an undertaking to keep Westfund informed of progress towards resolution of the claim and to provide Westfund with full particulars of the settlement terms reached; and
•an undertaking to notify Westfund within 14 days either personally or through the Member's solicitor when a settlement is reached.

G CLAIMS

G1 General

G1.1 Claims shall be submitted to Westfund on the required form either by mail, in person to a Westfund Care Centre, via fax or email. A claim may also be submitted via the Westfund website (www.westfund.com.au) or via the Westfund App. Phone claims may only be submitted via Westfund providers.
G1.2 Claim forms, where required, must be completed in full including declarations by the Member in relation to third party and workers compensation claims. A recorded verbal declaration over the phone can only be accepted for claims submitted by a Westfund provider.
G1.3 Westfund reserves the right to refuse a claim that is not submitted on the correct form.
G1.4 Documentation required in support of a Benefit claim is detailed below:

Claim Type	Claim Form and Account	Supplementary Information or Documentation Required
Medical (non-Access Gap)	Claim Form plus Medicare Account/ Receipt	Nil
Dental •General Dental •Major Dental	Claim Form plus Account/Receipt	Nil
Dental •Orthodontic	Claim Form plus Account/Receipt	Certification of work completed for progress payments.
Optical	Claim Form plus Account/Receipt	Nil
Other Therapies • Acupuncture • Chinese Herbalism • Chiropractic • Clinical Psychology • Counselling • Dietetic • Exercise Physiology • Home Nursing • Myotherapy • Nutrition • Occupational Therapy • Osteopathic • Physiotherapy • Podiatry • Remedial Massage • Speech Therapy • Vision (Eye) Therapy	Claim Form plus Account/Receipt	Nil
Non PBS Pharmaceuticals / Vaccinations / Injections	Claim Form plus Account/Receipt	Official Pharmacy Receipt required where provided by pharmacy. Contraceptives, anabolic steroids or cosmetic injections must be accompanied with a letter from a Medical Practitioner detailing that the pharmaceutical is treating a specific health condition. (Letter is valid for the Lifetime of the Policy)
Health Aids and Appliances • Artificial Limbs • Braces • Burns Suit • Cardiac Monitors • Compression Garments/Devices • Devices for Sleep Apnoea and diagnosed snoring • INR Monitor • Low Vision Aids • Mammary Prostheses and Brassieres • Mobility Aids • Orthopaedic Boots (custom made) • Orthotics (custom made/preformed) • Oximeter • Oxygen and Accessories • Repairs to Devices • Respiratory Aids • TENS Machine • Wigs	Claim Form or Health Management Declaration Claim Form plus Account/ Receipt. or: Claim Form plus Account/Receipt if Health Aid or Appliance is provided by or purchased/hired from a Medicare Registered Practitioner.	Letter of recommendation or Health Management Declaration Claim Form must be provided by a Medicare Registered Practitioner and detail the need for the appliance to treat the specific health condition. Lifetime Documentation Required: •Artificial Limbs •Cardiac Monitors •Compression Garments/Devices •Devices for Sleep Apnoea and diagnosed snoring •INR Monitor •Low Vision Aids •Mammary Prostheses and Brassieres (no letter required if a hospitalisation for a mastectomy is on Westfund's system) •Oximeter •Oxygen and Oxygen Accessories •Repairs to Devices (no letter required if initial purchase of the device is recorded with Westfund) •Respiratory Aids •TENS Machine •Wigs (no letter required if a hospitalisation for a medical condition is on Westfund's system) Documentation Required every Calendar Year: •Braces •Burns Suit •Mobility Aids •Orthopaedic Boots •Orthotics
Health Aids and Appliances • Blood Glucose Monitors • Blood Pressure Monitors • FM Systems • Hearing Aids and Accessories • Sleep Apnoea Accessories • Sleep Apnoea Masks • TENS Accessories	Claim Form plus Account/Receipt	Nil

Membership Terms and Conditions

Claim Type	Claim Form and Account	Supplementary Information or Documentation Required
Prevention and Health Management •Aquatic Programs •Fitness Centre •Mental Health Programs •Virtual Gastric Banding •Weight Loss Programs	Claim Form or Health Management Declaration Claim Form plus Account/ Receipt	Letter of recommendation or Health Management Declaration Claim Form must be completed by a Medicare Registered Practitioner and detail the specific health condition being treated
Prevention and Health Management •Antenatal Classes •Audiology Test •Bone Density Tests •Bowel Testing Kits •Calcium Score •Chronic Disease Association Fees •Chronic Disease Health Screen •Diabetes Education •Eye Health Tests •Hypnotherapy •Mammograms •Mole Scanning •Omega 3 •Probiotics •Thin Prep Pap Tests •Vitamins	Claim Form plus Account/Receipt	Nil
Ambulance •Emergency Ambulance Transport •Non-Emergency Patient Transport	Claim Form plus Account/Receipt	Nil
Funeral Expenses	Claim Form plus Funeral Account/ Receipt	Confirmation of date of death is required (refer rule C8.10)
Accommodation	Travel & Accommodation Claim Form plus Hotel/Motel or Hospital Receipt	Record of hospitalisation on membership
Inpatient Travel	Travel & Accommodation Claim Form	Record of hospitalisation on membership
Outpatient Travel	Travel & Accommodation Claim Form	Receipt or letter of attendance from specialist

