



Fund Rules

Part III Relating to Queensland Country Health Fund

Effective 1 May 2026

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A INTRODUCTION

A1 Rules Arrangement

HBF has established, conducts and administers a Health Benefits Fund (the Fund). Since 30 June 2024 private health insurance policies issued under the “Queensland Country Health Fund” brand are taken to have been issued by HBF and form part of the Fund administered by HBF. Unless otherwise indicated, nothing in this part of the Fund Rules relates to health insurance products issued by HBF under its own brand or any brand other than Queensland Country Health Fund. Persons covered by HBF Products or GMF Products are directed to Part I of the Fund Rules. Persons covered by see-u Products are directed to Part II of the Fund Rules.

This part of the Fund Rules apply to all Queensland Country Health Fund policies and consist of:

- The General Conditions (Fund Rules A to G); and
- The Schedules (Fund Rules H to M)

A2 Health Benefits Fund

1. HBF is a registered Private Health Insurer trading as “Queensland Country Health Fund” (referred to throughout this part of the rules as “Queensland Country Health Fund”).
2. The Health Benefits Fund is established in accordance with the constitution of HBF.
3. The chief administration office of Queensland Country Health Fund is “Queensland Country Centre” Level 1, 333 Ross River Road Aitkenvale Townsville Queensland 4814.
4. This part of the Fund Rules govern the establishment and operation of the Health Benefits Fund and describe the obligations, requirements and entitlements of Members of the Health Benefits Fund issued with Queensland Country Health Fund branded products in accordance with this part of the Fund Rules and the obligations, requirements and entitlements of Queensland Country Health Fund in the operation of the Health Benefits Fund.
5. The Health Benefits Fund provides a financial service through the provision of health insurance business to assist people insured under complying health insurance products to meet the costs associated with treatment, goods or services that are provided to manage or prevent diseases, injuries or conditions.

A3 Obligations to Fund

A person applying for admission to the Fund with Queensland Country Health Fund branded Products shall:

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

The Policy Holder or their spouse or de facto partner shall inform the Fund as soon as reasonably possible after a change in any membership details.

A4 Governing Principles

This part of the Fund Rules relate to the health insurance business of Queensland Country Health Fund.

A5 Use of Funds

A5.1 Income credited to the Fund

Queensland Country Health Fund shall credit to the Fund:

- i) all Premiums paid by Policy Holders; and
- ii) any other moneys or income as required by the PHI(PS) Act to be credited.

A5.2 Use of Assets

Queensland Country Health Fund may use the assets of the Fund to:

- i) pay benefits in accordance with this part of the Fund Rules;
- ii) pay for other liabilities or expenses incurred for the business operations of the Fund;
- iii) make investments; or
- iv) make other distributions, payments or transfers permitted or required under the PHI(PS) Act or Corporations Act.

A6 No Improper Discrimination

The Fund must not:

- (a) take or fail to take any action; or
- (b) in making a decision, have regard or fail to have regard to any matter;

that would result in the insurer improperly discriminating between people who are or wish to be insured under a complying health insurance policy of the insurer.

Improper discrimination is discrimination that relates to:

- (a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or
- (b) the gender, race, sexual orientation or religious belief of a person; or
- (c) the age of a person, except to the extent allowed under the Act; or
- (d) where a person lives, except as permitted by the Act; or
- (e) any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for hospital treatment or general treatment; or
- (f) the frequency with which a person needs hospital treatment or general treatment; or
- (g) the amount or extent of the benefits to which a person becomes entitled during a period under a complying health insurance policy, except to the extent allowed under section 66-15 of the Act; or
- (h) any matter set out in the Private Health Insurance (Complying Product) rules or the Act for the purposes of this paragraph.

A7 Changes to Rules

- i) Queensland Country Health Fund may amend this part of Fund Rules at any time subject to any requirement to obtain approval from the Minister for Health in relation to any contribution rate increase.
- ii) All approved alterations to this part of the Fund Rules shall be duly promulgated without delay for the information of Members.

A8 Dispute Resolution

A Member may make a complaint to Queensland Country Health Fund about any aspect of their membership at any time.

Queensland Country Health Fund will make reasonable endeavours to respond to the complaint quickly and efficiently.

The complaint can either be oral or in writing addressed to:

The Complaints Officer
PO Box 42
Aitkenvale Qld 4814

If Queensland Country Health Fund cannot resolve the issue, the Member may contact the Private Health Insurance Ombudsman directly at:

Website: www.ombudsman.gov.au
Email: phio.info@ombudsman.gov.au
Phone: 1300 362 072
Write to: Private Health Insurance Ombudsman
Commonwealth Ombudsman
GPO Box 442
Canberra, ACT 2601 Australia

A9 Notices

- i) A copy of this part of the Fund Rules shall be available for perusal by Members at the chief administration office of the Health Benefits Fund.
- ii) Queensland Country Health Fund will send any correspondence to the most recently advised email or postal address of the relevant Member.

A10 Winding Up

- i) In the event of the Fund ceasing to be registered under the Act, the Fund shall be wound up in accordance with the requirements of the Act
- ii) In the event of the winding up of the Fund all monies not required for meeting outstanding liabilities, staff allowances, contracted payments and other expenses of winding up including the requirements of the Act, shall be applied in such manner as required by the Act.

A11 Other

- i) Continuity of this part of the Fund Rules
 - (1) The Rules of the Fund that are in force at the date of the provision of a service for which a Fund Benefit under this part of these Rules is provided, are the Rules which shall govern the provision of that Fund Benefit.
 - (2) Contributions paid in Advance for Tables provided under previous set of Rules shall be credited to Tables provided under this part of these Rules in such manner as to establish a common due date to which the Contribution is paid to each Table of these Rules.
 - (3) For the purpose of these Rules, a Table under a previous set of Rules shall be regarded as a Table under these Rules if Queensland Country Health Fund has effected an automatic transfer to Members of the previous Table to the Table specified in this part of these Rules.
 - (4) Any specified entitlements accrued to a Member under the previous set of this part of the Rules shall be deemed to accrue to the Member under this part of these Rules if the Member is automatically transferred to a Table that contains the specified entitlement that accrues.
 - (5) Any specified accrual for the purpose of a Deductible, limitation or qualification of Fund Benefits to be provided to a Member under a Table of a previous set of this part of the Rules, shall be deemed to have accrued for the same or similar Deductible, limitation or

qualification under this part of these Rules if the Member is automatically transferred to a Table that contains the Fund Benefit which is subject to the same or similar limitation or qualification.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

In this part of the Fund Rules:

- i) References to a previous set of Fund Rules include by implication a reference to the Fund Rules of the MIM or Queensland Country Health Fund Pty Ltd ABN 18 085 048 237.
- ii) The meanings attached to definitions in the Act shall unless otherwise specified in Rule B.2 be deemed to apply to this part of the Fund Rules of Queensland Country Health Fund.
- iii) A reference to a statute or a provision in a statute shall be read as if the words “or any amendment or re-enactment thereof or provision substituted therefore,” be added.
- iv) A reference to a Contract or a provision in a Contract shall be read as if the words “or any amendment thereof or provision substituted therefore,” be added.
- v) A reference to a Private Hospital shall include by implication a reference to a Day Hospital Facility and a reference to a Hospital shall include by implication a reference to a Public Hospital, a Private Hospital and a Day Hospital Facility.
- vi) Unless the context otherwise requires a term not defined in this part of the Fund Rules will be taken to have been taking to be defined in accordance with the meaning of the Act.

