FUND RULES

EFFECTIVE
30 NOVEMBER
2021

Members are bound by these Rules, the Member Guide, the Product Information, their completed application form and any HCF or rHealth policy notified to Members such as the HCF Privacy Policy.
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PART I – GENERAL
A INTRODUCTION

A1 RULES ARRANGEMENT
A1.1 This Part I of these Rules applies to all HCF Policies and rt Health Policies.
A1.2 Part II of these Rules applies to HCF Policies only.
A1.3 Part III of these Rules applies to rt Health Policies only.
A1.4 Overseas Visitors Health Cover is governed under separate Rules.

A2 HEALTH BENEFITS FUND
A2.1 The Hospitals Contribution Fund of Australia Ltd (ABN 68 000 026 746) is a private health insurer trading as HCF.
A2.2 HCF operates a Health Benefits Fund for the purposes of its health insurance business and any health related business in accordance with the Private Health Insurance Act.

A3 MEMBER OBLIGATIONS TO HCF
A3.1 HCF requires that a person who applies to be a Member provides full and complete disclosure on all matters that HCF may reasonably require including their residential address.
A3.2 A Member shall inform HCF, as soon as reasonably possible, of a change to their details relevant to HCF or the terms of the Policy including a change of address or a change in the status of a Dependant.
A3.3 All Members are bound by these Rules, the Product Information, their completed application form and any HCF policy notified to Members such as the HCF Privacy Policy.
A3.4 Without limiting rule A3.3, all Members covered by an HCF Policy are also bound by the Member Guide.
A3.5 The Policyholder will ensure that all Members covered by the Policy are aware of, agree to and abide by each of the documents referred to in 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.
A4.5 Where any inconsistency exists between these Rules and the constitution of HCF, the constitution of HCF will prevail.
A4.6 Where any inconsistency exists between Parts II or III of these Rules, respectively, and Part I of these Rules, Part I of these Rules prevails to the extent of the inconsistency.

A5 USE OF FUNDS
A5.1 HCF must apply:
(a) the assets of the Fund;
(b) the Premiums paid by Members;
(c) the income from investment of assets of the Fund; and
(d) any other moneys received by HCF in relation to the Fund, in accordance with the Private Health Insurance Act.
A5.2 HCF must ensure that the Fund complies with the solvency standards and capital adequacy standards of the Private Health Insurance Act.

A6 NO IMPROPER DISCRIMINATION
A6.1 HCF will not improperly or illegally discriminate when making decisions in relation to accepting a Member or in the payment of Benefits, whether under the Private Health Insurance Act, or other relevant legislation relating to anti-discrimination.

A7 CHANGES TO RULES
A7.1 HCF shall have the power to vary, delete or add to these Rules at any time, subject to the Private Health Insurance Act and any required notification period.
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 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
   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
   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.

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

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

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

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

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

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

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

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

A13 DEFINITIONS

In this Part I of these Rules:

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

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

Ambulance Service Provider includes the following service providers:

(a) ACT Ambulance Service;
(b) Ambulance Service of NSW;
(c) Non-Emergency Patient Transportation NSW;
(d) Ambulance Victoria;
(e) Queensland Ambulance Service;
(f) South Australia Ambulance Service;
(g) St John Ambulance Service NT;
(h) St John Ambulance Service WA; and
(i) Tasmanian Ambulance Service.

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

(a) includes the six States, the Northern Territory (NT), the Australian Capital Territory (ACT), the Territory of Cocos (Keeling Islands), the Territory of Christmas Island and Norfolk Island; but
(b) excludes all other Australian external territories.

Benefit:

(a) in relation to an HCF Policy, means an amount paid or payable to a Member, or a Recognised Provider on behalf of a Member, for goods or services for which a financial obligation or loss is incurred by the Member and which are Covered (in whole or part) under their Policy in accordance with these Rules; and
(b) in relation to a rt Health Policy, has the meaning given in Part III of these Rules.

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

(a) reduce the complications in a person with a diagnosed chronic disease; or
(b) prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

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

(a) insulin infusion pumps;
(b) continuous ambulatory drug delivery Devices;
(c) cochlear speech processors;
(d) Devices listed in Part C of the Prostheses List; and
(e) other Devices approved by the Medical Director from time to time.

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

Dependant:

(a) in relation of an HCF Policy, has the meaning given in Part II of these Rules; and
(b) in relation to a rt Health Policy, has the meaning given in Part III of these Rules.

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

Extras Cover:

(a) in relation of an HCF Policy, has the meaning given in Part II of these Rules; and
(b) in relation to a *rt Health Policy*, has the meaning given to the term “*Extras Product*” in Part III of these *Rules.*

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

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

*Fund* means a Fund that:

(a) is established in the records of a private health insurer; and
(b) relates solely to:

(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.*

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

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

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

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

*Hospital*:

(a) in relation to an *HCF Policy,* means any public or private facility declared by the Minister as a *Hospital,* and
(b) in relation to a *rt Health Policy,* has the meaning given in Part III of these *Rules.*

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

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

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

(a) whose registration, or licence to practise, as a *Medical Practitioner* in any State or Territory has been suspended, or cancelled, following an inquiry relating to their conduct; and
(b) who has not, after that suspension or cancellation, again been authorised to register or practise as a *Medical Practitioner* in that State or Territory.

*Member* means:

(a) a person covered by a *Policy,* and who has become a *Member* of the *Health Benefits Fund,* and their agents, executors, administrators and permitted assignees; and
(b) does not mean a person who is solely a *member* of *HCF* according to the constitution of *HCF.*

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

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

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

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

*Policyholder* means the person:

(a) in whose name the *Policy* is taken out; and
(b) is responsible for payment of the *Premiums* and for the ongoing maintenance of the *Policy.*

*Premiums*:

(a) in relation to an *HCF Policy,* means the amount payable by the *Policyholder* for their *Policy* as set out in the *Product Information* and amended by *HCF* in accordance with these *Rules,* and
(b) in relation to a *rt Health Policy*, has the meaning given to the term "*Contributor*" set out in Part III of these *Rules*.

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

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

*Private Practice* means:

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

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

*Product*:

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

(b) in relation to a *rt Health Policy*, has the meaning given in Part III of these *Rules*.

*Product Information*:

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

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

*Recognised Provider* means:

(a) a *Hospital*;

(b) a *Medical Practitioner*;

(c) a provider of *Extras Services* in Australia who:

(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 Parts I and II of these *Rules*.

*Recognition Criteria* means the following:

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

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

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

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

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

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

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

*Service*:

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

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

*TGA* means the Therapeutic Goods Administration.

*Waiting Period*:

(a) in relation to an *HCF Policy*, means a specific period 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; and

(b) in relation to a *rt Health Policy*, has the meaning given in Part III of these *Rules*. 

PART II – HCF POLICIES
B  INTERPRETATION AND DEFINITIONS

B1  INTERPRETATION

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

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

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

B2  DEFINITIONS

In this Part II of these Rules:

Accident means:

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

Accident 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;
(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 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 Dependents 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 single 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.

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 and which is not an rt Health Policy.

Policyholder means the person:

(a) in whose name the Policy is taken out; and
(b) is responsible for payment of the Premiums and for the ongoing maintenance of the Policy.
Pre-Existing Condition means an ailment, illness or condition, the signs or symptoms of which in the opinion of a Medical Practitioner appointed by HCF, existed at any time during the 6 months 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 them, that defines the Services in respect of which a Benefit is payable under a Policy; subject to these Rules, in respect of approved expenses incurred by a Member.

Product Information means the schedule of Benefits and Premiums for each relevant Product set out and updated in HCF’s database and lodged with the Department of Health and 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 Policies covered by Part II of these Rules.

Recognition Criteria means the following:

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

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

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

rt Health Policy means a complying health insurance policy that is referable to the Health Benefits Fund that Covers a defined group of Benefits payable, subject to these Rules, and which was transferred to the Health Benefits Fund on or about 1 November 2021 pursuant to section 33 of the Private Health Insurance (Prudential Supervision) Act 2015 (Cth) and to which Part III of these Rules apply.
Rules means this Fund Rules document and the schedule of Benefits and Premiums for each Product set out and updated in HCF’s database and lodged with the Department of Health 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 Dependents 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 (including an rt Health Policy which was transferred to the Health Benefits Fund on or about 1 November 2021 pursuant to section 33 of the Private Health Insurance (Prudential Supervision) Act 2015 (Cth)) or from another HCF Policy (the Old Policy).

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

C6.3 HCF will not recognise Waiting Periods previously served on an Old Policy if:
   (a) there is a gap of more than thirty (30) days between the date up to which Premiums have
been paid under the Old Policy and the date
the New Policy commenced; or
(b) the relevant Services were not covered under
the Old Policy.

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

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

C6.6 If an Extras Benefit is higher under the New Policy
than under the Old Policy, Extras Benefits will only
be payable as per the entitlements of:
(a) where the Old Policy was another HCF Policy
(including an rt Health Policy), the Old Policy; and
(b) where the Old Policy was a policy with another
registered private health insurer, an HCF Policy
that HCF determines is the nearest equivalent
to the Old Policy,
for the duration of the Waiting Period specified for
that Extras Service in Rule F3.3.

