CBHS Health Fund Limited

Health Benefit Fund Rules

1 August 2019
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A 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;

A2 HEALTH BENEFITS FUND

(a) These Rules govern the operation of the Fund, including the obligations and entitlements of Members, and the obligations and entitlements of CBHS in operating the Fund.
(b) The Fund is established to enable CBHS to conduct health insurance business and health-related businesses.

A3 OBLIGATIONS TO INSURER

A3.1 Provision of information
(a) If CBHS 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 in forms such as the application form.
(c) A Policy Holder shall inform CBHS 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 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 that the claim has been made.
(c) The Member shall advise CBHS of any determination or settlement of the claim within a reasonable period of the determination or settlement.
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.
(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 not to engage in Improper Discrimination

CBHS 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.

A6.2 CBHS is restricted access insurer

Nothing in Rule A6.1 prevents CBHS as a restricted access insurer from limiting access to its products to persons to whom CBHS’ Constitution and the Act prohibits CBHS from making its products available.

**A7 CHANGES TO RULES**

A7.1 General Changes to Rules
(a) CBHS may, subject to its Constitution and the Act, change these Rules at any time.
(b) CBHS 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 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 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 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.
If CBHS waives the application of particular Rules on one occasion, this does not bind CBHS to waive those Rules on any other occasion.

**A8 DISPUTE RESOLUTION**

(a) CBHS 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.cbhs.com.au or by calling Member Care on 1300 654 123, or email help@cbhs.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 shall direct its correspondence with Members to the most recently advised postal address, fax number, mobile number or e-mail address for the Policy Holders in relation to the membership.

(b) Where the Rules require CBHS to notify a Member, or give the Member a notice, CBHS 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 or alternatively at www.cbhs.com.au

(b) CBHS 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.

**A11 OTHER**

**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 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 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 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 has affected 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 and a Recognised Provider have entered into an agreement whereby CBHS 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.
“Age-based Discount” means a discount on Hospital Cover contributions for an Age-based Discount Policy.

“Age-based Discount Policy” means a hospital insurance policy that offers an Age-based Discount to a Member who is between 18 and 29 years of age.

“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 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 as essential to the management and treatment of a Member’s diabetes related conditions.

“Board” means the Board of Directors of CBHS.

“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 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 has entered into an agreement for selected preventative dental and optical 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.

“Commonwealth Bank Group” means –

(a) the Commonwealth Bank of Australia;
(b) current subsidiaries (within the meaning of the Act) of the Commonwealth Bank of Australia;
(c) each former subsidiary (within the meaning of the Act) of the Commonwealth Bank of Australia; and
(d) Gateway Bank Ltd.

“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 Health Fund Limited.

“Contractor” for the purposes of the Restricted Access Group means a company within the meaning of the Corporations Act 2001 (Cth) that is, or was, supplying goods and services under a written contract with the Commonwealth Bank Group.

“Co-payment” means an amount to be paid by the Member each time a service is provided. For example, a Member may agree to pay a Co-payment for each day’s hospital accommodation.

“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 persons being a Policy Holder and their Partner.

“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 or Non-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, 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 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.

“Employee” for the purposes of the Restricted Access Group means an employee as defined by the Australian Taxation Office - Taxation Ruling TR 2005/16.

“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 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.

“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.

“Gap Assist Benefit” means a benefit which Members can claim for out-of-pocket medical expenses which may be incurred as a result of hospitalization prescribed in Rule J6, J7 and J11.
“Gym Membership” means gym membership approved by CBHS 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 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 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; or

i. a Health Management Program.

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

“Lifetime” means the period commencing on the date the Member was first insured and ceases to be insured by CBHS (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 will pay in respect of a claim for a particular type of service (as specified in the benefits tables maintained by CBHS in its database).

“Massage Therapy” means a service or treatment provided by a Recognised Provider in
deep tissue massage, lymphatic drainage, myotherapy, remedial massage, sports massage, Swedish massage and therapeutic massage.

“Medical Adviser” means a qualified medical practitioner appointed by CBHS 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.

“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 (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 Fund” means the health benefits fund of a private health insurer, other than CBHS.

“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 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.

“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 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.

“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 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.

“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 from time to time and received as part of a Physiotherapy Service.

“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 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 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 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 and any other provider.

“Retained Age-based Discount” means an Age-based Discount that CBHS will retain for a Member who transfers into a Retained Age-based Discount Policy of CBHS, either from a Non-CBHS Fund or from another Retained Age-based Discount Policy of CBHS.

“Retained Age-based Discount Policy” means an Age-based Discount Policy that states the policy is a Retained Age-based Discount Policy.

“Recognised Provider” means a provider recognised by CBHS in a particular discipline or calling as a provider of services to a Member for which CBHS 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 Members (the Policy Holder) being Dependents 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, 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 or a first or second year apprentice; and
iii. is under the age of twenty-five years.

“Transfer Certificate” means a certificate issued under s 99-1 of the Act.

“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 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 of a Policy commences to the date that either certain services or items provided to the Member may attract Benefits.
C1 GENERAL CONDITIONS OF MEMBERSHIP

CBHS 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 Family (only available on selected products)
6) Non-Student Dependant Sole Parent (only available on selected products)

CBHS offers the following levels of cover:

1) Comprehensive Hospital (Gold)
2) Active Hospital (Silver Plus)
3) Limited Hospital (Bronze Plus)
4) Basic Plus Hospital
5) KickStart (Basic Plus) (including Extras Benefits cover)
6) StepUp (Bronze Plus) (including Extras Benefits cover)
7) Prestige (Gold) (including Extras Benefits cover)
8) Top Extras (with or without Emergency Ambulance cover)
9) Intermediate Extras (with or without Emergency Ambulance cover)
10) Essential Extras (with or without Emergency Ambulance cover)
11) Emergency Ambulance
12) Hospital ‘a’ Excess (Gold) (closed to new members and transfers)
13) Hospital ‘b’ Excess (Bronze Plus) (closed to new members and transfers)
14) LiveLife (Gold) (closed to new members and transfers)
15) FlexiSaver (Basic Plus) (including Extras Benefits cover)

- All Members in a membership are covered by the same category of 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 CBHS is registered as a restricted access insurer under the Private Health Insurance (Prudential Supervision) Act. Membership of CBHS is restricted to a Restricted Access Group comprising:
(a) a person who is, or was, an employee of the Commonwealth Bank Group; and
(b) a person who, by the operation of the Private Health Insurance (Registration) Rules is taken to belong to the Restricted Access Group.

C2.2 CBHS must not:
(a) issue a complying health insurance product to a person who does not belong to the Restricted Access Group; or
CBHS Health Benefit Fund Rules – as at 1 August 2019

(b) cease to insure a person for the reason that the person has ceased to belong to the Restricted Access Group.

C3 DEPENDANTS

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

(b) If:
   i. the Policy Holder requests CBHS 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 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 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.

(b) CBHS shall refuse to accept an application to become a Policy Holder from a person who is not entitled to apply under Rule C2.1.

(c) CBHS shall refuse to accept an application for a person to become a Member, if the person is not entitled to be the subject of an application under Rule C2.2 (a).

(d) CBHS 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.

(e) CBHS 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.

(f) Before becoming a Policy Holder, CBHS shall give the applicant information detailing the entitlements and benefits under the proposed policy.

(g) After acceptance of an application for membership, CBHS shall give the Policy Holder the following information:
   i. The Private Health Information Statement (PHIS) for the policy;
   ii. The name of the person or persons covered by the policy; and
   iii. For Hospital Cover policies, the Lifetime Health Cover loading information applicable to each adult Policy Holder.

C5 CONDITION OF MEMBERSHIP

(a) If CBHS accepts an application for membership, the membership commences on the day on which CBHS receives the application, unless CBHS 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.
If CBHS cancels a membership under Rule C7, that termination takes effect in accordance with Rule C7.2.

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

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

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

## C6 TRANSFERS

### C6.1 Persons transferring from Non-CBHS Fund – Waiting Periods and Benefit Limits

(a) If a person:
   i. is a member of a Non-CBHS Fund; and
   ii. applies for membership of this Fund within one calendar month of leaving the Non-CBHS Fund; and
   iii. CBHS accepts the application for membership;

then CBHS 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 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 Fund when determining whether Waiting Periods have been served, CBHS will also consider:
   i. the level of benefits payable by the Non-CBHS 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 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 will count the amount of time a person held the level of cover under the policy with the Non-CBHS 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 Fund is lower than the level of Benefits payable and the scope of coverage of this Fund then:
   i. CBHS will count the amount of time a person held the level of cover with the Non-CBHS 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 Fund; and
   ii. CBHS 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 Fund.
   iii. CBHS may apply the full Waiting Period for Extras Benefits in excess of Extras Benefits previously held under the Non-CBHS Fund.
(e) If, in relation to a Pre-existing Condition, the Excess or Co-payment applied under the Non-CBHS Fund in relation to a Benefit was higher than that applicable under this Fund, CBHS 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 Non-CBHS Fund – Excesses, Co-payments and limitations

(a) If:
   (i) a Member has transferred to CBHS from a Non-CBHS Fund; and
   (ii) the policy held under the Non-CBHS 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 shall treat the payment of the Excess or Co-payment as if it had been made to CBHS under the new cover.