B2 Definitions

In this part of the Fund Rules unless the contrary intention appears:

“Accident” means accidental bodily injury caused solely and directly by external means, but excluding sporting accidents sustained by sportspeople in activities relating to their full-time employment as a sporting professional, including training and competition.

“Accredited Private Hospital” means a facility declared as a hospital by the Minister that is accredited with the Australian Council on Healthcare Standards.

“Act” means the Private Health Insurance Act (2007).

“Acupuncture Service” means service or treatment provided by an Acupuncturist accredited as an Acupuncturist with an organisation recognised by Queensland Country Health Fund and Australian Regional Health Group.

“ADA Schedule” means the Schedule of Dental Services published by the Australian Dental Association Incorporated.

“Admitted Patient” means an admitted patient as defined in the National Health Data Dictionary (version 4.0)

“Base Rate” means the contribution rate without an added Lifetime Health Cover loading.

“Benefit Table” means a Table providing a benefit or a range of benefits as specified in this part of these Rules.

“Better Hospital (Silver+) Table” means the Private Hospital Tables that provide benefits prescribed under Schedule H5 of this part of the Fund Rules.

“Budget Hospital (Basic+) 750” means the private hospital tables that provide benefits prescribed under Schedule H8 of this part of the Fund Rules.

“Certified Age at Entry” means the age that matches your age when you join a private health insurance hospital table.

“Chiropractic Service” means a service or treatment provided by a registered chiropractor or osteopath in private practice and includes x-rays.

“Clinical Psychological Service” means a clinical service provided by a registered Psychologist who is a member of an Association recognised by Queensland Country Health and excludes psychotherapy or similar services that may also be provided by a psychiatrist.

“Comprehensive Hospital (Gold) Table” means the Private Hospital Tables that provide benefits prescribed under Schedule H4 of this part of the Fund Rules.

“Contract” means a Purchaser-Provider Agreement.

“Contribution Group” means a group of Members approved by Queensland Country Health Fund for the purposes of Fund Rule C1 4.

“Cooling Off Period” means Queensland Country Health Fund will upon receipt of a written request allow any Member who has not yet made a claim to cancel their policy and receive a full refund of any premiums paid within a period of thirty (30) days from the commencement of their policy or upgraded policy.

“Core Hospital (Basic+) Table” means the private hospital tables that provide benefits prescribed under Schedule H9 of this part of the Fund Rules.

“Coronary Care Unit” means a coronary care unit in an Accredited Private Hospital.

“Couples Membership” means a membership containing two Members neither being a Dependent of the other Member.

“Cover” means Health Insurance cover offered by a fund which provides benefits for a specified range of services.

“Critically Ill” means a documented clinical condition of a patient where the attending medical practitioner certifies that in view of the medical signs evident the patient required treatment in an Intensive Care Unit because there was an immediate and significant threat to the patient’s likely survival.

“Deductible” means that amount of benefits of a Table not provided by a lesser benefits option of that Table.

“Default Benefit” means an amount determined by the Minister to be the minimum benefit payable under a Hospital Cover for a particular type of treatment in a Hospital.

“Delivery Date” means the expected due date of confinement as determined and provided in writing by the attending Physician/Obstetrician.

“Department” means the Commonwealth Department of Health or its successor or replacement.

“Dental Service” means a service, treatment, item or appliance provided by a registered dentist or dental prosthetist in private practice and included in the ADA Schedule.

“Dependent” means a person who is:

- (a) the natural child, adopted child, foster child, or stepchild of the Policy Holder or their covered Partner; or
- (b) a child being cared for under guardianship arrangements approved by Queensland Country Health Fund; and
- (c) is either a Dependent Child, a Non-classified Dependent, a Dependent Non-Student or a Dependent Student.

“Dependent Child” means a person who:

- (a) is under 18; and
- (b) does not have a partner.

“Dependent Non-Student” means a person who:

- (a) is aged 21 to 31 (inclusive);
- (b) is not receiving full-time education at a school, college or university, or working as an apprentice; and
- (c) does not have a partner.

“Dependent Student” means a person who:

- (a) is aged 21 to 31 (inclusive);
- (b) is receiving full-time education at a school, college or university (including by participating in a recognised vocational education program comprising structured training and work); and
- (c) does not have a partner.

“Dietetic Services” means a service or advice provided by a dietitian in private practice who is a member of the Dietitians Association of Australia, or any other organisation approved by Queensland Country Health Fund or who has proved conclusively to Queensland Country Health Fund that he/she is qualified to become a member of the Dietitians Association of Australia.

“Elective Admission” means an admission of a patient for care or treatment which, in the opinion of the treating clinician optional or open to the choice of the patient.

“Emergency” means an emergency admission of a patient for care of treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.

“Emergency Ambulance Transport Service” means where, in the opinion of a medical officer, a person requires immediate medical treatment in circumstances where there is a serious threat to a Member’s life or health.

“Essential Care Extras General Treatment Table” means a General Treatment Table providing the benefits that are specified in Schedule 18 of this part of the Fund Rules.

“Essential Extras General Treatment Table” means a General Treatment Table providing the benefits that are specified in Schedule 12 of this part of the Fund Rules.

“Essential Support Extras General Treatment Table” means a General Treatment Table providing the benefits that are specified in Schedule 19 of this part of the Fund Rules.

“Excess” means an amount of money the Policy Holder agrees to pay before Queensland Country Health Fund is liable to pay a benefit for hospital treatment.

“Excluded Service” means the Member will not be covered for care or treatment in either public or private hospital and will not receive a payment from Queensland Country Health

Fund for procedures outlined in an Excluded Service Table included in any product that contains excluded service/s.

“Exercise Physiology Service” means a service or treatment provided by a registered Exercise Physiologist in private practice.

“Extended Family Cover” means a Family Membership or Single Parent Family Membership with at least one Dependent Non-Student up to the age of 32 years, and is available on Top Hospital (Gold), Comprehensive Hospital (Gold), Better Hospital (Silver+), Vital Hospital (Bronze+), Intermediate Hospital (Basic+), Value Hospital (Basic+), Singles & Couples (Basic+) and Budget Hospital (Basic+) covers as a stand-alone product or packaged with an Extras product that is available for sale.

“Family Membership” means a membership that includes more than two Members of the same family not being a Single Parent Family Membership.

“Fund” means the Registered Health Benefit Fund conducted by Queensland Country Health Fund.

