OVERSEAS VISITORS HEALTH COVER FUND RULES

EFFECTIVE 12 SEPTEMBER 2023

All *Members* are bound by these *Rules* including the *Product Schedules* for their cover, their completed application form, Overseas Visitors Health Cover Member Guide and any *HCF* policy notified to *Members* such as the HCF Privacy Policy.

HCF

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A INTRODUCTION

A1 RULES ARRANGEMENT

These *Rules* apply to *Overseas Visitors Health Cover* only.

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 the *Overseas Visitors Health Cover* business through its *Health Benefits Fund* as a health related business in accordance with the *Private Health Insurance Act*.

A3 OBLIGATIONS TO INSURER

A3.1 When *Members* apply for cover with *HCF*, or change or renew their *Policy*, they have a duty of disclosure and a duty to take reasonable care not to make a misrepresentation to *HCF*. This means *Members* must share honest and complete information about themselves and other *Members* covered (or to be covered) under the same *Policy* including their *Country of Origin*, residential address in their *Country of Origin*, passport details, visa class, residential address in *Australia* and any *Pre-Existing Conditions*. *Members* must respond fully and truthfully to any questions *HCF* asks, or in a way that a reasonable person in the circumstances could be expected to know how to respond.

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 to their status as an *Overseas Visitor*, change of address in *Australia* or a change in the status of a *Dependant*.

A3.3 If a *Member* does not comply with their duty of disclosure under clause A3.1 or A3.2, *HCF* may:

(a) cancel their *Policy*;
(b) reject a *Claim*;
(c) reduce the *Benefits* they are eligible for if they have made a *Claim*;
(d) treat the *Policy* as if it never existed and refuse to pay if they make a *Claim* or seek repayment of *Premiums* from the *Member*;
(e) in the event that a *Member* misrepresents a fact, seek damages from you.

A3.4 All *Members* are bound by these *Rules* including the *Product Schedules* for their cover, their completed application form, *Overseas Visitors Health Cover Member Guide* and any *HCF* policy notified to *Members* such as the *HCF Privacy Policy*.

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 A3.4.

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) these *Rules*; and
(b) any policies of *HCF* notified to the *Member*.

A4.2 For *Visa Compliant Cover*, where the *DHA Requirements* are in conflict with these *Rules*, the *DHA Requirements* take precedence over these *Rules* to the extent of the inconsistency.

A4.3 Where no clear conflict is in existence between the *DHA Requirements* and these *Rules*, these *Rules* take precedence.

A5 CHANGES TO RULES

A5.1 *HCF* shall have the power to vary, delete or add to these *Rules* at any time, subject to the *DHA Requirements* and any required notification period. HCF will provide the updated version of these *Rules* on the HCF website. If the change to the *Rules* is detrimental to the interests of *Members*, HCF will inform those *Members* a reasonable time before the change takes effect.

A5.2 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*.

A5.3 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 undergoing a course of *Treatment*; and
  (ii) a change to the *Rules* would have a detrimental effect on the *Member* in relation to that *Treatment*, in which case *HCF* will make provision for a reasonable transition period for any *Member* affected by the change.

A6 DISPUTE RESOLUTION

A6.1 Any *Member* who has a complaint or concern with any aspect of *HCF*'s service or any information provided, or with the standard of *Treatment* 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 *Treatment* or care should also be referred to the *Health Care Complaints Commission (HCCC)* or similar body.

A6.2 *HCF* has a complaint resolution process to ensure that all complaints are resolved as quickly as possible.

A6.3 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.

A6.4 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.

A7 NOTICES

A7.1 *HCF* shall send any necessary correspondence to the most recently advised email address of the *Policyholder* unless a reasonable request is made by the *Policyholder* to receive the correspondence in a different form of communication.

A8 OTHER

A8.1 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 A8.1(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.

A8.2 Set-off of benefits payable against amounts owed

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

A8.3 Set-off of premiums refundable against amounts owed

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

A8.4 Waiver of Rules

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

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

(b) *Waiting Periods*; and

(c) eligibility for *Benefits*.

B INTERPRETATION AND DEFINITIONS

B1 INTERPRETATION

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

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

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

B1.4 A reference to:

(a) 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; and

(b) the *DHA Requirements* means those requirements as amended or varied from time to time.

B1.5 In the case of legislation, regulations or rules having been repealed, any references in these *Rules* are to be read as references to the replacement legislation, regulations or rules.

B1.6 In these *Rules*, words importing the masculine gender will include the feminine gender and words importing the singular or plural number will include the plural and singular number respectively.

B2 DEFINITIONS

In these rules:

Accident means:

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

(b) excludes unforeseen conditions attributable to medical causes.

Acupuncture means *Treatment* 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*.

Allied Health Services means services provided by allied health professionals referred to in the MBS Allied Health Services schedule as determined by the Department of Health from time to time and any *Service* referred to in the *Extras* section of a *Product Schedule*.

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 Transportation*.

(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* can provide.

Ambulance Service Provider means the following service providers or a party that has an arrangement with one of them:

(a) ACT Ambulance Service;
(b) Ambulance Service of NSW;
(c) Ambulance Victoria;
(d) Queensland Ambulance Service;
(e) South Australia Ambulance Service;
(f) Royal Flying Doctor Service (SA);
(g) St John Ambulance Service NT;
(h) St John Ambulance Service WA; and
(i) Tasmanian Ambulance Service.

Australia for the purposes of these *Fund Rules*:

(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 for which they are entitled to reimbursement (in whole or part) under their *Policy* in accordance with these *Rules*.

Benefits Schedule means the schedule in *HCF*'s systems that sets out the amount of *Extras Benefits* payable for each *Product*.

Calendar Year means the period from the date a *Policy* commences to 31 December and every 1 January to 31 December thereafter.

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*.

Country of Origin means a country other than *Australia* where an *Overseas Visitor* holds a passport and citizenship and has specified that country as their country of origin in their visa application.

Dependant means a person who:

(a) is aged 22 or less;
(b) is unmarried and not in a de facto relationship;
(c) is not employed on a full-time basis;
(d) is primarily reliant on the *Policyholder* (or *Partner* listed on the *Policy*) for maintenance and support; and
(e) 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.

DHA means the Department of Home Affairs, formerly known as the Department of Immigration and Border Protection.

DHA Minimum Benefits means the requirements in the *DHA Requirements* that relate to the minimum level of benefits that must be paid for *Treatment* under *Visa Compliant Cover*.

DHA Requirements means the requirements for health insurance cover that an overseas visitor must hold as a condition of certain visas to work in *Australia*, as determined by *DHA* from time to time.

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 *Treatment* and *Services* (including accommodation, theatre, *Prostheses* and *Medicines*) provided to a *Member* from the date of admission to a *Hospital* to the date of discharge.

Exceptional Drugs List means the list developed by the Exceptional Drugs List Committee and last updated as at 1 May 2013.

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 in relation to a *Product*, *Hospital Treatment* that is specified in the *Product Schedules* as being an 'Excluded Service' for that Product and therefore no *Product Schedule* is payable for that Service.

Extras Benefits means *General Benefits* payable to a *Member* under a *Product* in accordance with these *Rules* as a result of *Extras Treatment* provided to that *Member* such as optical, physiotherapy, dental and natural therapies.

Extras Treatment means *General Treatment* that constitutes allied health *Services* such as optical, physiotherapy, dental and natural therapies.

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.

Gazetted Rates means, in relation to *Hospital Treatment*, the rates for that treatment gazetted by the State or Territory health authority in which that treatment was provided.

General Benefits means *Benefits* payable to a *Member* under a *Product* in accordance with these *Rules* as a result of *General Treatment* provided to that *Member*, and includes *Extras Benefits*.

General Treatment means *Treatment* that is not *Hospital Treatment*.

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 Network means the network of general practitioners that have an agreement with *HCF* in relation to the fees charged for their services to *Overseas Visitors*.

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

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

Hospital Contract means an agreement entered into between *HCF* and an *HCF Participating Private Hospital* in relation to charges payable by *HCF* and to limit the gaps that can be charged to a *Member* when a *Member* receives *Hospital Treatment* at that *HCF Participating Private Hospital*.

Hospital Benefits means *Benefits* payable to a *Member* under a *Product* in accordance with these *Rules* as a result of *Hospital Treatment* provided to that *Member*.

Hospital Treatment has the meaning set out in section 121-5 of the *Private Health Insurance Act*.

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*.

Inpatient means a person who receives *Hospital Treatment* when admitted to a *Hospital*.

Insured Group means one of the following:

(a) a *One Adult Membership* (also referred to as singles cover);
(b) a *Two Adult Membership* (also referred to as couples cover);
(c) *One Parent Family Membership* (also referred to as single parent family cover); and
(d) *Family Membership* (also referred to as family cover).

Intensive Care Unit means a unit for intensive care including a 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*.

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 Schedules*.

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* or *General Treatment* and the amount of *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 or MBS means the schedule of benefits determined by the Department of Human Services (known formerly as Medicare) under which a *Medicare Benefit* is payable.

Medicare Eligible Person means a person who is an 'eligible person' under the *Health Insurance Act* but not because of an agreement between the Commonwealth and another country which permits visitors of that country to be treated as eligible persons under subsection 7(2) of that Act.

Medicine means a medicine approved by the *TGA* under the *Therapeutic Goods Act 1989 (Cth)* and prescribed to a *Member* according to approved indications.

Medicover means *HCF*'s Medicover no gap and known gap arrangement under which a *Medical Practitioner* may opt to enter into an agreement with *HCF* to fix the amount of, or to not charge, the gap between the charge for their services and amounts paid by *HCF* and Medicare, when a *Member* receives their services.

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*.

Minimum Benefits means benefits for *Hospital Treatment* that are equivalent to the minimum benefits that *HCF* would have had to pay for Australian resident health cover under the *Private Health Insurance Act*.

Minimum Benefit Services means in relation to a *Product*, *Hospital Treatment* that is specified in the *Product Schedules* as being a 'Minimum Benefit Service' for that Product.

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.

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 *Treatment* has previously been sought; or
(b) an acute flare-up of an existing condition where there has been no *Treatment* for that condition provided in the previous 3 months.

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

Non-Visa Compliant Cover means a *Product* does not meet *DHA Requirements* and includes the following Products: Short Stay, Essentials and Essentials Plus.

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*.

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

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

Outpatient means a person who receives *Hospital Treatment* or *General Treatment* when not admitted to a *Hospital*.

Outpatient Services means *General Treatment* that is not *Extras Treatment*.

Overseas Visitor means a person who:

(a) is 18 years or over;
(b) is not an Australian citizen, does not hold an Australian passport and does not reside permanently in *Australia*;
(c) is not a *Medicare Eligible Person*;
(d) holds a valid work or holiday *Visa*; and
(e) meets other eligibility criteria determined by *HCF*.

Overseas Visitors Health Cover means the suite of *Products* under which *Benefits* are payable for *Services* to *Overseas Visitors*.

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

PBS means the Pharmaceutical Benefits Scheme.

PBS Medicine means a medicine which is claimable under *Overseas Visitors Health Cover* which is:

(a) prescribed by a *Medical Practitioner* or dental practitioner on prescription 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; and
(d) prescribed for *Treatment* of the approved specific indications as detailed in the Australian Register of Therapeutic Goods; and
    (i) the item is listed on the Australian Government's Pharmaceutical Benefits Scheme (PBS) and prescribed according to the PBS approved indications; and
    (ii) the item is available only with a prescription.

Policy means a policy issued under a *Product*.

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* is covered for *Hospital Benefits* or upgrades to a higher *Product* or *Insured Group*. The test applied relies on the presence of signs or symptoms of the illness, ailment or condition; not on a diagnosis.

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

Premiums Schedule means the schedule in *HCF*'s systems that sets out the amount of *Premiums* payable for each Product.

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

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 Hospital has the meaning given to that term under the *Private Health Insurance (Benefit Requirements) Rules*.

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 *General Benefits*, 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 health insurance product for *Overseas Visitors* that covers a defined group of *Benefits* and is set out in the *Product Schedules*.

Product Schedules means the schedules to these *Rules* for each *Product* that sets out the amount and/or rules for the payment of *Benefits*, the *Benefits Schedules* and the *Premium Schedules*.

Prosthesis means items listed on the *Prostheses List*.

Prostheses List means the Australian Government-approved list of *Prostheses*, 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*.

Public Hospital has the meaning given to that term under the *Private Health Insurance (Benefit Requirements) Rules*.

Recognised Provider means:

(a) a *Hospital*;
(b) a *Medical Practitioner*;
(c) a provider of *General Treatment* in *Australia* who:
  (i) is in *Private Practice*;
  (ii) for each relevant class of *Service*, satisfies all *Recognition Criteria*; and
  (iii) is recognised by *HCF*;
(d) an *Ambulance Service Provider*; or
(e) any other provider recognised by *HCF* for the purpose of these *Rules*.

