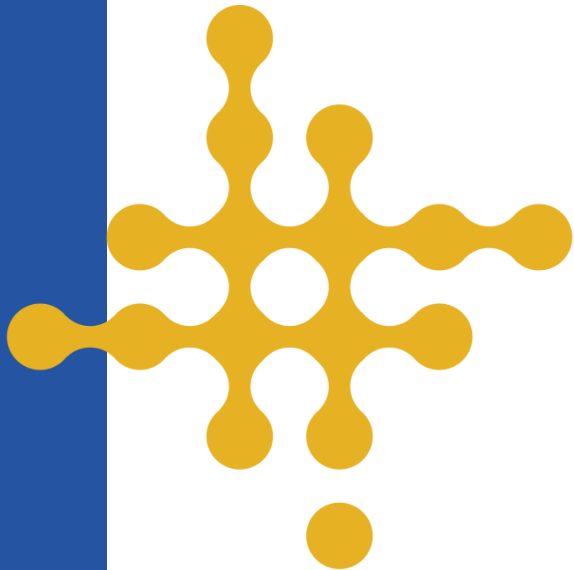

CBHS Corporate Health Pty Ltd

Health benefit fund rules

23 November 2018

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INTRODUCTION

A1 Rules Arrangement

These **Rules** set out:

(a) Part A – the general principles and operating environment of the **Fund**;

(b) Part B – how to read the **Rules**, including the meaning of terms;

(c) Part C – who can be a **Member**, and on what basis;

(d) Part D – the cost of membership contributions, and conditions on payment of contributions;

(e) Part E – the **Benefits** we offer under different kinds of health cover;

(f) Part F – conditions on the **Benefits** we offer, including **Excesses** and **Waiting Periods**;

(g) Part G – requirements for making a claim for **Benefits**;

(h) Part I – detailed schedules of our **Extras Benefits** cover;

(i) Part J – detailed schedules of our combined **Hospital Benefits** and **Extras Benefits** covers; and

(j) Part K – contribution rates.

A2 Health Benefits Fund

(a) These **Rules** govern the operation of the **Fund**, including the obligations and entitlements of **Member**, and the obligations and entitlements of CBHS Corporate Health Pty Ltd ("CBHS Corporate") in operating the **Fund**.

(b) The **Fund** is established to enable CBHS Corporate to conduct health insurance business and health-related businesses.

A3 Obligations to Insurer

A3.1 Provision of information

(a) If CBHS Corporate requests information from a **Member** which is reasonably required for the administration of his or her membership, the **Member** shall provide that information.

(b) Information includes any information requested by CBHS Corporate in forms such as the application form.

(c) A **Policy Holder** shall inform CBHS Corporate as soon as reasonably possible after any change in membership details, including contact details.

A3.2 Obligations relating to Compensable Injuries

(a) A **Policy Holder** shall advise CBHS Corporate within a reasonable period of becoming aware that any **Member** (including him or herself) in the membership has sustained a **Compensable Injury** in respect of which a **Benefit** has been claimed.

(b) If a **Member** makes a claim for compensation in relation to a **Compensable Injury** he or she has sustained, then:

i. the **Member** shall include in the compensation amount sought an amount for treatment to which **Benefits** would otherwise apply; and

ii. the **Member** shall advise CBHS Corporate that the claim has been made.

(c) The **Member** shall advise CBHS Corporate of any determination or settlement of the claim within a reasonable period of the determination or settlement.

(d) **Members** may still be able to claim **Benefits** for **Compensable Injuries** subject to **Rule F7**.

A4 Governing Principles

(a) The **Fund** is established and maintained under the **Constitution** of CBHS Corporate.

(b) These **Rules** are made under the **Constitution**. They have effect subject to the **Constitution**.

(c) These **Rules** are also made subject to the **Act**. If they are inconsistent with the requirements of the **Act**, the **Act** prevails to the extent of the inconsistency.

A5 Use of Funds

(a) The **Fund** shall be maintained in accordance with the **Act**.

(b) Without limiting the above, the assets of the **Fund** shall not be applied for any purpose other than:

i. meeting policy liabilities and other liabilities, or expenses, incurred for the purpose of the business of the **Fund**; or

ii. any other purpose required or permitted by the **Act**.

A6 No Improper Discrimination

A 6.1 CBHS Corporate not to engage in Improper Discrimination

CBHS Corporate shall not engage in **Improper Discrimination** between people who are, or who wish to be, insured under a complying health insurance policy of the **Fund**.

A7 Changes to Rules

A7.1 General Changes to Rules

(a) CBHS Corporate may, subject to its **Constitution** and the **Act**, change these **Rules** at any time.

(b) CBHS Corporate shall notify **Members** about changes to the **Rules** in accordance with the **Act**.

(c) Changes to the **Rules** will not apply to an admission to **Hospital** which was already booked at the time the change was notified to **Members**.

(d) If:

i. a **Member** is undergoing a course of treatment; and

ii. a change to the **Rules** would have a detrimental effect on the **Member** in relation to that treatment;

then CBHS Corporate will make provision for a reasonable transition period for any **Member** so affected when making that change.

A7.2 Waiver of Rules in Specific Cases

(a) CBHS Corporate may waive the application of particular **Rules** at its sole discretion, as long as the waiver is not detrimental to a **Member** or inconsistent with the **Act**.

(b) CBHS Corporate may waive the application of particular **Rules** by making an ex-gratia payment of a **Benefit** in accordance with an ex-gratia payment policy approved by the **Board**.

(c) If CBHS Corporate waives the application of particular **Rules** on one occasion, this does not bind CBHS Corporate to waive those **Rules** on any other occasion.

A8 Dispute Resolution

(a) CBHS Corporate offers an internal dispute resolution process to **Members** through its Complaint Handling Policy and Procedures.

(b) **Members** may make a complaint about any aspect of their membership at any time.

(c) **Members** can obtain information about the Complaint Handling Policy and Procedures at www.cbhscorporatehealth.com.au or by calling Member Care or email help@cbhscorp.com.au

(d) **Members**, or people seeking to become **Members,** can also complain to the Private Health Insurance Ombudsman (PHIO) about matters arising out of, or in connection with a private health insurance policy. The PHIO is a Commonwealth Government official who is independent of private health insurers.

A9 Notices

A9.1 Correspondence with Members

(a) CBHS Corporate shall direct its correspondence with **Members** to the most recently advised postal address, fax number or e-mail address for the **Policy Holders** in relation to the membership.

(b) Where the **Rules** require CBHS Corporate to notify a **Member,** or give the **Member** a notice, CBHS Corporate has satisfied that requirement if it has complied with **Rule A9.1 (a)** above.

A9.2 Availability of Rules

(a) **Members** may view the **Rules** at the office of CBHS Corporate or alternatively at www.cbhscorporatehealth.com.au

(b) CBHS Corporate shall post a copy of the **Rules** to a **Member**, if it receives a written request from the **Member** to do so.

A10 Winding Up

The **Fund** shall be wound up in accordance with the requirements of the **Act** and the **Constitution** of CBHS Corporate Health Pty Ltd.

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

B1.1 General

(a) A term not defined in these **Rules** which is given a meaning in the **Constitution** of CBHS Corporate has that meaning in these **Rules**.

(b) A reference to a gender includes the other gender and to the singular includes the plural and vice versa.

(c) A term not defined in these **Rules** or the **Constitution** of CBHS Corporate which is given a meaning in the **Act** has the same meaning in these **Rules**.

(d) A reference to $ is to Australian currency.

(e) Unless otherwise stated in these **Rules**, a reference to a person, including a **Member**, includes the person's executors, administrators, successors and permitted assigns for the purposes of any right, obligation or benefit of the person.
(f) A reference to, or to a provision in, a statute or legislative instrument includes a reference to the statute or instrument as amended, re-enacted, remade or substituted from time to time
(g) A reference to a particular Minister, Department or Government Agency includes a reference to a different or renamed Minister, Department or Government Agency which deals with matters relevant to these rules.
(h) In these **Rules** headings are inserted for ease of reference only and do not form part of the **Rules** and do not affect the construction of the **Rules**.
(i) If a word or phrase is defined, any other grammatical form of that word or phrase (including the use of a plural) has a corresponding meaning.

B1.2 Continuity of the Rules

(a) Contributions paid in advance for **Products** provided under previous **Rules** of CBHS Corporate shall be credited to **Products** provided under these **Rules** in such manner as to establish a common due date to which the contribution is paid to each **Product** of these Rules.
(b) For the purpose of these **Rules**, a **Product** under a previous set of **Rules** is to be regarded as a **Product** under these **Rules** if CBHS Corporate has effected an automatic transfer of **Members** of the previous **Product** to the **Product** specified in these **Rules**.
(c) Any specified entitlement that accrued to a **Member** under the previous set of **Rules** is taken to have accrued to the **Member** under these **Rules** if the **Member** is automatically transferred to a **Product** that contains that entitlement.

B2 Definitions

In these **Rules** unless the contrary intention appears:

"Access Gap Cover Scheme" means an arrangement where CBHS Corporate and a **Recognised Provider** have entered into an agreement whereby CBHS Corporate pays a **Benefit** directly to the **Recognised Provider** for services rendered to a **Member**.

"**Accident**" means an unexpected or unforeseen event caused by an external force or object resulting in an injury to the body which requires treatment by a medical practitioner, **Hospital** or dentist (as the context requires) but excludes pregnancy.

"**Accident Related Treatment**" means treatment provided in relation to an **Accident** that occurs after a **Member** joins the **Fund** and the **Member** provides documented evidence of seeking treatment from a **Health Care Provider** within 7 days of the **Accident** occurring. If **Hospital Treatment** is required, the **Member** must be admitted to a **Hospital** within 180 days of the **Accident** occurring. Any additional **Hospital Treatment** (after the initial 180 days) will be paid as per the level of **Benefits** payable on the **Member's** chosen level of cover (if applicable).

"Acupuncture" means an acupuncture service or treatment provided by a **Recognised Provider**.

"Act" means the *Private Health Insurance Act 2007* (Cth).

"Admitted Patient" means a patient who has been admitted to a **Hospital** as a patient and is receiving services under the direction of a medical practitioner or dentist.

"Adopted Child" means a child adopted under the relevant law of the jurisdiction where the adoption took place, whether in Australia or not, that relates to the adoption of children.

"Aged Care Service" has the same meaning as in the *Aged Care Act 1997* (Cth).

"Alternative Therapy" is either **Natural Therapy**, **Oriental Therapy** or **Massage Therapy**.

"Ante and Post Natal Classes" means ante and post-natal courses or classes provided by a **Recognised Provider**.

"Any 3 Years" or **"Any 5 Years"** means the timeframe, measured on an anniversary basis (rather than a **Calendar Year** basis), over which an overall limit is to apply. Accordingly, over any 3 or 5-year period (whichever timeframe is relevant for a particular item); the total of the available Benefits for an item shall not exceed the specified overall limit. The value of a **Benefit** paid for a service, treatment or goods, connected to any item which has an overall limit measured over **Any 3 Years** or **Any 5 Years**, shall become available again on the third or fifth anniversary (whichever is relevant) of the date when the service or treatment was provided or the goods received.

"Artificial Aids" are items that are provided upon referral by a **Recognised Provider** and recognised by CBHS Corporate as essential to a **Member's** health care needs, but does not include any **Health Care Appliance**.

"Audiology Service" means an audiology service provided by a **Recognised Provider**.

"Australia" means:

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

"Autistic Social Skills Service" means a service for the treatment of autism provided by a **Recognised Provider**.

"Benefit" means a benefit payable under these **Rules** and includes a service provided in lieu of payment.

"Blood Glucose Monitoring Accessories / Insulin Syringes" are syringes, lancets, swabs and other items recognised by CBHS Corporate as essential to the management and treatment of a **Member's** diabetes related conditions.

"Board" means the Board of Directors of CBHS Corporate.

"Boarder Fees" means the fee charged by a **Hospital** for accommodation of a **Member** assisting with the care of another **Member** on the same membership who is undergoing **Admitted Patient** treatment.

"Business Hours" means from 8:30am to 5:00pm for walk in and 7:00am to 7:00pm over the phone; on a day (other than a Saturday, Sunday or public holiday) on which banks are open for general banking business in the **State** where the relevant CBHS Corporate office is located.

"Calendar Year" means 1 January to 31 December of the same year.

"Chiropractic Service" means a service or treatment provided by a **Recognised Provider** and includes chiropractic x-rays.

"Choice Network Provider" means a provider of extras type treatment with whom CBHS Corporate has entered into an agreement for selected services.

"Chronic Disease Management Program" means a program defined in rule 12 of the *Private Health Insurance (Health Insurance Business) Rules* made under the **Act.**

"Clinical Psychology Service" means a clinical psychological service provided by a **Recognised Provider**.

"Compensable Injury" means an injury which the **Member** knows, or reasonably suspects, is subject to a right to make a claim for compensation.

"Constitution" means the Constitution of CBHS Corporate Health Pty Ltd.

"Contribution Group" means a group of persons determined by CBHS Corporate at its discretion and may include:

a) employees of a particular enterprise or group of enterprises; or
b) members of a particular organisation or membership program.

"Cosmetic service" means an operation, procedure or treatment undertaken for the dominant purpose of improving appearance or improving psychological wellbeing.

"Couple Membership" means a membership that includes two **Policy Holders** on the same membership.

"De facto spouse" in relation to a person means a person (whether of the opposite sex or the same sex as the first mentioned person) who lives with the first mentioned person as if they were spouses on a bona fide domestic basis.

"Dental Services" means dental services, treatments, items or appliances provided by a **Recognised Provider**.

"Dependant" means a person who does not have a **Partner** and who is:

i. a child, stepchild or **Foster Child** under the age of eighteen (18) years who normally resides with a **Policy Holder**; or
ii. a **Student Dependant** of the **Policy Holder**; or
iii. such other person dependent on a **Policy Holder** as the **Board** may approve.

"Dietetic Service" means:

i. Dietetic service or dietetic advice provided by a **Recognised Provider**; and
ii. Diabetes education provided by a **Recognised Provider** who is a nurse or an accredited practicing dietitian.

"Dressings" means bandages and dressings, approved by CBHS Corporate, used for the treatment of wounds and provided during a **Nursing Service**, or from a **Recognised Provider**.

"Emergency Ambulance" means an ambulance service that consists of transporting a seriously ill person to a **Hospital** by a **State** Government Ambulance Service or an ambulance service recognised by CBHS Corporate in order to receive urgently needed treatment. This includes transportation from the scene of an **Accident** or the scene of a medical event such as a heart attack or stroke, but does not include transportation to **Hospital** for the routine management of an ongoing medical condition or transportation between hospitals.

"Excess" means an amount of that a **Member** agrees to pay towards the cost of hospital treatment before any **Benefit** is payable.

"Excess Contributions" means contributions paid by a **Policy Holder** for a membership which relate to a day or days after the end date of the membership.

"Exclusion" means CBHS Corporate will not pay benefits towards hospital and medical costs for services listed as Exclusion. If **Member** needs treatment for any Excluded services it may result in significant out of pocket expense.

"Extras Benefits" means **Benefits** in respect of treatments (including the provision of goods and services) that are intended to manage or prevent a disease, injury or condition and are not **Hospital Benefits**. These **Benefits** cover treatment that is called "General Treatment" under the Act.

"Facility Fee" means a fee raised by an accident/emergency department of a **Hospital** for the **Member's** use of the facility.

"Family Membership" means a membership that includes two or more **Policy Holders** of the same family, not being a **Sole Parent Membership** or **Couple Membership.**

"First Aid Courses" means first aid courses approved by CBHS Corporate and provided by a **Recognised Provider**.

"Foster Child" means a foster child who is under eighteen (18) years of age who is a **Dependant**, or a foster child who is a **Student Dependant** of a **Policy Holder** and:

i. who is domiciled with a **Policy Holder** or at a school, college or university; and
ii. who has been placed in the care of a **Policy Holder** by court order or at the direction of a competent authority.

"Fund" means the health benefits fund conducted by CBHS Corporate Health Pty Ltd.

"Gym Membership" means gym membership approved by CBHS Corporate from time to time and received as part of a **Health Management Program**.

"Health Care Appliances" are appliances that are provided upon referral by a **Recognised Provider** and recognised by CBHS Corporate as essential to the **Member's** diabetic, asthmatic, or blood pressure related conditions.

"Health Care Provider" means a person who provides treatment and who satisfies the *Private Health Insurance (Accreditation) Rules*.

"Health Checks" means preventive screenings and tests relating to breast cancer (mammograms or ultra sound), bone density, skin cancer, bowel, prostate or eye health.

“Health Management” means:

i. a weight management program, quit smoking program or stress management course provided by a **Recognised Provider** which is intended to manage or prevent a disease, injury or condition and which has been approved by CBHS Corporate; or
ii. a **First Aid Course**; or
iii. a **Health Management Program**.

“Health Management Program” means a program approved by CBHS Corporate that is intended to ameliorate a **Member’s** specific health condition or conditions. A program will be taken to be approved by CBHS Corporate if it is recommended by a **Recognised Provider**. A program may involve any one or more of the following: **Yoga**, **Pilates**, **Gym Membership** or **Personal Training**.

“Hospital” means a hospital as defined in section 121-5(5) of the **Act** and includes a day hospital facility declared as a hospital under section 121-5(5) of the **Act**.

“Hospital Benefits” means **Benefits** payable in relation to **Hospital Treatment** provided by a **Hospital**.

“Hospital Pharmaceuticals” means a pharmaceutical benefit listed in the **PBS** that is dispensed to a hospital patient and is intrinsic to the hospital treatment provided, clinically indicated and essential for the meeting of satisfactory health outcomes for that patient.

"Hospital Treatment" has the same meaning as in the **Act**.

“Hospital Cover” means a policy for which benefits are prescribed under **Rule E1, E2** and **J**.

“Hypnotherapy Service” means a hypnotherapy service or treatment conducted by a **Recognised Provider**.

“Improper Discrimination” means discrimination defined in section 55-5 of the **Act**.

“In-patient” means a **Member** who has been formally admitted to a **Hospital** with a doctor’s order for a medical service or treatment.

“Lifetime” means the period commencing on the date the **Member** was first insured and ceases to be insured by CBHS Corporate (irrespective of any suspension of membership or other period without cover).

“Limit per Service” under a level of extras cover means the maximum amount of **Benefit** which CBHS Corporate will pay in respect of a claim for a particular type of

service (as specified in the benefits tables maintained by CBHS Corporate in its database).

"Massage Therapy" means a service or treatment provided by a **Recognised Provider** in alexander technique, aromatherapy, Bowen therapy, deep tissue massage, Feldenkrais, lymphatic drainage, Myotherapy, remedial massage, Rolfing, sports massage, Swedish massage and therapeutic massage.

"Medical Adviser" means a qualified medical practitioner appointed by CBHS Corporate to give technical advice on professional matters.

"Medical Emergency" means an injury or illness that is acute and poses an immediate risk to the **Member's** life or long term health.

"Medicare Benefits Schedule Fee" is the amount published as the fee for a particular service in the *Medicare Benefits Schedule Book* published by the Department of Health and Ageing which was applicable at the time the service was rendered.

"Member" means a **Policy Holder**, **Dependant** or **Non-Student Dependant**.

"Midwifery Service" means a service encompassing pre-natal and post-natal services provided by a **Recognised Provider**.

"Minimum Default Benefit" means the minimum **Hospital Benefit** prescribed by the *Private Health Insurance (Benefit Requirement) Rules*.

"Natural Therapy" means a service or treatment provided by a **Recognised Provider** in Buteyko, herbal medicine consultations, homeopathy, naturopathy and nutrition.

"Non-Admitted Patient" means a patient who undergoes minor surgery in a **Hospital**, but is not formally admitted.

"Non-Admitted Theatre Fee" means a theatre fee for treatment received as a **Non-Admitted Patient**.