“Fund Benefit” or “Benefit” means in relation to a Policy issued under the QCHF Brand a benefit payable under this part of the Fund Rules.

“Fund Service” or “Service” means a service provided by or arranged by Queensland Country Health Fund to be directly provided in lieu of a Benefit.

“Gap Cover Scheme” means a scheme prepared by a registered organisation under which the registered organisation is able to offer no gap policies or known gap policies on a non contractual basis. A scheme is of no effect unless Ministerial approval has been given.

“General Dental” means a dental treatment that is generally performed within one visit including services such as diagnostic (e.g. examinations, consultations, x-rays etc), preventative (e.g. cleaning and scaling, fluoride treatment, mouth guards and oral hygiene instruction), simple extractions, restorative (e.g. composite and amalgam fillings) and general services (e.g., occlusal splints).

“General Treatment Table” means any general treatment benefit table for which benefits are prescribed under Schedule I of this part of the Fund Rules.

“Group Therapy Service” means a service or treatment that is provided by a registered physiotherapist or exercise physiologist in private practice and forms part of a Member’s treatment plan.

“HBF” means HBF Health Limited ABN 11 126 884 786.

“Health Benefits Fund” means the health benefits fund established and maintained by QCHF in compliance with Division 134 of the Act.

“Health Screening Services” means a medical examination or test that is not reasonably required for the medical condition of the patient or is not a Clinically Relevant Service e.g. for employment or life insurance purposes.

“Homoeopathic Service” means a service or treatment by a homoeopath in private practice who is accredited as a Homoeopath with an organisation recognised by Queensland Country Health Fund and Australian Regional Health Group.

“Hospital Purchaser-Provider Agreement” means an agreement entered into between Queensland Country Health Fund and a Hospital and as amended from time to time.

“Hospital Table” means a Table of hospital insurance that provides Benefits prescribed under Schedule H of this part of the Fund Rules.

“Hospital-substitute treatment” means General Treatment that:

- (a) substitutes for an episode of hospital treatment; and
- (b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury, or condition; and
- (c) is not specified in the Private Health Insurance (Complying Product) Rules as a treatment that is excluded from this definition.

“Intensive Care Unit” means an intensive care unit in an Accredited Private Hospital.

“Intermediate Hospital (Basic+) Table” means the Private Hospital Tables that provide benefits prescribed under Schedule H3 of this part of the Fund Rules.

“Known Gap Cover” means a contract of insurance entered into by a registered organisation that covers all but a specified amount or percentage of the full cost of particular hospital treatment and associated professional attention for the person or persons insured.

“Major Dental” means extensive dental treatment that cannot be completed in one visit including services such as periodontics (e.g. specialised gum treatment), surgical extractions (e.g. wisdom teeth extraction, removal of impacted teeth), endodontic (e.g. root canal therapy, root fillings), crowns and bridges, prosthodontics (dentures) and orthodontics (braces etc).

“Major Surgery” means surgery which is payable in accordance with Procedure Groupings 9, 10, 11, 12 or 13 as listed in the Surgical Procedures Handbook.

“Massage Service” means a therapeutic massage service provided by a registered Remedial Massage Therapist or Myotherapist accredited with an organisation recognised by Queensland Country Health Fund and Australian Regional Health Group.

“Medical Adviser” means a qualified medical practitioner appointed by Queensland Country Health Fund to give technical advice on professional matters.

“Medical Gap” is the amount of benefit payable for a professional service rendered to a patient in respect of Hospital Treatment received in a Hospital or a Facility for which a Medicare Benefit is payable:

- where the incurred medical expense is greater than the Schedule Fee, a benefit of 25% of that Schedule Fee;
- where the incurred medical expense is less than the Schedule Fee, the benefit is the amount by which the incurred expense exceeds 75% of that Schedule Fee.

“Medical Purchaser-Provider Agreement” means in relation to a Policy issued under the QCHF Brand an agreement entered into between Queensland Country Health Fund and a Medical Practitioner.

“Medicare Benefit” means a Medicare Benefit under Part II of the Health Insurance Act (1973).

“Member” means in relation to a Policy issued under the QCHF Brand a person covered by a health insurance policy provided by the Fund who pays contributions or on whose behalf contributions are paid.

“Membership Year” means in relation to a Policy issued under the QCHF Brand a year from the date of commencement of membership of a Table or from the anniversary date of the commencement of membership of a Table.

“MIM” means the MIM Employees Health Society.

“Minimum Default Benefit” means the minimum benefits which health funds have to pay for a hospital treatment if the health fund does not have a hospital purchaser-provider agreement with the hospital covering the hospital treatment.

“Minister” means the Minister for Health and Aged Care in the Commonwealth Government.

“No Gap Cover” means in relation to a Policy issued under the QCHF Brand a contract of insurance entered into by a registered organisation that covers the full cost of particular hospital treatment and associated professional attention for the person or person insured.

“Non-Australian Resident” means a person who is not entitled to Medicare Benefits and shall include an Australian Resident who is employed overseas during the periods of time that the Australian Resident is not entitled to Medicare Benefits.

“Non-classified Dependent” means a person who:

- (a) is aged 18 or over but under 21; and
- (b) does not have a partner.

“Occupational Therapy Service” means a service or treatment provided by an occupational therapist in private practice who is a member of the Occupational Therapists’ Association or the Queensland Association of Occupational Therapists, or any other organisation recognised by Queensland Country Health Fund or has proved conclusively to Queensland Country Health Fund that he/she is qualified to become a member of the Occupational Therapists Association.

“On-the-spot emergency treatment” means where an ambulance is called to provide immediate professional attention but transport by ambulance in the opinion of the attending medical officer is not required.

“Optical Service” means a repair or appliance provided by a registered optician or optometrist in private practice and excludes sunglasses.

“Orthoptic Therapy Service” means a service provided by an orthoptist in private practice who is a member of the Orthoptic Association of Australia or who has proved conclusively to Queensland Country Health Fund that he/she is qualified to become a member of the Orthoptic Association of Australia.

“Orthotist” is a provider in private practice who has been issued a Medicare Provider Number to supply orthotics.

“Out of Pocket Expense” means the amount the Policy Holder pays from their own pocket for a professional service. It is the difference between fees charged by doctors for in-hospital medical services and the combined health insurance and Medicare Benefit.

“Palliative Care” refers to the episode of care provided to a patient whose condition has progressed beyond the stage where curative treatment is effective and attainable or, where

the person chooses not to pursue curative treatment. Palliation provides relief of suffering and enhancement of quality of life for such a person. Interventions such as radiotherapy, chemotherapy, and surgery are considered part of the palliative episode if they are undertaken specifically to provide symptomatic relief.

“Participating Doctor” means in relation to a Policy issued under the QCHF Brand a medical practitioner who provides services under a no and or known gap agreement.

“Partner” means the spouse or other person living with the Policy Holder in a genuine domestic relationship.

“PBS” means the Commonwealth Government’s Pharmaceutical Benefits Scheme.