Recognition Criteria means the following:

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

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

RHC Recipient means a *Member* whose *Country of Origin* is a country that has a reciprocal health care agreement with *Australia* which entitles them to publicly funded medical care and/or *PBS Medicines*.

Rules means this *Fund Rules* document and the *Product Schedules*.

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.

Service means hospitalisation, medical or allied health *Treatment*, *Ambulance* transportation, care or supply or provision of an item (whether goods or services) for which a *Benefit* is included 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.

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*.

Treatment means services provided to a *Member* that are needed to diagnose, alleviate, or manage an injury, illness, condition or disease.

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.

Visa means a work or holiday visa that permits entry into Australia as determined by *HCF* from time to time, but does not include student visa classes.

Visa Compliant Cover means a *Product* other than a *Non-Visa Compliant Cover*.

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 OF MEMBERSHIP

C1.1 *Policyholders* may, provided they meet the eligibility requirements for the individual *Policies*, select only one *Product*.

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 Schedules*.

C2 ELIGIBILITY FOR MEMBERSHIP

C2.1 Subject to these *Rules*, an *Overseas Visitor* is entitled to apply for a *Policy* with the *Health Benefits Fund* and therefore becomes eligible to receive *Benefits*.

C3 DEPENDANTS

C3.1 *Dependants* can be added to a *Policy* at any time as long as the option is available on the *Product*. After a *Dependant* has been added to a *Policy*, the *Dependant* must serve all applicable *Waiting Periods* before they are eligible for *Hospital Benefits*, and, if applicable, *General Benefits*.

C3.2 *One Adult Memberships* and some *Two Adult Memberships* must convert to *One Adult Family Memberships* or *Family Memberships* within 2 months of the date of birth of a child and the new policy must commence on or prior to the date of birth of the 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 timeframe set out in clause C3.2.

C4 MEMBERSHIP APPLICATIONS

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

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

C5 DURATION OF MEMBERSHIP

C5.1 A *Policy* commences:

(a) if the *Member* is not in *Australia*, on the later of:
  (i) the date nominated on the application form; or
  (ii) the *Policyholder's* date of arrival in *Australia*; or
(b) if the *Member* is already in *Australia* when the application is submitted, the later of:
  (i) the date nominated on the application form; or
  (ii) the start date of their *Visa*, 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 Australian registered private health insurer or from another *HCF* health insurance policy (the *Old Policy*).

C6.2 Subject to *Rules* C6.3 and C6.6, 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 a *Hospital Treatment Policy* if:

(a) there is a gap of seven days or more between the date up to which *Premiums* have been paid under the *Old Policy* and the date the *New Policy* commenced, and where the *New Policy* is a *Non-Visa Compliant Cover Policy*; or
(b) there is a gap of more than 30 days between the date up to which *Premiums* have been paid under the *Old Policy* and the date the *New Policy* commenced, and where the *New Policy* is a *Visa Compliant Cover Policy*; or
(c) the *Hospital Treatment* was not covered under the *Old Policy*.

C6.4 If a *Hospital Benefit* 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 *Hospital Treatment* in Rule F2.

C6.5 If a *Hospital Benefit* 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 Treatment* in Rule F2.

C6.6 *HCF* will not recognise *Waiting Periods* previously served for *General Treatment* if:

(a) there is a gap of seven days or more between the date up to which *Premiums* have been paid under the *Old Policy* and the date the *New Policy* commenced; or
(b) the *General Benefit* was not covered on the *Old Policy*.

C6.7 If a *General Benefit* is higher under the *New Policy* than under the *Old Policy*, *General Benefits* will only be payable as per the entitlements of the *Old Policy* for the duration of the *Waiting Period* specified for that *General Treatment* in Rule F2.4.

C6.8 *HCF* may deduct *Extras Benefits* paid under the *Old Policy* to determine the annual limit that applies and therefore the *Member's* entitlement to *Benefits* under the *New Policy*.

C7 CANCELLATION OF MEMBERSHIP

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

C7.2 Subject to clause A8.3, any *Premiums* paid in advance of the date of cancellation will be refunded to the *Policyholder* on a pro rata basis except for the first month's *Premium* which is non-refundable.

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* will supply it within 14 days of the request.

C7.6 A *Policyholder* must notify *HCF* of the following:

(a) a *Member's* visa is expiring or has expired, or if any other changes to their visa have occurred; or
(b) a *Member* will be leaving or has left *Australia*.

C7.7 If a *Policyholder* notifies *HCF* that they wish to cancel a *Policy*, the effective date of the cancellation of the *Policy* will be the later of:

(a) the date elected by the *Policyholder* in writing and the date *HCF* receives the written notice (provided that the *Policy* is paid to that date); or
(b) the date of the most recent *Claim* paid in respect of the *Policy*; or
(c) if a cancellation date is not elected by the *Policyholder*, the date on which the next *Premium* would otherwise be due.

C7.8 *HCF* will not backdate the cancellation of a *Policy* and will not backdate the refund of Premiums.

C8 TERMINATION OF MEMBERSHIP

C8.1 *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 committed or attempted to commit fraud upon *HCF*;
(b) the application for the *Policy* is discovered to have been inaccurate in a material respect or incomplete and the *Member* has failed to provide material information requested by HCF within a reasonable time of the request;
(c) any *Member* included in the *Policy* has a concurrent health insurance policy with another private health insurer that covers *Overseas Visitors*;
(d) the *Policy* is in arrears as set out in clause D3.2;
(e) any *Member* included in the *Policy* has behaved inappropriately towards *HCF* staff, providers or other *Members*.

C8.2 If any *Member* included in the *Policy* has died or been permanently repatriated to their *Country of Origin*, *HCF* may terminate the *Policy* if the *Member* is on a Singles Policy or terminate the *Member* from a *Policy* for other types of cover.

C8.3 *HCF* will give written advice of termination, to the *Policyholder* and/or *Member* and will, subject to clause A8.3, refund any *Premiums* paid in advance as at the date of termination.

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

C8.5 Where *HCF* has exercised its rights to terminate a *Policy*, *HCF* shall have the right to refuse another application for a *Policy* from the cancelled *Member* for a *Policy* referrable to any *Fund* conducted by *HCF*, subject to the *DHA Requirements* for *Visa Compliant Cover*.

C9 OTHER

C9.1 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 *DHA Requirements* for *Visa Compliant Cover*. *HCF* will provide affected *Members* with prior notice and *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*.

C9.2 AUTHORITY TO ACT

(a) *HCF* Authority Nomination by OVHC Policyholder form must be completed by a *Policyholder* when they wish to nominate another person as their authorised representative for the purposes of maintenance of the *Policy*.
(b) Authority to Act – Nomination by Authorised Representative – a Nomination by Authorised Representative form must be completed where the *Policyholder* is a person who lacks capacity in which case, it must be completed by their authorised representative.
(c) A written Authority to Act as described above is required when a *Partner*, *Dependant* or other person, who is not the *Policyholder*, is requesting:
  (i) changes to the *Policy* including:
    (A) removing *Dependants*
    (B) requesting membership cards to be posted to an address other than that of the *Policyholder*;
    (C) changing the *Policy* to a different level of cover;
    (D) changing bank account details; or
    (E) changing mailing address;
  (ii) changes to *Benefits*, including 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 CONTRIBUTIONS

D1 PAYMENT OF CONTRIBUTIONS

D1.1 The *Product Schedules* contain the *Premiums* payable by a *Policyholder* for their *Policy*.

D1.2 *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.

D1.3 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.

D1.4 Where a *Policy* is cancelled, *HCF* will refund *Premiums* paid in advance, except for the first month's *Premium* which is non-refundable.

D2 CONTRIBUTION 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 ARREARS IN CONTRIBUTIONS

D3.1 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.

D3.2 A *Policy* may be terminated by HCF providing reasonable prior notice to the *Member* when:

(a) *Premiums* are more than 30 days in arrears for *Non-Visa Compliant Cover*; or

(b) *Premiums* are more than 60 days in arrears for *Visa Compliant Cover*.

D3.3 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.

D3.4 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.

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, or where the *Service* was paid for before taking out an eligible *Policy*.

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 reasonably required in the manner and form requested.

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

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

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

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

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

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

(b) the *Member* to whom the *Service* was provided was employed in an industrial undertaking and the *Service* was provided to him or her for purposes connected with the operation of that undertaking; or

(c) 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 *DHA Minimum Benefits* for *Visa Compliant Cover*, *Benefits* are not payable in respect of any *Service* where the *Treatment*, after receiving independent medical or clinical advice, is deemed by *HCF* to be inappropriate, not reasonable or experimental.

E2 HOSPITAL TREATMENT

E2.1 No *Hospital Benefits* are payable if the *Member* has not received *Hospital Treatment*.

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 *DHA Minimum Benefits* for *Visa Compliant Cover*, *Benefits* for *Medicines* 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, 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 (unless specified otherwise in the *Product Schedules*).

E2.5 *Member*s 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.

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 an operating theatre in a private *Hospital* is limited to a maximum of three (3) procedures per theatre visit.

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 prescribed under the *DHA Minimum Benefits* for *Visa Compliant Cover*.

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

E2.10 *Benefits* for *Prostheses* will include handling fees where applicable.

E2.11 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 *Member*s.

E2.12 The amount of a *Benefit* described in Rule E2.11 and any conditions on payment of that *Benefit*, will be in *HCF*'s absolute discretion.

E2.13 This section (E2) is subject to *HCF*'s obligations to pay D*HA Minimum Benefits* for *Visa Compliant Cover*.

E3 GENERAL TREATMENT

E3.1 *Benefits* for certain *General Treatment* 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 Schedules*, the *Overseas Visitors Health Cover Member Guide*, or elsewhere in these *Rules*.

E3.3 *Member*s will only be entitled to *Benefits* for *General Treatment*, courses and programs provided by *Recognised Providers* in *Private Practice*.

E3.4 *Dental Services* are provided at *HCF Dental Centres* for *Member*s 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 *Treatment* 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 *Treatment* is provided (where possible and practicable) in writing to enable informed financial consent to be given by the *Member* prior to the commencement of *Treatment*.

E3.7 *HCF* may decide that *Benefits* will no longer be payable in respect of Services supplied by a provider whose status as a *Recognised Provider* has been terminated by HCF in accordance with the *Recognised Provider terms and conditions*.

E3.8 In these cases outlined in Rule E3.7, *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.

E3.9 The provider identified in *Rules* E3.7 and E3.8, will thereafter no longer be considered to be an *HCF Recognised Provider*.

E3.10 Optical *Benefits* are payable for frames, lenses and contact lenses that are prescribed by an optometrist or ophthalmologist (who is a *Recognised Provider*) and supplied by an optometrist, ophthalmologist or optical dispenser (who is a *Recognised Provider*). Depending on the *Product*, *Benefits* may also be payable for attendances with an optometrist for certain *Services*.

E4 OTHER

E4.1 AMBULANCE TRANSPORTATION

(a) *HCF* pays *Benefits* towards eligible *Emergency Ambulance Transport Services* provided by an *Ambulance Service Provider*.
(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.

E4.2 EMERGENCY AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* for:
  (i) transport to the nearest *Hospital*;
  (ii) transfers from one *Hospital* to another *Hospital*, if included under the *Policy*; or
  (iii) where on-the-spot *Emergency 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* which do not require *Emergency Ambulance Transport* or where not included under the *Policy*, 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 (regardless of whether the *Member* was admitted as an Inpatient);
  (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 Provider*s not recognised by *HCF*; and
  (ix) where a *Member* is entitled to a waiver of the charges from the *Ambulance Service Provider*.

E4.3 PARTIAL COVER FOR AMBULANCE TRANSPORTATION

Benefits for *Emergency Ambulance Transport* are only 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 Schedules* where no *Benefits* are payable.

F LIMITATION OF BENEFITS

F1 EXCESSES

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

F2 WAITING PERIODS

F2.1 *Waiting Periods* apply to *Services* for which *Benefits* are provided under a *Policy*.

F2.2 A *Waiting Period* commences at the same time as a *Policy*holder's *Policy* under clause C5.1.

F2.3 *Hospital Treatment Waiting Periods* for *Visa Compliant Cover* are as follows:

2 MONTHS	Psychiatric, Rehabilitation and Palliative Care (whether or not for a *Pre-Existing Condition*)
12 MONTHS	*Services* for *Treatment* of a *Pre-Existing Condition*
	Obstetric Services

F2.4 *Outpatient Services Waiting Periods* for *Visa Compliant Cover* are as follows:

2 MONTHS	*Psychiatric Services* (if *Outpatient Services* are not excluded from the *Policy*) *Medicine* (if *Outpatient Services* are not excluded from the *Policy*)
12 MONTHS	*Services* for *Treatment* of a *Pre-Existing Condition* (if *Outpatient Services* are not excluded from the *Policy*). *Obstetric Services* (if *Outpatient Services* are not excluded from the *Policy*)

F2.5 *Extras Treatment Waiting Periods* for *Visa Compliant Cover* are as follows:

2 MONTHS	All *Extras Benefits*, unless specified otherwise in accordance with these *Rules*
12 MONTHS	Indirect dental fillings, surgical dental extractions, periodontics, endodontics, dental implants, veneers, crowns and bridges, dentures, occlusal therapy, orthodontics and foot orthotics.

