HOSPITAL OVERSEAS

POLICY SUMMARY

By law, some visas are required to maintain adequate health insurance for the length of their visa. For more information please refer to the Department of Immigration and Border Protection at www.border.gov.au.

Working and Skilled Visas (family and spousal visas are accepted where the main member is one of the below)

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HOSPITAL COVER
Westfund has contracts with numerous private hospitals throughout Australia covering theatre fees and hospital accommodation costs for most procedures. Hospital policies do not provide cover for treatment for which Medicare pays no benefit eg. Non-Therapeutic Cosmetic Surgery, or if disallowed by the Private Health Insurance Act 2007. Where no contract exists with a private hospital, benefits are payable at a default rate determined by the Government. In these cases, out of pocket expenses may be incurred.
We recommend that members check with us prior to admission to hospital to ensure they are covered. Hospitals which have contracts with Westfund are listed at www.westfund.com.au or details can be obtained by calling Member Services on 1300 937 838.
As a private patient in a public hospital, you will receive cover for accommodation and your choice of doctor from doctors with a right to practice at that hospital.
Westfund will pay benefits for surgically implanted prostheses up to the approved benefits in the Government's Prostheses List and in accordance with the requirements of the Act.
All Pharmaceutical Benefits Scheme (PBS) listed drugs that are prescribed according to the PBS approved indications, that are administered during and form part of an admitted episode of care - a benefit equal to the PBS listed price in excess of the patient contribution.

EXCESS OPTIONS

| Nil |

Exclusions - Do not apply to this policy
Restrictions - Westfund will pay Benefits that cover the charges for Hospital Treatment up to the public hospital shared room accommodation rate, as set out by the Private Health Insurance (benefit requirements) Rules, when admitted to hospital for Obstetrics including Assisted Reproductive, Palliative or Psychiatric Services. Significant out of pocket expenses may apply for admissions into a private hospital.
Co-payments - Do not apply to this policy
Benefit Limitation Periods - Do not apply to this policy

MEDICAL COVER
For in-patient services, Westfund pays benefits for the fees charged by a doctor, surgeon, anaesthetist or other specialist. While you are in hospital Westfund will pay the lesser of charges or 100% of the Commonwealth Medical Benefits Schedule (CMBS - listing of eligible services, standard fees and benefits for medical services, regulated by the Department of Health and Aged Care). Where the fees charged exceed the CMBS fee, Westfund will pay an additional benefit to reduce or eliminate out of pocket expenses where the doctor or specialist has participated in our Access Gap Scheme.
Our Access Gap Scheme allows patients with hospital cover to eliminate or reduce out-of-pocket expenses for medical gap payments for in-patient hospital treatments. Westfund does not pay an amount charged by your doctor above the CMBS fees unless your doctor agrees to participate in the Access Gap Scheme. If a doctor does not use the Access Gap Scheme, patients will be responsible for any additional charges. Doctors are independent of Westfund and each doctor can choose on a case by case basis whether to participate in the Access Gap Scheme.
Please visit our website www.westfund.com.au or contact Member Services on 1300 937 838 for further information on Access Gap Scheme. We encourage members to contact us before their scheduled appointment to any referred medical specialist.
For out-patient services, Westfund will pay a benefit of 100% of the CMBS fee for services provided by a General Practitioner and a benefit 85% of the CMBS fee for services provided by a Specialist (including pathology and x-ray).
No benefits are paid for non-therapeutic cosmetic surgery.
AMBULANCE COVER

Westfund fully covers the cost of emergency ambulance transport including on the spot emergency treatment, by a Westfund recognised Ambulance service provider in Australia by covering the cost of the emergency ambulance account. Emergency transport 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. Ambulance services where subsequent transport to a hospital is not required is covered under non-emergency ambulance transport.

Westfund fully covers the cost up to $5,000 per member per calendar year for non-emergency ambulance transport by a Westfund recognised Ambulance service provider in Australia by covering the cost of the non-emergency ambulance transport account.

Non-emergency ambulance transport is 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.