G1.5 Westfund will accept a photocopy, faxed or emailed copy of any account or receipt. In the case of photocopied, faxed and emailed accounts/receipts, original documents must be retained by the Member for a minimum of 24 months from the date the claim is made. Westfund may request to sight the original document during this time and may seek to recover Benefits paid where this cannot be produced.
G1.6 Westfund will not accept any account, receipt, prescription or any other document which has been altered in any way by any person so as to misrepresent any of the original details contained on those documents.
G1.7 Accounts or receipts issued by providers must be in English and contain the following information to permit payment of a Benefit:
•The name and provider number of the issuing provider
•The date of issue of the invoice
•The name of the patient
•Date of service
•Description of service and any applicable item number
•Cost of service or services should be shown as individual amounts (except in dental as these may be bulked as a total amount)
•Any amount paid to the provider and date paid including any discounts given
•Any amount outstanding•Any notations such as 'Quote' or 'Duplicate' where necessary.
Additional Information required for Prescriptions/Vaccinations/ Injections where official pharmacy receipt is provided:
•Private/Non NHS/Non PBS
•Script number
•Prescriber Name(doctor)
•Prescriber Number
G1.8 Benefits are not payable if an application or claim form contains false or misleading information.
G1.9 All documents submitted in connection with a claim become the property of Westfund, unless otherwise agreed.
G1.10 Westfund reserves the right to request further information including a copy of any treatment plans.
G1.11 Benefits are not payable where a claim is lodged more than two (2) years after the date of service. Westfund may waive this rule at its discretion.
G1.12 Benefits paid by cheque are only payable to the Provider or the Primary Member unless the Primary Member requests otherwise.
G1.13 Any supplementary documentation required from a Medicare Registered Practitioner or medical practitioner as noted in G1.4 must be less than 12 months old at the date the service was provided.

G2 Other

G2.1 Westfund may require certain claims to be submitted on or accompanied by specific forms depending on the nature or circumstances of the service including but not limited to WorkCover, acute care, intensive care and specific services in contracted Hospitals.

DEFINITIONS

Accident means accidental bodily injury caused solely and directly by external means requiring an Admitted Episode of Care within seven days of the accident. An accident is determined by the admitting Hospital.
Accident Excess Waiver means the excess amount that would normally be payable by the Member,will be paid by Westfund where a Member has required an Admitted Episode of Care as the direct result of an Accident.
Admitted Episode of Care means an admission to a Hospital in order to receive the level of care that is only available as an inpatient. The patient must have undergone the admission process and then the discharge/separation process by the facility before it can be classed as an admitted episode of care.
Adult means a person who is not a Dependant.
Adult Dependant means a person who is between the age of 25 and 30 (inclusive) and is not in a relationship on a bona fide domestic basis.
Adult Disability Dependant means is aged over 18 and is defined as dependent person with a disability as outlined in the PHI Act.
Age-Based Discount means a discount on private health insurance for persons aged between 18 and 29 years.
Age-Based Discount Policy means an insurance Policy that provides Age-Based Discounts.
Annual Group Limit means the maximum amount of Benefits that can be claimed for an individual service or group of services outlined within that group subject to Item Limits and Sub-limits that may apply. The Annual Group Limit is per Calendar Year.
Australia means the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), Norfolk Island, the Territory of Cocos (Keeling) Islands and the Territory of Christmas Island.
Benefit means an amount of money payable or the provision of appliances under a Policy.
Calendar Year means the twelve month period from 1 January to 31 December in a year.
Cardiac Monitors means Holter Monitors, Heart Event Monitors and Mobile Cardiac Telemetry.