“Pharmaceutical benefit” is defined as any medicine listed in the Schedule of Pharmaceutical Benefits (published by the Department) that is dispensed to the Member.

“Physiotherapy Service” means a service or treatment provided by a registered physiotherapist in private practice.

“Plan” means one or more Products marketed together by Queensland Country Health Fund.

“Podiatry Service” means a service or treatment provided by a registered podiatrist in private practice.

“Policy Holder” means a holder of a policy that is referable to the Fund.

“Practitioner Agreement (PA)” means an agreement between a hospital and a medical practitioner relating to the rendering of hospital treatment by the medical practitioner.

“Pre-Existing Condition” means an ailment, illness or condition which, in the opinion of the Medical Adviser, or other relevant health care practitioner appointed by Queensland Country Health Fund to give advice on such matters, having regard to any information furnished by the health care practitioner providing the treatment and any other relevant information furnished in respect of the claim for benefit, existed at any time during the six months preceding the commencement of contributions for the benefit.

“Premium Care Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I6 of this part of the Fund Rules.

“Premium Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I1 of this part of the Fund Rules.

“Premium Support Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I7 of this part of the Fund Rules.

“Prescribed List” means the list of medical devices and human tissue products as approved by the Minister under the Private Health Insurance (Medical Devices and Human Tissue Products) Rules (No.1) 2026 (Cth), as amended from time to time.

“Private Health Insurer” means an organisation registered, or taken to be registered as such under the Act.

“Product” means Health Insurance cover offered by a fund which provides benefits for a specified range of services.

“Professional Service” means a professional service as defined in the Health Insurance Act (1973).

“Proof of Age” means the type of evidence that a fund will accept as proof of age. Queensland Country Health Fund may at its discretion accept other forms of evidence in addition to, or instead of current driver’s licence; current passport; and original birth certificate. The Fund may at its discretion in the absence of any documentation showing age, accept a statutory declaration.

“Prosthetist” is a provider in private practice who has been issued a Medicare Provider Number to supply orthotics.

“Psychiatric Patient” means a patient undergoing a psychiatric program under the supervision of a psychiatrist in a Public or Private Hospital, which has a Contract with Queensland Country Health Fund to provide such a program.

“Public Hospital (Basic+) Table” means the Hospital Table that provides benefits prescribed under Schedule H1 of this part of the Fund Rules.

“Pure Care Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I14 of this part of the Fund Rules.

“Pure Support Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I15 of this part of the Fund Rules

“Purchaser-Provider Agreement” means a Hospital Purchaser-Provider Agreement or a Medical Purchaser-Provider Agreement and includes a purchaser-provider agreement between Queensland Country Health Fund and any other provider.

“QCHF” means HBF trading as Queensland Country Health Fund.

“QCHF Brand” means Queensland Country Health Fund.

“QCHF Products” means products issued under the QCHF Brand, which for clarity are administered in accordance with the rules in this part of the Fund Rules.

“Registered or Recognised” in relation to a health care practitioner means a practitioner that is registered by a state registry body, if existing for that particular modality, or otherwise a practitioner accredited to practice privately with an accreditation or practitioners’ body nominated or to be nominated in this part of these Rules. A “Recognised practitioner” does not mean a practitioner that is “recognised” solely by Queensland Country Health Fund for the purpose of only paying benefits for that practitioner’s services.

“Rehabilitation Patient” means a patient undergoing a rehabilitation program under the supervision of a specialist in rehabilitative medicine in a Public or Private Hospital, which has a contract with Queensland Country Health Fund to provide such a program.

“Respite Care” refers to the accommodation of a patient in a Hospital where the primary reason for the admission is to provide temporary relief from the home care of the patient to the person who is administering the home care, rather than to provide care for the patient.

“Restricted Service” means a service or treatment in respect of which the benefit payable under a specified Hospital Cover is limited to the relevant Default Benefit.

“Schedule of Fees” means a table of fees in respect of professional medical services determined by the Fund or other professional body as the level of benefit reasonable for the particular service.

“Select Care Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I12 of this part of the Fund Rules.

“Select Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I4 of this part of the Fund Rules.

“Select Support Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I13 of this part of the Fund Rules.

“see-u Products” means a Product issued by HBF from 1 March 2024 under the brand “see-u by HBF” and prior to 1 March 2024 under the brand “CUA Health”.

“Signature Hospital (Silver+) Table” means the private hospital tables that provide benefits prescribed under Schedule H10 of this part of the Fund Rules.

“Single Membership” means a membership that only includes one person.

“Single Parent Family Membership” means a membership that includes at least two Members all but one of them being Dependents of the other Member.

“Singles & Couples (Basic+) Table” means the combined Private Hospital & Extras Tables that provide benefits prescribed under Schedule J1 of this part of the Fund Rules.

“Speech Pathology Service” means a service provided by a speech pathologist in private practice who is accredited by the Speech Pathology Association of Australia or who has proved conclusively to Queensland Country Health Fund that he/she is qualified to be an accredited member of that association.

“Table” means a Hospital Table or a General Treatment Table that provides entitlement to benefits specified in Schedule H and I, respectively of this part of the Fund Rules.

“Top Hospital (Gold) Table” means the Private Hospital Tables that provide benefits prescribed under Schedule H2 of this part of the Fund Rules.

“Ultra Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I5 of this part of the Fund Rules.

“Usual Customary and Reasonable Charge” means in relation to a service, the usual or customary fee charged for that service by other similarly qualified practitioners or a reasonable charge for that service as determined by Queensland Country Health Fund having regard for the usual or customary charges for a similar service and/or advice from the practitioner’s professional association or body.

“Value Hospital (Basic+) Table” means the Private Hospital Tables that provide benefits prescribed under Schedule H6 of this part of the Fund Rules.

“Vital Hospital (Bronze+) Table” means the Private Hospital Tables that provide benefits prescribed under Schedule H7 of this part of the Fund Rules.

“Waiting Period” means the waiting period that applies to a person for a benefit under an insurance policy:

- (a) starting at the date membership of a particular Table commences or recommences after the membership has lapsed and the person becomes insured under the policy; and
- (b) ending at the time specified in the particular Table of the policy during which the person is not entitled to the benefit.

“Young Care Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I10 of this part of the Fund Rules.

“Young Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I3 of this part of the Fund Rules.

“Young Support Extras Table” means the General Treatment Table that provides the Benefits specified in Schedule I11 of this part of the Fund Rules

B3 Other

C MEMBERSHIP

C1 General Conditions of Membership

C1 1 Membership Categories (Insured Groups)

- (a) Single – only one person
- (b) Couple – two adults (and no one else)
- (c) Family – this consists of
 - (ii) three or more people (only two of whom are adults, the rest of whom are Dependent Children, Non-classified Dependents, or Dependent Students); or
 - (iii) two or more people, none of whom is an adult (Dependents only)
- (d) Single parent family – two or more people (only one of whom is an adult and the rest of whom are Dependents)
- (e) Single parent extended family – two or more people (only one of whom is an adult, at least one of whom is a Dependent Non-Student, as well as any Dependent)
- (f) Extended family – three or more people (two of whom are adults, and at least one of whom is a Dependent Non-Student), as well as any Dependents.