MEMBER ADVANTAGES

Member Advantages provide additional benefits to our members. Please refer to Important Terms and Conditions regarding claiming conditions of these benefits. Individual claim forms are required to be completed in relation to these benefits. Forms are available for download at www.westfund.com.au/helpful-resources/forms-and-downloads/

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<td>Access to Westfund Dental Care Practices and Westfund Eye Care Practices.</td>
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Finding Hospital Agreements
We recommend that you contact us before going to hospital to check if we have an agreement in place with your chosen private hospital. You can search the list of hospitals we have agreements with online at www.westfund.com.au/health-services/find-a-hospital

Finding a No Gap or Known Gap Doctor
We provide a search facility on our website to help you find a doctor who has previously participated or have indicated their intention to participate in the Access Gap Cover scheme, as well as those who have agreed to alternative no gap arrangements. We have listed some key questions that you can ask your doctor prior to progressing with treatment. Please read the general information provided on our website about this search facility. You can search for Doctors who have previously participated at www.westfund.com.au/health-services/find-a-doctor

How to find a registered extras (ancillary) provider
We provide a search facility at the Members Online Area of our website to help you find registered providers. Just go to www.westfund.com.au, log in and go to provider search. Alternatively you can find a registered provider at www.ahpra.gov.au. Benefits payable are dependent upon policy.

Where to find Westfund’s privacy policy
Westfund’s privacy statement is available online at www.westfund.com.au/privacy

Resolving any complaints
If you have any complaints about your health cover, please contact us so we can resolve your issue:
• Email us at complaints@westfund.com.au
• Call in to one of our Care Centres. You’ll find our Care Centres at: www.westfund.com.au/why-westfund/branch-locations
• Telephone us on our Member Services number 1300 937 838
If you feel that your problem has not been adequately addressed, free independent advice is available from The Commonwealth Ombudsman:
• Call 1300 362 072
• Visit www.ombudsman.gov.au/making-a-complaint
• Post Commonwealth Ombudsman, GPO Box 442, Canberra ACT 2601

What is a pre-existing condition?
A pre-existing condition is an illness or condition for which, in the opinion of a medical practitioner appointed by Westfund, signs or symptoms existed during the six months before the date you joined Westfund or upgraded to a higher level of cover. A 12 month waiting period applies to all new members for hospital costs relating to the treatment of pre-existing conditions.

30 Day Cooling Off Period
The cooling off period is in place if you decide you no longer want this cover or want to change to a different level of cover. Westfund provides new and existing members with a 30 day review period from the date your policy starts. This cooling off period does not apply if a claim has been paid during the 30 days.

Private Health Insurance Code of Conduct
Westfund Health Insurance is a signatory to the Private Health Insurance Code of Conduct. The code is designed to help you by providing clear information and transparency in your relationship with health funds. You can get a copy of the code at www.privatehealthcareaustralia.org.au/codeofconduct
**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 H, J and L 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 2011, if no certificate for that procedure has been provided under clause 7 of that Schedule; and
- • treatment provided to a person at an emergency department of a Hospital; and
- • treatment provided to a person who is not a patient within the meaning of that word in paragraph (a) unless the person is in a hospital in accordance with restriction (i) 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 or
- • any other provision in the Private Health Insurance (Complying Products) Rules 2011 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 (Complying Product) Rules 2010 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 CMBS Fee for Hospital Treatment covered under the Policy for which a Medicare Benefit is payable. The amount detailed in the Private Health Insurance (Prostheses) Rules 2014 as the minimum benefit for a prosthesis where a prosthesis is provided in circumstances in which a Medicare Benefit is payable

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 rates as applicable, determined under the Private Health Insurance (Benefit Requirements) Rules 2014

E2.6 Westfund will also pay on some Hospital Treatment policies, all or part of the fee that is above the CMBS (Commonwealth Medical Benefits Schedule) 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 provided 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 by the Minister.

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.

E2.14 For Medical Treatment in hospital, Medicare pays a Benefit of 75% of the CMBS fee for Professional Services.

E2.15 For Medical Treatment in hospital, Westfund will pay a Benefit of 25% of the CMBS fee for Professional Services.

E2.16 Where the charge for the Professional Service is less than the CMBS fee, the Benefit is the amount by which the charge exceeds 75% of the CMBS fee.

E2.17 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.

**E3 Optical Benefits**

E3.10 Optical Benefits are payable as set out in schedule M1 of these fund rules

E3.10.1 Optical Benefits (other than Sunglasses Benefit) are only payable for sight correction. These include lenses specially tinted for dyslexia. Where lenses are provided by a Recognised Provider, they will receive a Benefit that is equivalent to a single vision benefit (212) as set out in schedule M1 of these fund rules.

E3.10.2 No Benefits available for tinting, coatings or add-ons.

E3.10.4 No Sunglasses Benefit is payable for sunglasses provided by external (non-Westfund) providers. This benefit is available only for non-prescription “off the shelf” Sunglasses. This benefit can be used for fit overs.