Membership Terms and Conditions

Chronic Disease Management Program a program approved by Westfund that is intended to
(a)reduce 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 and otherwise meets the requirements set out in the Private Health Insurance (Health Insurance Business) Rules.
Claimable Period means a continuous period of time that can elapse for the maximum Item Limit to be exhausted.
Dependant means
• a natural, adopted or foster child of the Primary Member; or
• a stepchild of the Primary Member (that is, a natural, adopted or foster child of a Partner); or
• a child being cared for under guardianship arrangements granted by a court of law of the Primary Member or Partner.
•And includes, for the purposes of these rules, a Dependant Child, Adult Dependant, Adult Disability Dependant or Non-Classified Dependant of the Primary Member or Partner.
Dependant Child/ren means a person under the age of 18 and is not in a relationship on a bona fide domestic basis
Emergency Ambulance Transport means is ambulance transportation of an unplanned and non-routine nature for the purpose of providing immediate medical attention to a person in the opinion of the treating medical officer. This can include;
•transport to Hospital requiring treatment at an emergency department
•transport to Hospital requiring admission
Excess means an amount payable by a Member for Hospital Treatment or Hospital-Substitute Treatment in a Calendar Year where the payment would normally attract the Benefit in accordance with the Policy. The Excess is either paid by the Member or subtracted from any Benefit which would otherwise be payable.
Informed Financial Consent is the consent to treatment obtained by a doctor from a patient prior to treatment whenever possible, after the doctor has sufficiently explained his or her fees to the patient to enable the patient to make a fully informed decision about costs.
Item Limit means the Benefit payable per service.
Lifetime Limit means the maximum amount of Benefits that can be claimed for an individual service or group of services outlined within that group within a Member's lifetime subject to any Item Limits, Sub-limits and Annual Group Limits that may apply. This includes Benefits claimed from other Private Health Insurers or another Westfund Policy.
MBS (Medicare Benefits Schedule) is a schedule of fees for Professional Services which attract Medicare Benefits maintained by the Department of Health.
Member means an insured person under a Policy.
Non-Classified Dependant means
• a person who is between the age of 18 and 24 (inclusive)
• is not in a relationship on a bona fide domestic basis
Non-Emergency Patient Transport means ambulance transportation including on the spot treatment where a time critical ambulance response is not essential however clinical monitoring is required for the purpose of providing medical attention to a person in the opinion of the treating medical officer. Transport will be provided to a person where he or she is assessed by a medical practitioner as medically unsuitable for community, public or private transport.
Non-Emergency Patient Transport must be requested from the treating medical practitioner and be provided under a state-based ambulance service scheme and recognised with Westfund. This may include services such as:
•Ambulance service fees where subsequent transport is not required
•Inter Hospital transfers (excluding public hospital to public hospital)
•Admissions to Hospital from home
Partner means a person who:
• is married to the Primary Member, or
• lives with the Primary Member in a relationship on a bona fide domestic basis
Pharmaceutical Benefits Schedule means the Schedule of Pharmaceutical Benefits kept by the Department of Health and Aged Care.
PHI Act means the Private Health Insurance Act 2007 (Cth).
Policy Year means a year from the date of commencement of a Policy or from the anniversary date of the commencement of a Policy.
Primary Member means the person in whose name the Policy is registered with Westfund and who is a policy holder as defined in the PHI Act.
Recognised Provider means a provider recognised by Westfund for the purpose of paying Benefits. To become a Recognised Provider, the provider must be in Australia and among other things, satisfy the standards in the Private Health Insurance (Accreditation) Rules. Recognised Providers include Hospitals, medical practitioners providing a Professional Service and providers of General Treatment that meet Westfund's Recognition Criteria.
Recognition Criteria in relation to Recognised Providers of General Treatment are:
• the provider is professionally qualified or belongs to a professional body recognised by Westfund;
• the provider is in independent private practice;
• the provider is registered, or holds a licence under State or Territory legislation within Australia;
• other recognition criteria determined by Westfund.
Retained Age-Based Discount means the Age-Based Discount that a Member held on a previous health insurance product. The Member will retain the same discount that they were eligible for on their previous product unless they do not fulfil the criteria for a Retained Age-Based Discount as set out in the Private Health Insurance (Complying Product) Rules.
Retained Age-Based Discount Policy means a Policy that is an Age-Based Discount Policy and that states it is a Retained Age-Based Discount Policy.
Spouse has the same meaning as Partner.
Sub-limit means the maximum limit within the Annual Group Limit that the Item Limit can be claimed up to.
TGA Approved means an item that has been registered on the Australian Register of Therapeutic Goods for sale in Australia.
Therapeutic Goods Administration (TGA) means part of the Department of Health and Aged Care with responsibility to regulate and approve therapeutic goods in Australia including how they are manufactured and advertised.
Waiting Period as set out in section 75-5 of the PHI Act means the period that applies to a person for a Benefit under a Policy being the period:
• starting at the time the person becomes insured under the Policy; and
• ending at the time specified in the Policy; during which the person is not entitled to the Benefit.

Other important information

Westfund's Privacy Policy is available at www.westfund.com.au/privacy-policy/

Westfund is committed to providing the best possible service to our members. We welcome your feedback - both good and not so good. You can provide your feedback via one of the channels listed on **www.westfund.com.au/feedback/**.If you are not satisfied with our response, your complaint can be lodged with the Commonwealth Ombudsman on 1300 362 072.

More information is available at ombudsman.gov.au. General information about private health insurance is available online at privatehealth.gov.au
Westfund Health Insurance is a signatory to the Private Health Insurance Code of Conduct. You can get a copy of the code at: **www.westfund.com.au/feedback/**

Membership Terms and Conditions effective as at 1 September 2024. Westfund Limited. ABN 55 002 080 864. Telephone 1300 937 838.
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