C1 2 Levels of Cover

A person may be admitted as a Policy Holder to the Fund in one of the membership categories in respect of one of the following covers:

- Any one level of hospital cover set out in Schedule H of this part of the Fund Rules: or
- Any combination of one level of hospital cover and one level of General Treatment cover set out in Schedule I of this part of the Fund Rules.
- General treatment cover limited to Select Extras and Young Extras. Details of these products are set out in Schedule I of this part of the Fund Rules.

C1 3 Membership Responsibilities

i) Responsibility for the Membership

A Policy Holder and their spouse or de facto partner included on the same membership (where applicable) is deemed by the Fund to have responsibility for the administration and maintenance of the policy and will:

- Ensure that all information supplied to the Fund is true and correct for all persons on the policy
- Keep the membership information up to date and notify the Fund of any changes as soon as possible
- Be the recipient/s of all correspondence for the policy
- Be the only person/s who can add others to the policy
- Have access to details of claims information for all persons on the policy except a Dependent aged 16 years and over. Claims information includes services claimed, date, provider and cost and benefit for each service.

Administration and maintenance of the policy is deemed to include:

- Changing any details on a policy (e.g. contact details, debit and credit information)
- Changing the level of cover
- Adding eligible persons to the policy
- Receiving benefits on behalf of other persons on the policy.

The only exclusion to this authority applies to a spouse or de facto partner. They cannot:

- Terminate the policy, or
- Remove the Policy Holder from the policy.

ii) Sole Responsibilities of the Policy Holder

It is the Policy Holder's sole responsibility to:

- Ensure that all persons on the membership are aware of and abide by the terms and conditions of the health insurance policy, including this part of the Fund Rules our Fund Rules and Fund Policies as amended from time to time.
- Make the minimum advanced premium payments required to keep the policy financial.

The Policy Holder may withdraw this authority for their spouse or de facto partner to have administration and maintenance rights on their policy at any time by calling the QCHF Contact Centre on 1800 813 415.

C1 4 Contribution Groups

Queensland Country Health Fund may, at its discretion, approve any group of Members as a contribution group.

C2 Eligibility for Membership

- Subject to this part of the Fund Rules any person is entitled to apply for his or her own contributory membership of the Fund.

C3 Dependents

- Once a person no longer meets the requirements of a Dependent as defined in section B2 of this part of the Fund Rules, that person will not continue to be covered under the family membership policy.

C4 Membership Applications

- Applications for membership must be in the format required by Queensland Country Health Fund.
- Any person who applies for membership may also apply for membership to cover his or her Partner and/or his or her Dependents.
- If a Dependent is an adopted child or foster child, written evidence of the adoption/foster is required prior to adding this child to a family membership.
- The applicant must supply all information requested in their application and any additional information relevant to the application that is requested by Queensland Country Health Fund.
- Before an application may be accepted by Queensland Country Health Fund it must be accompanied by at least one month's contribution payment for the Table nominated.
- Before an application for a General Treatment table may be accepted by Queensland Country Health Fund it must be purchased with at least the Budget Hospital (Basic+) table, with the exception of Young Extras and Select Extras which can be purchased as a stand-alone product.
- Subject to this part of the Rules all applications for admission as a Policy Holder to Queensland Country Health Fund shall be in such format and shall contain such information concerning the Policy Holder, Partner and Dependents as Queensland Country Health Fund shall from time to time prescribe. Upon acceptance of an application for admission as a Policy Holder to a Benefits Table, a person shall, subject to this part of the Rules, continue to be entitled to make contributions to that table.
- Private Health Information Statements will be made available to people who ask for information about health insurance products.
- Private Health Information Statements will be provided to an adult insured under each policy:
 - when the Policy Holder first becomes insured by Queensland Country Health Fund; and
 - at least once every twelve months thereafter.

- x) If Queensland Country Health Fund is proposing to change this part of the Fund Rules Queensland Country Health Fund will inform an adult insured under each policy of the proposed change in a reasonable time before the proposed change takes effect and;
- xi) If Queensland Country Health Fund is proposing to change this part of the Fund Rules in a way which is or might be detrimental to the interests of an insured person and the proposed change will require an update to the Private Health Information Statement, Queensland Country Health Fund will also give the updated Private Health Information Statement to an insured adult under each policy.
- xii) Queensland Country Health Fund shall have the right to refuse to accept an application for membership of the Fund from a person whose membership was cancelled through application of Rule C.7.
- xiii) Queensland Country Health Fund shall not refuse to accept any membership application on the grounds of the health of the applicant or any of the persons included in the application.
- xiv) The commencement date of an accepted membership shall be the day the membership application is accepted by Queensland Country Health Fund or such date nominated by the applicant whichever is the later date.
- xv) All persons included in a membership application that is accepted shall be, whilst eligible under this part of the Fund Rules, included as Members within the membership granted.
- xvi) Members of the Fund shall have the right to obtain from Queensland Country Health Fund, the Benefits as provided under this part of the Fund Rules.
- xvii) Queensland Country Health Fund has the right to apply the Waiting Periods specified under this part of the Fund Rules but shall generally not exercise that right in accepting membership of:
 - (1) a previous Member of a current membership who successfully applies for new membership within two months of being rendered ineligible under this part of the Fund Rules to continue in that previous membership.
 - (2) a new born child of a Family Membership.

C5 Duration of Membership

- i) A membership has the right to continue until the death of the last survivor of the membership subject to the following conditions:-
 - (1) The contributions appropriate to the status of the membership are paid according to this part of the Fund Rules,
 - (2) Each Member of the membership observes the membership requirements of this part of the Fund Rules.

C6 Transfers

- i) If a person who is a Member of a fund of another registered private health insurer applies for membership of a Table of this Fund, and that person is eligible for membership under this part of the Fund Rules, then that person shall be accepted for membership of that Table. Any period of immediately prior membership of the table providing the same or similar benefits in the previous fund shall count as membership of the Table of membership of this Fund for the purpose of any Waiting Period to be served. For Extras and mechanical aids benefits, membership of a previous fund shall not count for the purpose of any incremental benefit or benefit limit where the increment requires accrued Membership of a specific Table of this Fund.
- ii) In accepting a transfer of membership from another Health Benefits Fund, Queensland Country Health Fund shall have the right to include Waiting Period conditions to the

- membership for such portions of any benefit payable under the Table that are in excess of the previous benefit entitlements.
- iii) A transfer initiated by a Policy Holder from one Table to another Table providing similar benefits, or from one option to a different option of the same Table resulting in a reduction of an excess, shall be treated as a transfer from another health benefits fund.
 - iv) A transfer initiated by Queensland Country Health Fund from one Table to another Table providing similar benefits or from one option to a different option of the same Table, shall not require any extra Waiting Periods to be served for additional Fund Benefits that may be provided other than those Waiting Periods that would otherwise have been required under this part of the Fund Rules. Membership of the previous Table shall also be counted as membership of the new Table for the purpose of any incremental Benefit or Benefit Limit based on accrued membership of the Table.
 - v) Persons transferring to a retained age-based discount policy from another age-based discount policy will retain their discount assessment date that applied under the old policy, and consequently the applicable discount percentage applying at the time of transfer.
 - vi) If a person ceases to be insured under a policy of Queensland Country Health Fund and does not become insured under another policy of Queensland Country Health Fund, Queensland Country Health Fund will give the person a transfer certificate as required under section 99-1 of the Act within 14 days of the person ceasing to be insured.
 - vii) If a transfer certificate is requested by a new insurer Queensland Country Health Fund will give a transfer certificate to the new insurer within 14 days of the request from the new insurer.