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

C7 CANCELLATION OF POLICY

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

C7.2 Subject to 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.

C7.6 Termination of Policy

C7.7 HCF may not terminate the Policy of any Member
on the grounds of the health of that Member.

C7.8 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 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.

C7.9 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.

C7.10 Benefits will not be paid for any Service provided to
a Member after the date of termination.

C7.11 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.

C8 TEMPORARY SUSPENSION OF
POLICY

C8.1 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.
C8.2 The minimum suspension time is 30 days and the maximum is 24 months, after which time, the Policy will lapse.

C8.3 A Policy must be active and financial for at least 6 months between suspensions.

C8.4 No Benefits are payable during any period of suspension.

C8.5 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.

C8.6 The period of a suspended Policy will not count towards any Loyalty Bonus or Limit Boost.

C8.7 Applications to suspend cannot be backdated.

C8.8 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.

C8.9 The period of a suspended Policy will not be taken into account for the purposes of Lifetime Health Cover calculations.

C9 OTHER

C9.1 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 C9.2; 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.

C9.2 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.

C9.3 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 C9.3(c) above, the Partner of a Policyholder may request to remove themselves from the Policy without a written Authority to Act.

C9.4 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 the Policyholder has:

(A) provided a separation form from their previous employer;

(B) provided a statutory declaration stating the Policyholder is unemployed and seeking employment on application for Involuntary Unemployment Assistance and every month after that; and

(C) has completed an HCF Involuntary Unemployment Assistance Application.

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

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

(ii) 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

(iii) voluntarily became unemployed.

C9.5 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 include the date on which the Service was provided.
D5.4  An amount received as a Premium which would entitle a Member to receive Benefits will be applied first to payment of any arrears of such Premiums and then applied in respect of future periods in chronological order, and any amount received as a Premium which would entitle a Member to receive Benefits in accordance with more than one Product will be applied in such a manner as to establish a common date to which the Policyholder is paid in respect of each Product.
E BENEFITS

E1 GENERAL CONDITIONS

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

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

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

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

E1.5 HCF will have the right to refuse payment in respect of any claim if the claim in HCF’s 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 Estds 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 E1.14 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;
(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) they are set out on HCF’s approved Health Management Aids and Appliances list;
(c) 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
(d) 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 prescription glasses (frames and lenses) and contact lenses to help correct a members vision and that are prescribed by an optometrist or ophthalmologist (who is a Recognised Provider) and supplied by an optometrist, ophthalmologist or optical dispenser (who is a Recognised Provider).

E4 OTHER CONDITIONS

E4.1 Loyalty Bonus – Health Dollars

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

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

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

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

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

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

E4.2 Length of Policy for Loyalty Bonuses

In calculating the length of a Policy for Health Dollars, the Policy commences on the date the first Premium is paid and each Membership Year from that date, as long as a continuous period of Premiums is paid by, or on behalf of, the Member in relation to any eligible Hospital Cover and Extras Cover combination on or after 1 January 2000.

E4.3 Circumstances affecting calculation of length of Policy

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

(a) an approved period of a suspended Policy;

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

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

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

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

E4.5 Loyalty Bonus – Limit Boost

(a) Limit Boost allows Members to top up their annual Limit on a range of 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 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;
(vii) for Ambulance Service Providers not recognised by HCF, and
(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 Accident Safeguard

(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>Period</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>
<tr>
<td></td>
<td>Hospital Psychiatric Services*, Rehabilitation and Palliative Care (whether or not for a Pre-Existing Condition)</td>
</tr>
<tr>
<td>12 MONTHS</td>
<td>Services for a Pre-Existing Condition</td>
</tr>
<tr>
<td></td>
<td>Obstetric Services (excluding miscarriage and termination of pregnancy which has a 2 month waiting period)</td>
</tr>
<tr>
<td></td>
<td>Chronic Disease Management Programs</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>Period</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>Period</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

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 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.
PART III – RT HEALTH POLICIES
B INTERPRETATION AND DEFINITIONS

B1 INTERPRETATION

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

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

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

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

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

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

B2 DEFINITIONS

In these Rules, unless the contrary intention appears:

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

Accredited Private Hospital means a Private Hospital or Private Day Hospital Facility that is accredited with an Accreditation Agency and includes private facilities that are not accredited but will in the opinion of the Company become accredited within twelve months.

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

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

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

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

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

Adult means a person who is neither a Dependent Child nor a Dependent Child Non-Student.

Adult Dependant is a person who is related to the Principal Member or of the Principal Member’s Partner in the same manner as required for a Child Dependant and:

(a) is not a Policyholder;
(b) is aged 21 to 24 years;
(c) is not in Full-Time Study;
(d) is not married or in a De Facto Relationship;
(e) who the Policyholder has nominated to stay on the Policy,

and is financially dependent on the Principal Member or the Principal Member’s Partner.

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

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

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

Approved – see Recognised.

Arrears – see Unfinancial.

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

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

Australian Resident is a person who resides in Australia and has permission to remain permanently—either because they are: an
AUI - as some services defined as Schedules that provides Product Combined Hospital and General Treatment within the relevant Pr
Recognised performed or rendered by a treatment such as a procedure or service that is Clinically
Principal in a twenty Member’s
time of the guardian and as approved by the whom the
Child Dependant
Benefit Year
Benefit Replacement Period means a continuous period that must occur between any two purchases of the same type of Artificial Aid or Appliance item before Benefits are payable.
Calendar Year means the twelve-month period commencing 1 January and finishing 31 December of the same year and has the same meaning as Benefit Year.
Child Dependant means a natural child; legally adopted child; foster child, step-child; or child to whom the Policyholder is appointed as legal guardian and as approved by the Fund from time to time of the Principal Member or of the Principal Member’s Partner who has not attained the age of twenty-one (21) years and is not married or living in a De Facto Relationship and is financially dependent on the Principal Member or the Principal Member’s Partner.
Clinically Relevant means an appropriate course of treatment such as a procedure or service that is performed or rendered by a Medical Practitioner, Dental Practitioner, Optometrist, or other Recognised Practitioner that is generally accepted within the relevant Profession.
Combined Hospital and General Treatment Product means a Product referred to in the Schedules that provides Benefits towards all or some services defined as General Treatment and as Hospital Treatment through a single Product.

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

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

Compensation means any of the following:
(a) a payment of Compensation or damages pursuant to a judgment, award or settlement;
(b) a payment in accordance with a scheme of insurance or Compensation provided for by Commonwealth or State law (for example, Workers Compensation insurance);
(c) settlement of a claim for damages (with or without admission of liability);
(d) a payment for negligence; or
(e) any other payment that, in the opinion of the Company, is a payment in the nature of Compensation or damages.

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

Constitution means the Constitution of the Company.

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

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

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

Co-payment or Daily Excess means:
(a) a daily amount of money the Member agrees to pay the Hospital for a Hospital stay before Benefits are payable under the relevant Hospital Treatment Product; and
(b) when used in Rule C6 in this Part III of these Rules in relation to a New Product) under Rule C6.4, has the meaning given to the term Co-Payment; in Part II of these Rules.

Cosmetic Procedure means any surgery, treatment or other procedures which are not allocated an item number within the Medicare Benefits Schedule (MBS) issued by the Medical Services Advisory Committee (MSAC).
General Treatment payable. Treatment Product (b) Excess type. discharged between an admission and separation such as Episode Triage Scale. assessed as Category 1, 2 or 3 on the Australasian present at a Emergency transfers). inter management of an ongoing medical condition or transportation to hospital for the routine to a medical emergency and excludes directly to a pay the Company from time to time. service) or a private ambulance service recognised substituted for a State Government ambulance service (or a private ambulance service provide Emergency Ambulance Dependant Dependant 2011 Health Insurance (Benefit Requirement) Rules prescribed by the Minister pursuant to the Private Health Insurance (Benefit Requirement) Rules 2011 (Cth). Dependant means a person who is one of the following: a Child Dependant; a Student Dependant; or an Adult Dependant. Emergency Ambulance means an ambulance service provided by a State Government ambulance service (or a private ambulance service substituted for a State Government ambulance service) or a private ambulance service recognised by the Company from time to time. Benefits are payable where the Insured Member is transported directly to a Hospital or treated at the scene due to a medical emergency and excludes transportation to hospital for the routine management of an ongoing medical condition or inter Hospital transfers (other than emergency transfers). Emergency means a situation where the patient presenting at a Hospital or other medical facility is assessed as Category 1, 2 or 3 on the Australasian Triage Scale. Episode means the period of Admitted Patient care between an admission and separation such as discharge, characterised by only one (1) care type. Excess is:
(a) an amount of money the Member agrees to pay the Hospital towards the accommodation costs of a Hospital admission before Benefits are payable under the terms of a Hospital Treatment Product; and
(b) when used in Rule C6 in relation to a New Product under Rule C6.4, has the meaning given in Part II of these Rules.
Excluded refers to treatment under a Hospital Treatment Product for which Benefits are not payable.
Extras Product means a Product that covers General Treatment under these Rules.

