FUND RULES

EFFECTIVE 26 FEBRUARY 2025

Members **are bound by these** ***Rules*****, the Member Guide, the** ***Product Information*****, their completed application form and any** ***HCF or RT Health*** **policy notified to** ***Members*** **such as the** ***HCF Privacy Policy*****.**

HCF

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PART I – GENERAL

INTRODUCTION

A1 RULES ARRANGEMENT

A1.1 This Part I of these *Rules* applies to all *HCF Policies and RT Health Policies.*

A1.2 Part II of these *Rules* applies to *HCF Policies* only.

A1.3 Part III of these *Rules* applies to *RT Health Policies* only.

A1.4 *Overseas Visitors Health Cover* is governed under separate *Rules*.

A2 HEALTH BENEFITS FUND

A2.1 The Hospitals Contribution Fund of Australia Ltd (ABN 68 000 026 746) is a private health insurer trading as *HCF*.

A2.2 *HCF* operates a *Health Benefits Fund* for the purposes of its health insurance business and any health related business in accordance with the *Private Health Insurance Act.*

A3 MEMBER OBLIGATIONS TO HCF

A3.1 *HCF* requires that a person who applies to be a *Member* provides full and complete disclosure on all matters that *HCF* may reasonably require including their residential address.

A3.2 A *Member* shall inform *HCF*, as soon as reasonably possible, of a change to their details relevant to *HCF* or the terms of the *Policy* including a change of address or a change in the status of a *Dependant*.

A3.3 All *Members* are bound by these *Rules*, the *Product Information*, their completed application form and any *HCF* policy notified to *Members* such as the HCF Privacy Policy.

A3.4 Without liming rule A3.3, all *Members* covered by an *HCF Policy* are also bound by the Member Guide.

A3.5 The *Policyholder* will ensure that all *Members* covered by the *Policy* are aware of, agree to and abide by, each of the documents referred to in Rule A3.3.

A4 GOVERNING PRINCIPLES

A4.1 The operation of *HCF* and the *Health Benefits Fund* and the relationship between *HCF* and each *Member* is governed by:

a) the *Private Health Insurance Act*;
b) the *Health Insurance Act*;
c) the constitution of *HCF*;
d) these *Rules*; and
e) any policies of *HCF* notified to the *Member*.

A4.2 Where the *Private Health Insurance Act* is in conflict with these *Rules*, the *Private Health Insurance Act* takes precedence over these *Rules* to the extent of the inconsistency.

A4.3 Where no clear conflict is in existence between the *Private Health Insurance Act* and these *Rules*, these *Rules* take precedence.

A4.4 Where any inconsistency exists between these *Rules* and the Member Guide or *Product Information* or any other information notified to the *Policyholder* by *HCF*, these *Rules* take precedence.

A4.5 Where any inconsistency exists between these *Rules* and the constitution of *HCF*, the constitution of *HCF* will prevail.

A4.6 Where any inconsistency exists between Parts II or III of these *Rules*, respectively, and Part I of these *Rules*, Part I of these *Rules* prevails to the extent of the inconsistency.

A5 USE OF FUNDS

A5.1 *HCF* must apply:

a) the assets of the *Fund*;
b) the *Premiums* paid by *Members*;
c) the income from investment of assets of the *Fund*; and
d) any other moneys received by *HCF* in relation to the *Fund*,

in accordance with the *Private Health Insurance Act*.

A5.2 *HCF* must ensure that the *Fund* complies with the solvency standards and capital adequacy standards of the *Private Health Insurance Act.*

A6 NO IMPROPER DISCRIMINATION

A6.1 *HCF* will not improperly or illegally discriminate when making decisions in relation to accepting a *Member* or in the payment of *Benefits*, whether

under the *Private Health Insurance Act*, or other relevant legislation relating to anti-discrimination.

A7 CHANGES TO RULES

A7.1 *HCF* shall have the power to vary, delete or add to these *Rules* at any time, subject to the *Private Health Insurance Act* and any required notification period. *HCF* will provide the updated version of these *Rules* on the *HCF* website. If the change to the *Rules* is detrimental to the interests of *Members*, we will inform those *Members* a reasonable time before the change takes effect.

A7.2 The *Rules* that are in force at the date a *Service* is provided are the *Rules* that govern the provision of the *Benefit* for that *Service*.

A7.3 Changes to the *Rules* will not apply to an admission to *Hospital*:

a) if the *Member* was already booked with the *Hospital* at the time the change was notified to *Members*; or

b) if: a *Member* is receiving a series of *Services*; and a change to the *Rules* would have a detrimental effect on the *Member* in relation to that *Service*, in which case *HCF* will make provision for a reasonable transition period for any *Member* affected by the change.

A8 DISPUTE RESOLUTION

A8.1 *HCF* is a signatory to the Private Health Insurance Code of Conduct and is committed to providing the highest level of service to all *Members*.

A8.2 Any *Member* who has a complaint or concern with any aspect of *HCF's* service or any information provided, or with the standard of *Services* from any provider of *Services Covered* under their *Policies* is invited to lodge their complaint with *HCF* at any time. Complaints or concerns relating to standards of *Services* or care should also be referred to the Health Care Complaints Commission or similar body.

A8.3 *HCF* has a complaint resolution process to ensure that all complaints are resolved as quickly as possible.

A8.4 A *Member* may also complain to the Commonwealth Ombudsman if they have a dispute with *HCF*, which is an independent body established by the Commonwealth Government to resolve complaints and to be an umpire in dispute resolution within the private health insurance industry.

A8.5 The law of New South Wales will apply, and the courts of New South Wales will have jurisdiction in relation to, disputes arising between *HCF* and *Members* and between *HCF* and others who are affected by these *Rules* regardless of the State or Territory in which the *Member* or affected person resides.

A9 NOTICES

A9.1 *HCF* shall send correspondence to the most recently advised postal address, email address or mobile phone number of the *Policyholder*.

A9.2 *HCF* will supply *Private Health Information Statements* to:

a) all newly insured *Policyholders*;

b) *Policyholders* every 12 months;

c) *Policyholders* who change their *Policy* with HCF; and

d) any *Member* upon request.

A10 WINDING UP

A10.1 In the event of *HCF* ceasing to be registered under the *Private Health Insurance Act*, the *Health Benefits Fund* shall be wound up in accordance with the requirements of the *Private Health Insurance Act*.

A11 OTHER

A11.1 Recovery of Moneys Paid By Reason of an Error

a) *HCF* may recover from a *Member* any moneys incorrectly paid to them due to *HCF's* error within 2 years of the date of the incorrect payment.

b) Rule A11.1a) includes errors made by *HCF* because: it relied on a mistaken fact or interpretation of the law or a mixture of both; it miscalculated figures; or it made an administrative or clerical error.

A11.2 Set-Off of Benefits Payable Against Amounts Owed

If a *Member* owes any moneys to *HCF* due to an error by *HCF* or due to inappropriate claiming by the *Member,* the *Member* must pay the debt within 30 days of receiving a request from *HCF*. If the *Member* does not pay within 30 days, *HCF* can recover those amounts by setting them off against any *Benefits* payable to the *Member*.

A11.3 Set-Off of Premiums Refundable Against Amounts Owed

If a *Member* owes any moneys to *HCF* due to an error by *HCF* or due to inappropriate claiming by the *Member*, the *Member* must pay the debt within 30 days of receiving a request from *HCF*. If the *Member* does not pay within 30 days, *HCF* can recover those amounts by setting them off against any *Premiums* or other moneys refundable to the Member.

A11.4 Waiver of Rules

HCF may from time to time, and in its absolute discretion, waive *Policy* conditions including:

a) any formalities that apply to *Policy* applications;

b) *Waiting Periods*; and

c) eligibility for *Benefits*.

A12 INTERPRETATION

A12.1 Capitalised and italicised words or expressions in this Part I of these *Rules* are defined pursuant to Rule A13 (except the names of *Products*) and are intended to be interpreted accordingly.

A12.2 Unless otherwise specified, the definitions in Rule A13 only apply to this Part I of these *Rules*.

A12.3 Where not defined or italicised, words and expressions are intended to have their ordinary meaning.

A12.4 These *Rules* are to be interpreted, where possible, in a manner that is consistent with the *Private Health Insurance Act*.

A12.5 Unless the context requires otherwise, a term that is not defined in these *Rules* but is defined in the *Private Health Insurance Act* will be interpreted as having the meaning that it is given in the *Private Health Insurance Act*.

A12.6 A reference to any legislation shall be taken as a reference to that legislation as amended from time to time and of all other subordinate statutory instruments, including regulations and rules, made under that legislation.

A12.7 In the case of legislation, regulations or rules having been repealed, any references in these *Rules* are to be read as references to the replacement legislation, regulations or rules.

A12.8 In these *Rules*, words importing the masculine gender will include the feminine gender and words importing the singular or plural number will include the plural and singular number respectively.

A13 DEFINITIONS

In this Part I of these *Rules*:

Ambulance means a road vehicle, boat or aircraft operated by an *Ambulance Service Provider* for the transport and/or paramedical treatment of persons requiring medical attention.

Ambulance Services means *Services* provided by way of an *Ambulance* that are *Covered* under a *Policy*.

Ambulance Service Provider includes the following service providers:

a) ACT Ambulance Service;

b) Ambulance Service of NSW;

c) Non-Emergency Patient Transportation NSW;

d) Ambulance Victoria;

e) Queensland Ambulance Service;

f) South Australia Ambulance Service;

g) St John Ambulance Service NT;

h) St John Ambulance Service WA; and

i) Tasmanian Ambulance Service.

Australia for the purposes of these Rules from 1 July 2016:

a) includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling Islands), the Territory of Christmas Island and Norfolk Island; but

b) excludes all other Australian external territories.

Benefit:

a) in relation to an *HCF Policy,* means an amount paid or payable to a *Member*, or a *Recognised*

Provider on behalf of a *Member*, for goods or services for which a financial obligation or loss is incurred by the *Member* and which are *Covered* (in whole or part) under their *Policy* in accordance with these *Rules*; and

b) in relation to an *RT Health Policy*, has the meaning given in Part III of these *Rules*.

Chronic Disease Management Program means a program approved by *HCF* that is *General Treatment* and intended to either:

a) reduce the complications in a person with a diagnosed chronic disease; or

b) prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

Chronic Disease Management Device or *CDMD* means *General Treatment* that is the provision of any of the following types of *Devices*:

a) insulin infusion pumps;

b) continuous ambulatory drug delivery *Devices*;

c) cochlear speech processors;

d) *Devices* listed in Part C of the *Prescribed List of Medical Devices and Human Tissue Products*; and

e) other *Devices* approved by the *Medical Director* from time to time.

Cover or *Covered* has the meaning set out in section 69-5 of the *Private Health Insurance Act* in relation to Services provided to Members for which *HCF* has a liability to pay some or all of the fees or charges under a *Policy*.

Dependant:

a) in relation to an *HCF Policy*, has the meaning given in Part II of these *Rules*; and

b) in relation to an *RT Health Policy,* has the meaning given in Part III of these *Rules.*

Device means a device approved by the *TGA* under the *Therapeutic Goods Act 1989* (Cth).

Extras Cover:

a) in relation to an *HCF Policy*, has the meaning given in Part II of these *Rules*; and

b) in relation to an *RT Health Policy,* has the meaning given to the term "*Extras Product*" in Part III of these *Rules*.

Extras Services means *General Treatment* that is a service listed in the 'Extras' section of the *Product Information*, which is not any of the following:

a) *Hospital Treatment*;

b) *Hospital-Substitute Treatment*;

c) *Chronic Disease Management Programs*;

d) *Chronic Disease Management Devices*; or

e) *Ambulance Services*.

Fund means a Fund that:

a) is established in the records of a private health insurer; and

b) relates solely to: its health insurance business, or a particular part of that business; or its health insurance business, or a particular part of that business, and some or all of its health-related businesses, or particular parts of those businesses.

General Treatment has the meaning set out in section 121-10 of the *Private Health Insurance Act* and includes *Extras Services, Chronic Disease Management Programs, Chronic Disease Management Devices, Hospital-Substitute Treatment* and *Ambulance Services*.

HCF means The Hospitals Contribution Fund of Australia Limited (ABN 68 000 026 746) and will include, where it is not contrary to the context, any employee or agent of *HCF*.

HCF Policy means a complying health insurance policy that is referrable to the *Health Benefits Fund* that *Covers* a defined group of *Benefits* payable, subject to these *Rules,* and which is not an *RT Health Policy*.

Health Benefits Fund means the *Fund* established and conducted by *HCF* from which *Benefits* are provided to or for *Policyholders* in accordance with these *Rules*.

Health Insurance Act means the *Health Insurance Act 1973* (Cth).

Hospital:

a) in relation to an *HCF Policy,* means any public or private facility declared by the Minister as a *Hospital*; and

b) in relation to an *RT Health Policy,* has the meaning given in Part III of these *Rules.*

Hospital-Substitute Treatment has the meaning set out in section 69-10 of the *Private Health Insurance Act* and is *General Treatment* provided in an alternative setting to a *Hospital* and substitutes for hospitalisation.

Hospital Treatment has the meaning set out in section 121-5 of the *Private Health Insurance Act*, and includes *Services* provided to *Members* as admitted patients of a *Hospital*.

Medical Practitioner means a person registered or licensed as a *Medical Practitioner* under a law of a State or Territory that provides for the registration or licensing of *Medical Practitioners* but does not include a person so registered or licensed:

a) whose registration, or licence to practise, as a *Medical Practitioner* in any State or Territory has been suspended, or cancelled, following an inquiry relating to their conduct; and

b) who has not, after that suspension or cancellation, again been authorised to register or practise as a *Medical Practitioner* in that State or Territory.

Member means:

a) a person covered by a *Policy*, and who has become a *Member* of the *Health Benefits Fund*, and their agents, executors, administrators and permitted assignees; and

b) does not mean a person who is solely a member of *HCF* according to the constitution of *HCF*.

Medical Director means the *HCF* officer who carries the prime management responsibility for arbitration of *Benefit* decisions for *HCF*.

Minister means the Federal *Minister* for the relevant Commonwealth Department or if there ceases to be such a *Minister*, the *Minister* whose portfolio includes responsibilities for matters relating to health.

Overseas Visitors Health Cover means health insurance cover under which *Benefits* are payable for *Services* to non-resident visitors to *Australia* with a valid and current work or tourist visa.

Policy means an *HCF Policy or RT Health Policy,* as applicable.

Policyholder means the person:

a) in whose name the *Policy* is taken out; and

b) is responsible for payment of the *Premiums* and for the ongoing maintenance of the *Policy*.

Premiums:

a) in relation to an *HCF Policy,* means the amount payable by the *Policyholder* for their *Policy* as set out in the *Product Information* and amended by *HCF* in accordance with these *Rules*; and

b) in relation to an *RT Health Policy,* has the meaning given to the term "*Contribution*" set out in Part III of these *Rules*.

Private Health Information Statement means a 'Private Health Information Statement' as defined in the *Private Health Insurance Act*.

Private Health Insurance Act means the *Private Health Insurance Act 2007* (Cth) and *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) and, where the context requires, any rules made under either Act.

Private Practice means:

a) in relation to *Hospital Treatment*, a *Medical Practitioner* operating on an independent and self-supporting basis either as a sole, partnership or group practice but not employed by or subsidised by another party for the provision of accommodation, facilities or other services. For the avoidance of doubt, this does not include *Medical Practitioners* employed by or on contract in a public *Hospital* or any other type of publicly funded facility; and

b) in relation to *Extras Services*, a professional practice (whether sole, partnership or group) that is self-supporting and where its accommodation, facilities and services are not provided, funded or subsidised by another party such as a *Hospital* or publicly funded facility.

Product:

a) in relation to an *HCF Policy,* means a *Hospital Cover* or *Extras Cover*, or combination of them, that defines the *Services* that a *Benefit* is payable, subject to these *Rules*, in respect of approved expenses incurred by a *Member*; and

b) in relation to an *RT Health Policy*, has the meaning given in Part III of these *Rules.*

Product Information:

a) in relation to an *HCF Policy,* means the schedules of *Benefits* and *Premiums* for each *Product* set out and updated in *HCF's* database and lodged with the Department of Health and Aged Care and the documents provided to a *Policyholder* by *HCF* that contains information about the particular *Product* held by the *Member* including the Product Summary document; and

b) in relation to an *RT Health Policy,* has the meaning given to the term "*Product Cover Guide*" in Part III of these *Rules*.

Recognised Provider means:

a) a *Hospital*;

b) a *Medical Practitioner*;

c) a provider of *Extras Services* in Australia who: is in *Private Practice*; for each relevant class of *Service*, satisfies all *Recognition Criteria*; and is recognised by *HCF*;

d) an *Ambulance Service Provider*; or

e) any other provider recognised by *HCF* for the purpose of Parts I and II of these *Rules*.

Recognition Criteria means the following:

a) the standards in the Private Health Insurance (Accreditation) Rules; and

b) any other criteria that *HCF* considers reasonable for the purpose of recognition.

RT Health Policy means a complying health insurance policy that is referrable to the *Health Benefits Fund* that *Covers* a defined group of *Benefits* payable, subject to these *Rules*, and which was transferred to the *Health Benefits Fund* on or about 1 November 2021 pursuant to section 33 of the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) or to which Part III of these *Rules* apply.

Rules means this Rules document and the schedules of *Benefits* and *Premiums* for each *Product* set out and updated in *HCF's* database and lodged with the Department of Health and Aged Care that:

a) governs the establishment and operation of the *Health Benefits Fund*;

b) describes the obligations, requirements and entitlements of *Members* of the *Health Benefits Fund*; and

c) describes the obligations, requirements and entitlements of *HCF* in the operation of the *Health Benefits Fund*.

Service:

a) in relation to an *HCF Policy,* means *Hospital Treatment* or *General Treatment,* which is *Covered* under an *HCF Policy*; and

b) in relation to an *RT Health Policy,* means a treatment *Covered* under the *RT Health Policy*.

TGA means the Therapeutic Goods Administration.

Waiting Period:

a) in relation to an *HCF Policy,* means a specific period during which *Benefits* are not payable or *Benefits* are only payable as per the entitlements of the old *Policy* for *Services* received, starting from the date a new *Policy* has commenced for all *Services* except for *Choosable 12 month Services* where the period of time starts the date the *Choosable 12 month Service* is selected under the *Choosable Extras Policy*; and

b) in relation to an *RT Health Policy,* has the meaning given in Part III of these *Rules*.

PART II – HCF POLICIES

B INTERPRETATION AND DEFINITIONS

B1 INTERPRETATION

B1.1 Capitalised and italicised words or expressions in this Part II of these *Rules* are defined pursuant to Rule B2 (except the names of *Products*) and are intended to be interpreted accordingly.

B1.2 Unless otherwise specified, the definitions in Rule B2 only apply to this Part II of these *Rules*.

B1.3 Unless a contrary intention appears, references to "these *Rules*" in this Part II are references to the Rules in Parts I and II of the *Rules,* but only insofar as they relate to *HCF Policies* (as defined in Part I of these *Rules)*.

B2 DEFINITIONS

In this Part II of these *Rules*:

Accident means:

a) an unforeseen event, occurring by chance and caused by an external force or object, which results in involuntary injury to the body requiring immediate treatment from a registered medical practitioner; but

b) excludes unforeseen conditions attributable to medical causes.

Accident Benefit is a feature on some *Extras Covers* which tops up exhausted *Limits* if the *Member* is claiming as a result of an *Accident*, up to a maximum amount as defined in the *Product Information*.

Accident Safeguard means a feature on some *Hospital Covers* which permits *Excluded Services* or *Restricted Services* to be *Covered* under the *Hospital Cover* as if the *Service* was not an *Excluded Service* or *Restricted Service* when the *Service* is required directly as a result of an *Accident* that occurs after joining. Excludes elective cosmetic surgery, podiatric surgery by a registered podiatric surgeon and services not covered by Medicare.

Acupuncture means *Extras Services* provided by application of stimuli on or through the surface of the skin by needles, that is related to the condition being treated and is performed by a *Recognised Provider*.

Adult means a person who is not a *Dependant* that is, not a *Child Dependant*, *Non-Classified Dependant*, *Student Dependant* or *Adult Dependant*.

Adult Dependant is a person who:

a) is related to the *Policyholder* or their *Partner* as a child, step-child, or foster child or other child that the *Policyholder* or their *Partner* has legal guardianship over;

b) is between 22 and 30 years of age (inclusive);

c) is unmarried and not in a de facto relationship;

d) is not a *Student Dependant*;

e) is primarily reliant on the *Policyholder* (or *Partner* listed on the *Policy*) for maintenance and support; and

f) is insured under an *Extended Family Membership* or *One Parent Extended Family Membership*.

Ambulance means a road vehicle, boat or aircraft operated by an *Ambulance Service Provider* for the transport and/or paramedical treatment of persons requiring medical attention.

a) *Emergency Ambulance Transport* means a road vehicle, boat or aircraft operated by an *Ambulance Service Provider* for the transport and/or paramedical treatment of persons requiring *Emergency Treatment*, and does not include *Non-Emergency Ambulance Transport*.

b) *Non-Emergency Ambulance Transport* means a road vehicle, boat or aircraft operated by an *Ambulance Service Provider* that is requested by the *Member's* treating doctor because the *Member's* medical condition requires a level of support and medical monitoring in transit that only an *Ambulance Service Provider* can provide.

Ambulance Services means *Services* provided by way of an *Ambulance* that are *Covered* under a *Policy*.

Ambulance Service Provider includes the following service providers:

a) ACT Ambulance Service;

b) Ambulance Service of NSW;

c) Non-Emergency Patient Transportation NSW;

d) Ambulance Victoria;

e) Queensland Ambulance Service;

f) South Australia Ambulance Service;

g) St John Ambulance Service NT;

h) St John Ambulance Service WA; and

i) Tasmanian Ambulance Service.

Artificial Appliances means those that are ordinarily claimable under an eligible *Extras Cover* as meeting all the following criteria:

j) intended for repeated use i.e., not disposable or one-time use products;

k) used primarily to alleviate or address a medical condition;

l) not useful to a person in the absence of an illness, injury or disability;

m) supplied by a reputable supplier;

n) authorised by the attending doctor or allied health professional;

o) approved by the *Medical Director*; and

p) listed on HCF's list of approved artificial appliances.

Australia for the purposes of these *Rules* from 1 July 2016:

a) includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling Islands), the Territory of Christmas Island and Norfolk Island; but

b) excludes all other Australian external territories.

Benefit means an amount paid or payable to a *Member*, or a *Recognised Provider* on behalf of a *Member*, for goods or services for which a financial obligation or loss is incurred by the *Member* and which are *Covered* (in whole or part) under their *Policy* in accordance with these *Rules*.

Calendar Year means a period of 12 months from 1 January to 31 December inclusive.

Child Dependant means a person who:

a) is less than 18 years of age;

b) is unmarried and not in a de facto relationship;

c) is primarily reliant on the *Policyholder* (or *Partner* listed on the *Policy*) for maintenance and support; and

d) is related to the *Policyholder* (or *Partner* listed on the *Policy*) as a child, step-child, foster child or other child that the *Policyholder* (or *Partner* listed on the *Policy*) has legal guardianship over.

Choosable 12 month Service means an *Extras Service* covered under *Choosable Extras* that is specified as having a 12 month waiting period in the *Product Information*.