**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, J and L.

E3.2 General Treatment provided in Policies set out in Schedules I, J and L excludes:

- a) Services for which a Medicare Benefit is payable except the professional medical therapeutic services identified in Group T1 to T11 of the Health (General Medical Services Table) Regulation 2012 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
  - • oral and maxillofacial surgery in Groups O1 to O11 of the Health Insurance (General Medical Services Table) Regulation 2012 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) the associated services in the:

- • Department of Health - Pathology Services Table (PST); and

- • Health Insurance (Diagnostic Imaging Services Table) Regulation 2013, 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 programme or a Health Management Programme where the programme has been approved by Westfund.

3. Benefits paid in connection with the birth of a baby, general benefit, and disability benefits, other than where Members were entitled to these benefits as at the commencement of the Act, is 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 CMBS 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 CMBS fee is not claimed for the treatment (in which case no Benefit is payable)

- No more than the amount (if any) set out in the Private Health Insurance (Prostheses) Rules 2015 as the maximum benefit for a Prostheses where the Prostheses is provided in circumstances in which a Medicare Benefit is payable

- The amount set out in the Private Health Insurance (Complying Product) Rules 2010 as the minimum benefit for any treatment mandated for Benefits to be provided in those Rules.

E3.4 Benefits for General Treatment are only payable where the service or item is provided by a Recognised Provider of General Treatment.

E3.5 Westfund may Contract with Recognised Providers of General Treatment. The Benefits that apply within these Contracts may differ from those shown in these rules.

E3.6 Westfund may at any time 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.

E3.7 Benefits payable in respect of General Treatment will be the lesser of:

- • the actual charge; or
- • the Benefit payable under these rules for the service or item.

E3.8 Benefits for General Treatment covered under the Policy for which a Medicare Benefit is payable, other than where Members were entitled to these benefits as at the commencement of the Act is provided in accordance with the specific product rules.

E3.9 Benefits for General Treatment are payable for one on one Consultations (in person, video and telecommunication).

E3.11 Consultations

E3.11.1 Benefits for all services are only payable for one on one Consultations (in person, video and telecommunication).

- a) Exception to one on one Consultations are Antenatal Classes, Exercise Physiology, Physiotherapy and benefits listed under Health Management Programs. These services can be provided in a group setting by a Recognised Provider.
Important Terms and Conditions are ONLY applicable to benefits which are provided in the Policy Summary section of this document.

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). Recognition of providers by Westfund is subject to change without notice as Westfund's sole discretion. Recognition by Westfund is for Benefit payment purposes only and is not to be construed as any recom- mendation 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 moneys 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 given by that Recognised Provider;
   • General Treatment Benefits are not payable for services or treatment performed by a Recognised Provider to the spouse, de facto partner or Dependents of the provider.Benefits are not payable in respect of Dependents of De- pendents registered on a Policy.

E1.7 Westfund may, in lieu of Benefits, provide services or appliances to a Member or Dependents.

E1.8 Where Benefits are determined as a percentage of the received cost of a service and the received 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 these rules) then Westfund will be entitled to commence recovery of any such amount or by deducting the amount from any other Benefits payable in respect of the Policy or any Premiums paid in advance.

E1.10 Notwithstanding these rules, Westfund shall have the right to recover, without prejudice, an ex gratia payment of Benefit in accordance with Westfund's Ex-Gratia policy.

E1.11 Waiting Periods are as detailed in Part F3 of these Rules

E1.12 Other conditions relating to Benefits, Limitation of Benefits and Claims are detailed in Parts F, E and G of these rules

E3.14 Prevention and Health Management

E3.14.1 Benefits for membership or classes fees with a fitness, pilates, yoga or swim centre are only payable where:
   • the membership or class is required to enable the Member to undertake a Health Management Programme for the treatment of a specific health condition or conditions; and
   • the Health Management Programme 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.

E3.14.2 Westfund may, at any time, and at its discretion, refuse to provide Benefit under this section to a Member that it deems to be in breach of the terms and conditions of the Policy.

E3.9 Dental Benefits

E3.9.1 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.

E3.9.2 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 at its absolute discretion, 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.

E3.9.3 The Dental Expert shall be at liberty, should they think fit, to satisfy themselves as to all matters in relation to the claim and make a decision as to the amount of the Benefits that are properly payable in accordance with these rules by Westfund. The Dental Expert shall act as an expert and not as an arbitrator and his decision shall be binding on Westfund and the Member. 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.

E3.9.4 No Benefits for Orthodontia are payable until a service has been provided. Where a member pays in advance of the service, Benefits will be paid progressively against the orthodontic completion of the orthodontist/general dentist. Benefits will be paid up to the full value of work completed and invoiced within the Benefit limit entitlement.