CPAP Machine means a Continuous Positive Airway Pressure machine.

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

De Facto Relationship means a relationship between two (2) people who are:
(a) not legally married, but live together as a couple in a marriage type relationship
(b) otherwise, as determined by relevant laws, to be living in a De Facto Relationship.

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

Dependant means a person who is one of the following: a Child Dependant; a Student Dependant; or an Adult Dependant.

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

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

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

Excess is:
(a) an amount of money the Member agrees to pay the Hospital towards the accommodation costs of a Hospital admission before Benefits are payable under the terms of a Hospital Treatment Product; and
(b) when used in Rule C6 in relation to a New Product under Rule C6.4, has the meaning given in Part II of these Rules.

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

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

Full Time Study means a course of education at a secondary school or tertiary institution, trade, which is accredited by a State or Federal Government, at least three (3) quarters of the normal fulltime workload or otherwise deemed by the Company as being Full-Time Study, and provided that the course of study results, upon completion, in the Student Dependant being qualified to seek or maintain gainful employment in the general workforce and that the Dependant is not, or will not remain, dependent upon the Principal Member for personal care, domestic or social support after having attended the course of study.

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

Gap Cover means an arrangement where a Medical Practitioner agrees to participate in a scheme with the Company that covers Members in excess of the Medicare Benefits Schedule (MBS) for:
(a) all but a specified amount of the full cost of inpatient medical treatments; or
(b) the full cost of inpatient medical treatments.

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

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


Health Benefits Fund – See Fund.

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

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

Health Management Program has the same meaning ascribed to that term in the Health Insurance Legislation.
Hospital Benefit means any Benefit in respect of any Hospital as set out in the relevant Product Cover Guide.

Home Nursing – see Hospital Substitute Treatment.

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

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

Hospital Substitute Treatment is treatment that substitutes for an Episode of Hospital Treatment and is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition.

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

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

(c) is intended to manage a disease, injury or condition; and

(d) is provided to a person:

(i) by a person who is authorised by a Hospital to provide the treatment; or

(ii) under the management or control of such a person; and either:

(A) is provided at a Hospital; or

(B) is provided, or arranged, with the direct involvement of a Hospital, and

(C) includes any other treatment, or treatment included in a class of treatments, specified in the Private Health Insurance Legislation; and

(e) when used in Rule 6 in this Part III of these Rules in relation to a New Product under Rule 6.4, has the meaning given in Part II of these Rules.

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

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

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

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

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

Medical Treatment means Treatment provided by a Medical Practitioner.

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


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

MLS means Medicare Levy Surcharge.

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

Member means a Principal Member or a Dependant.

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

Minimum Default Benefit – see Default Benefit.

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

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

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

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

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

Partner of a person means the partner recognised by law (including common law) of that person and/or a person living in a bona fide domestic relationship.

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

PBS means the Pharmaceutical Benefits Scheme.

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

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

Policyholder – see Principal Member.

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

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

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

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

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

Private Hospital means:
(a) a Private Hospital which is a Recognised Hospital; or
(b) such other private health facility as approved by the Company in Writing from time to time as a Private Hospital.

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

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

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

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

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

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

Registered Health Insurer means an organisation that is permitted to provide, or is registered as a provider of, private health insurance in Australia under the Private Health Insurance Legislation.

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

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

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

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

**Student Dependant** means a person who is related to the **Principal Member** or of the **Principal Member's Partner** in the same manner as required for a **Child Dependant** who is financially dependent on the **Principal Member** or the **Principal Member's Partner**; aged 21 to 24 years; not married or living in a **De Facto Relationship**, and who is enrolled full-time and attending an approved school, college or university.

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

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

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

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

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

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

**Waiting Period** means:

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

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

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

C1 GENERAL CONDITIONS OF MEMBERSHIP

C1.1 Membership Categories

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

(a) Single Membership – Being a Membership that consists of the Principal Member only;
(b) Couples Membership – Being a Membership that consists only of the Principal Member and the Principal Member’s Partner;
(c) Single Parent Membership – being a Membership that consists of the Principal Member and one (1) or more Child Dependents or Student Dependents only;
(d) Family Membership – being a Membership that consists of the Principal Member and the Principal Member’s Partner and may include one (1) or more Child Dependents or Student Dependents only;
(e) Single Parent Family Extension membership – being a Membership that consists of the Principal Member and may include one or more Child Dependents, Student Dependents or one or more young adults aged 21 to 24 years not registered as a Student Dependant.
(f) Family Extension Membership – being a Membership that consists of the Principal Member, the Principal Member’s Partner and may include one or more Child Dependents, Student Dependents or one or more young adults aged 21 to 24 years not registered as a Student Dependant.

In the event that the Company does not offer a Single Parent Membership or a Couples Membership in relation to a Product, the Member may apply to join the Single Membership or Family Membership Category.

C1.2 Types of Products

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

(a) a Hospital Product;
(b) a General Treatment Product;
(c) any combination of Hospital Product and General Treatment Product allowed to be purchased concurrently in the Product Cover Guides;
(d) a Combined Hospital and General Treatment Product;
(e) an Ambulance only Product; or
(f) a combined Ambulance and General Treatment Product.

C1.3 Product Availability

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

(a) as a Singles only or Single and Couples Membership;
(b) in the case of a Hospital Product, available only where a General Treatment Product must be purchased along with the Hospital Product;
(c) in the case of a General Treatment Product, available only where a particular Hospital Product must be purchased along with the General Treatment Product.

C1.4 Rights of Principal Member

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

(a) submit claims on behalf of the Principal Member, their Partner and any Dependents on the Membership;
(b) request from the Company a statement of claims made by the Principal Member, their Partner and any Dependents on the Membership, unless their Partner or eligible Dependents have requested the Company to not disclose their personal claims history;
(c) request that their claims history and/or any other personal information including address not be disclosed to any person, including their Partner and any Dependents under the Membership;
(d) change the contact/notice details on the Membership;
(e) change the payment method and frequency;
(f) register or de-register Dependents on the Membership;
(g) change the Product(s) referable to the Membership;
(h) apply to receive the Government Rebate and nominate a rebate tier in relation to the Membership;
(i) cease being the Principal Member on the Membership by nominating the Principal Member’s Partner as the Principal Member;
(j) cancel and, subject to these Rules, suspend or re-instate the Membership; and
(k) request Contribution records of the Membership.
C1.5 Rights of the Principal Member’s Partner and Dependants

In relation to a Membership, the Principal Member’s Partner (if named on the Membership) or a Dependant aged 18 years and older may:

(a) pay Contributions;
(b) de-register themselves from the Membership (permanently – not by suspension) without the approval of the Principal Member.

A Child Dependant cannot make any administrative decisions, including in relation to claims, with respect to the Membership or his or her registration under the Membership.

C1.6 Delegated Authority

The Company may permit a Principal Member to authorise, either orally or in Writing, a nominated representative to access or make changes to the Membership on behalf of the Principal Member until further notice is given. This authority will not provide the nominated representative with the authority to nominate further delegated authorities, suspend or cancel the Membership on behalf of the Principal Member.

C1.7 Eligibility for Benefits

Only persons who are registered as Members on a Membership are eligible to receive Benefits under a Membership.

C2 ELIGIBILITY FOR MEMBERSHIP

C2.1 Eligibility

Subject to these Rules any person, as determined by the Company, is eligible to apply to be an insured person under a Policy.

C2.2 Minimum Age of Principal Member

Unless the Company otherwise determines, a person may be a Principal Member at any age. In the case where the Principal Member is under the age of 18 years, the submission of an application for Membership must be made by the legal parent/guardian who accepts all terms and conditions of Membership, including these Rules, on behalf of the Principal Member.

C2.3 State of Residence

A Member may hold Membership for the version of the Product applicable to the Member’s State of residence.

C3 DEPENDANTS

C3.1 Types of Dependents

The three types of Dependents are:

(a) Child Dependant;
(b) Student Dependant;
(c) Adult Dependant.

C3.2 Registration of Dependants and Principal Member’s Partner

Subject to the eligibility requirements in Rule C2 in this Part III of these Rules, a Principal Member may register a person as their Dependant or Partner on a Membership by providing the personal details of the person in the form and in the manner reasonably required by the Company.

Where the Membership was a Single Membership prior to their Dependant or Partner being added, the Membership category (as described in Rule C1.1 in this Part III of these Rules) will be amended from the date the Dependant or Partner is added. Contributions for the Membership will be adjusted accordingly.

C3.3 Rights of Dependents and the Principal Member’s Partner

In relation to a Membership, the rights of Dependents and the Member’s Partner are set out in Rule C1.5 in this Part III of these Rules.

C3.4 Continuity of Cover – Former Partner, Former Student, Child Dependant or Adult Dependant

A Principal Member’s Partner, Child Dependant over the age of 18, Student or Adult Dependant may transfer from a Family Membership to his or her own Product, becoming a Member in his or her own right (Own Product) with no Waiting Periods applying to the Product, subject to the following:

(a) an application for cover must be received by the Fund within two months of the Dependant ceasing to be covered under their previous Membership held with the Company;
(b) the applicant must transfer to an Own Product that offers an equivalent or lower level of benefits to that offered under the previous Membership;
(c) the applicant must have served all Waiting Periods that apply to the previous Membership;
(d) Contributions are paid back to the date at which the previous Membership ceased.