F2.6 *Hospital Treatment Waiting Periods for Non-Visa Compliant Cover are as follows:*

12 MONTHS	*Services for Treatment of a Pre-Existing Condition (unless specified otherwise in the Product Schedules)*

F2.7 *Outpatient Services Waiting Periods for Non-Visa Compliant Cover are as follows:*

2 MONTHS	Medicine received as an Outpatient (if Outpatient Services are not excluded from the Policy)
12 MONTHS	Treatment for a Pre-Existing Condition (if Outpatient Services are not excluded from the Policy)

F3 EXCLUSIONS

F3.1 *Benefits* are not payable under a *Policy* in the following circumstances unless *HCF* is required to pay *Benefits* for *Visa Compliant Cover* in accordance with the *DHA Minimum Benefits*:

(a) if a *Service* is listed as an *Excluded Service* in the *Product Schedules* (regardless of whether required as a result of an *Accident*);
(b) any *Service* for an insulin pump *Treatment* classed as an *Outpatient Service*;
(c) *Hospital Treatment* relating to procedures (and other associated goods and services) that do not require a hospital admission (except certified Type C procedures);
(d) claims made 2 years or more after date of *Service*;
(e) 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;
(f) *Treatment* 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 *Member*s and *Member*s upgrading their *Policy* to any higher level *Benefits* under their *New Policy*), or at any time where *Treatment* for *Pre-Existing Conditions* is not covered by the *Member's Policy*;
(g) *Services* received during any period where payment is in arrears (unless clause D3.3 applies), the *Policy* is not financial, the *Policy* is not activated or within a *Waiting Period*;
(h) Treatment that *HCF* deems to be inappropriate or not reasonable, after receiving independent medical or clinical advice;
(i) any *Service* where the *Treatment* does not meet the standards in the *Private Health Insurance (Accreditation) Rules*;
(j) *Services* supplied by a provider not recognised by *HCF*;
(k) *Services* provided or arranged, or goods purchased outside *Australia* or en route to or from *Australia*; or
(l) *Services* including accommodation provided in a nursing home;
(m) *Services* including investigations that would not be covered by *Medicare* even if they were provided to a *Medicare Eligible Person*;
(n) *Treatments* or *Services* not covered under the *Policy*; and
(o) claims that do not meet *HCF*'s criteria as set out in these *Rules*.
(p) *HCF* will not pay for the costs of returning mortal remains or ashes to home country or the funeral costs if *Member* passed away due to a medical condition not covered under the policy and the body is not buried or cremated in *Australia*.
(q) Cost for medical examinations, x-ray, vaccinations or any *Treatment* required for obtaining a *Visa* to enter *Australia*, change in *Visa* or application for permanent residency or examination for pre-employment purpose.

F3.2 In addition, *Hospital Benefits* will not include the following unless *HCF* is required to pay *Benefits* for *Visa Compliant* Cover in accordance with the *DHA Minimum Benefits*:

(a) *Hospital Benefits* (including medical *Benefits*) for *Excluded Services* or for *Services* in respect of which the claim would not be approved for payment by *Medicare* even if the *Member* was a *Medicare Eligible Person*;
(b) experimental treatment;
(c) experimental, non-PBS Medicines and *TGA* approved *Medicines* used for a purpose other than that for which they were approved;
(d) private room accommodation supplement for same-day procedures or for overnight or same day accommodation in a public *Hospital*;
(e) respite care;
(f) *Benefits* for *Nursing Home Type Patients*;
(g) special or home nursing;
(h) hospital in the home (HITH);
(i) luxury room surcharge;
(j) donated blood and blood products;
(k) donated blood collection and storage;
(l) *Medicines* and discharge *Medicines* (including *PBS Medicines*) and other sundry supplies not directly associated with the reason for admission or that do not form part of the admitted *Episode of Care*;
(m) take home items including crutches and dressings;
(n) personal convenience items including the cost of phone calls, newspapers, magazines and beauty salon services;
(o) massage and aromatherapy services;
(p) select *Services* provided while in *Hospital* by non-hospital providers;
(q) *Benefits* where a *Service* is an *Excluded Service* for the payment of *Benefits* in a *Hospital*, and any other *Services* including medical, diagnostic, *Prosthesis* and *Medicines* received at the same time;
(r) the gap on government approved gap-permitted *Prostheses* items; and
(s) *Benefits* greater than *Minimum Benefits* for *Minimum Benefit Services* (regardless of whether required as a result of an *Accident*).

F3.3 In addition, *Extras Benefits* will not include:

(a) psychological and developmental assessments;
(b) *Services* while a *Hospital* patient except for eligible oral surgery;
(c) *Services* that had not been provided at time of claim or paid for prior to joining an eligible *Policy*;
(d) fees for completing claim forms and/or reports;
(e) *Services* received overseas or purchased from overseas including items sourced over the internet;
(f) where no specific health condition is being treated or in the absence of symptoms, illness or injury except preventative dental care;
(g) routine health checks, screening and mass immunisations, other than routine optometry or ophthalmology health checks;
(h) more than one therapy *Service* performed by the same provider in any one day; or
(i) where a provider is not in an independent *Private Practice*.

F4 MINIMUM BENEFITS

F4.1 For those *Services* specified as *Minimum Benefit Services* in the *Product Schedules*, a *Member's* costs (including private or public *Hospital* costs) may not be fully covered by the *Benefit* paid by *HCF*, and *Member*s may have to pay out of pocket costs for those *Services*.

F5 COMPENSATION DAMAGES AND PROVISIONAL PAYMENT OF CLAIMS

F5.1 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.

F5.2 As to future expenses, *Benefits* will not be payable to the extent that the moneys received by the *Member* cover these expenses.

F5.3 If a Member has not made a claim against a third party for future expenses that should have been included in the claim, *HCF* will be entitled to exercise for itself all rights of the *Member* to make the claim and the *Member* will co-operate with *HCF* and will provide *HCF* with all reasonable assistance in that regard.

G CLAIMS

G1 GENERAL

G1.1 *Benefits* are not payable in the circumstances listed in Rule F3 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* and *MBS* item numbers where applicable;

(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 *Members* or by the parent, guardian or administrator of the *Member*.

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

(a) a *Member* only where claims are paid and supported by receipts; or

(b) the *Recognised Provider* where accounts are unpaid and supported by documents providing valid claim details.

G1.7 *HCF* may pay *Benefits* by electronic funds transfer in accordance with the arrangements that it determines from time to time.

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.

PRODUCT SCHEDULE – TOP PLUS

1 PRODUCTS

This *Product Schedule* applies to Top Plus with $0 Excess or $250 Excess.

2 HOSPITAL SERVICES

2.1 PUBLIC HOSPITAL

(a) If a *Member* is admitted as a private patient to a *Public Hospital* and receives *Hospital Treatment* (other than for an *Excluded Service*), the *Benefits* payable are:

(i) for *Hospital* accommodation (including theatre, intensive care or labour ward), the *Gazetted Rates* which is determined by the state or territory health authority. This *Benefit* is higher than *Minimum Benefits* but if the *Hospital* charges more than the *Gazetted Rate*, the *Member* will have an out-of-pocket cost; and

(ii) For *PBS Medicines* that are charged by the *Public Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *PBS Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change.

(b) *Benefits* are not payable for medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.2 HCF PARTICIPATING PRIVATE HOSPITALS

If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) in an *HCF Participating Private Hospital*, the *Benefits* payable are specified in the *Hospital Contract* with that *HCF Participating Private Hospital*. This includes 100% of the agreed charge for accommodation, theatre, labour ward, disposable surgical equipment, hospital in the home services provided by the *HCF Participating Private Hospital*, allied health and therapy services and *PBS Medicines* directly related to or associated with the reason for admission for the *Hospital Treatment*. *Benefits* may be payable for non-*PBS Medicines* (excluding high cost non-*PBS Medicines*) if specified in the *Hospital Contract* with the relevant *HCF Participating Private Hospital*.

2.3 NON-PARTICIPATING HOSPITALS

(a) If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service*) at a *Non-Participating Hospital*, the *Benefits* payable are the *Minimum Benefits*. *Minimum Benefits* means *Benefits* are only payable at the *Minimum Benefit* rate (an amount set by the *Federal Government*) for *Non-Participating Hospitals*, and for surgically implanted *Prosthesis* on the *Australian Government* approved *Prosthesis List*. These *Benefits* may not cover all of your *Hospital* costs. The out-of-pocket cost could be significant.

(b) For *PBS Medicines* that are charged by the *Non-Participating Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the *Department of Health* and is subject to change.

(c) *Benefits* are not payable for theatre, intensive care, medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.4 MEDICAL SERVICES RECEIVED WHILE AN INPATIENT

(a) If a *Member* receives medical services from a *Medical Practitioner* as part of *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) at any *Hospital*, *HCF* will pay 100% of the *MBS* fee for the medical service.

(b) If a *Medical Practitioner* participates in *Medicover* or has an agreement with *HCF* in relation to the *Hospital Treatment*, *HCF* will pay an additional amount towards the medical service in accordance with the *Medicover* terms and conditions or the agreement with *HCF*.

2.5 DISCHARGE PBS PHARMACEUTICALS

(a) *Benefits* are payable for *PBS Medicines* administered to a *Member* post discharge from a *Hospital* if they form part of the *Episode of Care*.

(b) The amount of *Benefits* payable for *PBS Medicines* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* for *PBS Medicines* are subject to payment by the *Member* of the co-payment.

2.6 SURGICALLY IMPLANTED PROSTHESES

(a) *Benefits* are payable for *Prostheses* provided as part of *Hospital Treatment* if they are charged by a *Hospital* to the *Member*.

(b) For no-gap prostheses, the *Benefit* payable is the benefit amount on the *Prostheses List*. For gap-permitted prostheses, the *Benefit* payable is the minimum benefit amount on the *Prostheses List*.

2.7 NURSING HOME TYPE PATIENTS

Where a *Patient* of a *Hospital* is classified as a Nursing Home Type Patient, *Benefits* payable are:

(a) in a *Public Hospital*, the *DHA Minimum Benefit*; and

(b) in a *Private Hospital*, a set *Benefit* determined by the *Federal Government* and the *Member* will be required to make a contribution towards the cost of their *Hospital* stay.

2.8 EXCESSES

The following *Excess* option is available on Top Plus: $250 *Excess* per admission for *Hospital Treatment* up to $250 per person, per *Calendar Year*.

2.9 MINIMUM BENEFITS SERVICES

The *Minimum Benefit Services* are:

(a) Podiatric surgery (provided by an accredited podiatric surgeon)

If a *Member* receives a *Minimum Benefit Service* at an *HCF Participating Hospital*, the *Benefits* payable would be the same as those payable in a *Non-Participating Hospital* under this *Product Schedule*.

2.10 EXCLUDED SERVICES

Excluded Services are:

(a) Assisted reproductive services (e.g. IVF, GIFT);
(b) Elective cosmetic surgery;
(c) Bone marrow transplants;
(d) Stem cell transplants; or
(e) Organ transplants.

HCF will reasonably apportion the costs associated with an *Episode of Care* between the *Services* covered under this *Product* and the *Excluded Services*. HCF will pay *Benefits* for the costs apportioned to the covered *Services* and will not pay *Benefits* for the costs apportioned to the *Excluded Services*.

3 OUT OF HOSPITAL MEDICAL SERVICES

3.1 EMERGENCY DEPARTMENT FACILITY FEES

(a) *Benefits* are payable for emergency department facility fees in either a *Public Hospital* or *Private Hospital*.

(b) The amount of the *Benefits* payable is 100% of the cost charged by the *Hospital* to the *Member*, subject to a *Limit* of $200 per *Member* per attendance where the attendance did not result in a *Member* being admitted to the *Hospital*.

3.2 OUT OF HOSPITAL MEDICAL SERVICES

(a) *Benefits* are payable for *Services* provided by *Medical Practitioners* except *Allied Health Services* (other than *Optometry Services* under paragraph **3.2(b)(ii)** to a *Member* that is an *Outpatient* where the *Service* is for an item listed on the *MBS* and the *Service* would be eligible for a *Medicare Benefit* if provided to a *Medicare Eligible* Person.

