Health Insurance Fund of Australia Limited

Fund Rules

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A INTRODUCTION

A1 Rules Arrangement

Composition

Health Insurance Fund of Australia Limited's ACN 128 302 161 ("HIF") fund rules ("Fund Rules") consist of:

Sections A to G of this document; and
Schedules H to M of this document.

Unless otherwise stipulated, in the Fund Rules the terms "Fund Rules", "Business Rules" and "Rules" mean the same.

A2 Health Benefits Fund

1. Registered Legal Entity

HIF is a public company limited by guarantee registered pursuant to the *Corporations Act 2001* (Cth) and is registered with the Australian Prudential Regulation Authority ("APRA") as a private health insurer.

2. Purpose

HIF has a health benefits fund established in its records ("Fund"). HIF may have more than one Fund but must not have more than one of them in respect of a particular risk equalisation jurisdiction.

Unless otherwise stipulated or unless the context requires otherwise, or a contrary intention exists in the Fund Rules, the terms "health benefits fund" and "Fund" mean the same.

The Fund Rules operate to guide, clarify, govern and/or regulate as the case may be the business operations and any other relevant or related activities of HIF in respect of the Fund that relates solely to:

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.

A3 Obligations to Insurer

To the extent that the law permits, an applicant for a Fund Membership shall provide any information relevant to that application that HIF may reasonably require. Information relevant to an application for a Fund Membership includes but is not limited to information relating to any or all persons who the applicant proposes in the application to be covered by or to benefit from the Fund Membership.

The Fund Rules determine the manner by which an application for a Fund Membership is to be lodged with HIF.

An applicant for a Fund Membership agrees to be and shall during the time they remain a Fund Member be bound by the Fund Rules.

A4 Governing Principles

1. Risk Equalisation Special Account

HIF shall at all times participate in the operation of the Risk Equalisation Special Account in accordance with the Relevant Laws, principles and Fund Rules as the case may be. HIF, its Fund Members and persons recognised under HIF Fund Memberships acknowledge and agree that HIF shall be entitled to do all things necessary to ensure it complies with the Relevant Laws, principles or the Fund Rules as the case may be in relation to the Risk Equalisation Special Account including assisting and/or complying with the lawful instructions of APRA relating to its administration of the Risk Equalisation Special Account.

2. Compliance with Federal and State Laws

HIF shall at all times comply with any relevant State law, except where such law is inconsistent with the laws of the Commonwealth of Australia ("Commonwealth") then the law of the Commonwealth shall prevail.

HIF shall at all times comply with any relevant Commonwealth law including but not limited to the *Private Health Insurance Act 2007* (Cth) ("PHI Act 2007") and *Private Health Insurance Rules* (Cth) ("PHI Rules"), the *National Health Act 1953* (Cth), the *Health Insurance Act 1973* (Cth) and the *Corporations Act 2001* (Cth).

A5 Use of Funds

1. Health Benefits Fund business

A Fund shall relate solely to:

1.1 health insurance business or a particular part of that business; or

1.2 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.

2 Assets of a Fund(s)

Assets of a Fund shall be kept distinct and separate from assets of any other Fund that HIF might have and from all other money, assets or investments of HIF. HIF must maintain separate bank accounts for each Fund that it has. Assets of a Fund include:

2.1 the balance of money represented by amounts credited to the relevant Fund in accordance with section 137-5 of the PHI Act 2007;

2.2 assets of HIF obtained as a result of the expenditure or application of money credited to a Fund;

2.3 investments held by HIF as a result of the expenditure or application of money credited to a Fund;

2.4 other money, assets or investments of HIF transferred to a Fund, whether under the PHI Act 2007 or otherwise.

Assets or investments obtained by the application of assets (other than money) of a Fund are themselves assets of the relevant Fund. Assets of a Fund:

2.5 include assets that, in accordance with a restructure or arrangement approved under Division 146 of the PHI Act 2007, are to be assets of the relevant Fund; but

2.6 do not include assets that, in accordance with such a restructure or arrangement, are no longer to be assets of the relevant Fund.

Notwithstanding subparagraphs 2.2 and 2.3 above and that assets or investments obtained by the application of assets (other than money) of a Fund are themselves assets of the relevant Fund, assets or investments obtained by the expenditure of money of, or the application of other assets of a Fund are not assets of the Fund if:

2.7 HIF is registered as a for profit insurer; and

2.8 the expenditure or application was not done for the purposes of the relevant Fund.

3 Payments to HIF's Fund(s)

HIF shall credit the following amounts to the Fund:

3.1 premiums payable under policies of insurance that are Referable to the Fund;

3.2 amounts paid to HIF in relation to a liability under Division 152 of the PHI Act 2007 in relation to the Fund;

3.3 income from the investment of assets of the Fund;

3.4 money paid to or by HIF under a judgment of a court relating to any matter concerning the business of the Fund or any failure to comply with Part 4-4 of the PHI Act 2007 in relation to the Fund;

3.5 any other money received by HIF in connection with its conduct of the business of the Fund;

3.6 any other amounts that the PHI (Health Benefits Fund Policy) Rules (Cth) specify.

The PHI Act 2007 does not prevent HIF from making a capital payment to a Fund. A capital payment to a Fund would occur if HIF credits to that Fund an amount that is not required to be credited to that Fund pursuant to paragraphs 3.1 – 3.6 above and either:

3.7 does not represent any part of the assets of another health benefits fund; or

3.8 is credited to that Fund with APRA's written approval.

4 Expenditure and application of health benefits funds

HIF shall not apply, or deal with, assets of a Fund, whether directly or indirectly, except in accordance with section 137 of the PHI Act 2007.

The assets of a Fund shall not be applied for any purpose other than:

4.1 meeting Insurance Product liabilities and other liabilities, or expenses incurred for the purposes of the business of the Fund (including Insurance Product liabilities and other liabilities that are treated, in accordance with a restructure or arrangement approved under Division 146 of the PHI Act 2007, as Insurance Product liabilities and other liabilities incurred for the purposes of the Fund); or

4.2 making investments in accordance with section 137-20 of the PHI Act 2007; or

4.3 making a distribution under Division 149 of the PHI Act 2007; or

4.4 a purpose specified in the PHI (Health Benefits Fund Policy) Rules (Cth) for the purposes of this Rule; or

4.5 for a purpose specified in the PHI (Health Benefits Fund Policy) Rules (Cth) for the purposes of this Rule.

HIF shall not mortgage or charge any of the assets of a Fund except:

4.6 to secure a bank overdraft; or

4.7 for such other purposes, and subject to such conditions, as are specified in the PHI (Health Benefits Fund Administration) Rules (Cth) for the purposes of this Rule.

HIF shall not borrow money for the purposes of the business of a Fund except in accordance with the PHI (Health Benefits Fund Administration) Rules (Cth).

Despite paragraphs 4.1 – 4.4, if HIF is registered as a for profit insurer, the assets of a Fund conducted by HIF may be applied for any purpose, except an application of the assets that is inconsistent with:

4.8 the solvency standard; or

4.9 the capital adequacy standard; or

4.10 a solvency direction or capital adequacy direction given to HIF.

This Rule does not apply to the transfer of assets:

4.11 from one Fund to another in accordance with Division 146 of the PHI Act 2007; or

4.12 in accordance with a direction under sub-section 134-10(2) of the PHI Act 2007.

A6 No Improper Discrimination

1. Community rating principle

HIF shall not:

1.1 take or fail to take any action; or

1.2 in making a decision, have regard or fail to have regard to any matter, that would result in HIF improperly discriminating between people who are or wish to be insured under any of HIF’s complying health insurance policies.

2. Improper discrimination

Improper discrimination is discrimination that relates to:

2.1 the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind;

2.2 the gender, race, sexual orientation or religious belief of a person;

2.3 the age of a person, except to the extent allowed under Part 2-3 (Lifetime Health Cover) of the PHI Act 2007;

2.4 where a person lives, except to the extent allowed under sub-section 66-10(2) or section 66-20 of the PHI Act 2007; or

any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for Hospital Treatment or General Treatment;

2.5 the frequency with which a person needs Hospital Treatment or General Treatment;

2.6 the amount or extent of the Benefits to which a person becomes entitled during a period under an Insurance Product, except to the extent allowed under section 66-15 of the PHI Act 2007; or

2.7 any matter set out in the PHI (Complying Product) Rules 2015 (Cth) for the purposes of this Rule.

3. Closed products

The community rating principle in this Rule does not prevent HIF from closing an Insurance Product, such that the Insurance Product will not be available to anyone except those persons, who at the time of closing, are insured under a policy forming part of the product and;

(i) to an existing Fund Member, who is also an Eligible Person, on the closed Insurance Product seeking their own Fund Membership on the same closed Insurance Product.

(ii) to a Secondary Member, Child Dependant or Student Dependant being added to a Fund Membership on the same closed Insurance product.

4. Terminated products

The community rating principle in this Rule does not prevent HIF from terminating an Insurance Product or a product subgroup of an Insurance Product, such that:

(a) in the case of an Insurance Product, the Insurance Product will not be available to anyone insured under a policy forming part of the Insurance Product; and

(b) in the case of a product subgroup of an Insurance Product, the product subgroup will not be available to anyone insured under a policy that belongs to the product subgroup.

HIF will notify Policyholders of the termination of an Insurance Product (or product subgroup of an Insurance Product) in accordance with Rule C6.4.

A7 Changes to Rules

1. Private Health Information Statement

HIF shall ensure that it at all times maintains an up to date Private Health Information Statement (**PHIS**):

1.1 for each product sub-group of each Insurance Product that it makes available; and

1.2 for each product sub-group of each Insurance Product under which it insures people.

A single PHIS may be the PHIS for more than one product sub-group of an Insurance Product if the premiums payable under policies in the sub-groups the PHIS covers are the same.

The PHIS for a product sub-group of an Insurance Product is up to date at a particular time, if, at that time, the information in the statement is accurate.

A PHIS for a product sub-group of an Insurance Product is a statement about the product sub-group that contains the information, and is in the form, set out in the PHI (Complying Product) Rules 2015 (Cth).

The *PHI (Complying Product) Rules 2015* (Cth) may set out methods by which PHIS's are to be made available to people who ask for information about Insurance Products.

When supplying a person with a copy of a PHIS in accordance with section 93-15 or subsection 93-20 (1) of the Act, HIF must inform the person of the following:

(a) the name of each person who is covered by the policy;

(b) if the product subgroup to which the policy belongs covers Hospital treatment, the following statements for each adult who is covered by the policy and to whom a lifetime health cover loading applies, with the bracketed text replaced with the appropriate amounts:

  (i) "Your Lifetime Health Cover Loading is [Number]%.";

  (ii) "You have [the period of time expressed in years, months, days as appropriate] remaining until you have reached 10 continuous years of cover and your loading is removed.".

HIF shall ensure that, if a person asks an officer, employee or authorised agent of HIF for information about an Insurance Product of HIF:

1.3 the person is told about the PHIS for the product sub-group that is likely to apply to the person and how to obtain a copy of the PHIS; and

1.4 if the person asks for a copy of the PHIS for that product sub-group, the person is provided with an up to date copy of the relevant PHIS as soon as practicable.

HIF shall ensure that, when an adult first becomes insured under an Insurance Product, the adult is given:

1.5 an up to date copy of the PHIS for the product sub-group that the Insurance Product belongs to, by a method (if any) set out in the *PHI (Complying Product) Rules 2015* (Cth); and

1.6 details about what the Insurance Product covers and how Benefits provided under it are worked out; and

1.7 a statement identifying the Fund to which the policy is Referable.

If more than one adult becomes insured under a single Insurance Product, HIF is taken to comply with these requirements (sub-paragraphs 1.5 – 1.7 of this Rule) if HIF complies with those requirements in relation to only one of those adults.

HIF shall ensure that an adult insured under an Insurance Product is given the PHIS for the product sub-group that the Insurance Product belongs to, at least once every 12 months.

If a change to the Rules is detrimental to the interests of a Fund Member and will require an update to the PHIS for an Insurance Product, in addition to informing each affected Policyholder about the change in accordance with Rule A7.2, HIF will provide the updated PHIS as soon as practicable.

If HIF changes the Fund to which an Insurance Product is Referable, HIF must ensure that before the change takes effect, an adult insured under the Insurance Product is given a statement identifying the Fund to which the Insurance Product will be Referable as a result of the change or within 2 weeks after the change takes effect. The Fund to which an Insurance Product is Referable may change in accordance with Division 146 of the PHI Act 2007.

2. Notification of Detrimental changes

HIF will ensure that, if a change to its Rules is detrimental to the interests of a Fund Member, each affected Policyholder is informed about the change within a reasonable time before the change takes effect.

If more than one adult is insured under a single policy in an Insurance Product, HIF will satisfy this obligation by notifying the Primary Fund Member.

3. Giving information relating to private health information statements

In relation to a request from the Secretary of the Department of Health (“DoH”), APRA or the Commonwealth Ombudsman for HIF’s PHIS’s or any one or some of them, HIF shall supply up

to date copies to the relevant person as soon as practicable and in the manner or by the method so requested.

A request by the Secretary of the DoH, APRA or the Commonwealth Ombudsman for information about an Insurance Product or products, shall be in writing and must specify the time by which the information requested is to be given.

In relation to new Insurance Products, HIF shall supply a PHIS in respect of each and every new product to DoH, APRA and the Commonwealth Ombudsman no later than the first day on which HIF commences to make the product(s) available.

In relation to updated PHIS's, HIF shall supply an updated PHIS to the DoH, APRA and the Commonwealth Ombudsman as soon as practical after HIF has updated the relevant PHIS(s).

HIF shall comply with any requirement set out in the *PHI (Complying Product) Rules 2015* (Cth) in relation to:

3.1 information in relation to Insurance Products;

3.2 persons to whom such information is to be given to, including but not limited to the Secretary of the DoH, APRA or the Commonwealth Ombudsman;

3.3 the time during which, or the intervals at which, the information is to be given to a person; or

3.4 the manner and form in which the information is to be given to a person.

A8 Dispute Resolution

1. Definitions

In A8 Dispute Resolution, unless a contrary intention appears:

Complaint means an expression of dissatisfaction with an Insurance Product, Benefit or service offered or provided.

Complainant means a person, organisation or entity making a complaint.
Dispute means a pursued unsatisfied complaint.

Service means the provision of assistance, help and support to all Fund Members and prospective new Fund Members, to facilitate, improve, and assist in the answering of a question, problem or query that a Fund Member or prospective new Fund Member may have in respect of their Fund Membership or proposed Fund Membership as the case may be.

2. Matters not covered by HIF's Rules

If any dispute, question, matter, inquiry, issue or complaint arises that is not or appears not to be covered in these Rules, the question, matter, inquiry, issue or complaint as the case may be shall be referred to the Managing Director or their authorised nominee for a determination. In the case of a complaint by a Fund Member, HIF shall apply the principles, Rules and procedures as are contained in HIF's complaints handling system, or if in the opinion of the Managing Director or their authorised nominee, the nature and/or circumstances of the complaint warrants, the Managing Director or their authorised nominee may use additional or other appropriate means to

determine the complaint. HIF may at its absolute and unfettered discretion make such decisions, determinations and interpretations of these Rules in the best interests of Fund Members and HIF. Fund Members shall be informed of the existence of the Commonwealth Ombudsman.

3. HIF's complaint handling

The primary objectives of the HIF's complaint handling policy include to:

3.1 recognise and protect Fund Members' rights including the right to make a comment or complain;

3.2 increase the level of Fund Member satisfaction;

3.3 increase the level of service provided to Fund Members and prospective new Fund Members;

3.4 provide an efficient and fair process that is easily accessible by Fund Members;

3.5 provide clear information to Fund Members about a process or procedure;

3.6 record and monitor the nature of complaints for identification of common themes and issues; and

3.7 report the nature of complaints for review of current Insurance Products, Benefits and services with a view to improvement.

4. Commitment

HIF is committed to providing Fund Members with access to the highest possible level of service and values the feedback that Fund Members provide. As part of HIF's commitment to continuous improvement if any person should have a concern regarding a Fund Membership, Insurance Product Benefits or the level of service HIF provides, HIF will ensure it operates effective mechanisms to collect, monitor, review and where appropriate respond to feedback and/or concerns.

5. Access

A complaint can be lodged with HIF by telephone, email, mail or in person.

Contact details

Call: 1300 134 060 (Mon-Fri: 8.30am – 5.00pm (AEST)

Write: Member Culture Manager, GPO BOX X2221, Perth WA 6847

Online: hif.com.au/complaints

In person: By visiting Level 4, 100 Stirling Street, Perth 6000.