Choosable Extras are *Extras Covers* where the *Policyholder* may select a defined number of *Extras Services* they wish to be covered for from a range of *Services* available, as defined in the relevant *Product Information*.

Choosable Extras Policy means a *Policy* issued under *Choosable Extras*.

Chronic Disease Management Program means a program approved by *HCF* that is intended to either:

a) reduce the complications in a person with a diagnosed chronic disease; or

b) prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

Chronic Disease Management Device or *CDMD* means the provision of any of the following types of *Devices*:

a) insulin infusion pumps;

b) continuous ambulatory drug delivery *Devices*;

c) cochlear speech processors;

d) *Devices* listed in Part C of the *Prescribed List of Medical Devices and Human Tissue Products;* and

e) other *Devices* approved by the *Medical Director* from time to time.

Coronary Care Unit means an *Intensive Care Unit* designated for the monitoring and management of critically ill patients with cardiac and coronary illness or complications, particularly post-operative that has been approved under any relevant Commonwealth, State or Territory licensing or other regulatory requirements and has been recognised by *HCF* for the purposes of these *Rules*.

Co-payment means an amount a *Member* agrees to pay for each night of an overnight *Hospital* stay under their *Policy*.

Couples or Family Consultation means a mental health consultation with a counsellor, psychologist or accredited mental health social worker which is attended by more than one person and all of those persons are either:

a) related by birth, adoption, fostering, or related or previously related, by marriage or de facto relationship; or

b) in, or were previously in, a romantic relationship,

or any combination of the above, and are receiving the consultation for issues concerning the relationships between them including, but not limited to, parenting, family stresses, separation, trauma, grief, conflict and gender / sexuality.

Cover or *Covered* has the meaning set out in section 69-5 of the *Private Health Insurance Act* in relation to *Services* provided to *Members* for which *HCF* has a liability to pay some or all of the fees or charges under a *Policy.*

Dependant means:

a) *Child Dependant;*
b) *Non-Classified Dependant*;
c) *Student Dependant; or*
d) *Adult Dependant.*

Device means a device approved by the *TGA* under the *Therapeutic Goods Act 1989* (Cth).

Drug means a drug approved by the *TGA* under the *Therapeutic Goods Act 1989* (Cth) and used for the purpose for which it was approved.

Eligible Musculoskeletal Condition means a disease/health problem that is accepted under the More for Backs Program as eligible for a no-gap *Benefit* payment. *Eligible Musculoskeletal Conditions* are included in the Program where *HCF* is satisfied (in its discretion) that there is a sufficient evidence base to support chiropractic or osteopathy treatment of the disease/health problem. The list of *Eligible Musculoskeletal Conditions* may be varied by *HCF* from time to time.

Eligible Podiatric Condition means a condition in a recognised podiatrist's scope of practice that is not general maintenance such as nail clipping.

Emergency Treatment means those *Services* received in connection with a sudden and unexpected onset of a serious injury or illness requiring surgical or medical attention within 24 hours after the onset, and in the absence of such care the *Member* could reasonably be expected to suffer serious physical impairment or death.

Episode of Care means all *Services* (including accommodation, theatre, *Prostheses* and *Drugs*) provided to a *Member* from the date of admission to a *Hospital* to the date of discharge.

Exempt Policy Holder means a *Policyholder* in respect of whose *Premiums HCF* is not required to pay a levy under any legislation dealing with *Ambulance* levies or associated levies in effect in the State or Territory in which the *Policyholder* resides.

Excess means a non-refundable amount of money a *Member* agrees to pay towards the cost of *Services* before *Benefits* are payable when admitted to *Hospital*.

Excluded Service means a *Service* that is not included or *Covered* under a *Member's Policy* and therefore no *Benefit* is payable for that *Service*.

Extended Family Membership means an applicable *Policy* where *Adult Dependants* can be covered by a *Family Membership* or *One Parent Family Membership*, for an additional charge.

Extras Benefits means *Benefits* payable under an *Extras Cover* in accordance with these *Rules* as a result of *Extras Services* provided to a *Member*.

Extras Cover means a *Policy* under which *HCF* pays *Extras Benefits*.

Extras Services means *General Treatment* that is a service listed in the 'Extras' section of the *Product Information*, which is not any of the following:

a) *Hospital Treatment*;
b) *Hospital-Substitute Treatment*;
c) *Chronic Disease Management Programs*;
d) *Chronic Disease Management Devices*; or
e) *Ambulance Services*.

Family Membership means a *Policy* of the *Health Benefits Fund* under which the *Policyholder*, their *Partner* and all of their *Dependants* are eligible to be covered.

First Visit in relation to the More for Muscles, More for Backs and More for Feet programs means a *Service* that is an initial consultation received for an *Eligible Musculoskeletal Condition* or *Eligible Podiatric Condition* which is:

(a) a new health condition, where the symptoms are not related to a condition for which *Services* have previously been sought; or

(b) an acute flare-up of an existing condition where there has been no *Services* provided for

that condition provided in the previous 3 months.

Fund means a Fund that:

a) is established in the records of a private health insurer; and

b) relates solely to: its health insurance business, or a particular part of that business; or its health insurance business, or a particular part of that business, and some or all of its health-related businesses, or particular parts of those businesses.

Gap Bonus means the ability of Members to top up their Benefits on any covered Extras Services under eligible Extras Covers.

General Treatment has the meaning set out in section 121-10 of the *Private Health Insurance Act* and includes *Extras Services, Chronic Disease Management Programs* and *Chronic Disease Management Devices* provided to a *Member* that is not an admitted patient of a *Hospital, Hospital-Substitute Treatment* and *Ambulance Services*.

Half Calendar Year means a period of 6 months from 1 January to 30 June inclusive or 1 July to 31 December inclusive in any *Calendar Year*.

HCF means The Hospitals Contribution Fund of Australia Limited (ABN 68 000 026 746) and will include, where it is not contrary to the context, any employee or agent of *HCF*.

HCF Participating Private Hospital means a *Hospital* where an agreement has been negotiated for specific charges for accommodation, theatre and other *Services* under which the *Hospital* agrees to accept the payment by *HCF* for the agreed accommodation, theatre and *Services* in satisfaction of the amount that would be owed by a *Member*.

Health Benefits Fund means the *Fund* established and conducted by *HCF* from which *Benefits* are provided to or for *Policyholders* to the *Fund* in accordance with these *Rules*.

Health Dollars means a *Loyalty Bonus* payable to those *Members* on eligible *Hospital Cover* and *Extras Cover*.

Health Management Program means a program approved by *HCF* that is an *Extras Service* which is intended to manage, prevent or improve a specific health condition or conditions.

Health Insurance Act means the Health Insurance Act 1973 (Cth).

Hearing Aids are electronic sound-amplifying devices, designed to treat or compensate for an individual's diagnosed hearing condition and are customised to the individual's needs. Personal sound amplification products and devices that may be used in the absence of diagnosed hearing condition are excluded.

Hospital is any public or private facility declared by the *Minister* as a *Hospital*.

Hospital Benefits means *Benefits* payable in accordance with these *Rules* for any or all of the following *Services* provided to a *Member*:

a) *Hospital Treatment; and*

b) *Hospital-Substitute Treatment.*

Hospital Cover means a *Policy* under which *HCF* pays *Hospital Benefits*.

Hospital Cover Services means a *Service Covered* under a *Hospital Cover.*

Hospital-Substitute Treatment has the meaning set out in section 69-10 of the *Private Health Insurance Act* and is *General Treatment* provided in an alternative setting to a *Hospital* and substitutes for hospitalisation.

Hospital Treatment has the meaning set out in section 121-5 of the *Private Health Insurance Act*, and includes *Services* provided to *Members* as admitted patients of a *Hospital.*

Insured Group means one of the following:

a) a *One Adult Membership* (also referred to as singles cover);

b) a *Two Adult Membership* (also referred to as couples cover);

c) *One Parent Family Membership* (also referred to as single parent family cover);

d) *Family Membership* (also referred to as family cover);

e) *Extended Family Membership* (included under family cover); and

f) *No Adult Membership* (where approved by *HCF*).

Intensive Care Unit means a unit for intensive care including paediatric intensive care unit (PICU) in a *Hospital* that:

a) is a specifically staffed and equipped, separate and self-contained area dedicated to the management and monitoring of patients with life-threatening illnesses, injuries and complications;

b) has been approved under any relevant Commonwealth, State or Territory licencing or other regulatory requirements;

c) meets minimum standards as determined by the College of Intensive Care Medicine of Australia and New Zealand or other relevant body relating to the level of intensive care; and

d) has been recognised by *HCF* for the purposes of these *Rules*.

Involuntary Unemployment Assistance means a subsidy that is equivalent to the *Premiums* payable by a *Policyholder* or *Partner* under their *Policy* and paid by *HCF* into the *Health Benefits Fund* on behalf of the *Policyholder* or *Partner*.

Lifetime Health Cover has the meaning given in the *Private Health Insurance Act*.

Limit means the maximum total *Benefit* payable for a particular *Service* or group of *Services* in a specified period or a maximum number of times a *Benefit* may be payable as defined in the *Product Information*.

Limit Boost means the ability of *Members* to top up their annual *Limit* on general dental and optical *Services* under eligible *Extras Covers*.

Loyalty Bonus means a scheme where *Members* gain certain benefits depending on the length of their *Policy* with *HCF* under eligible *Extras Covers*.

Medical Adviser means a *Medical Practitioner* appointed by *HCF* to give technical advice from time to time on professional matters and includes the *Medical Director*.

Medical Director means the *HCF* officer who carries the prime management responsibility for arbitration of *Benefit* decisions for *HCF*.

Medical Gap means the difference between the amount charged to a *Member* by a *Medical Practitioner* for medical *Services* as part of *Hospital Treatment* and the amount of *HCF Benefits* and *Medicare Benefits* to which the *Member* is entitled, which is an amount payable by the *Member*.

Medical Practitioner means a person registered or licensed as a *Medical Practitioner* under a law of a State or Territory that provides for the registration or licensing of *Medical Practitioners* but does not include a person so registered or licensed:

a) whose registration, or licence to practise, as a *Medical Practitioner* in any State or Territory has been suspended, or cancelled, following an inquiry relating to their conduct; and

b) who has not, after that suspension or cancellation, again been authorised to register or practise as a *Medical Practitioner* in that State or Territory.

Medicare Benefit means a benefit payable under the *Medicare Benefits Schedule* by Services Australia (formerly known as Department of Human Services) under the *Health Insurance Act*.

Medicare Benefits Schedule means the schedule of benefits determined by Services Australia (known formerly as Department of Human Services) under which a *Medicare Benefit* is payable.

Member means:

a) a person covered by a *Policy*, and who has become a *Member* of the *Health Benefits Fund*, and their agents, executors, administrators and permitted assignees; and

b) does not mean a person who is solely a member of *HCF* according to the constitution of *HCF*.

Membership Year means a period of 12 calendar months from the date a *Member* joins or transfers to a *Policy*.

Mental Health Services means a collective group of mental health *Extras Services* that *HCF* pays *Benefits* for under certain *Extras Covers* and are:

(a) provided by one of the following *Recognised Providers*: psychologists; counsellors; or accredited mental health social workers; or

(b) Online Cognitive Behavioural Therapy courses.

Minimum Benefits means the *Benefits* payable under Schedules 1 to 4 of the *Private Health Insurance (Benefit Requirements) Rules* for accommodation and any other amounts *HCF* is

required to pay under the *Private Health Insurance Act*.

Minister means the Federal *Minister* for the relevant Commonwealth Department or if there ceases to be such a *Minister*, the *Minister* whose portfolio includes responsibilities for matters relating to health.

National Procedures Banding Schedule means the publication of the National Procedures Banding Committee which allocates theatre bands to *Medicare Benefits Schedule* items.

Neonatal Intensive Care means an intensive care facility designated for the care of pre-term, very low birth weight and seriously ill babies, that has been identified and approved under any relevant Commonwealth, State or Territory licencing or other regulatory requirements and has been recognised by *HCF* for the purposes of these *Rules*.

No Adult Membership means a *Policy* of the *Health Benefits Fund* where two or more people are insured but none of the people insured are *Adults*.

Non-Classified Dependant means a person who:

a) is between 18 and 21 years of age (inclusive);
b) is unmarried and not in a de facto relationship;
c) is primarily reliant on the *Policyholder* (or *Partner* listed on the *Policy*) for maintenance and support;
d) and is related to the *Policyholder* (or *Partner* listed on the *Policy*) as a child, step-child, foster child or other child that the *Policyholder* (or *Partner* listed on the *Policy*) has legal guardianship over.

Non-Participating Hospital is a *Hospital* which is not an *HCF Participating Private Hospital*.

Nursing Home Type Patient means, in relation to a *Hospital*, a patient in the *Hospital* who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days.

Offsale Product means all *Products* that *HCF* has closed and are no longer available for sale.

One Adult Membership, also referred to as a singles cover, means a *Policy* of the *Health Benefits Fund* under which only one *Adult* (the *Policyholder*) is eligible to receive *Benefits.*

One Parent Family Membership, also referred to as single parent family cover, means a *Policy* of the *Health Benefits Fund* under which only one *Adult*, who is the parent or guardian, and all of their *Dependants* are eligible to be covered.

Onsale Product means all *Products* that *HCF* is currently selling and excludes all *Offsale Products*.

Other General Treatment means *General Treatment* other than *Extras Services, Hospital-Substitute Treatment, Chronic Disease Management Programs and Chronic Disease Management Devices*, including *Ambulance Services*.

Partner means a person who is a spouse or de-facto partner with whom the *Policyholder* lives.

PBS means the Pharmaceutical Benefits Scheme.

PBS Equivalent Co-payment means an amount that is equivalent to the prevailing *PBS* co-payment for general patients.

Pharmaceutical Item means a medicinal item which is ordinarily claimable under an eligible *Extras Cover*, is not a *Vaccine* and which is:

a) a Schedule 4 or Schedule 8 drug as outlined in the Poisons Standard, that has been prescribed in accordance with relevant State or Territory legislation;
b) supplied by a pharmacist or *Medical Practitioner* in *Private Practice* under relevant State or Territory legislation;
c) registered and labelled with an AUSTR number on the Australian Register of Therapeutic Goods. This means the item must also not be compounded or extemporaneously prepared;
d) prescribed for treatment of the approved specific indications as detailed in the Australian Register of Therapeutic Goods; and
e) complies with *HCF's* Clinical Pharmaceutical Procedure for Extras Benefits as approved by the *Medical Director* or equivalent, provided that none of the following criteria apply: the item is listed or was listed under the *PBS* in any brand, formulation, strength or pack size and regardless of whether *PBS* availability is subject to any specified purpose or patient type;

f) the Minimum Standard Supply for the item is customarily charged at an amount that is less than, or equal to the current *PBS* co-payment for general patients (Minimum Standard Supply means the smallest commercially available pack size of a drug that is supplied by its manufacturer to pharmacies);

g) the item is generally prescribed for purposes outside of illness or disease or for reproductive medicine including contraception or for the enhancement of sporting, sexual or work performance;

h) the item is generally prescribed for weight loss;

i) the item is excluded under the *HCF* Clinical Pharmaceutical Procedure for *Extras Benefits*; or

j) the item is available without a prescription.

Pharmaceutical Items are updated regularly and subject to change.

Policy means a complying health insurance policy that is referrable to the *Health Benefits Fund* that *Covers* a defined group of *Benefits* payable, subject to these *Rules* and which is not an *RT Health Policy*.

Policyholder means the person:

a) in whose name the *Policy* is taken out; and

b) is responsible for payment of the *Premiums* and for the ongoing maintenance of the *Policy*.

Pre-Existing Condition means an ailment, illness or condition, the signs or symptoms of which in the opinion of a *Medical Practitioner* appointed by *HCF*, existed at any time during the 6 months up to and including the day on which the *Policyholder* has *Hospital Cover* or upgrades to a higher *Product* or *Insured Group*. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition; not on a diagnosis.

Pregnancy and Birth Services means the services that are listed under the clinical category Pregnancy and Birth in the *Medicare Benefits Schedule*.

Pregnancy and postnatal recovery compression garments means compression garments specifically designed to prevent or relieve conditions associated with pregnancy and postnatal recovery. This does not include garments that are purchased solely for sport, recreation or entertainment in the absence of a pregnancy related condition.

Premiums means the amount payable by the *Policyholder* for their *Policy* as set out in the *Product Information* and amended by *HCF* in accordance with these *Rules*.

Prescribed List of Medical Devices and Human Tissue Products means the list of medical devices and human tissue items in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules (No.1) 2023* made pursuant to the *Private Health Insurance Act*, as updated from time to time.

Prescribed Procedure is a medical procedure prescribed by the *Minister* as Advanced Surgery, Surgery or Obstetric Services.

Private Health Information Statement means a 'Private Health Information Statement' as defined in the *Private Health Insurance Act*.

Private Health Insurance Act means the *Private Health Insurance Act 2007* (Cth) and *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) and, where the context requires, any rules made under either Act.

Private Practice means:

a) in relation to *Hospital Treatment*, a *Medical Practitioner* operating on an independent and self-supporting basis either as a sole, partnership or group practice but not employed by or subsidised by another party for the provision of accommodation, facilities or other services. For the avoidance of doubt, this does not include *Medical Practitioners* employed by or on contract in a public *Hospital* or any other type of publicly funded facility; and

b) in relation to *Extras Services*, a professional practice (whether sole, partnership or group) that is self-supporting and where its accommodation, facilities and services are not provided, funded or subsidised by another party such as a *Hospital* or publicly funded facility.

Product means a *Hospital Cover* or *Extras Cover*, or combination of them, that defines the *Services* in respect of which a *Benefit* is payable under a

Policy, subject to these *Rules*, in respect of approved expenses incurred by a *Member*.

Product Information means the schedule of *Benefits* and *Premiums* for each relevant *Product* set out and updated in *HCF's* database and lodged with the Department of Health and Aged Care and the documents provided to a *Policyholder* by *HCF* that contains information about the particular *Product* held by the *Member* including the Product Summary document.

Prosthesis means items listed on the *Prescribed List of Medical Devices and Human Tissue Products.*

Psychiatric Patient means a patient who is admitted by a specialist in psychiatric medicine to a psychiatric program approved by *HCF* at a *Hospital* recognised by *HCF* as a psychiatric *Hospital* or as having a psychiatric *Service*.

Recognised Provider means:

a) a *Hospital*;
b) a *Medical Practitioner*;
c) a provider of *Extras Services* in Australia who: is in *Private Practice*; for each relevant class of *Service*, satisfies all *Recognition Criteria*; and is recognised by *HCF*;
d) an *Ambulance Service Provider*; or
e) any other provider recognised by *HCF* for the purpose of *Policies* covered by Part II of these *Rules*.

Recognition Criteria means the following:

a) the standards in the Private Health Insurance (Accreditation) Rules; and
b) any other criteria that *HCF* considers reasonable for the purpose of recognition.

Rehabilitation Patient means a patient who is admitted by a specialist in rehabilitation medicine to a rehabilitation program approved by *HCF* at a *Hospital* recognised by *HCF* as a rehabilitation *Hospital* or as having a rehabilitation *Service*.

Restricted Services means the *Services* specified in the *Product Information* as only having 'restricted cover' under a *Product*.

RT Health Policy means a complying health insurance policy that is referrable to the *Health Benefits Fund* that *Covers* a defined group of *Benefits* payable, subject to Parts I and III of these *Rules*, and which was transferred to the *Health Benefits Fund* on or about 1 November 2021 pursuant to section 33 of the *Private Health Insurance (Prudential Supervision) Act 2015* (Cth) or to which Parts I and III of these *Rules* apply.

Rules means this *Fund Rules* document and the schedule of *Benefits* and *Premiums* for each *Product* set out and updated in *HCF's* database and lodged with the Department of Health and Aged Care that:

a) governs the establishment and operation of the *Health Benefits Fund*;
b) describes the obligations, requirements and entitlements of *Members* of the *Health Benefits Fund*; and
c) describes the obligations, requirements and entitlements of *HCF* in the operation of the *Health Benefits Fund*.

Same-Day Treatment means *Hospital Treatment* where the period of hospitalisation commences and finishes on the same day and does not include any part of an overnight stay.

School Accident Benefit means a *Benefit* that helps pay for out-of-pocket expenses if a *Child Dependant* attending before and after school care, primary or secondary school receives *Extras Services* covered under their *Policy* as a result of an *Accident* that occurred at school, at approved and regulated before and after school care, on the way to or from school or on the way to or from a school activity.

Service means *Hospital Treatment* or *General Treatment,* which is *Covered* under a *Policy*.

Service Category means, in relation to *Choosable Extras*, the categories of *Services* that can be selected as specified in the *Product Information* for that *Choosable Extras* product.

Single Private Room is a suitable room in a Hospital which is:

a) purpose built;
b) holds a single bed;
c) has facility for no more than a single admitted patient; and
d) includes an ensuite.

Student Dependant means a person who:

a) is between 22 and 30 years of age (inclusive);

b) is a full time student at school, college or university;
c) is unmarried and not in a de facto relationship;
d) is primarily reliant on the *Policyholder* or their *Partner* (listed on the *Policy*) for maintenance and support; and
e) is related to the *Policyholder* or their *Partner* as a child, step-child, foster child or other child that the *Policyholder* or their *Partner* has legal guardianship over.

Telehealth Extras Service means a one to one, real time consultation with a *Recognised Provider* through video or telephone for childbirth education, dietetics, exercise physiology, lactation consultation, occupational therapy, physiotherapy, podiatry, psychology, mental health consultations with a counsellor or accredited mental health social worker, speech pathology or weight management under a *Health Management Program*, that is provided in accordance with telehealth protocols or policies developed by the relevant professional association.

TGA means the Therapeutic Goods Administration.

Transfer Certificate means a certificate issued by a *Member's* previous health insurer containing information relevant to administering a *Member's Policy*.

Two Adult Membership, also known as couples cover, means a *Policy* of the *Health Benefits Fund* under which only the *Policyholder* and their *Partner* are eligible to receive *Benefits*.

Vaccine means a medicine used to stimulate the body's immune response to protect against specific diseases caused by bacteria and viruses that is ordinarily claimable under an eligible Extras Cover and which is:

a) a Schedule 4 drug, as outlined in the Poisons Standard, that has been prescribed in accordance with relevant State or Territory legislation;
b) supplied by a pharmacist or *Medical Practitioner* in *Private Practice* under relevant State or Territory legislation;
c) registered and labelled with an AUSTR number on the Australian Register of Therapeutic Goods.;
d) prescribed in accordance with the specific indications as detailed in the Australian Register of Therapeutic Goods; and
e) complies with *HCF's* Clinical Pharmaceutical Procedure for Extras Benefits as approved by the *Medical Director* or equivalent, provided that none of the following criteria apply: the item is generally prescribed for reproductive medicine including contraception or for the enhancement of sporting, sexual or work performance; the item is generally prescribed for weight loss; the item is excluded under the *HCF* Clinical Pharmaceutical Procedure for *Extras Benefits*; or the item is available without a prescription.

Waiting Period means a specific period during which *Benefits* are not payable or *Benefits* are only payable as per the entitlements of the o*ld Policy* for *Services* received starting from the date a new *Policy* has commenced for all *Services* except for *Choosable 12 month Services* where the period of time starts the date the *Choosable 12 month Service* is selected under the *Choosable Extras Policy*.