(b) If a Member:
   (i) has transferred to CBHS from a Non-CBHS Fund; and
   (ii) the Member has claimed Extras Benefits from the Non-CBHS 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 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 Fund or provide CBHS with permission to obtain a Transfer Certificate from the Non-CBHS Fund on the Member’s behalf.

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

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

(a) If a Member asks CBHS to transfer their membership from one level of cover to another, CBHS 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 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 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 the Calendar Year, Any 3 years, Any 5 years or Lifetime periods.

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

(a) If CBHS 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 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 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 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 may apply in full any Waiting Period required for that Benefit under these Rules.

(e) If:
   i. CBHS 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 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 may not cancel the membership of any Member on the grounds of the health of that Member.

(b) CBHS 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, committed or attempted to commit fraud upon CBHS;
   (ii) CBHS 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 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 cancels a membership under Rule C7.1(b)(ii), CBHS may cancel the membership with effect from the date of commencement of the membership.

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

C7.3 Treatment of excess contributions

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

C8 TERMINATION OF MEMBERSHIP BY MEMBER

(a) A Policy Holder may terminate a membership by:
   i. notice in writing to CBHS; or
   ii. by telephone advice to CBHS.
   If a Policy Holder terminates their membership by telephone advice, CBHS 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 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 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, demonstrates to CBHS that he or she has the authority under Rule C10.2.

(e) CBHS 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 Health Cover) chooses to terminate his or her membership within 30 days of the commencement of the membership, then CBHS 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 upon application by the Policy Holder.

(b) CBHS 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 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 12 months may apply to CBHS to suspend their membership where:
i. Overseas travel suspension: all membership contribution must be up to date.
ii. Financial hardship: the membership is in arrears for an amount of not greater than 2 months contributions.

(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 has previously suspended a membership because of financial hardship, then CBHS 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 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 in writing.

(h) If the Members:
   i. have served any Waiting Periods or accrued any credit against a 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 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 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;
   ii. 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
   iii. the applicable Waiting Period will commence on the end date of the suspension period.

(k) Following commencement of a period of suspension under Rule C9(c), CBHS will refund any Excess Contributions to Member. CBHS will not hold any contributions and any further contributions are payable at the current contribution rate.

C10 OTHER

C10.1 Privacy

CBHS 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 in relation to their policy (including to change any details of or to remove Dependents from the policy) unless a Policy Holder advises CBHS in writing that one or more Policy Holders are not authorised to deal with CBHS in relation to the policy.
(b) CBHS may, at any time, require a Policy Holder to provide evidence to the satisfaction of CBHS that:
   (i) a Policy Holder has the consent of other Policy Holders to deal with CBHS in relation to their policy; or
   (ii) a Policy Holder has legal authority to deal with CBHS 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 arranged by CBHS; or
   ii. by direct debit; or
   iii. by any other arrangement authorised by CBHS 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 arranged by CBHS; or
   ii. by direct debit; or
   iii. by any other arrangement authorised by CBHS 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 Emergency 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.

D1.4 Contributions Paid in Advance
(a) CBHS will not accept payment of contributions more than 12 months in advance. CBHS reserves the right to refund any contributions paid in excess of 12 months.

**D2 CONTRIBUTION RATE CHANGES**

CBHS 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**

(a) The Company may only offer a discount if to do so will comply with section 66-5 of the PHI Act.

(b) If CBHS chooses to offer Age-based Discount, then it will apply as per the table below:

<table>
<thead>
<tr>
<th>Person's age at discount assessment date</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 or older, but under 26</td>
<td>10%</td>
</tr>
<tr>
<td>26</td>
<td>8%</td>
</tr>
<tr>
<td>27</td>
<td>6%</td>
</tr>
<tr>
<td>28</td>
<td>4%</td>
</tr>
<tr>
<td>29</td>
<td>2%</td>
</tr>
</tbody>
</table>

(c) If a Policy Holder is covered under a Retained Age-based Discount Policy, the discount will continue to apply in relation to each person insured under the policy until it is reduced to zero in accordance with the following table:

<table>
<thead>
<tr>
<th>Persons age for period of cover</th>
<th>Percentage discount for that period</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 or older, but under 41</td>
<td>the person's base percentage</td>
</tr>
<tr>
<td>41</td>
<td>the person's base percentage minus 2%</td>
</tr>
<tr>
<td>42</td>
<td>the person's base percentage minus 4%</td>
</tr>
<tr>
<td>43</td>
<td>the person's base percentage minus 6%</td>
</tr>
<tr>
<td>44</td>
<td>the person's base percentage minus 8%</td>
</tr>
<tr>
<td>45 or older</td>
<td>zero</td>
</tr>
</tbody>
</table>

**D4 LIFETIME HEALTH COVER**

CBHS 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.
CBHS 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, and CBHS has accepted them.

CBHS may refuse to accept outstanding contributions for a membership if that membership has lapsed.

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; or

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

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

ix. the service is listed as Exclusion; or

x. the medical service have 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 shall pay the Benefit directly to the provider.
(b) If the Recognised Provider participates in an electronic claims system with CBHS (such as HICAPS or iSoft Healthpoint) then;
   i. a claim may be lodged electronically; and
   ii. CBHS 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.

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 to be excessive;

then, subject to Rule E1.3(a), CBHS 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 pays a Benefit for a Member by mistake, CBHS can recover the amount paid by mistake from that Member within 24 months of making the payment.
(b) CBHS 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 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 may only pay Hospital Benefits in relation to Admitted Patient hospital treatment provided in a Hospital; or
(b) After special consideration by the Board, CBHS may only pay a Hospital Benefit whereby a treatment is provided to the Member outside of Australia to manage a disease, injury or condition:
   i. if the disease, injury or condition is chronic and permanent;
   ii. if the treatment would be required routinely, whether or not the Member had remained in Australia;
   iii. the amount of Benefits payable for the overseas treatment does not exceed the amount of that would be payable by CBHS if the treatment were provided in Australia; and
   iv. the treatment is administered to a Member within 60 days after the Member last departed from Australia.
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 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 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 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 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 does not have a Purchaser-Provider Agreement.

(e) If a Member receives an Admitted Patient service from a private Hospital with which CBHS 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 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 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 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 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 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 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.
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 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 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 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 may require the Member to reimburse CBHS 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 with exception of Schedule J12 FlexiSaver) may be invited to participate in a Chronic Disease Management Program arranged by CBHS with an external party. Participation in such a program will be provided at the discretion of CBHS 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 with exception of Schedule J12 FlexiSaver) may be provided access to Hospital Substitute Treatment arranged by CBHS with an external party. Access to this treatment will be provided at the discretion of CBHS. The Benefit will generally only be available in circumstances where CBHS 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 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

(a) A Policy Holder may, at his or her option, choose to make a Co-payment in accordance with Rule J1 10, J2 10, J3 10, J6 10, J7 10, J8 10, J9 10 or J13 10 in which case a Co-payment as set out in the relevant rule applies to the Benefit payable.

(b) No Co-payment is payable with respect to Schedule J4 Basic Hospital and Schedule J12 FlexiSaver.

F2 EXCESSES

(a) A Policy Holder may, at his or her option, choose to have an Excess in accordance with Rule J2 11, J4 11, J8 11, J9 11 or J12 11 in which case an Excess as set out in that relevant Rule applies to the Benefit payable.

F3 WAITING PERIODS
CBHS Health Benefit Fund Rules – as at 1 August 2019

(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.

(c) CBHS 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, inlays, onlays, facings, veneers, occlusal therapy, dentures and implants.
   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, Medical Emergency and Emergency Ambulance.

(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

Cosmetic services are excluded from all hospital covers. Additional Exclusions apply to:

   i. Limited Hospital (Bronze Plus) as described at Rule J3 14
   ii. Basic Plus Hospital as described at Rule J4 14
   iii. StepUp (Bronze Plus) as described at Rule J6 14
   iv. Hospital b Excess (Bronze Plus) as described at Rule J9 14
   v. FlexiSaver (Basic Plus) as described at Rule J12 14
   vi. Active Hospital (Silver Plus) as described at Rule J13 14.

F5 BENEFIT LIMITATION PERIODS

No benefit limitation periods apply to cover offered by CBHS.

