HBF Fund Rules

All registered health funds are required to have Fund Rules under the Private Health Insurance Act of 2007. These Fund Rules set out the general principles and rules of membership under which each fund conducts its business.

Important Notes

Before taking out private health insurance with HBF, you and all Adult Members and Dependants over 18 to be covered on your HBF policy, must read these Fund Rules.

By taking out private health insurance with HBF, you and all other persons on your Membership become Members of our Fund and agree to our Fund Rules as amended from time to time.

We recommend that these Fund Rules be read together with the brochures relevant to your cover.

Terms that are defined in section B of these Fund Rules will be capitalised. For example, the term Fund Rules is defined in section B.

Contents

A INTRODUCTION

A1 Rules Arrangement

A1 1 Content

These Fund Rules are the rules which govern the day to day operation of the Fund conducted by HBF to ensure compliance with the Private Health Insurance Act and the requirements of the Department and the Private Health Insurance Administration Council.

The following schedules make up the Fund Rules:

General Conditions (Schedules A-G);
Schedule of Hospital Products (Schedule H);
Schedule of Extras Products (Schedule I);
Schedule of Combined Products (Schedule J);
Schedule of Premium Rates (Schedule K);
Schedule of Overseas Products (Schedule L); and
Other schedules (Schedule M).

A1 2 Application

These Fund Rules apply to all Products.

HBF may supplement the Fund Rules with Fund Policies that are not inconsistent with the Fund Rules.

All Members of HBF are bound by the Fund Rules and Fund Policies.

A2 Health Benefits Fund

HBF is a not-for-profit organisation, incorporated under the Corporations Act 2001 and is a Private Health Insurer under the Private Health Insurance Act.

HBF established, conducts and administers the Fund.

The Fund relates solely to the Health Insurance Business and some or all of the Health Related Businesses of HBF.

A3 Obligations to Fund

A person applying for admission to the Fund and a Member must comply with Fund Rules and any other requirements of HBF and provide all information reasonably requested by HBF relevant to their Membership or proposed Membership.

A Member will inform HBF as soon as reasonably possible after a change in any Membership details.

A4 Governing Principles

The provisions of the Private Health Insurance Act, Health Insurance Act and National Health Act govern important aspects of the operation of the Fund and the relationship between the Fund and its Members and take precedence over any inconsistency in the Fund Rules.

A5 Use of Funds

To the extent provided by the Private Health Insurance Act, the whole of the income of the Fund arising out of HBF carrying on Health Insurance Business or Health Related Business as a Private Health Insurer (including any income arising from investment of money not immediately required for payment of Benefits to Members) must be credited to the Fund.

Payments from the Fund may not be made for any purpose other than to:

a. meet the Membership liabilities in accordance with these Fund Rules;

b. meet other liabilities or expenses incurred for the purposes of the business of the Fund; and

c. make distributions, investments and for any other purpose allowed under the Private Health Insurance Act.

A6 No Improper Discrimination

As required by the Private Health Insurance Act, when conducting the Fund and making decisions in relation to Members, HBF will not take into account:

a. the suffering by a Member from a chronic disease, illness or other medical condition;

b. the age of a Member, except in relation to the calculation of Lifetime Health Cover loading;

c. where a person lives, except in relation to different risk equalisation jurisdictions;

d. the frequency with which a Member needs General or Hospital Treatment;

e. any characteristic of a person that is likely to result in an increased need for General or Hospital Treatment;

f. the amount, or extent of the Benefits to which a Member becomes or has become entitled during a period;

g. the race, gender, religious belief or sexual orientation of a Member; or

h. any other matters which are, from time to time, prescribed by the Private Health Insurance Act for these purposes;

unless it has been permitted to under any legislative or regulatory provision.

A7 Changes to Rules

A7 1 Fund Rules

HBF may change the Fund Rules at any time in a manner consistent with the Private Health Insurance Act.

If the change is or might be detrimental to the interests of a Member on a Membership, HBF will ensure at least one Adult Member on that Membership is informed of the change a reasonable time before the change takes effect.

Where a Member became entitled to receive a Benefit at a time when a previous Fund Rule applied, the Benefit specified in that earlier Fund Rule will be payable.

A7 2 Hardship

Where circumstances beyond the control of a Member arise or the loss of Benefits by any Member will cause hardship, HBF may (at its discretion and within the requirements of the Private Health Insurance Act) waive or vary the application of a Fund Rule.

The waiver of a particular Fund Rule in a given circumstance does not suggest that HBF will, or require HBF to, waive the application of that Fund Rule in any other circumstance.

A7 3 Discretion

HBF (at its discretion and within the requirements of the Private Health Insurance Act) may waive strict compliance with any time period or date by which an action will take place under these Fund Rules in the interests of efficiency, administration practice and convenience to HBF.

A7 4 Standard Information Statements

HBF will issue a Standard Information Statement (SIS) to one Adult Member on every Membership except in relation to Overseas Products:

a. at least once every twelve months;

b. when a change to Fund Rules that is or might be detrimental to the interests of a Member requires an update to the SIS for that Member's Product;

c. upon request;

d. that is commenced with HBF, along with details of what the Membership covers and how benefits under it are calculated and a statement identifying that the Membership is referable to the Fund operated by HBF; and

e. that is transferred from another Product or Private Health Insurer.

A SIS is available to any person on request.

A8 Dispute Resolution

A Member may make a complaint to HBF about their Membership or any action taken by HBF and HBF will respond to and make every effort to resolve the complaint quickly and efficiently under HBF's Internal Dispute Resolution Process. The Private Health Insurance Ombudsman is available to assist Members who have been unable to resolve a complaint with HBF.

A9 Notices

Unless stated otherwise in these Fund Rules, a written notice sent by HBF by post, email or other electronic means to the address or number last supplied by the Member or provider will be deemed notice to the Member or provider under these Fund Rules.

An Adult Member who receives a written notice from HBF regarding the Membership that is not specific solely to that Adult Member (such as a notice regarding a detrimental change to the Fund Rules pursuant to Fund Rule A7 1) must inform all other Members on the Membership of the contents of that notice.

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

A10 Winding Up

Subject to the provisions of the Private Health Insurance Act, in the event of the winding up or dissolution of the Fund, any property that remains after payment of all its debts and liabilities will not be paid to or distributed to any Board members, officers, councillors or Members of HBF, but will be given to some other institution (selected by those councillors or Members at or before the time of winding up or dissolution) which is not carried on for the profit or gain of its members or shareholders and is prohibited from distributing its income, profit or gain and property to its members or shareholders.

A11 Other

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

The following applies to the interpretation of these Fund Rules:

a. nothing in these Fund Rules will require HBF to act in breach of its constitution;

b. words and expressions used in the Private Health Insurance Act and the Health Insurance Act have the same meaning in the Fund Rules, unless otherwise specified;

c. words in the singular will include the plural and words in the plural will include the singular;

d. a reference to legislation should be taken as a reference to that legislation as amended from time to time;

e. these Fund Rules are to be interpreted as far as possible in a manner that is consistent with the Private Health Insurance Act; and

f. wherever "include", "for example" or any form of those words or similar expressions is used, it must be construed as if it were followed by "(without being limited to)".

B2 Definitions

In these Fund Rules, unless otherwise stated, the following definitions apply:

Accident

An unforeseen event, occurring by chance and caused by an external force or object which results in an injury to the body requiring admission to Hospital for medical treatment.

Acute Care Certificate

A certificate required by HBF from a Medical Provider in a form approved by HBF confirming the need for continued acute Hospital care after 35 days of continuous hospitalisation.

Adult Member

A person aged 18 or over, other than a Dependant, who is covered by a Membership.

Where the only Member(s) on a Membership is/are under 18, Adult Member means the parent or legal guardian of the Member(s) covered.

Agreed Fee

The total charge for an Agreed Service provided by a Participating Hospital as specified in the relevant Participating Hospital Provider Agreement or otherwise agreed by HBF.

Agreed Service

A treatment, good or service that constitutes Hospital Treatment provided by a Participating Hospital to a Member, which is specified as an agreed service (as that term is defined in the relevant Participating Hospital Provider Agreement or otherwise agreed by HBF) in relation to that Participating Hospital.

Approved Provider

A provider of General Treatment (whether the provider is an individual or an organisation) who:

a. is approved and registered by HBF as a provider of relevant treatment, goods or services pursuant to Fund Rule E3;

b. holds all necessary registrations, licences or approvals under relevant State or Territory legislation to render the relevant treatment, goods or services including in relation to the premises from which the treatment, goods or services are to be, or are being, provided; and

c. complies with all other requirements of the Private Health Insurance (Accreditation) Rules.

Assisted Reproductive Services (ARS)

All aspects of a program of ARS (inclusive of IVF) including treatment leading up to pregnancy.

Benefit

An amount of money payable to a Member, or on behalf or for the benefit of a Member, to an Approved Provider, Medical Provider or Hospital by the Fund in accordance with the terms of these Fund Rules.

Board

The Board of HBF or its delegate.