C MEMBERSHIP

C1 GENERAL CONDITIONS

C1.1 *Policyholders* may, provided they meet the eligibility requirements for the individual *Policies*, select only one *Hospital Cover* and/or one *Extras Cover*, or may select one combined *Hospital Cover* and *Extras Cover*.

C1.2 Subject to meeting the relevant eligibility requirements, *Policyholders* may select one *Insured Group* for each *Policy*.

C1.3 Not all *Insured Groups* are available on all *Products*.

C1.4 *Benefits* payable in respect of each *Policy* are as set out in the *Product Information*.

C2 ELIGIBILITY

C2.1 Subject to these *Rules*, any person who is:

a) aged 18 years of age or more; or

as otherwise determined by *HCF*, is entitled to apply for a *Policy* with the *Health Benefits Fund* and therefore becomes eligible to receive *Benefits*.

C2.2 Subject to these *Rules*, any person is eligible to become a *Member* with *HCF* and therefore becomes eligible to receive *Benefits*.

C2.3 Where *HCF* exercises its discretion under Rule C2.10, and the individual is aged under 18 years and wishes to hold a *No Adult Membership*, then the parent or legal guardian of the child must complete an authority form approved by *HCF* which includes reasons for the request.

C2.4 Under Rule C2.3, the parent or guardian of the child agrees to take out the *Policy* on behalf of the child, to handle the maintenance of the *Policy*, be responsible for payment of *Premiums* and notifying *HCF* of changes to the *Policy* and the child will be taken to be the insured person under the *Policy*, who is entitled to receive *Benefits*.

C3 DEPENDANTS

C3.1 *Dependants* can be added to a *Policy* at any time as long as the option is available on the *Product*.

C3.2 Babies can be retrospectively added to a *Policy* with effect from the date of their birth if:

a) for *Policyholders* with *One Adult Memberships* and some *Two Adult Memberships*, they:

take out a *One Adult Family Membership* or *Family Membership* and add the baby as a *Dependant* within 2 months of the baby's date of birth; and

pay the increased *Premiums* within the 2 month period; or

b) for *Policyholders* with a *One Adult Family Membership* or *Family Membership*, they add the baby as a *Dependant* within 12 months of the baby's date of birth.

C3.3 *HCF* will not apply any *Waiting Periods* to a *Dependant* that is added to a *Policy* in accordance with Rule C3.2

C4 APPLICATIONS

C4.1 *HCF* has the absolute power to declare the admission of any *Member* void in the event that the *Member* supplies or supplied *HCF* incorrect information in a material respect or the *Member* failed to provide information requested by *HCF* within a reasonable time of the request.

C4.2 Upon voidance of a *Policy* under Rule C4.1, all rights which the *Policyholder* and other *Members* covered by the *Policy* otherwise would have accrued are forfeited and all *Premiums* paid in advance by the *Policyholder* will be refunded, less the amount of any *Benefits* received by the *Policyholder* or others covered by the *Policy* before the declaration was made.

C5 DURATION OF POLICY

C5.1 A *Policy* commences on the later of:

a) the time and date on which an application is received by *HCF*; or

b) the date nominated on the application form, or

c) a date mutually agreed between the *Policyholder* and *HCF*,

provided that the *Policyholder* has paid *Premiums* from the date of commencement and all application procedures are completed to the satisfaction of *HCF*.

C5.2 A *Policy* continues until the date the *Policyholder* notifies *HCF* in writing that the *Policyholder* wishes to cancel the *Policy* under Rule C7, or *HCF* notifies the *Policyholder* that the *Policy* has been terminated under Rule C8.

C6 TRANSFERS

C6.1 For the purposes of Rule C6, a 'transfer' is where a *Member* has transferred to an *HCF Policy* (the New *Policy*) from a policy with another registered private health insurer (including an *RT Health Policy* which was transferred to the *Health Benefits Fund* on or about 1 November 2021 or from another *HCF Policy* (the Old *Policy*)).

C6.2 Subject to Rules C6.3 to C6.7, if a *Member* transfers to a New *Policy*, *HCF* will recognise *Waiting Periods* served under an Old *Policy* for *Hospital Treatment* or *General Treatment*.

C6.3 *HCF* will not recognise *Waiting Periods* previously served on an Old *Policy* if:

a) there is a gap of more than thirty (30) days between the date up to which *Premiums* have been paid under the Old *Policy* and the date the New *Policy* commenced; or

b) the relevant *Services* were not covered under the Old *Policy;* or

c) a *Choosable 12 month Service* is selected under a *Choosable Extras Policy* more than thirty (30) days after the date the New *Policy* commenced.

C6.4 If a *Hospital Benefit* for a *Service* is higher under the New *Policy* than under the Old *Policy*, *Hospital Benefits* will only be payable as per the entitlements of the Old *Policy* for the duration of the *Waiting Period* specified for that *Service* in Rule F3.

C6.5 If a *Hospital Cover Service* was Covered under the Old *Policy* and in respect of which *Co-payments* or *Excesses* are lower under the New *Policy* than under the Old *Policy*, the higher *Co-payment* or *Excess* continues to apply under the New *Policy* for the duration of the *Waiting Period* specified for the *Hospital Cover Service* in Rule F3.

C6.6 If an *Extras Benefit* is higher under the New *Policy* than under the Old *Policy*, *Extras Benefits* will only be payable as per the entitlements of:

a) where the Old *Policy* was another *HCF Policy* (including an *RT Health Policy*), the Old *Policy;* and

b) where the Old *Policy* was a policy with another registered private health insurer, an *HCF Policy* that *HCF* determines is the nearest equivalent to the Old *Policy*,

for the duration of the *Waiting Period* specified for that *Extras Service* in Rule F3.3.

C6.7 *HCF* may deduct benefits paid under the Old *Policy* to determine the *Member's* entitlement to *Benefits* for *Extras Services* under the New *Policy*.

C7 CANCELLATION OF POLICY

C7.1 A *Policyholder* will be entitled to cancel their *Policy* by providing notice in writing to *HCF*.

C7.2 Subject to Rule A11.3, any *Premiums* paid in advance of the date of cancellation will be refunded to the *Policyholder* on a pro rata basis.

C7.3 *Benefits* will not be paid for any *Service* provided to a *Member* after the date of cancellation.

C7.4 *HCF* will supply a *Transfer Certificate* within 14 days of the date of cancellation of the *Policy* to a *Member* who ceases to be insured under an *HCF Policy*.

C7.5 If a *Transfer Certificate* is requested by a *Member's* new insurer, *HCF* must supply it within 14 days of the request.

C8 TERMINATION OF POLICY

C8.1 *HCF* may not terminate the *Policy* of any *Member* on the grounds of the health of that *Member*.

C8.2 *HCF* may terminate the *Policy* of any *Policyholder* or terminate a *Member* from a *Policy* (with or without advanced written notice) on any of the following grounds:

a) any *Member* included in the *Policy* had, in the opinion of *HCF*, committed or attempted to commit fraud upon *HCF*;

b) the application for the *Policy* is discovered to have been inaccurate in a material respect or incomplete and the *Member* has failed to provide information requested by *HCF* within a reasonable time of the request;

c) any *Member* included in the *Policy* has a concurrent *Hospital Cover* and/or *Extras Cover Policy* with another private health insurer;

d) the *Policy* is in arrears for a period of more than 2 months; or

e) any *Member* included in the *Policy* has, in the opinion of *HCF*, behaved inappropriately towards *HCF* staff, providers or other *Members*.

C8.3 *HCF* will give written advice of termination, to the *Policyholder* and/or *Member* and will, subject to Rule A11.3, refund any *Premiums* paid in advance as at the date of termination.

C8.4 *Benefits* will not be paid for any *Service* provided to a *Member* after the date of termination.

C8.5 Where *HCF* has exercised its rights to terminate a *Policy*, *HCF* shall have the right to refuse another application for a *Policy* from the cancelled *Member* for a *Policy* referable to any *Fund* conducted by *HCF*, subject to the *Private Health Insurance Act*.

C9 TEMPORARY SUSPENSION OF POLICY

C9.1 Applications to Pause / Suspend

A *Policy* may be temporarily suspended or paused under Rule C9. A *Policyholder* may request for a *Policy* to be paused by contacting *HCF*.

HCF has discretion to approve the request on a case-by-case basis, considering the eligibility criteria in Rule C9. If HCF approves the request, the following will apply to the *Policyholder* and all *Members* on the *Policy* from the date requested by the *Policyholder*:

a) No *Benefits* are payable during any paused period;
b) The paused period will not be taken into account for the purpose of determining whether *Waiting Periods* have been satisfied;
c) The paused period will not count towards any *Loyalty Bonus*, *Limit Boost* or *Gap Bonus*;
d) The paused period of a *Policy* will not be taken into account for the purposes of *Lifetime Health Cover* calculations;
e) *Premiums* paid in advance in respect of any part of the paused period can be refunded to the *Policyholder* or it can be held to the credit of the *Policy* pending resumption.

C9.2 Overseas Travel

HCF may consider pausing a *Policy* where the *Policyholder* plans to travel overseas if:

a) the Policy has been active and financial for more than 6 months;
b) a *Member* covered by the *Policy* is temporarily absent from Australia for more than 1 month and no more than 24 months;
c) the *Policyholder* agrees to resume and pay *Premiums* for the *Policy* within 1 month of returning to Australia;
d) the requested paused period is a minimum of one month and maximum of 24 months; and
e) the *Policyholder* has applied to HCF to pause their *Policy* prior to their departure from Australia.

C9.3 Financial Hardship

HCF may consider pausing a *Policy* for financial hardship if:

a) the *Policyholder* is unable to continue payments of *Premiums* because of financial hardship, unemployment, sickness or any other reason approved by HCF;~~.~~
b) the *Policy* has been active and financial for more than 6 months;
c) the requested paused period is a minimum of one month and maximum is 24 months.

C9.4 Members' Responsibility to Provide Information

HCF may reasonably request that the *Policyholder* provides information or documents to support an application to pause a *Policy* and the *Policyholder* must provide the requested information or documents. For overseas travel applications, *HCF* may request evidence of departure and return to Australia.

C9.5. Resumption of *Policy*

a) HCF will resume a paused *Policy* on the day before the Member's indicated date of arrival (for Overseas Travel), or the resumption date approved by HCF in the application (for Financial Hardship);
b) All *Premiums* held in credit shall be applied to the *Policy* from the applicable resumption date set out in Rule C9.5(a)and will be applied at the *Premium* rates prevailing on the resumption date.

c) Any outstanding *Waiting Periods* must be served upon resumption of the *Policy*.

C10 OTHER

C10.1 *Offsale Product* Policies

a) *HCF* may, in its discretion, decide not to allow anyone to take out, or transfer to, a *Product* from a specified date. In relation to all the *Members* who were covered under that *Product* on that date, *HCF* may either: migrate those *Members* to another *Product* in accordance with C10.2; or allow those *Members* to continue holding *Policies* under that *Product*.

b) A person may not take out, or transfer to, an *Offsale Product* unless: the person is a *Dependant* or *Partner* of a *Member* who holds an *Offsale Product* and wishes to join that *Member's Policy*, or the person is a *Member* who holds an *Offsale Product* and wishes to transfer to another *Offsale Product*. This includes transfers to a different excess option or *Insured Group* within the same *Product* and transfers to a different type of *Product*.

C10.2 Migration

a) If *HCF* decides to close a *Product* or change eligibility for a *Product*, it may migrate some or all *Members* who hold that *Product* to another comparable *Product* as determined by *HCF*, subject to the *Private Health Insurance Act*. *HCF* will provide affected *Members* with prior written notice of the details of the migration to a comparable *Product*, in accordance with the *Private Health Insurance (Complying Product) Rules*. *Members* may transfer to another *Product* of their choosing prior to the date of migration.

b) The rules in relation to the recognition of *Waiting Periods* in Rule C6 will apply when *Members* are migrated to another *Product* by *HCF* or if *Members* voluntarily transfer to another *Product* due to an impending migration under this Rule.

C10.3 Authority to Act

a) Authority to Act – Nomination by *Policyholder* – a Nomination by *Policyholder* form must be completed by a *Policyholder* when they wish to nominate another person as their authorised representative for the purposes of maintenance of the *Policy*.

b) Authority to Act – Nomination by Authorised Representative – a Nomination by Authorised Representative form must be completed where:

the *Policyholder* is a person who lacks capacity in which case, it must be completed by their authorised representative; or

a *Policyholder* is a minor in which case, it must be completed by a person over 18 years of age who is their parent or legal guardian.

c) A written Authority to Act as described above is required when a *Partner*, *Dependant* or other person, who is not the *Policyholder,* is requesting: changes to the *Policy* including:

(i) removing Dependants

(ii) requesting membership cards to be posted to an address other than that of the Policyholder;

(iii) changing the *Policy* to a lower level of cover;

(iv) changing bank account details; or

(v) changing mailing address; changes to *Benefits* including:

(vi) a claims benefit to be made payable to his/her name/bank account when the *Service* was not provided to him/her; or

(vii) changing direct credit details. Statement of Benefits for other *Members* listed on the *Policy* other than themselves; *Transfer Certificate* for other *Members* listed on the *Policy*; termination of a *Policy*; and any other changes to a *Policy*.

d) Notwithstanding Rule C10.3c) above, the *Partner* of a *Policyholder* may request to remove themselves from the *Policy* without a written Authority to Act.

C10.4 Involuntary Unemployment Assistance

A *Policyholder* or *Partner* is eligible for *Involuntary Unemployment Assistance* if the *Policy* they hold is: Top Hospital, Healthmate Ultimate, Healthmate Advanced, Healthmate Essentials, Healthy First Hospital, Healthstart Hospital, Healthclub or Healthmate Starter (a **Healthmate Hospital**

Product); or if the *Policy* is any other *HCF Hospital Cover* except Ambulance Cover (a **Standard Hospital Product**) provided the following conditions are met:

a) the *Policyholder* or *Partner* has been unemployed for more than 29 days; and

b) the *Policyholder* or *Partner* has either:

(i) been involuntarily retrenched or made redundant by their employer from permanent employment (over 20 hours per week and not temporary in nature or related to a fixed period contract of employment) which was not due to an unsuccessful probation period, resignation, voluntary redundancy, unsatisfactory work performance or unemployment due to medical reasons; and the *Policyholder* or *Partner* had permanent employment for 6 months prior to their unemployment; or

(ii) if the *Policyholder* or *Partner* is self-employed, then the business of the *Policyholder* or *Partner* must have been either legally declared bankrupt or have been put into involuntary liquidation; and

c) the *Policyholder* or *Partner* is actively seeking employment;

d) the *Policyholder* or *Partner* has held a *Hospital Cover* that included *Involuntary Unemployment Assistance* for at least:

(i) 2 months for *Policyholders* or *Partners* that hold a Healthmate Hospital Product; or

(ii) 12 months for *Policyholders* or *Partners* that hold a Standard Hospital Product; and

e) the *Policyholder* or *Partner* has applied for *Involuntary Unemployment Assistance* within 3 months of becoming unemployed; and

f) the *Policyholder* or *Partner* has:

(i) provided a separation form from their previous employer; or provided a statutory declaration stating the *Policyholder* or *Partner* is unemployed and seeking employment on application for *Involuntary Unemployment Assistance* and every month after that; or

(ii) provided a notification from the Australian Financial Security Authority or a legal practitioner or accountant stating the business had gone into involuntary liquidation or made bankrupt.

HCF shall have the right to deny Involuntary *Unemployment Assistance* to a *Policyholder* or *Partner* who, in the reasonable opinion of *HCF*, has:

g) intentionally sought a *Policy* that includes *Involuntary Unemployment Assistance* knowing that the *Policyholder's* employment had a high probability of ceasing;

h) in the case of a self-employed *Policyholder* or *Partner*, the business had a high probability of failing or involuntary liquidation was impending at the date of commencement of the *Policy*; or

i) voluntarily became unemployed.

If *HCF* determines that the *Policyholder* or *Partner* is eligible for *Involuntary Unemployment Assistance* under Rule C10.4, HCF will pay *Premiums* on the *Policy* for 2 months, on top of what has already been paid for the *Policy* on the date *HCF* makes payment. *HCF* will then pay *Premiums* on a monthly basis after it receives either of the following for each month:

(i) certification from Centrelink or other registered employment service that the *Policyholder* or *Partner* is unemployed and seeking employment; or

(ii) a statutory declaration from the *Policyholder* or *Partner* that they are unemployed and seeking employment, subject to a maximum period of:

(i) 12 consecutive calendar months for *Policyholders* or *Partners* that hold a Healthmate Hospital Product; or

(ii) 183 days in any 2 year period for *Policyholders* or *Partners* that hold a Standard Hospital Product.

C10.5 Cooling Off Period

If you change your mind and cancel your *HCF Policy* within 30 days of joining, *HCF* will give the *Policyholder* a 100% refund, as long as a claim has not been made in that time.

D PREMIUMS

D1 PAYMENT OF PREMIUMS

D1.1 The *Product Information* contains the *Premiums* payable by a *Policyholder* for their *Policy.*

D1.2 The amount of *Premiums* payable for a *Policy* may be impacted by eligibility for the Australian Government Rebate on private health insurance.

D1.3 *Premiums* are payable to cover periods in advance of your nominated direct debit or scheduled payment date. *Premiums* can be paid so that the financial date (date paid to) is up to 18 months in advance at any time.

D1.4 Where a *Policy's* financial date (date paid to) is in excess of 18 months in advance, HCF may, at its discretion, refund the *Premiums* in excess of the 18 months.

D2 PREMIUM RATE CHANGES

D2.1 A *Policyholder* who has paid their *Premiums* in advance of a rate increase will not be required to make any adjusting payments in order to compensate for that rate increase for the period covered for by their advance payment.

D3 PREMIUM DISCOUNTS

D3.1 *HCF* may offer a discount to any contribution group. A 'contribution group' is a group of persons determined by *HCF* at its discretion.

D4 LIFETIME HEALTH COVER

D4.1 HCF must apply *Lifetime Health Cover* loadings to *Premiums* in accordance with the *Private Health Insurance Act*.

D5 ARREARS IN PREMIUMS

D5.1 A *Policyholder* will be deemed to be in arrears if the date paid to on their *Policy* is before the current date and a payment for the *Premiums* is not pending.

D5.2 A *Policy* will be terminated when *Premiums* are more than 2 calendar months in arrears. *HCF* may, at its discretion, reinstate a *Policy* that is in arrears by up to 4 months without a gap, as long as full payment of the arrears is received by *HCF*. *Waiting Periods* already served will not be required to be served again.

D5.3 Where a *Policyholder* is in arrears and pays the arrears in *Premiums* up to the date the *Policy* is terminated, he or she will be entitled to *Benefits* for *Services* which were provided during the arrears period, as long as the *Policy's* date paid to include the date on which the *Service* was provided.

D5.4 An amount received as a *Premium* which would entitle a *Member* to receive *Benefits* will be applied first to payment of any arrears of such *Premiums* and then applied in respect of future periods in chronological order, and any amount received as a *Premium* which would entitle a *Member* to receive *Benefits* in accordance with more than one *Product* will be applied in such a manner as to establish a common date to which the *Policyholder* is paid in respect of each *Product*.

E BENEFITS

E1 GENERAL CONDITIONS

E1.1 *Benefits* are not available for any *Service* if *Premiums* paid in accordance with these *Rules* do not cover the date of *Service*.

E1.2 A claim for *Benefits* by either a *Member*, or a *Recognised Provider* on behalf of a *Member*, cannot be made before the *Service* has been provided or received.

E1.3 A *Member*, in making a claim for *Benefits*, must comply with the policies and procedures prescribed by *HCF* and must supply all information required in the manner and form requested.

E1.4 *HCF* will not be liable for any costs associated with the supply of information specified in Rule E1.3.

E1.5 *HCF* will have the right to refuse payment in respect of any claim if the claim in *HCF's* reasonable opinion is not properly payable under these *Rules*.

E1.6 *Benefits* payable in accordance with these *Rules* will not exceed 100% of the fee charged for any *Service* less any amounts recoverable from any other source.

E1.7 *Benefits* paid for a *Service* by *HCF* must be returned to *HCF* if a refund of charges is made to a *Member* by a provider for the same *Service*.

E1.8 *Benefits* are not payable in respect of any *Service* provided to a *Member* if:

a) the expenses in respect of that *Service* were incurred by the employer of that *Member*; or

b) the expenses in respect of that *Service* are payable by any other source, such as SafeWork NSW, State Insurance Regulatory Authority (SIRA) or the Transport Accident Commission.

E1.9 Subject to *HCF's* obligation to pay *Benefits* under the *Private Health Insurance Act*, *Benefits* are not payable in respect of any *Service* that is deemed by *HCF*, after receiving independent medical or clinical advice, to be inappropriate, not reasonable or experimental or not falling within a clinical category, as set out in Schedule 5 of the *Private Health Insurance (Complying Product) Rules*.

E1.10 *Members* with *Hospital Cover* may from time to time be invited to participate in *Chronic Disease Management Programs*, which are designed to improve health outcomes by education and by support to *Members* with chronic and progressive conditions.

E1.11 Amounts paid to deliver *Chronic Disease Management Programs* to *Members* will be considered to be *Benefits*.

E1.12 *Members* with *Extras Cover* may from time to time be invited to participate in *Health Management Programs*.

E1.13 Amounts paid to deliver *Health Management Programs* to *Members* will be considered to be *Benefits*.

E1.14 Notwithstanding anything contained elsewhere in these *Rules*, *HCF* may permit the payment of a *Benefit* if the *Medical Adviser* is of the opinion that the payment is appropriate and in accordance with *HCF's* support of health outcomes for *Members*.

E1.15 The amount of a *Benefit* described in Rule E1.14 and any conditions on payment of that *Benefit*, will be in *HCF's* absolute discretion.

E1.16 Where a person has paid for a *Service* in advance and before the person became a *Member*, that person may only be eligible to receive *Benefits* for the components of the *Service* the person received after becoming a *Member*. The claim requirements in Rule G1 must be met for each component of the *Service* received after the person became a *Member*.

E2 HOSPITAL BENEFITS CONDITIONS

E2.1 No *Hospital Benefits* are payable if the *Member* has not received a *Hospital Cover Service*.

E2.2 In calculating *Benefits* for *Hospital* accommodation, the day of admission will be counted as a day for *Benefit* purposes and the day of discharge will not be counted as a day for *Benefit* purposes, unless it is the day of admission.

E2.3 Subject to the *Private Health Insurance Act*, *Benefits* for *Drugs* directly associated with the reason for admission to an *HCF Participating Private Hospital* will be payable in accordance with any relevant agreement or arrangement with that *Hospital*.

E2.4 *Hospital Benefits* are not payable for the following:

(a) experimental non-*PBS Drugs;*

(b) high cost non-*PBS Drugs;* or

(c) drugs approved by the *TGA*, but used for a purpose other than that for which they were approved.

E2.5 *Members* will only be entitled to *Benefits* for private *Hospital* accommodation at the rate provided for patients undergoing a particular *Prescribed Procedure* from the day prior to the day on which the procedure is carried out, or the day of admission to *Hospital*, whichever is the later. In respect of the days prior to this date, *Benefits* for private *Hospital* accommodation will be paid in accordance with the rate provided for medical patients unless HCF is required to pay a higher rate under the *Private Health Insurance Act*.