Via email: complaints@hif.com.au

HIF will acknowledge a complaint as soon as possible or within two business days after the complaint has been received.

6. Escalation

The process for escalating a dispute, question, matter, inquiry, issue, concern or complaint is as follows:

6.1 the matter giving rise to the dispute, question, matter, inquiry, issue, concern or complaint is firstly logged with a customer service representative; and

6.2 if the customer service representative is unable to assist the complainant, they are referred to the relevant Team Leader; and

6.3 in the case where the Team Leader/Manager is unable to assist the complainant, the complainant shall be referred to the Executive Manager - Operations or the Managing Director; and

6.4 in the event that a complaint relates to an area of HIF's business that falls outside these Rules, the complaint shall be referred to the (Fund) Member Action Review Committee ("MARC") for its determination and decision; and

6.5 where a complaint cannot be resolved to the mutual satisfaction of all of the parties included in the dispute, and the complainant wishes to take the matter further, they may:

6.6 Contact the Commonwealth Ombudsman

(a) Via the website at www.ombudsman.gov.au;

(b) By ringing on 1300 362 072; or

(c) By writing to:
Commonwealth Ombudsman
GPO Box 442
CANBERRA, ACT 2601

Nothing in this Rule shall operate to prevent a person from referring a complaint, whether or not it is in dispute, directly to the relevant statutory authority or body, including but not limited to PHIO and APRA, either instead of or in addition to referring the complaint to HIF.

A9 Notices

Unless stated otherwise in these Fund Rules, a written notice sent by post to the address last supplied by the Primary Fund Member will be deemed to be notice to all persons named in the Insurance Product under these Fund Rules.

Fund Members may contact HIF to request a copy of the Fund Rules at any reasonable time. Fund Rules may also be available on HIF's website.

A10 Winding Up

In the event that HIF is to be wound up or the Fund dissolved, subject to the PHI Act 2007, HIF shall be wound up or the Fund dissolved in accordance with HIF's Constitution.

A11 Other

This section intentionally left blank.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

Notwithstanding anything contained in these Fund Rules, subject to relevant legislation and/or other authority, including but not limited to the PHI Act 2007, the PHI Rules and the *Corporations Act 2001* (Cth), HIF may at its absolute and unfettered discretion make such decisions, determinations and / or interpretations in relation to these Fund Rules as are, in the opinion of the Managing Director or his/her authorised delegate nominee, required to serve the interests of the Fund Members and/or HIF.

B2 Definitions

In these Rules:

Access Gap means, unless a contrary intention appears, the difference between the standard contribution charge and the Health Care Provider charge under Access Gap Cover.

Access Gap Cover means the system operated by Australian Health Service Alliance on behalf of members' funds including HIF, that is aimed at covering some or all of the cost of medical services and / or treatments provided to a person insured under a Hospital cover including an Overseas Visitors Hospital cover of a Fund Member, provided that the services and / or treatments are received by that person whilst an Inpatient in a registered Hospital or Day Hospital Facility.

Access Gap Schedule means the Access Gap Cover schedule containing the maximum amount or a maximum percentage of rebate Benefit payable by HIF for Inpatient medical services and / or treatments charges and / or fees in excess of the standard Contribution as contained in the Medicare Benefit Schedule, provided that if a person is covered under an Overseas Visitors Hospital cover, Access Gap Schedule rebate Benefits are payable for Hospital Inpatient and non-Hospital (i.e. non-Inpatient) related medical services.

Accident means an unplanned or unexpected and unintentional event without apparent cause.

Accredited means in relation to the provision of Hospital Treatment, Hospital-Substitute Treatment or General Treatment, a person authorised, approved or sanctioned:

(a) By the Minister or a person authorised by the Minister;
(b) By a governing, professional or industry body; or
(c) By virtue of the issue of a written instrument evidencing a minimum standard, qualification or level of achievement or proficiency.

Admission means the period of time when admitted as an Inpatient for a condition or illness into a Hospital or Day Hospital Facility for the purpose of receiving Hospital Treatment until discharged.

Agent means a person who HIF approves to act on its behalf:

(a) to accept premium Contributions and pay rebate Benefits to a Fund Member;
(b) to promote HIF's products and services including Insurance Products; or
(c) to refer people (including a group employer of people) to HIF in anticipation of commission.

AHSA means Australian Health Service Alliance.

Annual means unless a contrary intention appears, the period starting on the 1st January and ending on the 31st December.

Annual Financial Limit means the maximum financial limit of rebate Benefits payable to a Fund Member or another person in respect of a Fund Membership in a year.

Annual Limit means an Annual Financial Limit or some other Annual limitation restricting or preventing access to an unlimited amount or number of goods, services or treatments.

Applicable Benefits Arrangement means an Applicable Benefits Arrangement within the meaning of the *National Health Act 1953* (Cth) as in force before the 1st April 2007.

Application means, unless a contrary intention appears, a Fund Membership Application.

APRA means Australian Prudential Regulation Authority.

Approved means formally recognised in writing by HIF.

Approved Facility means a Facility including an Approved Hospital Facility provide goods, services or treatments to Fund Members.

Approved Health Management Program means an Approved program that is intended to ameliorate a person's specific health condition or conditions, provided that the program may include treatment that primarily takes the form of sport, recreation or entertainment.

Approved Health Care Provider means a Health Care Provider who, at the absolute discretion of HIF, is Approved to provide goods, services or treatments to Fund Members.

Approved Service Provider means, unless a contrary intention appears, an Approved Health Care Provider.

Arrears means in relation to a Fund Member or Fund Membership, the amount owing to HIF in respect of a period between the last date paid to and the Current date or other date determined by HIF.

ART means Assisted Reproductive Services.

Assisted Reproductive Services means services or treatments and any investigation related to fertility, including IVF.

Australian Health Service Alliance means Australian Health Service Alliance Ltd ABN 75 062 860 584, comprising a group of like-minded health insurers that have banded together by the signing of an agency agreement to become Fund Members, to negotiate contracts with Health Care Providers on a collective basis and to provide other services as required.

Base Rate means for Hospital cover the amount of premium that would be payable for that cover if:

(a) the premium was not increased under Division 34 of Part 2-3 of the PHI Act 2007; and
(b) there was no discount of the kind allowed under these Rules pursuant to section 66-5(2) of the PHI Act 2007.

Benefit means, unless a contrary intention appears, an entitlement including a rebate that is available under an Insurance Product.

Benefit Exclusion means, in relation to an Insurance Product, a charge or fee of a provider for a service or treatment, including the provision of goods and services by the Health Care Provider, supplied to a Fund Member, that HIF will not pay a rebate Benefit on.

Benefit Restriction means, in relation to an Insurance Product, a charge or fee of a Health Care Provider for a service or treatment, including the provision of goods and services by the Health Care Provider, supplied to a Fund member, which HIF will only pay a Minimum Benefit on.

Board means Board of Directors.

Board of Directors means the Board of Directors of HIF duly constituted in accordance with HIF’s Constitution.

Business Rules means, unless a contrary intention appears, these Fund Rules.

Calendar Year means the period from the 1st January to the 31st December.

Certified Age at Entry means Lifetime Health Cover age.

Child means a person who is less than 21 years of age and is:

(a) a biological child;
(b) a step-child;
(c) a legally adopted child;
(d) a child of a Legal Guardian;

Clearance Certificate means transfer certificate.

Clinical Categories means those Clinical Categories documented within Schedule 5 of the *Private Health Insurance (Reforms) Amendment Rules 2018*.

Clinically Relevant Service means a service or treatment rendered by a medical or Dental Practitioner or an Optometrist that is generally accepted in the medical, dental or optometry profession as the case may be as being necessary for the appropriate treatment of the patient to whom it is rendered.

Commonwealth Ombudsman means Ombudsman appointed for the purposes of Part 6-2 of the PHI Act 2007.

Compensation means:

(a) payment by way of damages;
(b) payment, other than a payment of Benefits from the Fund, under a scheme of insurance or Compensation provided for by a law of a State or Territory;
(c) payment, whether with or without admission of liability, in settlement of a claim for damages or of a claim under a scheme referred to in (b);
(d) payment by way of damages or, whether with or without admission of liability, in settlement of a claim for damages for professional negligence in relation to a claim for payment referred to in (a), (b) or (c); or
(e) any other payment that, in the opinion of HIF, is a payment in the nature of compensation or damages.

Constitution means the constitution of HIF last lodged with the Australian Securities and Investments Commission.

Consultation means an attendance by a HIF Approved Service Provider or Health Provider, who provides an Approved Extras, Hospital or Hospital-Substitute treatment, to an eligible member in a face to face setting, or as otherwise approved by HIF. For the removal of doubt, telephone or online services, with the exception of HIF Approved Hospital-Substitute treatment or Chronic Health Disease Management programs, are not consultations.

Continuous Period of Hospitalisation means, for the purpose of counting days of Hospital Treatment, includes any two periods during which a patient was, or is, receiving Hospital Treatment as a patient at a Hospital, whether or not the same Hospital, where the periods are separated from each other by a period of not more than 7 days during which the patient was not receiving Hospital Treatment as a patient at any Hospital.

Contracted Hospital means a Hospital including a Hospital group that is under contract either directly with HIF or indirectly with HIF via the Australian Health Service Alliance in its capacity as agent of HIF, to provide Inpatient services or treatments to Fund Members.

Contribution means a financial payment in advance in Australian legal tender to HIF, entitling a

person(s) to be, subject to these Rules, a Fund Member.

Cosmetic Surgery means a surgical procedure that is:

(a) listed in Group T8 – Surgical Operations, Subgroup 13 - Plastic and Reconstructive Surgery of the Medicare Benefits Schedule that:

(1) is not clinically relevant, or

(2) does not meet the eligibility conditions for the payment of a Medicare Benefit; or

(b) a plastic or reconstructive surgical procedure that is not listed in the Medicare Benefits Schedule.

Cth means Commonwealth of Australia.

Current means in relation to a Fund Member or Fund Membership, they are, or it is financial.

Day Hospital Facility means a Facility that operates as a day only Facility that is registered or licensed as the case may be with a Commonwealth, State or Territory Government and is approved to render services or treatments to Fund Members without involving overnight accommodation.

Dental Benefit means an entitlement including a rebate in respect of a dental service or treatment that is available under an Insurance Product, including goods supplied or consumed in the provision of the service or treatment, by an Approved Dental Practitioner.

Dental Practitioner means a person who is:

(a) in private practice;
(b) registered by the Dental Board of Australia; and
(c) Approved by HIF.

Dependant means, unless a contrary intention appears:

(a) a Child Dependant; or
(b) a Student Dependant.

Child Dependant means a Fund Member who is aged less than twenty one years and does not have a partner.

DoH means the Australian Government Department of Health.

Eligible Person means, in relation to Fund Membership, a person who:

(a) is aged at least sixteen and any Dependants; and
(b) pursuant to the PHI Act 2007 and / or the PHI Rules, is not prevented from being or becoming a Fund Member.

Episode Duration means the period of time associated with a specified episode of care.

Excluded Benefit means Benefit Exclusion.

Extras Benefit means a Benefit including a payment of a rebate in respect of a service or treatment including a treatment that is Hospital-Substitute Treatment, including the provision of goods and services by an Approved Health Care Provider in private practice.

Extras Product means an Insurance Product that is an Insurance Product covering General Treatment, whether or not it is Hospital-Substitute Treatment, including the provision of goods

and services, that:

(a) is intended to manage or prevent a disease, injury or condition; and
(b) is not Hospital Treatment.

Extras Service means a service or treatment including a Hospital-Substitute Treatment, including the provision of goods and services, which are provided to a Fund Member by an Approved Provider in private practice.

Facility means a Public Hospital, a Private Hospital, a public Day Hospital or a private Day Hospital.

Fund means a health benefits fund conducted by HIF.

Fund Contributor means a person who makes Contribution payments to and in favour of HIF in respect of a Fund Membership.

Fund Member means a Primary Fund Member, Secondary Member, or a Dependant in respect of whom premium Contributions have been paid in advance by a Fund Contributor, towards a Current Insurance Product that provides a person named in the Insurance Product cover of a type permitted by the PHI Act 2007 and PHI Rules.

Fund Membership means, unless a contrary intention appears, a system operated by HIF, involving a person being admitted to the Fund as a Fund Member pursuant to the Rules, for identifying Fund Members.

Fund Membership Application means an Application, in the form prescribed by HIF, to be admitted to the Fund as a Fund Member.

Fund Membership Cessation means, unless a contrary intention appears, at the time:

(a) in the case of a single Fund Member, of death of the Fund Member;
(b) the Fund Membership becomes unfinancial, provided that the Fund Membership has not been returned to a Current financial Fund Membership during two months following the time it became unfinancial;
(c) a Fund Membership is cancelled; or
(d) a Fund Membership is terminated;

Provided that HIF shall give reasonable written notice to the Primary Fund Member or their authorised representative, that the Fund Membership has ceased according to these Business Rules.

Fund Membership Termination means, unless a contrary intention appears, at the time:

(a) determined pursuant to the Constitution;
(b) a Fund Contributor or Fund Member of a Membership, acting alone or in concert with another person, obtains or attempts to obtain an improper advantage, financial or otherwise, from HIF; or
(c) HIF, at its absolute discretion, determines that, under the circumstances, a Fund Membership is terminated;

Provided that HIF shall give reasonable written notice, including reasons and the amount (if any) to be refunded for Contributions received in advance of the date of termination, to the Primary Fund Member that the Fund Membership is terminated according to this Business Rule.

Fund Rules means, unless a contrary intention appears, these Rules.

Gap Cover Scheme means, unless a contrary intention appears, the same as Access Gap Cover.

General Treatment means treatment that is:

(a) of a kind that is covered under an Extras Product of HIF;
(b) not Hospital Treatment.

Gold Card means a card that evidences a person's entitlement to be provided with treatment:

(a) in accordance with the Treatment Principles prepared under section 90 of the *Veterans' Entitlements Act 1986* (Cth); or
(b) in accordance with a determination made under section 286 of the *Military Rehabilitation and Compensation Act 2004* (Cth) in respect of the provision of treatment.

Health Care Provider means:

(a) a person who provides goods or services as or as part of Hospital Treatment or General Treatment; or
(b) a person who manufactures or supplies goods provided as or as part of Hospital Treatment or General Treatment.

Health Insurance Fund of Australia Limited means Health Insurance Fund of Australia Limited ACN 128 302 161, being an Australian public company limited by guarantee that is registered with APRA as a private health insurer.

HIF means Health Insurance Fund of Australia Limited.

Holder means, in relation to an Insurance Product, a person who is insured under the Insurance Product and who is not a Child Dependant.

Hospital means a Facility that the Minister has, pursuant to sub-section 121-5(6) of the PHI Act 2007, declared in writing is a Hospital, provided that the declaration is at no time revoked.

Hospital Patient means, in relation to a Hospital, an Inpatient in respect of whom the Hospital provides Hospital Treatment.

Hospital Product means an Insurance Product that is a complying health insurance policy covering Hospital Treatment.

Hospital Purchaser Provider Agreement means an agreement entered into between HIF or HIF through AHSA acting in its capacity as agent for HIF, and a Health Care Provider that operates a hospital or Day Hospital Facility.

Hospital-Substitute Treatment means General Treatment that:

(a) substitutes for an episode of Hospital Treatment; and
(b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition; and
(c) is not specified in the *PHI (Complying Product) Rules 2015* (Cth) as a treatment that is excluded from this definition.

Hospital Treatment means treatment (including the provision of goods and services) that:

(a) is intended to manage a disease, injury or condition; and
(b) is provided to a person:
    (i) by a person who is authorised by a Hospital to provide the treatment; or

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

(c) either:
(i) is provided at a Hospital; or
(ii) is provided, or arranged, with the direct involvement of a Hospital;

(d) any other treatment or class of treatments specified in the PHI Rules as being Hospital Treatment; and

(e) includes any of, or any combination of, accommodation, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition.

Hospital Treatment Table means the schedule of Benefits and entitlements associated with hospital tables as contained in the AHSA Hospital Purchased Provider Agreement or other Benefits as prescribed by the Commonwealth.

Independent Private Practice means a professional practice (whether sole, partnership, company, group or other identifiable person) that is a Self-Supporting Approved Provider.

Inpatient means in relation to a hospital Admission, for the purpose of Hospital Treatment.

Insurance Policy Benefit means, unless a contrary intention appears, disbursements from the Fund to meet Insurance Product liabilities and other liabilities or expenses incurred for the purposes of the business of the Fund.