F6 RESTRICTED BENEFITS

Restricted benefits apply to:

   (i) KickStart (Basic Plus), as described at Rule J1 13;
   (ii) Comprehensive Hospital (Gold) as described at Rule J2 13;
   (iii) Limited Hospital (Bronze Plus) as described at Rule J3 13;
   (iv) Basic Plus Hospital as described at Rule J4 13;
   (v) StepUp (Bronze Plus) as described in Rule J6 13;
   (vi) LiveLife (Gold) as described at Rule J7 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 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 (in a form and on terms and conditions acceptable to CBHS 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 and CBHS 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.

F8 OTHER

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;
   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 which CBHS reasonably requires to process the claim for Benefits.

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

(c) CBHS will assess and pay a valid claim for a Benefit within 2 months of a Member making a complete and accurate claim for that Benefit.

G2 OTHER

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

I1 SCHEDULE GENERAL TREATMENT TABLES

I1 1 TABLE NAME OR GROUP OF TABLE NAMES
Top Extras cover.

I1 2 ELIGIBILITY
Any person who is eligible to become a Member is eligible to be insured under Top Extras.

I1 3 GENERAL CONDITIONS
I1 3.1 Emergency Ambulance Cover
If a Policy Holder wishes to obtain Emergency Ambulance cover in addition to Top Extras cover, then the Policy Holder must pay the additional contribution for the Emergency Ambulance cover product.

I1 3.2 Limits per Service
(a) CBHS may impose a Limit per Service on Extras Benefits.
(b) CBHS may change a Limit per Service on Extras Benefits from time to time.
(c) If CBHS 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 website; or
   (ii) during Business Hours from the CBHS office.

I1 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 available 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

<table>
<thead>
<tr>
<th>Preventative Dental Services (2 months waiting period)</th>
<th>Unlimited</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental (2 months waiting period)</td>
<td>Unlimited</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Fillings, consultations &amp; examinations, x-rays and extractions or surgical dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental (6 month waiting period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td>$630</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Endodontics</td>
<td>$660</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Inlays, onlays &amp; facings</td>
<td>$1,440</td>
<td>Any 5 years</td>
</tr>
<tr>
<td></td>
<td>($360 per tooth)</td>
<td></td>
</tr>
<tr>
<td>Dentures and Implants</td>
<td>$1,350</td>
<td>Any 5 years</td>
</tr>
<tr>
<td>Occlusal Therapy</td>
<td>$920</td>
<td>Lifetime</td>
</tr>
<tr>
<td>Dental (12 month waiting period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>$2,800</td>
<td>Lifetime</td>
</tr>
<tr>
<td>Crown and bridges</td>
<td>$3,000</td>
<td>Any 5 years</td>
</tr>
<tr>
<td></td>
<td>($720 per tooth)</td>
<td></td>
</tr>
</tbody>
</table>

(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

(a) 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

(a) 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

(a) 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

(a) 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

(a) 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

(a) 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

Not available on this product.

I1 14 SPEECH THERAPY

(a) 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

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

I1 16 DIETETICS

(a) 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

(a) 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

Not available on this product.

I1 19 ACUPUNCTURE
See Rule I1 12 Alternative Therapies.

I1 20 OTHER THERAPIES

(a) 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

(a) 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.

I1 24 AMBULANCE TRANSPORTATION
Not available on this product.

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.

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial Aids</td>
<td>$1,000</td>
<td>Any 3 years</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>$360</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Orthoptic Therapy Services</td>
<td>$455</td>
<td>Calendar Year</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen and Related Apparatus</td>
<td>$500</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Vitamin Therapy</td>
<td>$250</td>
<td>Calendar year</td>
</tr>
<tr>
<td>Hypnotherapy Service</td>
<td>$360</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Physiology Services</td>
<td>$360</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>$2,800</td>
<td>Calendar Year</td>
</tr>
</tbody>
</table>

(b) 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 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 policy on costing private car travel, as updated from time to time. A **Member** may obtain CBHS’ policy on costing private car travel during **Business Hours** from the CBHS office.
INTERMEDIATE EXTRAS

I2 SCHEDULE GENERAL TREATMENT TABLES

I2 1 TABLE NAME OR GROUP OF TABLE NAMES
Intermediate Extras cover.

I2 2 ELIGIBILITY
Any person who is eligible to become a Member is eligible to be insured under Intermediate Extras.

I2 3 GENERAL CONDITIONS

I2 3.1 Emergency Ambulance
If a Policy Holder wishes to obtain Emergency Ambulance cover in addition to Intermediate 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 may impose a Limit per Service on an Extras Benefit.
(b) CBHS may change a Limit per Service Extras Benefits from time to time.
(c) If CBHS 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 website; or
   ii. during Business Hours from the CBHS 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 available 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.

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

(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

(a) 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
(a) 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

(a) 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

(a) 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

(a) 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
Not available on this product.

I2 14 SPEECH THERAPY
Not available on this product.

I2 15 ORTHOTICS
Not available on this product.

I2 16 DIETETICS

(a) 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
Not available on this product.

I2 19 ACUPUNCTURE
See Rule I2 12.
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.

I2 24 AMBULANCE TRANSPORTATION
Not available on this product.

I2 25 ACCIDENT COVER
Not available on this product.

I2 26 ACCIDENTAL DEATH

H 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.

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Monitoring Accessories</td>
<td>$100</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Health Care Appliances</td>
<td>$300</td>
<td>Any 3 years</td>
</tr>
<tr>
<td>Artificial Aids</td>
<td>$350</td>
<td>Any 3 years</td>
</tr>
</tbody>
</table>
I3 SCHEDULE GENERAL TREATMENT TABLES

I3 1 TABLE NAME OR GROUP OF TABLE NAMES
Essential Extras cover.

I3 2 ELIGIBILITY
Any person who is eligible to become a Member is eligible to be insured under Essential Extras.

I3 3 GENERAL CONDITIONS

I3 3.1 Emergency Ambulance
If a Policy Holder wishes to obtain Emergency Ambulance cover in addition to Essential Extras cover, then the Policy Holder must pay the additional contribution for Emergency Ambulance cover.

I3 3.2 Limits per Service
(a) CBHS may impose a Limit per Service on an Extras Benefit.
(b) CBHS may change a Limit per Service on Extras Benefits from time to time.
(c) If CBHS 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 website; or
   ii. during Business Hours from the CBHS 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 available 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2 month waiting period)</td>
<td>$210</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Dental (2 month waiting period)</td>
<td>$170</td>
<td></td>
</tr>
</tbody>
</table>
Fillings, consultations & examinations, x-rays and extraction or surgical dental

<table>
<thead>
<tr>
<th>Dental (6 month waiting period)</th>
<th>Not Covered</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peridontic, endodontic, Inlays, onlays, facings, dentures, implants and occlusal therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dental (12 month waiting period)
Orthodontia, Crown and bridges

(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

(a) 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

(a) 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

(a) 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
Not available on this product.

I3 14 SPEECH THERAPY
Not available on this product.

I3 15 ORTHOTICS
Not available on this product.

I3 16 DIETETICS
(a) 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
Not available on this product.

I3 19 ACUPUNCTURE
See Rule I3 12.

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.
I3 24 AMBULANCE TRANSPORTATION
Not available on this product.

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.

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Monitoring Accessories</td>
<td>$100</td>
<td>Calendar Year</td>
</tr>
</tbody>
</table>

EMERGENCY AMBULANCE ONLY

I4 SCHEDULE GENERAL TREATMENT TABLES

I4 1 TABLE NAME OR GROUP OF TABLE NAMES

Emergency Ambulance only cover.

I4 2 ELIGIBILITY

A person who is eligible to become a Policy Holder is eligible to be insured under Emergency Ambulance only cover.

I4 3 GENERAL CONDITIONS

Emergency Ambulance only contributions must be paid annually in advance.

I4 4 LOYALTY BONUSES

Not available on this product.

I4 5 DENTAL

Not available on this product.

I4 6 OPTICAL

Not available on this product.

I4 7 PHYSIOTHERAPY
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
I4 23 PREVENTION HEALTH MANAGEMENT
Not available on this product.

I4 24 AMBULANCE TRANSPORTATION
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.
KICKSTART (BASIC PLUS)

J1 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J1 1 TABLE NAME OR GROUP OF TABLE NAMES
KickStart (Basic Plus)

J1 2 ELIGIBILITY
Any person who is eligible to become a Member is entitled to be insured under KickStart (Basic Plus).

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J1 3 GENERAL CONDITIONS

J1 3.1 General Product Description
(a) This product provides cover for only a limited range of Hospital Admitted Patient services and for Extras Benefits.
(b) This product is available only to a Member who has a Single, Couple, Family or Sole Parent Membership.