Class Physiotherapy Consultation

The personal attendance of an Approved Provider for the purpose of simultaneously providing a homogenous Medically Necessary treatment to four or more individuals, where there has been an individual assessment by a physiotherapist.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Compensation

Compensation means any of the following:

a. a payment made pursuant to a judgment, award or settlement by way of damages;

b. a payment in accordance with a scheme of insurance or compensation provided by a law of the Commonwealth, a State or a Territory; or

c. any other payment that, in the opinion of HBF, is a payment in the nature of compensation or damages.

Consultation

The personal attendance of an Approved Provider upon the individual Member on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary General Treatment.

The treatment rendered must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation (except in the case of a Class, Group or Small Group Physiotherapy Consultation).

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

This definition does not apply to Group or Family Clinical Psychology Consultations.

Contribution Group

A group of Members approved by HBF for the purposes of Fund Rule C.1.4.

Co-payment

A predetermined out-of-pocket expense that is payable by the Member towards treatment or services.

Corporate Membership

A Membership subject to an agreement that has been negotiated between HBF and an employer or other body approved by HBF, which may include terms and conditions that benefit the Member.

Cover

A defined group of Benefits payable by HBF, subject to relevant Fund Rules, for approved expenses incurred by a Member.

Department

The Department of Health and Ageing of the Commonwealth of Australia or its successor or replacement.

Dependant for GMF Products

A dependant child (including a step-child and/or foster child), who is not in a marital or de facto relationship and is covered by a Membership that also covers at least one parent or legal guardian. A person is considered a dependant up until they turn 21, or up to the age of 25 if they:

a. are a full-time student; or

b. do not have a taxable income in excess of the amount published by HBF.

Dependant

A dependant child (including a step-child and/or foster child), who is not in a marital or de facto relationship and is covered by a Membership that also covers at least one parent or legal guardian. A person is considered a dependant up until they turn 18, or up to the age of 25 if they:

a. are a full-time student; or

b. do not have a taxable income in excess of the amount published by HBF.

Emergency Treatment

Medically Necessary Hospital Treatment required for the diagnosis and management of acute and urgent illness or injury.

Excess

An amount of money a Member agrees to pay for a Hospital Treatment before Benefits are payable.

[Example: where a Member's Product has an excess of $250, the Member will be required to pay the first $250 of the cost of Hospital Treatment where they are a Private Patient.]

Exclusion

Members may elect to pay a lower Premium and take out a Hospital Product with one or more exclusions for a particular condition or procedure.

Where a Product features an exclusion for a particular condition, Members will receive no Benefit for treatment as a Private Patient in a Public or Private Hospital for that condition.

[Example: if a Member purchases a Product that excludes Maternity or joint replacements, and they go into Hospital as a Private Patient for one of these conditions, HBF will not pay any Benefits towards the Hospital or medical costs.]

Extras Product

A Product offered by HBF which covers General Treatment.

Fund

The health benefits fund conducted by HBF in accordance with the Private Health Insurance Act.

Fund Policy

A policy relating to the operation of the Fund by HBF which supplements the Fund Rules.

Fund Rules

These rules relating to the operation of the Fund by HBF.

Gap Cover

An arrangement under a Medical Provider Agreement which may eliminate or reduce the Medical Gap payable by a Member, including:

a. a Known Gap agreement that covers Members for all but a specified amount of the full cost of inpatient medical treatments;

b. a No Gap agreement that covers Members for the full cost of inpatient medical treatments; or

c. any other arrangement with that purpose that is entered into by HBF from time to time, for example an Access Gap agreement.

General Treatment

Treatment (including the provision of goods and services) that is intended to manage or prevent a disease, injury or condition and is not Hospital Treatment. General Treatment includes Hospital-substitute Treatment.

GMF Products

A Product including the letters GMF in the Product name.

Gold Card

A card issued by the Department of Veterans' Affairs (DVA) to veterans and dependants who are eligible under the Veterans' Entitlements Act 1986 or under Section 286 of the Military Rehabilitation and Compensation Act 2004 for treatment at the DVA's expense.

Group or Class Consultation

The personal attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment to more than one individual.

The treatment provided must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

This definition does not apply to Class Physiotherapy Consultations, Group Physiotherapy Consultations and Small Group Physiotherapy Consultations.

Group or Family Clinical Psychology Treatment

The personal attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary clinical psychology treatment to more than one individual.

The treatment provided must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Group Physiotherapy Consultation

The personal attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment to four or more individuals, where there has been an individual assessment by a physiotherapist.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

HBF

HBF means HBF Health Limited ABN 11 126 884 786.

Health Insurance Act

The Health Insurance Act 1973 (Cwlth).

Health Insurance Business

The business of providing insurance that relates to Hospital Treatment or General Treatment.

Health Related Business

Business that is not Health Insurance Business and that provides goods or services (or both) in order to manage or prevent diseases, injuries or conditions, as defined in the Private Health Insurance Act.

Hospital

A hospital, including a day hospital, that is declared by the Minister as a Hospital and complies with all requirements of the Private Health Insurance (Accreditation) Rules.

Hospital Product

A Product offered by HBF which covers Hospital Treatment.

Hospital-substitute Treatment

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

Hospital Treatment

Treatment (including the provision of goods and services) that is intended to manage a disease, injury or condition, where that treatment is provided by a person who is authorised by a Hospital to provide the treatment or a person under the control of such a person; and is provided at a Hospital or with the direct involvement of a Hospital.

For the avoidance of doubt, a non-admitted service is not Hospital Treatment.

Individual Clinical Psychology Treatment

The attendance of an Approved Provider upon the Member, or where clinical circumstances require, a person responsible for support or care of the member, on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary clinical psychology treatment.

The treatment rendered must be in accordance with accepted principles of professional practice and the Approved Provider must be in attendance for the duration of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes. For services provided by an approved Neuropsychologist up to 4 services per day are permitted.

Maternity

Any Hospital admission that results from pregnancy and/or birth, including but not limited to, ante-natal and post-natal care for any complications or illness related to pregnancy and/or birth.

Medical Gap

The difference between the Medical Provider's fees for services provided in Hospital and the Medicare Benefits Schedule fee as set by the Commonwealth Government.

Medical Provider

A person who:

a. is registered or licensed as a medical provider under a law of a State or Territory;

b. satisfies the provider eligibility requirements for the payment of Medicare benefits; and

c. complies with all other requirements of the Private Health Insurance (Accreditation) Rules.

Medical Provider Agreements

An agreement entered into between HBF and a Medical Provider.

Medically Necessary

Medically necessary in the opinion of a Medical Provider or other suitably qualified person appointed by HBF.

Medicare Benefits Schedule (MBS)

The schedule of medical services performed by a Medical Provider that have been assigned a schedule fee by the Commonwealth Government published in the 'Medicare Benefits Schedule Book'. This includes any updates and supplements to the schedule published from time to time.

[Explanation: By law, the only part of these services that can be covered by funds is the part of the MBS fee not covered by Medicare for medical services that are received as part of Hospital Treatment.]

Member

A person covered by a Membership.

Membership

A policy issued by HBF to one or more Members which provides Cover for Hospital Treatment and/or General Treatment.

Minimum Default Benefit

An amount determined by the Minister under the Private Health Insurance Act to be the minimum Benefit payable for a particular episode or type of treatment in a Hospital.

Minister

The Minister for Health in the Commonwealth Government.

National Health Act

The National Health Act 1953 (Cth)

Nursing Home Type Patient

A long-term Hospital patient who has been admitted to a Hospital for a continuous period exceeding 35 days and for whom an Acute Care Certificate is currently not in force.

NHTP Benefit

The Benefit determined by the Minister for any Hospital Treatment provided to a person while they are a Nursing Home Type Patient.

Non-Agreed Service

A treatment, good or service that constitutes Hospital Treatment provided by a Participating Hospital to a Member which is not an Agreed Service.

Out-of-pocket

The difference between the Benefit for a particular treatment and the provider's fees.

Overseas Product

Products offered by HBF intended for persons who are not eligible for full Medicare benefits as described in Schedule L.

Participating Hospital Provider Agreement

An agreement between HBF and another party which specifies, amongst other things, the fees that may be raised to Members by that party and the Benefits HBF will pay for certain Hospital Treatment provided to Members.

Participating Hospital

A Hospital which:

a. is subject to a Participating Hospital Provider Agreement; or

b. HBF deems to be a participating hospital from time to time.

Participating Providers

Approved Providers who have agreed to participate in arrangements with HBF relating to the level of Benefits HBF will pay for specified treatment, goods or services that the Approved Provider may render to a Member.

Partner

A person who lives with an Adult Member, of the same or a different gender, in a marital or de facto relationship and who is covered under the same Membership.

For the purposes of this definition, a person who is temporarily living apart (eg. for work, study or family commitments, or to receive health-related treatment) but whose marital or de facto relationship is continuing is still regarded as a Partner.

Pharmaceutical Benefits Schedule (PBS)

The Schedule of Pharmaceutical Benefits published by the Department.

Physiotherapy Assessment Consultation

The personal attendance of an Approved Provider upon the individual Member on a one to one basis, exclusive of all others, for the purpose of providing a Medically Necessary physiotherapy treatment.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Pre-Existing Ailment

An ailment, illness or condition, the signs or symptoms of which, in the opinion of a Medical Provider appointed by HBF, existed at any time in the period of 6 months ending on the day on which the Member joined a Hospital Product or upgraded to a Product which provides a higher level of Cover.