C4 MEMBERSHIP APPLICATIONS

C4.1 Application for Membership

A person shall apply to be admitted to the Fund as a Member.
C4.2 Obligations of Person Applying for Membership

The person applying for Membership must:

(a) make full, true and proper disclosure in the application form as to all matters referred to therein;

(b) provide such evidence in support of any statement made in the application form as the Proper Officer may require; and

(c) unless otherwise agreed to by the Company, pay to the Company an amount which is not less than the first Contribution payable if accepted as a Member of the Fund.

C4.3 Newborn Child

Provided a newborn’s parents have held a Single Parent Family, Couple or Family Membership for at least 2 months, a newborn can be added from date of birth provided the application is received by the Fund within 12 Months of the date of birth. Newborns added after 12 months from date of birth may be subject to waiting periods.

C4.4 Right to Reject an Application

Subject to Rule A6 in Part I of these Rules, the Company reserves the right to reject an application for admission to the Fund. If an application is refused by the Fund, then any Contributions paid at the time of application will be refunded in full.

C4.5 Cooling Off Period

(a) Without prejudice to the Member’s right to cancel his or her Membership under Fund Rule C7 in this Part III of these Rules, the Company may permit the Member to cancel his or her Membership at any time within 30 days of the Commencement Date with prior written notice to, or as otherwise agreed by the Company.

(b) If the Company permits a cancellation of the Membership in accordance with Fund Rule C4.5(a) in this Part III of these Rules then the Member may seek a refund of Contributions paid towards the Membership, provided no event has occurred for which a claim is payable under the Membership.

C4.6 Reinstatement of a Terminated Membership

If a Membership has been terminated under the conditions outlined in Rule C8 in this Part III of these Rules, the Company has the discretion to reinstate the Membership under a request for Special Consideration (see C8.4 in this Part III of these Rules) from the Principal Member. Continuity of Benefits will be subject to the back-payment of all outstanding Contributions.

C5 DURATION OF MEMBERSHIP

C5.1 Commencement Date

Subject to any applicable Waiting Periods as set out in these Rules and without limiting any other provision of these Rules, a person’s cover under a Product commences on:

(a) in the case of the Principal Member, the date and time at which the application form and first Contribution is received and accepted by the Company; or

(b) in the case of a Principal Member’s Partner or Dependant, when the Principle Member validly registers that Partner or Dependant on the Membership;

(c) where there is a change of Policy under Rule C5.3 in this Part III of these Rules, the date such change takes effect in relation to the Member; or

(d) a date other than the date set out in Rules C5.1(a), (b) or (c) in this Part III of these Rules and as agreed between the Company and the Member.

Where the Contribution is received and accepted by the Company, the Company will provide to the Member:

(a) a Private Health Information Statement (PHIS); and

(b) a Product Cover Guide in relation to the Member’s selected Product which provides the details of what the Product covers, how Benefits are calculated and a statement identifying that the Membership is referrable to the Fund operated by the Company.

C5.2 Duration of Membership

Coverage under the Membership will commence on the Commencement Date and will continue until cancelled or terminated in accordance with Rule C7 or Rule C8 in this Part III of these Rules (as applicable) and subject to the Membership not being Unfinancial.
C5.3 Change of Policy
A Principal Member may apply to the Company to change the Product referable to his or her Membership or to become an insured person under an HCF Policy. Such application for change will be made in the manner specified by the Company from time to time.

C6 TRANSFERS

C6.1 Transfer – Australian Registered Health Insurer
An applicant for Membership may transfer from a Product issued by another Registered Health Insurer (Old Product) to a Product, provided by the Company (New Product) and be accepted as a Member of the Fund subject to this Fund Rule C6.

C6.2 Transfers – Australian Registered Health Insurers when no Waiting Periods apply
An applicant may transfer from an Old Product to a New Product with continuity of Benefits, subject to the following:
(a) the transfer must take place within two (2) months of the applicant ceasing to be covered under the Old Product;
(b) the applicant must transfer to a New Product that offers an equivalent or lower level of Benefits to that offered under the Old Product;
(c) the applicant must have served all applicable Waiting Periods that apply to the Old Product; and
(d) the receipt by the Company of the applicant’s Transfer Certificate from his or her former Registered Health Insurer.

C6.3 Transfers – Australian Registered Health Insurers when Waiting Periods apply
If an applicant transfers from an Old Product to a New Product, Waiting Periods apply in the following circumstances:
(a) where the applicant transfers to the New Product more than two (2) months after the applicant ceased to be covered under the Old Product;
(b) where the New Product offers higher Benefits to that offered by the Old Product, then the Waiting Period for the higher Benefit must be served before Benefits at the higher level are available;
(c) where an Excess applied under the Old Product is higher than that which applies under the New Product, then the Waiting Period must be served before the new Excess is payable;
(d) where Hospital Treatment is deemed Pre-Existing, Benefits will be applied with the higher Excess for a period no longer than allowed under the Private Health Insurance Legislation;
(e) where the Old Product and New Product offer comparable Benefits, but the applicant has not served all applicable Waiting Periods under the Old Product, then the balance of any unexpired Waiting Period or Benefit Replacement Period for those Benefits must be served before the new Benefits are available.

The above can be confirmed by the Company on the receipt of the applicant’s Transfer Certificate from his or her former Registered Health Insurer.

Any Benefits payable for a major dental item, or under a MPPA or Gap Cover service in respect of any Pre-Existing Ailment/Conditions will, for a period of twelve months from the date of commencement of the New Product, be equal to those payable by the previous Registered Health Insurer or those set out in the New Product, whichever is the lesser amount.

C6.4 Transfers Between Products Within the Fund
Where a Member transfers to a New Product (including a product offered or made available under an HCF Policy), the following day after the Member ceased to be covered under the Old Product the following will apply:
(a) a Member transferring from an Old Product offering lower Benefits to a New Product offering higher Benefits shall receive only the lower Benefits available under the Old Product until the Waiting Periods under the New Product have been served;
(b) where the New Product has lower Benefits compared to the Benefits of the Old Product, the Member shall receive the lower level of Benefits available under the New Product;
(c) where Hospital Treatment is deemed Pre-Existing, Benefits will be applied with the higher Excess or Co-payment/Daily Excess for a period no longer than allowed under the Private Health Insurance Legislation;
(d) where the Old Product and New Product offer comparable Benefits, but the applicant has not served all applicable Waiting Periods under the Old Product, the balance of any unexpired Waiting Period or Benefit Replacement Period
for those Benefits must be served before the new Benefits are available.

**C6.5 Benefits Paid Under Old Product to be Taken into Account**

Benefits paid under an Old Product referred to in this Fund Rule C6 in this Part III of these Rules shall be deemed to be Benefits paid from the Calendar Year Benefit limits or lifetime Benefit limits to which a Member or Membership may be entitled under the New Product.

**C6.6 Changes in Principal Member**

Where the Principal Member dies, the Member who is registered under the Membership as the Principal Member’s Partner may continue that Membership (either at the Single Rate or Family Rate) in his or her own name as a Principal Member with full continuity of Benefits, provided all applicable Waiting Periods have been served by the Principal Member’s Partner at such time.

**C7 CANCELLATION OF MEMBERSHIP**

**C7.1 Cancellation by Principal Member**

(a) The Principal Member may cancel a Membership at any time with prior written notice to, or as otherwise agreed by, the Company. The cancellation will take effect on the day such notice is received by the Company or such later date as set out in the notice.

(b) Retrospective cancellation of a Membership from the day after the date of a Principal Member’s death will be accepted by the Company subject to receipt of official documentation issued by the relevant State agency providing confirmation of the Principal Member’s date of death.

(c) A Principal Member may remove a Partner or any Dependants from his or her Membership at any time.

(d) A Principal Member’s Partner or Dependant aged at least 18 years may remove themselves from a Membership at their own request at any time.

(e) Unless otherwise permitted by the Company, a Dependant who is under the age of 18 years may leave the Membership only with the Principal Member’s written consent.

**C7.2 Refund of Contributions Paid in Advance**

The Principal Member is entitled to a refund of Contributions paid in advance on cancellation of a Membership. Any refund will be calculated from the date of cancellation of the Membership.

**C7.3 Issue of Transfer Certificate**

The Company must, if a person ceases to be insured under a Product and does not become insured under another Product of the Fund (including under a product offered or made available in respect of an HCF Policy), give the person a Transfer Certificate within the period required by the Private Health Insurance Legislation.

**C8 TERMINATION OF MEMBERSHIP**

**C8.1 Termination of Memberships in Arrears**

Without limiting Rules C8.2 or C8.3 in this Part III of these Rules, the Company may terminate a Membership that is in Arrears for a period of 90 days or longer.

**C8.2 Cancellation by the Company**

Where, in the opinion of the Company, a Member may have engaged in fraudulent activity; misleads or deceives the Company; materially or repeatedly breaches any of these Rules or any other term or condition of Membership, the Company may terminate or suspend a Member’s Membership at any time by giving reasonable notice in Writing, describing the reason for the cancellation or suspension and, in the event of cancellation, refund any Contributions paid in advance.