C7 Cancellation of Membership

- i) Queensland Country Health Fund shall not have the right to cancel the membership of any Member on the grounds of the health of that Member.
- ii) Queensland Country Health Fund shall have the right to cancel the membership of a Member from the date of notification to that Member, if any Member in that membership has, in the opinion of Queensland Country Health Fund, committed or attempted to commit fraud upon Queensland Country Health Fund. Any contributions paid in advance of the date of cancellation of membership may be first applied by Queensland Country Health Fund to offset the cost of the fraud or attempted fraud, with Queensland Country Health Fund being only liable to the Policy Holder of the cancelled membership for any balance remaining.
- iii) If contributions tendered by a health care provider have been returned in accordance with Rule D1 (ii), Queensland Country Health Fund shall have the right to cancel the membership for which contributions have been returned from the date paid to, prior to the date the returned contributions were tendered.
- iv) Queensland Country Health Fund shall have the right to cancel the membership of a Member if the application for membership for that Member contained inaccurate or incomplete information in a material respect and such right may be effected from the date such membership commenced.
- v) Queensland Country Health Fund shall have the right to cancel a membership if any Member of that membership is a Member of another registered health benefits organisation.
- vi) If Queensland Country Health Fund has exercised its rights to cancel a membership, Queensland Country Health Fund shall have the right to refuse an application for membership from the cancelled Member.
- vii) The liability of Queensland Country Health Fund to refund any contribution payments received, shall be limited to the period of two (2) years prior to the date of the receipt by Queensland Country Health Fund of written notification of the circumstances which would

render a Policy Holder, Partner or Dependent ineligible to receive benefits under this part of the Fund Rules.

- viii) A cooling off period may apply if a Member makes written application to cancel their policy within thirty (30) days of commencement of their policy or upgraded policy.

C8 Termination of Membership

- i) A Policy Holder has the right to terminate a membership from any due date of contributions on or after the date the advice in writing of termination of membership has been received by Queensland Country Health Fund. On termination the contributor shall receive a refund of any contributions paid in advance of the date of termination.
- ii) The Policy Holder and their spouse or de facto partner has the right to terminate the membership of any one or more Members for whom contributions are paid but continue Membership of any other Member or Members for whom contributions are paid. The exception to this rule is that the spouse or de facto partner cannot remove the Policy Holder from the policy or terminate the membership.

C9 Temporary Suspension of Membership

- i) Membership of the Fund may be suspended by Queensland Country Health Fund upon application by the Policy Holder or their spouse or de facto partner.
- ii) Suspension of membership may be granted by Queensland Country Health Fund upon application if the reason for the suspension is:
 - (1) The temporary absence from Australia for more than 4 weeks (28 days) and no more than 24 months (730 days) and provided that:
 - (a) the membership is paid at least one (1) month in advance of the suspension date and when the membership is reactivated any premiums paid in advance will be applied to the membership at the rate applicable at the time the membership is reactivated; and
 - (b) all waiting periods have served on the membership at the time of suspension; and
 - (c) the entire membership is suspended. The suspension applies to all persons with cover under the membership. There is no allowance for partial suspension; and
 - (d) if the membership has previously been subject to a period of suspension, at least six (6) months active cover have been maintained since the previous suspension.
 - (2) For any other reason and for any other period that Queensland Country Health Fund considers appropriate until such time as a further contribution is paid provided that such payments are resumed from the date as directed by Queensland Country Health Fund.
- iii) Services provided to a Member during a period of suspension of membership shall not be eligible for benefits.
- iv) A period of suspended membership shall not qualify for the purpose of completing any Waiting Periods that are to be served by a Member before the Member is eligible to receive benefits.

C10 Other

D CONTRIBUTIONS

D1 Payment of Contributions

- i) Contributions may be paid by a Policy Holder or on behalf of a Policy Holder, through a payroll deduction scheme arranged by Queensland Country Health Fund, by Bpay, by direct debit from a Queensland Country Credit Union Ltd account or other financial institution account or such other arrangements as are authorised by Queensland Country Health Fund from time to time.
- ii) All contributions must be paid in advance, but a Policy cannot be more than 2 years in advance in total.
- iii) Any amounts tendered as contributions by a health care provider on behalf of a Member other than the provider's Partner or Dependent shall be returned to that provider if the Member attempts to claim benefits in respect of services rendered by the provider who tendered the contributions.
- iv) An amount received as contribution to a particular Benefits Table shall be applied first in payment of any arrears of contribution to that Benefit Table and then applied in respect of future periods in chronological order.

D2 Contribution Rate Changes

Queensland Country Health Fund must apply to the Minister for approval to change the premium charged for a complying health insurance product.

D3 Contribution Discounts

Queensland Country Health Fund may apply discounts in accordance with Act, including in relation to Members of a Contribution Group.

D4 Lifetime Health Cover

Queensland Country Health Fund will increase premiums and apply other Lifetime Health Cover criteria as required in accordance with the Act.

D5 Arrears in Contributions

- i) If a Policy Holder has not met a contribution payment prior to the 'paid to' date, then that Policy Holder shall be regarded as being in arrears.
- ii) When a Policy Holder is more than two months (63 days) contribution payments in arrears then the membership shall lapse from the date two months (63 days) after the 'paid to' date of the membership.
- iii) No benefits shall be paid for services rendered to a Member during the period in which the membership is in arrears until the membership arrears contributions are paid.
- iv) Queensland Country Health Fund shall have the right to refuse to accept membership arrears contributions to reinstate the membership if these contributions are tendered after the date of lapse of the membership.