Insurance Product means any Hospital or Extras Product of HIF, or combinations of those products.

IVF means in vitro fertilisation.

Legal Guardian means a person who the Commonwealth, State and Territory Governments recognise as holding full legal responsibility for another person.

LHC means Lifetime Health Cover.

Lifetime Health Cover means the scheme to encourage people to take out Hospital cover by the time they turn 30, including Rules contained in these Rules at D4 Lifetime Health Cover that require persons to pay higher premiums for Hospital cover where they are older than 30 when they take out hospital cover for the first time, or they drop Hospital cover for a period after having turned 30.

Lifetime Health Cover Age means, in relation to an adult who takes out hospital cover after his or her Lifetime Health Cover base day, means the adult's age on the 1st July before the day on which the adult took out the hospital cover.

Long Term Benefits means those categories of Ancillary Services which have provision for Benefit levels to increase on a year by year basis.

MBS means Medicare Benefit Schedule.

Medical Practitioner means, unless a contrary intention appears, 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 licensed to practice, as a medical practitioner in any State or Territory has been suspended, or cancelled, following an inquiry relating to his or her conduct; and

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

Medical Purchaser Provider Agreement means an agreement entered into between HIF or HIF through AHSA acting in its capacity as agent for HIF, and a medical practitioner.

Medicare Benefit Schedule means the schedule comprised of tables that list general medical services, diagnostic imaging services and pathology services, including for each service, a Schedule Benefit as defined in the *Health Insurance Act 1973* (Cth).

Minimum Benefit means at least the amount set out, or worked out using the method set out, in the PHI (Benefit Requirements) Rules as the Minimum Benefit, or method for working out the Minimum Benefit, for that treatment, provided that HIF may reduce the Minimum Benefit by the amount of any co-payment or excess that is required to be paid under the Insurance Product in respect of that treatment.

Minister means the Commonwealth Minister for Health.

Non-Contracted Private Hospital means a Private Hospital not contracted by the Australian Health Service Alliance or HIF, to provide services to Fund Members. Out of pocket costs cannot be guaranteed in these Hospitals.

Non-PBS Pharmaceutical Benefit means a Benefit that is available under an Extras Insurance Product that relates to medicines / pharmaceutical products not included on the Schedule of Pharmaceutical Benefits for approved Pharmacists and Medical Practitioners. Oral contraceptives are excluded where prescribed for the purpose of contraception only. Effective 28 February 2023 a Benefit is payable on oral contraceptives where prescribed for a medical condition. The claim must be accompanied with a letter from the treating medical practitioner to state the medical condition the medication is being prescribed for. With the exception of influenza (flu) vaccinations, to be eligible, medicines must be prescribed by a registered Medical Practitioner or dentist pursuant to a prescription.

Nursing Care means nursing care given by or under the supervision of a registered nurse.

Nursing Home means premises:

(a) that are fitted, furnished and staffed for the purpose of providing accommodation and Nursing Care for patients who, by reason of infirmity or illness, disease, incapacity or disability, have a continuing need for Nursing Care; and
(b) in which patients of that kind are received and lodged exclusively for the purpose of providing them with accommodation and Nursing Care.

Nursing Home Type Patient means, in relation to a Hospital, a patient who has been provided with Hospital Treatment whether:

(a) acute care; or
(b) accommodation and Nursing Care, as an end in itself; or
(c) a mixture of both,

for a Continuous Period of Hospitalisation exceeding 35 days (*35-day period*), but a patient receiving acute care immediately after the 35-day period does not become a Nursing Home Type Patient unless the period of acute care ends and the patient is then provided with accommodation and Nursing Care, as an end in itself, as part of a Continuous Period of Hospitalisation.

Note 1: See definition of "continuous period of hospitalization" in section B2 of these Rules.

Note 2: If a Nursing Home Type Patient is provided with acute care at the hospital (the *first hospital*), or at another hospital, the patient:

(a) ceases to be a Nursing Home Type Patient only for the days on which the acute care is provided; and

(b) again becomes a Nursing Home Type Patient when the provision of acute care ends and the patient is then provided with accommodation and Nursing Care as an end in itself, whether at the first hospital or another hospital.

Note 3: If there is disagreement as to whether a patient is, or is not, a Nursing Home Type Patient, an insured person, a private health insurer or a Health Care Provider may make a complaint to the Commonwealth Ombudsman under Part 6-2 of the PHI Act 2007. The Commonwealth Ombudsman has various powers to deal with complaints, including conducting mediation if the complainant agrees.

Options means a brand name word that is combined with other brand name words to describe HIF's Ancillary Products.

Overseas Visitor means a person who:

(a) is not a permanent Australian resident;

(b) is not entitled to full Medicare Benefits;

(c) is visiting Australia on a temporary visa.

Partner means a person who lives with a Fund Member of the same or different gender in a marital or de facto relationship and who is covered under the same Fund Membership notwithstanding the Primary Fund Member and a Partner may live apart temporarily.

PBS means Pharmaceutical Benefits Scheme.

Pharmaceutical Benefit means a Benefit attributable to any medicine or pharmaceutical product listed in the Schedule of Pharmaceutical Benefits for approved Pharmacists and Medical Practitioners.

Pharmaceutical Benefits Scheme means the schedule of medicines and pharmaceutical products approved for clinical use and subsidised by the Commonwealth Department of Health.

PHI Act 2007 means the *Private Health Insurance Act 2007* (Cth) as amended from time to time.

PHI Rules means *Private Health Insurance Rules* (Cth) as amended from time to time.

PHIS – means Private Health Information Statement.

Podiatric Surgeon – means a surgeon who holds specialist registration in the specialty of podiatric surgery under the National Law.

Policy Holder means a Holder of an Insurance Product that is referrable to HIF.

Policyholder means the same as Policy Holder and vice versa.

Portability means the requirements that HIF has in relation to transfers between Insurance Products, pursuant to Division 78 of the PHI Act 2007.

Practitioner in Private Practice means a practitioner who:

(a) does not use any publicly funded hospital, clinic, health centre or other such Facility, including a Facility provided by a municipal authority for or in connection with the provision of an Extras Service for which a Benefit is claimable by a Fund Member under an Extras Product;
(b) does not receive publicly funded assistance or support, whether by way of remuneration, subsidy or otherwise, in connection with the provision of an Extras Service, except where the Extras Service is provided at an Approved Facility of a strategic alliance partner or joint venture partner of HIF, or at a HIF Facility; and
(c) is Self-Supporting,

provided that HIF may at its absolute discretion include a practitioner not in private practice or a practitioner not in private practice in certain circumstances as if the practitioner is a Practitioner in Private Practice, including:

1. Dental services and treatments (including the supply of materials) provided by an Approved person who is registered with the Dental Board of a State or Territory of Australia to which paragraph (a) refers.

Pre-Existing Condition means in relation to a person insured under an Insurance Product the person has a Pre-Existing Condition if:

(a) the person has an ailment, illness or condition; and
(b) in the opinion of a Medical Practitioner appointed by HIF, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the Insurance Product.

Pregnancy-Related Services means all services and treatments provided or rendered to a Fund Member during their confinement, including ultra-sounds and all services and treatments directly related to the delivery of a baby.

Primary Fund Member means the Fund Member who is the person named in the Fund Membership Application form as the applicant in respect of a Fund Membership and is the person ultimately responsible for ensuring the Fund Membership remains Current at all times.

Private Health Information Statement means a summary of the features of a Complying Health Insurance Product pursuant to the *Private Health Insurance Act 2007* (Cth). This new format replaces the Standard Information Statement (SIS).

Private Hospital means a Facility that the Minister has, pursuant to sub-section 121-5(6) of the PHI Act 2007, declared in writing is a hospital and is, pursuant to sub-section 121-5(8), a private hospital, provided that the declaration is at no time revoked.

Public Hospital means a Facility that the Minister has, pursuant to sub-section 121-5(6) of the PHI Act 2007, declared in writing is a hospital and is, pursuant to sub-section 121-5(8), a public hospital, provided that the declaration is at no time revoked.

Qualifying Period means any period, occurring immediately after joining HIF or joining a higher benefiting Insurance Product, during which either some or all Benefits are either reduced or not payable.

Recognised Educational Institution means an educational institution including but not limited to a school, college or university, recognised by the Commonwealth, State or Territory Governments.

Recognised Hospital means Hospital.

Referable means, in relation to an Insurance Product, that:

(a) HIF is identified under sub-section 93-15(1)(c) of the PHI Act 2007 as the Fund to which the Insurance Product is referable (and the Insurance Product has not been made referable to another health benefits fund under Division 146 of the PHI Act 2007); or
(b) the Insurance Product has been made referable to HIF under Division 146 of the PHI Act 2007.

Registered means, unless a contrary intention appears, a private health insurer registered under Part 4-3 of the PHI Act 2007.

Registered Office means the Registered Office of HIF as is recorded by the Australian Securities and Investments Commission.

Relevant Law means:

(a) Act;
(b) *Health Insurance Act 1973* (Cth);
(c) *Private Health Insurance Act 2007* (Cth); and
(c) Any other present or future law of the Commonwealth of Australia or any State or Territory of Australia which HIF may determine to be a Relevant Law for the purposes of these Rules.

Restricted Benefit means Benefit Restriction.

Risk Equalisation Special Account means the Private Health Insurance Risk Equalisation Special Account under Part 6-7 of the PHI Act 2007.

Rules means, unless a contrary intention appears, these Fund Rules.

Second Tier Default Benefit means at least the amount set out, or worked out using the method set out, in the *PHI (Benefit Requirements) Rules 2011* (Cth) as the Minimum Benefit, or method for working out the Minimum Benefit, for an episode of Hospital Treatment at a Facility that does not have a negotiated agreement with HIF, provided that HIF may reduce the Minimum Benefit by the amount of any co-payment or excess that is required to be paid under the Insurance Product in respect of that treatment.

Secondary Member means a Fund Member who is a Partner of the Primary Fund Member and who is covered under the same Fund Membership as the Primary Fund Member.

Self-Supporting means to be able to continue in and for the purpose of existence and pay costs and other expenses relating to or incidental to that existence from internal sources or from proceeds or Benefits derived or received through personal exertion including personal exertion of a principal's agent acting in the same or substantially similar way, provided that no proceed or Benefit shall be derived or received through receipt of a payment, subsidy, rebate, financial

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exemption or similar credit for value or its equivalent, whether or not it is received directly or indirectly from a publicly funded entity or person acting on behalf of a publicly funded entity or person.

Service Provider means, unless a contrary intention appears, an Approved Health Care Provider.

Student Declaration means a written declaration, in the form prescribed or otherwise accepted by HIF, that satisfies HIF that the Fund Member is a Student Dependant.

Student Dependant means a Fund Member who:

(a) is aged twenty one years and less than thirty one years;
(b) does not have a partner;
(c) is enrolled and studying on a full time basis at an HIF recognised educational or training institution.
(d) Is a Student Dependant's Child;

Third Party means a person other than HIF or a person covered under an Insurance Product.

Transfer Certificate means a form approved pursuant to section 333-10 of the PHI Act 2007 relating to a transfer of a person from a (the old) policy of a health insurer to another (the new) policy of another health insurer.

Visit means a Consultation.

Waiting Period means the period that applies to a Fund Member for a Benefit under an Insurance Product:

(a) starting at the time the person becomes insured under the Insurance Product; and
(b) ending at the time specified in the Insurance Product;

during which the Fund Member is not entitled to a Benefit.

Workcover means the Western Australian statutory authority that is responsible for administering the *Workers' Compensation and Injury Management Act 1981* on behalf of the state.

Year means, unless a contrary intention appears, the period from the 1st January to the 31st December.

C MEMBERSHIP

C1 General Conditions of Membership

Subject to the PHI Act 2007, PHI Rules and the Constitution, upon acceptance of a Fund Membership Application by the Managing Director or his/her authorised delegate and payment of such amount(s) of premium(s) as the Board may determine from time to time, any Eligible Person may become a Fund Member of HIF and they shall upon becoming a Fund Member, but subject to these Rules, be entitled to participate in Benefits for themselves, Secondary Member and Dependants included under the Fund Membership.

1. Change of Fund Membership details

(a) Subject to these Rules, where Fund Membership details change, a Primary Fund Member shall inform HIF within two (2) months of such change. The Primary Fund Member may, in writing addressed to HIF, authorise another Fund Member to contact HIF on their behalf, to give effect to the required changes to a Fund Membership.

(b) Changes to Fund Membership details include, but are not limited to:

(1) change of address of any Fund Member;
(2) change of contact details (e.g. phone, e-mail, or fax number) of any Fund Member who is covered under the Insurance Product;
(3) change of Australian residency status;
(4) change of name;
(5) in the case of a Student Dependant, cessation or deferral of full-time study;
(6) change of marital status or de facto status of a Dependant; or
(7) a Dependant is no longer eligible to be a Dependant.

HIF accepts Applications for Fund Membership or changes to Fund Membership details only in the prescribed form.

A Fund Member changing their Insurance Product may revert to their old Insurance Product within **two (2) months** if no Benefits have been claimed against the new Insurance Product. Where the old Insurance Product is subject to rule A6 No Improper Discrimination and is no longer available, HIF will offer the Fund Member an Insurance Product that HIF considers is most similar to that which is no longer available.

2. Insured groups

HIF provides cover for the following insured groups:

(a) only one person (Single);
(b) 2 Adults (and no-one else) (Couple);
(c) 2 or more people, only one of whom is an Adult (Single Parent); or
(d) 3 or more people, only 2 of whom are Adults (Family).

3. Levels of cover

HIF currently provides levels of cover that include the coverage requirements pursuant to Division 69 of the PHI Act 2007 and the *PHI (Complying Product) Rules 2015* (Cth).

C2 Eligibility for Membership

1. Fund Membership eligibility (generally)

Subject to these Rules, any Eligible Person may become a Fund Member. An application for Fund Membership shall not be denied on the grounds that the applicant or other person to be covered under an Insurance Product is not eligible for Medicare Benefits.

2. Portability

HIF recognises Portability when new Fund Members transfer from another registered private health insurer (refer C6 Transfers for details).

C3 Dependants

1. Types of Dependant

HIF recognises the following two types of Dependants:

(a) Child Dependant - a Fund Member who is aged less than twenty one (21) years including but not limited to a dependant's own child, step-child, legally adopted child, or a Child to whom the Primary Fund Member is the Legal Guardian, provided that the Child Dependant and their Child (if any) does not have a partner;

(b) Student Dependant - a person who is aged twenty one (21) years and less than thirty one (31) years including a Student Dependant's Child, provided that the Student Dependant does not have a partner and provided that the Student Dependant is enrolled and studying on a full time basis at an HIF recognised educational or training institution.

A Child Dependant or a Student Dependant as the case may be shall only be covered:

(a) for the period that they remain eligible; and

(b) in relation to a Student Dependant, during the period covered by a Student Declaration.

For the purpose of determining coverage in respect of a Dependant under a Fund Membership, HIF shall only recognise a Fund Member. To be a Fund Member of a Fund Membership, a Primary Fund Member must supply HIF a valid notice in the prescribed form.

Upon registration by the Primary Fund Member in the prescribed form, of a Fund Member's Child who is born after the Waiting Periods have been served, the Child will be immediately entitled to Benefits on the same level of cover as provided by the Primary Fund Member's Membership, provided that:

(a) in the case of a single person or couple's Fund Membership, the Child is registered within 2 months from the date of their birth or adoption and the appropriate Contribution premium for the single parent or family Membership level of cover required to include the Child from the date of their birth or is paid; and

(b) in the case of a single parent or family Fund Membership, the Child is registered within 4 years from the date of their birth or adoption.

The Benefits of a single parent or family Fund Membership for a Child Dependant or Student Dependant applies to them regardless of whether or not they are working or living away from home.

Student Dependant

Student Dependant Benefits under the single parent or family Fund Membership will apply from the 1st March to the 28th (or 29th in the case of a leap year) of February of each Year, provided that a Student Dependant remains validly registered with HIF continuously. A registration, in the form of a Student Declaration, must be submitted to HIF within two (2) months of the commencement of academic or training program or course of study each year.

A Student Dependant who has not held continuous cover with HIF during the Calendar Year commencing the 1st March, may be required to serve Waiting Periods when cover is resumed. A Fund Member's registration as a Student Dependant is effective from the date a properly completed Student Declaration that satisfies HIF is received by HIF at its Registered Office.