**C8.3 Retained Rights**

The termination or cancellation of a Membership under Rules C7 or C8 in this Part III of these Rules will not affect the right of the Company to recover from a former Member any monies payable or otherwise owing by that person to the Fund.

**C8.4 Special Consideration**

Where a Membership is terminated under this Rule C8 in this Part III of these Rules the Company may reinstate the Membership at its absolute discretion, upon written application by the Principal Member in a form prescribed by the Company, stating the valid reason why the Membership should be accepted and reinstated by the Fund. If a membership is reinstated by the Company, Continuity of all applicable Benefit entitlements will apply subject to back-payment of all outstanding Contributions by the Member.

**C9 TEMPORARY SUSPENSION OF MEMBERSHIP**

**C9.1 Application for Suspension**

A Principal Member may apply to the Company to suspend his or her Membership under the terms and conditions set out under this Rule C9 in this Part III of these Rules. An application for suspension of Membership must be made in the
form prescribed by the Company from time to time. The suspension shall apply to all registered Members and Products held under the Membership.

C9.2 Overseas Suspension of Membership

The following eligibility rules apply to an application to suspend a Membership where the Principal Member plans to travel overseas:

(a) the Principal Member will depart Australia for a period of no less than 28 days but no more than two (2) years;
(b) the Principal Member must have held their Membership for a minimum of 12 months before it can be suspended;
(c) there is a minimum period of six months between the end of one period of suspension and the beginning of another period of suspension;
(d) the Membership is paid up to the date of departure before it can be suspended;
(e) the suspension applies to all Products and Members on the Membership;
(f) in order to reactivate the Membership, a Principal Member must provide proof of travel for each person covered by the Membership within 30 days of returning to Australia.

C9.3 Financial Hardship Suspension of Membership

The Company may offer a suspension for financial hardship. Suspensions will be considered on a case by case basis at the discretion of the Fund.

C9.4 Member to Provide Information

It is a condition of application for suspension that Members produce evidence as reasonably required by the Company including for overseas suspension evidencing dates of departure and return to Australia.

In the case of suspension for financial hardship, it is a condition that the Principal Member provides to the Company any documentation the Company reasonably requests to substantiate any application due to financial hardship.

C9.5 Acceptance of Application at the Company’s Discretion

If the application for suspension is accepted by the Company, the Company shall confirm in Writing the term of the suspension to the Principal Member. The suspension, once accepted by the Company, is effective from:

(a) the day after the date of departure of the Member from Australia or from the date of receipt of the application for suspension, whichever is later; or
(b) the day after the application has been approved for financial hardship.

C9.6 Effect of Suspension

(a) Benefits are not payable for any services rendered to any Member of the Membership while the Membership is suspended.
(b) The period of suspension does not count towards the serving of Waiting Periods, Benefit Replacement Periods or the length of Membership.
(c) The Membership will not be entitled to the Australian Government Rebate on Private Health Insurance and may not be exempt from the Medicare Levy Surcharge (MLS) during this period.
(d) Pre-paid Contributions in respect of any part of the period of suspension are not refundable and shall be held to the credit of the Membership pending resumption of Membership. If the Membership is subsequently cancelled, refunds of pre-paid Contributions will be dealt with by the Company pursuant to Rule C7.2 in this Part III of these Rules.

C9.7 Resumption of Membership

(a) A suspended Membership resumes on the earlier of:
   (i) the day after the Last Day of the Suspension Period as approved by the Company; or
   (ii) the day the Principal Member requests the Company to resume the Membership.
(b) Where the Member complies in full with the terms and conditions of the suspension, subject to Rule C9.6(a) in this Part III of these Rules, the Membership shall be deemed to resume on the same Product with full continuity of Benefits at the end of the suspension period.
(c) All Contributions held in credit under Rule C9.6(d) in this Part III of these Rules shall be applied to the Membership from the day after the Last Day of the Suspension Period. If the Membership is in Arrears due to the Member’s failure to make a further Contribution payment, the Membership and all Benefit entitlements shall cease.
(d) Any outstanding Waiting Periods must be served upon resumption of the Membership.
D CONTRIBUTIONS

D1 PAYMENT OF CONTRIBUTIONS

D1.1 Determining Contribution Rates
Subject to Rule D4 in this Part III of these Rules, the Contribution in relation to a Product is to be calculated with reference to the applicable Membership category, Product and State of residence of the applicant or Principal Member (as applicable).

D1.2 Period for Which Contributions Can be Made
Subject to Rule D1.3 in this Part III of these Rules, unless otherwise offered or agreed by the Company, Contributions shall be payable weekly (or in weekly multiples) in advance.

Contributions will not be accepted for a period exceeding 12 months in advance. Where Contributions have been paid for a period exceeding 12 months in advance, the Fund at its discretion may refund the portion of Contribution exceeding 12 months.

D1.3 Group Deductions
Where Contributions are made through a group payroll payment arrangement for a Contribution Group as referred to in Rule D3.2 in this Part III of these Rules, Contributions may be paid in Arrears for a period determined by the Company. The Company may revoke this decision at any time with 30 days' notice to the relevant Members. If this occurs, Members will be liable to make a payment to catch up any Arrears and bring their Membership Contributions to a minimum of one week in advance.

D2 CONTRIBUTION RATE CHANGES

(a) Contribution rates may be changed in accordance with these Rules and any requirements set out in the Private Health Insurance Legislation.

(b) The Company may amend the Base Rates referable to a Product in a State as permitted by the Private Health Insurance Legislation and will provide Members notice of such amendments as set out in these Rules and as required by the Private Health Insurance Legislation.

(c) If, on the date the Company sends a notice under Rule D2(b) in this Part III of these Rules, the Company has received, in respect of a Membership, Contributions paid in advance, the amendment to the Base Rate in relation to that Membership does not take effect until the next due date of the Contributions for that Membership.

(d) The Company may, at its discretion offer Members rate protection for a period not exceeding 31 March the following Calendar Year.

(e) Where the Company receives a request from the Principal Member to change to a New Product of the Fund, the Contribution rate will be amended from the date of receipt of that request or future date as requested by the Principal Member. Contributions paid in advance will automatically be adjusted to the new Contribution rate which may adjust the current financial date of the Membership.

D3 CONTRIBUTION DISCOUNTS

D3.1 Discount Not to Exceed Prescribed Maximum
Contributions paid by Policyholders belonging to a Contribution Group may be discounted up to the maximum amount permissible under the Act.

D3.2 Contribution Groups
The Company may at its discretion approve any group of Members as a Contribution Group. A Contribution Group includes, but is not restricted to:

(a) employees of a body corporate, partnership, unincorporated body or other type of enterprise (either for profit or not for profit);

(b) members of a professional, industry or trade association;

(c) members of a community.

D4 LIFETIME HEALTH COVER

D4.1 Application of Lifetime Health Cover Provisions

(a) The Company shall increase the Base Rate for certain Members covered under a Hospital Treatment Product or Combined Hospital and General Treatment Product in the manner and where required under the Lifetime Health Cover provisions of the Private Health Insurance Legislation.

(b) The amount of Contributions payable for Hospital Treatment Product in respect to an Adult who did not have Hospital cover on his or her Lifetime Health Cover Base Day will be increased by an amount worked out as follows:

\[ \text{Base Rate} \times (30) \times 2\% \]

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D4.2 **Ten Years’ Continuous Cover**

Notwithstanding Rule D4.1 in this Part III of these Rules, the Company shall remove any loading on the Base Rate that is payable by a Member who has held a Hospital Treatment Product or Combined Hospital and General Treatment Product where a loading required by Rule D4.1 in this Part III of these Rules has been applied for a continuous period of 10 years, and has only been interrupted by Permitted Days of Absence as prescribed by the Private Health Insurance Legislation.

D5 **ARREARS IN CONTRIBUTIONS**

D5.1 **Continuation of Cover Following Arrears**

Where a Membership is in Arrears for a period not exceeding 90 days and the Member pays such Arrears before the 90-day period expires, the Membership will retain uninterrupted Benefit and Membership entitlements, provided the Member also complies with Rule D1.2 in this Part III of these Rules.

D5.2 **Termination of a Membership in Arrears**

Where the period of Arrears exceeds 90 days, Rule C8.1 in this Part III of these Rules will be applied and a Transfer Certificate will be issued to the Principal Member on termination of the Membership.