It is not necessary for the Member to be aware of a condition, ailment or illness for it to be considered Pre-existing.

Premiums

An amount of money a Member is required to pay to HBF for a specified period of Membership.

Premium Due Date

The due date for payment of Premiums by a Member.

Private Health Insurance Act

The Private Health Insurance Act 2007 (Cwlth) and any Private Health Insurance Rules and Regulations made by the Minister or by the Australian Prudential Regulation Authority.

Private Health Insurer

An insurer that is registered as a private health insurer under Division 126 of the Private Health Insurance Act.

Private Hospital

A Hospital, including a day Hospital, not operated by a State or Territory Government and declared by the Minister to be a private hospital.

Private Patient

A person admitted to a Public Hospital or Private Hospital who is not a Public Patient.

Private Practice

A professional practice (whether sole, partnership or group) that is self-supporting. This means that its accommodation, facilities and services are not provided or subsidised by another party (as is the case with a Public Hospital or publicly funded facility) but through the leveraging of fees directly to recipients of treatment, goods or services.

Product

A defined group of Memberships that cover the same treatments and provide Benefits that are worked out in the same way for approved expenses incurred by a Member and whose terms and conditions are the same as each other.

Prostheses List

Those prostheses as determined by the Minister under the Private Health Insurance Act.

Public Hospital

A Hospital that is operated by a State or Territory Government and declared by the Minister as a public hospital.

Public Patient

A person who receives treatment, goods or services by a doctor appointed by a Public Hospital without charge to the person.

Restricted

A Benefit payable under a Hospital Product, which is limited to the Minimum Default Benefit.

Small Group Physiotherapy Consultation

The personal attendance of an Approved Provider for the purpose of simultaneously providing a Medically Necessary treatment to no more than three individuals, where there has been an individual assessment by a physiotherapist.

The treatment performed must be in accordance with accepted principles of professional practice and the guidelines of the relevant professional board.

The Approved Provider must be in attendance for the duration of the consultation or, if not in full-time attendance, must remain readily accessible during the entire course of the consultation.

This excludes any personal attendance on the same day as a previous attendance unless the later attendance commences at least 2 hours after the first attendance finishes.

Standard Information Statements (SIS)

A SIS is a brief summary of the key features of a Product that contains the information, and is in the form, set out in the Private Health Insurance (Complying Product) Rules.

Terminal Illness

A terminal illness is an illness which in the opinion of a medical practitioner is likely to result in the Member's death within 12 months.

Transfer

A transfer is where a person moves from one Product or one Private Health Insurer to another.

Transfer Certificate

A certificate provided by a Private Health Insurer that explains the Cover provided by the Membership and meets the required criteria as detailed in the Private Health Insurance Act.

Waiting Period

A period of time during which a Member must hold continuous Membership under a particular Product before the Member has an entitlement to receive a Benefit at the level payable on that Product.

B3 Other

C MEMBERSHIP

C1 General Conditions of Membership

C1 1.1 Membership Categories

A single Membership may only include one person who is either an Adult Member or who is a Member under 18; it must not include a Partner or other Dependants.

A family Membership may include one Adult Member, a Partner (or without a Partner) and any number of Dependants. It may also include multiple Members under 18 who are siblings where there is no Adult Member covered by the Membership.

A parent plus Membership may include one Adult Member and any number of Dependants; it must not include a Partner.

A couples Membership may include one Adult Member and Partner only; it must not include Dependants.

All Products are available in all membership categories unless stated otherwise in the relevant Product Schedule.

C1 1.2 Membership Categories for GMF Products

A Single Membership may only include one person; it must not include a Partner or Dependants.

A Family Membership may include one Adult Member, a Partner (or without a Partner) and any number of Dependants.

A Couples Membership may include one Adult Member and Partner only; it must not include Dependants

C1 2 Levels of Cover

Subject to other Fund Rules, a Member may (at any one time) have a Membership under only one of the following:

a. any one Hospital Product that covers Hospital Treatment set out in Schedule H;

b. any one Extras Product that covers General Treatment set out in Schedule I;

c. any combination of a Hospital Product and an Extras Product covering Hospital Treatment and General Treatment set out in Schedules H and I;

d. any one of the combined package Products (Twinpacks) covering Hospital Treatment and General Treatment set out in Schedule J;

e. any one Overseas Product that covers the Hospital Treatment and medical costs set out in Schedule L; or

f. any combination of an Overseas Product and an Extras Product covering Hospital Treatment, medical costs and General Treatment set out in Schedules L and I;

with the following exceptions:

a. the Wellness Product detailed in Schedule I8 is not available for purchase by a new or existing Member from 8 October 2018. For Members who purchased the Wellness Product prior to 8 October 2018 it is only available as part of a package with the following Extras Products or Twinpack Products in Schedules: I1, I2, I5, I10, J1, J2, J3, J4;

b. the Ambulance Care Product detailed in Schedule I9 is only available as part of a package with the following Hospital, Twinpack or Overseas Product in Schedules: H2, H4, H5, H6, H7, H8, H9, H10, H11, H12, H19, H20, J1, J2, J3, J4;

c. the Urgent Ambulance Product detailed in Schedule I7 is only available as a standalone Product. It is not available in conjunction with any other Product.

d. GMF Products are not available in conjunction with any product other than another GMF Product.

C1 3 Other Treatments

No Benefits for funerals, disability or Benefits paid in connection with the birth of a baby are payable under any Hospital or Extras Product. For avoidance of doubt, Benefits paid in connection with the birth of a baby as referred to in the Private Health Insurance (Complying Product) Rules are not Maternity treatment.

C1 4 Contribution Group

HBF may, at its discretion, approve any group of Members as a contribution group. A contribution group may include, but is not limited to, Members who are covered by a Corporate Membership.

C1 5 Change of Membership details

Subject to the requirements otherwise set out in the Fund Rules, where any details of the Membership change, an Adult Member must inform HBF within 1 month of such changes.

Change of Membership details that trigger the notification obligation under Fund Rule C1 5 include:

a. change of address of any Member;

b. change of contact details of any Member (such as telephone, email or fax numbers);

c. change of name;

d. change of bank account details; and

e. a Dependant is no longer eligible to be a Dependant (for example, a Dependant ceases or defers study or there is a change of marital or de facto status of the Dependant); and

f. change of visa sub class.

C2 Eligibility for Membership

Any person may apply for any Product or any combination of Products set out in, and in accordance with, Fund Rule C1 2.

C3 Dependants

Unless otherwise stated in these Fund Rules, an Adult Member may request to have a Dependant added to their Membership.

Where the Membership was a Single Membership prior to a Dependant being added, the Membership category (as described in Fund Rule C1 1) will be amended from the date the Dependant is added. Premiums for the Membership will be adjusted accordingly.

If a Dependant does not meet the criteria under the definition of a Dependant (as defined in these Fund Rules):

a. the Dependant will become ineligible for Cover under the Adult Member's Membership;

b. the Dependant will be removed from the Adult Member's Membership; and

c. HBF will automatically offer a new single Membership for the Dependant.

C4 Membership Applications

C4 1 Application in the approved form

A person may make any application required by these Fund Rules in writing, by telephone or by any other oral or electronic means approved by HBF.

All relevant information reasonably requested by HBF in order to establish and maintain a Membership must be supplied by the applicant.

HBF may from time to time introduce or vary procedures or requirements with respect to applications made under this Fund Rule.

An application to join the Fund will be accepted by HBF only once the initial payment of the Premium required from the applicant is received by HBF.

C4 2 Refusal of Application to Join

HBF reserves the right to reject any application for admission to the Fund as a Member including where the applicant was a former Member of the Fund whose Membership was cancelled under Fund Rule C.8.

HBF will not reject any Membership application for reasons described as improper discrimination under the Private Health Insurance Act.

C4 3 Acceptance of Application to Join

On acceptance of a Membership application, HBF will provide one Adult Member with:

a. the relevant up to date SIS (except when the Product is an Overseas Product);

b. details of what the Membership covers and how Benefits are calculated; and

c. a statement identifying that the Membership is referable to the Fund operated by HBF.

C5 Duration of Membership

C5 1 Membership Commencement Dates

The commencement date of a Membership will be the day the Membership application is accepted by HBF.

Exceptions to this Fund Rule are:

a. where the applicant is transferring from another Private Health Insurer, the new Membership may be effective from the day after the date the policy with the other Private Health Insurer is paid up to;

b. Memberships automatically created by HBF for people who are no longer eligible to be covered on the Adult Member's Membership as Dependants. These new Memberships will commence on a date determined by HBF during the year the person becomes ineligible to be a Dependant;

c. where a cover note has been issued for a Member on a Product requested by the Member, the new Membership may be effective from the date stated on that cover note;

d. for Overseas Products a new Membership will commence from the date the Member arrives in Australia; and

e. any other exceptions determined by HBF,

unless otherwise determined by HBF.

C5 2 Membership End Dates

Memberships will end on the cancellation or termination dates determined under Fund Rules C7 or C8.