"**Non-Emergency Ambulance**" means ambulance transportation provided to a person where he or she has been assessed by a medical practitioner as being medically unsuitable for community, public or private transport. **Non-Emergency Ambulance** transport must be requested by the treating medical practitioner and be provided by a **State** Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as the Royal Flying Doctor Service). This may include transport services such as:

- Inter **Hospital** transfers;

- Admissions to **Hospital** from a Member's home or nursing home; or
- Discharge from **Hospital** to a Member's home or nursing home.

"Non-CBHS Corporate Health Fund" means the health benefits fund of a private health insurer, other than CBHS Corporate.

"Non-Student Dependant" means a person who is a child (including an **Adopted Child**) of a **Policy Holder**, and who is over the age of 18, under the age of 25 and does not have a **Partner**.

"Nursing Service"" means home nursing of a **Member** that is provided by a **Recognised Provider**.

"Nursing Home Type Patient" has the same meaning as in the *Private Health Insurance (Benefit Requirement) Rules*.

"Occupational Therapy Service" means an occupational therapy service or treatment provided by a **Recognised Provider**.

"Optical Service" means the provision of a sight-correcting appliance upon prescription by a **Recognised Provider**, or a repair of such appliance by a **Recognised Provider**.

"Oriental Therapy" means a service or treatment provided by a **Recognised Provider** in acupressure, acupuncture, Chinese herbal medicine consultation, Chinese massage, kinesiology, reflexology, shiatsu and traditional Chinese medicine consultation.

"Orthoptic Therapy Service" means an Orthoptic therapy service (eye therapy) provided by a **Recognised Provider**.

"Osteopathic Service" means an osteopathic service or treatment provided by **Recognised Provider** and includes osteopathic x-rays.

"Overseas Visitor" means a person who is a non-resident for the purposes of Medicare and who is not eligible for access to full Medicare entitlements.

"OVHC Policy" means Overseas Visitors Health Cover policy.

"OVHC Policy Holder" means a person who is insured under a **OVHC Policy** issued by CBHS Corporate and who is not a **Dependant**.

"Oxygen and Related Apparatus" means oxygen cylinders, masks, cylinder connections and cylinder refills that are provided upon referral of a **Recognised Provider** and recognised by CBHS Corporate as essential to a **Member's** health care needs.

"Paid to Date" means the last day of cover for which the **Member** has paid contributions to CBHS Corporate.

"Partner" of a person means a spouse or a person recognised by law to be a partner of that person and includes a **De facto spouse**.

"PBS" means the Commonwealth Pharmaceutical Benefits Scheme.

"Per admission" means a continuous period during which a **Member** is admitted to **Hospital** for treatment as an **Admitted Patient**.

"Personal Training" means personal training approved by CBHS Corporate from time to time and received as part of a **Health Management Program**.

"Pharmaceuticals" means a substance which:

i. has been prescribed by a medical practitioner or a dentist;
ii. has been supplied by a pharmacist in private practice or a medical practitioner; and
iii. can only be supplied on prescription under applicable **State** law;

But does not include a substance which:

iv. is available under the **PBS** in any formulation, presentation, strength or pack size with or without repeat dispensing or combination of the preceding regardless of whether of such availability is subject to the specified purpose, authority required, pensioner concession or special patient contribution conditions of that scheme; or
v. was prescribed in the absence of illness or disease or for contraceptive purposes or for enhancement of sporting, sexual or employment performance; or
vi. was supplied by a medical practitioner for the purposes of infertility treatment; or
vii. such other circumstances as have been approved by CBHS Corporate.

"Physical Trauma" means trauma caused when the body is struck with an object or force causing lacerations or fractures or an object pierces the skin or body usually creating an open wound.

"Physiology Service" means an exercise physiology service or treatment provided by a **Recognised Provider**.

"Physiotherapy Service" means a physiotherapy service or treatment provided by a **Recognised Provider**.

"Pilates" means a style or system of Pilates approved by CBHS Corporate from time to time and received as part of a **Health Management Program**.

"Podiatry Service" means a podiatry service or treatment provided by a **Recognised Provider** (excluding artificial aids: e.g. orthotics).

"Policy Holder" means a person who is insured under a complying health insurance policy issued by CBHS Corporate and who is not a **Dependant** or **Non-Student Dependant**.

"Pre-existing Condition" means an ailment or illness the signs or symptoms of which, in the opinion of the **Medical Adviser**, or other relevant health care practitioner appointed by CBHS Corporate to give advice on such matters, having regard to any information furnished by the **Member's Health Care Provider** providing the treatment and any other relevant information furnished in respect of the claim for **Benefit**, existed at any time in the period of six months ending on the day on which the person became insured under the policy and the commencement of contributions for the **Benefit**.

"Pregnancy related services" means any type of treatment related to the management of a pregnancy as certified by a medical practitioner.

"Preventive Health Service" means preventive screenings and tests as approved by CBHS Corporate from time to time.

"Private Hospital" means a Hospital in respect of which there is in force a statement under subsection 121-5 (8) of the **Act** that the Hospital is a Private Hospital.

"Product" has the same meaning as in the **Act**.

"Public Hospital" means a Hospital in respect of which there is in force a statement under subsection 121-5 (8) of the **Act** that the Hospital is a Public Hospital.

"Purchaser-Provider Agreement" means a hospital purchaser-provider agreement or a medical purchaser-provider agreement and includes a purchaser-provider agreement between CBHS Corporate and any other provider.

"Recognised Provider" means a provider recognised by CBHS Corporate in a particular discipline or calling as a provider of services to a **Member** for which CBHS Corporate will pay a **Benefit**. The provider must hold an Australian Business Number.

"Restricted Access Group" means the group defined in **Rule C2.1**.

"Rules" means this document as amended from time-to-time.

"Single Membership" means a membership that only includes one person, being a **Policy Holder**.

"Sole Parent Membership" means a membership that includes two or more **Members** of the same family, with all but one of those **Member** (the **Policy Holder**) being **Dependants** of that **Member**.

"Speech Pathology Service" means a speech pathology service provided by a **Recognised Provider**.

"State" means a State or Territory of **Australia**.

"Student Dependant" means a dependant of a **Policy Holder**, registered with CBHS Corporate, who is at least eighteen years of age and:

i. does not have a **Partner**;
ii. is a full-time student at a school, college, or university; and
iii. is under the age of twenty-five years.

"Transfer Certificate" means a certificate issued under s 99-1 of the **Act**.

"Terminally Ill" means, as diagnosed by a Medical Practitioner, someone with a life expectancy of less than 6 months.

"Usual, Customary and Reasonable Charge" means in relation to a service rendered by a **Recognised Provider**, the usual or customary fee charged for that service by other similarly qualified practitioners or a reasonable charge for that service as determined by CBHS Corporate having regard to the usual or customary charges for a similar service and/or advice from the practitioner's professional association/body or **Medical Adviser**.

"Vitamin Therapy" means vitamins and vitamin injections provided by a **Recognised Provider** that have been approved for sale in Australia by the authorities that regulate the sale of pharmaceuticals and therapeutic goods which are provided by a **Recognised Provider** who recommends the therapy as a necessary treatment in circumstances where no other treatment has been successful.

"Waiting Period" means the period of time from the date the membership commences to the date that either certain services or items provided to the **Member** may attract **Benefits**.

" Yoga" means a style or system of yoga approved by CBHS Corporate from time to time and received as part of a **Health Management Program**.

C MEMBERSHIP

C1 General Conditions of Membership

CBHS Corporate offers the following categories of membership in the **Fund**:

1) **Single Membership**;
2) **Couple Membership**;
3) **Family Membership**;
4) **Sole Parent Membership;** and
5) **Non-Student Dependant.**

CBHS Corporate offers the following levels of cover:

1) Gold Hospital ($0 and $500 Excess)
2) Silver Hospital ($0 and $500 Excess)
3) Bronze Hospital ($500 Excess)
4) Base Hospital ($500 Excess)
5) Gold Extras
6) Silver Extras
7) Bronze Extras
8) Ambulance Cover
9) Reciprocal Health Cover
10) Platinum Package

- All **Members** in a membership are covered by the same category of the membership.
- All **Members** in a membership are covered by the same level of **Hospital Benefits** cover (if any).
- All **Members** in a membership are covered by the same level of **Extras Benefits** cover (if any).
- All levels of **Hospital** cover include cover for **Emergency Ambulance** services.

C2 Eligibility for Membership

C2.1 Membership Eligibility: General

Subject to these Fund Rules, any person is entitled to apply as a **Member**.

C3 Dependants

(a) A **Policy Holder** may request CBHS Corporate to add a **Dependant** to a membership by submitting the form required by CBHS Corporate.

(b) If:

  i. the **Policy Holder** requests CBHS Corporate to add a **Dependant** to the membership; and

  ii. the **Policy Holder** makes that request within 2 calendar months of the child becoming a **Dependant** of the **Policy Holder** (for example through birth or adoption); and

iii. cover for the child is backdated to the date the child became a **Dependant** of the **Policy Holder**;

then CBHS Corporate will waive all **Waiting Periods** which would otherwise have applied to the **Dependant**.

(c) Where a **Policy Holder** holds a **Single Membership** and adds a **Dependant** to the membership, then:

i. the membership becomes a **Family Membership** or **Sole Parent Membership** from the date cover commences for the child; and

ii. the **Policy Holder** becomes liable to pay the contribution for **Family Membership** or **Sole Parent Membership**, as the case may be from that date.

(d) If a **Policy Holder** asks CBHS Corporate to add a **Dependant** to the membership in any other circumstances, then all **Waiting Periods** applicable to the type of cover will apply to the new **Member**.

C4 Membership Applications

(a) Application for membership shall be in the form required by CBHS Corporate.

(b) CBHS Corporate may refuse to accept an application for membership from or on behalf of a person who was previously a **Member** of the **Fund**, and had that membership cancelled under **Rule C7**.

(c) CBHS Corporate may refuse to accept an application for membership, if there would be grounds to cancel the membership under **Rule C7**, if the application were accepted.

(d) On or before acceptance of an application for membership, CBHS Corporate shall supply to the person who is, or becomes, a **Policy Holder** a standard information statement.

(e) CBHS Corporate shall supply a standard information statement to the **Policy Holders** in accordance with the **Act**.

C5 Duration of Membership

(a) If CBHS Corporate accepts an application for membership, the membership commences on the day on which CBHS Corporate receives the application, unless CBHS Corporate and the **Policy Holder** agree on a different starting date.

(b) If a **Policy Holder** chooses to terminate his or her membership, that termination takes effect in accordance with **Rule C8**.

(c) If CBHS Corporate cancels a membership under **Rule C7**, that termination takes effect in accordance with **Rule C7.2**.

(d) Subject to compliance with the **Rules** and **Constitution** of CBHS Corporate, a person may maintain membership as a **Dependant**, for so long as they remain a **Dependant**.

(e) Subject to compliance with the **Rules** and **Constitution** of CBHS Corporate, a person may maintain membership as a **Policy Holder** until he or she dies.

(f) **Benefits** may be payable after a **Member** dies for services rendered whilst the **Member** was alive.

C6 Transfers

C6.1 Persons transferring from another Non-CBHS Corporate Health Fund to this Fund – Waiting Periods and Benefit Limits

(a) If a person:

  i. is a **Member** of a **Non-CBHS Corporate Health Fund**; and
  ii. applies for membership of this **Fund** within one calendar month of leaving the **Non-CBHS Corporate Health Fund**; and
  iii. CBHS Corporate accepts the application for membership;

then CBHS Corporate shall take into account in accordance with **Rules C6.1(c)** and **(d)** the amount of time the person has held the cover with the **Non-CBHS Corporate Health Fund** when determining whether any **Waiting Periods** applicable to the cover have been served.

(b) In taking into account the amount of time a person has held cover with a **Non-CBHS Corporate Health Fund** when determining whether **Waiting Periods** have been served, CBHS Corporate will also consider:

  i. the level of benefits payable by the **Non-CBHS Corporate Health Fund** and scope of the coverage under the policy held by the person; and
  ii. the level of **Benefits** payable by this **Fund** and scope of coverage under the policy chosen by the person.

(c) Where:

  i. the level of **Benefits** payable and the scope of coverage under the policy of the **Non-CBHS Corporate Health Fund** and this **Fund** is the same; or
  ii. the level of **Benefits** payable and the scope of the coverage of this **Fund** is lower;

then CBHS Corporate will count the amount of time a person held the level of cover under the policy with the **Non-CBHS Corporate Health Fund** as time served against the **Waiting Period** for that **Benefit** under these **Rules**.

(d) Where the level of **Benefits** payable and the scope of coverage of the policy with the **Non-CBHS Corporate Health Fund** is lower than the level of **Benefits** payable and the scope of coverage of this **Fund** then:

i. CBHS Corporate will count the amount of time a person held the level of cover with the **Non-CBHS Corporate Health Fund** as time served against the **Waiting Period** for that portion of the **Benefits** which are equivalent to the **Benefits** payable under the policy with the **Non-CBHS Corporate Health Fund**; and

ii. CBHS Corporate may apply the full **Waiting Period** for **Benefits** payable in relation to that portion of the cover which is in excess to the **Benefits** payable under the policy with the **Non-CBHS Corporate Health Fund**.

iii CBHS Corporate may apply the full **Waiting Period** for **Extras Benefits** in excess of **Extras Benefits** previously held under the **Non-CBHS Corporate Health Fund**.

(e) If, in relation to a **Pre-existing Condition**, the **Excess** or **Co-payment** applied under the **Non-CBHS Corporate Health Fund** in relation to a **Benefit** was higher than that applicable under this **Fund**, CBHS Corporate may apply the higher **Excess** or higher **Co-payment** during the first 12 months of the person's membership of this **Fund**.

C6.2 Persons transferring from another fund to this Fund – Excesses, Co-payments and limitations

(a) If:

(i) a **Member** has transferred to CBHS Corporate from a **Non-CBHS Corporate Health Fund**; and

(ii) the policy held under the **Non-CBHS Corporate Health Fund** included the same or similar **Excess** or **Co-payment** as the policy transferred to with the **Fund**; and

(iii) the **Member** had paid an **Excess** or **Co-payment** within the **Calendar Year** of transfer,

then CBHS Corporate shall treat the payment of the **Excess** or **Co-payment** as if it had been made to CBHS Corporate under the new cover.

(b) If a **Member**:

(i) has transferred to CBHS Corporate from a **Non-CBHS Corporate Health Fund**; and

(ii) the **Member** has claimed **Extras Benefits** from the **Non-CBHS Corporate Health Fund** that have a limitation on the amount of **Extras Benefits** payable in **a Calendar Year** or **Lifetime**,

then any claims made under the **Non-CBHS Corporate Health Fund** in respect of **Extras Benefits** that are subject to the limitation shall be taken to be accrued and

applied under the policy with this **Fund** for the purposes of calculating any overall limit on the amount of **Extras Benefits** payable by this **Fund** under the policy in the respective period. Where a **Member** is serving a **Waiting Period** under **Rule C6.1(a),** the **Waiting Period** is included in calculating the **Calendar Year** or **Lifetime** periods.

(c) The **Member** shall obtain a **Transfer Certificate** from the **Non-CBHS Corporate Health Fund**, or provide CBHS Corporate with permission to obtain a **Transfer Certificate** from the **Non-CBHS Corporate Health Fund** on the **Member's** behalf.

(d) CBHS Corporate shall provide a **Transfer Certificate** to a **Non-CBHS Corporate Health Fund**, within 14 days of the **Member's** request or upon a **Non-CBHS Corporate Health Fund** request.

C6.3 Members choosing to transfer between covers offered by CBHS Corporate

(a) If a **Member** asks CBHS Corporate to transfer their membership from one level of cover to another, CBHS Corporate will deal with **Waiting Periods** in accordance with **Rules C6.1(c**) and **(d)** as if the first cover was cover with a **Non-CBHS Corporate Health Fund**, and the second cover was new cover with this **Fund**.

(b) If:

- (i) a **Member** has transferred between policies within the **Fund**; and
- (ii) the original policy held by the **Member** included the same or similar **Excess** or **Co-payment** as the policy transferred to; and
- (iii) the **Member** had paid an **Excess** or **Co-payment** within the **Calendar Year** of transfer,

then CBHS Corporate shall treat the payment of the **Excess** or **Co-payment** as if it had been made under the new cover.

(c) If a **Member**:

- (i) has transferred between policies within the **Fund**; and
- (ii) the **Member** has claimed **Extras Benefits** from the original policy that has a limitation on the amount of **Extras Benefits** payable in a **Calendar Year, Any 3 years**, **Any 5 years** or **Lifetime**,

then any claims made under the original policy in respect of **Extras Benefits** that are subject to the limitation shall be taken to be accrued and applied under the policy transferred to for the purposes of calculating any overall limit on the

amount of **Extras Benefits** payable under the policy transferred to in the respective period.
Where a **Member** is serving a **Waiting Period** under **Rule C6.3(a)**, the **Waiting Period** is included in calculating a **Calendar Year**, **Any 3 years**, **Any 5 years** or **Lifetime** periods.

C6.4 CBHS Corporate-initiated transfers of cover between covers offered by CBHS Corporate

(a) If CBHS Corporate initiates a transfer of a **Member's** membership:
   i. from one type of cover to another; or
   ii. from one option within a type of cover to another;

then CBHS Corporate shall take into account the amount of time the **Member** has held the previous cover, when determining whether any **Waiting Periods** required under these **Rules** have been served.

(b) In taking into account the amount of time a person has held the previous cover when determining whether **Waiting Periods** have been served, CBHS Corporate will also consider whether a **Benefit** is payable for a particular service under both types of cover.

(c) If a **Benefit** is payable for a service under both types of cover, then CBHS Corporate shall take into account the amount of time a person has held the previous cover when determining whether any **Waiting Period** required under these **Rules** for that service has been served.

(d) If a **Benefit** was not payable for a service under the previous cover, but is payable under the new cover, then CBHS Corporate may apply in full any **Waiting Period** required for that **Benefit** under these **Rules**.

(e) If:
   i. CBHS Corporate initiates a transfer of a **Member's** membership; and
   ii. the **Member** has paid an **Excess** or **Co-payment** or claimed a **Benefit** subject to a limitation under the previous cover;

then CBHS Corporate shall treat the payment or claim as if it had been made under the new cover, if it includes the same or similar **Excess**, **Co-payment** or limitation.

C7 Cancellation of Membership

C7.1 Grounds for cancellation

(a) CBHS Corporate may not cancel the membership of any **Member** on the grounds of the health of that **Member**.

(b) CBHS Corporate may cancel the membership of any **Member** on any of the following grounds:

   (i) any **Member** included in the membership has, in the opinion of CBHS Corporate, committed or attempted to commit fraud upon CBHS Corporate;

   (ii) CBHS Corporate becomes aware that the application for membership relating to the **Member** was incomplete or inaccurate in a material respect;

   (iii) the **Member** has concurrent membership in a **Non-CBHS Corporate Health Fund**;

   (iv) the **Member** is in arrears in respect of the membership for a period of more than two months;

   (v) the membership has lapsed in accordance with **Rule D5**; or

   (vi) the last surviving **Member** included in a membership has died. **Benefits** may be payable in this situation in accordance with **Rule C5 (f).**

C7.2 Date of effect of cancellation

(a) Where CBHS Corporate cancels a membership under **Rule C7.1(b)(ii)**, CBHS Corporate may cancel the membership with effect from the date of commencement of the membership.

(b) In all other cases, when CBHS Corporate cancels a membership the cancellation takes effect from the date CBHS Corporate notifies the **Policy Holders** of the cancellation.

C7.3 Treatment of excess contributions

(a) Where CBHS Corporate cancels a membership and a **Member** has paid **Excess Contributions**, the **Member** is entitled to a refund of **Excess Contributions**, subject to **Rule C7.3(b)**.

(b) Where CBHS Corporate has cancelled a **Member's** membership under **Rule C7.1(b)(i)**, CBHS Corporate may use any **Excess Contributions** to defray any costs to CBHS Corporate as a result of the **Member** committing or attempting to commit fraud against CBHS Corporate.