D5.3 **Treatment Where Contributions are in Arrears**

Subject to Rule D5.1 in this Part III of these Rules, if the Member does not pay Contributions due under the Membership by the due date, the Company will not pay Benefits towards any treatment received after the due date until the Arrears are paid to the Company by the Member.
E BENEFITS

E1 GENERAL CONDITIONS

E1.1 Payment of Benefits
(a) Details of Benefits available under each Product are set out in the relevant Product Cover Guide.
(b) The Company will pay Benefits to Members in accordance with the terms and conditions of the Product referable to the Member's Membership and these Rules. All Benefits and conditions of Benefits are those which are applicable at the date a service is received by a Member.
(c) Where a Member submits a claim for Benefits and the Member has paid the invoice of the provider, the Fund will make the Benefit payment directly into the financial institution account nominated by the Principal Member in accordance with Rule G.1.6 in this Part III of these Rules.
(d) Where a Recognised Provider’s invoice is submitted with the claim and is unpaid, the Fund will pay the applicable Benefit into that Recognised Provider’s nominated financial institution account, or where the provider has not provided such an account to the Company, issue a cheque made payable to the Recognised Provider and posted to the Member’s address or to the provider as the Company sees fit.

E1.2 Benefits Not to Exceed Charges
(a) Any Benefits available under a Product shall not exceed the charge(s) raised for any treatment or services rendered. Accordingly, Benefits shall be limited to 100% of the amount charged for the service or the amount of the Benefit set out in the relevant Product Cover Guide for the service, whichever is the lesser amount.
(b) Where a Benefit is calculated in reference to a percentage of a charge, if evidenced by the Company that a treatment or service charge is higher than the provider’s usual charge for the service, the Proper Officer may assess the claim as if the provider’s usual charge had applied.

E1.3 When Benefits are Not Payable
Notwithstanding any other provision of these Rules, the Fund shall have no liability in respect of a Member.
(a) for any aspect of a claim or higher Benefit in respect of services or treatment rendered during a Waiting Period;
(b) for any claim where the Membership remains in Arrears for the relevant time the services or treatment was rendered;
(c) for any claim in respect of services or treatment rendered to a Member as a patient of a Hospital associated with the Department of Defence or Veterans’ Affairs, or by any practitioner acting on behalf of any Naval, military, Veterans’ Affairs or Air Service Authority, unless the patient is a civilian and not entitled to treatment without charge;
(d) for any claim for General Treatment Benefits in respect of services rendered at a Public Hospital by one of its salaried employees, where such employee has established a practice within or directly associated with that Hospital and raises charges in his or her own name;
(e) for any claim in excess of fees charged or where no charge is made;
(f) for any claim for professional services rendered by a practitioner in the treatment of themselves as an individual (or Member) or to the practitioner’s partner/spouse or Dependants, or business partner, or the partner or Dependants of the practitioner’s business partner, provided that, where the service includes a material cost the Fund may consider payment of Benefits toward the cost of purchase and supply of those materials;
(g) for any claim where a service or transaction was rendered outside of Australia;
(h) for any claim where the service is not considered Private Health Insurance Business as prescribed under the Private Health Insurance Legislation;
(i) for treatment or services or an item where the expense was incurred by the employer of that Member or if the Member obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at the Company’s discretion;
(j) where the provider is not:
   (i) a Hospital, Medical Practitioner or Recognised Provider at the time the treatment, goods or services were provided to the Member; or
   (ii) working in Private Practice;
(k) where the Member has received, or established a right to receive, Compensation for treatment, goods or services;
(l) if the Member does not have an Acute Care Certificate after 35 days of hospitalisation;
(m) where the Member has received, or has the right to receive, payment for the treatment, goods or services from a third party including another Registered Health Insurer;

(n) where the Member has:

(i) failed to make full and complete disclosure as to all matters relied upon in support of, or relevant to, a claim for Benefits, or

(ii) provided in support of any claim for Benefits information which is false, inaccurate or misleading, whether such information is contained in a claim form, given orally or provided in any other manner whatsoever; or

(iii) failed to provide such information or medical evidence in respect of a claim as may be required by the Proper Officer; or

(iv) failed to provide a signed authority authorising the obtaining of medical evidence concerning the Member from a Medical Practitioner or Recognised Provider of the Member as required by the Proper Officer.

E1.4 Recovery of Benefits

Where:

(a) an amount or any part of an amount has been paid to a Member which, by reason of an error, whether on the part of the Company, or any employee or agent of the Company, or the Member or any other person, was not in whole or in part lawfully due to the Member, and

(b) the Company has within a period of 24 months from the date of the payment, notified the Member of the error then the Company shall be entitled to recover from the Member the whole or that part of the said amount, as the case may be.

(c) For the purposes of this Rule, the expression ‘error’ includes:

(i) any mistake of fact or of law or of mixed fact or law;

(ii) an error of omission or calculation; and

(iii) an error of an administrative or clerical nature.

For the purposes of this Rule, the expression ‘Member’ includes the Member, his or her agents, executors, administrators and assigns.

Without prejudice to any remedy otherwise available, the Company shall be entitled to set off against and deduct from monies otherwise payable then, or thereafter, by it to the Member, any amount recoverable by it pursuant to these Rules.

E1.5 Waiver and Ex-Gratia Benefits

The Company shall have the right to review any particular term or condition of these Rules in specific instances and shall also have the right to provide, without prejudice, an ex gratia payment of Benefit under such terms and conditions as defined in the Company’s ex-gratia policy. The Company reserves the right to vary this policy from time to time.

E1.6 Treatment Standard Requirements

Notwithstanding anything to the contrary in these Rules, in respect of any Product, the Company will not pay Benefits towards treatment or a person supplying treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules 2011.

E2 HOSPITAL TREATMENT

E2.1 Hospital Treatment Benefits

(a) Subject to the terms of a Product, Hospital Benefits shall only be available in respect of the cost of Hospital Treatment in a Hospital or other facilities as permitted by the Private Health Insurance Legislation.

(b) Where Benefits are payable in respect of admission for an Overnight Stay in a Public or Private Hospital, those Benefits will be paid according to patient classification and length of stay. Patients are classified according to the medical procedure they are admitted for and as per the guidelines issued by the Commonwealth Department of Health. The classifications are:

(i) Surgical

(ii) Advanced Surgical

(iii) Obstetric

(iv) Other (Medical)

(v) Psychiatric Care

(vi) Rehabilitation

(c) A procedure is identified by reference to the relevant item number within the Medicare Benefits Schedule (MBS) or by reference to the Private Health Insurance Legislation.

(d) Where Benefits are payable in respect of admission to Hospital for a Same Day procedure, those Benefits will be paid according to the Banding System as issued by the Commonwealth Department of Health from time to time plus (where relevant) any Benefits payable in respect of theatre fees, as listed in the Provider Benefit Schedule.
(e) The Company will pay the minimum Benefit as listed in the Private Health Insurance (Prostheses) Rules in respect of a surgically implanted prosthesis, human tissue item or other medical device that is provided as part of Hospital Treatment (or Hospital Substitute Treatment as applicable) where a Medicare Benefit is payable for the Associated Professional Service.

E2.2 Calculation of Benefits

In the absence of any term to the contrary appearing in a Hospital Purchaser Provider Agreement (HPPA), the following Rules will apply in calculating Benefits:

(a) The day of admission and the day of discharge shall be counted together as one day.

(b) For a Surgical patient, Benefits at the Advanced Surgical and Surgical rates shall be payable commencing from the day prior to the day upon which the surgery was performed provided that the Proper Officer may in his or her absolute discretion approve the payment of additional Benefits at the Advanced Surgical or Surgical rates after consideration of medical evidence and satisfactory proof that a longer pre-operative period was necessary for the particular procedure.

(c) For an Obstetric Patient, benefits at the Obstetrics rate shall be payable only from the day upon which labour (including induction of labour) commences. Benefits are not payable for admission for bed rest or observation prior to commencement of labour, unless the attending Medical Practitioner certifies that the Obstetric Patient needs Acute Care in Hospital, in which case Benefits are payable at the medical/other rate provided that the Proper Officer may in his or her absolute discretion approve additional Benefits at the Obstetrics rate in respect of other hospitalisation directly relating to Obstetrics, after consideration of the medical evidence.

(d) For Rehabilitation Patients, Benefits at the Rehabilitation rate shall be payable only where the treatment is provided in an Approved facility and is supported by a Rehabilitation certificate approved by the Company that medically evidences the patient’s need for a rehabilitation program to recover from an acute illness or injury.

(e) For Psychiatric Patients, benefits at the Psychiatric rate shall be payable only where the treatment is for a Psychiatric condition that is grouped to a mental disorder diagnostic related group (DRG) and is provided in an Approved facility or Approved program and is supported by a Psychiatric certificate approved by the Company. Benefits for treatment in an Approved facility or an Approved program are payable at the other (Medical) rate.

(f) Where a person is discharged from Hospital and readmitted (to the same Hospital or another Hospital) within a period of seven days, both periods of hospitalisation shall be regarded as continuous, unless the re-admitting Hospital establishes to the satisfaction of the Company that the readmission was for a different medical condition from the previous admission.

(g) Where a patient undergoes more than one operative procedure during one theatre admission, the procedure which attracts the highest fee under the Medicare Benefits Schedule (MBS) shall be used for patient classification purposes.

(h) Benefits at the Advanced Surgical and Surgical/Obstetrics rates are payable only in respect of the period of hospitalisation at the Hospital where the procedure was performed. Where a Member is subsequently transferred to another Hospital, the medical/other rates of Benefits shall be payable from the date of transfer to that other Hospital.