C6 Transfers

C6 1 Transfers From Another Private Health Insurer

When a member of another Private Health Insurer transfers to HBF within 2 months of the date the member ceased to be covered by the other Private Health Insurer under a policy (the "Old Policy"), and a Transfer Certificate is provided to HBF:

a. HBF may, at its discretion, recognise a period of cover under the Old Policy in determining maximum entitlements for Benefits for General Treatment under the new Membership.

b. The Member will not be required to serve Waiting Periods except:

   i. for services not covered by the Old Policy;

   ii. the unexpired portions of any Waiting Periods not fully served under the Old Policy; and

   iii. for Benefits greater than those payable under the Old Policy.

c. Any relevant Benefits that have been paid within a specified time period under the Old Policy may be taken into account by HBF in determining Benefits payable under the new Membership.

d. The maximum entitlement under the new Product may be applied immediately regardless of any Waiting Period for Benefits.

e. When the Old Policy had an Excess and the new Product with HBF does not, the Excess of HBF's Product most closely approximating the Old Policy will apply during any applicable Waiting Periods.

f. HBF does not take into account any agreements between the other Private Health Insurer and any provider for the purposes of calculating the level of Benefits covered under the Old Policy.

When a member of another Private Health Insurer transfers to HBF more than 2 months after the member ceased to be covered under the Old Policy, HBF will treat the person as a new Member for all purposes except those relating to Lifetime Health Cover as specified at Fund Rule D4.

HBF will provide one Adult Member with:

a. the relevant up to date SIS for the new Product (except when the new Product is an Overseas Product);

b. details of what the Membership covers and how Benefits are calculated; and

c. a statement identifying that the Membership is referable to the Fund operated by HBF.

C6 2 Transfers Between Products

An Adult Member may apply to Transfer from any Product to any other Product and HBF reserves the right (subject to these Fund Rules) to either approve or refuse the application.

Claims for Benefits for treatment or services provided during Membership under the previous Product will be paid under the previous Product.

Where a Member transfers to a Product with a higher level of Benefits:

a. HBF will pay Benefits at the level of the previous Product for treatment or services provided during any Waiting Period applicable to the new Product.

b. The Member will not be required to serve Waiting Periods except:

   i. for services not covered by the previous Product; and

   ii. the unexpired portions of any Waiting Periods not fully served under the previous Product.

Where a Member transfers to a Product with a lower level of Benefits, HBF will pay Benefits at the level of the new Product for treatment or services provided during Membership under the new Product.

Any relevant Benefits that have been paid within a specified time period under the previous Product may be taken into account by HBF in determining Benefits payable under the new Membership.

Where a Member transfers to a new Product the maximum entitlement under the new Product may be applied immediately regardless of any Waiting Period for Benefits.

When the Membership under the previous Product had an Excess and the Membership under the new Product does not, the Excess will apply for treatment or services provided during the applicable Waiting Periods.

HBF will provide one Adult Member with:

a. the relevant up to date SIS for the new Product (except when the new Product is an Overseas Product);
b. details of what the Membership covers and how Benefits are calculated; and
c. a statement identifying that the Membership is referable to the Fund operated by HBF.

C6 3 Products Eligible for Changing Electives

For avoidance of doubt, changing product electives (either one or more of the nominated General Treatment services) is a transfer between Products.

C6 4 Transfers to Another Private Health Insurer

A Member transferring to another Private Health Insurer will receive a Transfer Certificate within 14 days to enable continuity of membership.

C7 Cancellation of Membership

C7 1 Cancellation Requests

An Adult Member may request to cancel a Membership or remove a Dependant from a Membership by providing notice to HBF in the form determined under Fund Rule C4 1 unless otherwise agreed by HBF.

The above actions may not have retrospective effect unless:

a. the Member is deceased, in which case the Membership will be cancelled effective from the day after the date of death; or
b. otherwise permitted by HBF.

C7 2 Reinstatement

Where a Membership has been cancelled, HBF may in its discretion reinstate the Membership at the request of an Adult Member, with continuity of entitlements, subject to the payment of all Premiums as required under Fund Rule D5.

C7 3 Refund of Premiums

A pro-rata refund of not less than $10.00 may be payable when a Membership is cancelled effective prior to the Premium Due Date.

Where no Benefits have been paid, an Adult Member may cancel within a period of 30 days from the commencement date of their Membership and receive a full refund of any Premiums paid.

C8 Termination of Membership

C8 1 Termination by HBF

HBF may terminate a Membership:

a. immediately by written notice where a Member acts improperly in accordance with Fund Rule C8 2; or

b. at a time determined by HBF, without notice, if a Member has not paid a Premium due under the Membership within 2 months of the Premium Due Date; or

c. after payment of a repatriation Benefit; or

d. after the maximum period of suspension as specified in Fund Rule C9 2.1.

C8 2 Member Must Not Act Improperly

If at any time HBF determines that any Member (either whilst a Member or an applicant to become a Member) or any person acting on behalf of a Member or applicant has:

a. provided information to HBF which in the opinion of HBF is false or misleading;

b. misled or deceived HBF in any other manner including by failing to provide true and full information at any time;

c. acted or attempted to act improperly which has, or is likely to have, resulted in or may result in:

   i. the Member obtaining an unfair advantage for himself/herself and/or another person; or

   ii. loss or damage to HBF; or

d. materially or repeatedly breached any of these Fund Rules or any other term or condition of Membership,

HBF may at its discretion:

I. terminate immediately by written notice the Membership of the Member, after which time:
   a. the Member will not be entitled to payment of Benefits regardless of when the treatment was rendered;
   b. the Member must reimburse the money paid by HBF as a result of the improper conduct; and
   c. HBF will, after deducting all monies payable by the Member under (b) above, repay the Member any balance of Premiums paid by the Member for the period after the date of cancellation;

II. not pay any Benefits where the information or conduct has been provided or committed in or connection with the claim for those Benefits and, in addition, recover from the Member all monies paid by HBF arising from the information or conduct; and/or

III. set-off any amount payable by HBF to the Member under these Fund Rules against any amount payable by the Member to HBF under these Fund Rules.

C8 3 Member Entitlements on Termination and Cancellation

Unless Fund Rule C8 2 applies:

a. the termination or cancellation of the Membership will not affect any rights accrued by the Member prior to the date of termination or cancellation; and

b. the Member will be entitled to a pro-rata refund of any Premium paid for any period beyond the date of termination or cancellation.

C9 Temporary Suspension of Membership

C9 1 Overseas Travel

C9 1.1 An Adult Member may request to suspend a Membership if all Members will be overseas for a minimum period of 2 months and Premiums are paid up to the date of departure.

C9 1.2 Suspension must be arranged prior to leaving Australia and will be effective from the day after the date of departure. The Member will be entitled to a pro-rata refund of any Premiums paid in advance beyond the date of suspension.

C9 1.3 During the period of suspension:

a. no Benefits are payable for treatment or services received during the period of suspension;

b. the period of suspension does not count towards the serving of Waiting Periods or length of Membership;

c. a Member is not entitled to the Federal Government Rebate; and

d. the Medicare Levy Surcharge may apply.

C9 1.4 Adult Members on an Overseas Product may request to suspend their Membership once every 3 years for a minimum of 2 months up to a maximum of 6 months in each 3 year period. For Memberships under all other Products, the Membership may be suspended for overseas travel as many times as required and there is no maximum period of suspension.

C9 1.5 Any outstanding Waiting Periods must be served upon resumption of the Membership.

C9 1.6 A Membership is resumed from the date of the Member's arrival back into Australia. A boarding pass or similar document showing the date of departure and arrival must be sighted as confirmation.

C9 1.7 A Membership will be resumed on the same Product covered under the Membership prior to suspension.

C9 1.8 If the Membership was under a Product that is no longer available at the time of resumption, HBF will offer the Product most closely approximating the closed Product and waive Waiting Periods for any increased Benefits.

C9 1.9 A suspended Membership may not be resumed where the Member is:

a. returning to Australia for less than 6 months;

b. returning to Australia for a holiday; or

c. returning to Australia to receive treatment where permanent residence is not resumed.

C9 2 Overseas Travel for GMF Products

C9 2.1 An Adult Member may request to suspend a Membership if all Members will be overseas for a minimum period of 3 months and a maximum period of 3 years and Premiums are paid up to the date of departure.

C9 2.2 Suspension will be effective from:

a. the day after the date of departure if the application to suspend is received prior to travelling; or

b. the day after the date of departure or the day after the Premium Due Date (whichever is earliest), when the Member has already left Australia.

C9 2.3 During the period of suspension:

a. no Benefits are payable for treatment or services received during the period of suspension;

b. the period of suspension does not count towards the serving of Waiting Periods or length of Membership;

c. a Member is not entitled to the Australian Government Rebate on private health insurance;

d. the Medicare Levy Surcharge may apply; and

e. any Premiums paid in advance are held in credit pending resumption of Membership.

C9 2.4 Any outstanding Waiting Periods must be served upon resumption of the Membership.

C9 2.5 A Membership is resumed from the date of the Member's arrival back into Australia. A boarding pass or similar document showing the date of arrival must be sighted as confirmation.

C9 2.6 A Membership will be resumed on the same Product covered under the Membership prior to suspension.