C8 Termination of Membership

(a) A **Policy Holder** may terminate a membership by:

   i notice in writing to CBHS Corporate; or

   ii by telephone advice to CBHS Corporate.

   If a **Policy Holder** terminates their membership by telephone advice, CBHS Corporate will confirm the termination by notice in writing to the **Policy Holder**.

(b) A **Policy Holder** may terminate a membership with effect from any due date for payment of contributions which falls on or after the day on which CBHS Corporate receives the notice in writing or telephone advice.

(c) A **Member** who is 18 years old or older may terminate his or her inclusion in a membership by notice in writing to CBHS Corporate or telephone advice.

(d) A **Policy Holder** may not terminate the inclusion of a **Dependant** in a membership, unless the **Policy Holder**, on request from CBHS Corporate, demonstrates to CBHS Corporate that he or she has the authority under **Rule C10.2.**

(e) CBHS Corporate will notify the **Policy Holders** of any termination made in accordance with **Rule C8(c)** or **(d).**

(f) If a **Policy Holder** (excluding a policy holder with Overseas Visitor Cover) chooses to terminate his or her membership within 30 days of the commencement of the membership, then CBHS Corporate will refund any contributions paid during that period, so long as a claim has not been made under the membership.

C9 Temporary Suspension of Membership

(a) Membership of the **Fund** may be suspended by CBHS Corporate upon application by the **Policy Holder.**

(b) CBHS Corporate will maintain guidelines for determining whether to grant a request to suspend a membership.

(c) Subject to those guidelines and **Rule C.9(g)**, CBHS Corporate shall grant a request for suspension of a membership if the suspension is sought because:

  i. a **Member** will be temporarily absent from Australia for a period greater than six weeks but not more than 36 months; or

  ii. a **Policy Holder** is experiencing financial hardship over a period greater than three months but not more than 24 months.

(d) A **Policy Holder**, who has been a member with CBHS for at least twelve months and is up to date in their contribution payments, may apply to CBHS to suspend their membership in cases of overseas travel or financial hardship.

(e) If CBHS has previously suspended a membership because of being temporarily absent from Australia, then CBHS may not grant the **Policy Holders** another period of suspension for being temporarily absent from Australia, until 6 months has elapsed from the end of the previous period of suspension on that basis.

(f) If CBHS Corporate has previously suspended a membership because of financial hardship, then CBHS Corporate may not grant the **Policy Holders** another period of suspension for financial hardship until five years has elapsed from the end of the previous period of suspension on that basis.

(g) A period of suspension commences and ends on the dates advised by CBHS Corporate to the **Policy Holder** in writing, unless:

i. the **Policy Holder** reactivates the membership prior to the end date; or

ii. the **Policy Holder** reactivates the membership up to one calendar month after the end day nominated by CBHS Corporate in writing.

(h) If the **Member**:

i. have served any **Waiting Periods** or accrued any credit against an **Excess**, or limitation prior to the commencement of the suspension; and

ii. reactivate the membership on the end date of the period of suspension;

then CBHS Corporate will treat the service of **Waiting Periods** and the accrual of credit as if there had been no break in the continuity of the membership.

(i) **Benefits** are not payable by CBHS Corporate for services provided to a **Member** during a period of suspension of his or her membership.

(j) If a medical condition develops during the period of suspension, then:

i. that condition is deemed to be a **Pre-existing Condition**;

i. a **Waiting Period** of 12 months will apply to services related to that condition except where the services are psychiatric, rehabilitation or palliative care services which will incur a 2 month waiting period as per the **Act**; and

i. the applicable **Waiting Period** will commence on the end date of the suspension period.

C10 Other

C10.1 Privacy

CBHS Corporate will only share information about a **Member** (including with another **Member**) in accordance with the *Privacy Act 1988* (Cth) and applicable **State** privacy legislation.

C10.2 Authority to change membership details or remove Members from memberships

(a) **Policy Holders** are taken to have authority to deal with CBHS Corporate in relation to their policy (including to change any details of or to remove **Dependants** from the policy) unless a **Policy Holder** advises CBHS Corporate in writing that one or more **Policy Holders** are not authorised to deal with CBHS Corporate in relation to the policy.

(b) CBHS Corporate may, at any time, require a **Policy Holder** to provide evidence to the satisfaction of CBHS Corporate that:

(i) a **Policy Holder** has the consent of other **Policy Holders** to deal with CBHS Corporate in relation to their policy; or

(ii) a **Policy Holder** has legal authority to deal with CBHS Corporate in relation to the policy (for example, legal authority to add or remove a **Dependant**).

D CONTRIBUTIONS

D1 Payment of Contributions

D1.1 Method of payment (not Emergency Ambulance only cover)

(a) Contributions (other than contributions for **Emergency Ambulance** only cover) may be paid by or on behalf of Policy **Holders** on a fortnightly, monthly, quarterly, half yearly or annual basis. Contributions shall be paid in advance unless they are paid in accordance with **Rule D1.1(b)(i).**

(b) Contributions may be paid:

i. through the payroll deduction scheme if arranged by CBHS Corporate; or

ii. by direct debit, credit card; or

iii. by any other arrangement authorised by CBHS Corporate from time to time.

D1.2 Method of payment (Emergency Ambulance only cover)

(a) Contributions for **Emergency Ambulance** only cover must be paid annually in advance.

(b) Contributions may be paid:

i. through the payroll deduction scheme if arranged by CBHS Corporate; or

ii. by direct debit, credit card; or

iii. by any other arrangement authorised by CBHS Corporate from time to time.

D1.3 Amount of Payment

(a) The fortnightly rate of contributions for each kind of cover for **Single Membership** is the amount listed at **Part K**, subject to **Rule D4**.

(b) If the **Policy Holders** have Extras cover only, and decide to include Ambulance Cover in the Extras cover, then the fortnightly rate of contributions for that cover is increased by the amount at **Part K**.

(c) The fortnightly rate for **Couple Membership** for each kind of cover is the amount Listed at **Part K**, subject to **Rule D4**.

(d) The fortnightly rate for **Family Membership** for each kind of cover is the amount Listed at **Part K**, subject to **Rule D4**.

(e) The fortnightly rate for **Sole Parent Membership** is the amount listed at **Part K**, subject to **Rule D4**.

(f) The amount of contributions payable by **Policy Holders** on a monthly, quarterly, half yearly or annual basis will be calculated using the fortnightly rate for that cover as follows:

i. the fortnightly rate will be multiplied by 26 to give the total amount due for a twelve-month period and that amount will then be:

(A) divided by 12 to determine the monthly rate of contributions; or
(B) divided by 4 to determine the quarterly rate of contributions; or
(C) divided by 2 to determine the half yearly rate of contributions; or
(D) divided by 1 to determine the annual rate of contributions.

D2 Contribution Rate Changes

CBHS Corporate may amend the fortnightly contribution rates listed in **Part K**, subject to compliance with provisions in the **Act** relating to changes to contribution rates.

D3 Contribution Discounts

CBHS Corporate may only offer a discount if to do so complies with section 66-5 of the **Act**. This may include offering a discount to any **Contribution Group.**

D4 Lifetime Health Cover

CBHS Corporate shall apply Lifetime Health Cover loadings to contribution rates in accordance with the **Act**.

D5 Arrears in Contributions

(a) If a **Policy Holder** has not met a contribution payment prior to the **Paid to Date**, then that membership is in arrears.
(b) Any period of arrears is calculated as commencing on the **Paid to Date**.
(c) CBHS Corporate shall not pay any **Benefits** for goods or services rendered to a **Member** during a period in which the membership is in arrears until the outstanding contributions are paid to CBHS Corporate, and CBHS Corporate has accepted them.
(d) CBHS Corporate may refuse to accept outstanding contributions for a membership if that membership has lapsed.
(e) A membership lapses when it has been in arrears for a continuous period of more than two months.

E BENEFITS

E1 General Conditions

E1.1 When a Benefit is not payable

(a) A **Benefit** is not payable in respect of a service that was rendered to a **Member** if:
  i. the costs of that service were incurred by the **Member's** employer; or
  ii. the **Member** obtained the service in connection with:
    (A) employment; or
    (B) application for employment; or
    (C) an industrial undertaking or profession; or

(D) a life insurance examination; or

(E) other non-treatment function; or

iii. the service was rendered to the **Member** as part of care and accommodation in an **Aged Care Service**; or

iv. the service was rendered by a person who is not a **Recognised Provider**; or

v the service did not meet the standards set out in the *Private Health Insurance (Accreditation) Rules*; or

vi. the service is claimable from Medicare;

vii. the **Member** has not submitted a claim to CBHS Corporate in accordance with Part G;

viii the services can be claimable from any other source; or

ix the service is listed as **Exclusion**; or

x the medical service has been provided as a non-Admitted Patient (other than hospital substitute treatment); or

xi the treatment or service was experimental; or

xii the treatment is part of a clinical trial for pharmaceutical; or

xiii the claiming **Member** is also the **Recognised Provider** or is in the **Recognised Provider** immediate family or is employed at the same practice as the **Recognised Provider.**

E1.2 To whom the Benefit is payable

(a) If the **Benefit** relates to a service which was provided to a **Member** in accordance with a **Purchaser-Provider Agreement** or the **Access Gap Cover Scheme**, then:

i. the **Member** is taken to have assigned the right to the payment of the **Benefit** to the provider; and

ii. CBHS Corporate shall pay the **Benefit** directly to the provider.

(b) If the **Recognised Provider** participates in an electronic claims system with CBHS Corporate (such as HICAPS or iSOFT Healthpoint) then;

i. a claim may be lodged electronically; and

ii. CBHS Corporate may pay the **Benefit** directly to the provider.

(c) In all other cases, the **Benefit** is payable to the **Member**, if the **Member** has complied with the claim requirements in **Rule G1** unless otherwise agreed between the **Member** and CBHS Corporate.

E1.3 The amount of Benefit payable

(a) The amount of **Benefit** payable will be at least the minimum amount required in accordance with the **Act** (if any).

(b) The amount of **Benefit** payable is calculated by reference to the cover held by the **Member** and the **Rules** which applied to that cover on the day the service was rendered or the good was supplied.

(c) The amount of **Benefit** payable cannot exceed the total of the receipted cost of the good or service to the **Member**.

(d) Where a **Benefit**:

i. is calculated as a percentage of the receipted cost of a service; and

ii. the receipted cost of a service appears to CBHS Corporate to be excessive;

then, subject to **Rule E1.3(a)**, CBHS Corporate may determine the amount of **Benefit** payable by reference to the **Usual, Customary and Reasonable Charge** it determines for that service, rather than using the receipted cost.

E1.4 Payment of benefits by mistake

(a) If CBHS Corporate pays a **Benefit** for a **Member** by mistake, CBHS Corporate can recover the amount paid by mistake from that **Member** within 24 months of making the payment.

(b) CBHS Corporate can recover this amount from the **Member** whether it has been paid directly to the **Member** or to a third party (for example, such as a hospital or a medical practitioner) for goods or services provided to the **Member**.

(c) The amount paid by mistake is a debt due to CBHS Corporate from the **Member** and can be recovered from the **Member** at law.

E2 Hospital Treatment

E2.1 Treatment for which Hospital Benefits are payable

(a) CBHS Corporate may only pay **Hospital Benefits** in relation to **Admitted Patient** hospital treatment provided in a **Hospital**; or

(b) Whether a **Member** is eligible for particular **Hospital Benefits** is determined by reference to the level of cover held by the **Member** at the time the service was rendered.

E.2.2 Level of Hospital Benefits – place in which service is rendered

(a) The level of **Hospital Benefits** payable in relation to a service is calculated by reference to the **State** of Australia in which the service is rendered to a **Member**, irrespective of where the **Member** normally resides.

E2.3 Level of Hospital Benefits (acute care) – services rendered by a Hospital

(a) CBHS Corporate may enter into a **Purchaser-Provider Agreement** with a **Hospital** which (among other things):

i. sets an amount which the **Hospital** will accept for particular services rendered to **Members**; and
ii. specifies the level of accommodation which the **Hospital** will provide to **Members.**

(b) CBHS Corporate will maintain a list of each **Hospital** with which it has a **Purchaser-Provider Agreement**, and will make this available to **Members**.

(c) If:

i. an eligible **Member** receives an **Admitted Patient** service from a **Hospital** with which CBHS Corporate has a **Purchaser-Provider Agreement**; and
ii. the **Purchaser-Provider Agreement** deals with the kind of service rendered to the **Member**,

then the **Hospital Benefit** payable is the amount specified in the relevant **Purchaser-Provider Agreement** for that service, unless **Rule E2.7(a)** applies.

(d) If:

i. a **Member** receives an **Admitted Patient** service from a **Hospital** with which CBHS Corporate has **Purchaser-Provider Agreement**; but
ii. the **Purchaser-Provider Agreement** does not deal with the kind of service rendered to the **Member**,

then the **Hospital Benefit** payable is the same amount as if the service had been rendered at a private **Hospital** with which CBHS Corporate does not have a **Purchaser-Provider Agreement**.

(e) If a **Member** receives an **Admitted Patient** service from a private **Hospital** with which CBHS Corporate does not have a **Purchaser-Provider Agreement**, then the **Hospital Benefit** payable is the **Minimum Default Benefit**, or such higher amount as agreed between CBHS Corporate and the **Hospital** on a one off basis.

(f) If a **Member** receives services relating to a stay in a shared ward of a public **Hospital**, then the level of **Hospital Benefit** payable is the **Minimum Default Benefit**.

(g) If a **Member** receives services relating to a stay in a single private room of a public **Hospital**, then the **Hospital Benefit** payable will be the amount prescribed by the relevant State Health Minister, Department or Authority as the amount chargeable for that service, unless **Rule E2.7 (a)** applies or the policy provides that only **Minimum Default Benefits** are payable.

E2.4 Level of Benefits (acute care) – services rendered by a medical practitioner

(a) CBHS Corporate may enter into a **Purchaser-Provider Agreement** with a medical practitioner which (among other things) sets an amount which the medical practitioner will accept for particular services rendered to eligible **Members**.

(b) CBHS Corporate may enter into a **Purchaser-Provider Agreement** which (among other things) sets an amount which a particular medical practitioner will accept for particular services rendered to eligible **Members**, by reference to a practitioner agreement between the **Hospital** and the medical practitioner.

(c) If:

i. an eligible **Member** receives an **Admitted Patient** service from a medical practitioner who is subject to an agreement with CBHS Corporate or the **Hospital** concerned as described in **Rule E2.4(a)** or **(b)**; and

ii. the agreement deals with the kind of service rendered to the **Member**;

then the **Benefit** payable is the amount specified in the relevant **Purchaser-Provider Agreement** or practitioner agreement for that service, unless **Rule E2.7(a)** applies.

(d) If:

i. an eligible **Member** receives an **Admitted Patient** service from a medical practitioner; and

ii. the medical practitioner has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**;

then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner under the **Access Gap Cover Scheme** for that service.

(e) In any other case, if an eligible **Member** receives an **Admitted Patient** service from a medical practitioner, then the **Benefit** payable is the lower of:

i. the balance of the medical practitioner’s fee for the service, after the Medicare benefit payable for the services is deducted; or

ii. 25% of the **Medicare Benefits Schedule Fee**.

E2.5 Level of Benefits (acute care)– services rendered by an ambulance service

(a) If an eligible **Member**:

i. receives **Emergency Ambulance** services; and

ii. is not otherwise covered for the cost of **Emergency Ambulance** services;

then the **Benefit** payable in relation to those **Emergency Ambulance** services is 100% of their cost to the **Member**.

E2.6 Level of Hospital Benefits – goods

(a) If a **Member**:

i. receives **Hospital Pharmaceuticals** as part of receiving an **Admitted Patient** service at a **Hospital**; and

ii. CBHS Corporate has a **Purchaser-Provider Agreement** with the **Hospital**;

then the **Hospital Benefit** for those **Hospital Pharmaceuticals** is the level of benefit specified in the hospital agreement.

(b) A **Benefit** is only payable in respect of **Hospital Pharmaceuticals** that are not specified in the **Hospital Purchaser-Provider Agreement** where the **Hospital Pharmaceuticals** have been given prior approval by CBHS Corporate.

(c) If an eligible **Member** receives a surgically implanted prosthesis for which a Medicare benefit is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules* as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Hospital Benefit** payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules,* depending upon the level of cover held by the **Member**.

E2.7 Level of Hospital Benefits (non-acute care)

(a) If:

i. a **Member** has been hospitalised for a continuous period of 35 days; and

ii. CBHS Corporate is not satisfied that the patient requires further hospitalisation for acute care;

the **Member** will be classified as a **Nursing Home Type Patient** and any higher **Hospital Benefits** which would otherwise be payable to the **Member** are reduced to **Minimum Default Benefits** for a **Nursing Home Type Patient**.

(b) CBHS Corporate will be satisfied that the patient requires further hospitalisation for acute care having regard to:

i. the attending medical practitioner certifying that the **Member** needs further hospitalisation for acute care, and
ii. the attending medical practitioner providing CBHS Corporate with any further information which it reasonably requires.

E2.8 Level of Hospital Benefits (psychiatric services)

A **Member** who holds a policy with **Hospital Benefits** which are restricted to **Minimum Default Benefits** for psychiatric services and who has served a **Waiting Period** of 2 months, may upgrade their policy to receive full **Benefits** payable for psychiatric services with no **Waiting Period**. This exemption can only be used once in a person's lifetime.

E3 General Treatment

E3.1 General

(a) The **Extras Benefits** payable for goods and services, and the conditions that apply to those **Benefits**, are in Part I of these **Rules**.

(b) If a **Member**:

i. ceases to be a **Member**; and
ii. in the immediately preceding six months had incurred an expense and received a **Benefit** for:
 (A) artificial aids;
 (B) health care appliances;
 (C) oxygen and related apparatus;
 (D) optical appliances;
 (E) orthodontics; or
 (F) crowns or bridges;

in relation to which the **Waiting Period** had been waived or reduced in circumstances in which, had the **Waiting Period** applied, either no **Benefit** or a reduced **Benefit** would have been payable,

then **CBHS Corporate** may require the **Member** to reimburse CBHS Corporate for that part (if any) of the **Benefit** which would not have been paid, had the waiver or reduction been applied.

E3.2 Emergency Ambulance cover

(a) If a **Policy Holder** does not have hospital cover (which includes **Emergency Ambulance** cover), then he or she may choose to have **Emergency Ambulance** services as a standalone Extras cover or combined with another Extras cover.

(b) If an eligible **Member**:

i. receives **Emergency Ambulance** services; and

ii. is not otherwise covered for the cost of **Emergency Ambulance** services;

then the **Benefit** payable in relation to those **Emergency Ambulance** services is 100% of their cost to the **Member**.

E4 Other

E4.1 Chronic Disease Management Program

A **Member** covered by a product specified in Schedule J (hospital products or packaged products) may be in invited to participate in a **Chronic Disease Management Program** arranged by CBHS Corporate with an external party. Participation in such a program will be provided at the discretion of CBHS Corporate and at no cost to the **Member**.

E4.2 Hospital Substitute Treatment

A **Member** covered by a product specified in Schedule J (hospital products or packaged products) may be provided access to **Hospital Substitute Treatment** arranged by CBHS Corporate with an external party. Access to this treatment will be provided at the discretion of CBHS Corporate. The **Benefit** will generally only be available in circumstances where CBHS Corporate would have paid more than the **Minimum Default Benefit** for accommodation for the treatment of the relevant illness or injury in a Hospital as **Hospital Treatment.** However, in any particular instance, where the cost of **Hospital Substitute Treatment** is likely to be less than the **Minimum Default Benefit,** CBHS Corporate may also provide access to **Hospital Substitute Treatment.** The **Hospital Substitute Treatment** provided under this rule shall be at no cost to the **Member.**

F LIMITATION OF BENEFITS

F1 Co Payments

Not applicable.

