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 at www.border.gov.au.

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 e.g. 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.

Waiting periods may apply before you're eligible to claim for services covered under this policy.

Please refer to the Important Terms and Conditions section of this Policy Summary.
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 patient transport.

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

Non-emergency patient 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/

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westfund Services</td>
<td>Member fees at Westfund Dental Care Centres and Westfund Eye Care Centres.</td>
</tr>
</tbody>
</table>
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
- 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

Provider of Choice
Westfund has established a Provider of Choice Network to ensure members have no or known out of pocket expenses for selected General Treatment services. To see if a Provider of Choice is in your area use our search facility at www.westfund.com.au/health-services/provider-of-choice/
D6.2 Forced Retrenchment Benefit

D6.2.1 Westfund may waive Premiums 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 Forced Retrenchment Benefit.

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 Benefit:

- 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 Benefit, 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 D6.2 then he or she may be eligible for this benefit.

D6.2.3 The Forced Retrenchment Benefit is applied from the date of verification of the application and is valid for one (1) calendar month or until such time that the criteria set out in D6.2.2 are no longer met, up to a maximum of six (6) consecutive calendar months.

D6.3 Protected Industrial Action Benefit

D6.3.1 Westfund may waive Premiums 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 Protected Industrial Action waiver.

D6.3.2 Premiums may be waived by Westfund only if the following conditions have been met by the Member who has applied for the Protected Industrial Action waiver:

- 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 premium waiver, 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 the contractor is forced into retrenchment during the period of the contract and he or she satisfies all other criteria in D6.3 then he or she may be eligible for this Benefit.

D6.3.3 A Protected Industrial Action waiver may be granted provided the claim 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 Benefit may be extended for successive periods of one (1) week to a maximum of six (6) consecutive calendar months.

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:

- Hospital Treatment, and/or
- 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 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 provider’s business partner, or to the Spouse, Partner or Dependents of the provider;
- Benefits are not payable in respect of Dependents of Dependents 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 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 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 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 extension of time or 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 Fund Rules.

E1.13 Other conditions relating to Benefits, Limitation of Benefits and Claims are detailed in Parts E, F and G of Westfund Fund Rules.

E2 Hospital Treatment

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 Accommodation Benefit is payable for costs incurred as the result of boarding at a Hospital or nearby motel of the patient or one of the 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. This Benefit is not claimable for the patient while admitted.

E2.12 Accident Benefit is payable where a Member is admitted to Hospital as the result of an Accident. The Member must be hospitalised within 7 days of the Accident. The Benefit payable is per night of continued hospitalisation.
inous hospitalisation for a maximum 12 months. The Accident Benefit is not payable for rehabilitation.

E2.13 Advanced Surgery Benefit is payable where a Member undergoes a procedure classified as Advanced Surgical in the CMBS, for the treatment of heart disease, stroke or cancer. The Benefit payable is per night and commences the night following the Advanced Surgical procedure and concludes the night prior to the day of discharge of the initial hospitalisation. This Benefit is in addition to Hospital and Medical entitlements.

E3.1 General Treatment

E3.1.1 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:

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:
      • Department of Health - Pathology Services Table (PST); and
      • Health Insurance (Diagnostic Imaging Services Table) 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. 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 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 payable 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 as the maximum benefit for a prosthesis where the prosthesis is provided in circumstances in which a Medicare Benefit is payable.

• The amount set out in the Private Health Insurance (Complying Product) Rules 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 Westfund Fund Rules.

E3.6 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.

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

• the actual charge; or

• the Benefit payable under Westfund Fund Rules for the service or item.

E3.8 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 two services per day per Recognised Provider.

• Podiatry where a Member may receive Benefits for a Biomechanical Assessment and a general consultation on the same day per Recognised Provider.

E3.9 Dental Benefits

E3.9.1 Dental Benefits are payable as per Westfund’s Dental Schedules. A benefit quotation is available on request.

E3.9.5 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 certifications of work completed by the orthodontist/general dentist. Benefits will be paid up to the full value of work completed and invoiced within the Benefit limit entitlement (items 825 – 881).

E3.9.6 Members are eligible to claim a Benefit for a maximum of two services per item per Calendar Year for Dental Retainers (items 811, 821, 823 and 824).

E3.10 Optical Benefits

E3.10.1 Optical Benefits (other than sunglasses Benefit) are only payable for sight correction. This includes Irlen lenses specially tinted for dyslexia. Where Irlen lenses are provided by a Recognised Provider, they will receive a Benefit that is equivalent to a single vision Benefit.

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

E3.10.3 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.

E3.11 Consultations

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

• 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.

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 the amount 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:

• PBS Items supplied under the PBS scheme

• 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.

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 for:

• Artificial Limbs, CPAP Machines, EPAP Treatment, INR Monitor, Mammary Prostheses and Brassieries (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 for:

• 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 molded (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 Compression Garment Benefit, the compression garment or anti-embolism garment must be purchased as a consequence of diagnosed venous insufficiency, lymphoedema, chronic oedema or medically required post-operative treatment.

E3.13.6 to be eligible for 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 device being repaired has been previously claimed with Westfund.

E3.14 Prevention and Health Management Benefits

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 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.