E2.6 For the purposes of determining entitlement to *Benefits* for private *Hospital* accommodation, discontinuous periods of hospitalisation may be regarded as continuous unless the period between any two periods of hospitalisation is greater than 7 days.

E2.7 Entitlement to *Benefits* for *Restricted Services* for private *Hospital* accommodation will be at the *Minimum Benefit* level relevant to the class of patient. Where the class of patient is not specifically identified as either an Advanced Surgical, Surgical, Obstetric, Psychiatric or Rehabilitation patient then the entitlement to *Benefits* will be as per the Other Patients classification, unless otherwise recommended by the *Medical Adviser*.

E2.8 Notwithstanding anything else contained in these *Rules*, *Nursing Home Type Patients* will not be entitled to *Benefits* for *Hospital* accommodation other than as required under the *Private Health Insurance Act*.

E2.9 *Benefits* are payable for admissions to a *Non-Participating Hospital* as defined in the *Product Information.*

E2.10 *Benefits* payable for essential *Hospital* accommodation and theatre *Services* received as a result of an *Accident*, and not paid or payable from any other source, are not subject to *Excess* or *Co-payments* provided that:

a) the cost will not exceed the usual and recognised charges;

b) the *Benefits* are subject to the limitations stated elsewhere in these *Rules*; and

c) the *Services* are provided within 12 months of the date of the *Accident*.

E2.11 *Benefits* for *Prostheses* will include handling fees where applicable.

E2.12 Chronic Disease Management Device

a) *Benefits* for *CDMDs* provided to a *Member* that is not an admitted patient of a *Hospital* are payable subject to the following conditions: *Waiting Periods* have been served; the *CDMD* is not provided as part of *Hospital Treatment*; and the *Member* holds *Hospital Cover* with *HCF* that *Covers CDMDs* and *Hospital Treatment* for the chronic disease which is being treated by the CDMD, and has continuously held that *Hospital Cover* for at least 12 months; and for replacement speech processors, the *Member* is not eligible for funding from Hearing Australia or does not otherwise have the right to recover the costs in accordance with F4.1C.

b) If a *Member* receives a *CDMD* for the first time in the *Member's* life and they are not an admitted patient of a *Hospital*, the *Benefit* payable is 100% of the amount listed on the *Prescribed List of Medical Devices and Human Tissue Products* for the *CDMD*.

c) If a *Member* receives a *CDMD* as a replacement or upgrade of an existing *CDMD* and meets the conditions in clause E2.12(d), the *Benefit* payable is 100% of the highest benefit listed for that category of *CDMD* on the *Prescribed List of Medical Devices and Human Tissue Products.*

d) In addition to the conditions in clause E2.12(a), *Benefits* for replacement or upgrades of a *CDMD* are only payable if: at least 5 years has elapsed since the previous *CDMD* was funded by *HCF* or another party; and during the period referred to in E2.12(d)(i), the *Member* has continuously held a health insurance policy issued by *HCF* or another insurer that covers *CDMDs* and hospital treatment for the chronic disease which is being treated by the *CDMD*; and *HCF*

has documented evidence of the date on which the previous *CDMD* was funded by *HCF* or by another party.

If this evidence is not available, the date the previous *CDMD* was funded will be assumed to be the date the *Member* joined *HCF*.

e) In its absolute discretion, *HCF* may pro-rata the applicable *Benefit* for *Members* who wish to replace or upgrade their *CDMD* before 5 years has elapsed since the previous *CDMD* was funded, provided that: the *CDMD* is not under the manufacturer's warranty; and the *CDMD* is not lost, stolen or damaged.

E2.13 Chronic Disease Management Programs

Benefits for *Chronic Disease Management Programs* provided to a *Member* that is not an admitted patient of a *Hospital* are payable subject to the following conditions:

(i) *Waiting Periods* have been served; the *Chronic Disease Management Program* is not provided as part of *Hospital Treatment*; the *Member* holds *Hospital Cover* with *HCF* that *Covers Chronic Disease Management Programs* and *Hospital Treatment* for the chronic disease that is being managed by the *Chronic Disease Management Program* and has continuously held that *Hospital Cover* for at least 12 months; and any other eligibility criteria specified by *HCF* for the individual program.

E2.14 This section (E2) is subject to *HCF's* obligations to pay *Benefits* under the *Private Health Insurance Act*.

E3 EXTRAS BENEFITS CONDITIONS

E3.1 *Benefits* for certain *Extras Services* may be governed by agreements entered into between *HCF* and *Recognised Providers*.

E3.2 In these situations, *Benefit* entitlements may be at higher levels than those indicated in the *Product Information*, Member Guide, or elsewhere in these *Rules*.

E3.3 *Members* will only be entitled to *Benefits* for *Extras Services*, courses and programs provided by *Recognised Providers* in *Private Practice*.

E3.4 *Members* whose *Extras Cover* includes psychology treatment may be entitled to two levels of *Benefits*. To receive a higher *Benefit* for psychology treatment in a *Calendar Year*, a *Member* must:

a) have a Medicare Mental Health Treatment Plan and have used up the Plan in that *Calendar Year*, and is not eligible for Medicare benefits for the further psychology treatment; and

b) have a Medical Practitioner or a psychologist who is a *Recognised Provider* certify (in a form approved by HCF) that the further psychology treatment is necessary and ongoing; and

receive the further psychology treatment from a psychologist who is a *Recognised Provider* and treating the *Member* as a private patient. The higher *Benefit* will apply for the psychology treatment received during the remainder of that *Calendar Year*.

E3.5 Where a *Member* is *Covered* for *Mental Health Services*, the only *Member* eligible to receive *Benefits* for a *Couples or Family Consultation* is the *Member* who has been charged the full amount for the *Couples or Family Consultation* and is:

a) the only person specified on the invoice issued by the *Recognised Provider*; or

b) identified as the primary person receiving treatment by the *Recognised Provider* on the invoice; or

c) if paragraph a) or b) do not apply, the first person listed on the invoice issued by the *Recognised Provider*.

Benefits are only payable once per *Couples or Family Consultation*.

E3.6 Dental *Services* are provided at *HCF* Dental Centres for *Members* whose *Policy* entitles them to dental *Benefits* provided that:

a) *Premiums* on the *Policy* are not in arrears;

b) the *Policyholder* has paid all charges raised by *HCF* for any prior *Services* or failure to attend an appointment; and

c) the *Member* understands that any *Services* provided at an *HCF* Dental Centre are part of their annual dental *Benefit* entitlement and *HCF* will process a claim against their dental *Benefits* and *Limits* (where applicable).

E3.7 Some dental *Services* provided by *HCF* may be subject to fees and charges not claimable as a dental *Benefit* and any such charges will be payable by the *Member*.

E3.8 Information concerning charges for *Services* is provided (where possible and practicable) in writing to enable informed financial consent to be given by the *Member* prior to the commencement of the *Services*.

E3.9 *Members* from time to time may be invited to participate in or access additional services provided by *HCF* or arranged by *HCF* in relation to *Services* and subject to the *Private Health Insurance Act*. Amounts paid to deliver such services to *Members* will be considered to be *Benefits*.

E3.10 *HCF* may decide that *Benefits* will no longer be payable in respect of *Services* supplied by a provider whose status as a *Recognised Provider* has been terminated by HCF in accordance with the *Recognised Provider* terms and conditions.

E3.11 In these cases outlined in Rule E3.10, *Benefits* will not be payable for any *Service* supplied by that provider unless *HCF* is satisfied that the *Member* claiming *Benefits* was not aware of the decision at the time the *Service* was provided, or *HCF* otherwise considers that the *Member* would suffer hardship if the *Benefits* were not paid.

E3.12 The provider identified in Rules E3.10 and E3.11, will thereafter no longer be considered to be an *HCF Recognised Provider*.

E3.13 Health Management Aids and Appliances *Benefits* are payable only when:

a) specified as an inclusion in the *Product Information*;

b) they are set out on *HCF's* approved Health Management Aids and Appliances list; and

c) certification is provided by a *Medical Practitioner* that the item is required for the management of the patient's medical condition.

E3.14 Optical *Benefits* are payable for prescription glasses (frames and lenses) and contact lenses to help correct a *members* vision and that are prescribed by an optometrist or ophthalmologist (who is a *Recognised Provider*) and supplied by an optometrist, ophthalmologist or optical dispenser (who is a *Recognised Provider*).

E3.15 *Benefits* for Online Cognitive Behavioural Therapy are only payable for programs that are recognised and approved by *HCF,* that have been completed by the *Member* and for which a *Member* has provided HCF with a certificate of completion.

E4 OTHER CONDITIONS

E4.1 Loyalty Bonus – Health Dollars

a) *Health Dollars* may be used to claim for the costs of any *Excess* payable for eligible *Hospital Treatment* covered by the *Member's Hospital Cover* or toward the costs of eligible *Extras Services* covered by the *Member's Extras Cover* in accordance with the *Product Information*.

b) *Health Dollars* annual *Limits* are based on the length of *Hospital Cover* of the *Member* on an eligible *Hospital Cover.*

c) The length of a *Policy* is based on a *Membership Year*, not a *Calendar Year*.

d) All accounts must be paid by the *Member* before any *Health Dollars* will be paid.

e) *Health Dollar Benefits* are payable only to the *Member*.

f) *Health Dollars* cannot be used to cover out-of-pocket expenses for any procedure where *Medicare Benefits* are payable or for *Medical Gap* payments.

E4.2 Length of Policy for Loyalty Bonuses

In calculating the length of a *Policy* for *Health Dollars*, the *Policy* commences on the date the first *Premium* is paid and each *Membership Year* from that date, as long as a continuous period of *Premiums* is paid by, or on behalf of, the *Member* in relation to any eligible *Hospital Cover* and

Extras Cover combination on or after 1 January 2000.

E4.3 Circumstances affecting calculation of length of Policy

The calculation of the duration of a *Policy* for the purpose of calculating a *Member's* entitlements to *Health Dollars* does not take into account the following circumstances:

a) an approved period of a suspended *Policy*;

b) prior policy with another private health insurer (other than an *RT Health Policy*);

c) if the Policy is an *Extras Cover* (only) or a *Hospital Cover* (only); or

d) any other period during which the Member ceases to be a Member of the Health Benefits Fund.

E4.4 Unclaimed *Health Dollars* are forfeited upon the cancellation of a *Policy* unless the *Member* transfers to another eligible *HCF Policy* without any break in cover under eligible *Policies*.

E4.5 Loyalty Bonus – Limit Boost

a) *Limit Boost* allows *Members* to top up their annual *Limit* on a range of general dental and optical *Services*.

b) The *Limit Boost* commences after 12 months of continuously holding an eligible *Extras Cover* and increases annually on your *Policy* anniversary date from years 2 to 6.

c) The *Limit Boost* that applies to each eligible *Extras Cover* is as indicated in the *Product Information*.

d) Any unused *Limit Boost* cannot be carried into the following year.

e) The *Limit Boost* is only available when an eligible *Extras Cover* is taken together with eligible *Hospital Cover*.

f) The *Limit Boost* is applicable only once per *Membership Year* and is not available if allowance has already been used in that *Membership Year*.

E4.6 Loyalty Bonus – Gap Bonus

a) *Gap Bonus* allows *Members* to top up their *Benefit* on covered *Services* under eligible *Extras Cover*. An *Extras Cover* is eligible for *Gap Bonus* if the *Product Information* refers to the availability of *Gap Bonus*. The amounts of the *Gap Bonus* will also be stated in the *Product Information*.

b) *Gap Bonus* commences after 12 months of continuously holding an eligible *Extras Cover* and the amount of the *Gap Bonus* increases at the commencement of each *Calendar Year* in years 3 and 4.

c) The amount of the *Gap Bonus* can be used to top up *Benefits HCF* pays on any covered *Extras Service* under an eligible *Extras Cover* . *Gap Bonus* reduces or eliminates out-of-pocket costs for those *Extras Services*. .

d) Any *Gap Bonus* amount that is not used during a *Calendar Year* cannot be carried into any following *Calendar Year*.

e) The *Gap Bonus* is applicable per person per *Calendar Year* and is not transferrable between *Members*.

f) If a *Member* has reached their annual *Limit* for an *Extras Service*, *Gap Bonus* can still be used by the *Member* for that *Extras Service* subject to paragraph (g).

g) If a *Member* has reached their service limit for an *Extras Service*, *Gap Bonus* cannot be used by the *Member* for that *Extras.*

E4.7 Ambulance Transportation

a) *HCF* pays *Benefits* towards eligible *Emergency Ambulance Transport* and *Non-Emergency Ambulance Transport Services* provided by an *Ambulance Service Provider* depending on a *Member's Product* and up to their annual *Limit* (either a dollar or service *Limit*), as specified in the *Product Information*.

b) The *Ambulance* must be provided by an *Ambulance Service Provider* and the transportation must be to the nearest appropriate Australian *Hospital* able to provide the level of care required.

E4.8 Emergency Ambulance Transportation

a) *Benefits* are payable for *Emergency Ambulance Transport* where transport to the nearest *Hospital* or on-the-spot treatment is required.

b) *Benefits* are not payable for *Emergency Ambulance Transport*:

i. where *Non-Emergency Ambulance Transport* is requested;

ii. for transport on discharge from *Hospital* to a *Member's* home or nursing home;

iii. where a *Member* is covered by another funding arrangement such as a State government scheme;

iv. where a *Member* is covered by another third party (such as a *State Ambulance* subscription or the *Ambulance* charges are the subject of a compensation claim);

v. for transfers between *Hospitals*, including where a *Member* attended an emergency department, outpatient department, urgent care centre, short stay ward or other ward or medical department at a *Hospital* before or after the transfer (when formally admitted);

vi. for transfers to or from medical facilities such as diagnostic imaging, allied health or other health related facilities;

vii. for charges raised for a medical retrieval team escort;

c) for *Ambulance Service Providers* not recognised by *HCF*; and

d) where a *Member* is entitled to a waiver of the charges from the *Ambulance Service Provider* (such as a waiver due to pensioner status).

E4.9 Non-Emergency Ambulance Transportation

a) A limited number of Products include a *Non-Emergency Ambulance Transport Benefit*.

b) *Benefits* are not payable for *Non-Emergency Ambulance Transport*: where the transport does not meet the definition of *Non-Emergency Ambulance Transport* (such as for general patient transport); where the transport has been elected by the patient or family for reasons such as choice of doctor or *Hospital* or to be closer to family; where a *Member* is covered by another funding arrangement such as a State government scheme; where a *Member* is covered by another third party (such as a State *Ambulance* subscription or the *Ambulance* charges are the subject of a compensation claim);or transfers between *Hospitals*, including where a *Member* attended an emergency department, outpatient department, urgent care centre, short stay ward or other ward or medical department at a Hospital before or after the transfer (when formally admitted); for charges made for a medical retrieval escort; for *Ambulance Service Providers* not recognised by *HCF*; and

c) where a *Member* is entitled to a waiver of the charges from the *Ambulance Service Provider* (such as a waiver due to pensioner status).

E4.10 Partial Cover for Ambulance Transportation

Benefits for *Emergency Ambulance Transport* or *Non-Emergency Ambulance Transport* are payable after any subsidy, discount, waiver or rebate provided by a third party or the *Ambulance Service Provider* has been deducted.

There may be additional circumstances set out in the *Product Information* where no *Benefits* are payable.

E4.11 Accident Safeguard

a) A limited number of *Products* include *Accident Safeguard*.

b) *Benefits* are payable for *Accident Safeguard* under the following conditions You must seek treatment at a *Hospital* accident and emergency department within 24 hours of the *Accident*. It may be necessary to provide evidence to *HCF* that you sought such treatment. *HCF* does not pay *Benefits* for accident and emergency department attendances;

c) *Benefits* are limited to in-patient *Hospital Treatment* for services with a valid *Medicare Benefits Schedule* item; Excludes elective cosmetic surgery and podiatric surgery by an accredited podiatrist;

d) *Accident Safeguard* can apply if you are admitted initially for immediate treatment and/or sent home after the emergency department consult but admitted at a later date for treatment directly resulting from the *Accident*, as long as the re-admission date is within 90 days of the *Accident*;

e) If you are discharged and further in- patient treatment is needed you must be re-admitted to hospital within 90 days of the date of the *Accident*. Any readmissions for *Hospital Treatment* after the initial 90 days will be assessed as per the level of *Benefits* on your cover, i.e. *Minimum Benefits* for a *Restricted Service* or nil *Benefits* if for an *Excluded*

Service If you have an *Accident* and require *Hospital Treatment*, you may be asked to complete and provide an 'Accident or incident' form. The form can be downloaded from **hcf.com.au/forms**; and *Benefits* are not payable for expenses incurred in relation to an injury where compensation, damages or benefits may be claimed from another source.

E4.12 Accident Benefit

a) *Accident Benefit* is payable if :

i. the *Member's Policy* includes *Accident Benefit* at the time of the *Accident*;

ii. the *Member* has exhausted the *Limit* for the *Extras Service* they would like to claim as a result of the *Accident*; or

iii. *Members* would be eligible to claim a *Benefit* for the *Extras Service*, as a result of the *Accident*, if their *Limit* was not exhausted;

iv. costs that are *Covered cannot be* recovered from another source, except an *HCF Life* insurance policy; and

v. the *Member* received the first treatment for that *Extras Service* within 6 months of the *Accident* and the *Extras Service* they would like to claim is provided within 24 months of the *Accident*.

b) A completed claim form and receipts must be submitted to *HCF*, accompanied by a report detailing the *Accident*, including the extent and circumstances of the injury. The report must be completed by a treating *Medical Practitioner*, and on the letterhead of the treating *Medical Practitioner*, submitted within 6 months of the *Accident*.

c) If a Member is eligible for Accident Benefit for an Extras Service, Benefits are payable for the relevant Extras Services up to the Limit for Accident Benefit per Member per Calendar Year.

E4.13 School Accident Benefit

a) School Accident Benefit is payable if:

i. a *Child Dependant* attending before and after school care, primary or secondary school receives *Extras Services* covered under their *Policy* as a result of an *Accident* that occurred;

(A) at school; or
(B) on the way to-or-from school; or
(C) on the way to-or-from a school activity; or
(D) at approved and regulated before and after school care (***School Accident***);

b) the Child Dependent is an HCF Member with an Extras Cover that includes School Accident Benefit at the time of the School Accident;

c) if *Waiting Periods* have been served. The *Waiting Period* for *School Accident Benefit* is the same as the *Waiting Period* for the *Extras Service* being claimed; and

d) the *Services* for the *Accident* were received within 12 months of the *Accident* occurring for Super Multicover, Multicover, Extras Benefits and General Extras *Covers*), or within 24 months of the *Accident* occurring for HCF Top, Vital, Ultimate, Advanced and Active Extras *Covers* and My Family Advanced and Family Care Advanced packaged *Covers*. If a *Child Dependant* is eligible for *School Accident Benefit,* it can be used to:

i. cover out-of-pocket expenses (cost of a *Service* minus the *HCF Benefit* for that *Service*) incurred for *Extras Services* received due to a *School Accident*; or

ii. to cover out-of-pocket expenses for *Extras Services* received due to a *School Accident* because the *Child Dependant's* annual *Limit* for the *Extras Service* has been reached.

e) A completed claim form and receipts must be submitted to *HCF*, and are accompanied by a report detailing the *School Accident*, including the extent and circumstances of the injury and the date the *School Accident* occurred. The report must completed by the school, and on the letterhead of the school-and be submitted within 12 months of the *School Accident*.

School Accident Benefit is not payable for:

a) Services not listed as Covered under the Child Dependant's Extras Policy or for any Hospital Treatment, Treatment provided by a Medical

Practitioner or General Treatment (other than Extras Services);

b) costs that are *Covered* or recoverable from another source, except an *HCF Life* insurance policy.

E5 CHOOSABLE EXTRAS POLICIES

This Rule E5 applies to *Choosable Extras Policies*.

E5.1 Selection of Services

a) The *Policyholder* is the only *Member* who can choose a maximum number of *Service Categories* from the selected range described within the *Product Information.*

b) The *Policyholder* is the only *Member* who can swap out a *Service Category* for another *Service Category.* The *Policyholder* can only swap a *Service Category* during a *Calendar Year* if a claim for *Benefits* for *Services* in that *Service Category* has not been processed by HCF in relation to any *Member* in that *Calendar Year*.

c) Subject to Rule E5.2(b), when the *Policyholder* swaps out a *Service Category*, they agree to waive any rights they have or any *Member* on the policy has, to *Benefits* for the *Services* in that *Service Category* from the beginning of the relevant *Calendar Year*.

d) If any *Member* on a *Choosable Extras Policy* makes a claim for a *Service Category*, that *Service Category* is locked in for every *Member* covered on that *Policy* for the remainder of the *Calendar Year*.

e) If the *Member* who made a claim leaves the *Choosable Extras Policy* and no other *Member* on the *Policy* has made a claim for a *Service Category* , that *Service Category* is unlocked and can be swapped out by the *Policyholder*.

f) If a *Member* holds more than one *Choosable Extras Policy* during a *Calendar Year* and becomes the *Policyholder* on a subsequent *Choosable Extras Policy*, the *Service Categories* the *Member* claimed on during that *Calendar Year* will be locked in as selected *Service Categories* for everyone on the subsequent *Choosable Extras Policy* for the rest of the *Calendar Year*.

g) If a *Member* holds more than one *Choosable Extras Policy* during a *Calendar Year* and they are not the *Policyholder* on a subsequent *Choosable Extras Policy*, the *Service Categories* the *Member* claimed on during that *Calendar Year* will be locked in as selected *Service Categories* for everyone on the subsequent *Choosable Extras Policy* if the *Policyholder* selects any of those *Service Categories* during the same *Calendar Year*.

h) Backdating of a *Service Category* swap is not permitted. However, the *Policyholder* may request to undo a swap within 30 days of the request provided that a claim for *Benefits* for *Services* in the newly selected *Service Category* has not been processed.

i) All *Service Categories* will be unlocked on 1 January each year and the *Policyholder* may swap out a *Service Category* for another, until a claim for *Benefits* has been processed in the new *Calendar Year* for the newly selected *Service Category*, at which time these newly selected *Service Categories* will be locked on the *Choosable Extras Policy*.

j) Pre-selecting the start date of the *Service Category* is not permitted unless the start date is 1 January of the next *Calendar Year.*

E5.2 Eligibility for Benefits

a) Subject to Rule E5.2(b), a *Service Category* must be active on the *Member's Choosable Extras Policy* at the time of receiving the relevant *Extras Service*, making the claim and at the time *HCF* processes the claim, for that particular *Extras Service* for *Benefits* to be payable. For example, *Benefits* are not payable for an *Extras Service* in a *Service Category* if the *Service Category* is swapped out before the claim is processed by *HCF*.

b) If a *Member* is claiming *Benefits* for an *Extras Service* (except *Choosable 12 month Services*) that was received in a prior *Calendar Year* where there were less than four *Service Categories* locked in, and the Service Category was selected at the date of service,

Benefits will be payable for that *Extras Service*. If *Benefits* are paid in these circumstances, the relevant *Service Category* will be locked-in for that prior *Calendar Year.*

c) When swapping to an *Extras Services* with a 2 month *Waiting Period*, a *Member* will not be required to re-serve the *Waiting Period* if the *Member* has continuously held the *Choosable Extras Policy* for at least 2 months or if they continuity of cover from an Old *Policy* in accordance with Rule C6. .

d) If a *Choosable 12 month Service* is selected at any time, the *Waiting Period* for that *Extras Service* starts on the date that the relevant *Service Category* becomes active on the *Choosable Extras Policy*, and not the date the *Choosable Extras Policy* commenced, unless the *Member* has continuity of cover from an Old *Policy* and the relevant *Service Category* was selected within 30 days of the date the *Choosable Extras Policy* commenced.

e) If a *Service Category* with a *Choosable 12 month Service* is swapped out and re-selected more than 30 days later, the *Waiting Period* for the *Choosable 12 month Service* re-starts on the date the relevant *Service Category* was re-selected on the *Choosable Extras Policy.*

F LIMITATION OF BENEFITS

(f)

F1 CO-PAYMENTS

Any *Co-payment* applicable to a *Product* will be applied before any *Hospital Benefit* is payable.