D6.2 Forced Retrenchment Benefit

D6.2.1 Westfund may waive Premiums upon application by the Primary Member or Spouse/Partner, of the same Westfund Policy, who has had 3 continuous years of Mem- bership at the date of application for the Forced Retrenchment waiver.

D6.2.2 Premiums may be waived by Westfund only if the following conditions have been met by the Member who has applied for the Forced Retrenchment waiver:
   • Application has been received by Westfund within three (3) months from the last day of paid employment
   • 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 decision
   • The Spouse/Partner of the Member, who has applied for the Forced Retrenchment pre- mium waiver, earns no more than the National Minimum Wage (Fair Work Ombudsman) plus 30% per week.

D6.2.3 The Forced Retrenchment waiver of premiums is applied from the date of verifica- tion of the application and is valid for one (1) calendar month or until such time that the Member's employment was entered into on a "contractor" type employ- ment 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 they satisfy all other criteria in D6.2 then they may be eligible for this benefit.

D6.2.4 The Forced Retrenchment waiver of premiums is applied from the date of verifica- tion of the application and is valid for one (1) calendar month or until such time that the criteria set out in D6.2 is no longer met, up to a maximum of six (6) consecutive calendar months.

E1.11 Advanced Surgery Benefit

E1.12 Advanced Surgery Benefit is payable where a member undergoes a procedure classified as Advanced Surgical in the Commonwealth Medical Benefits Schedule (CMBS), for the treatment of heart disease, stroke or cancer. The benefit payable is per night and is in addition to Hospital and Medical entitlements.

E1.12.1 Accident Benefit

E1.12.2 Accident Benefit is payable where a member is admitted to hospital as the result of an accident. The member must be hospitalised within seven days of the accident. The benefit payable is per night of continuous hospitalisation for a maximum 12 months. The Accident Benefit is not payable for rehabilitation.

E1.13 Accommodation Benefit

E1.11.1 Accommodation Benefit is payable for costs incurred as the result of boarding an hospital or nearby hospital of the patient or one member covered by the same Westfund Policy. Benefits are paid for the night before admission, for the nights during hospitalisation and the night of discharge. Benefits are not claimable for patient while admitted.

E1.15 Accidental Death Funeral Expenses

E1.15.1 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).

E1.15.2 Members who have downgraded to an Ambulance Only cover within this period (1st April 2007 – present) are not eligible for the benefit.

 Members who have terminated their Westfund membership and re-joined the fund at a later date are not eligible for the benefit.

 Members who were born after 1st April 2007 are not eligible for the funeral benefit.
F3 Waiting Periods

F3.1 Benefits are not payable in respect of services provided to a Member during a Waiting Period.

F3.2 When a Member of the health benefits fund of another private health insurer transfers to Westfund without a break in coverage, Westfund may apply all relevant Waiting Periods:

• to any Benefits under the Westfund Policy that were not provided under the previous cover;
• to any difference between the Benefits that would have been provided under the previous cover and the Benefits payable by Westfund where the Westfund Policy is higher;
• to the unexpired portions of any Waiting Periods not fully served under the previous cover;
• to the difference between any Excess or Co-Payment payable under the previous policy and the new Policy (where the previous Policy carried a higher Excess or Co-Payment).

F3.3 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.

F3.4 A new born child of a Member will not be automatically covered from birth unless the Policy has been a Policy which covers more than one person which has included the mother of the new born child as a Main Member, Spouse or Partner for at least two months prior to the expected date of the birth.

F3.5 Waiting Periods do not apply to newborns of a Member that has served all Waiting Periods. Any Waiting Periods that remain for a Member at the time of birth will be applied to newborns.

F3.6 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 Act) or to members of

F3.7 Benefits are not payable in respect of services provided during a waiting period. The following waiting periods apply to benefits payable for Hospital Treatment:

<table>
<thead>
<tr>
<th>Waiting Period</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident-related</td>
<td>One day</td>
</tr>
<tr>
<td>Psychiatric, Rehabilitation and Palliative Care</td>
<td>Two months</td>
</tr>
<tr>
<td>Obstetrics-related services</td>
<td>One year</td>
</tr>
<tr>
<td>Treatment of a Pre-existing Condition*</td>
<td>One year</td>
</tr>
<tr>
<td>All other hospitalisations (not listed above)</td>
<td>Two months</td>
</tr>
</tbody>
</table>

* Pre-Existing Condition

A pre-existing condition is an illness or condition for which, in the opinion of a medical practitioner appointed by Westfund, signs or symptoms existed during the 6 months before the date you joined Westfund or upgraded to a higher level of cover. A 12 month waiting period applies to all new Members for hospital costs relating to the treatment of pre-existing conditions.