(b) Subject to paragraph 3.5, the amount of *Benefits* payable is:

(i) for attendances with a general practitioner including consultations, minor procedures and consumables used,

(A) 100% of the cost charged to the *Member* if the general practitioner is part of the *HCF Network*;

(B) 100% of the *MBS* fee for that item if the general practitioner is not part of the *HCF Network*;

(ii) for attendances with an optometrist for *MBS* item numbers 10905 to 10915 (inclusive) (Optometry Service), a *Benefit* set out in the *Benefits Schedule* for the Optometry Service is payable subject to a Limit of one Optometry Service every 3 years from the date of the previous Optometry Service;

(iii) for pathology and radiology services such as blood tests, scans and x-rays, 100% of the *MBS* fee for the relevant *MBS* item number; and

(iv) for all other attendances with a *Medical Practitioner* that are not referred to above, 100% of the *MBS* fee for the relevant MBS *item* number.

3.3 OUTPATIENT MEDICINE

(a) *Benefits* are payable for *PBS Medicines* prescribed to a *Member* that is an *Outpatient* including at a medical practice or emergency department.

(b) Subject to paragraph 3.5, the amount of the *Benefits* payable for the *PBS Medicine* is the *PBS* listed price for the *Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* are subject to:

(i) payment by the *Member* of the co-payment;

(ii) a Limit of $100 per *PBS Medicine*; and

(iii) a Limit of $500 for all *PBS Medicines* per *Member* per *Calendar Year*.

3.4 AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* to a *Hospital* where this would not otherwise be covered by third party arrangements. This includes inter-*Hospital* transfers that are necessary because the original *Hospital* does not have the required clinical facilities.

(b) The amount of the *Benefits* is 100% of the cost charged to the *Member*.

3.5 RHC RECIPIENTS

(a) If a *Member* is an *RHC Recipient*, the amount of the *Benefits* payable for a medical *Service* or *PBS Medicine* under paragraphs 3.2 and 3.3 is the difference between the amount that would otherwise be payable under those paragraphs and the amount of *Medicare Benefits* paid or payable for that *Service* or *PBS Medicine*. If the difference is zero then no *Benefits* are payable.

(b) *Benefits* are subject to the *RHC Recipient* first making a claim to the Department of Human Services for *Medicare Benefits*.

3.6 CHARGED LESS THAN MBS FEE

Where *HCF* is required to pay 100% of the *MBS* fee for a *Service* under this *Product Schedule* and the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.

4 EXTRAS

4.1 DENTAL

(a) *Benefits* are payable for dental services that are specified in the *Benefits Schedule* and provided by a dentist or, where applicable, a dental prosthetist, who is a *Recognised Provider*.

(b) The amount of *Benefits* payable is set out in the *Benefits Schedule* or if the dentist is a More For Teeth provider and the *Service* is covered under the More For Teeth terms and conditions, the amount set out under those terms.

(c) *Benefits* are subject to the *Service* or *Benefit Limit*s per *Member* over the relevant period detailed below and for *Benefits* payable under the More for Teeth program, two examinations and scale & cleans per *Member* per *Calendar Year* except for fluoride treatment which is one Service per *Member* per Calendar Year.

SERVICE		SERVICE LIMIT	RELEVANT PERIOD
Diagnostic	Examinations (check-ups)	*2 Services*	*1 Calendar Year*
Preventative	Single film x-rays	*4 Services* per day and *20 Services* per *Calendar Year*	
	Removal of plaque/ calculus (scale and clean)	*2 Services*	
	Application of fluoride	*1 Service*	
Direct Fillings		$1,200 subject to lifetime *Limit* for orthodontic services^	*1 Calendar Year*
Extractions			
Indirect Fillings			
Surgical Extractions			
Periodontics			
Endodontics			
Veneers			
Crowns & Bridges			
Occlusal Therapy			
Orthodontic Services			
Dentures			1 *Service* every 3 years from the date of previous *Service*

^ The Benefit Limit for orthodontic services provided by an orthodontist is subject to a Limit of $2,400 during a Member's lifetime and a sub-limit of $1,200 for orthodontic services provided by other dentist during a Member's lifetime.

4.2 OPTICAL

(a) *Benefits* are payable for frames, lenses and contact lenses:

(i) for which there is a *Benefit* specified in the *Benefits* Schedule;

(ii) that are prescribed by an optometrist or ophthalmologist who is a *Recognised Provider*; and

(iii) supplied by an optometrist, ophthalmologist or optical dispenser who is a *Recognised Provider*.

(b) The amount of *Benefits* payable is set out in the *Benefits Schedule* or if the optometrist or ophthalmologist is a More For Eyes provider and the *Service* is covered under the More For Eyes terms and conditions, the amount set out under those terms.

(c) *Benefits* are subject to a *Benefit Limit* of $250 per *Member* per *Calendar Year*.

4.3 PHYSIOTHERAPY/EXERCISE PHYSIOLOGY

(a) *Benefits* are payable for physiotherapy services that are specified in the *Benefits Schedule* and provided by a physiotherapist who is a *Recognised Provider* (*Physiotherapy Services*). *Benefits* are payable for exercise physiology services that are specified in the *Benefits Schedule* and provided by an exercise physiologist who is a *Recognised Provider* (Exercise Physiology Services).

(b) The amount of *Benefits* payable for Physiotherapy Services and Exercise Physiology Services is set out in the *Benefits* Schedule and if the physiotherapist is a More For Muscles provider and the *Service* is covered under the More For Muscles terms and conditions, the amount set out under those terms.

(c) *Benefits* are subject to a combined *Benefit Limit* of $600 per *Member* per *Calendar Year* and for *Benefits* payable under the More for Muscles program, a *Service Limit* of one *Initial Consultation* per *Member* per *Calendar Year*.

4.4 CHIROPRACTIC/OSTEOPATHY

(a) *Benefits* are payable for chiropractic services that are specified in the *Benefits Schedule* and provided by a chiropractor who is a *Recognised Provider* (Chiropractic Services). *Benefits* are payable for osteopathy services that are specified in the *Benefits Schedule* and provided by an osteopath who is a *Recognised Provider* (Osteopathy Services).

(b) The amount of *Benefits* payable for Chiropractic Services and Osteopathy Services are set out in the *Benefits Schedule* or if the chiropractor or osteopath is a More For Backs provider and the *Service* is covered under the More For Backs terms and conditions, the amount set out under those terms.

(c) *Benefits* are subject to:

(i) a combined *Benefit Limit* of $500 per *Member* per *Calendar Year* and a further *Limit* of $1,000 for all *Members* on a *Policy* per *Calendar Year*; and

(ii) for *Benefits* payable under the More for Backs program, a *Service Limit* of one *Initial Consultation* for Chiropractic Services and one *Initial Consultation* for Osteopathy Services per *Member* per *Calendar Year*.

4.5 NATURAL THERAPIES

a) Remedial Massage

Benefits are payable for remedial massage services that are specified in the *Benefits Schedule* and provided by a massage therapist who is a *Recognised Provider*. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $250 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $450 per *Member* per *Calendar Year* for remedial massage, myotherapy, acupuncture and Chinese herbal medicine. (**Natural Therapies**).

b) Myotherapy

Benefits are payable for myotherapy services that are specified in the *Benefits Schedule* and provided by a myotherapist who is a *Recognised Provider*. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $250 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $450 per *Member* per *Calendar Year* for Natural Therapies.

c) Acupuncture

Benefits are payable for Acupuncture services that are specified in the *Benefits Schedule* and provided by an acupuncturist who is a *Recognised Provider*. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $250 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $450 per *Member* per *Calendar Year* for Natural Therapies.

d) Chinese Herbal Medicine

Benefits are payable for Chinese herbal medicine consultations that are specified in the *Benefits Schedule* and provided by a Chinese herbal medicine practitioner who is a *Recognised Provider*. No *Benefits* are payable for herbal medicines, supplements, vitamins or other consumables. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $250 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $450 per *Member* per *Calendar Year* for Natural Therapies.

4.6 OTHER THERAPIES

a) Podiatry

Benefits are payable for podiatry services that are specified in the *Benefits Schedule* and provided by a podiatrist who is a *Recognised Provider*. The amount of *Benefits* payable is set out in the *Benefits Schedule* or if the podiatrist is a More For Feet provider and the *Service* is covered under the More For Feet terms and conditions, the amount set out under those terms.

Benefits are subject to a combined *Benefit Limit* of $250 per *Member* per *Calendar Year* for podiatry services, foot orthotics, and dietetics, and for *Benefits* payable under the More for Feet program, a *Service Limit* of one *Initial Consultation* per *Member* per *Calendar Year*.

b) Foot orthotics

Benefits are payable for orthotics (in-shoe appliances) that are not custom made if they are supplied by a podiatrist, pedorthist, orthotist, sports physician, physiotherapist, occupational therapist, chiropractor or osteopath who is a *Recognised Provider*. *Benefits* are only payable for custom made orthotics if they have been fitted and supplied by a podiatrist, orthotist or pedorthist who is a *Recognised Provider* following a biomechanical examination, gait analysis, negative or positive model or cast or 3D scan of the *Member's* feet.

The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $150 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $250 per *Member* per *Calendar Year* for podiatry services, foot orthotics and dietetics.

c) Dietetics

Benefits are payable for dietetic services that are specified in the *Benefits Schedule* and provided by a dietician who is a *Recognised Provider*.

The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a combined *Benefit Limit* of $250 per *Member* per *Calendar Year* for podiatry services, foot orthotics, and dietetics.

5 ADDITIONAL SERVICES

5.1 MEDICAL REPATRIATION

Benefits are payable for medical repatriation costs associated with returning a *Member* to their *Country of Origin* when:

(a) it is deemed medically necessary by a *Medical Practitioner* appointed by *HCF*;

(b) the *Member* is suffering from severe disability or serious permanent incapacity such that they cannot function without continuous support from a carer or mechanical assistance to sustain life; and

(c) this is caused by a medical condition for which the *Member* has received, or would be eligible to receive, *Hospital Benefits*.

Costs may include airfares, on-board stretcher, accompanying aero-medical specialists and nursing staff costs. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $110,000 for all the medical repatriation costs.

5.2 RETURN OF MORTAL REMAINS OR FUNERAL EXPENSES

Benefits are payable for the costs of returning a deceased *Member's* mortal remains or ashes to their *Country of Origin* or the funeral expenses of a deceased *Member* if the body is buried or cremated in *Australia*, if the death is caused by a medical condition for which the *Member* would have been eligible to receive *Hospital Benefits*. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $20,000 for all costs of returning the mortal remains or funeral expenses.

PRODUCT SCHEDULE – TOP

1 PRODUCTS

This *Product Schedule* applies to Top with $0 Excess or $250 Excess..

2 HOSPITAL SERVICES

2.1 PUBLIC HOSPITAL

(a) If a *Member* is admitted as a private patient to a *Public Hospital* and receives *Hospital Treatment* (other than for an *Excluded Service*), the *Benefits* payable are:

(i) for *Hospital* accommodation (including theatre, intensive care or labour ward), the *Gazetted Rates*, which is determined by the state or territory health authority. (This *Benefit* is higher than *Minimum Benefits* but if the Hospital charges more than the *Gazetted Rate*, the *Member* will have an out-of-pocket cost; and

(ii) for *PBS Medicines* that are charged by the *Public Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *PBS Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change.

(b) *Benefits* are not payable for medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.2 HCF PARTICIPATING PRIVATE HOSPITALS

If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit* Service) in an *HCF Participating Private Hospital*, the *Benefits* payable are specified in the *Hospital Contract* with that *HCF Participating Private Hospital*. This includes 100% of the agreed charge for accommodation, theatre, labour ward, disposable surgical equipment, hospital in the home services provided by the *HCF Participating Private Hospital*, allied health and therapy services and *PBS Medicines* directly related to or associated with the reason for admission for the *Hospital Treatment*. *Benefits* may be payable for non-*PBS Medicines* (excluding high cost non-*PBS Medicines*) if specified in the *Hospital Contract* with the relevant *HCF Participating Private Hospital*.

2.3 NON-PARTICIPATING HOSPITALS

(a) If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service*) at a *Non-Participating Hospital*, the *Benefits* payable are the *Minimum Benefits*. *Minimum Benefits* means *Benefits* are only payable at the *Minimum Benefit* rate (an amount set by the Federal Government) for *Non-Participating Hospitals*, and for surgically implanted *Prosthesis* on the Australian Government approved *Prosthesis List*. These *Benefits* may not cover all of your *Hospital* costs. The out-of-pocket cost could be significant.

(b) For *PBS Medicines* that are charged by the *Non-Participating Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change.

(c) *Benefits* are not payable for theatre, intensive care, medicines that are not PBS Medicines or for Allied Health Services.

2.4 MEDICAL SERVICES RECEIVED WHILE AN INPATIENT

(a) If a *Member* receives medical services from a *Medical Practitioner* as part of *Hospital Treatment* (other than for an *Excluded Service* or *Minimum Benefit Services*) at any *Hospital*, *HCF* will pay 100% of the *MBS* fee for the medical service.

(b) If a *Medical Practitioner* participates in *Medicover* or has an agreement with *HCF* in relation to the *Hospital Treatment*, *HCF* will pay an additional amount towards the medical service in accordance with the *Medicover* terms and conditions or the agreement with *HCF*.