A PBS Equivalent Co-payment is applied before any *Benefit* is paid for a *Pharmaceutical Item.*

F2 EXCESSES

F2.1 Subject to Rule F2.2, any *Excess* applicable to a *Product* will be applied before any *Hospital Benefit* is payable.

F2.2 HCF will waive any applicable *Excess* for *Same-Day Treatment* for *Members* who have held HCF Hospital Premium Gold or HCF Corporate Premium Gold for at least 12 months.

F3 WAITING PERIODS

F3.1 *Waiting Periods* apply to *Services* for which *Benefits* are provided under a *Policy*.

F3.2 *Waiting Periods* for *Hospital Cover Services (excluding Ambulance Services)* are as follows:

2 MONTHS	All *Services*, unless specified otherwise in accordance with these *Rules*
	Hospital Psychiatric Services*, Rehabilitation and Palliative Care (whether or not for a *Pre-Existing Condition*)
12 MONTHS	*Services* for a *Pre-Existing Condition*
	Pregnancy and Birth Services (excluding miscarriage and termination of pregnancy which has a 2 month waiting period)

* *Members* who have held a *Hospital Cover* for at least 2 months and upgrade to receive *Hospital Benefits* (or a higher level of *Hospital Benefits*) for hospital psychiatric services may elect to be exempted from the 2 month *Waiting Period* for hospital psychiatric services that usually applies to *Members* when they upgrade their *Hospital Cover*. *Members* who have held a *Hospital Cover* for less than 2 months may elect to serve a reduced *Waiting Period* of 2 months minus the length of time that the *Member* held *Hospital Cover*. This exemption or reduction can only be accessed once in a *Member's* lifetime.

F3.3 *Waiting Periods* for *Ambulance Services* are as follows:

1 DAY	*Emergency Ambulance Transport*
2 MONTHS	*Non-emergency Ambulance Transport*

F3.4 *Waiting Periods* for *Extras Services* are as follows:

2 MONTHS	All *Services*, unless specified otherwise in accordance with these *Rules*
12 MONTHS	Prosthodontic, orthodontic, crown and bridge *Services*, occlusal therapy *Services*, indirect restorations, dentures, dental implants, periodontal management surgical, oral surgery, endodontics, teeth whitening (dental bleaching) and veneers. Foot orthotics, minor podiatric procedures and hearing aids.
VARYING TIMEFRAMES AS NOTIFIED BY HCF	*Artificial Appliances*, *School Accident Benefits,* and *Accident Benefit.*

F3.5 For *Chronic Disease Management Programs* and *CDMDs*, *Members* must have held *Hospital Cover* with *HCF* that *Covers Chronic Disease Management Programs* and *CDMDs* (as applicable) and *Hospital Treatment* for the chronic disease which is being treated, for at least the following period:

12 MONTHS	*Chronic Disease Management Programs and CDMDs*

F4 EXCLUSIONS

F4.1 *Benefits* are not payable under a *Policy* in the following circumstances unless *HCF* is required to pay *Benefits* under the *Private Health Insurance Act*:

a) if a *Service* is listed as a 'service not included' or an *Excluded Service* in the *Product Information*. For some *Hospital Covers* this may not apply when a *Member* receives *Services* as the result of an *Accident* (see *Accident Safeguard*). For other *Hospital Covers*, this is

regardless of whether or not the *Service* was required as a result of an *Accident*;

b) claims made 2 years or more after date of *Service*;

c) when a *Member* has the right to recover the costs from a third party other than *HCF*, including an authority, another insurer or under an employee benefit scheme;

d) *Services* for *Pre-Existing Conditions* (other than for psychiatric rehabilitation or palliative care) within the 12 month *Waiting Period* (the *Pre-Existing Condition Waiting Period* applies to new *Members* and *Members* upgrading their *Policy* to any higher level *Benefits* under their new *Policy*);

e) *Services* received during any period where payment is in arrears (unless clause D5.3 applies), the *Policy* is not financial, the *Policy* is suspended or within a *Waiting Period*;

f) *Services* that *HCF* deems to be inappropriate or not reasonable, after receiving independent medical or clinical advice;

g) any *Service* where it does not meet the standards in the Private Health Insurance (Accreditation) Rules;

h) emergency room fees;

i) *Services* that are not delivered in person in a clinical setting, unless:

(i) a *Member* is participating in a *Chronic Disease Management Program;* or

(ii) the *Service* is a Telehealth *Extras Service* and is provided to and received by the Member in Australia;

j) *Services* supplied by a provider not recognised by *HCF*;

k) *Services* provided outside Australia which do not meet the requirements under the *Private Health Insurance Act*; or

l) claims that do not meet *HCF's* criteria as set out in these *Rules*.

F4.2 In addition, *Hospital Benefits* are not payable for the following (unless *HCF* is required to pay *Benefits* under the *Private Health Insurance Act)*:

a) *Hospital Treatment* (including medical *Benefits*) for *Services* in respect of which the claim is not approved for payment by Medicare;

b) experimental treatment or other treatment that does not fall within a clinical category, as set out in Schedule 5 of the *Private Health Insurance (Complying Product) Rules* that is *Covered* by the *Product*;

c) experimental *non-PBS Drugs*;

d) high cost *non-PBS Drugs;*

e) *TGA* approved drugs used for a purpose other than that for which they were approved;

f) *Hospital Treatment* relating to procedures (and other associated goods and services) that do not require a hospital admission (except certified Type C procedures);

g) private room accommodation for same-day procedures;

h) respite care;

i) *Services* for *Nursing Home Type Patients* except as required under the *Private Health Insurance Act*;

j) special nursing;

k) luxury room surcharge;

l) donated blood and blood products;

m) donated blood collection and storage;

n) *PBS* pharmaceutical benefits in private *Non-Participating Hospitals*;

o) pharmaceuticals (including *PBS* pharmaceuticals benefits) and other sundry supplies not directly associated with the reason for admission;

p) take home items including crutches, toothbrushes and drugs;

q) personal convenience items including the cost of phone calls, newspapers, magazines and beauty salon services;

r) massage and aromatherapy services;

s) select *Services* provided while in *Hospital* by non-hospital providers e.g. dental practitioners;

t) *Excluded Services* and any other *Services* directly related to those *Excluded Services*, such as medical, diagnostic, *Prosthesis* and pharmacy received at the same time, except when *Accident Safeguard* applies;

u) the gap on government approved gap-permitted *Prostheses* items; and

v) *Restricted Services* in excess of the *Minimum Benefits* for that *Service*. For some *Hospital Covers* this may not apply when a *Member* receives *Services* as the result of an *Accident* (see *Accident Safeguard*). For other *Hospital Covers*, this is regardless of whether or not *Services were* required as a result of an *Accident*.

F4.3 In addition, *Extras Benefits* are not payable for:

a) *Services* while a *Hospital* patient except for eligible oral surgery;

b) pharmacy items that are not on *HCF's* approved pharmacy list as meeting the definition of a *Pharmaceutical Item* for example items listed on the *PBS*, items prescribed without an illness, items that are available without a prescription, items that are not approved by the *TGA*, or items supplied by a *Hospital* as take home drug;

c) *Services* that had not been provided at time of claim;

d) fees for completing claim forms and/or reports;

e) *Services* received overseas or purchased from overseas including items sourced over the internet;

f) where no specific health condition is being treated or in the absence of symptoms, illness or injury (except some *Chronic Disease Management Programs*);

g) routine health checks, screening and mass immunisations;

h) more than one therapy *Service* performed by the same provider in any one day;

i) Co-payments and gaps for government funded health services including the co-payment for *PBS* items; or

j) where a provider is not in an independent *Private Practice*.

F5 RESTRICTED SERVICES

F5.1 For *Services* listed as 'Restricted Cover' or a *Restricted Service* in the *Product Information*, HCF will only pay *Minimum Benefits*. For some *Hospital Covers* this may not apply when a *Member* receives *Services* as the result of an *Accident* (see *Accident Safeguard*). For other *Hospital Covers*, this is regardless of whether or not *Services were* required as a result of an *Accident*;

F5.2 Reduced *Benefits* are paid for eligible admissions on some *Policies* for podiatric surgery by a registered podiatric surgeon at *HCF Participating Private Hospitals* where *Minimum Benefits* are payable plus a Band 1 theatre fee only.

F5.3 *Minimum Benefits* means that private *Hospital* costs will not be fully *Covered*.

F5.4 *Members* may face significant personal expenses if they have any *Restricted Services* in a private *Hospital*.

F5.5 In addition, there are some *Services* where doctors' charges are not payable including podiatric surgery by a registered podiatric surgeon and for these *Services* where a 'reduced benefit' is payable but a benefit from Medicare is not applicable, *HCF* will pay:

at *HCF Participating Private Hospitals*:

(i) *Benefits* at the agreed accommodation rates for overnight admissions or at the agreed accommodation rate for day only admissions; and

(ii) *Benefits* at the agreed Band 1 theatre rate; and

(iii) no medical *Benefits*; and

(iv) At *Non-Participating Hospitals* and *Public Hospitals*, *Benefits* equivalent to the minimum accommodation benefit determined under the *Private Health Insurance Act* but no theatre or medical *Benefits*.

F5.6 Unless otherwise included in this section (F5) or determined by the requirements of the *Private Health Insurance Act*, *Benefits* are not payable for *Restricted Services* for theatre fees or pharmaceuticals even if the *Restricted Services* are performed in an *Intensive Care Unit*, *Coronary Care Unit*, *Neonatal Intensive Care* Unit, labour ward or for operating theatre.

F6 COMPENSATION DAMAGES AND PROVISIONAL PAYMENT OF CLAIMS

F6.1 If a *Member* is entitled or becomes entitled to claim compensation or damages from a third party in any jurisdiction whatsoever for expenses that are, have been, or will be the subject of a claim on and/or *Benefits* paid by *HCF* (whether to benefit the *Member* or anyone else covered by the *Policy*) ('the claim'), then the *Member* must immediately inform *HCF* of their entitlement, make the claim, and account to *HCF* for all moneys received by them in respect of the current expenses, whether by way of settlement of the claim or otherwise, immediately on payment of the claim.

F6.2 As to future expenses, *Benefits* will not be payable to the extent that the moneys received by the *Member* cover these expenses.

F6.3 If a *Member* has not made a claim against a third party for future expenses that should have been included in the claim, *HCF* will be entitled to exercise for itself all rights of the *Member* to make the claim and the *Member* will co-operate with *HCF* and will provide *HCF* with all reasonable assistance in that regard.

G CLAIMS

G1 GENERAL

G1.1 *Benefits* are not payable in the circumstances listed in Rule F3.5 of these *Rules.*

G1.2 *HCF* requires that claims for *Benefits* must be:

a) made using an authorised claim form, or other means, approved by *HCF*; and

b) accompanied by original accounts and/ or receipts on the provider's letterhead or showing the official stamp of the provider, and including the following information:

i. the name of the provider, provider number and address;

ii. the full name of the patient and their address;

iii. the date of *Service*;

iv. the description of the *Service* including any required coding;

v. the amount charged; and

vi. any other information reasonably required by *HCF* for processing the claim.

G1.3 All documents submitted in connection with a claim become the property of *HCF*.

G1.4 Subject to the absolute discretion of *HCF* to waive this *Rule*, *Benefits* are not payable where a claim is received by *HCF* 2 years or more after the date of *Service*.

G1.5 *HCF* reserves the right to require that claim forms, which includes electronic claiming receipts, must be signed by a *Member* or by the parent, guardian or administrator of the *Member*.

G1.6 *HCF* reserves the right to make *Benefit* payments to:

a) a *Member* where the claims are submitted by the *Member* and the claims are paid and supported by receipts for the claims;

b) a *Member*, where the claims are submitted by the *Member* and the claims are unpaid and supported by appropriate claims information (where required) and invoice for payment of the claim and where the *Benefit* is unable to be paid to the *Recognised Provider*;

c) the *Recognised Provider*, where the claims are submitted by the *Recognised Provider* (or transmitted to HCF by Medicare on behalf of the *Recognised Provider*) the claims are unpaid and supported by appropriate claims information including (where required) an invoice for payment of the claim and where valid electronic funds transfer details are available; or

d) the *Recognised Provider* where accounts are submitted as unpaid and supported by documents providing valid claim details and where valid electronic funds transfer details are available.

G1.7 *HCF* will pay *Benefits* by electronic funds transfer to an account nominated by the *Policyholder* or the *Partner* of a *Policyholder* under Rule G1.6a) and b), or to a *Recognised Provider* under Rule G1.6 c) and **Error! Reference source not found.**.

G2 OTHER

G2.1 By submitting a claim for *Benefits* to *HCF*, whether submitted by a *Member* or a *Recognised Provider*, the *Member* understands and agrees to *HCF* having access to any information (including treatment records and other health information) needed to verify the claim.

G2.2 *HCF* may not pay a claim for *Benefits* where a *Member's* consent to access information in association with the claim is not provided. A *Member* may be requested to refund moneys paid for a claim where consent to access information to verify the claim is not provided or is withdrawn.

PART III – RT HEALTH POLICIES

B INTERPRETATION AND DEFINITIONS

B1 INTERPRETATION

B1.1 Capitalised and italicised words or expressions in this Part III of these *Rules* are defined pursuant to Rule B2 in this Part III of these *Rules* and are intended to be interpreted accordingly.

B1.2 Unless otherwise specified, the definitions in Rule B2 in this Part III of these *Rules* only apply to this Part III of these *Rules*.

B1.3 Unless defined in Rule B2 in this Part III of these *Rules*, capitalised terms have the meaning to be reasonably understood by the private health insurance industry.

B1.4 Unless a contrary intention appears, references to "these *Rules*" in this Part III are references to the Rules in Parts I and III of the *Rules,* but only insofar as they relate to *RT Health Policies* (as defined in Part I of these *Rules)*.

B1.5 Words defined in this Part III of these *Rules* shall have the same meaning when used in the *Product Cover Guides*, unless expressly stated otherwise.

B1.6 A capitalised or non capitalised word or expression mentioned in these Fund Rules that is also defined in the *Private Health Insurance Legislation* has the meaning given to it in the *Private Health Insurance Legislation*.

B2 DEFINITIONS

In these Rules, unless the contrary intention appears:

Accident means an unforeseen and unintentional event, occurring by chance and resulting from an external force or object causing an involuntary injury to the body requiring immediate medical treatment.

Act means the *Private Health Insurance Act 2007 (Cth)* and, where the context requires, includes regulations, rules and other subordinate legislation passed pursuant to that *Act* as amended or superseded from time to time.

Acute Care means the provision of treatment for an ailment or disability which cannot be provided by a nursing home.

Acute Care Certificate means a form required to be completed by a doctor for a *Hospital* stay over thirty-five (35) continuous days to verify the type of patient as needing *Acute Care*.

ADA Schedule means the Schedule of Dental Services published by the Australian Dental Association (ADA).

Admitted Patient means a person who meets a certain medical criterion and undergoes a *Hospital's* formal admission process as either an *Overnight Stay* patient or a same-day patient to receive a service under the required *Episode* of care.

Adult means a person who is not a *Dependant*.

Agreement Hospital means a *Private Hospital* that has entered into a *Hospital Purchaser Provider Agreement* (HPPA) with the *Company*.

Ancillary Health Benefit means any *Benefit* in respect of dental, medical and other ancillary services.

Associated Professional Services means *Professional Services* provided by a *Medical Practitioner* to, or in respect of, an inpatient of a *Hospital*.

Approved – see *Recognised*.

Arrears – see *Unfinancial*.

Artificial Aids/Appliances means any health aid or device designed to assist a *Member's* medical condition as approved by the *Company*, excluding prostheses.

Australia for the purposes of these *Rules* includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling) Islands, the Territory of Christmas Island and Norfolk Island but excludes other Australian external territories.

Australian Resident is a person who resides in Australia and has permission to remain permanently—either because they are: an Australian citizen; the holder of a permanent visa; or the holder of a protected Special Category Visa.

Banding System means the methodology used to categorise *Hospital* procedures including for the application of accommodation and theatre charges.

Base Rate means the *Base Rate* of *Contribution* in relation to a *Product* set by the *Company*, prior to application Rule D4 in this Part III of these *Rules* and any other change to a particular *Member's Base Rate* in accordance with the *Private Health Insurance Legislation* and these *Rules*.

Benefit means:

a) an amount of money paid or payable to a *Member* or to a *Recognised Provider* by the *Fund* in accordance with the terms and conditions of a *Product* and these *Rules*; and

d) when used in Rule C6 in this Part III of these *Rules* in relation to a *New Product* under Rule C6.4, has the meaning given in Part II of these *Rules*.

Benefit Year for the purpose of the calculation of *Benefits* and other entitlements payable shall be deemed to commence on 1 January each year to the 31 December.

Benefit Replacement Period means a continuous period that must occur between any two purchases of the same type of *Artificial Aid* or *Appliance* item before *Benefits* are payable.

Calendar Year means the twelve-month period commencing 1 January and finishing 31 December of the same year and has the same meaning as *Benefit Year*.

Clinically Relevant means an appropriate course of treatment such as a procedure or service that is performed or rendered by a *Medical Practitioner*, Dental Practitioner, Optometrist, or other *Recognised* Practitioner that is generally accepted within the relevant Profession.

Closed Product means a *P*roduct that has closed in accordance with section C10.1(a).

Combined Hospital and General Treatment Product means a *Product* referred to in the Schedules that provides *Benefits* towards all or some services defined as *General Treatment* and as *Hospital Treatment* through a single *Product*.

Commencement Date means the effective date of a *Member's* coverage under a *Product* as set out in Rule C5.1.

Company or *HCF* means The Hospitals Contribution Fund of Australia Limited (ABN 68 000 026 746).

Compensation means any of the following:

a) a payment of *Compensation* or damages pursuant to a judgment, award or settlement;

b) a payment in accordance with a scheme of insurance or *Compensation* provided for by Commonwealth or State law (for example, Workers Compensation insurance);

c) settlement of a claim for damages (with or without admission of liability);

d) a payment for negligence; or

e) any other payment that, in the opinion of the *Company*, is a payment in the nature of *Compensation* or damages.

Complying Health Insurance Product (CHIP) means an insurance *Product* issued by the Company under a *Policy* that takes the form of *Hospital Treatment Product*, *General Treatment Product* or *Combined Hospital* and *General Treatment Product* in accordance with *the Private Health Insurance Legislation*.

Contribution means the amount payable by an individual *Member* in respect of the *Product* referable to his or her *Membership* due to the application.

Contribution Group means a group of *Members* approved under these *Rules*.

Continuous Hospitalisation means where an *Admitted Patient* stays overnight in *Hospital* is then discharged and within seven (7) days is admitted to the same or different *Hospital* for the same or related condition.

Co-payment or Daily Excess means:

a) a daily amount of money the Member agrees to pay the *Hospital* for a *Hospital* stay before *Benefits* are payable under the relevant *Hospital Treatment Product*; and

b) when used in Rule C6 in this Part III of these *Rules* in relation to a *New Product*) under Rule C6.4, has the meaning given to the term *Co-Payment*, in Part II of these *Rules*.

Cosmetic Procedure means any surgery, treatment or other procedures which are not allocated an item number within the *Medicare Benefits Schedule* (MBS) issued by the *Medical Services Advisory Committee* (MSAC).

CPAP Machine means a Continuous Positive Airway Pressure machine.

Day Hospital Facility means a *Registered Hospital* and/or *Day Facility*.

De Facto Relationship means a relationship between two (2) people who are:

a) not legally married, but live together as a couple in a marriage type relationship

b) otherwise, as determined by relevant laws, to be living in a *De Facto Relationship*.

Default Benefit means the minimum *Benefits* prescribed by the *Minister* pursuant to the *Private Health Insurance (Benefit Requirement) Rules 2011* (Cth).

Dependant means a person who is one of the following: a Dependent Child; Non-Classified Dependant, Dependent Student or Dependent Non-Student.

Dependent Child means a person who:

(a) is less than 18 years;

(b) is unmarried and not in a de facto relationship;

(c) is primarily reliant on the Principal Member (or Principal Member's Partner listed on the Policy) for maintenance and support; and

(d) is related to the Principal Member (or Principal Member's Partner listed on the Policy) as a child, step-child, foster child or other child that the Principal Member (or Principal Member's Partner listed on the Policy) has legal guardianship over.

Dependent Student means a person who:

(a) is aged between 22 and 30 years (inclusive);

(b) is a full time student at a school, college or university in Australia;

(c) is unmarried and not in a de facto relationship,

(d) is primarily reliant on the *Principal Member* (or *Principal Member's Partner* listed on the *Policy*) for maintenance and support; and

(e) is related to the *Principal Member* or their Partner as a child, step-child, or foster child or other children that the *Principal Member* or their *Partner* has legal guardianship over.

Dependent Non-Student means a person who:

(a) is aged between 22 and 30 years (inclusive);

(b) is unmarried and not in a de facto relationship,

(c) is primarily reliant on the *Principal Member* (or *Principal Member's Partner* listed on the *Policy*) for maintenance and support is not a *Dependent Student*; and

(d) is related to the *Principal Member* or their Partner as a child, step-child, or foster child or other child that the *Principal Member* or their *Partner* has legal guardianship over.

Emergency Ambulance means an ambulance service provided by a State Government ambulance service (or a private ambulance service substituted for a State Government ambulance service) or a private ambulance service recognised by the Company from time to time. *Benefits* are payable where the *Insured Member* is transported directly to a *Hospital* or treated at the scene due to a medical emergency and excludes transportation to hospital for the routine management of an ongoing medical condition or inter *Hospital* transfers (other than emergency transfers).

Emergency means a situation where the patient presenting at a *Hospital* or other medical facility is assessed as Category 1, 2 or 3 on the Australasian Triage Scale.

Episode means the period of *Admitted Patient* care between an admission and separation such as discharge, characterised by only one (1) care type.

Excess is:

a) an amount of money the *Member* agrees to pay the *Hospital* towards the accommodation costs of a *Hospital* admission before *Benefits* are payable under the terms of a *Hospital Treatment Product*; and

b) when used in Rule C6 in relation to a *New Product* under Rule C6.4, has the meaning given in Part II of these *Rules*.

Excluded refers to treatment under a *Hospital Treatment Product* for which *Benefits* are not payable.

Extras Product means a *Product* that covers *General Treatment* under these *Rules*.

Fund means the Registered *Health Benefits Fund* conducted by the *Company* from which *Benefits* are provided to or for *Policyholders* in accordance with the *Private Health Insurance Legislation* and these *Rules*.

