FUND RULES

EFFECTIVE 1 JULY 2020

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

HCF

CONTENTS

A INTRODUCTION

A1 RULES ARRANGEMENT

These *Rules* apply to all *HCF Policies* other than *Overseas Visitors Health Cover* (which is governed under separate fund 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 Member Guide, the *Product Information*, their completed application form and any *HCF* policy notified to *Members* such as the *HCF Privacy Policy*.

A3.4 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 clause 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.

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.

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:
  (i) a *Member* is receiving a series of *Services*; and
  (ii) 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, fax number or email address 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) Clause A11.1(a) includes errors made by *HCF* because:

(i) it relied on a mistaken fact or interpretation of the law or a mixture of both;

(ii) it miscalculated figures; or

(iii) it made an administrative or clerical error.

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

(a) If a *Member* owes any moneys to *HCF* due to an error by *HCF* or due to inappropriate claiming by the *Member*, *HCF* can recover those amounts by setting it off against any *Benefits* or other moneys payable to the *Member*.

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

(a) If a *Member* owes any moneys to *HCF* due to an error by *HCF* or due to inappropriate claiming by the *Member*, *HCF* can recover those amounts by setting it off against any *Premiums* 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*.

B INTERPRETATION AND DEFINITIONS

B1 INTERPRETATION

B1.1 Capitalised and italicised words or expressions are defined pursuant to this Rule B (except the names of *Products*) and are intended to be interpreted accordingly.

B1.2 Unless otherwise specified, the definitions in Rule B2 apply throughout the *Rules*.

B1.3 Where not defined or italicised, words and expressions are intended to have their ordinary meaning.

B1.4 These *Rules* are to be interpreted, where possible, in a manner that is consistent with the *Private Health Insurance Act*.

B1.5 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*.

B1.6 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.

B1.7 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.

B1.8 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.

B2 DEFINITIONS

In 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;

(b) excludes unforeseen conditions attributable to medical causes.

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*, *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 aged between 22 and 24 (inclusive);

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

(d) is not a *Student Dependant*; and

(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:

(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;
(e) authorised by the attending doctor or allied health professional;
(f) approved by the *Medical Director*; and
(g) listed on HCF's list of approved artificial appliances.

Australia for the purposes of these Fund 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 22 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.

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 *Prostheses List*; 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*.

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) *Student Dependant; or*
(c) *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.

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.

Fund means a Fund that:

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

(b) relates solely to:

(i) its health insurance business, or a particular part of that business; or

(ii) 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*.

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 mean devices that are ordinarily claimable under eligible *Extras Cover* which are intended to treat or compensate for an individual's hearing loss. They are personalised to the user's hearing characteristics.

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;*

(b) *Hospital-Substitute Treatment;*

(c) *Chronic Disease Management Programs;*

(d) *Chronic Disease Management Devices; and*

(e) *Other General 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.*

Initial Consultation in relation to the More for Muscles, More for Backs and More for Feet programs means the first *Service* received for a *New Episode of Care*.

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* under their *Policy* and paid by *HCF* into the *Health Benefits Fund* on behalf of the *Policyholder*.

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 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 the Department of Human Services (formerly known as Medicare) under the *Health Insurance Act*.

Medicare Benefits Schedule means the schedule of benefits determined by the Department of Human Services (known formerly as Medicare) 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*.

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*.

New Episode of Care in relation to the More for Muscles, More for Backs and More for Feet programs means:

(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.

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*.

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*.

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.

Obstetric Services means the services that are listed under the Obstetrics Group in the *Medicare Benefits Schedule*.

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*.

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.

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 an item which is ordinarily claimable under an eligible *Extras Cover* 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:

  (i) 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;

  (ii) the Minimum Standard Supply for the item is customarily charged at an amount that is less than, equal to, or within $3 of 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);

(iii) 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;

(iv) the item is generally prescribed for weight loss;

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

(vi) 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 referable to the *Health Benefits Fund* that *Covers* a defined group of *Benefits* payable, subject to these *Rules*.

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 preceding 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 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 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, that defines the *Services* that a *Benefit* is payable, subject to these *Rules*, in respect of approved expenses incurred by a *Member*.

Product Information means 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 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 *Prostheses List*.

Prostheses List means the list of *Prostheses* in the Private Health Insurance (Prostheses) Rules made pursuant to the *Private Health Insurance Act*, as updated from time to time.

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:

(i) is in *Private Practice*;
(ii) for each relevant class of *Service*, satisfies all *Recognition Criteria*; and
(iii) is recognised by *HCF*;

(d) an *Ambulance Service Provider*; or

(e) any other provider recognised by *HCF* for the purpose 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*.