F3.8 The following Waiting Periods apply to Benefits under General Treatment Policies:

<table>
<thead>
<tr>
<th>Waiting Period</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Ambulance Transport, Accident Benefit</td>
<td>One day</td>
</tr>
<tr>
<td>Non-Emergency Ambulance Transport, General Dental, Optical, Chiropractic, Osteopathic, Physiotherapy, Exercise Physiology, Complementary Therapies, Prescriptions, Vaccinations, Injections, Prevention and Health Management (excluding antenatal classes)</td>
<td>Two months</td>
</tr>
<tr>
<td>Specialist Dental, Major Dental, Orthodontia, Dental Top Up, Surgical Treatment by a Podiatrist, Antenatal Classes, Non Surgically Implanted Prosthesis, Sunglasses</td>
<td>One year</td>
</tr>
<tr>
<td>Accommodation Benefit, Advanced Surgery Benefit</td>
<td>Two years</td>
</tr>
<tr>
<td>Forced Retrenchment Benefit, Protected Industrial Action Benefit, Hearing Aids</td>
<td>Three years</td>
</tr>
</tbody>
</table>

E3.13 Non Surgically Implanted Prostheses

E3.13.1 Refer to Rule G – Claims for the following benefits where a letter of recommendation from a Medicare Registered Practitioner is required to validate benefits payable.

- Letter is valid for lifetime of policy: Artificial Limbs, CPAP Machines, EPAP Treatment, INR Monitor, Mammary Prosthesis and Brasseries (no letter required if a hospitalisation for a mastectomy is on Westfund’s system), Oral Appliance for Diagnosed Snoring (no letter required if provider is a dentist), Oxygen and Oxygen Accessories, TENS Machine, Wigs (no letter required if a hospitalisation for a medical condition is on Westfund’s system).

- Letter is valid for 12 Months: Burns Suit, Braces, Orthotics, Orthopaedic Boots, Low Vision Aid for Age Related Macular Degeneration, Mobility Aids.

E3.13.2 To be eligible for an Orthotic Benefit, orthotic items must be specifically made (custom made) or moulded (preformed) for the member and be for the support, alignment, prevention or correction of deformities of the feet.

E3.13.3 To be eligible for an Orthopaedic Boots Benefit, the orthopaedic boots must be individually handmade (Custom Made) for the member and be for the correction of an abnormality.

E3.13.4 To be eligible for a Brace Benefit the Brace must contain a solid support stabilizer component.

E3.13.5 To be eligible for a Repairs to Listed Non Surgically Implanted Prostheses Benefit the claim for the Repairs must be accompanied with a letter of recommendation from a Medicare Registered Practitioner stipulating the need for the device. Exception to this rule is if the original purchase claim for the device being repaired is in our system.

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, email or online by accessing Westfund’s website (www.westfund.com.au)

G1.2 Claim forms need to be completed in full including declarations by Member in relation to third party and workers compensation claims.

G1.3 Westfund reserves the right to refuse a claim that is not submitted on the correct form.

G1.4.4 - refer to Fund Rules.

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 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 and type of service
- 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.

G1.8 Additional Information required for Dental and Optical Receipts.

- Dental/Optical Item Numbers
- Additional Information required for Prescription/Vaccinations/Injections where official pharmacy receipt is provided.

E3.12 Non PBS Pharmaceuticals

E3.12.1 A Pharmaceutical Benefit for a prescription, vaccination or injection is payable on an item that is prescribed or administered by a medical practitioner. Where the Non PBS Pharmaceutical is provided by a pharmacy the receipt must detail the pharmacy prescription number.

E3.12.2 A Pharmaceutical Benefit is only payable on items costing over the standard Pharmaceutical Benefit Scheme (PBS) co-payment charge. This is re-set each year, effective 1st January.

E3.12.3 Pharmaceutical Benefits for prescriptions, vaccinations and injections are not payable for:

1. PBS Items supplied under the PBS scheme
2. Medical preparations where not prescribed or administered by a medical practitioner
3. Experimental and clinical trial pharmaceuticals
4. Contraceptives, anabolic steroids or cosmetic injections (eg botox) unless prescribed specifically for the treatment of a medical illness.
5. Items which have not been approved for sale in Australia by the authorities that regulate the sale of pharmaceuticals

Important Terms and Conditions are ONLY applicable to benefits which are provided in the Policy Summary section of this document.

The documentation should be read carefully and retained.