E3.14.2 Vitamin Benefits are payable for vitamins and minerals listed with Westfund and Therapeutic Goods Administration (TGA) approved that contain the following:
• Vitamins must be any vitamin A-Z; or
• Mineral containing iron, potassium, calcium, magnesium or zinc, and excludes body building or weight loss food and drink.

E3.14.3 Benefits for Weight Loss Programs are payable only for joining or membership fees.

E3.14.4 For the purpose of chronic disease association fees Benefits, the chronic disease association must be either:
• Asthma Foundation, Diabetes Australia, Arthritis Australia, Coeliac Association, Crohn’s and Colitis Australia, Parkinson’s Australia, Multiple Sclerosis (MS) Australia, Alzheimer’s Australia, National Association of People with HIV Australia (NAPWHA), Lupus Association of Australia, MedicAlert Foundation, Stoma Associations (Ostomy, Colostomy).

E3.14.5 For the purpose of preventative health tests Benefits; the tests must not be Medicare claimable and be one of the following tests:
• Calcium score, Mole scan, Mammogram, Bowel testing kit, Bone density test, Thin prep pap test.

E3.14.6 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, Optical Coherence Tomography, Retinal Photography.

E3.14.7 Omega 3 Benefits are payable for Omega 3 listed with Westfund and Therapeutic Goods Administration (TGA) approved.

E3.14.8 Probiotic Benefits are payable for Probiotics containing Lactobacillus, Bifidobacterium and Streptococcus Thermophiles listed with Westfund and Therapeutic Goods Administration (TGA) approved.

E3.15 Accidental Death Funeral Expenses

E3.15.1 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). 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 Benefit.

E3.16 Laser Eye Surgery

E3.16.1 For the purpose of Laser Eye Surgery Benefits are payable for Lasik, ASLA and Smile procedures and must be performed by a Medicare registered Ophthalmologist.

E3.17 Travel Benefit

E3.17.1 A Travel Benefit is payable for travel to an outpatient specialist appointment when referred by a Medicare Registered Practitioner. A Travel Benefit will only be paid for a Medicare specialist consultation item number; or in the case of Specialist Dentists a dental consultation item number:
The provider must be a recognised specialist as per Westfund’s Recognition Criteria.

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.

<table>
<thead>
<tr>
<th>Distance Traveled</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 149km</td>
<td>Nil</td>
</tr>
<tr>
<td>150km - 200km</td>
<td>$20</td>
</tr>
<tr>
<td>201km - 250km</td>
<td>$25</td>
</tr>
<tr>
<td>251km - 300km</td>
<td>$30</td>
</tr>
<tr>
<td>301km - 350km</td>
<td>$40</td>
</tr>
<tr>
<td>351km - 400km</td>
<td>$50</td>
</tr>
<tr>
<td>401km - 450km</td>
<td>$60</td>
</tr>
<tr>
<td>451km +</td>
<td>$70</td>
</tr>
</tbody>
</table>

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 Benefit 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 newborn Child of a Member will be covered if they have been added to an eligible Policy (refer rule C1.3) within three months of birth.

F3.5 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 Child added to a Policy three months after their birth date will be subject to all Waiting Periods.

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 PHA Act) or to members of the Australian Defence Force or people in Antarctica who have health cover provided as part of their employment.

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>Service/Condition</th>
<th>Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident-related Accident Benefit</td>
<td>1 day</td>
</tr>
<tr>
<td>Psychiatric, Rehabilitation and Palliative Care</td>
<td>2 months</td>
</tr>
<tr>
<td>Obstetrics-related services</td>
<td>12 months</td>
</tr>
<tr>
<td>Accommodation Benefit, Travel Benefit</td>
<td>12 months</td>
</tr>
<tr>
<td>Treatment of a Pre-existing Condition*</td>
<td>12 months</td>
</tr>
<tr>
<td>Advanced Surgery Benefit</td>
<td>24 months</td>
</tr>
<tr>
<td>All other hospitalisations (not listed above)</td>
<td>2 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.

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

<table>
<thead>
<tr>
<th>Service/Condition</th>
<th>Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Ambulance Transport</td>
<td>1 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), Sunglasses</td>
<td>2 months</td>
</tr>
<tr>
<td>Specialist Dental, Major Dental, Orthodontia, Dental Top Up, Surgical Treatment by a Podiatrist, Antenatal Classes, Non Surgically Implanted Prostheses</td>
<td>12 months</td>
</tr>
<tr>
<td>Hearing Aids, Laser Eye Surgery, Forced Retrenchment Benefit, Protected Industrial Action Benefit, Hardship Provision</td>
<td>36 months</td>
</tr>
</tbody>
</table>

### F3.8 A Member who has held a Policy with Hospital cover for at least 2 months 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. The waiver can only be accessed once in a Member’s lifetime; as specified in the Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018.

### G Claims

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.

G1.2 Claim forms, where required, must 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 Refer to Westfund 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.

### Additional Information required for Dental and Optical Receipts

- Dental/Optical Item Numbers
- 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 Benefits paid by cash are payable to either the Primary Member or his or her authorised agent.

G1.14 Any supplementary documentation required from a Medicare Registered 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.

The documentation should be read carefully and retained.