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 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*.

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 24 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.

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*.

Waiting Period means a specific period after a new *Policy* has commenced during which *Benefits* are not payable or *Benefits* are only payable as per the entitlements of the o*ld Policy* for *Services* received.

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

(b) 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 C2.1(b), 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 *One Adult Memberships* and some *Two Adult Memberships* are advised to convert to *One Adult Family Memberships* or *Family Memberships* within 2 months of the date of birth of a child to ensure that the child is covered from the date of their birth.

C3.3 *HCF* does not provide *Benefits* for *Pre-Existing Conditions* within the 12 month *Waiting Period* for a child who is not added to a *Policy* within the time-frame set out in clause 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 or insufficient information in a material respect.

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 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 one (1) calendar month 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*.

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,* 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 clause 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 incomplete or inaccurate in a material respect;

(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 clause 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 A *Policy* may be temporarily suspended and resumed without having to re-serve *Waiting Periods* where:

(a) an active and financial *Policy* has been held for more than 6 months before suspension;

(b) a Policyholder is unable to continue payments of Premiums because of unemployment or sickness and who is in receipt of unemployment or sickness benefits from Centrelink;

(c) a Member is temporarily absent from Australia for more than 1 month and no more than 24 months; or

(d) for any other reason approved by HCF; and

(e) the *Policy* is resumed and paid within 1 month of:

(i) the date when the *Policyholder* ceases to be entitled to receive unemployment or sickness benefits; or

(ii) returning to Australia; or

(iii) the expiry date approved by *HCF*.

C9.2 The minimum suspension time is 30 days and the maximum is 24 months, after which time, the *Policy* will lapse.

C9.3 A *Policy* must be active and financial for at least 6 months between suspensions.

C9.4 No *Benefits* are payable during any period of suspension.

C9.5 The period of a suspended *Policy* will not be taken into account for the purpose of determining whether *Waiting Periods* required by these *Rules* to be satisfied, have been satisfied.

C9.6 The period of a suspended *Policy* will not count towards any *Loyalty Bonus* or *Limit Boost*.

C9.7 Applications to suspend cannot be backdated.

C9.8 *HCF* may specify that documents must be supplied in support of applications to reactivate a *Policy*, in which case, the *Member* must provide such documents.

C9.9 The period of a suspended *Policy* will not be taken into account for the purposes of *Lifetime Health Cover* calculations.

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:

(i) migrate those *Members* to another *Product* in accordance with C10.2; or

(ii) allow those *Members* to continue holding *Policies* under that *Product*.

(b) A person may not take out, or transfer to, an *Offsale Product* unless:

(i) the person is a *Dependant* or *Partner* of a *Member* who holds an *Offsale Product* and wishes to join that *Member's Policy*; or

(ii) 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:

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

(ii) 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:

(i) changes to the *Policy* including:

(A) removing Dependants

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

(C) changing the *Policy* to a different level of cover;

(D) changing bank account details; or

(E) changing mailing address;

(ii) changes to *Benefits* including:

(A) a claims benefit to be made payable to his/ her name/ bank account when

the *Service* was not provided to him/her; or

(B) changing direct credit details.

(iii) Statement of Benefits for other *Members* listed on the *Policy* other than themselves;

(iv) *Transfer Certificate* for other *Members* listed on the *Policy*;

(v) termination of a *Policy*; and

(vi) any other changes to a *Policy*.

(d) Notwithstanding Rule C10.3(a) 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) A *Policyholder* is eligible for *Involuntary Unemployment Assistance* if they hold Top Hospital, Healthmate Ultimate, Healthmate Advanced, Healthmate Essentials, Healthy First Hospital, Healthstart Hospital, Healthclub or Healthmate Starter (a **Healthmate Hospital Product**) or if the *Policyholder* holds any other *HCF Hospital Cover* other than Ambulance Cover (a **Standard Hospital Product**) provided the following conditions are met:

(i) the *Policyholder* has been unemployed for more than 29 days; and

(ii) the *Policyholder* has been involuntarily retrenched or made redundant by their employer from permanent full-time employment (over 25 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

(iii) the *Policyholder* had permanent full-time employment for 6 months prior to their unemployment; or

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

(v) the *Policyholder* is actively seeking employment;

(vi) the *Policyholder's Premiums* have been paid up to the 29th day of unemployment;

(vii) the *Policyholder* has held a *Hospital Cover* that included *Involuntary Unemployment Assistance* for at least:

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

(B) 12 months for *Policyholders* that hold a Standard Hospital Product; and

(viii) the *Policyholder* has applied for *Involuntary Unemployment Assistance* within 3 months of becoming unemployed; and

(C) the *Policyholder* has: provided a separation form from their previous employer; provided a statutory declaration stating the *Policyholder* is unemployed and seeking employment on application for *Involuntary Unemployment Assistance* and every month after that; and has completed an *HCF* Involuntary Unemployment Assistance Application.