C9 2.7 If the Membership was under a Product that is no longer available at the time of resumption, HBF will offer the Product most closely approximating the closed Product and waive Waiting Periods for any increased Benefits.

C9 2.8 A suspended Membership may not be resumed where the Member is:

a. Returning to Australia for less than 6 months;

b. Returning to Australia for a holiday; or

c. Returning to Australia to receive treatment where permanent residence is not resumed.

C9 3 Health Cover Protection (HCP)

HCP may provide complimentary Membership or suspend Membership for an unemployed Adult Member (referred to in this rule as "Member").

C9 3.1 The terms of HCP are:

a. the Member must have held Membership for at least 12 months with HBF;

b. the Member must be in receipt of either Newstart or Sickness Allowance benefits from Centrelink;

c. the Member must provide evidence of either Newstart or Sickness Allowance benefits in the form of a health care card;

d. the Membership Premiums must be paid up to the time the HCP application commences; and

e. HCP is not available for Members on Ambulance or Overseas Products.

C9 3.2 The terms of complimentary Membership are:

a. the Member does not pay Premiums and HBF will pay Benefit for eligible claims for treatment or services during the complimentary Membership period;

b. the complimentary Membership period commences from the later of the day after the Premium Due Date or the date the Centrelink benefit commences;

c. the complimentary Membership will be available for a period of between 3 and 9 months, depending on the length of Membership;

d. the complimentary Membership is only valid for the Product covered under the Membership prior to the receipt of Centrelink benefits; and

e. only one period of complimentary Membership may be granted every 10 years of Membership.

C9 3.3 The terms of suspension of Membership are:

a. the Member does not pay Premiums and HBF does not pay Benefits during the suspension period;

b. the suspension of Membership commences from the later of the day after the Premium Due Date or the date the Centrelink benefit commences;

c. the suspension will be available for a period of between 3 and 15 months, depending on the length of Membership;

d. if the Membership was under a Product that is no longer available at the time of resumption, HBF will offer the Product most closely approximating the closed Product and waive Waiting Periods for any increased Benefits;

e. only one period of suspension may be granted every 5 years from the commencement date of the last HCP entitlement; and

f. the period of suspension does not count towards the serving of Waiting Periods or length of Membership.

C9 3.4 If the Centrelink benefits are withdrawn during the 'complimentary' Membership or 'suspension' period an Adult Member must contact HBF within 30 days of the withdrawal. Payment of Premiums will re-commence from the date the Centrelink benefits are withdrawn.

C10 Other

D CONTRIBUTIONS

D1 Payment of Premiums

D1 1 Premiums Payable in Advance

Members must pay Premiums in advance, by the agreed frequency, on or before the Premium Due Date.

Premiums may not be paid more than 18 months in advance.

D1 2 State Premiums

Premiums may differ based on the State or Territory in which the Member permanently resides.

D2 Premium Rate Changes

D2 1 Rate Change

HBF may vary the Premiums for any Product in accordance with these Fund Rules and any requirements set out in the Private Health Insurance Act.

D2 2 Variations of Premium Rates and Premium Due Dates

Members paid in advance of the effective date of a Premium rate change, will not be required to pay the new rate of Premium until their next Premium Due Date.

D3 Premium Discounts

D3 1 Discounts for Premiums paid in advance

A Member will be entitled to the following discounts on Premiums for a Membership under any Hospital, Extras or Overseas Products, unless otherwise specified in the relevant Product Schedule. Discounts do not apply to any Gap Saver option under a Membership.

a. Annual payment in advance - 3.83%

b. Six monthly payment in advance - 1.92%

c. Quarterly payment in advance - 0.48%

D3 2 Direct Payment Discount

A Member who pays Premiums from an account with a financial institution by a direct debit arrangement will receive a 4% discount on Premiums for a Membership under any Hospital, Extras or Overseas Products unless otherwise specified in the relevant Product Schedule. Discounts do not apply to any Gap Saver option under a Membership.

D3 3 Contribution Group Discounts

A discount up to the maximum discount allowed under the Private Health Insurance (Complying Product) Rules may apply to Members of a Contribution Group.

D3 4 Cumulative Discounts

The discounts for Premiums outlined in Fund Rule D3 may be applied simultaneously, but only up to the maximum discount allowed under the Private Health Insurance (Complying Product) Rules.

D4 Lifetime Health Cover

HBF will comply with the Federal Government's initiative for Lifetime Health Cover as required by law.

D5 Arrears in Premiums

D5 1 Unfinancial Members

HBF deems a Member to be unfinancial and a Membership to be in arrears, if a Premium has not been paid on or before the Premium Due Date.

If a Premium is more than two months in arrears, then the Membership may be automatically terminated.

D5 2 Acceptance of Arrears

D5 2.1 If a Member pays all Premiums for the period of arrears within 2 months of the Premium Due Date, HBF will pay Benefits for treatment or services received during the period of arrears.

D5 2.2 Any person who is an unfinancial Member for a period exceeding 2 months may apply to continue Membership and pay all outstanding Premiums, and HBF may in its absolute discretion either approve or reject such application.

In approving an application, HBF may impose conditions not inconsistent with the Private Health Insurance Act.

D5 3 Treatment Where Premiums in Arrears

Subject to Fund Rules C8 1b and D5 2, if the Member does not pay Premiums due under the Membership by the Premium Due Date, HBF will not pay Benefits towards any treatment received after the Premium Due Date unless and until the arrears are accepted.

D6 Other

E BENEFITS

E1 General Conditions

E1 1 Benefits Available

Details of Benefits available under each Product are set out in the relevant Schedule of these Fund Rules.

E1 2 100% Rule

HBF will not pay Benefits that exceed the actual charge for treatment, goods or services received by the Member.

The Benefit payable may be reduced in the following circumstances:

a. where the amount paid by a Member for treatment is lower than the Benefit payable, the Benefit will be reduced to the amount paid;

b. where money is payable from more than one source for the same treatment, HBF may reduce its Benefit so that the total money payable from all sources does not exceed the amount charged; and

c. where in the opinion of HBF the charge is higher that the provider's usual charge for the treatment, good or service, in which case HBF may assess the claim as if the provider's usual charge had applied.

E1 3 Benefits Not Payable

Benefits are not payable:

a. for treatment, goods or services provided to a Member during the Waiting Period;

b. during a period for which the Premiums have not been paid (other than in the conditions specified in Fund Rule C9);

c. for treatment or services or an item where the expense was incurred by the employer of that Member or if the Member obtained that treatment, goods or services in connection with employment, application for employment, an industrial undertaking or profession, a life insurance examination or similar circumstances at HBF's discretion;

d. where the provider is not a Hospital, Medical Provider or Approved Provider at the time the treatment, goods or services were provided to the Member;

e. where the Member has received, or established a right to receive, Compensation for treatment, goods or services;

f. where the Member has received, or has the right to receive, and to the extent the Member has received, or has the right to receive, payment (in full or in part) for the treatment, goods or services from a third party including:

   I. another Private Health Insurer; or

   II. in the case of General Treatment, through publicly available funding;

g. for treatment, goods or services provided outside of Australia;

h. if false or misleading information is provided in respect of the treatment, goods or services;

i. where the Approved Provider:

   i. at the time the treatment, good or service was provided, has ceased to be engaged in Private Practice; or

   ii. does not provide the treatment, good or service while engaging in Private Practice; or

j. unless otherwise agreed to by HBF in its absolute discretion, where the Approved Provider provides the treatment, good or service from the premises of a Public Hospital or premises made available to the Approved Provider from the operator of a Public Hospital or an entity authorised or allowed by the operator of a Public Hospital to make the premises available to the Approved Provider.

E1 4 Members to contact HBF prior to receiving treatment, goods or services

If a Member expects to receive treatment, goods or services for which the Member anticipates a Benefit, the Member must first contact HBF before receiving that treatment, good or service to confirm any entitlement to a Benefit.

After HBF has paid any Benefit which the Member is entitled to under the Membership, the Member is responsible for paying any amounts which are still owing to the provider of the treatment, goods or services. The Member should confirm all likely Out-of-pockets with each provider before receiving the treatment, goods or services

E2 Hospital

E2 1 Participating Hospital Provider Agreements

Where a Member is charged for an Agreed Service provided in a Participating Hospital, the Benefit will be:

a. determined in accordance with the relevant Participating Hospital Provider Agreement; or

b. where no Participating Hospital Provider Agreement exists, as determined by HBF, and in accordance with the relevant Product Schedule in Schedules H, J or L.

E2 2 Medical Provider Agreements

HBF may, from time to time, for the benefit of Members enter into agreements with Medical Practitioners. Where a Member is charged for a professional medical treatment or service where a Medical Provider Agreement applies, the Benefits will, unless otherwise stated in these Fund Rules, be as specified in the Medical Provider Agreement.

E2 3 Lists of Provider Agreements

Any Member will be entitled to receive an up-to-date list of:

a. Participating Hospitals; and

b. the providers with whom HBF has Medical Provider Agreements.

E2 4 Non Agreement Providers and Non-Agreed Services

Notwithstanding any other Fund Rules, for treatment, goods or services provided at non-Participating Hospitals or for Non-Agreed Services provided at Participating Hospitals which are covered by the Member's Product, HBF will pay Benefits as determined by HBF from time to time which will be at least equivalent to the Minimum Default Benefit. Significant Out-of-pockets may apply.