2.5 DISCHARGE PBS PHARMACEUTICALS

(a) *Benefits* are payable for *PBS Medicines* administered to a *Member* post discharge from a *Hospital* if they form part of the *Episode of Care*.

(b) The amount of *Benefits* payable for *PBS Medicines* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* for *PBS Medicines* are subject to payment by the *Member* of the co-payment.

2.6 SURGICALLY IMPLANTED PROSTHESES

(a) *Benefits* are payable for *Prostheses* provided as part of *Hospital Treatment* if they are charged by a *Hospital* to the *Member*.

(b) For no-gap prostheses, the *Benefit* payable is the benefit amount on the *Prostheses List*. For gap-permitted prostheses, the *Benefit* payable is the minimum benefit amount on the *Prostheses List*.

2.7 NURSING HOME TYPE PATIENTS

Where a *Patient* of a *Hospital* is classified as a *Nursing Home Type Patient*, *Benefits* payable are:

(a) in a *Public Hospital*, the *DHA Minimum Benefit*; and

(b) in a *Private Hospital*, a set benefit determined by the Federal Government and the *Member* will be required to make a contribution towards the cost of their *Hospital* stay.

2.8 EXCESSES

The following *Excess* option is available on Top: $250 *Excess* per admission for *Hospital Treatment* up to $250 per person, per *Calendar Year*.

2.9 MINIMUM BENEFITS SERVICES

The *Minimum Benefit Services* are:

(a) Podiatric surgery (provided by an accredited podiatric surgeon).

(b) Gastric banding and obesity surgery.

If a *Member* receives a *Minimum Benefit Service* at an *HCF Participating Hospital*, the *Benefits* payable would be the same as those payable in a *Non-Participating Hospital* under this *Product Schedule*.

2.10 EXCLUDED SERVICES

Excluded Services are:

(a) Assisted reproductive services (e.g. IVF, GIFT);

(b) Elective cosmetic surgery;

(c) Bone marrow transplants;

(d) Stem cell transplants; or

(e) Organ transplants.

HCF will reasonably apportion the costs associated with an *Episode of Care* between the *Services* covered under this *Product* and the *Excluded Services*. HCF will pay *Benefits* for the costs apportioned to the covered *Services* and will not pay *Benefits* for the costs apportioned to the *Excluded Services*.

3 OUT OF HOSPITAL MEDICAL SERVICES

3.1 EMERGENCY DEPARTMENT FACILITY FEES

(a) *Benefits* are payable for emergency department facility fees in either a *Public Hospital* or *Private Hospital*.

(b) The amount of the *Benefits* payable is 100% of the cost charged by the *Hospital* to the *Member*, subject to a *Limit* of $200 per *Member* per attendance where the attendance did not result in a *Member* being admitted to the *Hospital*.

3.2 OUT OF HOSPITAL MEDICAL SERVICES

(a) *Benefits* are payable for *Services* provided by *Medical Practitioners* except *Allied Health Services* (other than Optometry Services under paragraph **3.2(b)(ii)** to a *Member* that is an *Outpatient* where the *Service* is for an item listed on the *MBS* and the *Service* would be eligible for a *Medicare Benefit* if provided to a *Medicare Eligible Person*.

(b) Subject to paragraph 3.5, the amount of *Benefits* payable is:

(i) for attendances with a general practitioner including consultations, minor procedures and consumables used,

(A) 100% of the cost charged to the *Member* if the general practitioner is part of the *HCF Network*;

(B) 100% of the *MBS* fee for that item if the general practitioner is not part of the *HCF Network*;

(ii) for attendances with an optometrist for *MBS* item numbers 10905 to 10915 (inclusive) (Optometry Service), a *Benefit* set out in the *Benefits Schedule* for the Optometry Service is payable subject to a *Limit* of one Optometry Service every 3 years from the date of the previous Optometry Service;

(iii) for pathology and radiology services such as blood tests, scans and x-rays, 100% of the *MBS* fee for the relevant *MBS* item number; and

(iv) for all other attendances with a *Medical Practitioner* that are not referred to above, 100% of the *MBS* fee for the relevant *MBS* item number.

3.3 OUTPATIENT MEDICINE

(a) *Benefits* are payable for *PBS Medicines* prescribed to a *Member* that is an *Outpatient* including at a medical practice or emergency department.

(b) Subject to paragraph 3.5, the amount of the *Benefits* payable for the *PBS Medicine* is the *PBS* listed price for the *Medicine* minus the amount of the current *PBS* general patient co-payment. Benefits are subject to:

(i) payment by the *Member* of the co-payment;

(ii) a *Limit* of $100 per *PBS Medicine*; and

(iii) a *Limit* of $250 for all *PBS Medicines* per *Member* per *Calendar Year*.

3.4 AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* to a *Hospital* where this would not otherwise be covered by third party arrangements. This includes inter-*Hospital* transfers that are necessary because the original *Hospital* does not have the required clinical facilities.

(b) The amount of the *Benefits* is 100% of the cost charged to the *Member*.

3.5 RHC RECIPIENTS

(a) If a *Member* is an *RHC Recipient*, the amount of the *Benefits* payable for a medical *Service* or *PBS Medicine* under paragraphs 3.2 and 3.3 is the difference between the amount that would otherwise be payable under those paragraphs and the amount of *Medicare Benefits* paid or payable for that *Service* or *PBS Medicine*. If the difference is zero then no *Benefits* are payable.

(b) *Benefits* are subject to the *RHC Recipient* first making a claim to the Department of Human Services for *Medicare Benefits*.

3.6 CHARGED LESS THAN MBS FEE

Where *HCF* is required to pay 100% of the *MBS* fee for a *Service* under this *Product Schedule* and the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.

4 EXTRAS

4.1 DENTAL

(a) *Benefits* are payable for dental services that are specified in the *Benefits Schedule* and provided by a dentist or, where applicable, a dental prosthetist, who is a *Recognised Provider*.

(b) The amount of *Benefits* payable is set out in the *Benefits Schedule* or if the dentist is a More For Teeth provider and the *Service* is covered under the More For Teeth terms and conditions, the amount set out under those terms.

(c) *Benefits* are subject to the *Service* or *Benefit Limits* per *Member* over the relevant period detailed below and for *Benefits* payable under the More for Teeth program, two examinations and scale & cleans per *Member* per *Calendar Year* except for fluoride treatment which is one *Service* per *Member* per *Calendar Year*.

SERVICE		SERVICE LIMIT	BENEFIT LIMIT
Diagnostic	Examinations (check-ups)	2 *Services* per *Calendar Year*	$600 per *Calendar Year*
Preventative	Single film x-rays	4 *Services* per day and 20 *Services* per *Calendar Year*	
	Removal of plaque/ calculus (scale and clean)	2 *Services* per *Calendar Year*	
	Application of fluoride	1 *Service* per *Calendar Year*	
Direct Fillings			
Extractions			
Indirect Fillings			
Surgical Extractions			
Periodontics			
Endodontics			
Veneers			
Crowns & bridges			
Dentures		1 *Service* every 3 years from the date of previous *Service*	

4.2 OPTICAL

(a) *Benefits* are payable for frames, lenses and contact lenses:

(i) for which there is a *Benefit* specified in the *Benefits Schedule*;

(ii) that are prescribed by an optometrist or ophthalmologist who is a *Recognised Provider*; and

(iii) supplied by an optometrist, ophthalmologist or optical dispenser who is a *Recognised Provider*.

(b) The amount of *Benefits* payable is set out in the *Benefits Schedule* or if the optometrist or ophthalmologist is a More For Eyes provider and the *Service* is covered under the More For Eyes terms and conditions, the amount set out under those terms.

(c) *Benefits* are subject to a *Benefit Limit* of $150 per *Member* per *Calendar Year*.

4.3 THERAPIES

a) Physiotherapy

(i) *Benefits* are payable for physiotherapy services that are specified in the *Benefits Schedule* and provided by a physiotherapist who is a *Recognised Provider* (Physiotherapy Services).

(ii) The amount of *Benefits* payable for Physiotherapy Services is set out in the *Benefits Schedule* and if the physiotherapist is a More For Muscles provider and the *Service* is covered under the More For Muscles terms and conditions, the amount set out under those terms.

(iii) *Benefits* are subject to:

(A) a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for physiotherapy, exercise physiology, chiropractic, osteopathy, remedial massage, myotherapy, acupuncture and Chinese herbal medicine (**Therapies** & **Natural Therapies**); and

(B) for *Benefits* payable under the More for Muscles program, a *Service Limit* of one *Initial Consultation* per *Member* per *Calendar Year*.

b) Exercise Physiology

(i) *Benefits* are payable for exercise physiology services that are specified in the *Benefits Schedule* and provided by an exercise physiologist who is a *Recognised Provider* (Exercise Physiology Services).

(ii) The amount of *Benefits* payable for *Exercise Physiology Services* is set out in the *Benefits Schedule*.

(iii) *Benefits* are subject to a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for Therapies & Natural Therapies.

c) Chiropractic

(i) *Benefits* are payable for chiropractic services that are specified in the *Benefits Schedule* and provided by a chiropractor who is a *Recognised Provider* (Chiropractic Services).

(ii) The amount of *Benefits* payable for Chiropractic Services are set out in the *Benefits Schedule* or if the chiropractor is a More For Backs provider and the *Service* is covered under the More For Backs terms and conditions, the amount set out under those terms.

(iii) *Benefits* are subject to:

(A) a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for Therapies & Natural Therapies; and

(B) for *Benefits* payable under the More for Backs program, a *Service Limit* of one *Initial Consultation* for Chiropractic Services per *Member* per *Calendar Year*.

d) Osteopathy

(i) *Benefits* are payable for osteopathy services that are specified in the *Benefits Schedule* and provided by an osteopath who is a *Recognised Provider* (Osteopathy Services).

(ii) The amount of *Benefits* payable for Osteopathy Services are set out in the *Benefits Schedule* or if the osteopath is a More For Backs provider and the *Service* is covered under the More For Backs terms and conditions, the amount set out under those terms.

(iii) *Benefits* are subject to:

(A) a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for Therapies & Natural Therapies; and

(B) for *Benefits* payable under the More for Backs program, a *Service Limit* of one *Initial Consultation* for Osteopathy Services per *Member* per Calendar Year.

4.4 NATURAL THERAPIES

a) Remedial Massage

Benefits are payable for remedial massage services that are specified in the *Benefits Schedule* and provided by a massage therapist who is a *Recognised Provider*. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $150 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for Therapies & Natural Therapies.

b) Myotherapy

Benefits are payable for myotherapy services that are specified in the *Benefits Schedule* and provided by a myotherapist who is a *Recognised Provider*. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $150 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for Therapies & Natural Therapies.

c) Acupuncture

Benefits are payable for Acupuncture services that are specified in the *Benefits Schedule* and provided by an acupuncturist who is a *Recognised Provider*. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $150 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for Therapies & Natural Therapies.

d) Chinese herbal medicine

Benefits are payable for Chinese herbal medicine consultations that are specified in the *Benefits Schedule* and provided by a Chinese herbal medicine practitioner who is a *Recognised Provider*. No *Benefits* are payable for herbal medicines, supplements, vitamins or other consumables. The amount of *Benefits* payable is set out in the *Benefits Schedule* and is subject to a sub-limit of $150 per *Member* per *Calendar Year* and a combined *Benefit Limit* of $350 per *Member* per *Calendar Year* for Therapies & Natural Therapies.

5 ADDITIONAL SERVICES

5.1 MEDICAL REPATRIATION

Benefits are payable for medical repatriation costs associated with returning a *Member* to their *Country of Origin* when:

(a) it is deemed medically necessary by a *Medical Practitioner* appointed by *HCF*;

(b) the *Member* is suffering from severe disability or serious permanent incapacity such that they cannot function without continuous support from a carer or mechanical assistance to sustain life; and

(c) this is caused by a medical condition for which the *Member* has received, or would be eligible to receive, *Hospital Benefits*.

Costs may include airfares, on-board stretcher, accompanying aero-medical specialists and nursing staff costs. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $100,000 for all the medical repatriation costs.

5.2 RETURN OF MORTAL REMAINS OR FUNERAL EXPENSES

Benefits are payable for the costs of returning a deceased *Member's* mortal remains or ashes to their *Country of Origin* or the funeral expenses of a deceased *Member* if the body is buried or cremated in *Australia*, if the death is caused by a medical condition for which the *Member* would have been eligible to receive *Hospital Benefits*. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $15,000 for all costs of returning the mortal remains or funeral expenses.

PRODUCT SCHEDULE – MID

1 PRODUCTS

This *Product Schedule* applies to Mid with $0 *Excess*.