J1 3.2 General Product Description
(a) CBHS may impose a Limit per Service on an Extras Benefit.
(b) CBHS may change a Limit per Service on Extras Benefits from time to time.
(c) If CBHS detrimentally changes a Limit per Service, it will advise affected Members before the change comes into effect.
(d) A Member can find out about Limits per Service:
   i. at any time on the CBHS website; or
   ii. during Business Hours from the CBHS office.

J1 3.3 Special Limits on Some Extras Benefits 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.

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.

(c) For a person covered by this product Benefits are reduced by $70 per day for the first 6 days of hospitalisation in a Calendar Year.

J1 4.2 Services rendered by a private hospital
(a) If a service received by a Member:
   i. is rendered by a Hospital with which CBHS 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; or
      (B) the consequence of a Medical Emergency; or
      (C) tonsils, adenoids and grommets; or
      (D) joint reconstructions; or
      (E) hernia and appendix; or
      (F) dental surgery; or
      (G) bone, joint and muscles,
   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.

J1 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 J1 4.3(b), 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; or
   (B) the consequence of a Medical Emergency; or
   (C) tonsils, adenoids and grommets; or
   (D) joint reconstructions; or
   (E) hernia and appendix; or
   (F) dental surgery; or
   (G) bone, joint and muscles,
   shall be equal to the charge raised by the public Hospital (whether the accommodation be in a shared ward or a single private room).

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; 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; 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 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 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 and the Hospital.

J1 7 NON PBS PHARMACEUTICALS

See Rule J1 21.

J1 8 SURGICALLY IMPLANTED PROSTHESSES

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 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 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 with any further information which it reasonable requires.

J1 10 CO PAYMENTS

A Co-payment of $70 per day of hospitalisation per Calendar Year (maximum of 6 days per person or 12 days per family) applies to all Members covered by the membership.

J1 11 EXCESSES

There is no Excess payable under this product.

J1 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J1 13 RESTRICTED BENEFITS

All services provided by Hospitals, other than those to which Rule E2.8, J1 4.2(a) and J1 14 applies, are subject to restricted Benefits in accordance with Rule J1 4.2(b) and J1 4.3.

J1 14 EXCLUSIONS

The following services are not covered (excluded):

- Podiatric surgery (provided by a registered podiatric surgeon)
- Services for which a Medicare benefit is not payable (e.g. cosmetic services, laser eye surgery)

J1 15 LOYALTY BONUSES

CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

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

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 below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Overall Limit</th>
<th>Extend for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Dental (2 month waiting period)</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Dental (2 month waiting period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental (6 month waiting period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extractions</td>
<td>$675</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

J1 18 OPTICAL

For Optical 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 $230 in a Calendar Year.

J1 19 PHYSIOTHERAPY

For Physiotherapy Service, Chiropractic Service or a Osteopathic 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 $250 in a Calendar Year.

J1 20 CHIROPRACTIC

For Physiotherapy Service, Chiropractic Service or a Osteopathic 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 $250 in a Calendar Year.

J1 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 $200 in a Calendar Year.

J1 22 PODIATRY

Not available on this product.
J1 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 $250 in a Calendar Year.

J1 24 ALTERNATIVE THERAPIES

For Alternative Therapy, 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 $200 in a Calendar Year.

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

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 $100 in a Calendar Year.

J1 29 OCCUPATIONAL THERAPY

Not available on this product.

J1 30 NATUROPATHY

Not available on this product.

J1 31 ACUPUNCTURE

See Rule J1 24.

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

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.

J1 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 (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.

J1 37 ACCIDENT COVER

See Rule J1 4.

J1 38 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

J1 39 OTHER SPECIAL GENERAL TREATMENT

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Monitoring Accessories</td>
<td>$100</td>
<td>Calendar Year</td>
</tr>
</tbody>
</table>

J1 40 HOSPITAL-SUBSTITUTE TREATMENT

See Rule E4.2.
**COMPREHENSIVE HOSPITAL (GOLD)**

**J2 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES**

**J2 1 TABLE NAME OR GROUP OF TABLE NAMES**
- Comprehensive Hospital (Gold)
- Comprehensive Hospital 70 (Gold)
- Comprehensive Hospital 100 (Gold)
- Comprehensive Hospital $750 Excess (Gold)

**J2 2 ELIGIBILITY**
Any person who is eligible to become a **Member** is entitled to be insured under products in **Rule J2 1**.

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

**J2 3 GENERAL CONDITIONS**
Not applicable.

**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 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 4.2(a)**, then the amount of Benefits payable is the **Minimum Default Benefits** for that service, or such higher amount agreed between CBHS 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) 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; 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; 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;
then the amount of Benefit payable is the amount agreed between CBHS 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.

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 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 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 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 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 with any further information which it reasonable requires

J2 10 CO PAYMENTS
(a) A Policy Holder may choose whether or not to have a Co-payment on the membership.
(b) If a Policy Holder chooses to have a Co-payment, then:
   (i) the Co-payment applies to all Members covered by the membership (with exception of Dependents); and
   (ii) the amount of the Co-payment may, at the option of the Policy Holder be:
       (A) $70 per day of hospitalisation per Calendar Year (maximum of 6 days per person or 12 days per family);
       (B) $100 per day of hospitalisation per Calendar Year (maximum of 6 days per person or 12 days per family).

J2 11 EXCESSES
(a) If a Policy Holder chooses a cover with an Excess, then the Excess applies to all Members (except for Dependents) covered by the membership.
(b) The amount of Excess payable by any Member covered is $750 per person per admission for overnight or same day admission to a Hospital up to a maximum of:
    i. For Single Membership - $750 per Calendar Year
    ii. For Couple Membership, Sole Parent Membership or Family Membership - $1500 per Calendar Year.

J2 12 BENEFIT LIMITATION PERIODS
Not applicable.

J2 13 RESTRICTED BENEFITS
Where a Member receives treatment in a Hospital for which there is no Medicare Benefit Schedule Fee payable (for example: podiatric surgery and laser eye surgery), then Benefits payable are restricted to Minimum Default Benefits.

J2 14 EXCLUSIONS
Cosmetic service is excluded on this level of cover.

J2 15 LOYALTY BONUSES
CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

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 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 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 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.

J2 37 ACCIDENT COVER
Not applicable 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.
LIMITED HOSPITAL (BRONZE PLUS)

J3 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J3 1 TABLE NAME OR GROUP OF TABLE NAMES
Limited Hospital (Bronze Plus)
Limited Hospital 70 (Bronze Plus)
Limited Hospital 100 (Bronze Plus)

J3 2 ELIGIBILITY

Any person who is eligible to become a Member is entitled to be insured under products in Rule J3 1.

This is a:
   i. Age-based Discount Policy
   ii. Retained Age-based Discount Policy

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 a private Hospital
(a) If a service received by a Member is:
   (i) rendered by a Hospital with which CBHS 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 J3 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 and the Hospital on a one off basis.

J3 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.
Subject to Rule J3.13, 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.

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; 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; 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;
(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 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 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 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 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 with any further information which it reasonable requires.

J3 10 CO PAYMENTS

(a) A Policy Holder may choose whether or not to have a Co-payment on the membership.

(b) If a Policy Holder chooses to have an Co-payment:
   (i) the Co-payment applies to all Members covered by the membership (with exception of Dependents); and
   (ii) the amount of the Co-payment may, at the option of the Policy Holder, be:
       (A) $70 per day of hospitalisation per Calendar Year (maximum of 6 days per person or 12 days per family);
       (B) $100 per day of hospitalisation per Calendar Year (maximum of 6 days per person or 12 days per family).

J3 11 EXCESSES

There is no Excess payable under this product.

J3 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J3 13 RESTRICTED BENEFITS

(a) Hospital psychiatric services: 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) Rehabilitation: If a Member is admitted to a Hospital for rehabilitation services, then the Benefits payable for services rendered by the Hospital are restricted to Minimum Default Benefits.

(c) 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.
J3 14 EXCLUSIONS

The following services are excluded (not covered):

- Cataracts
- Heart and vascular system
- Lung and chest
- Plastic and reconstructive surgery (medically necessary)
- Pregnancy and birth
- Assisted reproductive services
- Joint replacements
- Weight loss surgery
- Podiatric surgery (provided by a registered podiatric surgeon)
- Services for which a Medicare benefit is not payable (e.g. cosmetic services, laser eye surgery)

J3 15 LOYALTY BONUSES

CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

J3 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.

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
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 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 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.

**J3 37 ACCIDENT COVER**

**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.
BASIC PLUS HOSPITAL

J4 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J4 1 TABLE NAME OR GROUP OF TABLE NAMES

1. Basic Plus Hospital
2. Basic Plus Hospital $500 Excess
3. Basic Plus Hospital $750 Excess

J4 2 ELIGIBILITY

Any person who is eligible to become a Member is entitled to be insured under products in Rule J4 1.