2. Ceasing to be a Dependant

Subject to these Fund Rules, a person who ceases to be eligible to be a Child Dependant Fund Member or a Student Dependant Fund Member of HIF or of another (previous) fund may join HIF as an adult Fund Member, without having to serve an additional Waiting Period provided that:

(a) the new level of cover is no higher than the existing level of cover;

(b) the ex-dependant person applies for Fund Membership within 2 months of ceasing to be a Child Dependant or Student Dependant; and

(c) all Waiting Periods (if any) of a previous Fund Membership of another (previous) fund have been served.

C4 Membership Applications

1. Commencement of Fund Membership

Subject to these Fund Rules, Fund Membership shall commence on the date the person lodges a Fund Membership Application (i.e. "Application") together with payment for Admission as a Primary Fund Member or on such other date as is nominated and recorded by HIF ("nominated date") on the Application provided the nominated date is not earlier than (a) the date of lodgement of an Application or (b) the date on which the Primary Fund Member entered into or intended there be to HIF's satisfaction a binding commitment with HIF to become a Fund Member, whichever is the earlier.

HIF shall in its absolute discretion determine the date on which the Primary Fund Member entered into a binding commitment with HIF to become a Fund Member.

For avoidance of doubt, Fund Membership cannot commence on a date earlier than the date of lodgement of an Application together with payment or the date on which the Primary Fund Member entered into a binding commitment with HIF to become a Fund Member.

The lodgement date of an Application is the date it is received by HIF at its Registered Office or other receiving point authorised by HIF or the date it is received by an authorised agent of HIF.

2. Payment of Premium Contributions

Other than payment of premium Contributions by way of payroll group deduction or direct debit, all payments of premium Contributions shall be for a minimum period of one month in advance.

Where a Fund Member elects to pay premium Contributions via a group payroll deduction scheme authorised by HIF, if deductions do not commence immediately after the lodgement date or nominated date, a Fund Member shall make a payment (of the Arrears amount) to HIF to cover the period from the date of lodgement of a Fund Membership Application or nominated date and the date when the payroll deduction commenced.

If the Fund Member does not pay the Arrears amount, the Fund Membership commencement date shall be amended to coincide with the date the payroll deduction commenced.

Where the Fund Member elects to pay premium Contributions via HIF’s direct debit Facility and they have nominated a specific date in accordance with HIF’s direct debit Facility, the Fund Member shall be notified of any additional Contributions from the join date to the nominated commencing direct debit date and an automatic deduction including the Arrears will be deducted. HIF may require a minimum of one (1) month payment to commence Fund Membership regardless of the chosen payment method.

C5 Duration of Membership

1. Fund Membership Commencement

A Fund Membership commences under this Fund Rule at the time:

(a) an Application in the prescribed form is lodged with HIF;

(b) a phone enrolment is accepted and logged on HIF’s database system, provided that, within a reasonable time, an Application in the prescribed form is lodged with HIF; or

(c) where HIF agrees, nominated in an Application in the prescribed form; and

(d) in the case of Overseas Visitor cover, the date of arrival in Australia of the Primary Fund Member.

2. Fund Membership Cessation

A Fund Membership ceases under this Fund Rule, at the time:

(a) in the case of a single Fund Member, of death of the Fund Member;

(b) it becomes unfinancial, provided that the Fund Membership has not been returned to a Current financial Fund Membership during two months following the time it became unfinancial;

(c) it is cancelled; or

(d) it is terminated.

C6 Transfers

1. Portability

Portability refers to a person's ability to transfer from one Insurance Product, including one of another insurer, to another Insurance Product without having to serve a Waiting Period that has already been served under the first-mentioned Insurance Product.

HIF administers its responsibilities and obligations in relation to Waiting Periods and Portability in accordance with Divisions 75 and 78 of the PHI Act 2007.

2. Waiting Periods

A Waiting Period under an Insurance Product that applies to a person who did not transfer to the Insurance Product is:

(a) for a Benefit for Hospital Treatment or Hospital-Substitute Treatment that is Pregnancy and Birth related treatment or treatment for a Pre-Existing Condition (other than treatment covered by paragraph (b) - 12 months; and

(b) for a Benefit for Hospital Treatment or Hospital-Substitute Treatment that is psychiatric care, rehabilitation or palliative care (whether or not for a Pre-Existing Condition) - 2 months; and

(c) for any other Benefit for Hospital Treatment or Hospital-Substitute Treatment - 2 months.

3. Transfers

A person transfers to a policy of a health insurer (the new policy) from another policy of a health insurer (the old policy) if:

(a) either:

(1) the person is insured under the old policy at the time the person becomes insured under the new policy; or

(2) the person ceased to be insured under the old policy no more than 7 days, or a longer number of days allowed by HIF for this purpose, before becoming insured under the new policy; and

(b) the old policy is a complying health insurance policy; and

(c) the person's premium payments under the old policy were up to date at the time the person became insured under the new policy.

3.1 New Fund Members – transfers from Australian registered private health insurers.

HIF will give new Fund Members full Portability of cover to the level that is, at the time of transfer, equivalent to but not better than the level of cover with their old insurer, provided that:

(a) the new Fund Member has served all Waiting Periods with their old insurer;

(b) a Transfer Certificate detailing the level of cover, period of cover, persons covered, Certified Age at Entry and a claims history is received from the old insurer; and

(c) the financial date paid to with the old insurer is no greater than 2 months from the commencement date with HIF.

3.2 New Fund Members - transfers from Australian Registered private health insurers with a gap in cover greater than 2 months

A Fund Member who transfers from their old insurer shall be subject to Waiting Periods where the time from the financial date paid to with the old insurer to commencement is greater than 2 months.

Any of the following days that occur after an adult Fund Member ceases, for the first time after their Lifetime Health Cover base day to have hospital cover are permitted days without hospital cover in respect of that adult:

(a) days on which the cover is suspended by HIF in accordance with the Rules for suspensions set out in the *PHI (Lifetime Health Cover) Rules 2017* (Cth);

(b) days, not counting days covered by paragraph (a), on which the adult is overseas that form part of a continuous period overseas of more than one year;

(c) the first 1,094 days (not counting days covered by paragraph (a) or (b) on which they did not have hospital cover.

If the number of days without hospital applying to an adult Fund Member is greater than the number of permitted days without hospital cover, then an increased premium (a loading) shall apply to the Fund Membership in accordance with these Rules and Part 2-3 of the PHI Act 2007.

3.3 New Fund Members – transfers from Australian Registered private health insurers where Waiting Periods have not been fully served

Waiting Periods under an Insurance Product that applies to a person who transferred to the Insurance Product shall be equal to the periods referred to in paragraphs 2(a) – (c) of this Rule, less the Waiting Periods served (if any) with the old insurer at the time of transfer to the Insurance Product.

During a Waiting Period under an Insurance Product, persons covered under the Insurance Product shall not be entitled to Benefits.

3.4 New Fund Members - transfer from a Registered international health insurer

A new Fund Member who transfers from a policy of an international health insurer will be accepted with Portability of Benefits applicable to Basic Plus $750 Excess Hospital and Value Extras only during Waiting Periods of HIF, provided that:

(a) the financial date paid to with the old insurer is no greater than 2 months from the HIF joining date;

(b) the person’s old insurer provides HIF with relevant supporting documentation as may reasonably be required by HIF detailing, inter alia, the person’s previous level of cover, period of cover and those persons covered by that policy;

(c) the person has served all Waiting Periods of their old insurer.

The balance of a person’s 12 month Waiting Period with an old insurer shall be the greater

of:

(a) 12 months minus the actual Waiting Period served; and

(b) 0 month.

The balance of a person's 12 month Waiting Period with an old insurer shall be added to HIF's Waiting Period (if any).

3.5 New Fund Members – transfers from a lower level of cover of an Australian Registered private health insurer

A person who transfers from a lower level of cover under a policy of their old health insurer to a higher level of cover under an Insurance Product, in addition to any other Waiting Periods, shall serve HIF Waiting Periods in relation to those parts of the policy of HIF that were not available or not included under the policy of the old insurer.

To assist in removing doubt, the following situations would attract a HIF Waiting Period:

(a) where the Insurance Product does not include an excess or co-payment and the policy of the old insurer did, the excess or co-payment as the case may be shall apply to the person during the relevant HIF Waiting Period;

(b) where the Insurance Product does not include restricted services or treatments and the policy of the old insurer did, the restriction shall apply to the person during the relevant HIF Waiting Period;

(c) where the Insurance Product does include certain services or treatments and the policy of the old insurer did not include them or specifically excluded them, the exclusion shall apply to the person during the relevant HIF Waiting Period.

3.6 Waiting Periods – former Gold Card Holders

An Insurance Product that covers a person who:

(a) held a Gold Card, or was entitled to treatment under a Gold Card, before applying for the insurance; and

(b) applies for the insurance no longer than 2 months after the person ceased to hold, or be entitled under, the Gold Card,

shall not apply to the person any Waiting Period or Benefit Limitation Period for any Hospital Treatment or General Treatment covered by the Insurance Product.

3.7 Transfer Certificates

3.7.1 Certificate for the insured person

HIF (the **old insurer**) must, if a person ceases to be insured under an Insurance Product and does not become insured under another Insurance Product, give the person a certificate under this Rule:

(a) in the approved form; and

(b) within the period set out in the *PHI (Complying Product) Rules 2015* (Cth).

3.7.2 Certificate for the new insurer

HIF (the new insurer) must request a certificate from an old insurer if:

(a) a person who is or has been insured under a complying health insurance policy of the old insurer transfers to an Insurance Product; and

(b) the person does not give HIF the certificate the old insurer gave the person under sub-Rule (1) within 7 days of becoming insured by HIF.

The request must be made:

(c) in the approved form; and

(d) within the period set out in the *PHI (Complying Product) Rules 2015* (Cth), or otherwise, within 14 days.

HIF shall not request a certificate except in the circumstances set out in sub-Rule 3.7.2.

If a certificate is requested by HIF (whether or not the request is in the approved form or made within the period mentioned in sub-paragraph 3.7.2(d), the old insurer must give HIF a certificate in the approved form and within the period set out in the *PHI (Complying Product) Rules 2015* (Cth), or otherwise, within 14 days.

4. Terminating Insurance Products

4.1 Forced migration and notification requirements

If HIF terminates an Insurance Product or a product subgroup of an Insurance Product, HIF will transfer the policies of all Fund Members insured under that Insurance Product or product subgroup to a new policy and will inform each Policyholder whose policy is being terminated of the following a reasonable time before the transfer takes effect:

(a) that their policy forms part of an Insurance Product, or belongs to a product subgroup of an Insurance Product, that is being terminated and that will not be available to anyone (**Terminating Policy**);

(b) that, as a consequence, the Fund Members insured under the Terminating Policy are to be transferred to another insurance policy (**Default Policy**);

(c) the date by which the transfer is to take place (**Transfer Date**);

(d) that, before the Transfer Date, the Fund Members may transfer to any insurance policy of their choosing but, if they do not do so before the Transfer Date, they will be transferred to the Default Policy on the Transfer Date;

(e) information about the Default Policy (as set out in paragraph 4.2 below);

(f) information about Waiting Periods (as set out in paragraph 4.3 below); and

(g) information about excesses and co-payments (as set out in paragraph 4.4 below).

4.2 Information about the Default Policy

HIF will provide all Policyholders holding Terminating Policies with the following information regarding the Default Policy:

(a) the PHIS for the Default Policy;

RESTRICTED: Authorised Recipients Only.

(b) details of the premium that would be payable for the Default Policy (including any increase in the premium for Lifetime Health Cover and any discounts that might apply); and

(c) details of:

(i) any treatments that are covered under the Terminating Policy that will not be covered under the Default Policy; and

(ii) any differences between the excesses or co-payments payable under the Terminating Policy and the Default Policy.

4.3 Information about Waiting Periods

If a Fund Member transfers from the Terminating Policy to the Default Policy (or to an alternative policy) and there are particular Hospital Treatments or Hospital-Substitute Treatments that are covered by both the Terminating Policy and the policy to which the Fund Member is transferred or transfers, for each such treatment, HIF will treat the Fund Member as having satisfied the Waiting Period for that treatment (if any) provided that the Fund Member has satisfied the Waiting Period for that treatment under the Terminating Policy.

If a Fund Member transfers from the Terminating Policy to the Default Policy and subsequently transfers from the Default Policy to another insurance policy (**Replacement Policy**) and there are any treatments that were not covered by the Default Policy but that are covered by the Replacement Policy, then HIF may require the Fund Member to serve the Waiting Periods set out in Rule C6.2 in respect of those treatments even if the treatments were originally covered by the Terminating Policy.

4.4 Information about excesses and co-payments

If a Fund Member transfers from the Terminating Policy to the Default Policy and subsequently transfers from the Default Policy to a Replacement Policy and if the Default Policy had higher excesses or co-payments than the Replacement Policy, then those higher excesses or co-payments may continue to apply under the Replacement Policy for a period of time not exceeding the Waiting Periods set out in Rule C6.2.

C7 Cancellation of Membership

1. Cancellation

HIF will cancel a Fund Member's Fund Membership in the following circumstances:

(a) upon receipt by HIF of a request, in the prescribed form, from the Primary Fund Member to cancel the Fund Membership entirely;

(b) upon receipt by HIF of a request, in the prescribed form, from the Primary Fund Member to remove a Fund Member from the Fund Membership;

(c) upon receipt by HIF of a request, in the prescribed form, from a Fund Member covered under the Insurance Product other than the Primary Fund Member to remove that Fund Member from the Fund Membership; or

(d) immediately after 2 months after the Fund Membership becomes unfinancial (in Arrears).

HIF may at its absolute discretion and under such terms and conditions as HIF determines are appropriate, reinstate a previously cancelled Fund Membership. In considering a request of a

previous Fund Member (requester) to reinstate, HIF may determine the matter in favour of the requestor and give effect to continuity of service and related Fund Membership entitlements, provided that the reinstatement is subject to Rule D5.

2. Refund of Premium Contributions

(a) HIF will refund premium Contributions relating to the period after the date that a request in the prescribed form, to cancel a Fund Membership, is received by HIF or the period after the date specified in the prescribed form, whichever is the latter.

(b) HIF may at its absolute discretion, charge an administration fee in relation to a cancellation.

(c) HIF may, in the case of a refund of premium Contributions resulting from a cancellation, deduct the administration fee (if any).

3. Cooling Off Period

A new Fund Member who has not yet made a claim for Benefits under their policy and who terminates that policy within a period of 30 days from the start date of their Fund Membership is entitled to receive a full refund of any Contributions received by HIF.

C8 Termination of Membership

Termination of Fund Membership - Fund Member acting improperly

1. Termination

A Fund Membership may be terminated by HIF under this Fund Rule, at the time:

(a) determined pursuant to the Constitution;

(b) a Fund Contributor or Fund Member, acting alone or in concert with another person, obtains or attempts to obtain an improper financial or other advantage from HIF;

(c) in the opinion of HIF, a Fund Contributor or Fund Member, acting alone or in concert with another person, deceives or misleads HIF, or attempts to mislead or deceive HIF;

(d) a Fund Contributor or Fund Member does not provide HIF with true, accurate or full information with respect to the Fund Membership of a Fund Member or a Fund Member; or

(e) HIF, at its absolute discretion, determines that it is reasonable and appropriate in the circumstances that the Fund Membership be terminated;

provided that HIF shall give written notice to the Primary Fund Member, including reasons and the amount (if any) to be refunded for premium Contributions received in advance of the date of termination, that the Fund Membership is terminated according to this Fund Rule.

2. Reinstatement

Where a Fund Membership has been terminated under this Fund Rule, subject to a provision of a law to the contrary, HIF shall, upon receipt of a written request from a terminated Fund Contributor or Fund Member, have an absolute discretion to reinstate a Fund Membership,

including the giving of continuity of Fund Membership and entitlements, provided that the Fund Membership becomes financial at the date of reinstatement.

C9 Temporary Suspension of Membership

1. Suspension of Fund Membership and Insurance Product

HIF may approve a request, in the prescribed form, from a Primary Fund Member to suspend their Fund Membership including the insurance cover under the Fund Membership for any one of the following reasons, provided that the Fund Membership has been financial and held continuously for no less than 3 months ("Suspension Qualifying Period") prior to the date specified in the request as being the proposed effective date of suspension:

(a) Unemployment - where a Fund Member wishes to suspend their Fund Membership due to unemployment, the maximum period of suspension is 12 continuous months. Supporting documentation in the form of a health care card, supporting documents from Centrelink or other documentation may be reasonably required by HIF;

(b) Financial hardship - where a Fund Member wishes to suspend their Fund Membership due to financial hardship, the maximum period of suspension is 12 continuous months. A written request including supporting documentation may be reasonably required by HIF;

(c) Overseas travel - where a Fund Member wishes to suspend their Fund Membership due to overseas travel, the minimum period of suspension is 2 continuous months and the maximum period of suspension is 24 continuous months. A written request including supporting documentation may be reasonably required by HIF;

(d) Other - HIF may at its absolute discretion approve suspension of Fund Membership for a reason other than a reason detailed in subparagraphs (a) – (c) for a maximum of 12 continuous months provided that a written request, including supporting documentation, is made to HIF's Member Action Review Committee ("MARC").