Gap Cover means an arrangement where a *Medical Practitioner* agrees to participate in a scheme with the *Company* that covers *Members* in excess of the *Medicare Benefits Schedule* (MBS) for:

a) all but a specified amount of the full cost of inpatient medical treatments; or
b) the full cost of inpatient medical treatments.

General Treatment has the same meaning ascribed to that term in the *Private Health Insurance Legislation*. If the term is not defined in the *Private Health Insurance Legislation*, then the term means *Ancillary Health Benefit* – see *Extras*.

HCF Policy has the meaning given in Rule A13 of Part I of these Rules and being a policy to which Part II of these *Rules* apply.

Health Insurance Act means the *Health Insurance Act 1973*.

Health Benefits Fund – See *Fund*.

Health Aids means those that are ordinarily claimable under an eligible *Extras Cover* as meeting all the following criteria: (a) intended for repeated use; (b) used primarily to alleviate or address a medical condition; (c) not useful to a person in the absence of an illness, injury or disability; (d) supplied by a reputable supplier listed on the *Company's* list of approved artificial aid.

Hearing Aids means a hearing appliance when recommended by a *Medical Practitioner*.

Health Management Program has the same meaning ascribed to that term in the *Private Health Insurance Legislation*.

Hospital Benefit means any *Benefit* in respect of any *Hospital* as set out in the relevant *Product Cover Guide*.

Home Nursing – see *Hospital Substitute Treatment*.

Hospital has the same meaning ascribed to that term under the *Private Health Insurance Legislation* and includes a *Day Hospital Facility*, and any similar facility in which *Hospital Treatment* is provided.

Hospital Purchaser-Provider Agreement (HPPA) means an agreement entered between the *Company* and a *Hospital* or *Day Hospital Facility*.

Hospital Substitute Treatment is treatment that substitutes for an *Episode* of *Hospital Treatment* and 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.

Hospital Product means a *Product* that covers *Hospital Treatment* under these *Rules*.

Hospital Treatment, unless otherwise defined in the *Private Health Insurance Legislation*, is treatment (including the provision of goods and services) that:

a) is intended to manage a disease, injury or condition; and
b) is provided to a person:by a person who is authorised by a *Hospital* to provide the treatment; or under the management or control of such a person; and either:
    (i) is provided at a *Hospital*; or
    (ii) is provided, or arranged, with the direct involvement of a *Hospital*; and
    (iii) includes any other treatment, or treatment included in a class of treatments, specified in the *Private Health Insurance Legislation*; and
c) when used in Rule C6 in this Part III of these *Rules* in relation to a *New Product* under Rule C6.4, has the meaning given in Part II of these *Rules*.

Involuntary Unemployed Assistance means a subsidy that is equivalent to the *Premiums* payable by a *Principal Member* or *Partner* under their *Policy* and paid by *RT Health* into the *Health Benefits Fund* on behalf of the *Principal Member*.

Last Day of the Suspension Period or Last Day of Suspension means the day on which a suspended *Membership* shall cease to be suspended for the purposes of calculating the *Contribution* owing.

Lifetime Health Cover Age means, in relation to an *Adult* who takes out *Hospital* cover after his or her *Lifetime Health Cover Base Day*, the *Adult's* age on the 1 July before the day on which the *Adult* took out the *Hospital* cover.

Lifetime Health Cover Base Day has the meaning ascribed to it under section 34-25 of the *Private Health Insurance Act 2007 (Cth)*.

Medical Practitioner means a person as defined in section 3(1) of the *Health Insurance Act 1973* and as amended from time to time.

Medical Purchaser-Provider Agreement (MPPA) means an agreement entered into between the Company and a *Medical Practitioner*, as described under section 172-5 (1) of the *Private Health Insurance Act 2007 (Cth)* and as amended from time to time.

Medical Treatment means *Treatment* provided by a *Medical Practitioner*.

Medicare means *Australia's* public health insurance system available to eligible persons, such as *Australian Residents*.

Medicare Benefit means a Medicare Benefit under Part II of the *Health Insurance Act 1973*.

Medicare Benefits Schedule (MBS) means the schedule of items for which *Medicare Benefits* are payable.

MLS means Medicare Levy Surcharge.

MBS Fee means the fee specified for a given item in the *Medicare Benefits Schedule (MBS).*

Member means a *Principal Member* or a *Dependant or any Adult listed on the Policy.*

Membership means the collection of rights and obligations that apply to *Members* under these *Rules* arising out of the purchase of a *Product*.

Mental Health Services means a collective group of mental health *Extras Services* that *RT Health* pays *Benefits* for under certain *Extras Covers* and are:

(i) provided by one of the following *Recognised Providers*:

(ii) psychologists;

(iii) counsellors; or

(c) accredited mental health social workers; or(d) Online Cognitive Behavioural Therapy courses.

Minimum Default Benefit – see *Default Benefit*.

National Health Act means the *National Health Act 1953 (Cth).*

Non-Agreement Hospital means a *Private Hospital* or *Day Hospital Facility* that does not have a *Hospital Purchaser Provider Agreement (HPPA)* with the *Company*.

Non-Classified Dependant means a person who:

(a) is 18-21 years (inclusive)

(b) is unmarried and not in a de facto relationship,

(c) is primarily reliant on the *Principal Member* (or *Principal Member's Partner* listed on the *Policy*) for maintenance and support; and

(d) is related to the *Principal Member* (or *Principal Member's Partner* listed on the *Policy*) as a child, step-child, foster child or other child that the *Principal Member* (or *Principal Member's Partner* listed on the *Policy*) has legal guardianship over.

Obstetric Patient in respect of *Hospital Treatment Benefits* means *Hospital* care provided to a patient in the management of pregnancy, labour/childbirth including ante and post-natal care.

Overnight Stay means a period in a *Hospital* that spans both daylight hours and midnight.

Palliative Care in respect of *Hospital Treatment Benefits* means *Hospital* care provided to a patient where the patient's condition has progressed beyond the stage where curative treatment is effective and attainable or, where the patient chooses not to pursue curative treatment. *Palliative Care* provides relief of suffering and enhancement of quality of life. Interventions such as radiotherapy, chemotherapy and surgery are considered part of *Palliative Care* if they are undertaken specifically to provide symptomatic relief.

Partner of a person means the partner recognised by law (including common law) of that person

and/or a person living in a bona fide domestic relationship.

Permitted Days of Absence refers to time when a person does not incur any *Lifetime Health Cover* penalty due to not being covered by a *Hospital Product.*

PBS means the Pharmaceutical Benefits Scheme.

Podiatry Service means a service or treatment provided by a registered podiatrist.

Policy means a complying health insurance policy that covers *Hospital Treatment*, *General Treatment, Ambulance Services* or any combination (whether or not it also covers any other treatment or provides a *Benefit* for anything else) and is referable to the *Fund* and which is not an *HCF Policy*.

Policyholder – see *Principal Member*.

Pre-Existing Ailment/Condition is any ailment, illness or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of six (6) months ending on the day which the person became insured under the *Policy*. The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition; not on a diagnosis. It is not necessary for the member or their doctor to know what their condition is, or for it to be diagnosed. In forming an opinion about whether an illness is a *Pre-Existing Ailment/Condition*, the health insurer-appointed *Medical Practitioner* who makes the decision must consider information provided by the *Member's* treating doctor.

Principal Member or *Policyholder* means the person in whose name the *Membership* is registered to the *Fund* in accordance with these *Rules* and who is responsible for *Contribution* payments and is, by reason of those *Contributions*, entitled under these *Rules* to *Benefits* from the *Fund*.

Private Health Insurance Business has the meaning set out in the *Private Health Insurance Legislation*.

Private Health Insurance Legislation means the *Private Health Insurance Act 2007* (Cth) and its regulations, rules and other instruments under it and consolidations, amendments, re-enactments or replacements of any of them, and other related laws.

Private Health Information Statement (PHIS) means an information statement for a *Product* subgroup of a *Complying Health Insurance Product* and is in a form set out in the *Act*.

Private Hospital means a *Private Hospital* that has been declared to be a Hospital by the Minster for Health and Aged Care and is not a public hospital.

Private Practice means a professional practice (whether sole, partnership or group) that operates on an independent and self-supporting basis. This means that its accommodation, facilities and/or services are not provided or subsidised by another party, such as a *Public Hospital* or publicly funded facility.

Product means a *Hospital*, *Extras* or *Ambulance Product*, or any combination provided by the *Fund* pursuant to a *Policy*.

Product Cover Guide means a summary of material information applicable to a particular *Product* issued by the *Fund* to *Members* in respect of a *Policy* but is not an exhaustive statement of the *Product's* terms and conditions.

Provider Benefit Schedule refers to either the *Dental Schedule* as updated in the *Fund's* database or a set agreement with a provider to pay *Benefits* as per an agreed schedule, as updated from time to time.

Proper Officer means a senior manager of the *Fund* authorised to make operational decisions on behalf of the *Company* and in line with these *Rules* who is appointed by the *Company* from time to time and includes any delegate appointed by the *Proper Officer* to act on his or her behalf under these *Rules*.

Recognised or *Approved* in respect of a person, organisation, *Hospital*, facility, treatment or procedure, means a person, *Medical Practitioner*, organisation, *Hospital*, facility, treatment or procedure which has been *Recognised* or *Approved* by the *Company* for the purpose only of payment of *Benefits*.

Registered Health Insurer means an organisation that is permitted to provide, or is registered as a

provider of, private health insurance in *Australia* under the *Private Health Insurance Legislation*.

Rehabilitation Patient means a patient who is admitted by a specialist in rehabilitation medicine to a rehabilitation program *Approved* by the *Company* at a *Hospital* recognised by the Company as having a rehabilitation service.

Restricted Cover means cover where the *Company* pays only Minimum *Benefits* for the relevant types of treatment.

Rules means these rules relating to the operation of the *Fund* by the *Company*.

State means the State or Territory of *Australia* where a *Member* normally resides.

TGA means the Therapeutic Goods Administration, an authority that is part of the Australian Department of Health and Aged Care.

TGA Approved means an item that the *TGA* has registered on the Australian Register of Therapeutic Goods for the condition to be treated.

Transfer Certificate means a certificate issued by a *Registered Health Insurer*, in a form approved under the *Private Health Insurance Legislation*, detailing full health insurance cover details and claims histories of a person transferring from the *Fund* operated by that insurer.

Transfer Date means the date on which a person joins a *Product* from another *Product* of the *Fund* or joins a Product offered by the Fund from another Registered Health Insurer.

Unfinancial in respect of a *Membership* is where the *Principal Member* fails to pay in full all *Contributions* due to be paid by him or her on or before the due date in respect of the *Membership*.

Veterans' Entitlement Act means the *Veterans' Entitlement Act 1986* (Cth).

Waiting Period means:

a) the period from the date a *Policy* commences to the date that certain services or items provided to the *Member* may attract *Fund Benefits* under these *Rules* (refer to sections 75-1 and 75-5 of the *Private Health Insurance Act 2007* (Cth)); and

e) when used in Rule C6 in this Part III of these *Rules* in relation to a *New Product* under Rule C6.4 has the meaning given in Part II of these *Rules*.

Writing includes any mode of representing or reproducing words in a visible form, including electronic forms.

C MEMBERSHIP

C1 GENERAL CONDITIONS OF MEMBERSHIP

C1.1 Membership Categories

The *Company* has the following categories of *Policy* as set out in these *Rules*:

a) Single Membership – Being a *Membership* that consists of the *Principal Member* only;

b) Couples Membership – Being a *Membership* that consists only of the *Principal Member* and the *Principal Member's Partner*;

c) Single Parent Membership – being a *Membership* that consists of the *Principal Member* and one (1) or more *Dependent Children, Non-Classified Dependants or Dependent Students* only;

d) Family Membership – being a *Membership* that consists of the *Principal Member* and the *Principal Member's Partner* and may include one (1) or more *Dependent Children, Non-Classified Dependants or Dependent Students* only;

e) Single Parent Family Extension membership – being a *Membership* that consists of the *Principal Member* and may include one or more *Dependent Children*, *Non-Classified Dependants, Dependent Students* or *Dependent Non–Students.*

f) Family Extension Membership – being a *Membership* that consists of the *Principal Member*, the *Principal Member's Partner* and may include one or more *Dependent Children*, *Non- Classified Dependants, Dependent Students* or *Dependent Non-Students.* In the event that the *Company* does not offer a *Single Parent Membership* or a *Couples Membership* in relation to a *Product*, the *Member* may apply to join the Single Membership or Family Membership Category.

C1.2 Types of *Products*

A person may be admitted to the *Fund* as a *Member* in one of the Membership Categories following the purchase of one (1) of these *Products* and otherwise complying with the applicable *Rules*:

a) a *Hospital Product*;

b) a *General Treatment Product*;

c) any combination of *Hospital Product* and *General Treatment Product* allowed to be purchased concurrently in the *Product Cover Guides*;

d) a *Combined Hospital* and *General Treatment Product*;

e) an *Ambulance* only *Product*; or

f) a combined *Ambulance* and *General Treatment Product*.

C1.3 Product Availability

The *Company* may from time to time offer a *Product* that is only available to purchase:

a) as a Singles only or Single and Couples Membership;

b) in the case of a *Hospital Product*, available only where a *General Treatment Product* must be purchased along with the *Hospital Product*;

c) in the case of a *General Treatment Product*, available only where a particular *Hospital Product* must be purchased along with the *General Treatment Product*.

C1.4 Rights of *Principal Member*

In relation to a *Membership*, provided the *Principal Member* complies with the eligibility criteria in Rule C2 in this Part III of these *Rules*, the *Principal Member* may:

a) submit claims on behalf of the *Principal Member*, their *Partner* and any *Dependants* on the *Membership*;

b) request from the *Company* a statement of claims made by the *Principal Member*, their *Partner* and any *Dependants* on the *Membership*, unless their *Partner* or eligible *Dependants* have requested the *Company* to not disclose their personal claims history;

c) request that their claims history and/or any other personal information including address not be disclosed to any person, including their *Partner* and any *Dependants* under the *Membership*;

d) change the contact/notice details on the *Membership*;

e) change the payment method and frequency;

f) register or de-register *Dependants* on the *Membership*;

g) change the *Product*(s) referable to the *Membership*;

h) apply to receive the *Government Rebate* and nominate a rebate tier in relation to the *Membership*;

i) cease being the *Principal Member* on the *Membership* by nominating the *Principal Member's Partner* as the *Principal Member*;

j) cancel and, subject to these *Rules*, suspend or re-instate the *Membership*; and

k) request *Contribution* records of the *Membership*.

C1.5 Rights of the *Principal Member's Partner* and *Dependants*

In relation to a *Membership*, the *Principal Member's Partner* (if named on the *Membership*) or a *Dependant* aged 18 years and older may:

a) pay *Contributions*;

b) de-register themselves from the *Membership* (permanently – not by suspension) without the approval of the *Principal Member.*

A *Dependent Child* cannot make any administrative decisions, including in relation to claims, with respect to the *Membership* or his or her registration under the *Membership*.

C1.6 Delegated Authority

The *Company* may permit a *Principal Member* to authorise, either orally or in *Writing*, a nominated representative to access or make changes to the *Membership* on behalf of the *Principal Member* until further notice is given. This authority will not provide the nominated representative with the authority to nominate further delegated authorities, suspend or cancel the *Membership* on behalf of the *Principal Member*.

C1.7 Eligibility for Benefits

Only persons who are registered as *Members* on a *Membership* are eligible to receive *Benefits* under a *Membership*.

C2 ELIGIBILITY FOR MEMBERSHIP

C2.1 Eligibility

Subject to these *Rules* any person, as determined by the *Company,* is eligible to apply to be an insured person under a *Policy.*

C2.2 Minimum Age of *Principal Member*

Unless the *Company* otherwise determines, a person may be a *Principal Member* at any age. In the case where the *Principal Member* is under the age of 18 years, the submission of an application for *Membership* must be made by the legal parent/guardian who accepts all terms and conditions of *Membership*, including these *Rules*, on behalf of the *Principal Member*.

C2.3 State of Residence

A *Member* may hold *Membership* for the version of the *Product* applicable to the *Member's State* of residence.

C3 DEPENDANTS

C3.1 Types of *Dependants*

The four types of *Dependants* are:

a) *Dependent Child*;

b) *Non-Classified Dependant*;

c) *Dependent Student*; and

d) *Dependent Non-Student*.

C3.2 Registration of *Dependants* and *Principal Member's Partner*

Subject to the eligibility requirements in Rule C2 in this Part III of these *Rules*, a *Principal Member* may register a person as their *Dependant* or *Partner* on a *Membership* by providing the personal details of the person in the form and in the manner reasonably required by the *Company*.

Where the *Membership* was a Single Membership prior to their *Dependant* or *Partner* being added, the *Membership* category (as described in Rule C1.1 in this Part III of these *Rules*) will be amended from the date the *Dependant* or *Partner* is added. *Contributions* for the *Membership* will be adjusted accordingly.

C3.3 Rights of *Dependants* and the *Principal Member's Partner*

In relation to a *Membership*, the rights of *Dependants* and the *Member's Partner* are set out in Rule C1.5 in this Part III of these *Rules*.

C3.4 Continuity of Cover – Former *Partner*, *Dependent Student*, *Dependent Child* or *Dependant Non-Student.*

A *Principal Member's Partner*, *Dependent*, *Dependent Non-Student* or *Non Classified Dependant* may transfer from a *Family Membership* to his or her own *Product*, becoming a *Member* in his or her own right (**Own Product**) with no *Waiting Periods* applying to the *Product*, subject to the following:

a) an application for cover must be received by the *Fund* within two months of the applicant ceasing to be covered under their previous *Membership* held with the *Company*;

b) the applicant must transfer to an Own Product that offers an equivalent or lower level of *benefits* to that offered under the previous *Membership*;

c) the applicant must have served all *Waiting Periods* that apply to the previous *Membership*;

d) *Contributions* are paid to cover the period back to the date at which the previous *Membership* ceased.

C4 MEMBERSHIP APPLICATIONS

C4.1 Application for *Membership*

A person shall apply to be admitted to the *Fund* as a *Member*:

a) by submitting a true and correct completed application form (in paper or electronic form) or verbal application via telephone providing information as required by the *Company* from time to time; and

b) making a valid payment of the minimum required applicable *Contribution* or by completing the relevant documents or authorities that will facilitate a bank debit of the applicable *Contribution*.

C4.2 Obligations of Person Applying for *Membership*

The person applying for *Membership* must:

a) make full, true and proper disclosure in the application form as to all matters referred to therein;

b) provide such evidence in support of any statement made in the application form as the *Proper Officer* may require; and

c) unless otherwise agreed to by the *Company*, pay to the *Company* an amount which is not less than the first *Contribution* payable if accepted as a *Member* of the *Fund*.

C4.3 Newborn Child

Provided a newborn's parents have held a Single Parent Family, Couple or Family Membership for at least 2 months, a newborn can be added from date of birth provided the application is received by the *Fund* within 12 Months of the date of birth. Newborns added after 12 months from date of birth may be subject to waiting periods.

C4.4 Right to Reject an Application

Subject to Fund Rule A6 in Part I of these *Rules*, the *Company* reserves the right to reject an application for admission to the *Fund*. If an application is refused by the *Fund*, then any *Contributions* paid at the time of application will be refunded in full.

C4.5 Cooling Off Period

a) Without prejudice to the *Member's* right to cancel his or her *Membership* under Fund Rule C7 in this Part III of these *Rules*, the *Company* may permit the *Member* to cancel his or her *Membership* at any time within 30 days of the *Commencement Date* with prior written notice to, or as otherwise agreed by the *Company*.

b) If the *Company* permits a cancellation of the *Membership* in accordance with Fund Rule C4.5a) in this Part III of these *Rules* then the *Member* may seek a refund of *Contributions* paid towards the *Membership*, provided no event has occurred for which a claim is payable under the *Membership*.

C4.6 Reinstatement of a Terminated Membership

If a *Membership* has been terminated under the conditions outlined in Rule C8 in this Part III of these *Rules* the *Company* has the discretion to reinstate the *Membership* under a request for Special Consideration (see C8.4 in this Part III of these *Rules*) from the *Principal Member*. Continuity

of *Benefits* will be subject to the back-payment of all outstanding *Contributions*.

C5 DURATION OF MEMBERSHIP

C5.1 Commencement Date

Subject to any applicable *Waiting Periods* as set out in these *Rules* and without limiting any other provision of these *Rules*, a person's cover under a *Product* commences on:

a) in the case of the *Principal Member*, the date and time at which the application form and first *Contribution* is received and accepted by the *Company*; or

b) in the case of a *Principal Member's Partner* or *Dependant*, when the *Principle Member validly* registers that *Partner* or *Dependant* on the *Membership*;

c) where there is a change of *Policy* under Rule C5.3 in this Part III of these *Rules*, the date such change takes effect in relation to the *Member*; or

d) a date other than the date set out in Rules C5.1a), b) or c) in this Part III of these *Rules* and as agreed between the *Company* and the *Member*.

Where the *Contribution* is received and accepted by the *Company*, the *Company* will provide to the *Member*:

a) a *Private Health Information Statement (PHIS)*; and

b) a *Product Cover Guide* in relation to the *Member's* selected *Product* which provides the details of what the *Product* covers, how *Benefits* are calculated and a statement identifying that the *Membership* is referrable to the *Fund* operated by the *Company*.

C5.2 Duration of *Membership*

Coverage under the *Membership* will commence on the *Commencement Date* and will continue until cancelled or terminated in accordance with Rule C7 or Rule C8 in this Part III of these *Rules* (as applicable) and subject to the *Membership* not being *Unfinancial*.

C5.3 Change of *Policy*

A *Principal Member* may apply to the *Company* to change the *Product* referable to his or her *Membership* or to become an insured person under an *HCF Policy*. Such application for change will be made in the manner specified by the *Company* from time to time.

C6 TRANSFERS

C6.1 Transfer – Australian Registered Health Insurer

An applicant for *Membership* may transfer from a *Product* issued by another *Registered Health Insurer* (***Old Product***) to a *Product*, provided by the *Company* (***New Product***) and be accepted as a *Member* of the *Fund* subject to this Fund Rule C6.

C6.2 Transfers – Australian Registered Health Insurers when no Waiting Periods apply

An applicant may transfer from an *Old Product* to a *New Product* with continuity of *Benefits*, subject to the following:

a) the transfer must take place within two (2) months of the applicant ceasing to be covered under the *Old Product*;

b) the applicant must transfer to a *New Product* that offers an equivalent or lower level of *Benefits* to that offered under the *Old Product*;

c) the applicant must have served all applicable *Waiting Periods* that apply to the *Old Product*; and

d) the receipt by the *Company* of the applicant's *Transfer Certificate* from his or her former *Registered Health Insurer*.