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

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 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.

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; 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; 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;
then the amount of Benefit payable is the amount agreed between CBHS 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.

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 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 and the Hospital.

J4 7 NON PBS PHARMACEUTICALS
Not available on this product.

J4 8 SURGICALLY IMPLANTED PROSTHESSES
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 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 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 with any further information which it reasonably requires.

J4 10 CO PAYMENTS
Not applicable on this product.

J4 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 Members covered by the membership.

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

(d) If you choose $750 Excess, then the amount of Excess payable by any Member covered is $750 per person per admission for overnight or same day admission to a hospital up to a maximum of:
   i. For Single Membership - $750 per Calendar Year
   ii. For Couple Membership, Sole Parent Membership or Family Membership - $1500 per Calendar Year

J4 12 BENEFIT LIMITATION PERIODS
Not applicable on this product.

J4 13 RESTRICTED BENEFITS
All Benefits payable are restricted to Minimum Default Benefits only, unless Rule E2.8 or Rule J4 14 applies.

J4 14 EXCLUSIONS
The following services are not covered (excluded):

- Podiatric surgery (provided by a registered podiatric surgeon)
- Services for which a Medicare benefit is not payable (e.g. cosmetic services, laser eye surgery)

J4 15 LOYALTY BONUSES
CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

J4 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.
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 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 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.

J4 37 ACCIDENT COVER

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.
STEPUP (BRONZE PLUS)

J6 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J6 1 TABLE NAME OR GROUP OF TABLE NAMES
StepUp (Bronze Plus)

J6 2 ELIGIBILITY
Any person who is eligible to become a Member is entitled be insured under StepUp (Bronze Plus).

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J6 3 GENERAL CONDITIONS

J6 3.1 General Product Description
(a) This product provides cover for a range of Hospital inpatient services and for Extras Benefits.
(b) This product is available to Member’s on Single, Couple, Family and Sole Parent Membership.

J6 3.2 Limits per Extras Benefits
(a) CBHS may impose a Limit per Service on Extras Benefits.
(b) CBHS may change a Limit per Service on Extras Benefits from time to time.
(c) If CBHS detrimentally changes a Limit per Service, it will advise affected Members before the change comes into effect.
(d) A Member can find out about Limits per Service:
   (i) at any time on the CBHS website; or
   (ii) during Business Hours from the CBHS 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 may only be payable in relation to hospital accommodation and may not be payable in relation to non-accommodation fees including theatre fees and labour ward fees.
For a person covered by this product Benefits are reduced by $70 per day for the first 6 days of hospitalisation in a Calendar Year.

J6 4.2 Services rendered by a private hospital
(a) If a service received by a Member:
   (i) is rendered by a Hospital with which CBHS 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

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) Subject to Rule J6 13, if a service received by a Member relates to a stay in a 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:
      (A) has a medical Purchaser-Provider Agreement with CBHS; 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; 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 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 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**

a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS 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 and the **Hospital**.

**J6 7 NON PBS PHARMACEUTICALS**

See Rule J6 21.

**J6 8 SURGICALLY IMPLANTED PROSTHESSES**

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 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 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 with any further information which it reasonable requires.

**J6 10 CO PAYMENTS**

1. Unless Rule J6 10(2) applies, a **Co-payment** of $70 per day of hospitalisation per **Calendar Year** (maximum of 6 days per person or 12 days per family) applies to all **Members** covered by the membership.

2. The **Co-payment** of $70 per day of hospitalisation per **Calendar Year** (maximum of 6 days per person or 12 days per family) does not apply to **Dependants**.

**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

(a) Hospital psychiatric services: 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) Rehabilitation: If a Member is admitted to a Hospital for rehabilitation services, then the Benefits payable for services rendered by the Hospital are restricted to Minimum Default Benefits.

(c) 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.

J6 14 EXCLUSIONS

The following services are not covered (excluded):

- Cataracts
- Heart and vascular system
- Lung and chest
- Plastic and reconstructive surgery (medically necessary)
- Joint replacements
- Weight loss surgery
- Podiatric surgery (provided by a registered podiatric surgeon)
- Services for which a Medicare benefit is not payable (e.g. cosmetic services, laser eye surgery).

J6 15 LOYALTY BONUSES

CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

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 $100 per person per Calendar Year.

J6 17 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 for the relevant period specified below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Overall Limit</th>
<th>Extends for</th>
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Preventative Dental Services (2 month waiting period) | Unlimited |  
--- | --- |  
**Dental (2 month waiting period)**  
Fillings, consultations & examinations, x-rays and extractions or surgical dental | $350 | Calendar Year |  
**Dental (6 month waiting period)**  
Periodontics | $900 |  
Endodontic |  
Inlays, onlays & facings |  
Dentures and Implants |  
Occlusal Therapy |  
**Dental (12 month waiting period)**  
Crowns & Bridges |  
Orthodontics | Lifetime Limit $1,400 | Life |  

(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**.

**J6 18 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 $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, optical frames, lenses and contact lenses up to any relevant **Limit per Service** and the overall limit of $250 in a **Calendar Year**.

**J6 19 PHYSIOTHERAPY**  
See Rule J6 32.

**J6 20 CHIROPRACTIC**  
See Rule J6 32.

**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 $300 in a **Calendar Year**.

**J6 22 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 $150 in a **Calendar Year**.

**J6 23 PSYCHOLOGY AND COUNSELLING**  
See Rule J6 32.
J6 24 ALTERNATIVE THERAPIES

For Alternative Therapy a Member may claim a Benefit of 70% of the cost of the therapy up to any relevant Limit per Service and the total combined overall limit of $400 for therapies in a Calendar Year.

J6 25 NATURAL THERAPIES

Not available on this product.

J6 26 SPEECH THERAPY

See Rule J6 32.

J6 27 ORTHOTICS

See Rule J6 39.

J6 28 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.

J6 29 OCCUPATIONAL THERAPY

See Rule J6 32.

J6 30 NATUROPATHY

Not available on this product.

J6 31 ACUPUNCTURE

See Rule J6 24.

J6 32 OTHER THERAPIES

A Member may claim a Benefit of 70% of the cost of service for Physiotherapy Service (including ante natal/post-natal physiotherapy), Chiropractic Service, Osteopathic Service, Speech Therapy Service, Occupational Therapy Service, Clinical Psychology Service, up to any relevant sub limit of $300 per therapy and the overall limit of $600 of all therapies in a Calendar Year.

J6 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

J6 34 HEARING AIDS

Not available on this product.

J6 35 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.

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 (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.

J6 37 ACCIDENT COVER

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 70% of the cost of the service, up to any relevant Limit per Service and the overall limits for the relevant period specified below.

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial Aids</td>
<td>$150</td>
<td>Calendar year</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Glucose Monitoring Accessories</td>
<td>$100</td>
<td>Calendar Year</td>
</tr>
</tbody>
</table>

J6 40 HOSPITAL-SUBSTITUTE TREATMENT

See Rule E4.2.
LIVELIFE (GOLD)

J7 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J7 1 TABLE NAME OR GROUP OF TABLE NAMES
LiveLife (Gold)

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J7 2 ELIGIBILITY

This product is closed for new sales and transfer from February 2013.

J7 3 GENERAL CONDITIONS

J7.3.1 General Product Description
(a) This product provides comprehensive cover for a range of Hospital Admitted Patient services and for Extras Benefits.
(b) This product is available to a Member who has a Single Couple, Family or Sole Parent Membership.

J7.3.2 Limits per Extras Service
(a) CBHS may impose a Limit per Service on Extras Benefits.
(b) CBHS may change a Limit per Service on Extras Benefits from time to time.
(c) If CBHS 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 website; or
   (ii) during Business Hours from the CBHS office.

J7.3.3 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.

J7 4 HOSPITAL TREATMENT PAYMENTS

J7 4.1 General
(a) Levels of Benefit payable are subject to Rule J7 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.

(c) For a person covered by this product Benefits are reduced by $70 per day for the first 6 days of hospitalisation in a Calendar Year.

J7 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 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 J7 4.2(a), then the amount of Benefits payable is the Minimum Default Benefits for that service.

J7 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.

J7 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; 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; 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 J7 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 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.

### J7 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS 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 and the **Hospital**.

### J7 7 NON PBS PHARMACEUTICALS

See Rule J7 21.

### J7 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**.

### J7 9 NURSING HOME TYPE PATIENTS

(a) If:

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

(ii) CBHS 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**.

(a) CBHS 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 with any further information which it reasonable requires.
J7 10 CO PAYMENTS

1. Unless Rule J7 10(2) applies, a Co-payment of $70 per day of hospitalisation per Calendar Year (maximum of 6 days per person or 12 days per family) applies to all Members covered by the membership.