2 HOSPITAL SERVICES

2.1 PUBLIC HOSPITAL

(a) If a *Member* is admitted as a private patient to a *Public Hospital* and receives *Hospital Treatment* (other than for an *Excluded Service*), the *Benefits* payable are:

(i) for *Hospital* accommodation (including theatre, intensive care or labour ward), the *Gazetted Rates*, which is determined by the state or territory health authority. (This *Benefit* is higher than *Minimum Benefits* but if the *Hospital* charges more than the *Gazetted Rate*, the *Member* will have an out-of-pocket cost; and

(ii) for *PBS Medicines* that are charged by the *Public Hospital* to the *Member*, the *Benefit* payable will be 100% of the PBS listed price for that *PBS Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change.

(b) *Benefits* are not payable for medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.2 HCF PARTICIPATING PRIVATE HOSPITALS

If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) in an *HCF Participating Private Hospital*, the *Benefits* payable are specified in the *Hospital Contract* with that *HCF Participating Private Hospital*. This includes 100% of the agreed charge for accommodation, theatre, labour ward, disposable surgical equipment, hospital in the home services provided by the *HCF Participating Private Hospital*, allied health and therapy services and *PBS Medicines* directly related to or associated with the reason for admission for the *Hospital Treatment*. *Benefits* may be payable for non-*PBS Medicines* (excluding high cost non-*PBS Medicines*) if specified in the *Hospital Contract* with the relevant *HCF Participating Private Hospital*.

2.3 NON-PARTICIPATING HOSPITALS

(a) If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service*) at a *Non-Participating Hospital*, the *Benefits* payable are the *Minimum Benefits*. *Minimum Benefits* means *Benefits* are only payable at the *Minimum Benefit* rate (an amount set by the Federal Government) for *Non-Participating Hospitals*, and for surgically implanted *Prosthesis* on the Australian Government approved *Prosthesis List*. These *Benefits* may not cover all of your *Hospital* costs. The out-of-pocket cost could be significant.

For *PBS Medicines* that are charged by the *Non-Participating Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change

(b) *Benefits* are not payable for theatre, intensive care, medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.4 MEDICAL SERVICES RECEIVED WHILE AN INPATIENT

(a) If a *Member* receives medical services from a *Medical Practitioner* as part of *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) at any *Hospital*, *HCF* will pay 100% of the *MBS* fee for the medical service.

(b) If a *Medical Practitioner* participates in *Medicover* or has an agreement with *HCF* in relation to the *Hospital Treatment*, *HCF* will pay an additional amount towards the medical service in accordance with the *Medicover* terms and conditions or the agreement with *HCF*.

2.5 DISCHARGE PBS PHARMACEUTICALS

(a) *Benefits* are payable for *PBS Medicines* administered to a *Member* post discharge from a *Hospital* if they form part of the *Episode of Care*.

(b) The amount of *Benefits* payable for *PBS Medicines* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* for *PBS Medicines* are subject to payment by the *Member* of the co-payment.

2.6 SURGICALLY IMPLANTED PROSTHESES

(a) *Benefits* are payable for *Prostheses* provided as part of *Hospital Treatment* if they are charged by a *Hospital* to the *Member*.

(b) For no-gap prostheses, the *Benefit* payable is the benefit amount on the *Prostheses List*. For gap-permitted prostheses, the *Benefit* payable is the minimum benefit amount on the *Prostheses List*.

2.7 NURSING HOME TYPE PATIENTS

Where a *Patient* of a *Hospital* is classified as a *Nursing Home Type Patient*, *Benefits* payable are:

(a) in a *Public Hospital*, the *DHA Minimum Benefit*; and

(b) in a *Private Hospital*, a set benefit determined by the Federal Government and the *Member* will be required to make a contribution towards the cost of their *Hospital* stay.

2.8 EXCESSES

There are no *Excess* options.

2.9 MINIMUM BENEFITS SERVICES

The *Minimum Benefit Services* are:

(a) Podiatric surgery (provided by an accredited podiatric surgeon).

(b) Gastric banding and obesity surgery.

If a *Member* receives a *Minimum Benefit Service* at an *HCF Participating Hospital*, the *Benefits* payable would be the same as those payable in a *Non-Participating Hospital* under this *Product Schedule*.

2.10 EXCLUDED SERVICES

Excluded Services are:

(a) Assisted reproductive services (e.g. IVF, GIFT);

(b) Elective cosmetic surgery;

(c) Bone marrow transplants;

(d) Stem cell transplants; or

(e) Organ transplants.

HCF will reasonably apportion the costs associated with an *Episode of Care* between the *Services* covered under this *Product* and the *Excluded Services*. HCF will pay *Benefits* for the costs apportioned to the covered *Services* and will not pay *Benefits* for the costs apportioned to the *Excluded Services*.

3 OUT OF HOSPITAL MEDICAL SERVICES

3.1 EMERGENCY DEPARTMENT FACILITY FEES

(a) *Benefits* are payable for emergency department facility fees in either a *Public Hospital* or *Private Hospital* where the attendance results in a *Member* being admitted to the *Hospital*.

(b) The amount of the *Benefits* payable is 100% of the cost charged by the *Hospital* to the *Member* per attendance.

3.2 OUT OF HOSPITAL MEDICAL SERVICES

(a) *Benefits* are payable for *Services* provided by *Medical Practitioners* except *Allied Health Services* to a *Member* that is an *Outpatient* where the *Service* is for an item listed on the *MBS* and the *Service* would be eligible for a *Medicare Benefit* if provided to a *Medicare Eligible Person*.

(b) Subject to paragraph 4.3.4, the amount of *Benefits* payable is:

(i) for attendances with a general practitioner including consultations, minor procedures and consumables used,

(A) 100% of the cost charged to the *Member* if the general practitioner is part of the *HCF Network*;

(B) 100% of the *MBS* fee for that item if the general practitioner is not part of the *HCF Network*;

(ii) for pathology and radiology services such as blood tests, scans and x-rays, 100% of the *MBS* fee for the relevant *MBS* item number; and

(iii) for all other attendances with a *Medical Practitioner* that are not referred to above, 100% of the *MBS* fee for the relevant *MBS* item number.

3.3 OUTPATIENT MEDICINE

(a) *Benefits* are payable for *PBS Medicines* prescribed to a *Member* that is an *Outpatient* including at a medical practice or emergency department.

(b) Subject to paragraph 3.5, the amount of the *Benefits* payable for the *PBS Medicine* is the *PBS* listed price for the *Medicine* minus the amount of the current *PBS* general patient co-payment. Benefits are subject to:

(i) payment by the *Member* of the co-payment;

(ii) a Limit of $100 per *PBS Medicine*; and
(iii) a Limit of $200 for all *PBS Medicines* per *Member* per *Calendar Year*.

3.4 AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* to a *Hospital* where this would not otherwise be covered by third party arrangements. This includes inter-*Hospital* transfers that are necessary because the original *Hospital* does not have the required clinical facilities.
(b) The amount of the *Benefits* is 100% of the cost charged to the *Member*.

3.5 RHC RECIPIENTS

(a) If a *Member* is an RHC Recipient, the amount of the *Benefits* payable for a medical *Service* under paragraph 3.2 is the difference between the amount that would otherwise be payable under that paragraph and the amount of *Medicare Benefits* paid or payable for that *Service*. If the difference is zero then no *Benefits* are payable.
(b) *Benefits* are subject to the *RHC Recipient* first making a claim to the Department of Human Services for *Medicare Benefits*.

3.6 CHARGED LESS THAN MBS FEE

Where *HCF* is required to pay 100% of the *MBS* fee for a *Service* under this *Product Schedule* and the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.

3.7 NO EXTRAS BENEFITS

There are no *Extras Benefits* payable under this *Product Schedule*.

4 ADDITIONAL SERVICES

4.1 MEDICAL REPATRIATION

Benefits are payable for medical repatriation costs associated with returning a *Member* to their *Country of Origin* when:

(a) it is deemed medically necessary by a *Medical Practitioner* appointed by *HCF*;
(b) the *Member* is suffering from severe disability or serious permanent incapacity such that they cannot function without continuous support from a carer or mechanical assistance to sustain life; and
(c) this is caused by a medical condition for which the *Member* has received, or would be eligible to receive, *Hospital Benefits*.

Costs may include airfares, on-board stretcher, accompanying aero-medical specialists and nursing staff costs. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $100,000 for all the medical repatriation costs.

4.2 RETURN OF MORTAL REMAINS OR FUNERAL EXPENSES

Benefits are payable for the costs of returning a deceased *Member's* mortal remains or ashes to their *Country of Origin* or the funeral expenses of a deceased *Member* if the body is buried or cremated in *Australia*, if the death is caused by a medical condition for which the *Member* would have been eligible to receive *Hospital Benefits*. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $15,000 for all costs of returning the mortal remains or funeral expenses.

PRODUCT SCHEDULE – BASIC

1 PRODUCTS

This *Product Schedule* applies to Basic with $0 *Excess*.

2 HOSPITAL SERVICES

2.1 PUBLIC HOSPITAL

(a) If a *Member* is admitted as a private patient to a *Public Hospital* and receives *Hospital Treatment* (other than for an *Excluded Service*), the *Benefits* payable are:
(i) for *Hospital* accommodation (including theatre, intensive care or labour ward), the *Gazetted Rates*, which is determined by the state or territory health authority. (This *Benefit* is higher than *Minimum Benefits* but if the *Hospital* charges more than the *Gazetted Rate*, the *Member* will have an out-of-pocket cost; and
(ii) for *PBS Medicines* that are charged by the *Public Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *PBS Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS* medicine before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change
(b) *Benefits* are not payable for medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.2 HCF PARTICIPATING PRIVATE HOSPITALS

If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) in an *HCF Participating Private Hospital*, the *Benefits* payable are specified in the *Hospital Contract* with that *HCF Participating Private Hospital*. This includes 100% of the agreed charge for accommodation, theatre, labour ward, disposable surgical equipment, hospital in the home services provided by the *HCF Participating Private Hospital*, allied health and therapy services and *PBS Medicines* directly related to or associated with the reason for admission for the *Hospital Treatment*. *Benefits* may be payable for non-*PBS Medicines* (excluding high cost non-*PBS Medicines*) if specified in the *Hospital Contract* with the relevant *HCF Participating Private Hospital*.

2.3 NON-PARTICIPATING HOSPITALS

(a) If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service*) at a *Non-Participating Hospital*, the *Benefits* payable are the *Minimum Benefits*. *Minimum Benefits* means *Benefits* are only payable at the *Minimum Benefit* rate (an amount set by the Federal Government) for *Non-Participating Hospitals*, and for surgically implanted *Prosthesis* on the Australian Government approved *Prosthesis List*. These *Benefits* may not cover all of your *Hospital* costs. The out-of-pocket cost could be significant.
(b) For *PBS Medicines* that are charged by the *Non-Participating Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change
(c) *Benefits* are not payable for theatre, intensive care, medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.4 MEDICAL SERVICES RECEIVED WHILE AN INPATIENT

(a) If a *Member* receives medical services from a *Medical Practitioner* as part of *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) at any *Hospital*, *HCF* will pay 100% of the *MBS* fee for the medical service. Where the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.
(b) If a *Medical Practitioner* participates in *Medicover* or has an agreement with *HCF* in relation to the *Hospital Treatment*, *HCF* will pay an additional amount towards the medical service in accordance with the *Medicover* terms and conditions or the agreement with *HCF*.

2.5 DISCHARGE PBS PHARMACEUTICALS

(a) *Benefits* are payable for *PBS Medicines* administered to a *Member* post discharge from a *Hospital* if they form part of the *Episode of Care*.
(b) The amount of *Benefits* payable for *PBS Medicines* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* for *PBS Medicines* are subject to payment by the *Member* of the co-payment.

2.6 SURGICALLY IMPLANTED PROSTHESES

(a) *Benefits* are payable for *Prostheses* provided as part of *Hospital Treatment* if they are charged by a *Hospital* to the *Member*.

(b) For no-gap prostheses, the *Benefit* payable is the benefit amount on the *Prostheses List*. For gap-permitted prostheses, the *Benefit* payable is the minimum benefit amount on the *Prostheses List*.

2.7 NURSING HOME TYPE PATIENTS

Where a patient of a *Hospital* is classified as a *Nursing Home Type Patient*, benefits payable are:

(a) in a *Public Hospital*, the *DHA Minimum Benefit*; and

(b) in a *Private Hospital*, a set benefit determined by the Federal Government and the *Member* will be required to make a contribution towards the cost of their *Hospital* stay.

2.8 EXCESSES

There are no *Excess* options.

2.9 MINIMUM BENEFITS SERVICES

The *Minimum Benefit Services* are:

(a) Podiatric surgery (provided by an accredited podiatric surgeon).

(b) Gastric banding and obesity surgery.

If a *Member* receives a *Minimum Benefit Service* at an *HCF Participating Hospital*, the *Benefits* payable would be the same as those payable in a *Non-Participating Hospital* under this *Product Schedule*.

2.10 EXCLUDED SERVICES

Excluded Services are:

(a) Assisted reproductive services (e.g. IVF, GIFT);

(b) Elective cosmetic surgery;

(c) Bone marrow transplants;

(d) Stem cell transplants; or

(e) Organ transplants.