Upon written request by the Primary Fund Member, HIF may, at its absolute discretion, reduce or waive the Suspension Qualifying Period or increase the relevant maximum period of suspension under sub-paragraphs (a) – (d).

2. Overseas Visitors cover - sole reason and time limits

(a) A request in the form referred to in sub-Rule (1) of this Fund Rule relating to an Overseas Visitor's Insurance Product shall only be considered by HIF where all persons covered under the Insurance Product are overseas during the (requested) period of suspension.

(b) The minimum period a Fund Membership may be suspended under this sub-Rule is 14 days.

(c) The maximum duration a Fund Membership may be suspended in any continuous 12 month period shall not exceed 4 months.

3. Fund Membership and Insurance Product to be paid in advance

A Fund Membership shall not be suspended unless premium Contributions paid to HIF cause the Fund Membership to be financial up to and including the day prior to commencement of the period of suspension.

4. All parts of the Fund Membership and Insurance Product to be suspended

A Fund Membership that includes an Insurance Policy comprising a component relating to Hospital Treatment and a component relating to General Treatment cannot be partly suspended by suspending either the Hospital Treatment component or the General Treatment component but not both components.

5. Arrangements during Fund Membership and Insurance Product suspension period

During the period a Fund Membership is suspended:

- The Fund Membership category (Fund Membership status) will be adjusted to reflect the suspension;
- The Fund Membership shall not be taken into account for the purposes of generating a premium Contribution charge;
- Benefits shall not be payable for services and treatments received by any person covered under the Fund Member's Insurance Product; and

  The period of suspension does not count for any purpose in relation to the Fund Membership, including but not limited to Waiting Periods.

6. Minimum period between suspension periods

The period between two suspension periods that were Approved for the same reason shall be no less than 12 months between the end of a previous suspension and the start of another suspension approved for the same reason.

7. Documentation to be provided

The Primary Fund Member of a Fund Membership who wishes to either suspend or reactivate the Fund Membership shall make a request to HIF for the relevant change in the prescribed form and at the same time supply HIF with any relevant documentation requested by HIF.

8. Reactivation to occur within one (1) month

Where the relevant reason for approving suspension ceases to apply to a Fund Membership, or the maximum period of suspension has been reached, then:

(a) If the Primary Fund Member reactivates the Fund Membership within one (1) month, continuity of Fund Membership will apply;

(b) If the Primary Fund Member reactivates the Fund Membership later than one (1) month, the Fund Membership will be deemed to be a new Fund Membership for all purposes; and

(c) If the Fund Membership refers to an Insurance Product that is subject to rule A6 No Improper Discrimination and is no longer available at the time of resumption, HIF will

offer the Fund Member an Insurance Product that HIF considers is most similar to that which is no longer available.

9. Early reactivation - Waiting Periods

Where a suspended Fund Membership is reactivated while the relevant reason that gave rise to the approval for suspension continues to apply, and the maximum suspension period has not been reached, a new Waiting Period of two months shall apply to all persons covered under the relevant Fund Membership from the date of reactivation.

10. Lifetime Health Cover

Days on which an adult is overseas that form part of a continuous period overseas of more than one year count as permitted days without Hospital cover.

Lifetime Health Cover loading (if any) shall not include permitted days overseas that form part of a continuous period overseas of more than one year.
A person is taken to be overseas:

(a) During any period in which the person returns to Australia for less than 90 days.

A person is taken to have returned from overseas if the person returns to Australia for a period of at least 90 days.

11. Reactivation following termination of Insurance Product

Where an Insurance Product is terminated in accordance with Rule C6.4 during a period of suspension, HIF will, unless the Fund Member requests prior to reinstatement to be reinstated to an alternative policy, reinstate the Fund Member to the Default Policy for the Terminating Policy determined under Rule C6.4.

D CONTRIBUTIONS

D1 Payment of Contributions

1. Definition and Contributor or Member Obligation

A premium Contribution is an amount paid or payable by a Fund Contributor or Fund Member to HIF in consideration for an Insurance Product that covers Hospital Treatment or General Treatment or both (whether or not it also covers any other treatment or provides a Benefit for anything else) in respect of a Fund Member(s).

In these Fund Rules, unless otherwise stipulated, “premium Contribution”, “premium” and “Contribution” mean the same.

2. Contribution Methods and Frequency

HIF accepts premium Contributions on weekly, fortnightly, monthly, quarterly, half yearly and yearly payment cycles. Only the following premium Contribution payment cycles are available to Fund Members:

Payment Method	Available Payment Cycles
1. Direct payment	quarterly, half yearly, yearly
2. Direct debit	fortnightly, monthly, quarterly, half yearly, yearly
3. Payroll deduction	weekly, fortnightly, monthly, quarterly half yearly, yearly

A Fund Member can elect to alter their payment cycle at reasonable intervals.

A Fund Contributor or a Fund Member may by request nominate the day on which a payment cycle commences. The day on which a payment cycle commences shall not include a Saturday or a Sunday. Where a payment cycle commencement occurs on a public holiday, HIF shall determine an alternative day on which the relevant premium Contribution is to be paid.

Fund Members must pay premium Contributions in Australian legal tender currency by cash, cheque, money order, payroll deduction as part of a payroll group comprising not less than five Fund Memberships, direct debit, HIF accepted debit card, HIF accepted credit card or other method as might be agreed by the Fund Member and the Managing Director of HIF. Excepting payroll deduction or direct debit, the minimum period a premium Contribution payment shall cover is one month. Contributions shall be paid in advance.

3. State Premium Contribution Rates

Premium Contributions may differ for the same Insurance Product, based upon the State or Territory in which the Fund Contributor permanently resides. Where upon relocation a Fund Contributor does not advise HIF of their new State or Territory residential status and HIF determines this to be the case, it may reasonably backdate the change of premium Contributions for that Fund Contributor.

D2 Contribution Rate Changes

1. Effective Date

Premium Contribution rates may change from time to time. The date that a new or changed premium Contribution rate becomes applicable is the effective date. The published date, being a date prior to the effective date, is the date that HIF notifies its Fund Members that premium Contribution rates will change on the effective date.

2. Published Date

Where a premium Contribution payment made prior to a published date causes (i.e. without the imposition of a premium Contribution rate change) a Fund Member's paid to date to be later than the effective date of a change in premium Contribution rates, that paid to date shall not be altered as a consequence of that rate change.

Where a premium Contribution payment is made after a published date and before the effective date of a change to premium Contributions, so much of that payment as relates to the period from

the day after the previous paid to date to the day before the effective date shall be applied at the premium Contribution rates existing before the change, and the remainder of the payment (if any) shall be applied to the period commencing on the effective date to the next paid to date at the premium Contribution rates existing after the change.

3. Payment in Advance – Maximum Period

The maximum period payable in advance for cover under an Insurance Product is 12 months from the date of payment of a premium Contribution.

4. State or Territory Premiums

HIF may apply different premium Contribution rates based on the Australian State or Territory in which the Fund Member permanently resides.

D3 Contribution Discounts

HIF may, at its absolute discretion, discount premium Contributions for any or all of the following reasons:

(a) they are paid at least three months in advance;

(b) they are paid by payroll deduction;

(c) they are paid by pre-arranged automatic transfer from an account at a bank or other financial institution;

(d) Fund Members have agreed to communicate with HIF, or make claims under their Insurance Product, by electronic means;

(e) Fund Members insured under an Insurance Product are, under these Fund Rules, treated as belonging to a Contribution group;

(f) HIF is not required to pay a levy in relation to an Insurance Product under a law of a State or Territory; or

(g) it is permitted under the *PHI (Complying Product) Rules 2015* (Cth).

A discount in respect of an Insurance Product is the difference between the full premium and the net premium. The discount percentage (if any) is the percentage determined by dividing the monetary amount of discount for the relevant period by the monetary amount of the full premium for the same period.

The maximum percentage discount allowable is 12%. If during the relevant year, premium Contributions are discounted by more than 12%, HIF shall be entitled to recover from the Fund Contributor of the Fund Membership the amount(s) necessary to ensure the premium Contributions for the relevant year are not discounted by more than 12%.

A discount includes any of the following:

(a) an incentive payment;

(b) a promotional payment;

(c) a rebate; and

(d) any other inducement whatsoever,

made available by HIF to another person, including to an insured person, in respect of the payment of a premium Contribution for an Insurance Product, including inducing a person to purchase or maintain an Insurance Product.

A discount does not include the following:

(a) a brokerage fee or commission paid in respect of an Insurance Product; and

(b) the cost of any discount, product, service, waiver or other thing (promotion) offered to a person at the time the person first purchases a Product from HIF if:

(iii) the cost of the promotion does not exceed 12% of the full premium, for a year, for the Insurance Product purchased; and

(iv) the promotion is provided in the first year after a person purchases an Insurance Product.

Excepting payments in advance from Contribution groups, the following discounts apply automatically to full premiums:

(a) 2% in relation to a single payment in advance covering not less than six months but less than twelve months;

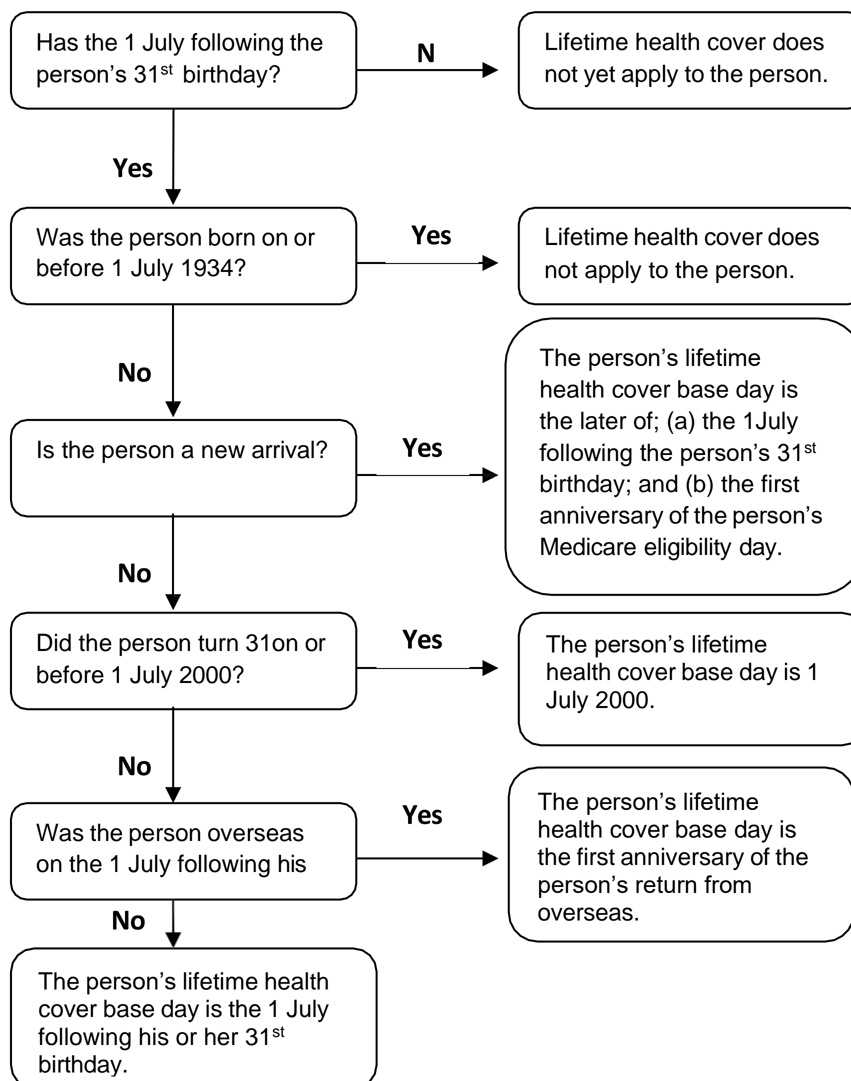
(b) 4% in relation to a single payment in advance covering not less than twelve months.

HIF may, at its absolute discretion, discount the full premium of all policies included in a premium Contributions group by between 4% and 12%.

D4 Lifetime Health Cover

Subject to the PHI Act 2007, from the 1st July 2000, adult Fund Members who take out Hospital cover late will have to pay increased premiums. An adult Fund Member takes out Hospital cover late when he or she does not have Hospital cover on their Lifetime Health Cover base day. Lifetime Health Cover base day is determined by using the following diagram:

Working out a person's lifetime health cover base day



The amount of increased premium is determined using the following formula:

(Lifetime Health Cover age – 30) X 2 % X Base rate, *where*:

Base rate for Hospital cover is the amount of premium that would be payable for that cover if:

(a) the premium was not increased under this Rule; and

(b) there was no discount of the kind allowed under these Rules pursuant to section 66-5(2) of the PHI Act 2007.

Lifetime Health Cover age, in relation to an adult who takes out Hospital cover after his or her Lifetime Health Cover base day, means the adult's age on the 1st July before the day on which the adult took out the Hospital cover.

If after the adult's Lifetime Health Cover base day, the adult ceases to have Hospital cover, HIF must increase the adult's premium determined using the following formula:

Years without Hospital cover X 2 % X Base rate, *where*:

Base rate is the base rate for the Hospital cover (see above), *and*

Years without Hospital cover is the number obtained by:

(a) dividing by 365 the number of days (other than permitted days without Hospital cover), after the first day on which the adult did not have Hospital cover; and

(b) rounding up the result to the nearest whole number.

HIF must stop increasing the amount of premiums payable for Hospital cover in respect of an adult under this Rule if the adult has had Hospital cover (including under an applicable Benefits arrangement), the premiums for which have been increased under this Rule or Schedule 2 to the *National Health Act 1953* as in force before the 1st April 2007:

(a) for a continuous period of 10 years; or

(b) for a period of 10 years that has been interrupted only by permitted days without Hospital cover or periods during which the adult was taken to have had Hospital cover otherwise than at any time during which the adult was covered by an applicable Benefits arrangement within the meaning of the *National Health Act 1953* as in force before the 1st April 2007 (none of which count towards the 10 years). The amount must stop being increased on the day after the last day of the 10 year period.

The amount of premiums payable for Hospital cover in respect of an adult must start to be increased under this Rule again if:

(a) after the end of the 10 year period, the adult ceases to have Hospital cover; and

(b) the adult later takes out Hospital cover again; and

(c) the days in the period between ceasing to have the cover and taking it out again are not all permitted days without Hospital cover in respect of the adult.

These Rules are not prevented from applying again in respect of any later 10 year period.

Hospital cover is so much of an Insurance Products covers Hospital Treatment. An adult has hospital cover if he or she is insured under an Insurance Product that covers Hospital Treatment.

An Adult is taken to have Hospital cover:

(a) at any time during which the adult was covered by an applicable Benefits arrangement; or

(b) at any time during which the adult holds a Gold Card; or

(c) at any time during which the adult is in a class of adults specified in the *PHI (Lifetime Health Cover) Rules 2017* (Cth) for the purposes of this Rule.

Gold Card means a card that evidences a person's entitlement to be provided with treatment:

(a) in accordance with the Treatment Principles prepared under section 90 of the *Veterans' Entitlements Act 1986* (Cth); or

(b) in accordance with a determination made under section 286 of the *Military Rehabilitation and Compensation Act 2004* (Cth) in respect of the provision of treatment.

Subject to the PHI Act 2007, persons born on or before the 1st July 1934 shall be exempt from increased premiums for Lifetime Health Cover (i.e. a "loading") under this Rule.

Subject to the PHI Act 2007, the maximum that the Base Rate can increase by under this Rule is 70 %.

In determining whether or not a person had Hospital cover at a particular time or for a particular period, the following types of evidence shall be accepted by HIF:

(a) the Annual statement issued to, or on behalf of, the person by the private health insurer (if any) providing the cover at the particular period;

(b) a determination referred to in the PHI Act 2007 in respect of the person, if the date to which the determination applies is the particular time or is included in the particular period;

(c) a written statement issued by the Australian Antarctic Division of the Department of the Environment and Heritage, that the person had health services provided by or through the Australian Antarctic Division at the particular time or during the particular period;

(d) a written statement issued by the Australian Defence Force that the person had health services provided by or through the Australian Defence Force at the particular time or during the particular period.