2. The Co-payment of $70 per day of hospitalisation per Calendar Year (maximum of 6 days per person or 12 days per family) does not apply to Dependants.

J7 11 EXCESSES

There is no Excess payable under this product.

J7 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J7 13 RESTRICTED BENEFITS

Where a Member receives treatment in a Hospital for which there is no Medicare Benefit Schedule Fee payable, then Benefits are restricted to Minimum Default Benefits (for example: podiatric surgery and laser eye surgery).

J7 14 EXCLUSIONS

Cosmetic service is excluded on this level of cover.

J7 15 LOYALTY BONUSES

CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

J7 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.

J7 17 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 for the relevant period specified below.
## CBHS Health Benefit Fund Rules – as at 1 August 2019

### Overall Limit

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

### Optical

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.

#### J7 18 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 $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.

### 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 $900 in a Calendar Year.

### J7 20 CHIROPRACTIC
For **Chiropractic Services and Osteopathy Service** (including ante natal/post-natal physiotherapy), 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 $1,000 in a **Calendar Year**.

**J7 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**.

**J7 22 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**.

**J7 23 PSYCHOLOGY AND COUNSELLING**

For **Clinical Psychology 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 $500 in a **Calendar Year**.

**J7 24 ALTERNATIVE THERAPIES**

For **Alternative Therapies**, 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 $1,000 in a **Calendar Year**.

**J7 25 NATURAL THERAPIES**

Not available on this product.

**J7 26 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**.

**J7 27 ORTHOTICS**

**Benefits** for orthotics are paid under the **Artificial Aids** benefits as detailed in the **Rule J7 39**.

**J7 28 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**.

**J7 29 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 $800 in a **Calendar Year**.

**J7 30 NATUROPATHY**
Not available on this product.

**J7 31 ACUPUNCTURE**
See Rule J7 24.

**J7 32 OTHER THERAPIES**
Not available on this product.

**J7 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES**
Not available on this product.

**J7 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 70% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $2,200 in **Any 3 years**.

**J7 35 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 $300 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 $200 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 $230 in a **Calendar Year**. The **Limit per Service** for **Gym Membership** is $230 and for **Personal Training**, $200 in a **Calendar Year**.

**J7 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 (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.

**J7 37 ACCIDENT COVER**

**J7 38 ACCIDENTAL DEATH FUNERAL EXPENSES**
Not available on this product.

**J7 39 OTHER SPECIAL GENERAL TREATMENT**

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

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
</table>
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 70% of the cost of the service and the overall limits for the relevant period specified below.

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

Travelling and Accommodation Expense

(a) For Travelling and Accommodation Expenses, a Member may claim a Benefit of 50% of the cost calculated in accordance with Rule J7 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 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 J7 39 (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 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 policy on costing private car travel, as updated from time to time.
Member may obtain the policy on costing private car travel during Business Hours from the CBHS office.

J7 40 HOSPITAL-SUBSTITUTE TREATMENT
See Rule E4.2.

HOSPITAL A EXCESS (GOLD)

J8 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J8 1 TABLE NAME OR GROUP OF TABLE NAMES
Hospital a Excess (Gold)

J8 2 ELIGIBILITY
This hospital product was closed to all new members and transfers effective April 2007.

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J8 3 GENERAL CONDITIONS

J8 4 HOSPITAL TREATMENT PAYMENTS

J8 4.1 General
(a) Levels of Benefit payable are subject to Rule J8 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.

J8 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 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 J8 4.2(a), then the amount of Benefits payable is the Minimum Default Benefits for that service, or such higher amount agreed between CBHS and the Hospital on a one off basis.

J8 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.

### J8 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; 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; 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 J8 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 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.

### J8 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS 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 and the **Hospital**.

### J8 7 NON PBS PHARMACEUTICALS

Not available on this product.
J8 8 SURGICALLY IMPLANTED PROSTHESES

If a Member receives an 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*.

J8 9 NURSING HOME TYPE PATIENTS

(a) If:
   
   (i) a Member has been hospitalised for a continuous period of 35 days; and
   
   (ii) CBHS 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 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 with any further information which it reasonable requires.

J8 10 CO PAYMENTS

A Co-payment of $70 per day is payable for every Hospital service as an Admitted Patient that does not include an overnight stay. The Co-payment is payable maximum of 6 days per person or 12 days per couple/family per Calendar Year and applies to all Members covered by the membership.

J8 11 EXCESSES

A Policy Holder will have an Excess which applies to all Members covered by the membership and:

(a) the amount of the Excess is $350 per admission to a hospital by any Member covered by any Member up to a maximum of:

   (i) for Single Membership - $350 per Calendar Year; or

   (ii) for Family Membership - $700 per Calendar Year.

J8 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J8 13 RESTRICTED BENEFITS

Where a Member receives treatment in a Hospital for which there is no Medicare Benefit Schedule Fee payable (for example: podiatric surgery and laser eye surgery), then Benefits are restricted to Minimum Default Benefits.

J8 14 EXCLUSIONS

Cosmetic service is excluded on this level of cover.
J8 15 LOYALTY BONUSES

CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

J8 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.

J8 17 DENTAL

Not available on this product.

J8 18 OPTICAL

Not available on this product.

J8 19 PHYSIOTHERAPY

Not available on this product.

J8 20 CHIROPRACTIC

Not available on this product.

J8 21 NON PBS PHARMACEUTICALS

Not available on this product.

J8 22 PODIATRY

Not available on this product.

J8 23 PSYCHOLOGY AND COUNSELLING

Not available on this product.

J8 24 ALTERNATIVE THERAPIES

Not available on this product.

J8 25 NATURAL THERAPIES

Not available on this product.

J8 26 SPEECH THERAPY

Not available on this product.
J8 27 ORTHOTICS
Not available on this product.

J8 28 DIETETICS
Not available on this product.

J8 29 OCCUPATIONAL THERAPY
Not available on this product.

J8 30 NATUROPATHY
Not available on this product.

J8 31 ACUPUNCTURE
Not available on this product.

J8 32 OTHER THERAPIES
Not available on this product.

J8 33 NON SURGICALLY IMPLANTED PROSTHESSES AND APPLIANCES
Not available on this product.

J8 34 HEARING AIDS
Not available on this product.

J8 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J8 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 (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.

J8 37 ACCIDENT COVER

J8 38 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.

J8 39 OTHER SPECIAL GENERAL TREATMENT
Not available on this product.

J8 40 HOSPITAL-SUBSTITUTE TREATMENT
See Rule E4.2.
HOSPITAL B EXCESS (BRONZE PLUS)

J9 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J9 1 TABLE NAME OR GROUP OF TABLE NAMES
Hospital b Excess (Bronze Plus)

J9 2 ELIGIBILITY
This hospital product was closed to all new members and transfers effective April 2007.

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J9 3 GENERAL CONDITIONS
Not applicable on this product.

J9 4 HOSPITAL TREATMENT PAYMENTS
J9 4.1 General
(a) Levels of Benefit payable are subject to Rule J9 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.

J9 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 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 J9 4.2(a), then the amount of Benefits payable is the Minimum Default Benefits for that service, or such higher amount as agreed between CBHS and the Hospital on a one off basis.

J9 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 J9 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.

J9 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; 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; 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 J9 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 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.

J9 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

(a) Pharmaceutical Benefits are only payable in relation to Admitted Patient treatment at a Hospital with which CBHS 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 and the Hospital.

J9 7 NON PBS PHARMACEUTICALS

Not available on this product.

J9 8 SURGICALLY IMPLANTED PROSTHESSES

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.

J9 9 NURSING HOME TYPE PATIENTS

(a) If:
(i) a Member has been hospitalised for a continuous period of 35 days; and
(ii) CBHS 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 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 with any further information which it reasonable requires.

J9 10 CO PAYMENTS

A Co-payment of $70 per day is payable for every Hospital service as an Admitted Patient that does not include an overnight stay. The Co-payment is payable maximum of 6 days per person or 12 days per couple/family per Calendar Year and applies to all Members covered by the membership.

J9 11 EXCESSES

A Policy Holder will have an Excess which applies to all Members covered by the membership and:
   (i) the amount of the Excess is $350 per admission to a hospital by any Member covered by any Member up to a maximum of:
       (A) for Single Membership - $350 per Calendar Year; or
       (B) for Family Membership - $700 per Calendar Year.

J9 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J9 13 RESTRICTED BENEFITS

(a) Hospital psychiatric services: 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) Rehabilitation: If a Member is admitted to a Hospital for rehabilitation services, then the Benefits payable for services rendered by the Hospital are restricted to Minimum Default Benefits.

(c) 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.