C6.3 Transfers – Australian Registered Health Insurers when Waiting Periods apply

If an applicant transfers from an *Old Product* to a *New Product*, *Waiting Periods* apply in the following circumstances:

a) where the applicant transfers to the *New Product* more than two (2) months after the applicant ceased to be covered under the *Old Product*;

b) where the *New Product* offers higher *Benefits* to that offered by the *Old Product*, then the

Waiting Period for the higher *Benefit* must be served before *Benefits* at the higher level are available;

c) where an *Excess* applied under the *Old Product* is higher than that which applies under the *New Product*, then the *Waiting Period* must be served before the new *Excess* is payable;

d) where *Hospital Treatment* is deemed *Pre-Existing*, *Benefits* will be applied with the higher *Excess* for a period no longer than allowed under the *Private Health Insurance Legislation*;

e) where the *Old Product* and *New Product* offer comparable *Benefits*, but the applicant has not served all applicable Waiting Periods under the *Old Product*, then the balance of any unexpired *Waiting Period* or *Benefit Replacement Period* for those *Benefits* must be served before the new *Benefits* are available.

The above can be confirmed by the *Company* on the receipt of the applicant's *Transfer Certificate* from his or her former *Registered Health Insurer*.

Any Benefits payable for a major dental item, or under a *MPPA* or Gap Cover service in respect of any *Pre-Existing Ailment/Conditions* will, for a period of twelve months from the date of commencement of the *New Product*, be equal to those payable by the previous *Registered Health Insurer* or those set out in the *New Product*, whichever is the lesser amount.

C6.4 Transfers Between *Products* Within the Fund

Where a *Member* transfers to a *New Product* (including a product offered or made available under an *HCF Policy*), the following day after the *Member* ceased to be covered under the *Old Product* the following will apply:

a) a *Member* transferring from an *Old Product* offering lower *Benefits* to a *New Product* offering higher *Benefits* shall receive only the lower *Benefits* available under the *Old Product* until the *Waiting Periods* under the *New Product* have been served;

b) where the *New Product* has lower *Benefits* compared to the *Benefits* of the *Old Product*, the *Member* shall receive the lower level of *Benefits* available under the *New Product*;

c) where *Hospital Treatment* is deemed *Pre-Existing*, *Benefits* will be applied with the higher *Excess* or *Co-payment/Daily Excess* for a period no longer than allowed under the *Private Health Insurance Legislation*;

d) where the *Old Product* and *New Product* offer comparable *Benefits*, but the applicant has not served all applicable *Waiting Periods* under the *Old Product*, the balance of any unexpired *Waiting Period* or *Benefit Replacement Period* for those *Benefits* must be served before the new *Benefits* are available.

C6.5 Benefits Paid Under *Old Product* to be Taken into Account

Benefits paid under an *Old Product* referred to in this Fund Rule C6 in this Part III of these *Rules* shall be deemed to be *Benefits* paid from the *Calendar Year Benefit* limits or lifetime *Benefit* limits to which a *Member* or *Membership* may be entitled under the *New Product*.

C6.6 Changes in *Principal Member*

Where the *Principal Member* dies, the *Member* who is registered under the *Membership* as the *Principal Member's Partner* may continue that *Membership* (either at the Single Rate or Family Rate) in his or her own name as a *Principal Member* with full continuity of *Benefits*, provided all applicable *Waiting Periods* have been served by the *Principal Member's Partner* at such time.

C7 CANCELLATION OF MEMBERSHIP

C7.1 Cancellation by *Principal Member*

a) The *Principal Member* may cancel a *Membership* at any time with prior written notice to, or as otherwise agreed by, the *Company*. The cancellation will take effect on the day such notice is received by the *Company* or such later date as set out in the notice.

b) Retrospective cancellation of a *Membership* from the day after the date of a *Principal Member's* death will be accepted by the *Company* subject to receipt of official documentation issued by the relevant State

agency providing confirmation of the *Principal Member's* date of death.

c) A *Principal Member* may remove a *Partner* or any *Dependants* from his or her *Membership* at any time.

d) A *Principal Member's Partner* or *Dependant* aged at least 18 years may remove themselves from a *Membership* at their own request at any time.

e) Unless otherwise permitted by the *Company*, a *Dependant* who is under the age of 18 years may leave the *Membership* only with the *Principal Member's* written consent.

C7.2 Refund of Contributions Paid in Advance

The *Principal Member* is entitled to a refund of *Contributions* paid in advance on cancellation of a *Membership*. Any refund will be calculated from the date of cancellation of the *Membership*.

C7.3 Issue of Transfer Certificate

The *Company* must, if a person ceases to be insured under a *Product* and does not become insured under another *Product* of the *Fund* (including under a product offered or made available in respect of an *HCF Policy*), give the person a *Transfer Certificate* within the period required by the *Private Health Insurance Legislation*.

C8 TERMINATION OF MEMBERSHIP

C8.1 Termination of Memberships in Arrears

Without limiting Rules C8.2 or C8.3 in this Part III of these *Rules*, the *Company* may terminate a *Membership* that is in *Arrears* for a period of 90 days or longer.

C8.2 Cancellation by the Company

Where, in the opinion of the *Company*, a *Member* may have engaged in fraudulent activity; misleads or deceives the *Company*; materially or repeatedly breaches any of these *Rules* or any other term or condition of *Membership*, the *Company* may terminate or suspend a *Member's Membership* at any time by giving reasonable notice in *Writing*, describing the reason for the cancellation or suspension and, in the event of cancellation, refund any *Contributions* paid in advance.

C8.3 Retained Rights

The termination or cancellation of a *Membership* under Rules C7 or C8 in this Part III of these *Rules* will not affect the right of the *Company* to recover from a former *Member* any monies payable or otherwise owing by that person to the *Fund*.

C8.4 Special Consideration

Where a *Membership* is terminated under this Rule C8 in this Part III of these *Rules* the *Company* may reinstate the *Membership* at its absolute discretion, upon written application by the *Principal Member* in a form prescribed by the *Company*, stating the valid reason why the *Membership* should be accepted and reinstated by the *Fund*. If a membership is reinstated by the *Company*, *Continuity* of all applicable *Benefit* entitlements will apply subject to back-payment of all outstanding *Contributions* by the *Member*.

C9 TEMPORARY SUSPENSION OF MEMBERSHIP

C9.1 Application for Suspension

A *Principal Member* may apply to the *Company* to suspend his or her *Membership* under the terms and conditions set out under this Rule C9 in this Part III of these *Rules*. An application for suspension of *Membership* must be made in the form prescribed by the *Company* from time to time. The suspension shall apply to all registered *Members* and *Products* held under the *Membership*.

C9.2 Overseas Suspension of Membership

The following eligibility rules apply to an application to suspend a *Membership* where the *Principal Member* plans to travel overseas:

a) the *Principal Member* will depart *Australia* for a period of no less than 28 days but no more than two (2) years;

b) the *Principal Member* must have held their *Membership* for a minimum of 12 months before it can be suspended;

c) there is a minimum period of six months between the end of one period of suspension and the beginning of another period of suspension;

d) the *Membership* is paid up to the date of departure before it can be suspended;

e) the suspension applies to the all *Products* and *Members* on the *Membership*;

f) in order to reactivate the *Membership*, a *Principal Member* must provide proof of travel for each person covered by the *Membership* within 30 days of returning to *Australia*.

C9.3 Financial Hardship Suspension of Membership

The *Company* may offer a suspension for financial hardship. Suspensions will be considered on a case by case basis at the discretion of the *Fund*.

C9.4 Member to Provide Information

It is a condition of application for suspension that *Members* produce evidence as reasonably required by the *Company* including for overseas suspension evidencing dates of departure and return to *Australia*.

In the case of suspension for financial hardship, it is a condition that the *Principal Member* provides to the *Company* any documentation the *Company* reasonably requests to substantiate any application due to financial hardship.

C9.5 Acceptance of Application at the Company's Discretion

If the application for suspension is accepted by the *Company*, the *Company* shall confirm in *Writing* the term of the suspension to the *Principal Member*. The suspension, once accepted by the *Company*, is effective from:

a) the day after the date of departure of the *Member* from *Australia* or from the date of receipt of the application for suspension, whichever is later; or

b) the day after the application has been approved for financial hardship.

C9.6 Effect of Suspension

a) *Benefits* are not payable for any services rendered to any *Member* of the *Membership* while the *Membership* is suspended.

b) The period of suspension does not count towards the serving of *Waiting Periods*, *Benefit Replacement Periods* or the length of *Membership*.

c) The *Membership* will not be entitled to the *Australian Government Rebate* on *Private Health Insurance* and may not be exempt from the *Medicare Levy Surcharge (MLS)* during this period.

d) Pre-paid *Contributions* in respect of any part of the period of suspension are not refundable and shall be held to the credit of the *Membership* pending resumption of *Membership*. If the *Membership* is subsequently cancelled, refunds of pre-paid *Contributions* will be dealt with by the *Company* pursuant to Rule C7.2 in this Part III of these *Rules*.

C9.7 Resumption of *Membership*

a) A suspended *Membership* resumes on the earlier of:

the day after the *Last Day of the Suspension Period* as approved by the *Company*; or

the day the *Principal Member* requests the *Company* to resume the *Membership*.

b) Where the Member complies in full with the terms and conditions of the suspension, subject to Rule C9.6a) in this Part III of these *Rules*, the *Membership* shall be deemed to resume on the same *Product* with full continuity of *Benefits* at the end of the suspension period.

c) All *Contributions* held in credit under Rule C9.6d) in this Part III of these *Rules* shall be applied to the *Membership* from the day after the *Last Day of the Suspension Period*. If the *Membership* is in *Arrears* due to the *Member's* failure to make a further *Contribution* payment, the *Membership* and all *Benefit* entitlements shall cease.

d) Any outstanding *Waiting Periods* must be served upon resumption of the *Membership*.

C10 OTHER

C10.1 Involuntary Unemployment Assistance

A *Principal Member* or *Partner* is eligible for *Involuntary Unemployment Assistance* if the *Policy* they hold is a *RT Health Hospital Cover* except Ambulance Cover (a **Standard Hospital Product**) provided the following conditions are met:

a) the *Principal Member* or *Partner* has been unemployed for more than 29 days; and

b) the *Principal Member* or *Partner* has:

i. been involuntarily retrenched or made redundant by their employer from permanent employment (over 20 hours per week and not temporary in nature or related to a fixed period contract of employment) which was not due to an unsuccessful probation period, resignation, voluntary redundancy, unsatisfactory work performance or unemployment due to medical reasons; and either the *Principal Member* or *Partner* had permanent employment for 6 months prior to their unemployment; or

ii. if the *Principal Member* or *Partner* is self-employed, then the business of the *Principal Member* or *Partner* must have been either legally declared bankrupt or have been put into involuntary liquidation; and

c) the *Principal Member* or *Partner* is actively seeking employment;

d) the *Principal Member* or *Partner* has held a Hospital Product that included *Involuntary Unemployment Assistance* for at least 12 months; and

e) the *Principal Member* or *Partner* has applied for *Involuntary Unemployment Assistance* within 3 months of becoming unemployed; and

f) the *Principal Member* or *Partner* has:

iii. provided a separation form from their previous employer; or

iv. provided a statutory declaration stating the *Principal Member* or *Partner* is unemployed and seeking employment on application for *Involuntary Unemployment Assistance* and every month after that; or

v. provided a notification from the Australian Financial Security Authority or a legal practitioner or accountant stating the business had gone into involuntary liquidation or made bankrupt.

HCF shall have the right to deny Involuntary *Unemployment Assistance* to a *Principal Member* or *Partner* who, in the reasonable opinion of *HCF*, has:

a) intentionally sought a *Policy* that includes *Involuntary Unemployment Assistance* knowing that the *Principal Member* or *Partner's* employment had a high probability of ceasing;

b) in the case of a self-employed *Principal Member* or *Partner*, the business had a high probability of failing or involuntary liquidation was impending at the date of commencement of the *Policy*; or

c) voluntarily became unemployed.

C10.2 If *HCF* determines that the *Policyholder* is eligible for *Involuntary Unemployment Assistance* under Rule C10.1, HCF will pay *Premiums* on the *Policy* for 2 months, on top of what has already been paid for the *Policy* on the date *HCF* makes payment. *HCF* will then pay *Premiums* on a monthly basis after it receives either of the following for each month;

(a) certification from Centrelink or other registered employment service that the *Principal Member* or *Partner* is unemployed and seeking employment; or

(b) a statutory declaration from the *Principal Member* or *Partner* that they are unemployed and seeking employment,

subject to a maximum period of183 days in any 2 year period.

Closed Product Policies

a) *The Company* may, in its discretion, decide not to allow anyone to take out, or transfer to, a *Product* from a specified date. In relation to all the *Members* who were covered under that *Product* on that date, *the Company* may either:

(i) migrate those *Members* to another *Product* in accordance with *Private Health Insurance Legislation*; or

(ii) allow those *Members* to continue holding *Policies* under that *Product*.

b) A person may not take out, or transfer to, a *Closed Product* unless:

(i) the person is a *Dependant* or *Partner* of a *Member* who holds a *Closed Product* and wishes to join that *Member's Policy*; or

(ii) the person is a *Member* who holds a *Closed Product* and wishes to transfer to a different excess option within the same *Product.*

D CONTRIBUTIONS

D1 PAYMENT OF CONTRIBUTIONS

D1.1 Determining Contribution Rates

Subject to Rule D4 in this Part III of these *Rules*, the *Contribution* in relation to a *Product* is to be calculated with reference to the applicable *Membership* category, *Product* and *State* of residence of the applicant or *Principal Member* (as applicable).

D1.2 Period for Which Contributions Can be Made

Subject to Rule D1.3 in this Part III of these *Rules*, unless otherwise offered or agreed by the *Company*, *Contributions* shall be payable weekly (or in weekly multiples) in advance.

Contributions will not be accepted for a period exceeding 18 months in advance. Where *Contributions* have been paid for a period exceeding 18 months in advance, the *Fund* at its discretion may refund the portion of *Contribution* exceeding 18 months.

D1.3 Group Deductions

Where *Contributions* are made through a group payroll payment arrangement for a *Contribution Group* as referred to in Rule D3.2 in this Part III of these *Rules*, *Contributions* may be paid in *Arrears* for a period determined by the *Company*. The *Company* may revoke this decision at any time with 30 days' notice to the relevant *Members*. If this occurs, *Members* will be liable to make a payment to catch up any *Arrears* and bring their *Membership Contributions* to a minimum of one week in advance.

D2 CONTRIBUTION RATE CHANGES

a) *Contribution* rates may be changed in accordance with these *Rules* and any requirements set out in the *Private Health Insurance Legislation*.

b) The *Company* may amend the *Base Rates* referable to a *Product* in a *State* as permitted by the *Private Health Insurance Legislation* and will provide *Members* notice of such amendments as set out in these *Rules* and as required by the *Private Health Insurance Legislation.*

c) If, on the date the *Company* sends a notice under Rule D2b) in this Part III of these *Rules*, the *Company* has received, in respect of a *Membership*, *Contributions* paid in advance, the amendment to the *Base Rate* in relation to that *Membership* does not take effect until the next due date of the *Contributions* for that *Membership*.

d) Where the *Company* receives a request from the *Principal Member* to change to a *New Product* of the *Fund*, the *Contribution* rate will be amended from the date of receipt of that request or future date as requested by the *Principal Member*. *Contributions* paid in advance will automatically be adjusted to the new *Contribution* rate which may adjust the current financial date of the *Membership*.

D3 CONTRIBUTION DISCOUNTS

D3.1 Discount Not to Exceed Prescribed Maximum

Contributions paid by *Policyholders* belonging to a *Contribution Group* may be discounted up to the maximum amount permissible under the *Act*.

D3.2 Contribution Groups

The *Company* may at its discretion approve any group of *Members* as a *Contribution Group*. A *Contribution Group* includes, but is not restricted to:

a) employees of a body corporate, partnership, unincorporated body or other type of enterprise (either for profit or not for profit);

b) members of a professional, industry or trade association; or

c) members of a community.

D4 LIFETIME HEALTH COVER

D4.1 Application of Lifetime Health Cover Provisions

a) The *Company* shall increase the *Base Rate* for certain *Members* covered under a *Hospital Treatment Product* or *Combined Hospital* and *General Treatment Product* in the manner and where required under the Lifetime Health

Cover provisions of the *Private Health Insurance Legislation*.

b) The amount of *Contributions* payable for *Hospital Treatment Product* in respect to an *Adult* who did not have *Hospital* cover on his or her *Lifetime Health Cover Base Day* will be increased by an amount worked out as follows:

(Lifetime Health Cover Age – 30) x 2% x Base Rate

D4.2 Ten Years' Continuous Cover

Notwithstanding Rule D4.1 in this Part III of these *Rules*, the *Company* shall remove any loading on the *Base Rate* that is payable by a *Member* who has held a *Hospital Treatment Product* or *Combined Hospital* and *General Treatment Product* where a loading required by Rule D4.1 in this Part III of these *Rules* has been applied for a continuous period of 10 years, and has only been interrupted by *Permitted Days of Absence* as prescribed by the *Private Health Insurance Legislation*.

D5 ARREARS IN CONTRIBUTIONS

D5.1 Continuation of Cover Following Arrears

Where a *Membership* is in *Arrears* for a period not exceeding 90 days and the *Member* pays such *Arrears* before the 90-day period expires, the *Membership* will retain uninterrupted *Benefit* and *Membership* entitlements, provided the *Member* also complies with Rule D1.2 in this Part III of these *Rules*.

D5.2 Termination of a Membership in Arrears

Where the period of *Arrears* exceeds 90 days, Rule C8.1 in this Part III of these *Rules* will be applied and a *Transfer Certificate* will be issued to the *Principal Member* on termination of the *Membership*.

D5.3 Treatment Where Contributions are in Arrears

Subject to Rule D5.1 in this Part III of these *Rules*, if the *Member* does not pay *Contributions* due under the *Membership* by the due date, the *Company* will not pay *Benefits* towards any treatment received after the due date until the *Arrears* are paid to the *Company* by the *Member*.

E BENEFITS

E1 GENERAL CONDITIONS

E1.1 Payment of Benefits

a) Details of *Benefits* available under each *Product* are set out in the relevant *Product Cover Guide*.

b) The *Company* will pay *Benefits* to *Members* in accordance with the terms and conditions of the *Product* referable to the *Member's Membership* and these *Rules*. All *Benefits* and conditions of *Benefits* are those which are applicable at the date a service is received by a *Member*.

c) Where a *Member* submits a claim for *Benefits* and the *Member* has paid the invoice of the provider, the *Fund* will make the *Benefit* payment directly into the financial institution account nominated by the *Principal Member* in accordance with Rule G.1.6 in this Part III of these *Rules*

d) Where a *Recognised Provider's* invoice is submitted with the claim and is unpaid, the *Fund* will pay the applicable *Benefit* into that *Recognised Provider's* nominated financial institution account.

E1.2 Benefits Not to Exceed Charges

a) Any *Benefits* available under a *Product* shall not exceed the charge(s) raised for any treatment or services rendered. Accordingly, *Benefits* shall be limited to 100% of the amount charged for the service or the amount of the *Benefit* set out in the relevant *Product Cover Guide* for the service, whichever is the lesser amount.

E1.3 When Benefits are Not Payable

Notwithstanding any other provision of these *Rules*, the *Fund* shall have no liability in respect of a *Member*:

a) for any aspect of a claim or higher *Benefit* in respect of services or treatment rendered during a *Waiting Period*;

b) for any claim where the *Membership* remains in *Arrears* for the relevant time the services or treatment was rendered;

c) for any claim in respect of services or treatment rendered to a *Member* as a patient of a *Hospital* associated with the Department of Defence or Veterans' Affairs, or by any practitioner acting on behalf of any Naval, military, Veterans' Affairs or Air Service Authority, unless the patient is a civilian and not entitled to treatment without charge;

d) for any claim for *General Treatment Benefits* in respect of services rendered at a *Public Hospital* by one of its salaried employees, where such employee has established a practice within or directly associated with that *Hospital* and raises charges in his or her own name;

e) for any claim in excess of fees charged or where no charge is made;

f) for any claim for professional services rendered by a practitioner in the treatment of themselves as an individual (or *Member*) or to the practitioner's partner/spouse or *Dependants*, or business partner, or the partner or *Dependants* of the practitioner's business partner, provided that, where the service includes a material cost the *Fund* may consider payment of *Benefits* toward the cost of purchase and supply of those materials;

g) for any claim where a service or transaction was rendered outside of *Australia*;

h) for any claim where the service is not considered *Private Health Insurance Business* as prescribed under the *Private Health Insurance Legislation*;

i) for treatment or services or an item where the expense was incurred by the employer of that *Member* or if the *Member* obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at the *Company's* discretion;

j) where the provider is not:

(i) a *Hospital*, *Medical Practitioner* or *Recognised Provider* at the time the treatment, goods or services were provided to the Member;

(ii) or working in *Private Practice*;

k) where the *Member* has received, or established a right to receive, *Compensation* for treatment, goods or services;

l) if the *Member* does not have an *Acute Care Certificate* after 35 days of hospitalisation;

m) where the *Member* has received, or has the right to receive, payment for the treatment, goods or services from a third party including another *Registered Health Insurer*;

n) where the *Member* has:

(i) failed to make full and complete disclosure as to all matters relied upon in support of, or relevant to, a claim for *Benefits*;

(ii) or provided in support of any claim for *Benefits* information which is false, inaccurate or misleading, whether such information is contained in a claim form, given orally or provided in any other manner whatsoever;

(iii) or failed to provide such information or medical evidence in respect of a claim as may be required by the *Proper Officer*; or failed to provide a signed authority authorising the obtaining of medical evidence concerning the Member from a *Medical Practitioner* or *Recognised Provider* of the *Member* as required by the *Proper Officer*.

E1.4 Recovery of Benefits

Where:

a) an amount or any part of an amount has been paid to a *Member* which, by reason of an error, whether on the part of the *Company*, or any employee or agent of the *Company*, or the *Member* or any other person, was not in whole or in part lawfully due to the *Member*; and

b) the *Company* has within a period of 24 months from the date of the payment, notified the *Member* of the error then the *Company* shall be entitled to recover from the *Member* the whole or that part of the said amount, as the case may be.

c) For the purposes of this Rule, the expression 'error' includes: any mistake of fact or of law or of mixed fact or law; an error of omission or calculation; and an error of an administrative or clerical nature.

For the purposes of this Rule, the expression 'Member' includes the Member, his or her agents, executors, administrators and assigns.

Without prejudice to any remedy otherwise available, the *Company* shall be entitled to set off against and deduct from monies otherwise payable then, or thereafter, by it to the *Member*, any amount recoverable by it pursuant to these *Rules*.

E1.5 Waiver and Ex-Gratia Benefits

The *Company* shall have the right to review any particular term or condition of these *Rules* in specific instances and shall also have the right to provide, without prejudice, an ex gratia payment of *Benefit* under such terms and conditions as defined in the *Company's* ex-gratia policy. The *Company* reserves the right to vary this policy from time to time.

E1.6 Treatment Standard Requirements

Notwithstanding anything to the contrary in these *Rules*, in respect of any *Product*, the *Company* will not pay *Benefits* towards treatment or a person supplying treatment that does not meet the standards in the *Private Health Insurance (Accreditation) Rules 2011*.