HCF will reasonably apportion the costs associated with an *Episode of Care* between the *Services* covered under this *Product* and the *Excluded Services*. HCF will pay *Benefits* for the costs apportioned to the covered *Services* and will not pay *Benefits* for the costs apportioned to the *Excluded Services*.

3 OUT OF HOSPITAL SERVICES

3.1 EMERGENCY DEPARTMENT FACILITY FEES

(a) *Benefits* are payable for emergency department facility fees in either a *Public Hospital* or *Private Hospital* where the attendance results in a *Member* being admitted to the *Hospital*.

(b) The amount of the *Benefits* payable is 100% of the cost charged by the *Hospital* to the *Member* per attendance.

3.2 AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* to a *Hospital* where this would not otherwise be covered by third party arrangements. This includes inter-*Hospital* transfers that are necessary because the original *Hospital* does not have the required clinical facilities.

(b) The amount of the *Benefits* is 100% of the cost charged to the *Member*.

3.3 CHARGED LESS THAN MBS FEE

Where *HCF* is required to pay 100% of the *MBS* fee for a *Service* under this *Product Schedule* and the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.

3.4 NO EXTRAS BENEFITS

There are no *Extras Benefits* payable under this *Product Schedule*.

4 ADDITIONAL SERVICES

4.1 MEDICAL REPATRIATION

Benefits are payable for medical repatriation costs associated with returning a *Member* to their *Country of Origin* when:

(a) it is deemed medically necessary by a *Medical Practitioner* appointed by *HCF*;

(b) the *Member* is suffering from severe disability or serious permanent incapacity such that they cannot function without continuous support from a carer or mechanical assistance to sustain life; and

(c) this is caused by a medical condition for which the *Member* has received, or would be eligible to receive, *Hospital Benefits*.

Costs may include airfares, on-board stretcher, accompanying aero-medical specialists and nursing staff costs. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $50,000 for all the medical repatriation costs.

4.2 RETURN OF MORTAL REMAINS OR FUNERAL EXPENSES

Benefits are payable for the costs of returning a deceased *Member's* mortal remains or ashes to their *Country of Origin* or the funeral expenses of a deceased *Member* if the body is buried or cremated in *Australia*, if the death is caused by a medical condition for which the *Member* would have been eligible to receive *Hospital Benefits*. The amount of the *Benefits* is the cost charged to the *Member* up to a limit of $15,000 for all costs of returning the mortal remains or funeral expenses.

PRODUCT SCHEDULE – ESSENTIALS PLUS

1 PRODUCTS

This *Product Schedule* applies to Essentials Plus with $250 *Excess*.

2 HOSPITAL SERVICES

2.1 HCF PARTICIPATING PRIVATE HOSPITALS

If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) in an *HCF Participating Private Hospital*, the *Benefits* payable are specified in the *Hospital Contract* with that *HCF Participating Private Hospital*. This includes 100% of the agreed charge for accommodation, theatre, labour ward, disposable surgical equipment, hospital in the home services provided by the *HCF Participating Private Hospital*, allied health and therapy services and *PBS Medicines* directly related to or associated with the reason for admission for the *Hospital Treatment*. *Benefits* may be payable for non-*PBS Medicines* (excluding high cost non-*PBS Medicines*) if specified in the *Hospital Contract* with the relevant *HCF Participating Private Hospital*.

2.2 NON-PARTICIPATING HOSPITALS/ PUBLIC HOSPITALS

(a) If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service*) at a *Non-Participating Hospital* or as a private patient at a *Public Hospital*, the *Benefits* payable are the *Minimum Benefits*. *Minimum Benefits* means *Benefits* are only payable at the *Minimum Benefit* rate (an amount set by the Federal Government) for *Non-Participating Hospitals*, and for surgically implanted *Prosthesis* on the Australian Government approved *Prosthesis List*. These *Benefits* may not cover all of your *Hospital* costs. The out-of-pocket cost could be significant.

(b) For *PBS Medicines* that are charged by the *Non-Participating Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change

(c) *Benefits* are not payable for medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.3 MEDICAL SERVICES RECEIVED WHILE AN INPATIENT

(a) If a *Member* receives medical services from a *Medical Practitioner* as part of *Hospital Treatment* (other than for an *Excluded Service*) at any *Hospital*, *HCF* will pay 100% of the *MBS* fee for the medical service.

(b) If a *Medical Practitioner* participates in *Medicover* or has an agreement with *HCF* in relation to the *Hospital Treatment*, *HCF* will pay an additional amount towards the medical service in accordance with the *Medicover* terms and conditions or the agreement with *HCF*.

2.4 DISCHARGE PBS PHARMACEUTICALS

(a) *Benefits* are payable for *PBS Medicines* administered to a *Member* post discharge from a *Hospital* if they form part of the *Episode of Care*.

(b) The amount of *Benefits* payable for *PBS Medicines* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* for *PBS Medicines* are subject to:

(i) payment by the *Member* of the co-payment;

(ii) a *Limit* of $100 per *PBS Medicine*; and

(iii) a further *Limit* of $300 for all *PBS Medicines* per *Member* per *Calendar Year* including *PBS Medicines* prescribed as an *Outpatient* under paragraph 6.3.3.

2.5 SURGICALLY IMPLANTED PROSTHESES

(a) *Benefits* are payable for *Prostheses* provided as part of *Hospital Treatment* if they are charged by a *Hospital* to the *Member*.

(b) For no-gap prostheses, the *Benefit* payable is the benefit amount on the *Prostheses List*. For gap-permitted prostheses, the *Benefit* payable is the minimum benefit amount on the *Prostheses List*.

2.6 NURSING HOME TYPE PATIENTS

Where a *Patient* of a *Hospital* is classified as a *Nursing Home Type Patient*, *Benefits* are no longer payable and the *Member* will be required to cover the cost of their *Hospital* stay.

2.7 EXCESSES

The following *Excess* option is available on Essentials Plus: $250 Excess per admission for *Hospital Treatment* up to $250 per person, per *Calendar Year*.

2.8 MINIMUM BENEFITS SERVICES

The *Minimum Benefit Services* are:

(a) Cataract and other lens related surgery.

If a *Member* receives a Minimum Benefit Service at an *HCF* Participating Hospital, the Benefits payable would be the same as those payable in a *Non-Participating Hospital* under this *Product Schedule*.

2.9 EXCLUDED SERVICES

Excluded Services are:

(a) Pregnancy and birth related services;
(b) Assisted reproductive services (e.g. IVF, GIFT);
(c) Sterilisations and reversals;
(d) Elective cosmetic surgery;
(e) Renal dialysis;
(f) Gastric banding and obesity surgery;
(g) Bone marrow transplants;
(h) Stem cell transplants;
(i) Organ transplants;
(j) Psychiatric services; or
(k) Podiatric surgery

HCF will reasonably apportion the costs associated with an *Episode of Care* between the *Services* covered under this *Product* and the *Excluded Services*. HCF will pay *Benefits* for the costs apportioned to the covered *Services* and will not pay *Benefits* for the costs apportioned to the *Excluded Services*.

3 OUT OF HOSPITAL MEDICAL SERVICES

3.1 EMERGENCY DEPARTMENT FACILITY FEES

(a) *Benefits* are payable for emergency department facility fees in either a *Public Hospital* or *Private Hospital*.
(b) The amount of the *Benefits* payable for the cost charged by the *Hospital* to the *Member* is subject to a *Limit* of $200 per *Member* per attendance (whether or not the attendance resulted in a *Member* being admitted to the *Hospital*).

3.2 OUT OF HOSPITAL MEDICAL SERVICES

(a) *Benefits* are payable for *Services* provided by *Medical Practitioners* except *Allied Health Services* to a *Member* that is an *Outpatient* where the *Service* is for an item listed on the *MBS* and the *Service* would be eligible for a Medicare *Benefit* if provided to a *Medicare Eligible Person*.
(b) Subject to paragraph 6.3.5, the amount of *Benefits* payable is:
  (i) for attendances with a general practitioner including consultations, minor procedures and consumables used,
    (A) 100% of the cost charged to the *Member* if the general practitioner is part of the *HCF Network*;
    (B) 100% of the *MBS* fee for that item if the general practitioner is not part of the *HCF* Network;
  (ii) for pathology and radiology services such as blood tests, scans and x-rays, 100% of the MBS fee for the relevant MBS item number; and
  (iii) for all other attendances with a *Medical Practitioner* that are not referred to above, 100% of the *MBS* fee for the relevant *MBS* item number.

3.3 OUTPATIENT MEDICINE

(a) *Benefits* are payable for *PBS Medicines* prescribed to a *Member* that is an *Outpatient* including at a medical practice or emergency department.
(b) Subject to paragraph 3.5, the amount of the *Benefits* payable for the *PBS Medicine* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* are subject to:
  (i) payment by the *Member* of the co-payment;
  (ii) a *Limit* of $100 per *PBS Medicine*; and
  (iii) a further *Limit* of $300 for all *PBS Medicines* per *Member* per *Calendar Year* including *PBS Medicines* prescribed post discharge from a *Hospital* under paragraph 2.4.

3.4 AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* to a *Hospital* where this would not otherwise be covered by third party arrangements.
(b) The amount of the *Benefits* is 100% of the cost charged to the *Member*.

3.5 RHC RECIPIENTS

(a) If a *Member* is an *RHC* Recipient, the amount of the *Benefits* payable for a medical *Service* or *PBS Medicine* under paragraphs 3.2 and 3.3 is the difference between the amount that would otherwise be payable under those paragraphs and the amount of *Medicare Benefits* paid or payable for that *Service* or *PBS Medicine*. If the difference is zero then no *Benefits* are payable.
(b) *Benefits* are subject to the *RHC Recipient* first making a claim to the Department of Human Services for *Medicare Benefits*.

3.6 CHARGED LESS THAN MBS FEE

Where *HCF* is required to pay 100% of the *MBS* fee for a *Service* under this *Product Schedule* and the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.

3.7 NO EXTRAS BENEFITS

There are no *Extras Benefits* payable under this *Product Schedule*.

PRODUCT SCHEDULE – ESSENTIALS

1 PRODUCTS

This *Product Schedule* applies to Essentials with $250 *Excess*.

2 HOSPITAL SERVICES

2.1 HCF PARTICIPATING PRIVATE HOSPITALS

If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit* Service) in an *HCF Participating Private Hospital*, the *Benefits* payable are specified in the *Hospital Contract* with that *HCF Participating Private Hospital*. This includes 100% of the agreed charge for accommodation, theatre, labour ward, disposable surgical equipment, hospital in the home services provided by the *HCF Participating Private Hospital*, allied health and therapy services and *PBS Medicines* directly related to or associated with the reason for admission for the *Hospital Treatment*. *Benefits* may be payable for non-*PBS Medicines* (excluding high cost non-*PBS Medicines*) if specified in the *Hospital Contract* with the relevant *HCF Participating Private Hospital*.

2.2 NON-PARTICIPATING HOSPITALS/ PUBLIC HOSPITALS

(a) If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service*) at a *Non-Participating Hospital* or as a private patient at a *Public Hospital*, the *Benefits* payable are the *Minimum Benefits*. *Minimum Benefits* means benefits are only payable at the *Minimum Benefit* rate (an amount set by the *Federal Government*) for *Non-Participating Hospitals*, and for surgically implanted *Prosthesis* on the Australian Government approved *Prosthesis List*. These *Benefits* may not cover all of your *Hospital* costs. The out-of-pocket cost could be significant.

  For *PBS Medicines* that are charged by the *Non-Participating Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change
(b) *Benefits* are not payable for medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.3 MEDICAL SERVICES RECEIVED WHILE AN INPATIENT

(a) If a *Member* receives medical services from a *Medical Practitioner* as part of *Hospital Treatment* (other than for an *Excluded Service*) at any *Hospital*, *HCF* will pay 100% of the *MBS* fee for the medical service.
(b) If a *Medical Practitioner* participates in *Medicover* or has an agreement with *HCF* in relation to the *Hospital Treatment*, *HCF* will pay an additional amount towards the medical service in accordance with the *Medicover* terms and conditions or the agreement with *HCF*.

2.4 DISCHARGE PBS PHARMACEUTICALS

(a) *Benefits* are payable for *PBS Medicines* administered to a *Member* post discharge from a *Hospital* if they form part of the *Episode of Care*.
(b) The amount of *Benefits* payable for *PBS Medicines* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* for *PBS Medicines* are subject to:
  (i) payment by the *Member* of the co-payment;
  (ii) a *Limit* of $100 per *PBS Medicine*; and
  (iii) a further *Limit* of $250 for all *PBS Medicines* per *Member* per *Calendar Year* including *PBS Medicines* prescribed as an *Outpatient* under paragraph 3.3.