E2 5 Nursing Home Type Patients (NHTP)

HBF will pay the NHTP Benefit for a Member while they are classified as a Nursing Home Type Patient.

E2 6 Medical Gap Cover

Where a Member is admitted as a Private Patient and incurs a fee for a medical service rendered as part of Hospital Treatment that has an MBS item number, the Benefit paid:

a. where the provider charges less than the MBS, is the difference between 75% of the MBS fee and the amount charged by the provider; or

b. where the provider charges the MBS fee or more, is 25% of the MBS fee.

Where the Medical Provider has a Medical Provider Agreement as part of HBF's Gap Cover, an additional Medical Gap Benefit may be payable.

Members may still need to pay Out-of-pockets for medical services rendered as part of Hospital Treatment.

Gap Cover is available to Members with Membership under any Hospital Products.

E2 7 Admission and Discharge Days

The date of admission to Hospital will be included in the period for which a claim may be made, but the date of discharge from Hospital will not be included.

E2 8 Location of Treatment

Hospital Benefits will only be payable for Hospital Treatment provided by a person who is authorised by a Hospital to provide treatment. Treatment must be provided either at a Hospital or with the direct involvement of a Hospital, subject to any Participating Hospital Provider Agreement.

E2 9 Surgically Implanted Prostheses

HBF will pay the fee up to the benefit determined by the Minister for any surgically implanted prostheses on the Prostheses List implanted during a medical procedure for which Medicare benefit is payable and which is provided as part of Hospital Treatment. Members may incur an Out-of-pocket.

No Benefit is payable for items that are not on the Prostheses List.

E2 10 Pharmaceuticals Provided During Hospital Treatment

No Benefit is payable for PBS items provided as part of the Member's Hospital Treatment, except for members on Ultimate or Overseas Products.

No Benefit is payable for Non-PBS pharmacy items unless they require a prescription.

E2 11 Limitation of Benefits for Podiatric Surgery

As determined from time to time by HBF, the podiatric surgery Benefits are subject to limitation where multiple procedures are provided at the same time or within particular periods.

Unless otherwise stated, limitations apply to each Member covered by a Membership.

E2 12 Non-Admitted Services

Unless otherwise determined by HBF, no Benefit is payable for non-admitted services.

E3 Ancillary

E3 1 Time Tiered Consultations

General Treatment consultations, described as a period of time, include only time during which a Member is receiving direct or active attention.

They do not include preliminary or subsequent attendances, such as the making of appointments and writing of reports. Preliminary or subsequent attendance cannot be treated as a separate consultation.

E3 2 Purpose of Treatment

No Benefit is payable for treatment primarily for the purposes of sport, recreation or entertainment unless the treatment is provided as part of a "chronic disease management program" or a "health management program" (as those terms are defined in the Private Health Insurance (Health Insurance Business) Rules) intended to improve a Member's specific health condition.

E3 3 Registration of Approved Providers

E3 3.1 Benefits are not payable for General Treatment unless the provider is an Approved Provider. HBF has absolute discretion to approve or not approve a provider as an Approved Provider under Fund Rule E3 3 and E3 4.

E3 3.2 An Approved Provider continues to be approved until:

a. the provider's registration is cancelled under Fund Rule E3 3.7;

b. the provider is declared an Unacceptable Provider under Fund Rule E3 4 (in which case the provider's registration is cancelled); or

c. one of the following occur:

i. the provider ceases to practise;

ii. the provider ceases to be registered by the relevant registration board or ceases to be a member of the relevant professional body approved by HBF;

iii. the relevant professional body of which the provider is a member ceases to meet Private Health Insurance Act or any HBF accreditation criteria; or

iv. the provider ceases to satisfy any of the requirements of the Private Health Insurance (Accreditation) Rules.

For the avoidance of doubt, if a provider is registered to provide treatment, goods or services in more than one speciality of General Treatment and they cease to practise in one or more of those specialities for the reasons specified in this Rule E3 3.2, then that provider will remain an Approved Provider for the other specialities for which the provider continues to practise in compliance with these Fund Rules.

E3 3.3 A provider who has not previously been registered by HBF or whose registration was cancelled as a result of that provider ceasing to be a provider of General Treatment under Fund Rule E3 3.2c, may, at any time, apply to be registered by HBF to be an Approved Provider.

A provider who has previously been registered by HBF and had their registration cancelled pursuant to Fund Rule E3 3.7 or otherwise been declared an Unacceptable Provider under Fund Rule E3 4 may, no earlier than one year after the date of the relevant cancellation or declaration, apply to again be registered by HBF to be an Approved Provider.

E3 3.4 An application for registration as an Approved Provider must be in the form requested, and contain the information required, by HBF from time to time.

E3 3.5 Unless HBF otherwise determines, registration of an Approved Provider is limited to provision of treatment from one stipulated location. An Approved Provider may apply for and obtain separate registration for different locations.

E3 3.6 HBF may, in its absolute discretion, register and keep registered a provider as an Approved Provider subject to compliance by the provider with conditions which have been or may be specified by HBF from time to time. These conditions may include requirements in relation to billing and accounting, the provision of treatment records and the repayment of Benefits paid to the provider contrary to these Fund Rules. Conditions may be imposed at the time a provider is registered as an Approved Provider and at any time while the provider remains so registered.

E3 3.7 HBF may cancel a provider's registration as an Approved Provider if the provider has:

a. failed to comply with any conditions:

i. of the Fund Rules;

ii. of any other document describing the relationship between HBF and the provider; or

iii. specified by HBF in accordance with Fund Rule E3 3.6;

b. been served with formal written notice requiring compliance with the condition; and

c. failed to comply with the terms of that notice.

E3 3.8 Upon cancellation of a provider's registration as an Approved Provider under Fund Rule E3 3.7, Fund Rule E3 4.2 will apply as though the registration was cancelled due to the provider being deemed unacceptable pursuant to Fund Rule E3 4.1 and the date of cancellation will be deemed the declaration date as per Fund Rule E3 4.

E3 4 Unacceptable Providers

E3 4.1 If:

a. a provider is found by any court, relevant statutory board or tribunal or professional association to have; or

b. HBF is otherwise satisfied that a provider has,

engaged in unlawful, improper or unprofessional conduct, HBF may declare, in its absolute discretion, that provider to be unacceptable (an "Unacceptable Provider") and cancel the provider's registration as an Approved Provider. For the avoidance of doubt in determining whether a provider has engaged in unlawful, improper or unprofessional conduct, HBF may have regard to, but is not obliged to have regard to, how a court, relevant statutory board or tribunal or professional association may view the facts under consideration.

E3 4.2 Where HBF declares a provider to be an Unacceptable Provider in accordance with Fund Rule E3 4.1 the following will apply:

a. Subject to the Private Health Insurance Act, no Benefits will be paid by HBF for treatment or services rendered by that provider at any time later than 2 months after the date of the declaration (the "Effective Date"), unless:

i. HBF is satisfied that the Member was not aware of the declaration at the time the treatment or services was or were rendered and, in its absolute discretion, elects to pay a Benefit; or

ii. HBF considers, in its absolute discretion, undue hardship would be caused to the Member if Benefits were not paid.

b. Within 7 days after the date of the declaration, HBF will notify the provider that they have been declared an Unacceptable Provider and that no Benefits will be paid for treatment or services rendered by them after the Effective Date.

c. Within 14 days after the date of the declaration, all Members who according to HBF's records have received Benefits for treatment or services from the provider declared unacceptable within the one year immediately prior to the declaration will be notified by HBF that treatments or services rendered by the provider after the Effective Date will not be eligible for Benefits.

d. A provider declared an Unacceptable Provider may apply to HBF (in the form required and with any evidence required by HBF) for HBF to revoke the declaration. In any such application the provider will need to demonstrate that the reason behind HBF's decision to declare the provider an Unacceptable Provider no longer exists. HBF may grant, with or without conditions, or refuse the application as HBF in its absolute discretion considers fit.

E3 5 Obligations of Approved Providers

An Approved Provider must:

a. undertake in a diligent and professional manner the provision of treatment, goods or services to Members and maintain the quality of the treatment, goods or services;

b. comply with each law, and each requirement arising from a law, and hold and maintain every required licence, permission and registration necessary to provide treatment, goods or services to Members including as required by the Private Health Insurance (Accreditation) Rules;

c. conform to the general standards required by all relevant regulatory bodies;

d. not act contrary to the interests of HBF or in a way which brings HBF into disrepute;

e. promptly advise HBF of any event or occurrence that the Approved Provider is aware of which may reasonably be expected to lead to a complaint about HBF from any person;

f. not provide information to HBF which is false or misleading;

g. not mislead or deceive HBF in any other manner including by failing to provide true and full information at any time;

h. not act or attempt to act improperly so as to:

   I. obtain an unfair advantage for himself/herself or another person; or

   II. cause loss or damage to HBF; and

i. only provide a treatment, good or service to a Member while engaging in Private Practice if they do not otherwise make that treatment, good or service available to persons while not engaging in Private Practice.

