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.
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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
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 the Health Insurance Act.

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 Dependents 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 old 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
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.

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, 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 Dependents
      (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.

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.
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 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.

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:

<table>
<thead>
<tr>
<th>Waiting Periods</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 MONTHS</td>
<td>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), 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</td>
</tr>
<tr>
<td>12 MONTHS</td>
<td>Artificial Appliances, School Accident Benefits, Prosthetic, 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.</td>
</tr>
</tbody>
</table>

* 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:

<table>
<thead>
<tr>
<th>Waiting Periods</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DAY</td>
<td>Emergency Ambulance Transport</td>
</tr>
<tr>
<td>2 MONTHS</td>
<td>Non-emergency Ambulance Transport</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Waiting Periods</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 MONTHS</td>
<td>All Services, unless specified otherwise in accordance with these Rules</td>
</tr>
</tbody>
</table>
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 pharmaceutical 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, Prosthetics 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.