J9 14 EXCLUSIONS

The following services are not covered (excluded):
- Cataracts
- Heart and vascular system
- Lung and chest
- Plastic and reconstructive surgery (medically necessary)
• Pregnancy and birth
• Assisted reproductive services
• Joint replacements
• Weight loss surgery
• Podiatric surgery (provided by a registered podiatric surgeon)
• Services for which a Medicare benefit is not payable (e.g. cosmetic services, laser eye surgery)

**J9 15 LOYALTY BONUSES**

CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

**J9 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; 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.

**J9 17 DENTAL**

Not available on this product.

**J9 18 OPTICAL**

Not available on this product.

**J9 19 PHYSIOTHERAPY**

Not available on this product.

**J9 20 CHIROPRACTIC**

Not available on this product.

**J9 21 NON PBS PHARMACEUTICALS**

Not available on this product.

**J9 22 PODIATRY**

Not available on this product.

**J9 23 PSYCHOLOGY AND COUNSELLING**

Not available on this product.

**J9 24 ALTERNATIVE THERAPIES**

Not available on this product.
J9 25 NATURAL THERAPIES
Not available on this product.

J9 26 SPEECH THERAPY
Not available on this product.

J9 27 ORTHOTICS
Not available on this product.

J9 28 DIETETICS
Not available on this product.

J9 29 OCCUPATIONAL THERAPY
Not available on this product.

J9 30 NATUROPATHY
Not available on this product.

J9 31 ACUPUNCTURE
Not available on this product.

J9 32 OTHER THERAPIES
Not available on this product.

J9 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

J9 34 HEARING AIDS
Not available on this product.

J9 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J9 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 (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.

J9 37 ACCIDENT COVER

J9 38 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.
CBHS Health Benefit Fund Rules – as at 1 August 2019

J9 39 OTHER SPECIAL GENERAL TREATMENT
Not available on this product.

J9 40 HOSPITAL-SUBSTITUTE TREATMENT
See Rule E4.2.

PRESTIGE (GOLD)

J11 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J11 1 TABLE NAME OR GROUP OF TABLE NAMES
Prestige (Gold)

J11 2 ELIGIBILITY
Any person who is eligible to become a Member is entitled to be insured under Prestige (Gold).

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J11 3 GENERAL CONDITIONS

J11 3.1 General Product Description
(a) This product provides comprehensive cover for a range of Hospital Admitted Patient services together with Extras Benefits.
(b) This product is available as a Single Membership, Couple Membership, Family Membership or Sole Parent Membership. The Policy Holders of either a Family Membership or a Sole Parent Membership may also elect to add one or more Non-Student Dependants to a policy for an additional premium. Any policy which includes a Non-Student Dependant will be a “non-student policy” as defined by the Private Health Insurance (Complying Product) Rules.

J11 3.2 Limits per Extras Service
(a) CBHS may impose a Limit per Service on Extras Benefits.
(b) CBHS may change a Limit per Service on Extras Benefits from time to time.
(c) If CBHS 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 website; or
   ii. during Business Hours from the CBHS office.

J11 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.
J11 4 HOSPITAL TREATMENT PAYMENTS

J11 4.1 General

(a) Levels of Benefit payable are subject to Rule J11 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.

J11 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 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 J11 4.2(a), then the amount of Benefits payable is the Minimum Default Benefits for that service.

J11 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.

J11 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; 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; 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 J11 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 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.

J11 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

1. Pharmaceutical Benefits are only payable in relation to Admitted Patient treatment at a Hospital with which CBHS 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 and the Hospital.

J11 7 NON PBS PHARMACEUTICALS

See Rule J11 21.

J11 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.

J11 9 NURSING HOME TYPE PATIENTS

(a) If:

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

ii. CBHS 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 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 with any further information which it reasonable requires.

J11 10 CO PAYMENTS

There is no Co-payment payable under this product.
J11 11 EXCESSES

There is no Excess payable under this product.

J11 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J11 13 RESTRICTED BENEFITS

Where a Member receives treatment in a Hospital for which there is no Medicare Benefit Schedule Fee payable, then Benefits are restricted to Minimum Default Benefits (for example: podiatric surgery and laser eye surgery).

J11 14 EXCLUSIONS

Cosmetic service is excluded on this level of cover.

J11 15 LOYALTY BONUSES

CBHS may introduce a loyalty bonus scheme by notice in writing to Members of its terms and conditions.

J11 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.

J11 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Dental Services (2 month waiting period)</td>
<td>Unlimited</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Dental (2 month waiting period)</td>
<td>Unlimited</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Fillings, consultations &amp; examinations, x-rays and extractions or surgical dental</td>
<td>Unlimited</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
### Dental (6 month waiting period)

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodontics</td>
<td>$700</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Endodontics</td>
<td>$700</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Inlays, onlays &amp; facings</td>
<td>$1,440</td>
<td>Any 5 years</td>
</tr>
<tr>
<td></td>
<td>($360 per tooth)</td>
<td></td>
</tr>
<tr>
<td>Dentures and Implants</td>
<td>$1,500</td>
<td>Any 5 years</td>
</tr>
<tr>
<td>Occlusal Therapy</td>
<td>$920</td>
<td>Lifetime</td>
</tr>
</tbody>
</table>

### Dental (12 month waiting period)

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia</td>
<td>$3,200</td>
<td>lifetime</td>
</tr>
<tr>
<td>Crown and bridges</td>
<td>$3,500</td>
<td>Any 5 years</td>
</tr>
<tr>
<td></td>
<td>($720 per tooth)</td>
<td></td>
</tr>
</tbody>
</table>

(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.

### J11 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.

### J11 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.

### J11 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.

### J11 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.
J11 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.

J11 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.

J11 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.

J11 25 NATURAL THERAPIES
Not available on this product.

J11 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.

J11 27 ORTHOTICS
Benefits for orthotics are paid under the Artificial Aids benefits as detailed in the Rule J11 39.

J11 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.

J11 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.

J11 30 NATUROPATHY
Not available on this product.

J11 31 ACUPUNCTURE
See Rule J11 24.

J11 32 OTHER THERAPIES
Not available on this product.

J11 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.
J11 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.

J11 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.

J11 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 (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.

J11 37 ACCIDENT COVER

J11 38 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

J11 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.

<table>
<thead>
<tr>
<th>Item</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial Aids</td>
<td>$1,500</td>
<td>Any 3 years</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>$360</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Orthoptic Therapy Services</td>
<td>$455</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Oxygen and Related Apparatus</td>
<td>$500</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Vitamin Therapy</td>
<td>$250</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Hypnotherapy Service</td>
<td>$360</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Physiology Services</td>
<td>$360</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>$2,800</td>
<td>Calendar Year</td>
</tr>
</tbody>
</table>

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

(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 J11 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 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 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 J11 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 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 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 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 which may exist from time-to-time.

J11 40 HOSPITAL-SUBSTITUTE TREATMENT

See Rule E4.2.
FLEXISAVER (BASIC PLUS)

J12 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J12 1 TABLE NAME OR GROUP OF TABLE NAMES
FlexiSaver (Basic Plus)

J12 2 ELIGIBILITY
Any person who is eligible to become a Member is entitled to be insured under FlexiSaver (Basic Plus).

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J12 3 GENERAL CONDITIONS

J12 3.1 General Product Description
(a) This product provides cover for only a limited range of Hospital Admitted Patient services and Extras Benefits.
(b) This product is available only to a Member who has a Single or Couple Membership.

J12 3.2 Limits per Extras Benefits
(a) CBHS may impose a Limit per Service on an Extras Benefit.
(b) CBHS may change a Limit per Service on Extras Benefits from time to time.
(c) If CBHS detrimentally changes a Limit per Service, it will advise affected Members before the change comes into effect.
(d) A Member can find out about Limits per Service:

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

J12 4 HOSPITAL TREATMENT PAYMENTS

J12 4.1 General
(a) Levels of Benefit payable are subject to Rule J12 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.
(c) A $500 Excess is payable for overnight or same day admission. The Excess is payable once per person up to twice per policy in a Calendar Year.

J12 4.2 Services rendered by a private hospital
(a) If a service received by a Member:
i. if a service is rendered by a Hospital with which CBHS has a Hospital Purchaser-Provider Agreement; and  

ii. if the Hospital Purchaser-Provider Agreement covers the level of Benefits paid for that kind of service; and  

iii. if the service is for:  

   (A) Accident Related Treatment; or  
   (B) the consequence of a Medical Emergency; or  
   (C) tonsils, adenoids and grommets; or  
   (D) joint reconstruction; or  
   (E) hernia and appendix; or  
   (F) dental surgery; or  
   (G) bone, joint and muscle,

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 J12 4.2(a), then no Benefits are payable for that service.