(i) If the Member has been in Hospital for 35 days of Continuous Hospitalisation an Acute Care Certificate is required by the attending Medical Practitioner certifying the need for either ongoing Acute Care, Psychiatric or Rehabilitation treatment, together with any other information requested by the Company. Upon expiry of the certificate the Member will be entitled only to those Benefits detailed in Schedule 4 Part 2 of the Private Health Insurance (Benefit Requirement) Rules as amended or replaced from time to time.

(j) Where a Member’s hospitalisation bridges the end of a Benefit Year and part of the next year the Excess amount for the New Year will apply to the first subsequent admission in the new Benefit Year.

E2.3 Benefits for Surgical Podiatry Procedures

If a Product provides a Benefit for procedures provided by an Accredited Specialist Podiatrist, the only Benefit payable as per the minimum requirement set out in the Private Health Insurance Accreditation Rules 2011 and the Private Health Insurance Act 2007 (Cth).

E2.4 Purchaser Provider Agreements
(a) The Company may from time to time enter into a Hospital Purchaser Provider Agreement (HPPA) with a Hospital or Medical-Purchaser Provider Agreement (MPPA) with a Medical Practitioner and may, as a result of such agreements, provide Benefits that vary from those listed in the Product Cover Guide.

(b) Where a Member is charged for Hospital Treatment or a professional Medical Treatment where a HPPA or MPPA applies, the Benefits will, unless otherwise stated in these Rules, be as specified in the HPPA or MPPA (as the case may be).

### E2.5 Non-Agreement Hospitals

Where a Member makes a claim for Benefits for hospitalisation in a Non-Agreement Hospital, Benefits will be payable as per the Private Health Insurance Legislation.

### E2.6 In-Hospital Pharmaceutical Benefits

(a) Subject to this Rule E2.6 in this Part III of these Rules, for Hospital Treatment and combined Hospital and General Treatment Products the Fund covers all costs that a Member incurs for Pharmaceutical Benefits dispensed to the Member while the Member is an Admitted Patient at an Agreement (HPPA) Hospital.

(b) The Fund covers costs for Pharmaceutical Benefits up to a maximum quantity dispensed as listed under the PBS or as recorded on an Authority Prescription Form.

(c) A Pharmaceutical Benefit referred to in this Rule E2.6 in this Part III of these Rules must be: (i) intrinsic to the Hospital Treatment provided, (ii) clinically indicated, (iii) essential for meeting satisfactory health outcomes for the Member, and (iv) non-experimental drugs. This does not include Pharmaceutical Benefits that are listed under the PBS or are dispensed to the Member but not directly related to treatment of the condition or ailment for which the Member has been admitted.

(d) Benefits will not be payable for high cost or experimental drugs that are not listed under the PBS or are not Approved by the Therapeutic Goods Administration (TGA) for the use in the specific condition.

(e) Where the cost to a Member for a drug or medicinal preparation listed under the PBS is less than the PBS co-payment, these drugs are not considered to be Pharmaceutical Benefits and are not covered by the Fund.

### E2.7 Medical Gap Cover

Where treatment is provided to a Member in a Hospital facility and medical services in respect of an Approved medical professional are rendered to which a Medicare Benefit is payable the following shall apply:

(a) the difference between the Benefit paid by Medicare and the Medicare Benefits Schedule (MBS) fee for eligible services - 25%; or

(b) under eligible Products where the service is rendered by or on behalf of a Medical Practitioner under the Gap Cover scheme up to the agreed schedule.

A Medical Practitioner who provides treatment under a Gap Cover arrangement shall give the Member written advice of any amount they can reasonably be expected to pay for those services. This is called Informed Financial Consent.

The Gap Cover scheme does not extend to costs such as Hospital Excess or medical services listed under the Pathology or Radiology category.

### E2.8 Miscellaneous Matters

(a) All Hospital Products and Combined Hospital and General Treatment Products offered by the Company will provide Benefits for Hospital Substitute Treatment provided by a Recognised provider in Private Practice. Services can be provided in substitution for days spent in Hospital on the condition that:

(i) the cost of Hospital Substitute Treatment is less than or equal to the equivalent costs of these Hospital-based services; and

(ii) a Medical Practitioner has certified that the care can be a substitute for hospitalisation and that the Proper Officer of the Company certifies the service to be reasonable and clinically appropriate.

(b) The Proper Officer may, after receiving evidence from a Medical Practitioner appointed by it, exercise discretion to extend the payment of Hospital Benefits beyond the maximum periods specified in this Rule in individual cases.

(c) Hospital Treatment Benefits that will not be payable:

(i) where Hospital Treatments are experimental or involve a clinical pharmaceutical trial;

(ii) for a Surgical Prosthesis that has not been Approved and listed on the Private Health Insurance (Prostheses) Rules, unless it is evidenced to be Clinically Relevant and then may be Approved by the Proper Officer for Benefit payment;

(iii) the Company shall have the right to seek an Acute Care Certificate.
E3 GENERAL TREATMENT

E3.1 When Benefits are Payable

(a) Benefits will only be payable in respect of charges made for services rendered by General Treatment providers who are Recognised Providers or who are members of organisations that are Recognised Associations and satisfy the requirements of the Private Health Insurance (Accreditation) Rules 2011.

(b) The Company may at its discretion require a General Treatment provider to complete a declaration concerning his, her or its Private Practice status, in the form prescribed by the Company from time to time, prior to payment of Benefits.

(c) Benefits for General Treatment consultations will only be payable based on one consultation per patient, per practitioner, per day.

(d) Benefits for General Treatment consultations will only be payable as described in the Product Cover Guides and only for the time during which a Member is receiving direct or active attention. It does not include preliminary or subsequent attendances such as making of appointments and writing reports, and these cannot be treated as separate consultations.

(e) The Benefits payable and the conditions associated with General Treatment services by Recognised Providers are listed within the Product Cover Guides.

E3.2 Determination of Benefits

(a) General Treatment Benefits for Dental Services will be provided only in respect of procedures or services recommended by the Australian Dental Association (ADA) and which are itemised under the headings General Dental or Major Dental or Orthodontics as set out in a relevant Product Cover Guides (the item numbers used therein being those provided by the ADA). Benefits are payable only in respect of Approved procedures or services performed by a dentist or dental technician who is a Recognised Provider in Private Practice or employed by a Registered Health Insurer.

(b) General Treatment Benefits towards pharmacy are payable after deduction of the current PBS contribution, on private prescription items (S4 and S8) which are:

(i) prescribed by a Medical Practitioner,

(ii) supplied by a registered pharmacist in Private Practice,

(iii) Approved by the Therapeutic Goods Administration (TGA) for the indication for which they have been prescribed;

(iv) not otherwise supplied or funded by a public arrangement scheme, including the PBS;

(v) not otherwise Excluded by the Company.

E3.3 Emergency Ambulance

(a) Where a Hospital Product or Combined Hospital and General Treatment Product provides Benefits towards Emergency Ambulance Services, Benefits will be payable in accordance with the Product Cover Guide for Emergency Ambulance Transportation or an Emergency Ambulance Attendance where it is coded or invoiced by the relevant State Ambulance authority as an Emergency Ambulance Transportation or Emergency Ambulance Attendance.

(b) There shall be no entitlement to Benefits where:

(i) coverage is included via a State levy included within the Contribution referable to a Hospital Product or Combined Hospital and General Treatment Product;

(ii) non-emergency transportation provided by the Ambulance service that is not clinically necessary;

(iii) transportation provided after Hospital discharge to a home or nursing home;

(iv) for transfers between Hospitals or from medical facilities;

(v) the Member holds a State based ambulance membership subscription; or

(vi) the Member is a resident of a State that provides a free Ambulance transportation scheme.

(c) Benefits are paid at the maximum as outlined in the relevant Product Cover Guide.

E3.4 Purchaser Provider Agreements – General Treatment

The Company may from time to time for the Benefit of its Members enter into purchaser provider agreements with General Treatment providers and may as a result of these agreements provide Benefits which vary from those listed in the Provider Benefit Schedule.

E4 OTHER

E4.1 Health Management Programs and Hospital Substitute Treatment

The Company may from time to time, at its discretion on eligible Products as referred to in the
Product Cover Guides, make available a Health Management Program and/or Hospital Substitute Treatment program. The program(s) must be provided by a Recognised provider in Private Practice.
**F LIMITATION OF BENEFITS**

**F1 EXCESSES**

**F1.1 Products with Excesses**

The Company may offer Hospital Products or Combined Hospital and General Treatment Products with Excess options. The Excess is deducted from the Treatment Benefits that would otherwise be payable by the Fund.

**F2 WAITING PERIODS**

**F2.1 Waiting Periods to Apply**

(a) Unless otherwise permitted by the Company, subject to Rule 6 in this Part III of these Rules, a Member must serve the Waiting Periods set out in this Rule F2 in this Part III of these Rules before receiving Benefits available under a Product and no Benefits are payable in relation to treatments received during an applicable Waiting Period.

(b) A Waiting Period starts from the Commencement Date of the Membership or date of transfer from another Registered Health Insurer in respect of the Member or the registration date of the Member on the Membership (whichever date is the later) as listed in this Rule F2 in this Part III of these Rules.