In establishing a person's age for the purpose of determining whether or not increased premiums (i.e. a "loading") under Lifetime Health Cover provisions of the PHI Act 2007 apply, HIF shall accept the following kinds of evidence as conclusive evidence of that person's age:

(a) an original birth certificate in respect of the person;

(b) a current driver's licence issued to the person;

(c) a current passport issued to the person.

HIF may accept other evidence if a document of a kind mentioned in this Rule is not available to be given as evidence.

D5 Arrears in Contributions

A Fund Membership (other than a suspended Fund Membership) is in Arrears or in a period of Arrears whenever the date to which premium Contributions have been paid (i.e. the "paid to date") is earlier than the Current date. A Fund Membership that is in Arrears is deemed to be "unfinancial" and one that is not "financial".

Rebates are not payable for services or treatments provided to a Fund Member or a person covered under a Fund Member's Fund Membership during a period of Arrears whilst a Fund Membership is in Arrears.

A Fund Member, who has fallen into Arrears, may with HIF's approval, within 2 months after the date of falling into Arrears, pay HIF the sum of:

(a) premium Contributions that are in Arrears; and

(b) one month's premium Contributions.

A Fund Member's claim that has not been assessed, processed or dealt with including a rebate that has been withheld because or whilst a Fund Membership remains in Arrears, shall become assessable, capable of being processed or dealt with or remitted as the case may be, upon payment of the amounts specified under (a) and (b) in the preceding paragraph.

On the day immediately after 2 months after an unfinancial Fund Membership was last financial, the Fund Membership shall automatically terminate from the day the Fund Membership was last financial. A terminated Fund Membership may, at the absolute discretion of the Managing Director or his/her authorised delegate nominee, be reinstated under such terms and conditions as might under the circumstances, in the opinion of the Managing Director or their authorised delegate nominee, be reasonable having, *inter alia*, regard to the interests of all Fund Memberships.

D6 Other

In the event that a Fund Member properly advises HIF that they have decided to transfer to another fund not operated by HIF, then if at the date of transfer the Fund Membership is paid in advance, HIF shall refund the net amount paid in advance, less an administration fee (if any), provided that such fee shall not exceed $50.

E BENEFITS

E1 General Conditions

The amount of any rebate Benefit paid or payable by HIF in relation to a claim by a person covered under an Insurance Product shall not result in the person receiving a greater amount than the fee or charge of the Health Care Provider in relation to that claim.

1. Services and treatments supplied by HIF recognised Health Care Providers

HIF shall only pay a rebate Benefit in respect of a service or treatment, including goods supplied as part of or integral to the provision of a service or treatment, if it is supplied by a Health Care Provider that is recognised by HIF, including:

(a) a Hospital declared by the Minister to be a Hospital pursuant to section 121-5(5) of the PHI Act 2007;

(b) a Health Care Provider other than a Hospital under sub-paragraph (a) of this Rule; and

The Health Care Provider provides the service or treatment whilst they are in Independent Private Practice.

HIF may at its absolute discretion, determine if a Health Care Provider is to be recognised, irrespective of whether or not the Health Care Provider meets all or only some of the HIF criteria for recognition.

In determining a Health Care Provider's eligibility for recognition, HIF shall have regard for, inter alia, the Health Care Provider's ability to demonstrate to HIF's absolute satisfaction that;

(a) they have the required skills, experience, standards, competencies and qualifications to supply the relevant service or treatment; or

(b) a service or treatment of the Health Care Provider is clinically relevant or appropriate.

2. Health Care Provider

For the purposes of this Rule, a Health Care Provider is:

(a) a person who provides goods or services as, or as part of, Hospital Treatment or General Treatment; or

(b) a person who manufactures or supplies goods provided as, or as part of, Hospital Treatment or General Treatment.

3. Health Care Provider fails to meet recognition requirements

HIF shall not pay a rebate Benefit in respect of a service or treatment, including goods supplied as part of or integral to the provision of a service or treatment, if or HIF has reasonable grounds to believe:

(a) premises or facilities do not meet the definition of Hospital as set out in Sub-Rule 1(a) above;

(b) a Health Care Provider is not in Independent Private Practice;

(c) a Health Care Provider does not meet the recognition criteria of HIF;

(d) a Health Care Provider does not supply a clinically relevant or appropriate service or treatment.

4. Recognised Health Care Provider ceases to meet recognition requirements

At the time that a previously recognised Health Care Provider no longer meets the HIF requirements for recognition, HIF shall, in addition to the right in Rule E1 (3) above, have the following rights:

(a) suspend the Health Care Provider's recognition;

(b) cancel the Health Care Provider's recognition.

5. Benefit reduction

Where a rebate Benefit is payable in respect of a claim by a person covered under an Insurance Product, the rebate Benefit shall be reduced in the following circumstances:

(a) where the Health Care Provider's fee or charge is lower that the rebate Benefit that would otherwise have been payable by HIF, the rebate Benefit shall be reduced to equal the amount of the Health Care Provider's fee or charge;

(b) where money is payable or a Benefit accrues, or both, to a claimant who is covered under an Insurance Product, from another source other than from HIF for a service or treatment that HIF would, but for the other source, pay, HIF shall pay a rebate Benefit to the claimant of such amount as to cause the total money and Benefit accruing to the claimant to equal the fee or charge of the Health Care Provider; and

(c) where in the reasonable opinion of HIF a fee or charge of a Health Care Provider is higher than their usual charge for a service or treatment, HIF shall when assessing a claim that includes a higher fee or charge, adopt the Health Care Provider's usual fee or charge as if it had applied from the outset.

6. Benefit liability where false or misleading information is provided

HIF shall not pay a rebate Benefit in respect of a service or treatment, including goods supplied as part of or integral to the provision of a service or treatment, if or HIF has reasonable grounds to believe that the rebate Benefit would have, had it been paid, resulted from false or misleading information.

E2 Hospital Treatment

1. Benefits applicable to all Hospital Treatment

For the purposes of this Fund Rule, Hospital Treatment is treatment (including the provision of goods and services) that:

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

(b) is provided to a person:

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

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

(c) either:

  (i) is provided at a Hospital; or

  (ii) is provided, or arranged, with the direct involvement of a Hospital;

(d) is specified in the *PHI (Health Insurance Business) Rules 2018* (Cth) as being Hospital Treatment.

2. Treatment included under Hospital Treatment

A reference to treatment in these Fund Rules includes a reference to any of, or any combination of accommodation, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition.

3. Continuous Period of Hospitalisation

HIF calculates a Continuous Period of Hospitalisation by counting consecutive days of Hospital Treatment, including any 2 periods of consecutive days during which a patient was or is receiving Hospital Treatment as an Inpatient of a Hospital, whether or not the same Hospital, where the periods are separated from each other by a period of not more than 7 consecutive days during which the Inpatient was not receiving Hospital Treatment as an Inpatient at any Hospital.

4. Hospital Benefits not payable in certain circumstances

HIF shall not pay a hospital Benefit in the following circumstances:

(a) where, pursuant to section 75-1 of the PHI Act 2007, a Fund Member has not served the applicable Waiting Periods for the service or treatment being undertaken;

(b) where the Fund Membership is unfinancial, cancelled or suspended at the date of service or treatment;

(c) where, pursuant to section 75-15 of the PHI Act 2007, the service or treatment being undertaken is a Pre-Existing Condition;

(d) in respect of a claim or that part of a claim in respect of a service or treatment, pursuant to Fund Rule F7, which has been or could be met out of a Third Party Compensation claim;

(e) where a claim is not submitted to HIF in the prescribed form;

(f) for a medical service or treatment that is classified as cosmetic or where a Benefit is not payable by Medicare Australia;

(g) for a medical service or treatment not recognised by Medicare Australia;

(h) for a medical service or treatment rendered or supplied outside of Australia;

(i) where a service or treatment is classified as a Type C procedure and would not normally require hospitalisation and where certification is not supplied by a medical practitioner;

(j) where a service or treatment has been rendered or supplied to a newborn who is not admitted in their own right as an Inpatient in Hospital;

(k) where a service or treatment has been rendered or supplied as part of an attendance at an emergency department of a Hospital;

(l) the cost of care or accommodation in an aged care service (within the meaning of the *Aged Care Act 1997* (Cth));

(m) where there is a charge for a pharmaceutical Benefit supplied under Part V11 of the *National Health Act 1953* (Cth) unless the charge is covered by section 92B of that Act;

(n) any other treatment specified in the *PHI (Complying Product) Rules 2015* (Cth) as treatment for which Benefits must not be provided.

5. Contracted Hospitals

Benefits shall be paid at Contracted Hospital Purchaser Provider Agreement rates that are agreed to between a Hospital and the AHSA. A full list of Contracted Hospitals is available from HIF.

6. Non-contracted and public Hospitals

HIF Benefits shall be paid in accordance with the following table, pursuant to the *PHI (Benefit Requirements) Rules 2011* (Cth) and section 72-1 of the PHI Act 2007:

Requirements of an Insurance Product that covers Hospital Treatment must meet		
Item	**There must be a Benefit for:**	**The amount of the Benefit must be:**
1.	Any part of Hospital Treatment that is one or more of the following: (a) psychiatric care; (b) rehabilitation; (c) palliative care; if the treatment is provided in a Hospital and no Medicare Benefit is payable for that part of the treatment.	At least the amount set out, or worked out using the method set out, in the *Private Health Insurance (Benefit Requirements) Rules 2011* as the Minimum Benefit, or method for working out the Minimum Benefit, for that treatment.
2.	Hospital Treatment covered under the Insurance Product for which a Medicare Benefit is payable.	(a) If the charge for the treatment is less than the schedule fee for the treatment—so much of the charge (if any) as exceeds 75% of the schedule fee; and (b) Otherwise—at least 25% of the treatment.
3.	If the Insurance Product covers Hospital-Substitute Treatment—Hospital-Substitute Treatment covered under the Insurance Product for which a Medicare Benefit is payable.	(a) If the charge for the treatment is less than the schedule fee for the treatment—so much of the charge (if any) as exceeds 75% of the schedule fee; and (b) Otherwise—at least 25% of the schedule fee for the treatment; but the Benefit must not be provided if a Medicare Benefit of an amount that is at least 85% of the schedule fee is claimed for the treatment.

Requirements of an Insurance Product that covers Hospital Treatment must meet		
Item	**There must be a Benefit for:**	**The amount of the Benefit must be:**
4.	(a) Hospital Treatment *covered under the Insurance Product; and (b) if the Insurance Product covers hospital-substitute treatment— Hospital-Substitute Treatment covered under the Insurance Product; that is the provision of Medical Devices and Human Tissue Products of a kind listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules* in circumstances: (c) in which a Medicare Benefit is payable; or (d) set out in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules* for the purposes of this table item.	(a) At least the amount set out, or worked out using the method set out, in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules* as the Minimum Benefit, or method for working out the Minimum Benefit, for the Medical Devices and Human Tissue Products; and (b) If the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules* set out an amount, or a method for working out an amount, as the maximum Benefit, or method for working out the maximum Benefit, for the Medical Devices and Human Tissue Products - no more than that amount, or the amount worked out using that method.
5.	Any treatment for which the *Private Health Insurance (Benefit Requirements) Rules 2011* specify there must be a Benefit.	At least the amount set out, or worked out using the method set out, in the *Private Health Insurance (Benefit Requirements) Rules 2011* as the Minimum Benefit, or method for working out the Minimum Benefit, for that treatment.

7. Multiple procedures

Where an Inpatient undergoes more than one procedure in a Hospital theatre, the procedure with the highest fee in the Medicare Benefits Schedule shall determine the Inpatient's classification.

Where an Inpatient undergoes a procedure in a Hospital theatre subsequent to an initial procedure in a Hospital theatre as part of the same period of hospitalisation (Admission):

(a) where the subsequent procedure results in the Inpatient having a higher classification, the Inpatient's classification increases from the date of the subsequent procedure;

(b) where the subsequent procedure would otherwise have resulted in the Inpatient moving to a lower classification, the Inpatient's classification shall remain the same as applies to the first classification;

(c) where the Inpatient is discharged, and within seven days is admitted to the same or a different Hospital for the same or a related condition, the two Admissions are regarded as forming one period of continuous hospitalisation;

(d) where the Inpatient is discharged, and within seven days is admitted to a different Hospital, Benefits at the advanced surgical, surgical or obstetric levels shall only be payable in respect of the subsequent Admission only if an appropriate procedure is rendered following that Admission.

8. Minimum Benefits

HIF shall pay the Minimum Benefit payable in respect to the following treatments pursuant to section 72-1 of the PHI Act 2007:

(a) psychiatric care, rehabilitation and palliative care; and

(b) Medical Devices and Human Tissue Products.

The Minimum Benefit payable in respect to treatment for psychiatric care, rehabilitation and palliative care may be reduced by any applicable excess or co-payment in accordance with the relevant product held by the Fund Member at the time of Admission.

9. Medical Devices and Human Tissue Products

HIF shall pay a Benefit towards Medical Devices and Human Tissue Products in accordance with the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules* and section 72-1 of the PHI Act 2007.

10. Boarder Benefits

10.1 Contracted Hospital

Unless covered under rule E2.10.3, a boarder Benefit is payable in accordance with the relevant Hospital contract where a separate charge for a boarder has been raised by the Hospital. Where a Hospital contract does not specify the circumstances upon which a charge shall be raised for a boarder Benefit, the following shall apply:

(a) Benefits are payable in respect of a parent of a Child Dependant who is admitted where all Fund Members are covered under the same Insurance Product;

(b) Benefits are payable for 2 parents where 2 or more Dependant children are admitted where all Fund Members are covered under the same Insurance Product;

(c) Benefits are payable for a Child Dependant or children where a sole parent Fund Member is admitted, and all Fund Members are covered under the same Insurance Product;

(d) applicable excess or co-payments under an Insurance Product will not be deducted from the boarder Benefit;

(e) boarder Benefits will be paid to a maximum of 10 days per Admission.

10.2 Public Hospital

Unless covered under rule E2.12.3, a boarder Benefit of $20 per day will be payable in accordance with the HIF criteria detailed for Contracted Hospitals.

10.3 Maternity Admission Boarder Fees

(a) Benefit will be paid in respect of boarder fees incurred in relation to an eligible maternity hospital admission for a Fund Member covered by a Gold Star or Gold Hospital product

(b) An eligible maternity admission is admission for management of labour and delivery, and where the Fund Member is admitted as a private patient

(c) The boarder's presence must be integral to the management of the patient's condition however the boarder can be any person nominated by the Fund Member

(d) Benefit will only be paid where boarder services are provided within the hospital facility to which the member is admitted (cannot be "outsourced" accommodation).

(e) A daily maximum Benefit of $115 will apply to each boarder day, charged by the hospital

(f) The maximum number of boarder days claimable per eligible maternity admission will be:

- **Gold Star Hospital** – no more than the days accommodation associated with the eligible maternity admission of the Fund member
- **Gold Hospital** – no more than the greater of 5 days or the days accommodation associated with the eligible maternity admission of the Fund Member

11. Medical Benefits

(a) HIF shall pay medical Benefits in accordance with section 72-1 of the PHI Act 2007;

(b) HIF shall pay a Benefit for all Inpatient medical procedures that are covered under an Insurance Product where a Medicare Benefit is payable by Medicare Australia;

(c) HIF shall pay a Benefit towards outpatient and Inpatient procedures that are covered under an overseas Hospital Insurance Product and

(d) HIF shall pay a Benefit in accordance with Access Gap Cover for inpatient medical services and treatment that is covered under eligible Hospital Insurance Product.

11.1 Access Gap Cover

(a) Access Gap Cover scheme allows HIF to pay where eligible, over the Medicare Benefits Schedule (MBS) amount for inpatient medical services and treatments in accordance with the AHSA Access Gap Scheme

(b) Access Gap Cover shall comprise known gap and no gap Benefits;

(c) Where the Medical Provider chooses not to participate in the Access Gap Cover Scheme HIF can only pay up to the MBS amount.