E3 6 Services Rendered to a Relative

No Benefit for General Treatment is payable where the patient is covered on the same Membership as the person prescribing or the Approved Provider rendering the treatment, goods or services.

E3 7 Participating Providers Arrangements

E3 7.1 HBF may enter into participating provider arrangements (Participating Provider Arrangements) with Approved Providers on terms and conditions determined by HBF at its absolute discretion. These conditions may include requirements in relation to agreed fees and services. Conditions may be imposed at the time a provider is registered as a Participating Provider and amended at any time while the provider remains so registered.

E3 7.2 An application for registration as a Participating Provider must be in the form requested, and contain the information required, by HBF from time to time.

E3 7.3 A Participating Provider Arrangement continues until:

a. the provider's Approved Provider registration is cancelled under these Fund Rules; or

b. HBF terminates the Participating Provider Arrangement on giving notice in accordance with the terms of the Participating Provider Arrangement.

E3 7.4 A provider who has previously been registered by HBF and had their registration cancelled pursuant to Fund Rule E3 7.6 or otherwise been declared an Unacceptable Provider under Fund Rule E3 4 may, no earlier than one year after the date of the relevant cancellation or declaration, apply to again be registered by HBF to be a Participating Provider.

E3 7.5 HBF may cancel a provider's arrangement as a Participating Provider:

a. if the provider has failed to comply with any conditions:

   i. of the Fund Rules;

ii. of the Participating Provider Arrangement or any other document describing the relationship between HBF and the provider; or

iii. specified by HBF in accordance with Fund Rule E3 7.1;

b. if the provider has been served with formal written notice requiring compliance with the condition; and

c. if the provider has failed to comply with the terms of that notice; or

d. at HBF's discretion; or

e. by agreement with the provider.

E4 Other

E4 1 Gap Saver

Gap Saver is an option available to Members with Membership under any Hospital or Extras Products except GMF Products, Overseas Products and Urgent Ambulance.

Where a Member receives:

a. Hospital Treatment as a Private Patient and incurs a fee for a medical service rendered as part of Hospital Treatment for which a Minimum Default Benefit is payable; or

b. Hospital Treatment as a Private Patient and incurs a fee for Hospital Treatment for which Benefit is payable in accordance with Schedule H; or

c. Hospital Treatment as a Private Patient and incurs a fee for a pharmaceutical item used during an episode of Hospital Treatment; or

d. Hospital Treatment as a Private Patient and incurs a fee for any Excess described in Fund Rule F 2; or

e. General Treatment for which HBF Benefit is payable and incurs a fee,

HBF may pay an additional amount from the Member's Gap Saver in accordance with the Schedule below.

Accrued Benefits are only available where the Member retains Membership under a Hospital or Extras Product.

The Benefit payable is based on the length of continuous Cover with Gap Saver as part of the Membership under a relevant Product as follows:

Continuous Membership	Gap Saver $50/$100		Gap Saver $100/$200		Gap Saver $200/$400		Gap Saver $400/$800		Gap Saver $600/$1200	
	Single Cover	Other Cover	Single Cover	Other Cover	Single Cover	Other Cover	Single Cover	Other Cover	Single Cover	Other Cover
Less than one quarter of a year	$12.50	$25.00	$25.00	$50.00	$50.00	$100.00	$100.00	$200.00	$150.00	$300.00
1 – 2 quarters	$25.00	$50.00	$50.00	$100.00	$100.00	$200.00	$200.00	$400.00	$300.00	$600.00
2 – 3 quarters	$37.50	$75.00	$75.00	$150.00	$150.00	$300.00	$300.00	$600.00	$450.00	$900.00
3 – 4 quarters	$50.00	$100.00	$100.00	$200.00	$200.00	$400.00	$400.00	$800.00	$600.00	$1200.00
Each additional quarter of a year	Add $12.50	Add $25.00	Add $25.00	Add $50.00	Add $50.00	Add $100.00	Add $100.00	Add $200.00	Add $150.00	Add $300.00

From 14 January 2019, the Gap Saver option with a Product is not available for purchase by a new or existing Member or on a Transfer by an existing Member.

From 14 January 2019, existing Members cannot change their level of contribution for Gap Saver.

F LIMITATION OF BENEFITS

F1 Co-payments

Co-payments may apply for:

a. accommodation fees;

b. theatre or procedure fees; and

c. pharmaceuticals administered in Hospital

as specified in the relevant Product Schedule in Schedules H, J and L.

F2 Excesses

F2 1 Excess Rule

An Excess is an amount by which the Hospital Benefit is reduced per person per calendar year to a maximum per Membership.

[Example: a $250/$500 Excess means that Benefit payable for Hospital Treatment is reduced by $250 per person per calendar year to a maximum of $500 per Membership per calendar year.]

F2 2 Excess Types

Excess levels and conditions are specified in the relevant Product Schedule.

F3 Waiting Periods

F3 1 Application of Waiting Periods

The Member must have paid Premiums on the chosen Product for a continuous period of time as specified in these Fund Rules, before the Member is entitled to receive a Benefit at the level payable on that Product.

HBF reserves the right to waive Waiting Periods at any time.

F3 2 Hospital Waiting Periods

F3 2.1 Hospital Waiting Periods

The Waiting Periods that apply to all Products in regards to Hospital Treatment (other than in respect of GMF Products, Overseas Products and Super Saver Hospital Cover) are:

- Maternity – 12 months
- Pre-Existing Ailments – 12 months
- Psychiatric, rehabilitation or palliative care (whether or not for a Pre-Existing Ailment) – 2 months
- All other Hospital Treatments – 2 months

Members who have held Cover for Hospital Treatment for at least 2 months may choose to upgrade their Cover in relation to psychiatric treatment and receive an exemption from the Waiting Period specified above. Members who have held Cover for Hospital Treatment for less than 2 months may choose to upgrade their Cover in relation to psychiatric treatment and receive a reduced Waiting Period (being 2 months less the period of time the Member has held Cover for Hospital Treatment). This choice can be made once in a Member's lifetime only.

The Waiting Periods that apply for GMF Products are detailed in F3 2.2, the waiting periods for Overseas Products are detailed under Schedule L and the Waiting Periods for Super Saver Hospital Cover are detailed in F3 9.

F3 2.2 Hospital Waiting Periods for GMF Products

The Waiting Periods that apply to all GMF Products in regards to Hospital Treatment are:

- Maternity – 12 months
- Pre-Existing Ailments – 12 months
- Psychiatric, rehabilitation or palliative care (whether or not for a Pre-Existing Ailment) – 2 months
- Accident or Emergency Treatment – 1 Day
- All other Hospital Treatments – 2 months

Members who have held Cover for Hospital Treatment for at least 2 months may choose to upgrade their Cover in relation to psychiatric treatment and receive an exemption from the Waiting Period specified above. Members who have held Cover for Hospital Treatment for less than 2 months may choose to upgrade their Cover in relation to psychiatric treatment and receive a reduced Waiting Period (being 2 months less the period of time the Member has held Cover for Hospital Treatment). This choice can be made once in a Member's lifetime only.

F3 3 General Treatment Waiting Periods

The Waiting Periods for General Treatment are specified in Schedules I and J.

F3 4 Multiple Waiting Periods

Where more than one Waiting Period applies to a Benefit, each Waiting Period is served independently of and concurrently with any other.

F3 5 Newborn Babies

If a newborn baby is added to the Membership within 30 days of birth (which means the joining date will be the baby's date of birth), the baby will be credited with the length of Cover of the Adult Member with the longest period of Cover.

The newborn baby will also be deemed to have already served the Waiting Periods served by the Adult Member with the longest period of Cover.

F3 6 Premature, Stillborn or Miscarried Pregnancies

If a baby is born prematurely or a Member is admitted for a Maternity related condition and the Medical Provider confirms the estimated date of birth was after the 12 month Waiting Period, HBF will pay Benefit. Stillborns and miscarriages are not subject to the 12 month Waiting or Pre-existing Ailment Period, however the 2 month Waiting Period still applies.

F3 7 Gold Card Holders

Where a person entitled to treatment under a Gold Card becomes a Member of HBF no more than 2 months after their Gold Card entitlements ceased, no Waiting Periods apply.

F3 8 Pre-existing Ailment

Unless HBF determines otherwise, a Member is not entitled to Benefits for any ailment, condition or illness where signs or symptoms existed at any time during the 6 months prior to and ending on the day on which the Membership under the Hospital Product to which the claim relates commenced.

Whether a Pre-existing Ailment exists will be determined by a Medical Provider appointed by HBF, taking into account information provided by the Member's Medical Provider and any other material the appointed Medical Provider believes is relevant to the claim.

It is not necessary for the Member to be aware of a condition, ailment or illness for it to be considered pre-existing.

This Fund Rule applies for the first 12 months after the Member commences a Membership under a new Product or transfers to a Membership under a Product that offers increased or additional Benefits.

The Pre-existing Ailment Waiting Period does not apply for psychiatric, rehabilitation or palliative care.