E2 HOSPITAL TREATMENT

E2.1 Hospital Treatment Benefits

a) Subject to the terms of a *Product*, *Hospital Benefits* shall only be available in respect of the cost of *Hospital Treatment* in a *Hospital* or other facilities as permitted by the *Private Health Insurance Legislation*.

b) Where *Benefits* are payable in respect of admission for an *Overnight Stay* in a *Public* or *Private Hospital*, those *Benefits* will be paid according to patient classification and length of stay. Patients are classified according to the medical procedure they are admitted for and as per the guidelines issued by the

Commonwealth Department of Health and Aged Care. The classifications are:

(i) Surgical
(ii) Advanced Surgical
(iii) Obstetric
(iv) Other (Medical)
(v) Psychiatric Care
(vi) Rehabilitation

c) A procedure is identified by reference to the relevant item number within the *Medicare Benefits Schedule (MBS)* or by reference to the *Private Health Insurance Legislation*.

d) Where *Benefits* are payable in respect of admission to *Hospital* for a *Same Day* procedure, those *Benefits* will be paid according to the *Banding System* as issued by the Commonwealth Department of Health and Aged Care from time to time plus (where relevant) any *Benefits* payable in respect of theatre fees, as listed in the *Provider Benefit Schedule*.

e) The *Company* will pay the minimum *Benefit* as listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules (No.1) 2023* in respect of a surgically implanted prosthesis, human tissue item or other medical device that is provided as part of Hospital Treatment (or *Hospital Substitute Treatment* as applicable) where a *Medicare Benefit* is payable for the *Associated Professional Service.*

E2.2 Calculation of Benefits

In the absence of any term to the contrary appearing in a *Hospital Purchaser Provider Agreement (HPPA),* the following *Rules* will apply in calculating *Benefits*:

a) The day of admission and the day of discharge shall be counted together as one day.

b) For a *Surgical* patient, *Benefits* at the *Advanced Surgical* and *Surgical* rates shall be payable commencing from the day prior to the day upon which the surgery was performed provided that the *Proper Officer* may in his or her absolute discretion approve the payment of additional *Benefits* at the *Advanced Surgical or Surgical* rates after consideration of medical evidence and satisfactory proof that a longer pre-operative period was necessary for the particular procedure.

c) For an *Obstetric Patient*, benefits at the Obstetrics rate shall be payable only from the day upon which labour (including induction of labour) commences. *Benefits* are not payable for admission for bed rest or observation prior to commencement of labour, unless the attending *Medical Practitioner* certifies that the *Obstetric Patient* needs *Acute Care in Hospital*, in which case *Benefits* are payable at the medical/other rate provided that the *Proper Officer* may in his or her absolute discretion approve additional *Benefits* at the Obstetrics rate in respect of other hospitalisation directly relating to Obstetrics, after consideration of the medical evidence.

d) For *Rehabilitation Patients*, *Benefits* at the Rehabilitation rate shall be payable only where the treatment is provided in an *Approved* facility and is supported by a Rehabilitation certificate approved by the *Company* that medically evidences the patient's need for a rehabilitation program to recover from an acute illness or injury.

e) For *Psychiatric Patients*, benefits at the Psychiatric rate shall be payable only where the treatment is for a Psychiatric condition that is grouped to a mental disorder diagnostic related group (DRG) and is provided in an *Approved* facility or *Approved* program and is supported by a Psychiatric certificate approved by the *Company*. *Benefits* for treatment in an *Approved* facility or an *Approved* program are payable at the other (Medical) rate.

f) Where a person is discharged from *Hospital* and readmitted (to the same Hospital or another Hospital) within a period of seven days, both periods of hospitalisation shall be regarded as continuous, unless the re-admitting *Hospital* establishes to the satisfaction of the *Company* that the readmission was for a different medical condition from the previous admission.

g) Where a patient undergoes more than one operative procedure during one theatre admission, the procedure which attracts the

highest fee under the *Medicare Benefits Schedule (MBS)* shall be used for patient classification purposes.

h) *Benefits* at the Advanced Surgical and Surgical/Obstetrics rates are payable only in respect of the period of hospitalisation at the *Hospital* where the procedure was performed. Where a *Member* is subsequently transferred to another *Hospital*, the medical/other rates of *Benefits* shall be payable from the date of transfer to that other *Hospital*.

i) If the *Member* has been in *Hospital* for 35 days of *Continuous Hospitalisation* an *Acute Care Certificate* is required by the attending *Medical Practitioner* certifying the need for either ongoing *Acute Care*, Psychiatric or Rehabilitation treatment, together with any other information requested by the *Company*. Upon expiry of the certificate the *Member* will be entitled only to those *Benefits* detailed in Schedule 4 Part 2 of the *Private Health Insurance (Benefit Requirement) Rules* as amended or replaced from time to time.

j) Where a *Member's* hospitalisation bridges the end of a *Benefit* Year and part of the next year the *Excess* amount for the *New Year* will apply to the first subsequent admission in the new *Benefit Year*.

E2.3 Benefits for Surgical Podiatry Procedures

If a *Product* provides a *Benefit* for procedures provided by an Accredited Specialist Podiatrist, the only *Benefit* payable as per the minimum requirement set out in the Private Health *Insurance Accreditation Rules 2011* and the *Private Health Insurance Act 2007 (Cth).*

E2.4 Purchaser Provider Agreements

a) The *Company* may from time to time enter into a *Hospital Purchaser Provider Agreement* (***HPPA***) with a *Hospital* or *Medical-Purchaser Provider Agreement* (***MPPA***) with *a Medical Practitioner* and may, as a result of such agreements, provide *Benefits* that vary from those listed in the *Product Cover Guide*.

b) Where a *Member* is charged for *Hospital Treatment* or a professional *Medical Treatment* where a *HPPA* or *MPPA* applies, the *Benefits* will, unless otherwise stated in these *Rules*, be as specified in the *HPPA* or *MPPA* (as the case may be).

E2.5 Non-Agreement Hospitals

Where a *Member* makes a claim for *Benefits* for hospitalisation in a *Non-Agreement Hospital*, *Benefits* will be payable as per the *Private Health Insurance Legislation*.

E2.6 In-Hospital Pharmaceutical Benefits

a) Subject to this Rule E2.6 in this Part III of these *Rules*, for *Hospital Treatment* and combined *Hospital* and *General Treatment Products* the *Fund* covers all costs that a *Member* incurs for Pharmaceutical Benefits dispensed to the *Member* while the *Member* is an *Admitted Patient* at an *Agreement (HPPA) Hospital.*

b) The *Fund* covers costs for Pharmaceutical Benefits up to a maximum quantity dispensed as listed under the *PBS* or as recorded on an Authority Prescription Form.

c) A Pharmaceutical *Benefit* referred to in this Rule E2.6 in this Part III of these *Rules* must be: (i) intrinsic to the Hospital Treatment provided, (ii) clinically indicated, (iii) essential for meeting satisfactory health outcomes for the Member, and (iv) non-experimental drugs. This does not include Pharmaceutical Benefits that are listed under the *PBS* or are dispensed to the *Member* but not directly related to treatment of the condition or ailment for which the *Member* has been admitted.

d) *Benefits* will not be payable for:

(i) high cost *non-PBS Drugs;* experimental *non-PBS Drugs;* or

(ii) drugs that are not *Approved* by the *Therapeutic Goods Administration (TGA)* for use in the specific condition. Where the cost to a *Member* for a drug or medicinal preparation listed under the *PBS* is less than the *PBS* co-payment, these drugs are not considered to be Pharmaceutical Benefits and are not covered by the *Fund*.

E2.7 Medical Gap Cover

Where treatment is provided to a *Member* in a *Hospital* facility and medical services in respect of

an *Approved* medical professional are rendered to which a *Medicare Benefit* is payable the following shall apply:

a) the difference between the *Benefit* paid by *Medicare* and the *Medicare Benefits Schedule (MBS)* fee for eligible services - 25%; or

b) under eligible *Products* where the service is rendered by or on behalf of a *Medical Practitioner* under the *Gap Cover* scheme then up to the agreed schedule.

A *Medical Practitioner* who provides treatment under a *Gap Cover* arrangement shall give the *Member* written advice of any amount they can reasonably be expected to pay for those services. This is called Informed Financial Consent.

The *Gap Cover* scheme does not extend to costs such as *Hospital Excess* or medical services listed under the Pathology or Radiology category.

E2.8 Miscellaneous Matters

a) All *Hospital Products* and *Combined Hospital* and *General Treatment Products* offered by the *Company* will provide *Benefits* for *Hospital Substitute Treatment* provided by a *Recognised* provider in *Private Practice*. Services can be provided in substitution for days spent in *Hospital* on the condition that:

(i) the cost of *Hospital Substitute Treatment* is less than or equal to the equivalent costs of these *Hospital*-based services; and

(ii) a *Medical Practitioner* has certified that the care can be a substitute for hospitalisation and that the *Proper Officer* of the *Company* certifies the service to be reasonable and clinically appropriate.

b) The *Proper Officer* may, after receiving evidence from a *Medical Practitioner* appointed by it, exercise discretion to extend the payment of *Hospital Benefits* beyond the maximum periods specified in this *Rule* in individual cases.

c) *Hospital Treatment Benefits* that will not be payable:

(i) where *Hospital Treatments* are experimental or involve a clinical pharmaceutical trial;

(ii) for a Surgical Prosthesis that has not been *Approved* and listed on the Private Health Insurance *(Medical Devices and Human Tissue Products) Rules (No.1) 2023*, unless it is evidenced to be *Clinically Relevant* and then may be *Approved* by the *Proper Officer* for *Benefit* payment

(iii) the *Company* shall have the right to seek an *Acute Care Certificate*.

E3 GENERAL TREATMENT

E3.1 When Benefits are Payable

a) *Benefits* will only be payable in respect of charges made for services rendered by *General Treatment* providers who are *Recognised* Providers or who are members of organisations that are *Recognised* Associations and satisfy the requirements of the *Private Health Insurance (Accreditation) Rules 2011.*

b) The *Company* may at its discretion require a *General Treatment* provider to complete a declaration concerning his, her or its *Private Practice* status, in the form prescribed by the *Company* from time to time, prior to payment of *Benefits*.

c) *Benefits* for *General Treatment* consultations will only be payable based on one consultation per patient, per practitioner, per day.

d) *Benefits* for *General Treatment* consultations will only be payable as described in the *Product Cover Guides* and only for the time during which a *Member* is receiving direct or active attention. It does not include preliminary or subsequent attendances such as making of appointments and writing reports, and these cannot be treated as separate consultations.

e) The *Benefits* payable and the conditions associated with *General Treatment* services by *Recognised Provider*s are listed within the *Product Cover Guides.*

E3.2 Determination of Benefits

a) *General Treatment Benefits* for Dental Services will be provided only in respect of procedures or services recommended by the Australian Dental Association (ADA) and which are itemised under the headings General Dental or Major Dental or Orthodontics as set out in a relevant *Product Cover Guides* (the item numbers used therein being those provided by the ADA). *Benefits* are payable only in respect of Approved procedures or services performed by a dental practitioner who is a *Recognised Provider* in *Private Practice* or employed by a *Registered Health Insurer.*

b) *General Treatment Benefits* towards pharmacy are payable after deduction of the current *PBS* contribution, on private prescription items (S4 and S8) which are:

(i) prescribed by a *Medical Practitioner*;

(ii) supplied by a registered pharmacist I in *Private Practice*; *Approved* by the *Therapeutic Goods Administration (TGA)* for the indication for which they have been prescribed;

(iii) not otherwise supplied or funded by a public arrangement scheme, including the *PBS*;

(iv) not otherwise *Excluded* by the *Company*.

E3.3 Emergency Ambulance

a) Where a *Hospital Product* or *Combined Hospital* and *General Treatment Product* provides *Benefits* towards *Emergency* Ambulance Services, *Benefits* will be payable in accordance with the *Product Cover Guide* for *Emergency Ambulance* Transportation or an *Emergency Ambulance* Attendance where it is coded or invoiced by the relevant State Ambulance authority as an *Emergency Ambulance* Transportation or *Emergency Ambulance* Attendance.

b) There shall be no entitlement to *Benefits* where:

(i) coverage is included via a State levy included within the *Contribution* referable to a *Hospital Product* or *Combined Hospital* and *General Treatment Product*;

(ii) non-emergency transportation provided by the Ambulance service that is not clinically necessary;

(iii) transportation provided after *Hospital* discharge to a home or nursing home;

(iv) for transfers between *Hospitals* or from medical facilities;

(v) the *Member* holds a *State* based ambulance membership subscription; or

(vi) the *Member* is a resident of a *State* that provides a free Ambulance transportation scheme.

c) *Benefits* are paid at the maximum as outlined in the relevant *Product Cover Guide*.

E3.4 Purchaser Provider Agreements – General Treatment

The *Company* may from time to time for the *Benefit* of its *Members* enter into purchaser provider agreements with *General Treatment* providers and may as a result of these agreements provide *Benefits* which vary from those listed in the *Provider Benefit Schedule*.

E4 OTHER

E4.1 Health Management Programs and Hospital Substitute Treatment

The *Company* may from time to time, at its discretion on eligible *Products* as referred to in the *Product Cover Guides*, make available *a Health Management Program* and/or *Hospital Substitute Treatment* program. The program(s) must be provided by a *Recognised* provider in *Private Practice*.

F LIMITATION OF BENEFITS

F1 EXCESSES

F1.1 *Products* with *Excesses*

The *Company* may offer *Hospital Products* or *Combined* Hospital and *General Treatment Products* with *Excess* options. The *Excess* is deducted from the Treatment *Benefits* that would otherwise be payable by the *Fund*.

F2 WAITING PERIODS

F2.1 Waiting Periods to Apply

a) Unless otherwise permitted by the *Company*, subject to Rule C6 in this Part III of these *Rules*, a *Member* must serve the *Waiting Periods* set out in this Rule F2 in this Part III of these *Rules* before receiving *Benefits* available under a *Product* and no *Benefits* are payable in relation to treatments received during an applicable *Waiting Period*.

b) A *Waiting Period* starts from the *Commencement Date* of the *Membership* or date of transfer from another Registered Health Insurer in respect of the *Member* or the registration date of the *Member* on the *Membership* (whichever date is the later) as listed in this Rule F2 in this Part III of these *Rules*

If during a *Waiting Period* the *Member* has upgraded to a *New Product* from a *Product* with lower *Benefits* and the *Member* would have been entitled to a *Benefit* under the *Old Product* which is also offered under the *New Product*, then the Member shall be entitled to those *Benefits* at the rate provided in the *Old Product* during the *Waiting Period*.

F2.2 *Hospital Treatment Waiting Periods*

The following *Waiting Periods* apply to a *Benefit* for *Hospital Treatment* or *Hospital Substitute Treatment* subject to the *Member's* chosen *New Product*:

a) For a *Benefit* for *Hospital Treatment* or *Hospital Substitute Treatment*:

(i) Obstetric treatment or treatment for a Pre-Existing Ailment/Condition (other than treatment covered by paragraph (ii))—12 months;

Note: in cases of premature births a Benefit will be applicable where the Member giving birth would have completed twelve months of Membership at the date the birth was due to occur.

(b) Psychiatric care, Rehabilitation or Palliative Care (whether or not for a Pre-Existing Ailment/Condition)—2 months;

(c) any other benefit—2 months.

F2.3 Mental Health Care Exemption

A *Member* is entitled to once in a lifetime exception to the normal two (2) month Waiting Period for Hospital Psychiatric Care provided the following conditions are met:

a) the *Member* holds a *Hospital Product* with any *Registered Health Insurer*;

b) the *Member* has not accessed the waiver at any other time with any *Registered Health Insurer*;

c) the Member is an *Admitted Patient* of a *Hospital*; and

d) the *Member* is under the care of an Addiction Medicine Specialist or Consultant Psychiatrist.

This exception can be backdated by up to five (5) business days.

F2.4 *General Treatment Waiting Periods*

a) For a *Benefit* for *Health Aids*, including braces and wigs, orthotics and orthopaedic shoes if covered by the Product – 12 months of continuous *Membership* of the *Product*. (For *CPAP Machine – the limit renews every 36 months in respect to a CPAP Machine*).

b) For a *Benefit* for crowns and bridges and other dental prosthetic services including inlays, dentures, denture repairs and implants, orthodontia, endodontia, periodontics, veneers and occlusal adjustments if covered by the *Product* – 12 months of continuous *Membership* of the *Product*.

c) For a *Benefit* for *Hearing Aids*, if covered by the *Product* – 24 months of continuous *Membership* of the *Extras Product*.

d) For a *Benefit* in respect of any other *General Treatment* – 2 months of continuous

Membership of a *Product* that covers *General Treatment*.

F2.5 No *Waiting Period* Applies to *Accident*-Related Services and *Emergency Ambulance*

Where there is a claim for *Benefits* in respect of:

a) an injury caused by an *Accident*, that took place after a *Member's Commencement Date*; or

b) *Emergency Ambulance* Transportation or *Emergency Ambulance* Attendance, as described in Rule E3.3 in this Part III of these *Rules*,

the two (2) month *Waiting Period* described in Rule F.2.2 in this Part III of these *Rules* shall not apply to the *Member* in respect of that *Benefit*.

F2.6 No *Waiting Period* Applies to Gold Card Holders

Where a person joins the *Fund* within two (2) months of ceasing entitlements to a Gold Card under the *Veterans' Entitlements Act 1986* (Cth) the *Member* will not be subject to any W*aiting Periods* as described in this Rule F2 in this Part III of these *Rules* in respect of *Hospital Treatment* or *General Treatment*.

F2.7 Waiver of *Waiting Periods*

The *Company* may, in its absolute discretion, waive or reduce a *Waiting Period* for *Benefits*, however, this waiver or reduction will not affect any other *Waiting Periods*, *Restricted Benefits* or other *Rule* that applies to the same *Benefit*.

F2.8 *Waiting Periods* – Newborns and Dependants

In the case of any newborn(s) added within twelve (12) months of the birth to a Family or Single Parent Membership, the newborn(s) will not be required to serve any *Waiting Period*.

In the case of a new *Dependant* (other than a newborn) being added to an existing Family or Single Parent Membership, any *Waiting Periods* that apply to that *Product* must be served in full by that new *Dependant*.

F3 EXCLUSIONS

As determined by the *Company*, selected *Hospital Products* or *Combined Hospital* and *General Treatment Products* detailed in the *Product Cover Guides* will have specified treatments that are listed as 'Exclusions' or 'Excluded benefits', which means no *Benefits* will be payable by the *Company* towards any costs incurred by a *Member* for those treatments.

F4 RESTRICTED BENEFITS

Treatments that are limited to the *Minimum Default Benefit* for the duration of a *Product's* cover are set out in selected *Hospital Product* or *Combined Hospital* and *General Treatment Products' Product Cover Guides*.

F5 COMPENSATION DAMAGES AND PROVISIONAL PAYMENT OF CLAIMS

a) *Benefits* are not payable under any of the *Company's Products* in relation to expenses incurred in respect of any condition, injury or ailment which is the subject of a claim where a *Member* has received or established a right to receive a payment by way of *Compensation* or damages from a third party.

b) Where the amount of the entitlement for *Compensation* or damages is less than the *Benefit* that would otherwise be payable under the relevant *Product*, partial *Benefits* are payable up to the limit of the difference between the full *Benefit* payable and the *Compensation* or damages entitlement.

c) Where the *Company* is of the opinion that a condition, injury or ailment is one which may give rise to a claim for *Compensation* or damages payable by a third party, the *Company* at its absolute discretion may require that before payment of any *Benefit* the *Member* in respect of whom *Benefits* are otherwise payable shall sign an irrevocable undertaking and authority in favour of the *Company*, in a form acceptable to the *Company*, pursuant to which the *Member* undertakes to:

(i) include in any such claim, all *Hospital*, paramedical and related expenses in respect of which *Benefits* otherwise are or may be payable by the *Company*;

(ii) not withdraw the claim for such expenses; and

(iii) notify the *Company* forthwith upon payment of the claim or any part thereof and the *Member* directs that from any such claim there is first deducted and paid to the *Company* by way of reimbursement, an amount equal to the amount of Benefits paid by the *Company* in respect of such condition, injury or ailment.

(iv) Where a *Benefit* has been paid and the *Member* receives or establishes the right to receive payment by way of *Compensation* or damages, the *Benefit* paid must be repaid to the *Company* immediately to the quantum of the recovery or right to recovery.

F6 OTHER

F6.1 Lifetime Benefit Limits

Lifetime Benefit Limits or 'lifetime limits' apply equally to *Members* for particular *General Treatments* and are not tied to the duration of *Products*. The amount of *Benefits* that count towards a lifetime limit can be accumulated over two or more *Products* that may cover a *Member* and *Benefits* received by *Members* for similar services and treatments from other insurance *Products* provided by *Registered Health Insurers* will be included in the calculation of a *Member's* total lifetime limit for a treatment or service. The applicable lifetime limit for a *Product* is stated in the relevant *Product Cover Guide*.

G CLAIMS

G1 GENERAL

G1.1 How claims may be made

a) *Claims* for *Benefits* shall be made in *Writing* in a form as required by the *Company* from time to time and where required by the *Company*, be accompanied by the account of the *Hospital*, *Medical Practitioner* or *Recognised Provider* for the period of hospitalisation or for the services or treatments rendered or such other evidence as may be considered by the *Company* to be sufficient proof that the hospitalisation has occurred or the services were rendered (Documentation).

b) A *Member* must make full and true disclosure in the claim form as to all matters referred to therein.

c) The *Company* may retain all such Documentation it receives under this Rule G1 in this Part III of these *Rules* and such documents will become the property of the *Company*.

G1.2 Evidence in Support of Claim

If required by the *Proper Officer*, a *Member* shall in support of any claim for *Benefits* under these *Rules*:

a) deliver to a *Proper Officer* a signed authority authorising that Officer to obtain from any *Hospital*, *Medical Practitioner* or *Recognised Provider* of the *Member* such medical evidence as the *Proper Officer* may in his or her absolute discretion require; or

b) provide such further evidence in support of the *Member's* claim for *Benefits* as the *Proper Officer* may in his or her absolute discretion require.

G1.3 Appointment of Medical Practitioner

The *Company* may appoint a suitably qualified *Medical Practitioner* to advise the *Company* on medical and technical aspects of any claim as necessary from time to time.

G1.4 Assessment of a Claim

The *Company* may request information from a *Member* about their healthcare provider prior to or after the payment of a *Benefit* for a claim.

Information requested by the *Company* will be directly related to a claim where the *Member* has acknowledged either verbally or in *Writing* a declaration requesting *Benefit* entitlements to be paid to the *Member* or their healthcare provider. Such information may include but is not limited to:

a) Prescriptions

b) Signed receipts

c) Invoices

d) Treatment plans

e) Medical/Patient records

f) Appointment schedule

G1.5 Claim Lodgement

a) The *Company* will not pay *Benefits* for a claim submitted to the *Fund* more than two (2) years after the date of *Hospital Treatment* or the date *General Treatment* services were rendered.

b) Where, in the opinion of the *Proper Officer,* hardship would otherwise be caused to the *Member*, the *Company* may waive Rule G1.5a) in this Part III of these *Rules* and pay *Benefits* in respect of that claim.

G1.6 Payment of Claims

For the *Company* to pay *Benefits* in respect of service accounts paid by the *Member*, the *Member* must provide to the *Company* details of their nominated financial institution account.

The *Company* may, upon receiving written authority from the *Member*, together with an unpaid account for *Hospital*, *Medical* or *General Treatment*, make payment of the appropriate *Benefit* to the *Recognised Provider's* or *Medical Practitioner's* nominated account.

H OVERSEAS

H1 OVERSEAS

No *Benefits* are paid for treatments, services or products rendered or provided to a *Member* outside *Australia*