(d) Access Gap Cover is automatically included in all eligible Hospital Products

(e) A Benefit paid to participating Medical provider under Access Gap Cover is determined by reference to the HIF schedule of Benefits which are set as a percentage above the Medicare Benefits Schedule;

(f) If a Medical Provider chooses to charge in excess of the HIF Access Gap Cover fee, there will be an out of pocket expense to the patient;

(g) Each individual Medical Provider in the admitted episode of care can choose to charge their patient a maximum out-of-pocket cost of up to $500 for MBS rebateable items only.

(h) Obstetricians can choose to charge their patient a maximum out-of-pocket cost of up to $800 per episode for MBS items that relate to 'Management of Labour and Delivery'.

(i) If a surgeon submits one claim with both their services and the assistant surgeon services, the maximum total out of pocket expense for their patient for both that claim, and the episode cannot exceed $500 if Access Gap Cover is to apply. The out of pocket rule requires one account per claiming provider and therefore only one co-payment is permissible per claim.

11.2 Informed Financial consent

If the Provider elects to charge the Fund Member an out of pocket expense, the Provider must obtain written Informed Financial Consent;

11.3 Submitting the claim

The Medical Provider must not charge the patient for the total cost of treatment up-front. Only the known out of pocket expense can be charged to the Member where written informed financial consent has been provided

The Medical provider must submit a single claim to the Fund that covers an entire episode, being all MBS services that form part of the episode. The claim must be sent directly to HIF unpaid and must disclose the total cost of treatment, including any patient out of pocket expenses.

HIF will lodge the claim with Medicare via EFT and on receipt of the payment from Medicare will forward that amount and any other entitlement payable by HIF to the medical provider;

11.4 Provider Audits and repayments

HIF or our respective nominees may conduct an audit on the Provider to request further information about a Claim, including to determine whether the Claim is a Valid Claim or whether AGC Benefits are otherwise payable.

The Provider agrees upon reasonable notice under to promptly provide relevant information and grant access to relevant documents and records;

Where it has been established that the Provider has received a benefit, they were not entitled or have not complied with the Access Gap Cover Agreement, the Provider will repay HIF within 21 days of it being established and notified.

Where this applies, the Provider cannot attempt to seek payment or reimbursement of the relevant amount from the Fund Member.

HIF may set off any amount it owes the Provider under the Agreement against any amount that the Provider owes the Fund under the Agreement.

11.5 Termination and disengagement

HIF or AHSA may withdraw the medical practitioner's name from the Participating Provider List immediately where:

(a) there is evidence that the Medical Practitioner has not complied with a term or condition of the Access Gap Scheme or claiming guidelines;

(b) there is evidence that the Medical Practitioner has not complied with the conditions for charging their patients including charging for non-clinical fees such as administrative charges, admission fees, processing fees, booking fees or reservation fees, technology fees, entertainment levies, insurance levy fees, hospital facility fees or similar;

(c) the Medical Practitioner is or becomes unregistered or suspended under the laws of the relevant State in which case they shall immediately notify HIF; or

(d) the Medical Practitioner no longer caries professional indemnity with a recognised indemnity Health Care Provider in which case they shall immediately notify HIF.

E3 General Treatment

General Treatment is treatment (including the provision of goods and services) that:

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

(b) is not Hospital Treatment.

Without limiting the above definition, General Treatment includes any other treatment, or treatment included in a class of treatments, specified in the *PHI (Health Insurance Business) Rules 2018* (Cth) as may affect this Fund Rule.

General Treatment shall not include:

(a) rendering in Australia of a service for which a Medicare Benefit is payable, unless the *PHI (Health Insurance Business) Rules 2018* (Cth) provide otherwise. Or

(b) any other treatment, or treatment included in a class of treatments, specified in the *PHI (Health Insurance Business) Rules 2018* (Cth) as may affect this Fund Rule.

The term "Extras" is used by HIF to mean "General" as it applies to General Treatment (i.e. not Hospital Treatment), and is intended to be used to include or in lieu of:

(a) a service;

(b) a good;

(c) a product;

(d) a cover; or

(e) an Insurance Product; that

does not relate to Hospital Treatment.

Benefits in respect of General Treatment are payable by HIF in the following circumstances:

(a) where all relevant Waiting Periods have been served;

(b) where the Fund Membership is financial at the date of service;

(c) where a claim has been submitted in the prescribed form;

(d) where the treatment or service has been rendered by a HIF recognised Health Care Provider;

(e) where the treatment or service has been rendered within Australia.

(f) where the service or treatment has been rendered as part of a Teleconsultation or Videoconference, the treatment or service must be performed in accordance with the relevant Australian peak body association's guidelines for teleconsultations and videoconferencing.

Benefits in respect of General Treatment shall not be payable by HIF in the following circumstances:

(a) where the Fund Member has not served a relevant Waiting Period that must be served prior to a treatment or service being rendered or supplied to the Fund Member;

(b) where the Fund Membership is unfinancial at the date of service;

(c) where a claim is the subject of a Third-Party Compensation claim (refer to F6);

(d) where a claim has not been submitted in the prescribed form (refer to G Claims);

(e) where a service or treatment was rendered or supplied outside of Australia;

(f) where a service or treatment provided by an allied health professional is eligible for a Benefit from Medicare Australia;

(g) where the date the treatment or service was rendered exceeds two years from the date the claim is submitted for payment;

(h) for the cost of care or accommodation in an aged care service;

(i) for a charge for a Pharmaceutical Benefit supplied under Part V11 of the *National Health Act 1953* unless the charge is covered by section 92B of that Act;

(j) any treatment specified in the *PHI (Complying Product) Rules 2015* (Cth) as treatment for which Benefits must not be provided;

(k) any treatment which primarily takes the form of sport, recreation or entertainment other than such treatment which is part of a chronic disease management program or an Approved Health Management Program if the programs have been Approved;

(l) for any item supplied is second hand or reconditioned for re-sale.

(m) where the claim is for a service which was provided less than two hours after an identical or similar service or treatment was provided by the same Health Provider.

E4 Other

1. Services rendered overseas

HIF Benefits are not payable under any HIF cover in respect of a service or treatment, including goods supplied as part of or integral to the provision of a service or treatment, if it is supplied or rendered outside Australia.

F LIMITATION OF BENEFITS

F1 Co Payments

HIF does not have co-payments on any Hospital Product.

F2 Excesses

An excess is an amount that he Fund Member agrees to pay towards the cost of hospital treatment, before a Benefit is payable by the Fund.

The excess amount, limits and conditions of when the excess is applied for each Hospital Product is set out in the Schedule H and J.

F3 Waiting Periods

1. Introduction

A Waiting Period of HIF that applies to a person for a Benefit under an Insurance Product is the period:

(a) starting at the time the person becomes insured under the Insurance Product; and

(b) ending at the time specified in the Insurance Product;

During which the person is not entitled to the Benefit.

2. Waiting Period requirements

An Insurance Product meets the Waiting Period requirements in this Fund Rule if the Waiting Period that applies to a person who did not transfer to the Insurance Product is no longer than:

(a) for a Benefit for Hospital Treatment or Hospital-Substitute Treatment that is Pregnancy and Birth related treatments or treatment for a Pre-Existing Condition (other than treatment covered by paragraph (b) - 12 months; and

(b) for a Benefit for Hospital Treatment or Hospital-Substitute Treatment that is psychiatric care, rehabilitation or palliative care (whether or not for a Pre-Existing Condition) - 2 months; and

(c) for any other Benefit for Hospital Treatment or Hospital-Substitute Treatment - 2 months.

The *PHI (Complying Product) Rules 2015* (Cth) may modify the requirements in this Fund Rule in relation to all or particular kinds of private health insurers, Benefits or insured persons. To the extent the Fund Rules do so, the Waiting Period requirements in this Fund Rule are taken to be met if the conditions in the *PHI (Complying Product) Rules 2015* (Cth) are met.

3. Pre-Existing Condition

A person insured under an Insurance Product has a Pre-Existing Condition if:

(a) the person has an ailment, illness or condition; and

(b) in the opinion of a Medical Practitioner appointed by HIF, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the Insurance Product.

In forming an opinion for the purposes of paragraph (b), the Medical Practitioner must have regard to any information in relation to the ailment, illness or condition that the Medical Practitioner who treated the ailment, illness or condition gives him or her.

If:

(a) HIF replaces an Insurance Product with another Insurance Product; and

(b) a person who was insured under an Insurance Product that was in the replaced product is transferred by HIF to an Insurance Product that is in the replacement product;

The reference in paragraph (b) to the day on which the person became insured under the Insurance Product is taken to be a reference to the day on which the person became insured under the replaced Insurance Product.

4. Waiting Periods and the Pre-Existing Conditions

The following Waiting Periods and the Pre-Existing Condition Fund Rule applies to all Fund Members who join HIF or upgrade their level of Hospital or Extras cover. Fund Members who

transfer to HIF from another registered health fund will not be subject to these restrictions if they have already served the Waiting Periods on an equivalent level of cover.

(a) Hospital cover Waiting Periods

For All Hospital Covers except Basic Working Visa Cover, Essentials Working Visa Cover, Intermediate Working Visa Cover, Comprehensive Working Visa Cover (No Excess), Comprehensive Working Visa Cover $500/$1000 Excess, Visitor Saver and Visitor Value

Waiting Period	Condition or treatment (where applicable)
1 day	Emergency ambulance
30 days	Non-emergency ambulance
0 months	Accidents.
2 months	Treatment for psychiatric care, rehabilitation and palliative care and all other treatment (except where otherwise specified).
12 months	Pregnancy and Birth related treatments and or treatment for a Pre-Existing Condition but not including pre-existing conditions for psychiatric care, rehabilitation or palliative care.

For Basic Working Visa Cover, Essentials Working Visa Cover, Intermediate Working Visa Cover, Comprehensive Working Visa Cover (No Excess), Comprehensive Working Visa Cover $500/$1000 Excess, Visitor Saver and Visitor Value

Waiting Period	Condition or treatment (where applicable)
1 day	Emergency ambulance
30 days	Non-emergency ambulance
0 months	All covered treatment (except where specified below).
2 months	Treatment for psychiatric care, rehabilitation and palliative care.
12 months	Pregnancy and Birth related treatments and or treatment for a Pre-Existing Condition but not including pre-existing conditions for psychiatric care, rehabilitation or palliative care.

(b) Extras cover Waiting Periods (where applicable and depending on level of cover)

Waiting Period	Condition or treatment (where applicable / depending on level of cover)
2 months	All services unless specified in this list.
1 day	Emergency Ambulance
30 days	Non-Emergency Ambulance
12 months	Blood glucose / Pressure monitor.
12 months	Non-general / Major Dental / Orthodontics.
12 months	Nebuliser / Humidifier.
12 months	Podiatry orthotic appliances.
12 months	Prosthesis non-surgically implanted/ Medical appliances.
12 months	Assisted reproductive drugs.
12 months	Hearing aids.
12 months	CPAP machine.
12 months	Peak flow meter/asthmatic spacers 12 months for Advanced Extras and Top Extras only 2 months for Super Options and Premium Options

(c) Waiting Periods – newborns

HIF shall waive all Waiting Periods and Pre-Existing Conditions (if any) for newborns where:

(i) the newborn's parent has served all Waiting Periods before the newborn's birth;

(ii) the parent is covered under a single parent or family Insurance Product at the time of the birth of the newborn and supplies HIF with relevant information about the newborn to enable HIF to include the newborn onto the single parent or family Insurance Product within a reasonable period, which period shall be determined by HIF at its absolute discretion, provided that it shall not exceed 4 years;

(iii) The newborn's parent is an existing HIF Fund Member on a single person's or couple's Fund Membership and subsequently changes to a single parent or family Fund Membership within two months of the birth of the newborn. However, should this change include an upgrade of cover; the newborn will be required to serve the same Waiting Period which the parent has to serve, for any upgraded cover or Benefits, relative to the parent's prior level of cover.

If the newborn's parent is still serving their Waiting Periods, the newborn will be required to serve the same Waiting Period which the parent has to serve. Waiting Periods already served by the newborns'

parent will be waived for the newborn.

(d) Waiting Periods – Psychiatric Care upgrade Waiting Period exemption

An insured person who holds a restricted Complying Hospital Product may be entitled to upgrade their hospital cover and apply for the Psychiatric care Waiting Period exemption if;

(i) The insured person has held a restricted Complying Hospital Product for at least 2 months

(ii) The insured person has not yet applied for this exemption

The psychiatric care upgrade applies to accommodation Benefit only.

Standard Waiting Periods will therefore apply to all other upgraded Benefits included in the higher level of hospital cover.

F4 Exclusions

A Fund Member can elect to take the highest cover available or they may elect to reduce their Contribution premium by reducing the size and / or scope of Benefits payable. This may be achieved by reducing the amount of Benefit payable by HIF by the Fund Member electing to pay an agreed amount to the Hospital in lieu of Benefits payable by HIF. This amount may take the form of a reduction in the scope of Benefits payable by HIF, by the Fund Member electing to take a level of cover that does not cover all episodes of hospitalisation. This option can occur in the following way:

(a) Exclusion – no Benefit is payable for a specific condition or a selected range of conditions.

F5 Restricted Benefits

A Fund Member can elect to take the highest cover available or they may elect to reduce their Contribution premium by reducing the size and / or scope of Benefits payable. This may be achieved by reducing the amount of Benefit payable by HIF, by the Fund Member electing to pay an agreed amount to the Hospital in lieu of Benefits payable by HIF. This amount may take the form of a reduction in the scope of Benefits payable by HIF, by the Fund Member electing to take a level of cover that does not cover all episodes of hospitalisation. This option can occur in the following way:

(a) Restriction – Benefits are only payable at the Minimum Benefit for a condition or a selected range of conditions.

Where a service / treatment attracts a Restricted Benefit under a HIF Insurance Product, HIF will pay a Benefit in accordance with the Minimum Benefit requirements as specified in the *PHI (Benefit Requirements) Rules 2011* (Cth) and the Minimum Benefit requirements in section 72-1 of the PHI Act 2007.

F6 Compensation Damages and Provisional Payment of Claims

1. Entitlements to Benefits as the result of a condition, ailment, injury or Accident

Unless permitted elsewhere in this Fund Rule, a Fund Member shall not be entitled to a rebate or other Benefit in respect of a cost or expense, whether or not it is paid or payable, unforeseen or

into the future and whether or not it is certain in value or otherwise, of a service or treatment, including the provision of goods and services, that relates to a condition,

ailment, injury or accident suffered by a Fund Member, where a person:

(a) has received Compensation; or

(b) is entitled to receive or forego damages Compensation; or

(c) has abandoned an entitlement to receive or forego Compensation;

in respect of that condition, ailment, injury or Accident.

2. Obligations of a Fund Member

A Fund Member who commences or initiates, or has a claim for, asserts or could properly assert a right to, foregoes a right to, receives or is entitled to receive, or discontinues an action for, damages Compensation in respect of a condition, ailment, injury or Accident (the “matter”), must:

(a) inform HIF, as soon as practicable, of details relating to the matter as might reasonably be expected in the circumstances or asked for by HIF;

(b) inform HIF of any decision that the Fund Member has made, intends to make, or is contemplating making in relation to the matter;

(c) in the case of a claim action relating to the matter, include the full amount of all costs and expenses for which Benefits are or would otherwise be payable;

(d) take all reasonable steps to pursue the matter to HIF’s reasonable satisfaction;

(e) keep HIF informed of and updated as to the progress of a claim relating to the matter; and

(f) inform HIF immediately upon the determination or settlement of a claim relating to the matter.

3. Provisional payment or Benefit

In the event that a required payment of damages and other costs pursuant to a finalised claim for Compensation to a Fund Member in respect of a condition, ailment, injury or Accident remains unpaid, HIF may at its absolute discretion, having regard to, but not limited to such matters as unemployment, hardship or other factors HIF considers relevant, effect a provisional Benefit payment to the claimant Fund Member in respect of out-of-pocket costs and expenses incurred by them, provided that those costs or expenses were paid in respect of the condition, ailment, injury or Accident that gave rise to the claim.

A provisional Benefit payment will only be made by HIF if an irrevocable and unconditional written undertaking is given to HIF to repay it, firstly from the damages payment, secondly, where there is a deficiency after repayment from the damages payment, by any other means.

HIF may, at its absolute discretion, having regard to, but not limited to such matters as unemployment, hardship or other factors HIF considers relevant, accept a repayment pursuant to an irrevocable and unconditional written undertaking, that is less than the sum of all Benefit payments made in favour of the Fund Member that relates to the matter.