D6 Other

E BENEFITS

E1 General Conditions

The following conditions apply to all benefits:

1. Benefits are not payable in respect of services provided to a Member during the Waiting Period.
2. Benefits are not payable in respect of services that have been provided to a Member during a period for which his membership contributions have not been paid.
3. Benefits are limited to 100% of the documented cost to the membership of any service or item for which benefits are payable, however Queensland Country Health Fund may at its discretion accept an assignment to a hospital of benefits payable for hospital treatment or hospital substitute treatment.
4. Where benefits are determined as a percentage of the receipted cost of a service and the receipted cost of a service appears excessive, Queensland Country Health Fund has the right to determine the benefit from the Usual, Customary and Reasonable charge it determines for that service.
5. Benefits are not payable in respect of a service, which has been provided by Queensland Country Health Fund or has been arranged to be provided directly to a Member through a Purchaser-Provider Agreement between Queensland Country Health Fund and the Provider.
6. Benefits are not payable in respect of a service that has been rendered to a Member if the expenses in respect of that service were incurred by the employer of that Member or if the Member to whom that service was rendered, obtained that service in connection with, or in conjunction with, employment or application for employment or an industrial undertaking or profession or a life insurance examination or the like.
7. Benefits are not payable in respect of services provided to a Member being services that have been provided by a Defence establishment or other Government authority which under the normal course of events would not have raised a fee for such service had the Member not been covered by health insurance.
 - i) 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 Queensland Country Health Fund, a right to claim compensation from a third party or authority at law or under any insurance or scheme of arrangement.
 - ii) In circumstances in which Rule E1.7(i) applies, and Queensland Country Health Fund pursuant to Rule E1.14 makes an "ex-gratia" payment, the Member shall repay to Queensland Country Health Fund any such ex-gratia payment, including the payment of interest at no more than commercially applicable interest rates, 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 Queensland Country Health Fund. Where the Member receives, or becomes entitled to receive, a lesser amount than the sum of ex-gratia payments made by Queensland Country Health Fund, then the Member's liability to repay to Queensland Country Health Fund shall be limited to such lesser amount.
 - iii) In addition to any other terms or conditions which Queensland Country Health Fund may apply under Rule E1.14, the Member shall provide:
 - (a) an undertaking in a form approved by Queensland Country Health Fund to repay to Queensland Country Health Fund the amount of the ex-gratia payment;
 - (b) an undertaking to keep Queensland Country Health Fund informed of progress towards resolution of the claim and to provide access to Queensland Country Health Fund to any settlement terms reached; and,

- (c) an undertaking to notify Queensland Country Health Fund within 14 days either personally or through his Solicitor when a settlement is reached.
8. Benefits are not payable in respect of a service rendered in the absence of illness, disability or disease except at the discretion of Queensland Country Health Fund.
 9. Benefits are not payable in respect of an in-patient Professional Service for which a Medicare Benefit is not payable.
 10. Where a membership includes a lesser benefits Table that includes a Deductible, benefits provided by that Table are not payable in each Membership Year in respect of the Deductible amount of benefits that would otherwise be payable.
 11. In the event that a benefit has been erroneously paid then Queensland Country Health Fund shall, within 24 months of making the erroneous payment, be entitled to recover any such amount that should not have been paid under this part of the Fund Rules.
 12. Without prejudice to any remedy otherwise available to it, Queensland Country Health Fund shall be entitled to set off against, and deduct from moneys otherwise payable then or thereafter by it to the contributor, any amount recoverable by it by virtue of Rule E1.11.
 13. Benefits shall not be payable for services which occurred more than 24 months before the lodgment of a valid claim.
 14. Notwithstanding the terms and conditions of this part of the Fund Rules, Queensland Country Health Fund shall have the right to relax any particular term or condition in specific instances and Queensland Country Health Fund shall also have the right to provide, without prejudice, an ex-gratia payment of benefit under such terms and conditions as it shall decide.
 15. For overseas hospitalisation and ancillary care, no benefits will be payable.
 16. Queensland Country Health Fund may request any medical or other evidence, which it considers necessary to determine eligibility for benefits. In the event that the supplier of any such evidence raises a charge, the Member shall be responsible for the charges incurred.
 17. Benefits are not payable for Health Screening Services.
 18. Benefits are not payable in respect of services or treatment rendered by a medical practitioner or by a provider of General Treatment Benefits to Dependents or Partners or a Partner's Dependents if a legally enforceable debt is not incurred.
 19. A benefit will be payable for any treatment for which the Private Health Insurance (Benefit Requirements) Rules specify there must be a benefit and the amount of the benefit will be the greater of:-
 - (i) The amount calculated in the Private Health Insurance (Benefit Requirements) Rules as the minimum benefit for that treatment; and
 - (ii) If Queensland Country Health Fund has entered into a Hospital Purchaser-Provider Agreement or a Medical Purchaser-Provider Agreement with the relevant hospital or relevant medical Practitioner, the amount agreed in that agreement.
 20. For Members who are Australian citizens and permanent residents Queensland Country Health Fund will pay a benefit of 25% of the schedule fee for hospital treatment and hospital substitute treatment. Members who are not eligible for Medicare, and these will include some Australian citizens and permanent residents who choose not to enroll with Medicare, as well as temporary Australian residents, international students and non-Australian residents Queensland Country Health Fund will also pay a benefit of 25% of the schedule fee on hospital treatment and hospital substitute treatment but these people may not be eligible to receive a benefit from Medicare which normally represents 75% of the schedule fee.
 21. A benefit will not be payable if the services are part of a course of treatment that is not recognised by Queensland Country Health Fund.
 22. A benefit will not be payable unless the service or treatment has been provided by a practitioner or therapist recognised by Queensland Country Health Fund.
 23. A benefit will not be payable unless the treatment or service is covered under the Member's level of cover and the treatment or service is provided to a person on the Membership.

24. A benefit will not be payable until the conditions of the level of cover have been met.
25. The amount of benefit is calculated on the cost of the treatment or aid to the Member, taking into account any allowances or discounts given by the Provider. No benefit paid by Queensland Country Health Fund can exceed the actual charge of the service or appliance.
26. A benefit will not be payable for an ancillary treatment if a Medicare Benefit is payable.

E2 Hospital

E2 1 i) All Hospital Tables shall provide entitlement to Fund Benefits as follows:

- (1) Benefits for the Medical Gap.
- (2) Subject to 4 and 5 below, where a Contract exists between Queensland Country Health Fund and a medical practitioner for an amount payable for a professional service rendered to a patient in respect of hospital treatment or hospital substitute treatment, the benefit will be that amount. Where a Contract exists between Queensland Country Health Fund and the Hospital or a billing entity operated by the doctors that implicitly includes the medical practitioners who provide services at the Hospital, then the amounts specified in that Contract for professional services rendered to patients of that Hospital.
- (3) If a Member resides in New South Wales or the Australian Capital Territory an entitlement from the respective State or Territory Governments of ambulance transport free of charge anywhere in Australia provided that a valid levy has been raised against Queensland Country Health Fund for the provision of this service.
- (4) For any part of hospital treatment that is one or more of the following:
 - (a) psychiatric care;
 - (b) rehabilitation;
 - (c) palliative care;

if the treatment is provided in a hospital and no Medicare Benefit is payable for that part of the treatment, then the benefit will be the greater of:-

- ii) The amount calculated in the Private Health Insurance (Benefit Requirements) Rules as the minimum benefit, for that treatment; and if Queensland Country Health Fund has entered into a Hospital Purchaser-Provider Agreement with the relevant hospital, the amount agreed in that agreement.
- (5) For the provision of surgically implanted medical devices and human tissue products on the Prescribed List implanted during a medical procedure in circumstances:
 - (a) in which a Medicare Benefit is payable; or
 - (b) set out in the Prescribed List for the purposes of this table item, the benefit will be the greater of:-
 - (i) the fee up to the benefit determined by the Minister on the Prescribed List; and
 - (ii) If Queensland Country Health Fund has entered into a Hospital Purchaser-Provider Agreement with the relevant hospital, the amount agreed in that agreement.