F2 Excesses

(a) A **Policy Holder** may choose to have an **Excess** in accordance with Rule **J1 11** or **J2 11** or **J3 11** or **J4 11** in which case an **Excess** as set out in that relevant **Rule** applies to the **Benefit** payable.

F3 Waiting Periods

(a) Except as otherwise provided in **Rule C3 (b)** and **C6**, the **Waiting Periods** apply to all **Members**.

(b) Except as otherwise provided in **Rules C6** and **C9**, the time served against a **Waiting Period** for a **Benefit** is calculated by reference to the continuous period

of time that a **Member** has held his or her current level of cover with CBHS Corporate.

(c) CBHS Corporate may not pay a **Benefit** for a service to which a **Waiting Period** applies until the **Member** has served the **Waiting Period** in full:

i. **12 months**: **Pre-existing Conditions**, pregnancy/obstetrics, crowns, bridges, orthodontia, artificial aids, healthcare appliances, oxygen apparatus and hearing aids.

ii. **6 months**: Optical, periodontics, endodontics, facings and dentures.

iii. **2 months**: Psychiatric, rehabilitation, palliative care whether or not there is a pre-existing condition.

iv **2 months**: other hospital and **Extras** services not listed in **Rule F3(c) (i), (ii) and (iii)** above.

v. **1 day**: **Accidents**, injuries and emergencies.

(d) Despite **Rule F3 (a)**, if a **Member**:

i. held a gold card, or was entitled to treatment under a gold card, before becoming a **Member**; and

ii. applies to become a **Member** no longer than two months after the **Member** ceased to hold, or be entitled under, the gold card;

no **Waiting Period** applies to that **Member**.

(e) Despite **Rule F3 (c)**, if a **Member** holds a policy with **Hospital Benefits** which are restricted to **Minimum Default Benefits** for psychiatric services and has served a **Waiting Period** of 2 months, the **Member** may upgrade their policy to receive full **Benefits** payable for psychiatric services with no **Waiting Period**. This exemption can only be used once in a person's lifetime.

F4 Exclusions

Exclusions apply in accordance to:

(i) Gold Hospital as described at **Rule J1 14**;

(ii) Silver Hospital as described at **Rule J2 14**;

(iii) Base Hospital as described at **Rule J3 14;**

(iv) Bronze Hospital as described at **Rule J4 14;**

(v) Reciprocal Health Cover as described at **Rule J5 14**;

(vi) Platinum Package as described at **Rule J6 14.**

F5 Benefit Limitation Periods

No benefit limitation periods apply to cover offered by CBHS Corporate.

F6 Restricted Benefits

Restricted benefits apply in accordance to:

(i) Gold Hospital as described at **Rule J1 13**;

(ii) Silver Hospital as described at **Rule J2 13**;
(iii) Base Hospital as described at **Rule J3 13**;
(iv) Bronze Hospital as described at **Rule J4 13;**
(v) Reciprocal Health Cover as described at **Rule J5 13**;
(vi) Platinum Package as described at **Rule J6 13**.

F7 Compensation Damages and Provisional Payment of Claims

(a) This **Rule** applies if a **Member** has received services in relation to a **Compensable Injury**.

(b) A **Member** is not entitled to **Benefits** for services related to treating a **Compensable Injury**, if the amount of compensation sought or received includes an amount for the treatment of the **Compensable Injury**.

(c) A **Member** is not entitled to **Benefits** for services related to treating a **Compensable Injury**, if the **Member** has not complied with the obligations imposed by **Rule A3.2**.

(d) CBHS Corporate may, however, in its sole and absolute discretion, make a provisional payment of **Benefits** to a **Member**, if:

i. the claim for compensation for the **Compensable Injury** has not yet been resolved; and

ii. the **Member** enters into a legally binding document with CBHS Corporate (in a form and on terms and conditions acceptable to CBHS Corporate at its sole and absolute discretion) to repay the **Benefits** upon resolution of the claim for compensation.

(e) If a **Member** receives a **Benefit** for services related to treating a condition which later becomes a **Compensable Injury**, and the amount of compensation sought or received includes an amount for the treatment of the **Compensable Injury**, then the amount of the **Benefit** is a debt owed to CBHS Corporate and CBHS Corporate may recover it at law.

(f) A **Member** is not entitled to **Benefits** for services related to treating a **Compensable Injury** for which an amount of compensation has been received for treating that **Compensable Injury**.

G CLAIMS

G1 General

(a) To make a claim for **Benefits** a **Member** shall:

(i) submit a completed and signed claim in the form required by CBHS Corporate;

(ii) provide all relevant receipts or accounts relating to the service rendered or good received; and

(iii) provide any other information or documents to CBHS Corporate which CBHS Corporate reasonably requires to process the claim for **Benefits**.

(b) A **Member** shall lodge a claim with CBHS Corporate within 24 months of receiving the good or service to which the claim relates.

G2 Other

CBHS Corporate may pay claims by cheque, electronic funds transfer to a bank account or any other method determined between CBHS Corporate and a **Policy Holder**.

I1 GOLD EXTRAS

I1 SCHEDULE GENERAL TREATMENT TABLES

I1 1 TABLE NAME OR GROUP OF TABLE NAMES

Gold Extras.

I1 2 ELIGIBILITY

Any person who is eligible to become a **Member** is eligible to be insured under Gold Extras.

I1 3 GENERAL CONDITIONS

Il 3.1 Emergency Ambulance Cover

If a **Policy Holder** wishes to obtain **Emergency Ambulance** cover in addition to Gold Extras cover, then the **Policy Holder** must pay the additional contribution for the **Emergency Ambulance** cover product.

Il 3.2 Limits per Service

(a) CBHS Corporate may impose a **Limit per Service** on **Extras Benefits**.

(b) CBHS Corporate may change a **Limit per Service** on **Extras Benefits** from time to time.

(c) If CBHS Corporate detrimentally changes a **Limit per Service**, it will advise affected **Policy Holders** before the change comes into effect.

(d) A **Member** can find out about **Limits per Service**:

  (i) at any time on the CBHS Corporate website; or

  (ii) during **Business Hours** from the CBHS Corporate office.

Il 3.3 Special limits on some services

A **Member** is not entitled to claim **Benefits** for more than one of each of the following services on any single day:

(a) **Physiotherapy Service**;

(b) **Chiropractic Service**;

(c) **Osteopathic Service**; and

(d) **Massage Therapy**.

I1 4 LOYALTY BONUSES

Not applicable on this product.

I1 5 DENTAL

(a) For **Dental Services**, a **Member** may claim a **Benefit** of 70% of the cost of service up to any relevant **Limit per Service** and the overall limit for the relevant period specified below.

Service	Overall limit	Extends for
Preventative Dental Services (2 month waiting period)	Unlimited	Not applicable
Dental (2 months waiting period) Fillings, consultations & examinations, x-rays and extractions or surgical dental	Unlimited	Not applicable
Dental (6 month waiting period)		
Periodontics	$630	Calendar Year
Endodontics	$660	Calendar Year
Inlays, onlays & facings	$1,440 ($360 per tooth)	Any 5 years
Dentures and Implants	$1,350	Any 5 years
Occlusal Therapy	$920	Lifetime
Dental (12 month waiting period)		
Orthodontia	$2,800	Lifetime
Crown and bridges	$3,000 ($720 per tooth)	Any 5 years

(b) For certain preventative **Dental Services**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost of services up to any relevant **Limit per Service**.

I1 6 OPTICAL

(a) For an **Optical Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $375 in a **Calendar Year**.

(b) For an **Optical Service**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost of services, of optical frames, lenses and contact lenses up to any relevant **Limit per Service** and the overall limit of $375 in a **Calendar Year**.

I1 7 PHYSIOTHERAPY

For **Physiotherapy Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $720 in a **Calendar Year**.

I1 8 CHIROPRACTIC

For **Chiropractic Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $720 in a **Calendar Year**.

I1 9 NON PBS PHARMACEUTICALS

For non-**PBS Pharmaceuticals**, a **Member** may claim a **Benefit** of 100% of the receipted cost of the prescription less a **Co-payment** equivalent to the current prescribed **PBS** co-payment for general patients, up to any relevant **Limit per Service** and the overall limit of $1,000 in a **Calendar Year**.

I1 10 PODIATRY

For **Podiatry Services**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $400 in a **Calendar Year**.

I1 11 PSYCHOLOGY AND COUNSELLING

For **Clinical Psychology Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $450 in a **Calendar Year.**

I1 12 ALTERNATIVE THERAPIES

For **Alternative Therapy**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $450, for each therapy type, in a **Calendar Year**.

I1 13 NATURAL THERAPIES

See **Rule I1 12** Alternative Therapies.

I1 14 SPEECH THERAPY

For **Speech Pathology Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $1,850 in a **Calendar Year**.

I1 15 ORTHOTICS

Benefits for orthotics are paid under the **Artificial Aids** benefits as detailed in the **Rule I1 27**.

I1 16 DIETETICS

For **Dietetic Services**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $360 in a **Calendar Year**.

I1 17 OCCUPATIONAL THERAPY

For **Occupational Therapy services**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $720 in a **Calendar Year**.

I1 18 NATUROPATHY

See **Rule I1 12** Alternative Therapies.

I1 19 ACUPUNCTURE

See **Rule I1 12** Alternative Therapies.

I1 20 OTHER THERAPIES

For **Osteopathic Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $720 in a **Calendar Year**.

I1 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

I1 22 HEARING AIDS

For hearing aids, when ordered by a medical practitioner and not payable from any other source, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $1,600 in **Any 3 years**.

I1 23 PREVENTION HEALTH MANAGEMENT

(a) For **Health Checks**, a **Member** may claim a **Benefit** of 90% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

(b) For **Health Management** (not including **Gym Membership** and **Personal Training**), a **Member** may claim a **Benefit** of 90% of the cost of the service up to any relevant **Limit per Service** and the overall limit of $100 in a **Calendar Year**.

(c) For **Gym Membership** and **Personal Training**, a **Member** may claim a **Benefit** of 90% of the cost of the service up to any relevant **Limit per Service.** The combined overall limit for **Gym Membership** and **Personal Training** is $115 in a **Calendar Year.** The **Limit per Service** for **Gym Membership** is $115 and for **Personal Training,** $100 in a **Calendar Year.**

(d) For the purpose of **Rule I1 23 (b)**:
   i. A **Benefit** is payable in relation to a **First Aid Course** only where the **Member** has completed that course.
   ii. A **Benefit** is payable in relation to a First Aid Kit only where the **Member** has completed a **First Aid Course**.

I1 24 AMBULANCE TRANSPORTATION

See **Rule I1 3.1** Emergency Ambulance Cover.

I1 25 ACCIDENT COVER

Not available on this product.

I1 26 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

I1 27 OTHER SPECIAL

(a) For the following, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Artificial Aids	$1,000	Any 3 years
Audiology Services	$360	Calendar Year
Orthoptic Therapy Services	$455	Calendar Year
Oxygen and Related Apparatus	$500	Calendar Year
Vitamin Therapy	$250	Calendar year
Hypnotherapy Service	$360	Calendar Year
Physiology Services	$360	Calendar Year
Nursing Services	$2,800	Calendar Year

(b) For the following, a **Member** may claim a **Benefit** of 70% of the cost up to the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Ante and Post Natal Physiotherapy	$105	Calendar Year
Autistic Social Skill Services	$360	Calendar Year
Blood Glucose Monitoring Accessories	$320	Calendar Year
Dressings	$1,500	Calendar Year
Health Care Appliances	$500	Any 3 years
Medical Catheters	$250	Calendar Year
Midwifery Services (excl. homebirths)	$500	Calendar Year
Non Admitted Theatre Fee	$160 per charge	Calendar Year

Travelling and Accommodation Expenses

(a) For Travelling and Accommodation Expenses, a **Member** may claim a **Benefit** of 50% of the cost calculated in accordance with **Rule I1 27 (d**) and **(e)**, up to the overall limit of $500 per membership in a **Calendar Year**.

(b) If a **Member:**

i. requires essential medical or dental treatment for which a **Benefit** would be payable under either hospital or extras cover held by the **Member**; and
ii. that treatment is not available at a facility within a 160km round trip from where the **Member** lives, then the **Member** is entitled to claim a **Benefit** of 50% of the cost of travelling to the nearest facility to receive treatment and back to where the **Member** lives (calculated in accordance with **Rule I1 27 (d)** and **(e)** and 50% of the costs of accommodation on such travel.

(c) Treatment is not essential medical or dental treatment unless:

i. the **Member** has been referred for the treatment by a medical practitioner or dentist; and
ii. the **Member** has given CBHS Corporate a medical certificate from the medical practitioner or dentist, which states that the treatment is essential medical treatment.

(d) The amount of **Benefit** payable is calculated by reference to the cost of travelling by:

i. economy class rail; or
ii. economy air; or
iii. economy bus;

when a **Member** chooses to travel by one of these modes of transport.

(e) When a **Member** chooses to travel by private car, then the amount of **Benefit** payable is calculated by reference to the CBHS Corporate policy on costing private car travel, as updated from time to time. A **Member** may obtain CBHS Corporate policy on costing private car travel during **Business Hours** from the CBHS Corporate office.

I2 SILVER EXTRAS

I2 SCHEDULE GENERAL TREATMENT TABLES

I2 1 TABLE NAME OR GROUP OF TABLE NAMES

Silver Extras

I2 2 ELIGIBILITY

Any person who is eligible to become a **Member** is eligible to be insured under Silver Extras.

I2 3 GENERAL CONDITIONS

I2 3.1 Emergency Ambulance

If a **Policy Holder** wishes to obtain **Emergency Ambulance** cover in addition to Silver Extras cover, then the **Policy Holder** must pay the additional contribution for the **Emergency Ambulance** cover product.

I2 3.2 Limits per Service

(a) CBHS Corporate may impose a **Limit per Service** on an **Extras Benefit**.

(b) CBHS Corporate may change a **Limit per Service Extras Benefits** from time to time.

(c) If CBHS Corporate detrimentally changes a **Limit per Service**, it will advise affected **Policy Holders** before the change comes into effect.

(d) A **Member** can find out about **Limits Per Service**:

- i. at any time on the CBHS Corporate website; or
- ii. during **Business Hours** from the CBHS Corporate office.

I2 3.3 Special limits on some services

(a) A **Member** is not entitled to claim **Benefits** for more than one of each of the following services rendered on any single day:

(i) **Physiotherapy Services;**

(ii) **Chiropractic Services**;

(iii) **Osteopathic Services**; and

(iv) **Massage Therapy**.

I2 4 LOYALTY BONUSES

Not applicable on this product.

I2 5 DENTAL

(a) For **Dental Services**, a **Member** may claim a **Benefit** of 70% of the cost of service up to any relevant **Limit per Service** and the overall limits below.

Service	Overall Limit	Extends for
Preventative Dental Services ***(2 month waiting period)***	$230	Calendar Year
Dental (2 month waiting period)		
Fillings, consultations & examinations, x-rays and extractions or surgical dental	$500	Calendar Year
Dental (6 month waiting period)		
Periodontics and Endodontics	$400	Calendar Year
Dental (12 month waiting period)		
Crowns and Bridges	$700	Any 5 years
Orthodontia	$700 Annual Limit ($1,400 Lifetime Limit)	Calendar Year
Other Major Dental Services	No Cover	No Cover

(b) For certain preventative **Dental Services**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost of services up to any relevant **Limit per Service**.

I2 6 OPTICAL

(a) For **Optical Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $250 in a **Calendar Year**.

(b) For an **Optical Service**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost of services, of optical frames, lenses and

contact lenses up to any relevant **Limit per Service** and the overall limit of $250 in a **Calendar Year**.

I2 7 PHYSIOTHERAPY

For **Physiotherapy Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $300 in **a Calendar Year**.

I2 8 CHIROPRACTIC

For **Chiropractic Service** and **Osteopathic Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $250 in a **Calendar Year**.

I2 9 NON PBS PHARMACEUTICALS

For non-**PBS Pharmaceuticals**, a **Member** may claim a **Benefit** of 100% of the receipted cost of the prescription less a **Co-payment** equivalent to the current prescribed **PBS** co-payment for general patients, up to any relevant **Limit per Service** and the overall limit of $300 in a **Calendar Year**.

I2 10 PODIATRY

For **Podiatry Services**, a **Member** may claim a **Benefit** of 70% of the cost of service up to any relevant **Limit per Service** and the overall limit of $250 in **a Calendar Year**.

I2 11 PSYCHOLOGY AND COUNSELLING

Not available on this product.

I2 12 ALTERNATIVE THERAPIES

For **Alternative Therapy**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $300 in a **Calendar Year**.

I2 13 NATURAL THERAPIES

See **Rule I2 12** Alternative Therapies.

I2 14 SPEECH THERAPY

Not available on this product.

I2 15 ORTHOTICS

Not available on this product.

I2 16 DIETETICS

For **Dietetic Services**, a **Member** may claim a **Benefit** of 70% of the cost of service up to any relevant **Limit per Service** and the overall limit of $100 in a **Calendar Year**.

I2 17 OCCUPATIONAL THERAPY
Not available on this product.

I2 18 NATUROPATHY
See **Rule I2 12** Alternative Therapies.

I2 19 ACUPUNCTURE
See **Rule I2 12** Alternative Therapies.

I2 20 OTHER THERAPIES
Not available on this product.

I2 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

I2 22 HEARING AIDS
Not available on this product.

I2 23 PREVENTION HEALTH MANAGEMENT

(a) For **Health Checks**, a **Member** may claim a **Benefit** of 90% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

(b) For **Health Management** (not including **Gym Membership** and **Personal Training**), a **Member** may claim a **Benefit** of 90% of the cost of the service up to any relevant **Limit per Service** and the overall limit of $100 in a **Calendar Year**.

(c) For **Gym Membership** and **Personal Training**, a **Member** may claim a **Benefit** of 90% of the cost of the service up to any relevant **Limit per Service.** The combined overall limit for **Gym Membership** and **Personal Training** is $115 in a **Calendar Year.** The **Limit per Service** for **Gym Membership** is $115 and for **Personal Training,** $100 in a **Calendar Year.**

(d) For the purpose of **Rule I2 23 (b)**:

   i. A **Benefit** is payable in relation to a **First Aid Course** only where the **Member** has completed that course.

   ii. A **Benefit** is payable in relation to a First Aid Kit only where the **Member** has completed a **First Aid Course**.

I2 24 AMBULANCE TRANSPORTATION

See **Rule I2 3.1** Emergency Ambulance Cover.

I2 25 ACCIDENT COVER

Not available on this product.

I2 26 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

I2 27 OTHER SPECIAL

(a) For the following, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Blood Glucose Monitoring Accessories	$100	Calendar Year
Health Care Appliances	$300	Any 3 years
Artificial Aids	$350	Any 3 years

I3 BRONZE EXTRAS

I3 SCHEDULE GENERAL TREATMENT TABLES

I3 1 TABLE NAME OR GROUP OF TABLE NAMES

Bronze Extras

I3 2 ELIGIBILITY

Any person who is eligible to become a **Member** is eligible to be insured under Bronze Extras.

I3 3 GENERAL CONDITIONS

I3 3.1 Emergency Ambulance

If a **Policy Holder** wishes to obtain **Emergency Ambulance** cover in addition to Bronze Extras cover, then the **Policy Holder** must pay the additional contribution for **Emergency Ambulance** cover.

I3 3.2 Limits per Service

(a) CBHS Corporate may impose a **Limit per Service** on an **Extras Benefit.**

(b) CBHS Corporate may change a **Limit per Service** on **Extras Benefits** from time to time.

(c) If CBHS Corporate changes a **Limit per Service**, it will advise affected **Policy Holders** before the change comes into effect.

(d) A **Member** can find out about **Limits per Service**:

i. at any time on the CBHS Corporate website; or

ii. during **Business Hours** from the CBHS Corporate office.