(viii) *HCF* shall have the right to deny *Involuntary Unemployment Assistance* to a *Policyholder* who, in the opinion of *HCF*, has:

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

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

(ix) voluntarily became unemployed.

C10.5 *Involuntary Unemployment Assistance* is payable for the period of the *Policyholder's* unemployment (except for the first 29 days) as certified by Centrelink or other registered employment service and shall cease on the resumption of employment, subject to a maximum period of:

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

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

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 includes 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* 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 by *HCF* must be returned to *HCF* if a refund of charges is made to a *Member* by a provider.

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 accord with *HCF's* support of health outcomes for *Members*.

E1.15 The amount of a *Benefit* described in Rule E2.17 and any conditions on payment of that *Benefit*, will be in *HCF's* absolute discretion.

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 Experimental, high cost non-*PBS Drugs* and *Drugs* approved by the *TGA*, but used for a purpose other than that for which they were approved, are not covered.

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) *Hospital Benefits* for *CDMDs* are payable subject to the following conditions:

(i) *Waiting Periods* have been served; and

(ii) the *CDMD* is not provided as part of *Hospital Treatment*; and

(iii) the *Member* holds *Hospital Cover* that *Covers Hospital Treatment* for the chronic disease which is being treated by the CDMD.

(b) For purposes of this Rule E2.12, *Hospital Benefits* are classified in the *Product Information* as either full or partial cover for each eligible *Product*.

(c) The following maximum level of benefit will apply where this is the first time in the *Member's* life that they have been provided with that category of *CDMD*:

(i) 100% of the benefit listed on the *Prostheses List* on all *Products* classified as either full or partial cover.

(d) The following maximum level of benefit will apply for replacement or upgrades of a *CDMD*:

(i) for *Products* classified as full cover:

(A) 100% of the highest benefit listed for that category of *CDMD* on the *Prostheses List* provided that they have maintained full cover since the funding of their previous *CDMD*; and

(B) 50% of the highest benefit listed for that category of *CDMD* on the *Prostheses List* if they have NOT maintained full cover since the funding of their previous *CDMD*; and

(ii) for *Products* classified as partial cover, 50% of the highest benefit listed for that category of *CDMD* on the *Prostheses List*.

(e) *Hospital Benefits* for replacement or upgrades of a *CDMD* are available provided that:

(i) 5 years has elapsed since the previous *CDMD* was funded (by *HCF* or another party); and

(ii) *HCF* has documented evidence of the date on which the previous *CDMD* was funded by *HCF* or provided 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*.

(f) In its absolute discretion, *HCF* may pro-rata the applicable *Hospital Benefit* for *Members* who wish to replace or upgrade their *CDMD* before 5 years has elapsed since the previous *CDMD* was funded, provided that:

(i) the *CDMD* is not under the manufacturer's warranty; and

(ii) the *CDMD* is not lost, stolen or damaged.

E2.13 Chronic Disease Management Programs

(a) *Hospital Benefits* for *Chronic Disease Management Programs* are payable subject to the following conditions:

(i) *Waiting Periods* have been served;

(ii) the *Chronic Disease Management Program* is not provided as part of *Hospital Treatment*;

(iii) the *Member* holds *Hospital Cover* that *Covers Hospital Treatment* for the chronic disease that is being managed by the *Chronic Disease Management Program*; and

(iv) 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 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).

E3.5 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*.

E3.6 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*.

E3.7 *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*.

E3.8 *HCF* may decide that *Benefits* will no longer be payable in respect of *Services* supplied by a *Recognised Provider* if it finds that the provider has engaged in practice that:

(a) is unlawful, in the sense that the provider has been convicted of a criminal offence or a civil penalty has been imposed on the provider, or a criminal offence has been proven but no conviction recorded;

(b) is improper or unprofessional, in the sense that professional proceedings have resulted in a finding adverse to the provider;

(c) amounts to a breach of any contractual agreement which the provider has with *HCF*;

(d) is such that *HCF* reasonably concludes that the conduct would be unacceptable to the general body of providers in that discipline;

(e) is in *HCF's* reasonable opinion, unsatisfactory as regards to billing;

(f) results in materially greater amounts of *Benefits* being paid by *HCF* to the provider when compared with the *Benefits* that *HCF* pays to the provider's competitors for the *Treatment* of comparable conditions;

(g) is adverse to the interests, business or reputation of *HCF*; or

(h) is substantially non-compliant with requests made of the provider by *HCF* in connection with a review of the provider under *HCF's* Terms and Conditions for *HCF* Recognised Providers of *Extras Services*.