2.5 SURGICALLY IMPLANTED PROSTHESES

(a) *Benefits* are payable for *Prostheses* provided as part of *Hospital Treatment* if they are charged by a *Hospital* to the *Member*.
(b) For no-gap prostheses, the *Benefit* payable is the benefit amount on the *Prostheses List*. For gap-permitted prostheses, the *Benefit* payable is the minimum benefit amount on the *Prostheses List*.

2.6 NURSING HOME TYPE PATIENTS

Where a *Patient* of a *Hospital* is classified as a *Nursing Home Type Patient*, Benefits are no longer payable and the *Member* will be required to cover the cost of their *Hospital* stay.

2.7 EXCESSES

The following *Excess* option is available on Essentials: $250 Excess per admission for *Hospital Treatment* up to $250 per person, per *Calendar Year*.

2.8 MINIMUM BENEFITS SERVICES

The *Minimum Benefit Services* are:

(a) Hip/knee joint replacement surgery; and
(b) Heart surgery including diagnostic and therapeutic cardiac procedures.

If a *Member* receives a *Minimum Benefit Service* at an *HCF Participating Hospital*, the *Benefits* payable would be the same as those payable in a *Non-Participating Hospital* under this *Product Schedule*.

2.9 EXCLUDED SERVICES

Excluded Services are:

(a) Pregnancy and birth related services;
(b) Assisted reproductive services (e.g. IVF, GIFT);
(c) Sterilisations and reversals;
(d) Cataract & other lens related surgery;
(e) Elective cosmetic surgery;
(f) Renal dialysis;
(g) Gastric banding and obesity surgery;
(h) Bone marrow transplants;
(i) Stem cell transplants;
(j) Organ transplants;
(k) Psychiatric services; or
(l) Podiatric surgery

HCF will reasonably apportion the costs associated with an *Episode of Care* between the *Services* covered under this *Product* and the *Excluded Services*. HCF will pay *Benefits* for the costs apportioned to the covered *Services* and will not pay *Benefits* for the costs apportioned to the *Excluded Services*.

3 OUT OF HOSPITAL MEDICAL SERVICES

3.1 EMERGENCY DEPARTMENT FACILITY FEES

(a) *Benefits* are payable for emergency department facility fees in either a *Public Hospital* or *Private Hospital*.
(b) The amount of the *Benefits* payable for the cost charged by the *Hospital* to the *Member* is subject to a *Limit* of $200 per *Member* per attendance (whether or not the attendance resulted in a *Member* being admitted to the *Hospital*).

3.2 OUT OF HOSPITAL MEDICAL SERVICES

(a) *Benefits* are payable for *Services* provided by *Medical Practitioners* except *Allied Health Services* to a *Member* that is an *Outpatient* where the *Service* is for an item listed on the *MBS* and the *Service* would be eligible for a *Medicare Benefit* if provided to a *Medicare Eligible Person*.
(b) Subject to paragraph 7.3.5, the amount of *Benefits* payable is:
  (i) or attendances with a general practitioner including consultations, minor procedures and consumables used,
    (A) 100% of the cost charged to the *Member* if the general practitioner is part of the *HCF Network*;
    (B) 100% of the *MBS* fee for that item if the general practitioner is not part of the *HCF Network*;
  (ii) for pathology and radiology services such as blood tests, scans and x-rays, 100% of the *MBS* fee for the relevant *MBS* item number; and
  (iii) for all other attendances with a *Medical Practitioner* that are not referred to above, 100% of the *MBS* fee for the relevant *MBS* item number.

3.3 OUTPATIENT MEDICINE

(a) *Benefits* are payable for *PBS Medicines* prescribed to a *Member* that is an *Outpatient* including at a medical practice or emergency department.
(b) Subject to paragraph 3.5, the amount of the *Benefits* payable for the *PBS Medicine* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* are subject to:
  (i) payment by the *Member* of the co-payment;
  (ii) a Limit of $100 per *PBS Medicine*; and
  (iii) a further *Limit* of $250 for all *PBS Medicines* per *Member* per *Calendar Year* including *PBS Medicines* prescribed post discharge from a *Hospital* under paragraph 2.4.

3.4 AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* to a *Hospital* where this would not otherwise be covered by third party arrangements.
(b) The amount of the *Benefits* is 100% of the cost charged to the *Member*.

3.5 RHC RECIPIENTS

(a) If a *Member* is an *RHC Recipient*, the amount of the *Benefits* payable for a medical *Service* or *PBS Medicine* under paragraphs 3.2 and 3.3 is the difference between the amount that would otherwise be payable under those paragraphs and the amount of *Medicare Benefits* paid or payable for that *Service* or *PBS Medicine*. If the difference is zero then no *Benefits* are payable.
(b) *Benefits* are subject to the *RHC Recipient* first making a claim to the Department of Human Services for *Medicare Benefits*.

3.6 CHARGED LESS THAN MBS FEE

Where *HCF* is required to pay 100% of the *MBS* fee for a *Service* under this *Product Schedule* and the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.

3.7 NO EXTRAS BENEFITS

There are no *Extras Benefits* payable under this *Product Schedule*.

PRODUCT SCHEDULE – SHORT STAY

1 PRODUCTS

This *Product Schedule* applies to Short Stay with $250 *Excess*.

2 HOSPITAL SERVICES

2.1 HCF PARTICIPATING PRIVATE HOSPITALS

If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service* or a *Minimum Benefit Service*) in an *HCF Participating Private Hospital*, the *Benefits* payable are specified in the *Hospital Contract* with that *HCF Participating Private Hospital*. This includes 100% of the agreed charge for accommodation, theatre, labour ward, disposable surgical equipment, hospital in the home services provided by the *HCF Participating Private Hospital*, allied health and therapy services and *PBS Medicines* directly related to or associated with the reason for admission for the *Hospital Treatment*. *Benefits* may be payable for non-*PBS Medicines* (excluding high cost non-*PBS Medicines*) if specified in the *Hospital Contract* with the relevant *HCF Participating Private Hospital*.

2.2 NON-PARTICIPATING HOSPITALS/ PUBLIC HOSPITALS

(a) If a *Member* receives *Hospital Treatment* (other than for an *Excluded Service*) at a *Non-Participating Hospital* or as a private patient at a *Public Hospital*, the *Benefits* payable are the *Minimum Benefits*. *Minimum Benefits* means *Benefits* are only payable at the *Minimum Benefit* rate (an amount set by the Federal Government) for *Non-Participating Hospitals*, and for surgically implanted *Prosthesis* on the Australian Government approved *Prosthesis List*. These *Benefits* may not cover all of your *Hospital* costs. The out-of-pocket cost could be significant.

  For *PBS Medicines* that are charged by the *Non-Participating Hospital* to the *Member*, the *Benefit* payable will be 100% of the *PBS* listed price for that *Medicine* minus the current *PBS* general patient co-payment. The *PBS* patient co-payment fee is an out-of-pocket cost the *Member* is required to pay towards the cost of *PBS Medicine* before *HCF* will calculate the *Benefit*. The patient co-payment fee is determined by the Department of Health and is subject to change
(b) *Benefits* are not payable for medicines that are not *PBS Medicines* or for *Allied Health Services*.

2.3 MEDICAL SERVICES RECEIVED WHILE AN INPATIENT

(a) If a *Member* receives medical services from a *Medical Practitioner* as part of *Hospital Treatment* (other than for an *Excluded Service*) at any *Hospital*, *HCF* will pay 100% of the *MBS* fee for the medical service.
(b) If a *Medical Practitioner* participates in *Medicover* or has an agreement with *HCF* in relation to the *Hospital* Treatment, *HCF* will pay an additional amount towards the medical service in accordance with the *Medicover* terms and conditions or the agreement with *HCF*.

2.4 DISCHARGE PBS PHARMACEUTICALS

(a) *Benefits* are payable for *PBS Medicines* administered to a *Member* post discharge from a *Hospital* if they form part of the *Episode of Care*.
(b) The amount of *Benefits* payable for *PBS Medicines* is the *PBS* listed price for the *PBS Medicine* minus the amount of the current *PBS* general patient co-payment. *Benefits* for *PBS Medicines* are subject to:
  (i) payment by the *Member* of the co-payment;
  (ii) a *Limit* of $100 per *PBS Medicine*; and
  (iii) a further *Limit* of $200 for all *PBS Medicines* per *Member* per *Calendar Year*.

2.5 SURGICALLY IMPLANTED PROSTHESES

(a) *Benefits* are payable for *Prostheses* provided as part of *Hospital Treatment* if they are charged by a *Hospital* to the *Member*.
(b) For no-gap prostheses, the *Benefit* payable is the benefit amount on the *Prostheses List*. For gap-permitted prostheses, the *Benefit* payable is the minimum benefit amount on the *Prostheses List*.

2.6 NURSING HOME TYPE PATIENTS

Where a *Patient* of a *Hospital* is classified as a *Nursing Home Type Patient*, *Benefits* are no longer payable and the *Member* will be required to cover the cost of their *Hospital* stay.

2.7 EXCESSES

The following *Excess* option is available on Short Stay: $250 Excess per admission for *Hospital Treatment* up to $250 per person, per *Calendar Year*.

2.8 MINIMUM BENEFITS SERVICES

The *Minimum Benefit Services* are:

(a) Heart surgery including diagnostic and therapeutic heart procedures.

If a *Member* receives a *Minimum Benefit Service* at an *HCF Participating Hospital*, the *Benefits* payable would be the same as those payable in a *Non-Participating Hospital* under this *Product Schedule*.

2.9 EXCLUDED SERVICES

Excluded Services are:

(a) Hip/knee joint replacement surgery;
(b) Spinal surgery;
(c) Pregnancy and birth related services;
(d) Assisted reproductive services (e.g. IVF, GIFT);
(e) Sterilisations and reversals;
(f) Cataract & other lens related surgery;
(g) Elective cosmetic surgery;
(h) Renal dialysis;
(i) Gastric banding and obesity surgery;
(j) Bone marrow transplants;
(k) Stem cell transplants;
(l) Organ transplants;
(m) Psychiatric services;
(n) Palliative care;
(o) Podiatric surgery; or
(p) Pre-Existing Conditions

HCF will reasonably apportion the costs associated with an *Episode of Care* between the *Services* covered under this *Product* and the *Excluded Services*. HCF will pay *Benefits* for the costs apportioned to the covered *Services* and will not pay *Benefits* for the costs apportioned to the *Excluded Services*.

3 OUT OF HOSPITAL MEDICAL SERVICES

3.1 EMERGENCY DEPARTMENT FACILITY FEES

(a) *Benefits* are payable for emergency department facility fees in either a *Public Hospital* or *Private Hospital*.
(b) The amount of the *Benefits* payable for the cost charged by the *Hospital* to the *Member* is subject to a *Limit* of $200 per *Member* per attendance (whether or not the attendance resulted in a *Member* being admitted to the *Hospital*).

3.2 OUT OF HOSPITAL MEDICAL SERVICES

(a) *Benefits* are payable for *Services* provided by *Medical Practitioners* except *Allied Health Services* to a *Member* that is an *Outpatient* where the *Service* is for an item listed on the *MBS* and the *Service* would be eligible for a *Medicare Benefit* if provided to a *Medicare Eligible Person*.
(b) Subject to paragraph 3.4, the amount of *Benefits* payable is:
  (i) for attendances with a general practitioner including consultations, minor procedures and consumables used,
    (A) 100% of the cost charged to the *Member* if the general practitioner is part of the *HCF Network*;
    (B) 100% of the *MBS* fee for that item if the general practitioner is not part of the *HCF* Network;
  (ii) for pathology and radiology services such as blood tests, scans and x-rays, 100% of the *MBS* fee for the relevant *MBS* item number; and
  (iii) for all other attendances with a *Medical Practitioner* that are not referred to above, 100% of the *MBS* fee for the relevant *MBS* item number.

3.3 AMBULANCE TRANSPORTATION

(a) *Benefits* are payable for *Emergency Ambulance Transport* to a *Hospital* where this would not otherwise be covered by third party arrangements.
(b) The amount of the *Benefits* is 100% of the cost charged to the *Member*.

3.4 RHC RECIPIENTS

(a) If a *Member* is an *RHC Recipient*, the amount of the *Benefits* payable for a medical *Service* under paragraph 3.2 is the difference between the amount that would otherwise be payable under that paragraph and the amount of *Medicare Benefits* paid or payable for that *Service*. If the difference is zero then no *Benefits* are payable.
(b) *Benefits* are subject to the *RHC Recipient* first making a claim to the Department of Human Services for *Medicare Benefits*.

3.5 CHARGED LESS THAN MBS FEE

Where *HCF* is required to pay 100% of the *MBS* fee for a *Service* under this *Product Schedule* and the *Member* is charged less than the *MBS* fee for that *Service*, *HCF* is only required to pay *Benefits* equal to the amount charged to the *Member*.

3.6 NO EXTRAS BENEFITS

There are no *Extras Benefits* payable under this *Product Schedule*.