I3 3.3 Special limits on some services

(a) A **Member** is not entitled to claim **Benefits** for more than one of each of the following services on any single day:

(i) **Physiotherapy Service**;

(ii) **Chiropractic Service**;

(iii) **Osteopathic Service**; and

(iv) **Massage Therapy**.

I3 4 LOYALTY BONUSES

Not applicable on this product.

I3 5 DENTAL

(a) For **Dental Services**, a **Member** may claim **Benefit** of 70% of the cost of service up to any relevant **Limit per Service** and the overall limits below.

Service	Overall Limit	Extends for
Preventative Dental Services ***(2 month waiting period)***	$210	Calendar Year
Dental (2 month waiting period) Fillings, consultations & examinations, x-rays and extraction or surgical dental	$170	
Dental (6 month waiting period) Periodontic, endodontic, inlays, onlays, facings, dentures, implants and occlusal therapy	Not Covered	Not Applicable
Dental (12 month waiting period) Orthodontia, Crown and bridges	Not Covered	

(b) For certain preventative **Dental Services**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost of services up to any relevant **Limit per Service** and the overall limit for the relevant period specified above.

I3 6 OPTICAL

(a) For **Optical Service**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

(b) For an **Optical Service**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost of services, of optical frames, lenses and contact lenses up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

I3 7 PHYSIOTHERAPY

For **Physiotherapy Service**, **Chiropractic Service** and **Osteopathic Service** a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

I3 8 CHIROPRACTIC

For **Physiotherapy Service**, **Chiropractic Service** and **Osteopathic Service** a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

I3 9 NON PBS PHARMACEUTICALS

For non-**PBS Pharmaceuticals**, a **Member** may claim a **Benefit** of 100% of the receipted cost of the prescription less a **Co-payment** equivalent to the current prescribed **PBS** co-payment for general patients, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

I3 10 PODIATRY

Not available on this product.

I3 11 PSYCHOLOGY AND COUNSELLING

Not available on this product.

I3 12 ALTERNATIVE THERAPIES

For **Alternative Therapy**, a **Member** may claim a **Benefit** of 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

I3 13 NATURAL THERAPIES

See **Rule I3 12** Alternative Therapies.

I3 14 SPEECH THERAPY

Not available on this product.

I3 15 ORTHOTICS

Not available on this product.

I3 16 DIETETICS

For **Dietetic Services**, a **Member** may claim a **Benefit** of 70% of the cost of service up to any relevant **Limit per Service** and the overall limit of $100 in a **Calendar Year**.

I3 17 OCCUPATIONAL THERAPY

Not available on this product.

I3 18 NATUROPATHY

See **Rule I1 12** Alternative Therapies.

I3 19 ACUPUNCTURE

See **Rule I1 12** Alternative Therapies.

I3 20 OTHER THERAPIES

Not available on this product.

I3 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

I3 22 HEARING AIDS

Not available on this product.

I3 23 PREVENTION HEALTH MANAGEMENT

(a) For **Health Checks**, a **Member** may claim a **Benefit** of 90% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

(b) For **Health Management** (not including **Gym Membership** and **Personal Training**), a **Member** may claim a **Benefit** of 90% of the cost of the service up to any relevant **Limit per Service** and the overall limit of $100 in a **Calendar Year**.

(c) For **Gym Membership** and **Personal Training**, a **Member** may claim a **Benefit** of 90% of the cost of the service up to any relevant **Limit per Service.** The combined overall limit for **Gym Membership** and **Personal Training** is $115 in a **Calendar Year.** The **Limit per Service** for **Gym Membership** is $115 and for **Personal Training,** $100 in a **Calendar Year.**

(d) For the purpose of **Rule I3 23 (b)**:

  i. A **Benefit** is payable in relation to a **First Aid Course** only where the **Member** has completed that course.

  ii. A **Benefit** is payable in relation to a First Aid Kit only where the **Member** has completed a **First Aid Course**.

I3 24 AMBULANCE TRANSPORTATION

See **Rule I3 3.1** Emergency Ambulance Cover.

I3 25 ACCIDENT COVER

Not available on this product.

I3 26 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

I3 27 OTHER SPECIAL

(a) For the following, a **Member** may claim a **Benefit** of 70% of the cost of service up to the overall limit of $100 in a **Calendar Year.**

Item	Overall Limit	Extends for
Blood Glucose Monitoring Accessories	$100	Calendar Year

I4 AMBULANCE COVER

I4 SCHEDULE GENERAL TREATMENT TABLES

I4 1 TABLE NAME OR GROUP OF TABLE NAMES

Ambulance Cover

I4 2 ELIGIBILITY

A person who is eligible to become a **Policy Holder** is eligible to be insured under Ambulance Cover.

I4 3 GENERAL CONDITIONS

Ambulance Cover contributions must be paid annually in advance.

I4 4 LOYALTY BONUSES

Not applicable on this product.

I4 5 DENTAL

Not available on this product.

I4 6 OPTICAL

Not available on this product.

I4 7 PHYSIOTHERAPY

Not available on this product.

I4 8 CHIROPRACTIC

Not available on this product.

I4 9 NON PBS PHARMACEUTICALS

Not available on this product.

I4 10 PODIATRY

Not available on this product.

I4 11 PSYCHOLOGY AND COUNSELLING

Not available on this product.

I4 12 ALTERNATIVE THERAPIES

Not available on this product.

I4 13 NATURAL THERAPIES

Not available on this product.

I4 14 SPEECH THERAPY

Not available on this product.

I4 15 ORTHOTICS
Not available on this product.

I4 16 DIETETICS
Not available on this product.

I4 17 OCCUPATIONAL THERAPY
Not available on this product.

I4 18 NATUROPATHY
Not available on this product.

I4 19 ACUPUNCTURE
Not available on this product.

I4 20 OTHER THERAPIES
Not available on this product.

I4 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

I4 22 HEARING AIDS
Not available on this product.

I4 23 PREVENTION HEALTH MANAGEMENT
Not available on this product.

I4 24 AMBULANCE TRANSPORTATION
Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes.

If a **Member**:

(a) receives **Emergency Ambulance** services; and

(b) is not otherwise covered for the cost of **Emergency Ambulance** services;

then the **Benefit** payable in relation to those services is 100% of the cost to the **Member**.

I4 25 ACCIDENT COVER
Not available on this product.

I4 26 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.

I4 27 OTHER SPECIAL

Not available on this product.

J1 GOLD HOSPITAL

J1 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J1 1 TABLE NAME OR GROUP OF TABLE NAMES

1. Gold Hospital $0 **Excess**
2. Gold Hospital $250 **Excess**
3. Gold Hospital $500 **Excess**

J1 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under Gold Hospital $0 **Excess**, Gold Hospital $250 **Excess** or Gold Hospital $500 **Excess**.

J1 3 GENERAL CONDITIONS

Not applicable on this product.

J1 4 HOSPITAL TREATMENT PAYMENTS

J1 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J1 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum Default Benefits**, then **Benefits** for services provided by **Hospitals** are only payable in relation to hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J1 4.2 Services rendered by a private Hospital

(a) If a service received by a **Member** is:

  (i) rendered by a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**; and

  (ii) the **Hospital Purchaser-Provider Agreement** covers the level of **Benefits** paid for that kind of service,

then the amount of **Benefits** payable is the amount listed in the **Hospital Purchaser-Provider Agreement** for that kind of service.

(b) If a service is received by a **Member** from a private **Hospital** other than in accordance with **Rule J1 4.2(a)**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service, or such higher amount agreed between CBHS Corporate and the **Hospital** on a one off basis.

J1 4.3 Services rendered by a public hospital

(a) If a service received by a **Member** relates to a stay in a shared ward of a public **Hospital**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service.

(b) If a service received by a **Member** relates to a stay in a single private room of a public **Hospital**, then the amount of **Benefits** payable is the amount prescribed by the relevant **State** Health Minister, Department or Authority as the chargeable amount for that service.

J1 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:
  (i) a **Member** receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) who:
    (A) has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or
    (B) has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and
  (ii) the agreement deals with the kind of service rendered to the **Member**,

then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service.

(b) If:
  (i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule J1 5(a)**; and
  (ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**;

then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service.

(c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** payable is the lower of:
  (i) the balance of the medical practitioner's fee (or fee from any other service provider registered with Medicare), after a payment of a Medicare benefit for the services is received; or
  (ii) 25% of the **Medicare Benefits Schedule Fee** for that service.

J1 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**.

(b) If a **Member** receives **Hospital Pharmaceuticals** as part of receiving an **Admitted Patient** service at a **Hospital,** then the level of **Benefits** payable is the level specified in the **Hospital Purchaser-Provider Agreement** between CBHS Corporate and the **Hospital**.

J1 7 NON PBS PHARMACEUTICALS

Not available on this product.

J1 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted prosthesis for which a Medicare benefit is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules*.

J1 9 NURSING HOME TYPE PATIENTS

(a) If:

- (i) a **Member** has been hospitalised for a continuous period of 35 days; and
- (ii) CBHS Corporate is not satisfied that the **Member** requires further hospitalisation for acute care;

the **Member** will be classified as a **Nursing Home Type Patient** and any higher **Hospital Benefits** which would otherwise be payable to the **Member** are reduced to **Minimum Default Benefits**.

(b) CBHS Corporate will be satisfied that the **Member** requires further hospitalisation for acute care if:

- (i) the attending medical practitioner certifies that the **Member** needs further hospitalisation for acute care; and
- (ii) the attending medical practitioner provides CBHS Corporate with any further information which it reasonable requires

J1 10 CO PAYMENTS

Not applicable on this product.

J1 11 EXCESSES

(a) A **Policy Holder** may choose whether or not to have an **Excess** on the membership.

(b) If a **Policy Holder** chooses to have an **Excess** the **Excess** applies to all **Member** (with exception of **Dependants)** covered by the membership.

(c) If you choose $250 **Excess**, then the amount of **Excess** payable is $250 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:
   i. For **Single Membership** - $250 per **Calendar Year**
   ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $500 per **Calendar Year**

(d) If you choose $500 **Excess**, then the amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:
   i. For **Single Membership** - $500 per **Calendar Year**
   ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year**

J1 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J1 13 RESTRICTED BENEFITS

Not applicable on this product.

J1 14 EXCLUSIONS

The following have **Exclusions** on this level of cover:

- **Cosmetic services**
- **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery)

J1 15 LOYALTY BONUSES

Not applicable on this product.

J1 16 OTHER SPECIAL HOSPITAL TREATMENT

(a) If not otherwise covered by a **Hospital Purchaser-Provider Agreement**, then
   (i) the **Benefit** payable in respect of **Boarder Fees** is 100% of the cost up to a total of $160 per admission of the **Member** admitted; and
   (ii) the **Benefit** payable in respect of **Facility Fees** is 70% of the cost up to a total of $160.

(b) If a **Member**:
   (i) receives **Emergency Ambulance** services; and
   (ii) is not otherwise covered for the cost of **Emergency Ambulance** services;

   then the **Benefit** payable in relation to those **Emergency Ambulance** services is 100% of the cost to the **Member**.

J1 17 DENTAL
Not available on this product.

J1 18 OPTICAL
Not available on this product.

J1 19 PHYSIOTHERAPY
Not available on this product.

J1 20 CHIROPRACTIC
Not available on this product.

J1 21 NON PBS PHARMACEUTICALS
Not available on this product.

J1 22 PODIATRY
Not available on this product.

J1 23 PSYCHOLOGY AND COUNSELLING
Not available on this product.

J1 24 ALTERNATIVE THERAPIES
Not available on this product.

J1 25 NATURAL THERAPIES
Not available on this product.

J1 26 SPEECH THERAPY
Not available on this product.

J1 27 ORTHOTICS
Not available on this product.

J1 28 DIETETICS
Not available on this product.

J1 29 OCCUPATIONAL THERAPY
Not available on this product.

J1 30 NATUROPATHY
Not available on this product.

J1 31 ACUPUNCTURE
Not available on this product.

J1 32 OTHER THERAPIES
Not available on this product.

J1 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

J1 34 HEARING AIDS
Not available on this product.

J1 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J1 36 AMBULANCE TRANSPORTATION
Includes cover for **Emergency Ambulance** transport services when transported directly to a Hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as the Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.

J1 37 ACCIDENT COVER
Not available on this product.

J1 38 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.

J1 39 OTHER SPECIAL GENERAL TREATMENT
Not available on this product.

J1 40 HOSPITAL-SUBSTITUTE TREATMENT
See **Rule E4.2** which sets out the benefits that may be payable towards **Hospital Substitute Treatment.**

J2 SILVER HOSPITAL

J2 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J2 1 TABLE NAME OR GROUP OF TABLE NAMES

1. Silver Hospital $0 **Excess**
2. Silver Hospital $250 **Excess**
3. Silver Hospital $500 **Excess**

J2 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under Silver Hospital $0 **Excess**, Silver Hospital $250 **Excess** or Silver Hospital $500 **Excess**.

J2 3 GENERAL CONDITIONS

Not applicable on this product.

J2 4 HOSPITAL TREATMENT PAYMENTS

J2 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J2 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum Default Benefits**, then **Benefits** for services provided by **Hospitals** are only payable in relation to hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J2 4.2 Services rendered by a private Hospital

(a) If a service received by a **Member** is:

   (i) rendered by a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**; and

   (ii) the **Hospital Purchaser-Provider Agreement** covers the level of **Benefits** paid for that kind of service;

then the amount of **Benefits** payable is the amount listed in the **Hospital Purchaser-Provider Agreement** for that kind of service.

(b) If a service is received by a **Member** from a private **Hospital** other than in accordance with **Rule J2 4.1(a)**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service, or such higher amount as agreed between CBHS Corporate and the **Hospital** on a one off basis.

J2 4.3 Services rendered by a public Hospital

(a) If a service received by a **Member** relates to a stay in a shared ward of a public **Hospital**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service.

(b) Subject to **Rule J2 13**, if a service received by a **Member** relates to a stay in a single private room of a public **Hospital**, then the amount of **Benefits** payable is the amount prescribed by the relevant **State** Health Minister, Department or Authority as the chargeable amount for that service.

J2 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

- (i) a **Member** receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) who:
  - (A) has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or
  - (B) has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and
- (ii) the agreement deals with the kind of service rendered to the **Member**,

then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service.

(b) If:

- (i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule J2 5(a)**; and
- (ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**;

(c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** payable is the lower of:

- (i) the balance of the medical practitioner's fee (or fee from any other service provider registered with Medicare), after a payment of a Medicare benefit for the services is received; or
- (ii) 25% of the **Medicare Benefits Schedule Fee** for that service.

J2 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**.

(b) If a **Member** receives **Hospital Pharmaceuticals** as part of receiving an **Admitted Patient** service at a **Hospital,** then the level of **Benefits** payable is the level specified in the **Hospital Purchaser-Provider Agreement** between CBHS Corporate and the **Hospital**.

J2 7 NON PBS PHARMACEUTICALS

Not available on this product.

J2 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted prosthesis for which a Medicare benefit is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules*.

J2 9 NURSING HOME TYPE PATIENTS

(a) If:

- (i) a **Member** has been hospitalised for a continuous period of 35 days; and
- (ii) CBHS Corporate is not satisfied that the **Member** requires further hospitalisation for acute care;

the **Member** will be classified as a **Nursing Home Type Patient** and any higher **Hospital Benefits** which would otherwise be payable to the **Member** are reduced to **Minimum Default Benefits** for a **Nursing Home Type Patient**.

(b) CBHS Corporate will be satisfied that the **Member** requires further hospitalisation for acute care if:

- (i) the attending medical practitioner certifies that the **Member** needs further hospitalisation for acute care; and
- (ii) the attending medical practitioner provides CBHS Corporate with any further information which it reasonable requires.

J2 10 CO PAYMENTS

Not applicable on this product.

J2 11 EXCESSES

(a) A **Policy Holder** may choose whether or not to have an **Excess** on the membership.

(b) If a **Policy Holder** chooses to have an **Excess** the **Excess** applies to all **Member** (with exception of **Dependants)** covered by the membership.

(c) If you choose $250 **Excess**, then the amount of **Excess** payable is $250 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

i. For **Single Membership** - $250 per **Calendar Year**

ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $500 per **Calendar Year**

(d) If you choose $500 **Excess**, then the amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

i. For **Single Membership** - $500 per **Calendar Year**

ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year.**

J2 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J2 13 RESTRICTED BENEFITS

(a) Psychiatric: If a **Member** is admitted to a **Hospital** for psychiatric services, then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Default Benefits**, unless **Rule E2.8 applies**.

(b) Palliative care: If a **Member** is admitted to a **Hospital** for palliative care services, then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Default Benefits.**

J2 14 EXCLUSIONS

The following have **Exclusions** on this level of cover:

- Hip replacement services
- Knee replacement services
- Other joint replacement services including Ankle and Shoulder replacement services
- Pregnancy and birth related services
- Assisted reproductive services

- All Bariatric services including revision and reversal procedures (e.g. gastric banding, sleeve gastrectomy)
- **Cosmetic services**
- **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery)

J2 15 LOYALTY BONUSES
Not applicable on this product.

J2 16 OTHER SPECIAL HOSPITAL TREATMENT

(a) If not otherwise covered by a **Hospital Purchaser-Provider Agreement**, then:
  (i) the **Benefit** payable in respect of **Boarder Fees** is 100% of the cost to the **Member**, up to a total of $160 **per admission** of the **Member** admitted; and
  (ii) the **Benefit** payable in respect of **Facility Fees** is 70% of the cost up to a total of $160.

(b) If a **Member**:
  (i) receives **Emergency Ambulance** services; and
  (ii) is not otherwise covered for the cost of **Emergency Ambulance** services,

then the **Benefit** payable in relation to those **Emergency Ambulance** services is 100% of the cost to the **Member**.

J2 17 DENTAL
Not available on this product.

J2 18 OPTICAL
Not available on this product.

J2 19 PHYSIOTHERAPY
Not available on this product.

J2 20 CHIROPRACTIC
Not available on this product.

J2 21 NON PBS PHARMACEUTICALS
Not available on this product.

J2 22 PODIATRY
Not available on this product.

J2 23 PSYCHOLOGY AND COUNSELLING
Not available on this product.

J2 24 ALTERNATIVE THERAPIES

Not available on this product.

J2 25 NATURAL THERAPIES
Not available on this product.

J2 26 SPEECH THERAPY
Not available on this product.

J2 27 ORTHOTICS
Not available on this product.

J2 28 DIETETICS
Not available on this product.

J2 29 OCCUPATIONAL THERAPY
Not available on this product.

J2 30 NATUROPATHY
Not available on this product.

J2 31 ACUPUNCTURE
Not available on this product.

J2 32 OTHER THERAPIES
Not available on this product.

J2 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

J2 34 HEARING AIDS
Not available on this product.

J2 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J2 36 AMBULANCE TRANSPORTATION
Includes cover for **Emergency Ambulance** transport services when transported directly to a Hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as the Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.

J2 37 ACCIDENT COVER
Not available on this product.

J2 38 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.

J2 39 OTHER SPECIAL GENERAL TREATMENT
Not available on this product.

J2 40 HOSPITAL-SUBSTITUTE TREATMENT
See **Rule E4.2** which sets out the benefits that may be payable towards **Hospital Substitute Treatment.**

J3 BASE HOSPITAL

J3 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J3 1 TABLE NAME OR GROUP OF TABLE NAMES

Base Hospital $500 **Excess**

J3 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under Base Hospital $500 **Excess**.

J3 3 GENERAL CONDITIONS

Not applicable on this product.

J3 4 HOSPITAL TREATMENT PAYMENTS

J3 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J3 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum Default Benefits**, then **Benefits** for services provided by **Hospitals** are only payable in relation to hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J3 4.2 Services rendered by any Hospital

If a service received by a **Member** is rendered by a **Hospital**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service.

J3 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

(i) a **Member** receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) who:

(A) has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or

(B) has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and

(ii) the agreement deals with the kind of service rendered to the **Member**,

then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service.