E3.9 In these cases outlined in Rule E3.8, *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.

E3.10 The provider identified in Rules E3.8 and E3.9, will thereafter no longer be considered to be an *HCF Recognised Provider*.

E3.11 Health Management Aids and Appliances *Benefits* are payable only when:

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

(b) an eligible *Hospital Cover* is held at the date of claim where the *Product Information* specifies that the *Member* must hold an eligible *Hospital Cover*; and

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

E3.12 Optical *Benefits* are payable for frames, lenses and contact lenses 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*).

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

(a) 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

(a) 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:

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

(ii) prior policy with another private health insurer;

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

(iv) 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 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 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.

E4.7 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;

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

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

E4.8 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*:

(i) where the transport does not meet the definition of *Non-Emergency Ambulance Transport* (such as for general patient transport);

(ii) 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;

(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) 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);

(vi) for charges made for a medical retrieval escort; and

(vii) for *Ambulance Service Providers* not recognised by *HCF*.

(viii) 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 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.

E4.10

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

(b) *Benefits* are payable for *Accident Safeguard* under the following conditions:

(i) 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;

(ii) *Benefits* are limited to in-patient *Hospital Treatment* for services with a valid *Medicare Benefits Schedule* item;

(iii) Excludes elective cosmetic surgery and podiatric surgery by an accredited podiatrist;

(iv) *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*;

(v) 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*;

(vi) 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

(vii) *Benefits* are not payable for expenses incurred in relation to an injury where compensation, damages or benefits may be claimed from another source.

F LIMITATION OF BENEFITS

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

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

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*
	Obstetric Services (excluding miscarriage and termination of pregnancy which has a 2 month waiting period)
	Chronic Disease Management Programs
12 MONTHS	Prosthodontic, orthodontic, crown and bridge *Services*, occlusal therapy *Services*, indirect restorations, dentures, dental implants, periodontal management surgical, oral surgery, endodontics, dental bleaching and veneers. Foot orthotics and hearing aids. *Services* for a *Pre-Existing Condition*
VARYING TIMEFRAMES AS NOTIFIED BY HCF	*Artificial Appliances*, School Accident *Benefits*

* *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*

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, 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 *Health Management Program;* or

  (ii) the *Service* is an *Extras Service* and HCF has authorised the *Recognised Provider* to deliver that *Extras Service* in another manner (such as online or by telephone consultation);

(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, high cost non-*PBS Drugs* and *TGA* approved *Drugs* used for a purpose other than that for which they were approved;

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

(e) private room accommodation for same-day procedures;

(f) respite care;

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

(h) special nursing;

(i) luxury room surcharge;

(j) donated blood and blood products;

(k) donated blood collection and storage;

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

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

(n) take home items including crutches, toothbrushes and drugs;

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

(p) massage and aromatherapy services;

(q) select *Services* provided while in *Hospital* by non-hospital providers;

(r) *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;

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

(t) *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) psychological and developmental assessments;

(b) psychology treatment (where included under a *Policy*) unless a mental health plan has been prescribed under Medicare entitlements and these entitlements have been used up for the *Calendar Year*;

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

(d) pharmacy items that are not on *HCF's* approved pharmacy list as meeting the definition of a *Pharmaceutical Item* for example items not 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;

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

(f) fees for completing claim forms and/or reports;

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

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

(i) routine health checks, screening and mass immunisations;

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

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

(l) 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 or prior to 31 March 2020 on some *Policies* for elective cosmetic surgery and 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 elective cosmetic surgery and 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:

(a) 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

(b) 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 or should, in *HCF's* opinion, have covered these expenses.

F6.3 *Benefits* for future expenses that, in *HCF's* opinion, should have been included in the claim but were not so included will not be payable.

F6.4 In default of the *Member* making 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.

F6.5 Failure on the part of the *Member* to inform *HCF* of their entitlement to make the claim, resulting in the loss of opportunity to bring the claim, will mean that *HCF* is entitled to recover as a debt due from the *Member* all *Benefits* paid to the *Member* that would, in *HCF's* opinion, have been recoverable under Rule F6 had the claim been made for future expenses.

G CLAIMS

G1 GENERAL

G1.1 *Benefits* are not payable in the circumstances listed in Rule F4 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*.

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 clause G1.6(a) and (b), or to a *Recognised Provider* under clause G1.6(c) and (d).

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.