If during a Waiting Period the Member has upgraded to a New Product from a Product with lower Benefits and the Member would have been entitled to a Benefit under the Old Product which is also offered under the New Product, then the Member shall be entitled to those Benefits at the rate provided in the Old Product during the Waiting Period.

**F2.2 Hospital Treatment Waiting Periods**

The following Waiting Periods apply to a Benefit for Hospital Treatment or Hospital Substitute Treatment subject to the Member’s chosen New Product.

(a) For a Benefit for Hospital Treatment or Hospital Substitute Treatment:

(i) Obstetric treatment or treatment for a Pre-Existing Ailment/Condition (other than treatment covered by paragraph (ii))—12 months;

(ii) Psychiatric care, Rehabilitation or Palliative Care (whether or not for a Pre-Existing Ailment/Condition)—2 months;

(iii) any other benefit—2 months.

**F2.3 Mental Health Care Exemption**

A Member is entitled to once in a lifetime exception to the normal two (2) month Waiting Period for Hospital Psychiatric Care provided the following conditions are met:

(a) the Member holds a Hospital Product with any Registered Health Insurer;

(b) the Member has not accessed the waiver at any other time with any Registered Health Insurer;

(c) the Member is an Admitted Patient of a Hospital; and

(d) the Member is under the care of an Addiction Medicine Specialist or Consultant Psychiatrist.

This exception can be backdated by up to five (5) business days.

**F2.4 General Treatment Waiting Periods**

(a) For a Benefit for Health Aids, including braces and wigs, orthotics and orthopaedic shoes if covered by the Product – 12 months of continuous Membership of the Product. (For CPAP Machine – there is a Waiting Period of three years in respect to a replacement CPAP Machine).

(b) For a Benefit for crowns and bridges and other dental prosthetic services including inlays, dentures, denture repairs and implants, orthodontia, endodontia, periodontics, and occlusal adjustments if covered by the Product – 12 months of continuous Membership of the Product.

(c) For a Benefit for Hearing Aids, if covered by the Product – 24 months of continuous Membership of the Extras Product.

(d) For a Benefit for optical appliances and repairs – 3 months of continuous Membership of any of the Extras Products (Except in the case of Fit & Healthy Extras where the Waiting Period is 6 months).

(e) For a Benefit in respect of any other General Treatment – 2 months of continuous Membership of a Product that covers General Treatment.
F2.5 No Waiting Period Applies to Accident-Related Services and Emergency Ambulance

Where there is a claim for Benefits in respect of:

(a) an injury caused by an Accident, that took place after a Member’s Commencement Date; or

(b) Emergency Ambulance Transportation or Emergency Ambulance Attendance, as described in Rule F3.3 in this Part III of these Rules;

the two (2) month Waiting Period described in Rule F2.2 in this Part III of these Rules shall not apply to the Member in respect of that Benefit.

F2.6 No Waiting Period Applies to Gold Card Holders

Where a person joins the Fund within two (2) months of ceasing entitlements to a Gold Card under the Veterans’ Entitlements Act 1986 (Cth) the Member will not be subject to any Waiting Periods as described in this Rule F2 in this Part III of these Rules in respect of Hospital Treatment or General Treatment.

F2.7 Waiver of Waiting Periods

The Company may, in its absolute discretion, waive or reduce a Waiting Period for Benefits, however, this waiver or reduction will not affect any other Waiting Periods, Restricted Benefits or other Rule that applies to the same Benefit.

F2.8 Waiting Periods – Newborns and Dependents

In the case of any newborn(s) added within twelve (12) months of the birth to a Family or Single Parent Membership, the newborn(s) will not be required to serve any Waiting Period.

In the case of a new Dependant (other than a newborn) being added to an existing Family or Single Parent Membership, any Waiting Periods that apply to that Product must be served in full by that new Dependant.

F3 EXCLUSIONS

As determined by the Company, selected Hospital Products or Combined Hospital and General Treatment Products detailed in the Product Cover Guides will have specified treatments that are listed as ‘Exclusions’ or ‘Excluded benefits’, which means no Benefits will be payable by the Company towards any costs incurred by a Member for those treatments.

F4 RESTRICTED BENEFITS

Treatments that are limited to the Minimum Default Benefit for the duration of a Product’s cover are set out in selected Hospital Product or Combined Hospital and General Treatment Products’ Product Cover Guides.

F5 COMPENSATION DAMAGES AND PROVISIONAL PAYMENT OF CLAIMS

(a) Benefits are not payable under any of the Company’s Products in relation to expenses incurred in respect of any condition, injury or ailment which is the subject of a claim where a Member has received or established a right to receive a payment by way of Compensation or damages from a third party.

(b) Where the amount of the entitlement for Compensation or damages is less than the Benefit that would otherwise be payable under the relevant Product, partial Benefits are payable up to the limit of the difference between the full Benefit payable and the Compensation or damages entitlement.

(c) Where the Company is of the opinion that a condition, injury or ailment is one which may give rise to a claim for Compensation or damages, the Company may require that before payment of any Benefits the Member in respect of whom Benefits are otherwise payable shall sign an irrevocable undertaking and authority in favour of the Company, in a form acceptable to the Company, pursuant to which the Member undertakes:

(i) to include in any such claim, all Hospital, paramedical and related expenses in respect of which Benefits otherwise are or may be payable by the Company;

(ii) not withdraw the claim for such expenses; and

(iii) to notify the Company forthwith upon payment of the claim or any part thereof and the Member directs that from any such claim there is first deducted and paid to the Company by way of reimbursement, an amount equal to the amount of Benefits paid by the Company in respect of such condition, injury or ailment.

(d) Where a Benefit has been paid and the Member receives or establishes the right to receive payment by way of Compensation or damages, the Benefit paid must be repaid to
the Company immediately to the quantum of the recovery or right to recovery.

F6 OTHER

F6.1 Lifetime Benefit Limits

Lifetime Benefit Limits or 'lifetime limits' apply equally to Members for particular General Treatments and are not tied to the duration of Products. The amount of Benefits that count towards a lifetime limit can be accumulated over two or more Products that may cover a Member and Benefits received by Members for similar services and treatments from other insurance Products provided by Registered Health Insurers will be included in the calculation of a Member’s total lifetime limit for a treatment or service. The applicable lifetime limit for a Product is stated in the relevant Product Cover Guide.
G CLAIMS

G1 GENERAL

G1.1 How claims may be made

(a) Claims for Benefits shall be made in Writing in a form as required by the Company from time to time and where required by the Company, be accompanied by the account of the Hospital, Medical Practitioner or Recognised Provider for the period of hospitalisation or for the services or treatments rendered or such other evidence as may be considered by the Company to be sufficient proof that the hospitalisation has occurred or the services were rendered (Documentation).

(b) A Member must make full and true disclosure in the claim form as to all matters referred to therein.

(c) The Company may retain all such Documentation it receives under this Rule G1 in this Part III of these Rules and such documents will become the property of the Company.

G1.2 Evidence in Support of Claim

If required by the Proper Officer, a Member shall in support of any claim for Benefits under these Rules:

(a) deliver to a Proper Officer a signed authority authorising that Officer to obtain from any Hospital, Medical Practitioner or Recognised Provider of the Member such medical evidence as the Proper Officer may in his or her absolute discretion require; or

(b) provide such further evidence in support of the Member’s claim for Benefits as the Proper Officer may in his or her absolute discretion require.

G1.3 Appointment of Medical Practitioner

The Company may appoint a suitably qualified Medical Practitioner to advise the Company on medical and technical aspects of any claim as necessary from time to time.

G1.4 Assessment of a Claim

The Company may request information from a Member about their healthcare provider prior to or after the payment of a Benefit for a claim. Information requested by the Company will be directly related to a claim where the Member has acknowledged either verbally or in Writing a declaration requesting Benefit entitlements to be paid to the Member or their healthcare provider. Such information may include but is not limited to:

(a) Prescriptions

(b) Signed receipts

(c) Invoices

(d) Treatment plans

(e) Medical/Patient records

(f) Appointment schedule

G1.5 Claim Lodgement

(a) The Company will not pay Benefits for a claim submitted to the Fund more than two (2) years after the date of Hospital Treatment or the date General Treatment services were rendered.

(b) Where, in the opinion of the Proper Officer, hardship would otherwise be caused to the Member, the Company may waive Rule G1.5(a) in this Part III of these Rules and pay Benefits in respect of that claim.

G1.6 Payment of Claims

For the Company to pay Benefits in respect of service accounts paid by the Member, the Member must provide to the Company details of their nominated financial institution account. The Company may at its absolute discretion determine to pay any such claim by way of a cheque payable to the Member.

The Company may, upon receiving written authority from the Member, together with an unpaid account for Hospital, Medical or General Treatment, make payment of the appropriate Benefit to the Recognised Providers or Medical Practitioners nominated account or by issuing a cheque in the name of the Recognised Provider or Medical Practitioner (as the case may be) who rendered the service.
H SCHEDULE OVERSEAS

H1 OVERSEAS

No Benefits are paid for treatments, services or products rendered or provided to a Member outside Australia.