(b) If:

(i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule J3 5(a)**; and

(ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**;

then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service.

(c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** payable is the lower of:

(i) the balance of the medical practitioner's fee (or fee from any other service provider registered with Medicare), after a payment of a Medicare benefit for the services is received; or

(ii) 25% of the **Medicare Benefits Schedule Fee** for that service.

J3 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**.

(b) If a **Member** receives **Hospital Pharmaceuticals** as part of receiving an **Admitted Patient** service at a **Hospital** then the level of **Benefits** payable is the level specified in the **Hospital Purchaser-Provider Agreement** between CBHS Corporate and the **Hospital**.

J3 7 NON PBS PHARMACEUTICALS

Not available on this product.

J3 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted prosthesis for which a Medicare benefit is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules*.

J3 9 NURSING HOME TYPE PATIENTS

(a) If:
   (i) a **Member** has been hospitalised for a continuous period of 35 days; and
   (ii) CBHS Corporate is not satisfied that the **Member** requires further hospitalisation for acute care,

   the **Member** will be classified as a **Nursing Home Type Patient** and any higher **Hospital Benefits** which would otherwise be payable to the **Member** are reduced to **Minimum Default Benefits** for a **Nursing Home Type Patient**.

(b) CBHS Corporate will be satisfied that the **Member** requires further hospitalisation for acute care if:
   (i) the attending medical practitioner certifies that the **Member** needs further hospitalisation for acute care, and
   (ii) the attending medical practitioner provides CBHS Corporate with any further information which it reasonably requires.

J3 10 CO PAYMENTS

Not applicable on this product.

J3 11 EXCESSES

(a) The **Excess** applies to all **Members** covered by the membership.
(b) The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

   i. For **Single Membership** - $500 per **Calendar Year**

   ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year**

J3 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J3 13 RESTRICTED BENEFITS

All services except for those shown as **Exclusions** in **J3 14** are restricted to **Minimum Default Benefits** only, unless **Rule E2.8** applies.

J3 14 EXCLUSIONS

The following have **Exclusions** on this level of cover:

- **Cosmetic services**
- **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery)

J3 15 LOYALTY BONUSES

Not applicable on this product.

J3 16 OTHER SPECIAL HOSPITAL TREATMENT

If a Member:

(a) receives **Emergency Ambulance** services; and
(b) is not otherwise covered for the cost of **Emergency Ambulance** services,

then the **Benefit** payable in relation to those **Emergency Ambulance** services is 100% of the cost to the **Member**.

J3 17 DENTAL

Not available on this product.

J3 18 OPTICAL

Not available on this product.

J3 19 PHYSIOTHERAPY

Not available on this product.

J3 20 CHIROPRACTIC

Not available on this product.

J3 21 NON PBS PHARMACEUTICALS

Not available on this product.

J3 22 PODIATRY

Not available on this product.

J3 23 PSYCHOLOGY AND COUNSELLING

Not available on this product.

J3 24 ALTERNATIVE THERAPIES

Not available on this product.

J3 25 NATURAL THERAPIES

Not available on this product.

J3 26 SPEECH THERAPY

Not available on this product.

J3 27 ORTHOTICS
Not available on this product.

J3 28 DIETETICS
Not available on this product.

J3 29 OCCUPATIONAL THERAPY
Not available on this product.

J3 30 NATUROPATHY
Not available on this product.

J3 31 ACUPUNCTURE
Not available on this product.

J3 32 OTHER THERAPIES
Not available on this product.

J3 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

J3 34 HEARING AIDS
Not available on this product.

J3 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J3 36 AMBULANCE TRANSPORTATION
Includes cover for **Emergency Ambulance** transport services when transported directly to a Hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as the Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.

J3 37 ACCIDENT COVER
Not available on this product.

J3 38 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.

J3 39 OTHER SPECIAL GENERAL TREATMENT
Not available on this product.

J3 40 HOSPITAL-SUBSTITUTE TREATMENT

See **Rule E4.2** which sets out the benefits that may be payable towards **Hospital Substitute Treatment.**

J4 BRONZE HOSPITAL

J4 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J4 1 TABLE NAME OR GROUP OF TABLE NAMES

1. Bronze Hospital $250 **Excess**
2. Bronze Hospital $500 **Excess**

J4 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under Bronze Hospital $250 **Excess** or Bronze Hospital $500 **Excess**.

J4 3 GENERAL CONDITIONS

Not applicable on this product.

J4 4 HOSPITAL TREATMENT PAYMENTS

J4 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J4 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum Default Benefits**, then **Benefits** for services provided by **Hospitals** are only payable in relation to hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J4 4.2 Services rendered by a private Hospital

(a) If a service received by a **Member** is:

(i) rendered by a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**; and

(ii) the **Hospital Purchaser-Provider Agreement** covers the level of **Benefits** paid for that kind of service; and

(iii) the service is for:

(A) **Accident Related Treatment** after joining; or
(B) the consequence of a **Medical Emergency** after joining; or
(C) the removal of tonsils; or
(D) the removal of adenoids; or

(E) the removal of appendix; or
(F) the removal of wisdom teeth; or
(G) the investigation, repair or reconstruction of bones or tissues of the knee, hip or shoulder that have been damaged as a result of **Physical Trauma**; or
(H) insertion of grommets in ears; or
(I) colonoscopies (sigmoidoscopy); or
(J) gastroscopies (oesophagoscopy, gastroscopy, duodenoscopy, panendoscopy, balloon enteroscopy, endoscopy); or
(K) the treatment for cancer related service (including radiotherapy, chemotherapy, brachytherapy and all other non-surgical cancer treatment) treatment for cancer related service; or
(L) the treatment related to kidney (renal tract) stones; or
(M) the treatment related to gallstones,

then the amount of **Benefits** payable is the amount listed in the **Hospital Purchaser-Provider Agreement** for that kind of service.

(b) If a service is received by a **Member** from a private **Hospital** other than in accordance with **Rule J4 4.2(a)** or **J4 14** then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service, or such higher amount as agreed between CBHS Corporate and the **Hospital** on a one-off basis.

J4 4.3 Services rendered by a public Hospital

(a) The accommodation benefit in a public **Hospital** for a service received by a **Member**, other than a service referred to in **Rule J4 4.3(b)** or **J4 14**, shall be the **Minimum Default Benefit** for that service.

(b) The accommodation benefit in a public **Hospital** for a service received by a **Member** relating to the:

(A) **Accident Related Treatment** after joining; or
(B) the consequence of a **Medical Emergency** after joining; or
(C) the removal of tonsils; or
(D) the removal of adenoids; or
(E) the removal of appendix; or
(F) the removal of wisdom teeth; or
(G) the investigation, repair or reconstruction of bones or tissues of the knee, hip or shoulder that have been damaged as a result of **Physical Trauma**; or
(H) insertion of grommets in ears; or
(I) colonoscopies (sigmoidoscopy); or

(J) gastroscopies (oesophagoscopy, gastroscopy, duodenoscopy, panendoscopy, balloon enteroscopy, endoscopy); or

(K) the treatment for cancer related service (including radiotherapy, chemotherapy, brachytherapy and all other non-surgical cancer treatment); or

(L) the treatment related to kidney (renal tract) stones; or

(M) the treatment related to gallstones,

shall be equal to the charge raised by the public **Hospital** (whether the accommodation be in a shared ward or a single private room).

J4 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

(i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) who:

(A) has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or

(B) has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and

(ii) the agreement deals with the kind of service rendered to the **Member**,

then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service.

(b) If:

(i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule J4 5(a)**; and

(ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**;

(c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** payable is the lower of:

   (i) the balance of the medical practitioner's fee (or fee from any other service provider registered with Medicare), after a payment of a Medicare benefit for the services is received; or

   (ii) 25% of the **Medicare Benefits Schedule Fee** for that service.

J4 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**.

(b) If a **Member** receives **Hospital Pharmaceuticals** as part of receiving an **Admitted Patient** service at a **Hospital,** then the level of **Benefits** payable is the level specified in the **Hospital Purchaser-Provider Agreement** between CBHS Corporate and the **Hospital**.

J4 7 NON PBS PHARMACEUTICALS

Not available on this product.

J4 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted prosthesis for which a Medicare benefit is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules*.

J4 9 NURSING HOME TYPE PATIENTS

(a) If:

   (i) a **Member** has been hospitalised for a continuous period of 35 days; and

   (ii) CBHS Corporate is not satisfied that the **Member** requires further hospitalisation for acute care;

the **Member** will be classified as a **Nursing Home Type Patient** and any higher **Hospital Benefits** which would otherwise be payable to the **Member** are reduced to **Minimum Default Benefits** for a **Nursing Home Type Patient**.

(b) CBHS Corporate will be satisfied that the **Member** requires further hospitalisation for acute care if:

(i) the attending medical practitioner certifies that the **Member** needs further hospitalisation for acute care; and

(ii) the attending medical practitioner provides CBHS Corporate with any further information which it reasonable requires.

J4 10 CO PAYMENTS

Not applicable on this product.

J4 11 EXCESSES

(a) The **Excess** applies to all **Members** covered by the membership.

(b) If you choose $250 **Excess**, then the amount of **Excess** payable is $250 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

i. For **Single Membership** - $250 per **Calendar Year**

ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $500 per **Calendar Year**

(c) If you choose $500 **Excess**, then the amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

i. For **Single Membership** - $500 per **Calendar Year**

ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year.**

J4 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J4 13 RESTRICTED BENEFITS

All services provided by **Hospitals**, other than those to which **Rule E2.8, J4 4.2(a)** and **J4 14** applies, are restricted to **Minimum Default Benefits** in accordance with **Rule J4 4.2(b)** and **J4 4.3**.

J4 14 EXCLUSIONS

The following have **Exclusions** on this level of cover:

- **Cosmetic services**
- **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery)

J4 15 LOYALTY BONUSES

Not applicable on this product.

J4 16 OTHER SPECIAL HOSPITAL TREATMENT

(a) If not otherwise covered by a **Hospital Purchaser-Provider Agreement**, then:

(i) the **Benefit** payable in respect of **Boarder Fees** is 100% of the cost to the **Member**, up to a total of $160 **per admission** of the **Member** admitted; and

(ii) the **Benefit** payable in respect of **Facility Fees** is 70% of the cost up to a total of $160.

(b) If a **Member**:

(i) receives **Emergency Ambulance** services; and

(ii) is not otherwise covered for the cost of **Emergency Ambulance** services,

then the **Benefit** payable in relation to those **Emergency Ambulance** services is 100% of the cost to the **Member**.

J4 17 DENTAL

Not available on this product.

J4 18 OPTICAL

Not available on this product.

J4 19 PHYSIOTHERAPY

Not available on this product.

J4 20 CHIROPRACTIC

Not available on this product.

J4 21 NON PBS PHARMACEUTICALS

Not available on this product.

J4 22 PODIATRY

Not available on this product.

J4 23 PSYCHOLOGY AND COUNSELLING

Not available on this product.

J4 24 ALTERNATIVE THERAPIES

Not available on this product.

J4 25 NATURAL THERAPIES

Not available on this product.

J4 26 SPEECH THERAPY

Not available on this product.

J4 27 ORTHOTICS

Not available on this product.

J4 28 DIETETICS

Not available on this product.

J4 29 OCCUPATIONAL THERAPY

Not available on this product.

J4 30 NATUROPATHY

Not available on this product.

J4 31 ACUPUNCTURE

Not available on this product.

J4 32 OTHER THERAPIES

Not available on this product.

J4 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

J4 34 HEARING AIDS

Not available on this product.

J4 35 PREVENTION HEALTH MANAGEMENT

Not available on this product.

J4 36 AMBULANCE TRANSPORTATION

Includes cover for **Emergency Ambulance** transport services when transported directly to a Hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as the Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.

J4 37 ACCIDENT COVER

Not available on this product.

J4 38 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

J4 39 OTHER SPECIAL GENERAL TREATMENT

Not available on this product.

J4 40 HOSPITAL-SUBSTITUTE TREATMENT

See **Rule E4.2** which sets out the benefits that may be payable towards **Hospital Substitute Treatment.**

J5 RECIPROCAL HEALTH COVER

J5 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J5 1 TABLE NAME OR GROUP OF TABLE NAMES

Reciprocal Health Cover

J5 2 ELIGIBILITY

Only available to Employees/Members of organisations which have this product included in their contract with CBHS Corporate.

J5 3 GENERAL CONDITIONS

Not applicable on this product.

J5 4 HOSPITAL TREATMENT PAYMENTS

J5 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J5 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum Default Benefits**, then **Benefits** for services provided by **Hospitals** are only payable in relation to hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J5 4.2 Services rendered by any Hospital

If a service received by a **Member** is rendered by a **Hospital**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service.

J5 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

(i) a **Member** receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) who:

(A) has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or

(B) has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and

(ii) the agreement deals with the kind of service rendered to the **Member**,

then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service.

(b) If:

(i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule J5 5(a)**; and

(ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**;

then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service.

(c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** payable is the lower of:

(i) the balance of the medical practitioner's fee (or fee from any other service provider registered with Medicare), after a payment of a Medicare benefit for the services is received; or

(ii) 25% of the **Medicare Benefits Schedule Fee** for that service.

J5 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**.

(b) If a **Member** receives **Hospital Pharmaceuticals** as part of receiving an **Admitted Patient** service at a **Hospital** then the level of **Benefits** payable is the level specified in the **Hospital Purchaser-Provider Agreement** between CBHS Corporate and the **Hospital**.

J5 7 NON PBS PHARMACEUTICALS

Not available on this product.

J5 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted prosthesis for which a Medicare **Benefit** is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules*.

J5 9 NURSING HOME TYPE PATIENTS

(a) If:

- (i) a **Member** has been hospitalised for a continuous period of 35 days; and
- (ii) CBHS Corporate is not satisfied that the **Member** requires further hospitalisation for acute care,

the **Member** will be classified as a **Nursing Home Type Patient** and any higher **Hospital Benefits** which would otherwise be payable to the **Member** are reduced to **Minimum Default Benefits** for a **Nursing Home Type Patient**.

(b) CBHS Corporate will be satisfied that the **Member** requires further hospitalisation for acute care if:

- (i) the attending medical practitioner certifies that the **Member** needs further hospitalisation for acute care, and
- (ii) the attending medical practitioner provides CBHS Corporate with any further information which it reasonably requires.

J5 10 CO PAYMENTS

Not applicable on this product.

J5 11 EXCESSES

(c) The **Excess** applies to all **Members** covered by the membership.

(d) The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

- i. For **Single Membership** - $500 per **Calendar Year**
- ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year**

J5 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J5 13 RESTRICTED BENEFITS

If a **Member** is admitted to a **Hospital** for any of the services listed below, then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Default Benefits**.

a) Rehabilitation
b) Psychiatric, unless **Rule E2.8** applies.
c) Palliative care

J5 14 EXCLUSIONS

All services have **Exclusions** except for those shown as Restricted **Benefits** in **J5 13**.

J5 15 LOYALTY BONUSES

Not applicable on this product.

J5 16 OTHER SPECIAL HOSPITAL TREATMENT

Not applicable on this product.

J5 17 DENTAL

Not available on this product.

J5 18 OPTICAL

Not available on this product.

J5 19 PHYSIOTHERAPY

Not available on this product.

J5 20 CHIROPRACTIC

Not available on this product.

J5 21 NON PBS PHARMACEUTICALS

Not available on this product.

J5 22 PODIATRY

Not available on this product.

J5 23 PSYCHOLOGY AND COUNSELLING

Not available on this product.

J5 24 ALTERNATIVE THERAPIES

Not available on this product.

J5 25 NATURAL THERAPIES

Not available on this product.

J5 26 SPEECH THERAPY

Not available on this product.

J5 27 ORTHOTICS

Not available on this product.

J5 28 DIETETICS

Not available on this product.

J5 29 OCCUPATIONAL THERAPY

Not available on this product.

J5 30 NATUROPATHY

Not available on this product.

J5 31 ACUPUNCTURE
Not available on this product.

J5 32 OTHER THERAPIES
Not available on this product.

J5 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

J5 34 HEARING AIDS
Not available on this product.

J5 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J5 36 AMBULANCE TRANSPORTATION
Not available on this product.

J5 37 ACCIDENT COVER
Not available on this product.

J5 38 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.

J5 39 OTHER SPECIAL GENERAL TREATMENT
Not available on this product.

J5 40 HOSPITAL-SUBSTITUTE TREATMENT
Not available on this product.

J6 PLATINUM PACKAGE

J6 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J6 1 TABLE NAME OR GROUP OF TABLE NAMES

Platinum Package

J6 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under Platinum Package cover.

J6 3 GENERAL CONDITIONS

J6 3.1 General Product Description

(a) This product provides comprehensive cover for a range of **Hospital Admitted Patient** services together with **Extras Benefits.**

J6 3.2 Limits per Extras Service

(a) CBHS Corporate may impose a **Limit per Service** on **Extras Benefits**.

(b) CBHS Corporate may change a **Limit per Service** on **Extras Benefits** from time to time.

(c) If CBHS Corporate detrimentally changes a **Limit per Service**, it will advise affected **Policy Holders** before the change comes into effect.

(d) A **Member** can find out about **Limits per Service**:

i. at any time on the CBHS Corporate website; or

ii. during **Business Hours** from the CBHS Corporate office.

J6 3.3 Special Limits on Some Extras Services

A **Member** is not entitled to claim **Benefits** for more than one of each of the following services on any single day:

(a) **Physiotherapy Service**;

(b) **Chiropractic Service**;

(c) **Osteopathic Service**; and

(d) **Massage Therapy**.

J6 4 HOSPITAL TREATMENT PAYMENTS

J6 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J6 9**

(b) Where the level of **Benefit** payable for a service is **Minimum Default Benefits**, then **Benefits** for services provided by **Hospitals** are only payable in relation to hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J6 4.2 Services rendered by a private Hospital

(a) If a service received by a **Member** is:

i. rendered by a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**; and

ii. the **Hospital Purchaser-Provider Agreement** covers the level of **Benefits** paid for that kind of service,

then the amount of **Benefits** payable is the amount listed in the **Hospital Purchaser-Provider Agreement** for that kind of service.

(b) If a service is received by a **Member** from a private **Hospital** other than in accordance with **Rule J6 4.2(a)**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service.

J6 4.3 Services rendered by a public Hospital

(a) If a service received by a **Member** relates to a stay in a shared ward of a public **Hospital**, then the amount of **Benefits** payable is the **Minimum Default Benefits** for that service.

(b) If a service received by a **Member** relates to a stay in a single private room of a public **Hospital**, then the amount of **Benefits** payable is the amount prescribed by the relevant **State** Health Minister, Department or Authority as the chargeable amount for that service.

J6 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

i. a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) who:

ii. has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or

iii. has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and

iv. the agreement deals with the kind of service rendered to the **Member**,

then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service.

(b) If:

i. a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule J6 5(a)**; and

ii. the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**;

then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service.

(c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** payable is the lower of:

i. the balance of the medical practitioner's fee (or fee from any other service provider registered with Medicare), after a payment of a Medicare benefit for the services is received; or

ii. 25% of the **Medicare Benefits Schedule Fee** for that service.

J6 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

1. **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS Corporate has a **Hospital Purchaser-Provider Agreement**.
2. If a **Member** receives **Hospital Pharmaceuticals** as part of receiving an **Admitted Patient** service at a **Hospital** then the level of **Benefits** payable is the level specified in the **Hospital Purchaser-Provider Agreement** between CBHS Corporate and the **Hospital**.

J6 7 NON PBS PHARMACEUTICALS

Not applicable on this product.

J6 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted prosthesis for which a Medicare benefit is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules*.

J6 9 NURSING HOME TYPE PATIENTS

(a) If:

i. a **Member** has been hospitalised for a continuous period of 35 days; and

ii. CBHS Corporate is not satisfied that the **Member** requires further hospitalisation for acute care;

the **Member** will be classified as a **Nursing Home Type Patient** and any higher **Hospital Benefits** which would otherwise be payable to the **Member** are reduced to **Minimum Default Benefits** for a **Nursing Home Type Patient**.