G CLAIMS

G1 General

Claims for Benefits must:

1. be made in a manner Approved by HIF; and
2. be supported by a tax invoice, statement of account or receipt on a Health Care Provider's official letterhead and *inter alia* other documents (as required by HIF) that will disclose the following information:
3. the Health Care Provider's name, number and address;
4. the patient's full name and address;
5. the date of service;
6. the description of the service;
7. the amount(s) charged; and
8. any other information that HIF reasonably requests.
9. All documents submitted in connection with a claim become the property of HIF, unless otherwise agreed to by HIF
10. Benefits are not payable where a claim is lodged more than two years after the date of service. HIF may waive this Rule at its absolute discretion.
11. Subject to practical limitations, HIF shall within two months of receipt of a claim, assess it and pay any Benefit in accordance with these Rules and / or where specified or required pursuant to the PHI Act 2007 and PHI Rules.

G2 Other

1. **Claim Benefit recovery**

   Where HIF has paid a Benefit or portion of Benefit for which a Fund Member or Access Gap Provider was not entitled, it will seek recovery of the overpaid Benefit amount from the Fund Member or Access Gap Provider.

   HIF may in its absolute discretion reduce the Benefit paid for a future claim in order to recover a prior Benefit overpayment.

L SCHEDULE OVERSEAS

L1 Overseas

L1.1 Table Name/Group of Table Names

- Comprehensive Working Visa Cover
- Comprehensive Working Visa $500/$1,000 Excess Cover
- Intermediate Working Visa Cover
- Essentials Working Visa Cover
- Basic Working Visa Cover
- Visitor Value Cover
- Visitor Saver Cover

L1.2 Eligibility

Comprehensive, **Intermediate**, **Essentials**, and **Basic Working Visa** covers are available to any non-resident of Australia who is permitted to live and work temporarily within Australia under an Australian Government Department of Immigration and Border Protection approved "Working Visa" and is less than 65 years of age.

Visitor Value and **Visitor Saver** covers are available to any non-resident of Australia who is temporarily residing in Australia and is less than 65 years of age.

L1.3 General Conditions

Cancellation of application Administration Fee

Where a future dated new membership application has been accepted but is cancelled prior to the commencement date, HIF may charge the applicant a $50 administration fee.

L1.4 Hospital Treatment Payments

1. Contracted Hospitals

In the case of:

- Shared and /or Private Room (see product exclusions below)
- Accommodation including Day patient, neo-natal, ICU, CCU, HDU
- Theatre and Labour ward fees
- Procedure room fees
- Outpatient fees
- All episodic items
- Inpatient Pharmaceutical drugs

For Intermediate Working Visa, **Comprehensive Working Visa** and **Comprehensive Working Visa Excess $500/$1,000** covers – Hospital and Medical private hospital accommodation, Benefits will be paid at the Contracted Hospital Purchaser Provider Agreement ("HPPA") rate(s) agreed between the relevant Hospital and Australian Health Service Alliance ("AHSA"), and in accordance with the table "Hospital Services Covered", subject to any excess or co-payment listed below. Accommodation Benefits will be paid for a shared or private room.

For public hospital accommodation, Benefits will be paid at the relevant State and territory health authority gazetted rates for ineligible patients.

For **Basic Working Visa, Essentials Working Visa, Visitor Value and Visitor Saver** cover – Hospital and Medical private hospital accommodation, Benefits will be paid at the Contracted Hospital Purchaser Provider Agreement ("HPPA") rate(s) agreed between the relevant Hospital and Australian Health Service Alliance ("AHSA"), and in accordance with the table "Hospital Services Covered", subject to any excess or co-payment listed below. A fund member may elect to take a private room in a private hospital however Benefit will be paid to the equivalent of a shared room only according to that HPPA.

For public hospital accommodation, Benefits will be paid at the relevant state and territory health authority gazetted rates for ineligible patients.

In the case of Medical Devices and Human Tissue Products, Benefits will be paid for all Overseas Visitor Cover products in accordance with the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*.

The Table entitled "Hospital Services Covered" located at the end of this Product Group section identifies those services which are eligible for Benefits under each of the Overseas Visitors products.

2. Ambulance

A Benefit will be paid for 100% of the Ambulance charge, that is not otherwise covered by third party arrangements, for transport by Ambulance provided by, or under an arrangement with, a government approved ambulance service when medically necessary for admission to hospital, emergency treatment on site, or inter-hospital transfer for emergency treatment. Benefits are not payable for off road or air ambulance.

3. Medical Rebate – Outpatient services

Outpatient services are not eligible for Benefit for persons covered under **Basic Working Visa** or **Essentials Working Visa**.

Outpatient services Benefits will be paid for Visitor Value, Visitor Saver, Intermediate Working Visa, Comprehensive Working Visa Nil Excess, Comprehensive Working Visa $500/$1000 Excess in accordance with the Medicare Benefit Scheduled Fee, up to a maximum amount per person per calendar year. The Benefit will be at least 100% of the Medicare Benefit Scheduled Fee for Visitor Value, Visitor Saver and Intermediate Working Visa, and 125% of the Medicare Benefits Scheduled Fee for Comprehensive Working Visa Nil Excess and Comprehensive Working Visa $500/$1000 Excess, applicable to that service but subject to any annual cover limitation which may apply.

The annual maximum amount per calendar year per person is:

- Outpatient services excluding pharmacy (PBS and Non-PBS): -

Visitor Saver, Intermediate Working Visa, Comprehensive Working Visa Nil Excess and Comprehensive Working Visa $500/$1000 Excess: No Maximum limits apply
Outpatient pharmacy: -
Visitor Saver and **Intermediate Working Visa** Benefit paid at 50% up to $300 person per calendar year on PBS (Pharmaceutical Benefits Scheme) items and non-PBS items that are part of the TGA listing.
Comprehensive Working Visa and **Comprehensive Working Visa Excess $500/$1000** Benefit paid at 50% up to $500 person per calendar year on PBS (Pharmaceutical Benefits Scheme) items and non-PBS items that are part of the TGA listing.

For Fund Members with an Extras Product that includes cover for pharmacy, Benefits are claimable from only one of the Hospital Product or Extras Product.

- **Visitor Value Covers**: Maximum of $500.

4. Non-contracted Hospitals and Public Hospitals

Where an HPPA does not exist between the Fund and the provider, Benefits will be paid in accordance with the minimum Benefit requirements as specified in the *PHI (Benefit Requirements) Rules 2011* (Cth) and in accordance with the Minimum Benefit Requirements in section 72-1 of the PHI Act 2007.

L1.5 Medical Services Payments while admitted

Benefits of at least 100% of the Medicare Benefits Schedule Fee are payable where Benefits for the service(s) received are payable by Medicare.
Where the medical practitioner meets the requirements of the Access Gap Scheme, Benefits are payable at the agreed rate under that scheme for all Working Visa and Visitor covers, with the exception of **Intermediate**, **Essentials**, **Basic Working Visa** covers, and **Visitor Value** and **Visitor Saver** covers.

Basic Working Visa cover: The annual maximum amount per calendar year per person is $1,000,000

L1.6 Pharmaceutical Benefits Scheme (PBS) Pharmaceuticals

For all Pharmaceutical Benefits Schedule (PBS) listed drugs that are prescribed according to the

PBS approved indications, that are administered during and form part of an admitted episode of care – a Benefit will be paid equal to the PBS listed price in excess of the patient contribution.

L1.7 Non PBS Pharmaceuticals

The cost of HIF approved pharmaceuticals is included in the charges agreed between the hospital and HIF.

L1.8 Surgically Implanted Medical Devices and Human Tissue Products

Benefits will be paid in accordance with the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules.*

L1.9 Nursing Home Type Patients

HIF will pay Benefits towards Nursing Home Type patients in accordance with the minimum Benefit requirements as specified in the *PHI (Benefit Requirements) Rules 2011* and in accordance with the minimum Benefit requirements in section 72-1 of the PHI Act 2007.

L1.10 Co Payments

Co-payments are not payable on any level of Working Visa or Visitor covers for the services for which each product is eligible to be covered.

L1.11 Excesses

Fund Members on Working Visa and Visitors Cover products which include an excess will be required to forego the applicable excess portion of Benefit otherwise payable for services provided to them whilst they are a patient admitted to a hospital as an overnight patient (i.e. Inpatient). The excess will apply once per person covered under the relevant cover to a maximum of two excesses in any calendar year for a family membership, with the exception of Basic Working Visa cover. An excess will not apply to services provided out of the hospital.

Product	Excess per Patient per Episode of Hospitalisation	Maximum Excess Payable per Insurance Product per Year
Comprehensive Working Visa Cover		
Single	$0	$0
Family	$0	$0
Comprehensive Working Visa $500/ $1,000 Excess Cover		
Single	$500	$500
Family	$500	$1,000
Intermediate Working Visa Cover		
Single	$0	$0
Family	$0	$0
Essentials Working Visa Cover		
Single	$0	$0
Family	$0	$0
Basic Working Visa Cover		

Product	Excess per Patient per Episode of Hospitalisation	Maximum Excess Payable per Insurance Product per Year
Single	$500	No person or family cap on excess
Family	$500	No person or family cap on excess
Visitor Value Cover		
Single	$250	$250
Family	$250	$500
Visitor Saver Cover		
Single	$250	$250
Family	$250	$500

L1.12 Restricted Benefits

This section intentionally left blank

L1.13 Excluded services

Fund Members on all HIF Working Visa and Visitor Cover products will not be covered for medical or hospital treatment if:

- Provided en-route to and from Australia;
- Provided outside of Australia;
- Arranged prior to coming to Australia;
- Covered by any entitlement to Compensation or damages;
- A Benefit is claimable or payable from another source;
- For any cosmetic reasons;
- For any service for which Australian residents would not be covered under the Australian Medicare scheme.

Fund Members on **Basic Working Visa**, **Essentials Working Visa**, and **Intermediate Working Visa** Covers and **Visitor Value** Cover are also ineligible for Benefits for:

- Artificial reproductive techniques or investigation of treatment relating to infertility;
- Bone marrow and Organ transplant.

Fund Members on **Visitor Saver** Cover are also ineligible for Benefit for:

- Hospital psychiatric services
- Palliative care
- Bone Marrow and Organ Transplants
- Heart and vascular systems
- Joint replacement
- Dialysis for chronic kidney failure
- Pregnancy and birth
- Assisted reproductive services
- Weight loss surgery

L1.14 Loyalty Bonuses

This section intentionally left blank.

L1.15 Other Special

Persons covered by HIF Working Visa policies may be eligible to receive a Benefit toward the cost of their repatriation to their home country (prior to temporary residence in Australia).

For eligible policy holders and any other eligible person(s) covered under the policy who have to be repatriated to their home country because they are terminally ill or suffer from a substantial life-altering illness or injury, HIF will pay a contribution towards the cost of that person's return travel with one other family member and one other person qualified to give that person medical supervision, provided that a Benefit, up to a maximum limit, is only payable after that person's treating medical practitioner and HIF agree that they are terminally ill or suffer from a substantially life-altering illness or injury.

In the event of death, the deceased person's mortal remains and those any other person, or any other person covered by that deceased person's policy may be repatriated to their home country if legally permissible. The repatriation Benefit amounts listed below are maximum amounts, payable once per person per lifetime of their policy.

Repatriation Benefit	Basic Working Visa Cover	Essentials Working Visa Cover	Intermediate Working Visa Cover	Comprehensive Working Visa Covers	Visitor Covers (Value and Saver)
Benefit Eligibility	Yes	Yes	Yes	Yes	Not eligible
Maximum Benefit per person per lifetime	$4,000	$4,000	$6,000	$8,000	Nil

Table: Hospital and Admitted Patient Services Covered

Working Visa Covers:

Services covered	Basic Working Visa Cover	Essentials Working Visa Cover	Intermediate Working Visa Cover	Comprehensive Working Visa Covers
Shared Room in Public Hospital	Yes	Yes	Yes	Yes
Shared Room in Private Hospital	Yes	Yes	Yes	Yes
Private Room in Public Hospital	Not covered	Not covered	Yes	Yes
Private Room in a Private Hospital	Not covered	Not covered	yYes	Yes
Emergency Ambulance	Yes	Yes	Yes	Yes
Non-Emergency Ambulance	Yes	Yes	Yes	Yes
Access Gap Cover	Not covered	Not covered	Not covered	Yes
Intensive care	Yes	Yes	Yes	Yes

Services covered	Basic Working Visa Cover	Essentials Working Visa Cover	Intermediate Working Visa Cover	Comprehensive Working Visa Covers
Private Hospital theatre charges	Yes	Yes	Yes	Yes
365 day per year cover, subject to approved certification after 35-days	Yes	Yes	Yes	Yes
Same day accommodation and theatre charges	Yes	Yes	Yes	Yes
In-hospital procedure room fees	Yes	Yes	Yes	Yes
Artificial appliances and Medical Devices and Human Tissue Products during surgery	Yes	Yes	Yes	Yes
Cardiac surgery and procedures	Yes	Yes	Yes	Yes
Pregnancy and birth related procedures	Yes	Yes	Yes	Yes
Eye surgery	Yes	Yes	Yes	Yes
Gastric banding and obesity services	Yes	Yes	Yes	Yes
Joint replacement surgery	Yes	Yes	Yes	Yes
Renal, Sterilisation, & Sleep disorders	Yes	Yes	Yes	Yes
Psychiatric treatment	Yes	Yes	Yes	Yes
Bone Marrow & Organ Transplant	Not covered	Not covered	Not covered	Yes
Assisted Reproductive Technology	Not covered	Not covered	Not covered	Yes
In patient pharmacy	Yes	Yes	Yes	Yes

Non-Working Visa Covers

Services covered	Visitor Value Cover
Shared Room in Public Hospital	Yes
Shared Room in Private Hospital	Yes
Private Room in Public Hospital	Yes
Private Room in a Private Hospital	Not covered
Emergency Ambulance	Yes
Non-Emergency Ambulance	Yes
Access Gap Cover	Not covered
Intensive care	Yes

Services covered	Visitor Value Cover
Private Hospital theatre charges	Yes
365 day per year cover, subject to approved certification after 35-days	Yes
Same day accommodation and theatre charges	Yes
In-hospital procedure room fees	Yes
Artificial appliances and Medical Devices and Human Tissue Products during surgery for covered procedures	Yes
Cardiac surgery and procedures	Yes
Pregnancy and birth related procedures	Yes
Eye surgery	Yes
Gastric banding and obesity services	Yes
Joint replacement surgery	Yes
Renal dialysis, Sterilisation, Sleep disorders	Yes
Psychiatric treatment	Yes
Bone Marrow & Organ Transplant	Not covered
Assisted Reproductive Technology	Not covered
In patient pharmacy	Yes

Services covered	Visitor Saver Cover
Shared Room in Public Hospital	Yes
Shared Room in Private Hospital	Yes
Private Room in Public Hospital	Not covered
Private Room in a Private Hospital	Not covered
Emergency Ambulance	Yes
Non-Emergency Ambulance	Yes
Access Gap Cover	Not covered
Intensive care	Yes
Private Hospital theatre charges	Yes
365 day per year cover, subject to approved certification after 35-days	Yes
Same day accommodation and theatre charges	Yes
In-hospital procedure room fees	Yes
Artificial appliances and Medical Devices and Human Tissue Products during surgery for covered procedures	Yes
Rehabilitation	Yes
Hospital psychiatric services	Not covered
Palliative	Not covered
Brain & nervous system	Yes

Services covered	Visitor Saver
Bone marrow transplants and organ transplants	Not covered
Eye (Not cataract)	Yes
Ear, nose and throat	Yes
Tonsils, adenoids & grommets	Yes
Bone, joint & muscle	Yes
Joint reconstructions	Yes
Kidney & bladder	Yes
Male reproductive system	Yes
Digestive system	Yes
Hernia & appendix	Yes
Gastrointestinal endoscopy	Yes
Gynaecology	Yes
Miscarriage & termination of pregnancy	Yes
Chemotherapy, radiotherapy & immunotherapy	Yes
Pain management	Yes
Skin	Yes
Breast surgery (medical necessary)	Yes
Diabetes (excluding insulin pumps)	Yes
Heart & vascular systems	Not covered
Lung & chest	Yes
Blood	Yes
Back, neck & spine	Yes
Plastic & reconstructive surgery (medically necessary)	Yes
Dental surgery	Yes
Podiatric surgery	Yes
Implantation of hearing device	Yes
Cataracts	Yes
Joint replacement	Not covered
Dialysis for chronic kidney failure	Not covered
Pregnancy and birth	Not covered
Assisted reproductive services	Not covered
Weight loss surgery	Not covered
Insulin pumps	Yes
Pain management with a device	Yes
Sleep studies	Yes
In patient pharmacy	Yes