F3 9 Super Saver Hospital Cover

The Waiting Periods that apply to all Hospital Treatment for Super Saver Hospital Cover are:

- Pre-Existing Ailments – 12 months
- Psychiatric, rehabilitation or palliative care (whether or not for a Pre-Existing Ailment) – 2 months

Members who have held Cover for Hospital Treatment for at least 2 months may choose to upgrade their Cover in relation to psychiatric treatment and receive an exemption from the Waiting Period specified above. Members who have held Cover for Hospital Treatment for less than 2 months may choose to upgrade their Cover in relation to psychiatric treatment and receive a reduced Waiting Period (being 2 months less the period of time the Member has held Cover for Hospital Treatment). This choice can be made once in a Member's lifetime only.

F4 Exclusions

Exclusions for Hospital Treatment are specified in the relevant Product Schedule.

For any rehabilitation services which are related to an acute episode of Hospital Treatment that is excluded on a Product, Benefit is restricted to the Minimum Default Benefit.

F5 Benefit Limitation Periods

No benefit limitation periods apply on Products.

F6 Restricted Benefits

Restricted benefits for Hospital Treatment are specified in the relevant Product Schedule.

For any rehabilitation services which are related to an acute episode of Hospital Treatment that is excluded or restricted on a Product, Benefit is restricted to the Minimum Default Benefit.

F7 Compensation Damages and Provisional Payment of Claims

F7 1 Entitlement

Subject to Fund Rule F7 4, Benefits are not payable for treatment, goods or services for which the Member has received (or may be entitled to receive) Compensation in respect of that treatment, good or service.

A reference to a Member receiving Compensation includes:

a. Compensation paid to another person at the direction of the Member; and

b. Compensation paid to another Member on the same Membership in connection with a treatment, good or service received by the Member.

F7 2 Obligations of a Member

A Member who has, or may have, a right to Compensation in respect of a treatment, good or service received, must:

a. inform HBF as soon as the Member knows or suspects that such a right exists;

b. inform HBF of any decision of the Member to claim for Compensation;

c. include in any claims for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable by HBF including any allocation for future medical expenses and the treatments and services relating to those expenses;

d. where requested by HBF, identify any and all treatment, goods or services the subject of, or potential subject of, a Compensation claim for which Benefits have been or may be paid;

e. take all reasonable steps to pursue the claim for Compensation to HBF's reasonable satisfaction;

f. keep HBF informed of and updated as to the progress of the claim for Compensation;

g. provide to HBF all documents and information in relation to injuries sustained or conditions suffered for which Benefits were paid or may be payable and any claim for Compensation (including details of the insurer or statutory body responsible for paying Compensation) which will enable HBF to assess the likelihood of recovering any or all Benefits paid;

h. authorise HBF to disclose to the Member's legal advisers any and all information held by HBF which reasonably relates to the claim for Compensation; and

i. inform HBF immediately upon the determination or settlement of a claim for Compensation or the establishment of a right to receive Compensation and provide a copy of the settlement or award and if not evident from the settlement or award, an explanation of how Compensation has been allocated.

F7 3 Amount of Entitlement

Where, in HBF's opinion, the amount of the Compensation is less than the Benefits that would otherwise be payable (if Fund Rule F7 1 did not apply), then Benefits are payable in an amount not exceeding the difference between the amount of Benefits that would otherwise have been payable, and the amount of the entitlement for Compensation.

F7 4 Claiming Restrictions

When a Member has not yet received, or established a right to receive, Compensation, and HBF, at its discretion, is of the opinion that there may be a right to make a claim for Compensation, HBF may pay Benefits provided an Adult Member signs for provisional payment in the form approved for this purpose by HBF from time to time. In these circumstances, the Member agrees to make the claim for Compensation on the following conditions:

a. the Member must comply with Fund Rule F7 2;

b. the Member must not withdraw the claim for HBF's expenses unless the Member withdraws the entire claim for Compensation;

c. the Member must disclose (and authorise the Member's legal advisers to disclose) to HBF, and keep HBF informed of, all matters relevant to the progress of the claim for Compensation in a timely manner including the time and place of all settlement or other negotiations or hearings in relation to the claim for Compensation;

d. from the Compensation, the amount that HBF paid in Benefits for the treatment, goods or services will be deducted and reimbursed to HBF and will be a debt immediately repayable to HBF upon the award or settlement of the claim and the Member must authorise the Member's legal adviser to pay that debt from the proceeds of any award or settlement following a claim for Compensation; and

e. HBF has specified rights of subrogation whereby HBF acquires all rights and remedies of the Member in relation to the recovery of the amount that HBF paid in Benefits.

HBF may, in its discretion, decline to pay Benefits to a Member for treatment, goods or services the subject of, or the potential subject of, a Compensation claim until the relevant Compensation claim is settled or determined or Compensation has been awarded.

F7 5 No Entitlement

HBF will pay Benefits where HBF is satisfied that the Member has no right to payment for Compensation.

F7 6 Default of Entitlement Agreement

Where a Member receives (or establishes a right to receive) payment for Compensation and:

a. by the terms of the settlement or award it is expressed or implied that the sum of money to be paid excludes or limits the expenses for which HBF has paid Benefits; or

b. the Member abandons or compromises any part of the Member's claim so that such expenses are excluded or limited,

HBF may decline to pay the Benefits which are excluded or limited and any Benefits paid to that extent may be recovered by HBF from the Member as a debt immediately repayable to HBF.

F7 7 Where Benefits Have Been Paid by HBF

Where:

a. HBF has paid Benefits, whether by way of provisional payments in accordance with Fund Rule F7 4 or otherwise, in relation to a treatment, good or service; and

b. the Member has received Compensation in respect of that treatment, good or service,

the Member must, unless otherwise agreed, repay to HBF the full amount that HBF paid in relation to the treatment, good or service, upon the determination or settlement of the claim for Compensation and HBF may set off any amount payable by HBF to the Member under these Fund Rules against any amount payable by the Member to HBF under these Fund Rules.

This Fund Rule applies whether or not:

a. the determination or settlement sum includes the full amount that HBF paid; or

b. the Member complied with their obligations under Fund Rule F7 2.

F7 8 Rights of HBF

If a Member makes a claim for Compensation in respect of a treatment, good or service received and fails to:

a. comply with any obligation in Fund Rule F7; or

b. include in their claim for Compensation any payments of Benefits by HBF in relation to a treatment, good or service,

HBF may, without prejudice to its rights (including its broader subrogation rights) in its absolute discretion take any action permitted by law to:

a. assume that all expenses in relation to the treatment, good or service have been met from the Compensation payable or received pursuant to the claim; and/or

b. pursue the Member for repayment of all Benefits paid by HBF in relation to the treatment, good or service; and/or

c. assume the legal rights of the Member in respect of all or any parts of the claim.

F8 Other

F8 1 Services Rendered by a Government Body

HBF will not pay Benefits for a treatment or service provided to a Member by, or on behalf of, or under an agreement with one of the following:

a. the Commonwealth;

b. a State;

c. a local government; or

d. an authority established by a law of the Commonwealth, a State or Territory,

unless under special agreement between HBF and the provider.

F8 2 Benefit Not Payable for an Epidemic

HBF will only pay Minimum Default Benefits where:

a. HBF has received certification from the appropriate delegate of any State, Territory or Federal Government that an epidemic of any disease or illness exists in all or any part of Australia; and

b. it is HBF's opinion that the interests of Members warrant the change to Benefits.

HBF will give at least 7 clear days' notice of its intention to pay Minimum Default Benefits for treatment relating to an epidemic by notice in a daily newspaper published in each State and Territory capital city where the epidemic exists.

For the avoidance of doubt, HBF may use this Fund Rule F8 2 on a national or State or Territory basis depending on the extent of any epidemic.

F8 3 Limitations of General Treatment Benefits

As determined from time to time by HBF, the General Treatment Benefits specified in Schedules I, J and M are subject to limitations of frequency of treatment for particular items and/or combinations of items, which may be provided at the same time or within particular periods.

Unless otherwise stated, limitations apply to each Member covered by a Membership.

G CLAIMS

G1 General

G1 1 Claims

Applications for Benefits must be made in the manner determined by HBF from time to time, which may include by paper form, electronically or in person. Where forms are required by HBF, they must be fully completed, including the Member's details and a signed authority for HBF to request information from the provider as required.

Claims may only be made or authorised by an Adult Member.

G1 2 Claims Must Be Accompanied By Account/Receipt

The account for the treatment to be claimed must be received by HBF and must note the treatment provided (descriptions and HBF item numbers), the dates of the treatment, the patient's name, provider details and the fees charged and paid.

Any hand-written alterations to a printed account or receipt are not acceptable. Where an account or receipt requires amendment, a new copy must be issued.

For GMF Products, any alterations to the invoice or receipt must be initialled by, or on behalf of, the Provider.

HBF may, in its discretion, waive some or all of these requirements for claims submitted electronically.

If the account is not accompanied by a receipt or does not indicate the account has been paid in full, then the Benefit for the treatment claimed will be paid in favour of the provider.

All documents submitted in connection with a claim become the property of HBF.

G1 3 Time Limit for Lodgement of Claims

Applications for Benefits are to be made within 2 years from the date of receiving treatment.

HBF may, in its absolute discretion, grant Benefits after the 2 year period.

G2 Other

PRODUCT SCHEDULES

For details on Product Schedules please contact HBF on 133 423.