(b) CBHS Corporate will be satisfied that the **Member** requires further hospitalisation for acute care if:

i. the attending medical practitioner certifies that the **Member** needs further hospitalisation for acute care; and

ii. the attending medical practitioner provides CBHS Corporate with any further information which it reasonable requires.

J6 10 CO PAYMENTS

There is no **Co-payment** payable under this product.

J6 11 EXCESSES

There is no **Excess** payable under this product

J6 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J6 13 RESTRICTED BENEFITS

Not applicable on this product.

J6 14 EXCLUSIONS

The following have **Exclusions** on this level of cover:

- **Cosmetic services**
- **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery)

J6 15 LOYALTY BONUSES

Not applicable on this product.

J6 16 OTHER SPECIAL HOSPITAL TREATMENT

(a) If not otherwise covered by a **Hospital Purchaser-Provider Agreement**, then

i. the **Benefit** payable in respect of **Boarder Fees** is 100% of the cost to the **Member**, up to a total of $160 **per admission** of the **Member** admitted; and

ii. the **Benefit** payable in respect of **Facility Fees** is 70% of the cost up to a total of $160.

(b) If a **Member**:

i. receives **Emergency Ambulance** services; and

ii. is not otherwise covered for the cost of **Emergency Ambulance** services;

then the **Benefit** payable in relation to those **Emergency Ambulance** services is 100% of the cost to the **Member**.

(c) A **Member** may claim a **Gap Assist Benefit** up to a total limit of $200 per person per **Calendar Year.**

J6 17 DENTAL

(a) For **Dental Services**, a **Member** may claim a **Benefit** of 100% of the cost of service up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Service	Overall Limit	Extends for
Preventative Dental Services	Unlimited	Not applicable
Dental (2 month waiting period) Fillings, consultations & examinations, x-rays and extractions or surgical dental	Unlimited	Not applicable
Dental (6 month waiting period)		
Periodontics	$700	Calendar Year
Endodontics	$700	Calendar Year
Inlays, onlays & facings	$1,440 ($360 per tooth)	Any 5 years
Dentures and Implants	$1,500	Any 5 years
Occlusal Therapy	$920	Lifetime
Dental (12 month waiting period)		
Orthodontia	$3,200	lifetime
Crown and bridges	$3,500 ($720 per tooth)	Any 5 years

(b) For certain preventative **Dental Services**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost services up to any relevant **Limit per Service** and the overall limit for the relevant period specified above.

J6 18 OPTICAL

(a) For an **Optical Service**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $450 in a **Calendar Year**.
(b) For an **Optical Service**, a **Member** may claim a **Benefit** of up to 100% from a **Choice Network Provider** of the cost of services, of optical frames, lenses and contact lenses up to any relevant **Limit per Service** and the overall limit of $450 in a **Calendar Year**.

J6 19 PHYSIOTHERAPY

For **Physiotherapy Service**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $900 in a **Calendar Year.**

J6 20 CHIROPRACTIC

For **Chiropractic Services and Osteopathy Service** (including ante natal/post-natal physiotherapy), a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $1,000 in a **Calendar Year**.

J6 21 NON PBS PHARMACEUTICALS

For non-**PBS Pharmaceuticals**, a **Member** may claim a **Benefit** of 100% of the receipted cost of the prescription less a **Co-payment** equivalent to the current prescribed **PBS** co-payment for general patients, up to any relevant **Limit per Service** and the overall limit of $1,000 in a **Calendar Year**.

J6 22 PODIATRY

For **Podiatry Services**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $400 in a **Calendar Year.**

J6 23 PSYCHOLOGY AND COUNSELLING

For **Clinical Psychology Services**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $500 in a **Calendar Year.**

J6 24 ALTERNATIVE THERAPIES

For **Alternative Therapies,** a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $1,000 in a **Calendar Year.**

J6 25 NATURAL THERAPIES

See **Rule J6 24** Alternative Therapies.

J6 26 SPEECH THERAPY

For **Speech Pathology Service**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $1,850 in a **Calendar Year**.

J6 27 ORTHOTICS

Benefits for orthotics are paid under the **Artificial Aids** benefits as detailed in the **Rule J6 39**.

J6 28 DIETETICS

For **Dietetic Services**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $360 in a **Calendar Year.**

J6 29 OCCUPATIONAL THERAPY

For **Occupational Therapy Services**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $800 in a **Calendar Year**.

J6 30 NATUROPATHY

See **Rule J6 24** Alternative Therapies.

J6 31 ACUPUNCTURE

See **Rule J6 24** Alternative Therapies.

J6 32 OTHER THERAPIES

Not available on this product.

J6 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

J6 34 HEARING AIDS

For hearing aids, when ordered by a medical practitioner and not payable from any other source, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $2,200 in **Any 3 years**.

J6 35 PREVENTION HEALTH MANAGEMENT

a. For **Health Checks**, a **Member** may claim a **Benefit** of 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $300 in a **Calendar Year**.
b. For **Health Management** (not including **Gym Membership** and **Personal Training**), a **Member** may claim a **Benefit** of 100% of the cost of the service up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.
c. For **Gym Membership** and **Personal Training**, a **Member** may claim a **Benefit** of 100% of the cost of the service up to any relevant **Limit per Service.** The

combined overall limit for **Gym Membership** and **Personal Training** is $230 in a **Calendar Year.** The **Limit per Service** for **Gym Membership** is $230 and for **Personal Training,** $200 in a **Calendar Year.**

d. For the purpose of **Rule J6 35 (b)**:
   i. A **Benefit** is payable in relation to a **First Aid Course** only where the **Member** has completed that course.
   ii. A **Benefit** is payable in relation to a First Aid Kit only where the **Member** has completed a **First Aid Course**.

J6 36 AMBULANCE TRANSPORTATION

Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes. Residents of WA are also eligible for **Non-Emergency Ambulance** services for up to $5000 per person per calendar year when approved by CBHS Corporate.

J6 37 ACCIDENT COVER

Not available on this product.

J6 38 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

J6 39 OTHER SPECIAL GENERAL TREATMENT

(A) For the following, a **Member** may claim a **Benefit** of 100% of the cost of the service, up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Artificial Aids	$1,500	Any 3 years
Audiology Services	$360	Calendar Year
Orthoptic Therapy Services	$455	Calendar Year
Oxygen and Related Apparatus	$500	Calendar Year
Vitamin Therapy	$250	Calendar Year
Hypnotherapy Service	$360	Calendar Year
Physiology Services	$360	Calendar Year
Nursing Services	$2,800	Calendar Year

(B) For the following, a **Member** may claim a **Benefit** of 100% of the cost of the service and the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Ante and Post Natal Physiotherapy	$105	Calendar Year
Autistic Social Skill Services	$360	Calendar Year
Blood Glucose Monitoring Accessories	$320	Calendar Year
Dressings	$1,500	Calendar Year
Health Care Appliances	$500	Any 3 years
Medical Catheters	$250	Calendar Year
Midwifery Services (excl. homebirths)	$500	Calendar Year
Non Admitted Theatre Fee	$160 per charge	Calendar Year

(C) Travelling and Accommodation Expense

(a) For Travelling and Accommodation Expenses, a **Member** may claim a **Benefit** of 100% of the cost calculated in accordance with **Rule J6 39(d)** and **(e),** up to the overall limit of $500 per membership in a **Calendar Year**.

(b) If a **Member**

i. requires essential medical or dental treatment for which a **Benefit** would be payable under either hospital or extras cover held by the **Membe**r; and

ii. that treatment is not available at a facility within a 160km round trip from where the **Member** lives, then the **Member** is entitled to claim a **Benefit** of 100% of the cost of travelling to the nearest facility to receive treatment and back to where the **Member** lives (calculated in accordance with **Rule J6 39(d)** and **(e)** and 100% of the costs of accommodation on such travel.

iii. Treatment is not essential medical or dental treatment unless:

(c) the **Member** has been referred for the treatment by a medical practitioner or dentist; and

(d) the **Member** has given CBHS Corporate a medical certificate from the medical practitioner or dentist, which states that the treatment is essential medical treatment.

(e) The amount of **Benefit** payable is calculated by reference to the cost of travelling by:

i. economy class rail; or

ii. economy air; or

iii. economy bus;

when a **Member** chooses to travel by one of these modes of transport.

(f) When a **Member** chooses to travel by private car, then the amount of **Benefit** payable is calculated by reference to the CBHS Corporate policy on costing private car travel, as updated from time to time. A **Member** may obtain the policy on costing private car travel during **Business Hours** from the CBHS Corporate office.

(D) Best Doctors

A person on a policy under this **Product** will be entitled to use the medical information services provided under the brand “Best Doctors” and in accordance with any agreement between Best Doctors Australasia Pty Limited and CBHS Corporate which may exist from time-to-time.

J6 40 HOSPITAL-SUBSTITUTE TREATMENT

See rule E4.2 which sets out the benefits that may be payable towards **Hospital Substitute Treatment**

K CONTRIBUTION RATES

K SCHEDULE CONTRIBUTION RATE

The **CBHS Corporate** fortnightly contribution rates (un-rebated and excluding Lifetime Health Cover Loading) are as follows:

Single Fortnightly Contribution Rates

Single FORTNIGHTLY	NSW & ACT	VIC	QLD	SA	WA	TAS	NT
Gold Hospital	106.02	113.72	113.14	100.14	93.28	110.04	83.14
Gold Hospital $250 Excess	96.62	104.18	103.90	92.14	84.90	100.24	76.72
Gold Hospital $500 Excess	88.94	96.36	96.34	85.60	78.04	92.24	71.46
Silver Hospital	98.48	108.90	106.96	94.06	82.40	97.26	76.86
Silver Hospital $250 Excess	89.86	99.62	97.36	87.16	76.50	90.48	70.94
Silver Hospital $500 Excess	82.80	92.02	89.52	81.50	71.68	84.94	66.10
Bronze Hospital $250 Excess	59.46	72.66	68.28	56.68	51.22	61.22	42.12
Bronze Hospital $500 Excess	54.80	67.12	62.78	53.00	48.00	57.46	39.24
Base Hospital $500 Excess	45.62	50.36	50.68	48.46	43.84	52.08	39.00
Gold Visitors $0 Excess	96.92	96.92	96.92	96.92	96.92	96.92	96.92
Gold Visitors $500 Excess	85.38	85.38	85.38	85.38	85.38	85.38	85.38
Silver Visitors $500 Excess	44.30	44.30	44.30	44.30	44.30	44.30	44.30
Bronze Visitors $500 Excess	29.24	29.24	29.24	29.24	29.24	29.24	29.24
Reciprocal Health Cover	39.36	39.36	39.36	39.36	39.36	39.36	39.36
Gold Extras	49.18	47.52	47.62	54.80	43.22	37.08	36.44
Silver Extras	29.08	28.92	25.72	27.22	26.98	24.78	27.24
Bronze Extras	15.74	15.64	15.74	16.40	15.18	14.70	15.50
Platinum Package	177.38	185.98	184.90	171.46	164.28	174.98	157.52
Ambulance Cover^	2.44	2.44	2.44	2.44	2.44	2.44	2.44

^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.

Couple Fortnightly Contribution Rates

Couple FORTNIGHTLY	NSW & ACT	VIC	QLD	SA	WA	TAS	NT
Gold Hospital	212.04	227.44	226.28	200.28	186.56	220.08	166.28
Gold Hospital $250 Excess	193.24	208.36	207.80	184.28	169.80	200.48	153.44
Gold Hospital $500 Excess	177.88	192.72	192.68	171.20	156.08	184.48	142.92
Silver Hospital	196.96	217.80	213.92	188.12	164.80	194.52	153.72
Silver Hospital $250 Excess	179.72	199.24	194.72	174.32	153.00	180.96	141.88
Silver Hospital $500 Excess	165.60	184.04	179.04	163.00	143.36	169.88	132.20
Bronze Hospital $250 Excess	118.92	145.32	136.56	113.36	102.44	122.44	84.24
Bronze Hospital $500 Excess	109.60	134.24	125.56	106.00	96.00	114.92	78.48
Base Hospital $500 Excess	91.24	100.72	101.36	96.92	87.68	104.16	78.00
Gold Visitors $0 Excess	238.46	238.46	238.46	238.46	238.46	238.46	238.46
Gold Visitors $500 Excess	203.66	203.66	203.66	203.66	203.66	203.66	203.66
Silver Visitors $500 Excess	176.92	176.92	176.92	176.92	176.92	176.92	176.92
Bronze Visitors $500 Excess	80.76	80.76	80.76	80.76	80.76	80.76	80.76
Reciprocal Health Cover	78.72	78.72	78.72	78.72	78.72	78.72	78.72
Gold Extras	98.36	95.04	95.24	109.60	86.44	74.16	72.88
Silver Extras	58.16	57.84	51.44	54.44	53.96	49.56	54.48
Bronze Extras	31.48	31.28	31.48	32.80	30.36	29.40	31.00
Platinum Package	354.76	371.96	369.78	342.92	328.54	349.94	315.06
Ambulance Cover^	4.88	4.88	4.88	4.88	4.88	4.88	4.88

^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.

Family Fortnightly Contribution Rates

Family FORTNIGHTLY	NSW & ACT	VIC	QLD	SA	WA	TAS	NT
Gold Hospital	212.04	227.44	226.28	200.28	186.56	220.08	166.28
Gold Hospital $500 Excess	177.88	192.72	192.68	171.20	156.08	184.48	142.92
Gold Hospital $250 Excess	193.24	208.36	207.80	184.28	169.80	200.48	153.44
Silver Hospital	196.96	217.80	213.92	188.12	164.80	194.52	153.72
Silver Hospital $250 Excess	179.72	199.24	194.72	174.32	153.00	180.96	141.88
Silver Hospital $500 Excess	165.60	184.04	179.04	163.00	143.36	169.88	132.20
Bronze Hospital $250 Excess	118.92	145.32	136.56	113.36	102.44	122.44	84.24
Bronze Hospital $500 Excess	109.60	134.24	125.56	106.00	96.00	114.92	78.48
Base Hospital $500 Excess	91.24	100.72	101.36	96.92	87.68	104.16	78.00
Gold Visitors $0 Excess	261.54	261.54	261.54	261.54	261.54	261.54	261.54
Gold Visitors $500 Excess	234.62	234.62	234.62	234.62	234.62	234.62	234.62
Silver Visitors $500 Excess	201.16	201.16	201.16	201.16	201.16	201.16	201.16
Bronze Visitors $500 Excess	111.54	111.54	111.54	111.54	111.54	111.54	111.54
Reciprocal Health Cover	78.72	78.72	78.72	78.72	78.72	78.72	78.72
Gold Extras	98.36	95.04	95.24	109.60	86.44	74.16	72.88
Silver Extras	58.16	57.84	51.44	54.44	53.96	49.56	54.48
Bronze Extras	31.48	31.28	31.48	32.80	30.36	29.40	31.00
Platinum Package	354.76	371.96	369.78	342.92	328.54	349.94	315.06
Ambulance Cover^	4.88	4.88	4.88	4.88	4.88	4.88	4.88

Sole Parent Fortnightly Contribution Rates

Sole Parent FORTNIGHTLY	NSW & ACT	VIC	QLD	SA	WA	TAS	NT
Gold Hospital	185.54	199.02	198.00	175.24	163.24	192.58	145.50
Gold Hospital $250 Excess	169.08	182.32	181.82	161.24	148.58	175.42	134.26
Gold Hospital $500 Excess	155.64	168.64	168.60	149.80	136.58	161.42	125.06
Silver Hospital	172.34	190.58	187.18	164.60	144.20	170.20	134.50
Silver Hospital $250 Excess	157.26	174.34	170.38	152.54	133.88	158.34	124.14
Silver Hospital $500 Excess	144.90	161.04	156.66	142.62	125.44	148.64	115.68
Bronze Hospital $250 Excess	104.06	127.16	119.50	99.20	89.64	107.14	73.72
Bronze Hospital $500 Excess	95.90	117.46	109.86	92.76	84.00	100.56	68.68
Base Hospital $500 Excess	79.84	88.14	88.70	84.80	76.72	91.14	68.26
Gold Visitors $0 Excess	261.54	261.54	261.54	261.54	261.54	261.54	261.54
Gold Visitors $500 Excess	234.62	234.62	234.62	234.62	234.62	234.62	234.62
Silver Visitors $500 Excess	201.16	201.16	201.16	201.16	201.16	201.16	201.16
Bronze Visitors $500 Excess	111.54	111.54	111.54	111.54	111.54	111.54	111.54
Reciprocal Health Cover	78.72	78.72	78.72	78.72	78.72	78.72	78.72
Gold Extras	86.06	83.16	83.34	95.90	75.64	64.90	63.78
Silver Extras	50.90	50.62	45.02	47.64	47.22	43.36	47.68
Bronze Extras	27.54	27.38	27.54	28.70	26.56	25.72	27.12
Platinum Package	324.62	340.34	338.34	313.76	300.62	320.20	288.28
Ambulance Cover^	4.28	4.28	4.28	4.28	4.28	4.28	4.28

^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.

Family Non-Student Dependant (NSD) Fortnightly Contribution Rates

Family NSD FORTNIGHTLY	NSW & ACT	VIC	QLD	SA	WA	TAS	NT
Gold Hospital $0 Excess (with NSD)	265.04	284.32	282.84	250.36	233.20	275.12	207.84
Gold Hospital $250 Excess (with NSD)	241.56	260.46	259.76	230.36	212.26	250.60	191.80
Gold Hospital $500 Excess (with NSD)	222.36	240.92	240.84	214.00	195.12	230.60	178.64
Silver Hospital $0 Excess (with NSD)	246.20	272.24	267.40	235.16	206.00	243.16	192.16
Silver Hospital $250 Excess (with NSD)	224.66	249.06	243.40	217.90	191.26	226.20	177.36
Silver Hospital $500 Excess (with NSD)	207.00	230.04	223.80	203.76	179.20	212.36	165.24
Bronze Hospital $250 Excess (with NSD)	148.66	181.66	170.70	141.70	128.06	153.06	105.30
Bronze Hospital $500 Excess (with NSD)	137.00	167.80	156.96	132.52	120.00	143.64	98.12
Base Hospital $500 Excess (with NSD)	114.04	125.92	126.72	121.16	109.60	130.20	97.52
Gold Extras (with NSD)	127.88	123.56	123.80	142.48	112.36	96.40	94.76
Silver Extras (with NSD)	75.60	75.20	66.88	70.76	70.16	64.44	70.84
Bronze Extras (with NSD)	40.92	40.68	40.92	42.64	39.48	38.24	40.32
Platinum Package (with NSD)	449.38	471.16	468.38	434.38	416.16	443.26	399.10
Ambulance Cover (with NSD) ^	6.36	6.36	6.36	6.36	6.36	6.36	6.36

Sole Parent Non-Student Dependant (NSD) Fortnightly Contribution Rates

Sole Parent NSD FORTNIGHTLY	NSW & ACT	VIC	QLD	SA	WA	TAS	NT
Gold Hospital $0 Excess (with NSD)	231.92	248.78	247.48	219.06	204.06	240.74	181.86
Gold Hospital $250 Excess (with NSD)	211.36	227.90	227.28	201.56	185.72	219.28	167.82
Gold Hospital $500 Excess (with NSD)	194.56	210.80	210.74	187.26	170.74	201.78	156.32
Silver Hospital $0 Excess (with NSD)	215.42	238.22	233.98	205.76	180.26	212.76	168.14
Silver Hospital $250 Excess (with NSD)	196.58	217.92	212.98	190.68	167.36	197.92	155.18
Silver Hospital $500 Excess (with NSD)	181.12	201.28	195.82	178.30	156.80	185.82	144.58
Bronze Hospital $250 Excess (with NSD)	130.08	158.96	149.38	124.00	112.06	133.92	92.16
Bronze Hospital $500 Excess (with NSD)	119.88	146.82	137.34	115.96	105.00	125.68	85.86
Base Hospital $500 Excess (with NSD)	99.78	110.18	110.88	106.02	95.90	113.92	85.34
Gold Extras (with NSD)	111.90	108.12	108.32	124.68	98.32	84.36	82.92
Silver Extras (with NSD)	66.16	65.80	58.52	61.92	61.40	56.38	61.98
Bronze Extras (with NSD)	35.80	35.60	35.80	37.32	34.54	33.46	35.28
Platinum Package (with NSD)	411.20	431.10	428.56	397.44	380.80	405.60	365.16
Ambulance Cover (with NSD) ^	5.56	5.56	5.56	5.56	5.56	5.56	5.56

^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.