PROVIDED HOWEVER that if the Prescribed List sets out an amount, or a method of calculating an amount, as the maximum benefit for the item, then the benefit will be no more than that amount. Members may incur an out of pocket expense.

- (6) For Members who are not covered for emergency ambulance transport services by their State or Territory Government or other state ambulance service recognised by Queensland Country Health Fund, we will provide a benefit for persons covered under QCHF hospital covers for nationwide Ambulance Cover. The benefit is capped at one Emergency Ambulance Transport Service or one On-The-Spot Emergency Treatment per person per Membership Year and there is a one (1) day waiting period. Emergency ambulance transport is covered when it results from an event that is unplanned, non-routine and which requires immediate medical attention. No benefit will be paid in respect of air services (including helicopter services) or road transport services that are not

operated by a State or Territory Government or an organisation that is not recognised by us.

- (7) Queensland Country Health Fund will pay an accommodation benefit related to an in-hospital admission in accordance with the Act. The benefit will be paid towards the accommodation costs for a carer, partner or parent/s of a Dependent who accompany the patient limited to the duration of the patient's hospital admission when the treatment or service is covered by a current hospital policy. The accommodation benefit will be paid where the total return distance is 300 kilometres or more from where the patient resides, except in the situation where a parent or carer travels with a Dependent aged 12 years and under (the patient), where there is no minimum travel distance required. The benefit is limited to \$50 per night for the duration of the hospital admission, including the night prior to admission and the night of discharge and eligibility criteria applies.

E2 1 ii) The following conditions apply to Benefits payable from all Hospital Tables:

- (1) Hospital Benefits and Professional Services benefits shall, where applicable, be paid in accordance with the terms and conditions of the National Health Act and the Private Health Insurance Act.
- (2) Hospital benefits are not payable for Respite Care.
- (3) The Deductible amounts which apply to Members covered under the lesser benefits Private Hospital Table applies per person per Membership Year.
- (4) Where a Member is transferred to another hospital or re-admitted to the same or another hospital for the same medical condition or for a medical condition, which, in the opinion of the Medical Adviser is closely related to the condition for which the earlier Hospital accommodation benefits were payable, the Patient Classification at transfer or re-admission will be deemed to be a continuation of the previous Patient Classification for which there is an entitlement to accommodation benefits under this part of the Fund Rules.

E3 General Treatment

1. For the provision of Hospital-substitute treatment for surgically implanted medical devices and human tissue products on the Prescribed List implanted during a medical procedure in circumstances:

- (a) in which a Medicare Benefit is payable; or
- (b) set out in the Prescribed List for the purposes of this table item, the benefit will be the greater of:-
 - (i) the fee up to the benefit determined by the Minister on the Prescribed List; and
 - (ii) If Queensland Country Health Fund has entered into a Hospital Purchaser-Provider Agreement with the relevant hospital, the amount agreed in that agreement

PROVIDED HOWEVER that if the Prescribed List sets out an amount, or a method of calculating an amount, as the maximum benefit for the item, then the benefit will be no more than that amount. Members may incur an out of pocket expense.

2. All other Hospital-substitute treatment covered by the Tables shall provide entitlement to Fund Benefits as follows:

- i) Benefits for the Medical Gap provided however that no benefit is provided if a Medicare Benefit of an amount that is at least 85% of the schedule fee is claimed for the treatment.

3. Other General Treatments and the benefits payable in relation to such treatments are detailed in Section I of this part of the Fund Rules.

E4 Other

F LIMITATION OF BENEFITS

F1 Co-Payments

F2 Excesses

An excess is an amount that a Policy Holder agrees to contribute towards the cost of hospital treatment if a person covered on their policy has been admitted as a private patient at a public or private hospital or a day hospital facility.

The excess is payable on the first hospital admission per person covered within a Membership Year and the excess resets at the start of the next Membership Year. If the excess contribution on the first hospital admission is less than the excess option chosen, if admitted to hospital again in the same Membership Year the remainder of the excess obligation is required to be paid.

The amount of excess and relevant limits and conditions are as specified in the Schedule relevant to the Policy Holder's cover.

F3 Waiting Periods

A Waiting Period is a period of time, from the commencement/recommencement of cover that is required to be served before benefit entitlements commence. Immediate benefits are available in the event of an accident that occurred after joining (excluding sporting accidents sustained by sportspeople in activities relating to their full-time employment as a sporting professional, including training and competition).

Twelve month Waiting Periods apply for the following: Pre-existing Conditions, Australian Hearing Services, hearing aids, pregnancy and birth related treatment and services, childbirth education and midwifery services, artificial aids and mechanical appliances, nursing services, mammograms and bone densitometry, periodontic services, endodontic services, oral surgery services, prosthodontic services, orthodontic services, crowns and bridges.

Two month Waiting Periods apply for most other items or services including psychiatric care, rehabilitation or palliative care (whether or not for pre-existing).

A one day Waiting Period applies to emergency ambulance treatment.

Babies born under a parent's single membership are covered so long as the policy is upgraded to a family or single parent cover within two months after the birth date of the baby. The baby will not have to serve any Waiting Periods that have already been fully served by the Policy Holder providing that the change is made to the policy within this time frame. For Policy Holders who have not fully served their Waiting Periods, the pre-existing condition Waiting Periods may apply to the baby within the first twelve (12) months.

A foster child being added to a family membership must serve all relevant Waiting Periods.

The Fund may at its discretion waive or reduce any Waiting Period.

F4 Exclusions

Hospital Treatment for which Medicare is not required to pay a benefit is excluded from all products.

Benefits are only considered for cosmetic surgery if the procedure attracts a Medicare item number and a Medicare claim is successful.

Some products may exclude the Member from receiving benefits for the cost of certain forms of Hospital Treatment. Details of exclusions are contained in the associated Schedules.

F5 Restricted Benefits

Some products may have benefits that are restricted to the Minimum Default Benefit on particular Hospital Treatments. Details of restrictions are contained in the associated Schedules.

F6 Compensation Damages and Provisional Payment of Claims

Benefits are not payable where a Member receives services which, in the opinion of Queensland Country Health Fund, relate to an accident, illness, injury, condition or other incident 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.

F7 Other

G CLAIMS

G1 General

No benefits are payable on services where the claim is submitted more than 24 months after the date of service.

G2 Other