L OVERSEAS VISITORS HEALTH COVER

L1 OVERVIEW OF PRODUCTS

L1.1 (A) ELIGIBILITY

1.1.1 These products are open to an eligible **Overseas Visitor**, their **Partner** and/or **Dependant** who:

- Holds or applies for an eligible temporary resident visa sub class to enter Australia; and
- Is in reasonable health at the time of the application; and
- Is not concurrently covered by an equivalent or corresponding policy with another insurer;

are eligible to become a CBHS Corporate insured person.

1.1.2 Subject to these **Rules**, and the policy held by the person remaining up to date with premium payments, CBHS Corporate will supply the selected **Product** for the intended duration of the visa being applied for or held.

1.1.3 An **OVHC Policy Holder** who also holds a complying health insurance policy is not entitled to a benefit for a claim on both **Product**. Where a service is covered by an **OVHC Policy** and a complying health insurance policy, the **Benefit** is only claimable on one **Product**.

L1.1 (B) GENERAL CONDITIONS

Dependants

(a) CBHS Corporate may elect not to make a **Product** available to a category of insured that includes **Dependant** children.

(b) An application is required to add a **Dependant** to a policy. The following provisions apply when adding a **Dependant**:

   (i) Where a policy is a **Single Membership**, an upgrade to a **Sole Parent Membership** is required to add the **Dependant**, and pay any premium adjustment;

   (ii) Where a policy is a **Couple Membership**, an upgrade to a **Family Membership** is required to add the **Dependant**, and pay any premium adjustment;

   (iii) Where a policy is a **Family Membership**, a **Dependant** can be added, subject to paying any premium adjustment.

Commencement of Policy

(a) Subject to acceptance of an application for OVHC by CBHS Corporate, an **OVHC Policy** commences:
  (i) On the date that CBHS Corporate confirms that the policy has been accepted; and
  (ii) When the visa start date has passed; and
  (iii) When the policy is up to date with premium payments.

(b) A minimum payment for the **OVHC Policy** is required at the time of application.
(c) OVHC policies must not be paid more than 12 months in advance.
(d) The effective date of an **OVHC Policy** may be adjusted to align with:
- The date the **OVHC Policy Holder** arrives in Australia, where the visa was applied for outside of Australia; or
- The visa start date, where the visa was applied for and approved in Australia; or
- The following day after transferring from cover provided by another health insurance provider.

(e) If an application we have accepted for an **OVHC Policy** is withdrawn or cancelled prior to arrival in Australia or within 30 days of the start date of the policy if the applicant is in Australia, CBHS Corporate may apply an administration fee equal to one calendar month's premium contribution.
(f) CBHS Corporate may define an administration fee from time to time.
(g) The **OVHC Policy** continues until the visa duration expires and while the policy remains up to date with premium payments unless we are otherwise notified. The **OVHC Policy Holder** must notify CBHS Corporate if the visa class changes or expires.
(h) Where a **OVHC Policy Holder** is officially advised that their permanent Australian residency or full Medicare entitlements has been granted, they are no longer eligible to hold an **OVHC Policy** and must:
  - Inform CBHS Corporate that Medicare entitlement has been granted;
  - Cancel their **OVHC Policy**.

L1.2 LIST OF PRODUCTS

CBHS Corporate offers the following levels of cover:

1. Gold Visitors $0 Excess
2. Gold Visitors $500 Excess
3. Silver Visitors $500 Excess
4. Bronze Visitors $500 Excess

L1.3 HOSPITAL AND MEDICAL BENEFITS

(a) Medical Services Payments - Admitted Patient

Where the **Benefit** is to be calculated, the **Benefit** payable shall be the lower of:

(i) The fee of the medical practitioner (or other service provider registered with Medicare); or

(ii) 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.

(b) Medical Services Payments - Not Related to a Hospital Admission

A **Benefit** shall be provided for fees that are charged by a medical practitioner (or other service provider registered with Medicare) for services that are not part of an **Admitted Patient** episode (except psychiatric and psychology services). The **Benefit** shall only be payable where the service provided would have been covered by Medicare had it been provided to the holder of a valid Medicare Card. The **Benefit** shall be the lower of:

(i) The fee of the medical practitioner (or other service provider registered with Medicare); or

(ii) 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.

(c) Accommodation at Public Hospitals

The **Benefit** payable with respect to accommodation at a **Public Hospital** shall be the rate charged by the **Public Hospital** for the episode for patients who do not hold a valid Medicare card. The **Benefit** shall include accommodation charges and other charges raised by the **Hospital** in connection to the admission. Where, however, the service was such that it would have only been entitled to restricted benefits then the **Benefit** payable shall be the **Minimum Default Benefits**.

(d) Accommodation at Non-Contracted Private Hospitals

The **Benefit** payable with respect to accommodation at a non-contracted **Private Hospital** shall be restricted to the **Minimum Default Benefits**.

(e) Cooling off period not applicable

These products are not complying health insurance products. Consequently the 30-day cooling off period referred to in **Rule C8 (f)** is not applicable.

L1.4 WAITING PERIODS

In accordance with **Rule F3**, the following waiting periods apply to **Overseas Visitor** products:

Waiting periods	Calendar months
Pre-existing Condition, pregnancy related services	12 months
All other treatments (including **Pre-existing Condition** relating to psychiatric, rehabilitation and palliative care)	2 months
Accidents, emergency ambulance transport	1 day

L1.5 GENERAL EXCLUSIONS

In addition to Rule **E1.1** benefits are not payable for:

- Treatment (or goods) provided in countries outside of Australia
- Treatment arranged in advance to arrival in Australia
- Services and treatments which are covered by compensation and damage provisions of any kind
- Same treatment or service claimed under more than one **Product**

L2 PRODUCT SPECIFICATION – GOLD VISITORS

L2.1 PRODUCT NAME

1. Gold Visitors $0 Excess
2. Gold Visitors $500 Excess

L2.2 HOSPITAL TREATMENTS AND MEDICAL BENEFITS

Covered Item	Description	Benefits, Exclusions and Restricted Benefits
HOSPITAL BENEFITS		
Accommodation	For overnight, same day and intensive care for private or shared room in agreement **Private Hospital** and **Public Hospital**. If an excess option has been selected, the excess will apply (does not apply to **Dependants**).	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Operating theatre, labour ward and critical care fees	Operating theatre, labour ward, and intensive care fees covered in agreement **Private Hospitals**.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Emergency department facility fees	Fees charged by a **Private Hospital** or **Public Hospital** emergency department for attending the facility.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
In-patient supplied pharmaceuticals	Medicines listed on the PBS Schedule and provided as part of an **Admitted Patient** treatment.	Covered in full except for services where an **Exclusion** applies and as otherwise stated below: Note: Other medicines (including experimental or high cost drugs) may not be covered.

		Cost of pharmaceuticals supplied upon discharge from hospital will not be covered under **Admitted Patient** supplied pharmaceutical. Discharge medication may be covered under **Non-Admitted Patient** prescription medicine **Benefits**.
Surgically implanted prostheses	At least the minimum **Benefits** specified in the prostheses list under Private Health Insurance legislation.	Covered up to the relevant amount on the prostheses list except for services where an **Exclusion** applies
ADMITTED PATIENT MEDICAL BENEFITS		
Admitted Patient Medical Expenses	Services provided by doctors, surgeons or anesthetists in hospital.	(a) If: (i) a **Member** receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) who: (A) has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or (B) has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and (ii) the agreement deals with the kind of service rendered to the **Member**, then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service.

		(b) If: (i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule (a)**; and (ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**; then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service. (c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** is 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.
NON-ADMITTED PATIENT MEDICAL BENEFITS		

Medical services in private clinics and by providers	Treatment provided by doctors and specialists in private clinics, including services provided by: doctors, medical specialists, medical imaging providers and pathology providers.	Up to 100% of **Medicare Benefits Schedule Fee**, except for services where **Exclusion** applies.
Hospital Non-Admitted Patient medical treatment	Treatment provided at a **Public Hospital Non-Admitted Patient** clinic, including Accident and Emergency, when the insured is not an admitted patient.	Up to 100% of **Medicare Benefits Schedule Fee**, except for services where **Exclusion** applies.
Pharmaceuticals and medicines	Selected pharmacy items prescribed by a doctor or specialist which are **Pharmaceuticals** approved for the condition for which the item is being prescribed.	Selected pharmacy items including discharge medications. 100% benefit up to $75 per script. Maximum overall limit of $600 per person per calendar year.
AMBULANCE COVER		
Ambulance cover	Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as Royal Flying Doctor Service). Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.	Full cover for **Emergency Ambulance**. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.

L2.3 EXCESS

- Gold Visitors $0 Excess: No excess payable

- Gold Visitors $500 Excess: $500 excess payable.

  The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member**
  (with exception of **Dependants)** covered up to a maximum of:
  i. For **Single Membership** - $500 per **Calendar Year**
  ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year**

L2.4 RESTRICTED BENEFITS

None applicable on this product.

L2.5 EXCLUSIONS

The following have **Exclusions** on this level of cover:

a) **Non-Admitted Patient** psychiatric and psychology services
b) Assisted reproductive services (e.g. IVF and GIFT)
c) **Cosmetic services**
d) **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery).

L2.6 OTHER SPECIAL HOSPITAL TREATMENT

If not otherwise covered by a **Hospital Purchaser-Provider Agreement**, then

(i) the **Benefit** payable in respect of **Boarder Fees** is 100% of the cost up to a total of $160 per admission of the **Member** admitted; and
(ii) the **Benefit** payable in respect of **Facility Fees** is 70% of the cost up to a total of $160.

L2.7 REPATRIATION

The **Benefit** is for one one-way repatriation, per membership per **Calendar Year**, up to a maximum of $10,000 if the **Member** becomes **Terminally Ill** or suffers a life altering injury, including the return of mortal remains.

CBHS Corporate reserves to refer applications to a **Medical Advisor** and payment of the benefit shall be on a case-by-case basis and at the absolute discretion of CBHS Corporate.

L3 PRODUCT SPECIFICATION – SILVER VISITORS

L3.1 PRODUCT NAME

1. Silver Visitors $500 Excess

L3.2 HOSPITAL TREATMENTS AND MEDICAL BENEFITS

Covered Item	Description	Benefits, Exclusions and Restricted Benefits
HOSPITAL BENEFITS		
Accommodation	For overnight, same day and intensive care for private or shared room in agreement **Private Hospital** and **Public Hospital**. The excess will apply.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Operating theatre, labour ward and critical care fees	Operating theatre, labour ward, and intensive care fees covered in agreement **Private Hospitals**.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Emergency department facility fees	Fees charged by a **Private Hospital** or **Public Hospital** emergency department for attending the facility.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Admitted Patient supplied pharmaceuticals	Medicines listed on the PBS Schedule and provided as part of an **Admitted Patient** treatment.	Covered in full except for services where an **Exclusion** applies and as otherwise stated below: Note: Other medicines (including experimental or high cost drugs) may not be covered. **Cost of pharmaceuticals supplied upon discharge** from hospital will not be covered under **Admitted**

<table>
<tr><td></td><td></td><td>Patient supplied pharmaceutical. Discharge medication may be covered under Non-Admitted Patient prescription medicine Benefits.</td></tr>
<tr><td>Surgically implanted prostheses</td><td>At least the minimum Benefits specified in the prostheses list under Private Health Insurance legislation.</td><td>Covered up to the relevant amount on the prostheses list except for services where an Exclusion applies</td></tr>
<tr><td colspan="3">ADMITTED PATIENT MEDICAL BENEFITS</td></tr>
<tr><td>Admitted Patient Medical Expenses</td><td>Services provided by doctors, surgeons or anesthetists in hospital.</td><td>(a) If:

(i) a Member receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) who:

(A) has a medical Purchaser-Provider Agreement with CBHS Corporate; or

(B) has a practitioner agreement with the Hospital where the Member received the service, and the practitioner agreement has been incorporated into a Hospital Purchaser-Provider Agreement between the Hospital and CBHS Corporate; and

(ii) the agreement deals with the kind of service rendered to the Member,

then the Benefit is the amount specified in the relevant medical Purchaser-Provider Agreement or practitioner agreement for that service.

(b) If:

(i) a Member receives an Admitted Patient service from a medical practitioner (or service from any other</td></tr>
</table>

		service provider registered with Medicare) which is not subject to **Rule (a)**; and (ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the rendering of that service to that **Member**; then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service. (c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** is 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.
NON-ADMITTED PATIENT MEDICAL BENEFITS		
Medical services in private clinics and by providers	Treatment provided by doctors and specialists in private clinics, including services provided by: doctors, medical specialists, medical imaging providers and pathology providers.	Up to 100% of MBS fee, except for services where **Exclusion** applies.

Hospital Non-Admitted Patient medical treatment	Treatment provided at a **Public Hospital Non-Admitted Patient** clinic, including Accident and Emergency, when the insured is not an admitted patient.	Up to 100% of MBS fee, except for services where **Exclusion** applies.
Pharmaceuticals and medicines	Selected pharmacy items prescribed by a doctor or specialist which are **Pharmaceuticals** approved for the condition for which the item is being prescribed.	Selected pharmacy items including discharge medications. 100% benefit up to $75 per script. Maximum overall limit of $300 per person per calendar year.
AMBULANCE COVER		
Ambulance cover	Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as Royal Flying Doctor Service). Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.	Full cover for **Emergency Ambulance**. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.

L3.3 EXCESS

- Silver Visitors $500 Excess: $500 excess payable.

The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

i. For **Single Membership** - $500 per **Calendar Year**

ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year**

L3.4 RESTRICTED BENEFITS

If a **Member** is admitted to a **Hospital** for any of the services listed below, then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Default Benefits**.

a) Pregnancy related services
b) Rehabilitation
c) Psychiatric
d) Palliative care
e) Bariatric services – all including revision and reversal procedures (e.g. gastric banding, sleeve gastrectomy, gastric by-pass)

L3.5 EXCLUSIONS

The following have **Exclusions** on this level of cover:

a) **Non-Admitted Patient** psychiatric and psychology services
b) Stem cells, bone marrow transplants
c) Organ transplants
d) Assisted reproductive services (e.g. IVF and GIFT)
e) **Cosmetic services**
f) **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery).

L3.6 OTHER SPECIAL HOSPITAL TREATMENT

If not otherwise covered by a **Hospital Purchaser-Provider Agreement**, then

(i) the **Benefit** payable in respect of **Boarder Fees** is 100% of the cost up to a total of $160 per admission of the **Member** admitted; and
(ii) the **Benefit** payable in respect of **Facility Fees** is 70% of the cost up to a total of $160.

L3.7 REPATRIATION

The **Benefit** is for one one-way repatriation, per membership per **Calendar Year**, up to a maximum of $10,000 if the **Member** becomes **Terminally Ill** or suffers a life altering injury, including the return of mortal remains.

CBHS Corporate reserves to refer applications to a **Medical Advisor** and payment of the benefit shall be on a case-by-case basis and at the absolute discretion of CBHS Corporate.

L4 PRODUCT SPECIFICATION – BRONZE VISITORS

L4.1 PRODUCT NAME

1. Bronze Visitors $500 Excess

L4.2 HOSPITAL TREATMENTS AND MEDICAL BENEFITS

Covered Item	Description	Benefits, Exclusions and Restricted Benefits
HOSPITAL BENEFITS		
Accommodation	For overnight, same day and intensive care for private or shared room in agreement **Private Hospital** and **Public Hospital**. The excess will apply.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Operating theatre, labour ward and critical care fees	Operating theatre, labour ward, and intensive care fees covered in agreement **Private Hospitals**.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Emergency department facility fees	Fees charged by a **Private Hospital** or **Public Hospital** emergency department for attending the facility.	Covered in full, except for services where restricted benefits or **Exclusion** applies.
Admitted Patient supplied pharmaceuticals	Medicines listed on the PBS Schedule and provided as part of an **Admitted Patient** treatment.	Covered in full except for services where an **Exclusion** applies and as otherwise stated below: Note: Other medicines (including experimental or high cost drugs) may not be covered.
Surgically implanted prostheses	At least the minimum **Benefits** specified in the prostheses list under Private Health Insurance legislation.	Covered up to the relevant amount on the prostheses list except for services where an **Exclusion** applies

ADMITTED PATIENT MEDICAL BENEFITS		
Admitted Patient Medical Expenses	Services provided by doctors, surgeons or anesthetists in hospital.	(a) If: (i) a **Member** receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) who: (A) has a medical **Purchaser-Provider Agreement** with CBHS Corporate; or (B) has a practitioner agreement with the **Hospital** where the **Member** received the service, and the practitioner agreement has been incorporated into a **Hospital Purchaser-Provider Agreement** between the **Hospital** and CBHS Corporate; and (ii) the agreement deals with the kind of service rendered to the **Member**, then the **Benefit** is the amount specified in the relevant medical **Purchaser-Provider Agreement** or practitioner agreement for that service. (b) If: (i) a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to **Rule (a)**; and (ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the **Access Gap Cover Scheme** in relation to the

		rendering of that service to that **Member**; then the amount of **Benefit** payable is the amount agreed between CBHS Corporate and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service. (c) In any other case, if a **Member** receives an **Admitted Patient** service from a medical practitioner (or service from any other service provider registered with Medicare), then the **Benefit** is 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.
NON-ADMITTED PATIENT MEDICAL BENEFITS		
No benefits payable for non-admitted patient.		
AMBULANCE COVER		
Ambulance cover	Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as Royal Flying Doctor Service). Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.	Full cover for **Emergency Ambulance**. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per calendar year.

L4.3 EXCESS

- Bronze Visitors $500 Excess: $500 excess payable.

  The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:

  iii. For **Single Membership** - $500 per **Calendar Year**

  iv. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1000 per **Calendar Year**

L4.4 RESTRICTED BENEFITS

If a **Member** is admitted to a **Hospital** for any of the services listed below, then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Default Benefits**.

a) Pregnancy related services
b) Rehabilitation
c) Psychiatric
d) Palliative care
e) Bariatric services – all including revision and reversal procedures (e.g. gastric banding, sleeve gastrectomy, gastric by-pass)

L4.5 EXCLUSIONS

The following have **Exclusions** on this level of cover:

a) **Non-Admitted Patient** psychiatric and psychology services
b) Stem cells, bone marrow transplants
c) Organ transplants
d) Assisted reproductive services (e.g. IVF and GIFT)
e) **Cosmetic services**
f) **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery).

L4.6 OTHER SPECIAL HOSPITAL TREATMENT

If not otherwise covered by a **Hospital Purchaser-Provider Agreement**, then

(i) the **Benefit** payable in respect of **Boarder Fees** is 100% of the cost up to a total of $160 per admission of the **Member** admitted; and
(ii) the **Benefit** payable in respect of **Facility Fees** is 70% of the cost up to a total of $160.

L4.7 REPATRIATION

The **Benefit** is for one one-way repatriation, per membership per **Calendar Year**, up to a maximum of $10,000 if the **Member** becomes **Terminally Ill** or suffers a life altering injury, including the return of mortal remains.

CBHS Corporate reserves to refer applications to a **Medical Advisor** and payment of the benefit shall be on a case-by-case basis and at the absolute discretion of CBHS Corporate.