J12 4.3 Services rendered by a public hospital

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

   (A) Accident Related Treatment; or  
   (B) the consequence of a Medical Emergency; or  
   (C) tonsils, adenoids and grommets; or  
   (D) joint reconstructions; or  
   (E) hernia and appendix; or  
   (F) dental surgery; or  
   (G) bone, joint and muscle,

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

(b) If a service is received by a Member from a public Hospital other than in accordance with Rule J12 4.3(a), then no Benefits are payable for that service.

J12 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) For services listed in J12 4.2(a) and J12 4.3(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; 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; 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) For services listed in J12 4.2(a) and J12 4.3(a), 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 J12 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 and the medical practitioner (or other service provider) under the **Access Gap Cover Scheme** for that service.

(c) In any other case for services listed in **J12 4.2(a)** and **J12 4.3(a)**, 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.

(d) If a service is received by a **Member** for medical treatment other than in accordance with **Rule J12 4.2(a)** and **J12 4.3(a)**, then no **Benefits** are payable for that service.

---

**J12 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS**

(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS 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 and the **Hospital**.

(c) **Pharmaceutical Benefits** are not payable for services other than in accordance with **Rule J12 4.2(a)** and **J12 4.3(a)**.

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**J12 7 NON PBS PHARMACEUTICALS**

Not available on this product.

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**J12 8 SURGICALLY IMPLANTED PROSTHESES**

(a) 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**

(b) No benefits are payable for surgically implanted prosthesis if not related to services other than in accordance with **Rule J12 4.2(a)** and **J12 4.3(a)**.

---

**J12 9 NURSING HOME TYPE PATIENTS**

(a) If:

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

ii. CBHS 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 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 with any further information which it reasonable requires.

J12 10 CO PAYMENTS
Not applicable on this product.

J12 11 EXCESSES
The Excess applies to all Members covered by the membership.

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 - $1000 per Calendar Year

J12 12 BENEFIT LIMITATION PERIODS
Not applicable on this product.

J12 13 RESTRICTED BENEFITS
If a Member is admitted to a Hospital for the services listed below then the Benefits payable for services rendered by the Hospital are restricted to Minimum Default Benefits.

(a) Hospital psychiatric services, unless Rule E2.8 applies
(b) Rehabilitation
(c) Palliative care

J12 14 EXCLUSIONS
All hospital and medical services other than those to which Rule J12 4.2(a) and Rule J12 4.3(a) applies are excluded (not covered) on this level of cover.

J12 15 LOYALTY BONUSES
Not available on this product.

J12 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 for a service listed under Rule J12 4.2(a) and J12 4.3(a); 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.

J12 17 DENTAL
(a) For Dental Services, a Member may claim a Benefit of 55% of the cost of service up to a combined overall limit of $700 per person per Calendar Year inclusive of preventative dental, general dental, optical and physiotherapy as per the table below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Overall Limit</th>
<th>Extends for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Dental Services (2 month</td>
<td>$700</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>waiting period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g. oral examinations, x-ray, scale and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clean, mouth guards)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Dental (2 month waiting period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g. fillings, extractions or surgical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dental)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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.

J12 18 OPTICAL
(a) For Optical Service a Member may claim a Benefit of 55% of the cost of service up to a sublimit of $150 within the overall limit of $700 per person per Calendar Year inclusive of preventative dental, general dental, optical and physiotherapy.

(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, optical frames, lenses and contact lenses up to any relevant Limit per Service.

J12 19 PHYSIOTHERAPY
For Physiotherapy Service a Member may claim a Benefit of 55% of the cost of service up to a combined overall limit of $700 per person per Calendar Year inclusive of preventative dental, general dental, optical and physiotherapy.

J12 20 CHIROPRACTIC
Not available on this product.

J12 21 NON PBS PHARMACEUTICALS
Not available on this product.

J12 22 PODIATRY
Not available on this product.
J12 23 PSYCHOLOGY AND COUNSELLING
Not available on this product.

J12 24 ALTERNATIVE THERAPIES
Not available on this product.

J12 25 NATURAL THERAPIES
Not available on this product.

J12 26 SPEECH THERAPY
Not available on this product.

J12 27 ORTHOTICS
Not available on this product.

J12 28 DIETETICS
Not available on this product.

J12 29 OCCUPATIONAL THERAPY
Not available on this product.

J12 30 NATUROPATHY
Not available on this product.

J12 31 ACUPUNCTURE
Not available on this product.

J12 32 OTHER THERAPIES
Not available on this product.

J12 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

J12 34 HEARING AIDS
Not available on this product.

J12 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J12 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 (such as Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance service.
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.

J12 37 ACCIDENT COVER
See Rule J12 4.

J12 38 ACCIDENTAL DEATH FUNERAL EXPENSES
Not available on this product.

J12 39 OTHER SPECIAL GENERAL TREATMENT
Not available on this product.

J12 40 HOSPITAL-SUBSTITUTE TREATMENT
Not available on this product.

ACTIVE HOSPITAL (SILVER PLUS)

J13 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J13 1 TABLE NAME OR GROUP OF TABLE NAMES
Active Hospital (Silver Plus)

J13 2 ELIGIBILITY
Any person who is eligible to become a Member is entitled to be insured under products in Rule J13 1.

This is a:

i. Age-based Discount Policy
ii. Retained Age-based Discount Policy

J13 3 GENERAL CONDITIONS

J13 4 HOSPITAL TREATMENT PAYMENTS

J13 4.1 General
(a) Levels of Benefit payable are subject to Rule J13 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.

J13 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 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 J13 4.2(a), then the amount of Benefits payable is the Minimum Default Benefits for that service, or such higher amount as agreed between CBHS and the Hospital on a one-off basis.

J13 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 J13 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.

J13 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; 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; 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 J13 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 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.

J13 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS
(a) **Pharmaceutical Benefits** are only payable in relation to **Admitted Patient** treatment at a **Hospital** with which CBHS 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 and the **Hospital**.

**J13 7 NON PBS PHARMACEUTICALS**

Not available on this product.

**J13 8 SURGICALLY IMPLANTED PROSTHESSES**

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**.

**J13 9 NURSING HOME TYPE PATIENTS**

(a) If:

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

(ii) CBHS 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 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 with any further information which it reasonable requires.

**J13 10 CO PAYMENTS**

A **Co-payment** applies to all **Members** covered by the membership (with exception of **Dependants**). The amount of the **Co-payment** is:

(a) $100 per day of hospitalisation per **Calendar Year** (maximum of 6 days per person or 12 days per family).

**J13 11 EXCESSES**

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

**J13 12 BENEFIT LIMITATION PERIODS**

Not applicable on this product.

**J13 13 RESTRICTED BENEFITS**

(a) Hospital psychiatric services: 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.

(c) Podiatric surgery (provided by a registered podiatric surgeon): If a Member is admitted to a Hospital for podiatric surgery (provided by a registered podiatric surgeon), then the Benefits payable for services rendered by the Hospital are restricted to Minimum Default Benefits.

### J13 14 EXCLUSIONS

The following services are not covered (excluded):

- Pregnancy and birth
- Assisted reproductive services
- Joint replacements
- Weight loss surgery
- Services for which a Medicare benefit is not payable (e.g. cosmetic services, laser eye surgery)

### J13 15 LOYALTY BONUSES

Not available on this product.

### J13 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.

### J13 17 DENTAL

Not available on this product.

### J13 18 OPTICAL

Not available on this product.

### J13 19 PHYSIOTHERAPY

Not available on this product.

### J13 20 CHIROPRACTIC

Not available on this product.

### J13 21 NON PBS PHARMACEUTICALS

Not available on this product.
J13 22 PODIATRY
Not available on this product.

J13 23 PSYCHOLOGY AND COUNSELLING
Not available on this product.

J13 24 ALTERNATIVE THERAPIES
Not available on this product.

J13 25 NATURAL THERAPIES
Not available on this product.

J13 26 SPEECH THERAPY
Not available on this product.

J13 27 ORTHOTICS
Not available on this product.

J13 28 DIETETICS
Not available on this product.

J13 29 OCCUPATIONAL THERAPY
Not available on this product.

J13 30 NATUROPATHY
Not available on this product.

J13 31 ACUPUNCTURE
Not available on this product.

J13 32 OTHER THERAPIES
Not available on this product.

J13 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

J13 34 HEARING AIDS
Not available on this product.

J13 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J13 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 (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.

**J13 37 ACCIDENT COVER**

**J13 38 ACCIDENTAL DEATH FUNERAL EXPENSES**
Not available on this product.

**J13 39 OTHER SPECIAL GENERAL TREATMENT**
Not available on this product.

**J13 40 HOSPITAL-SUBSTITUTE TREATMENT**
See Rule E4.2.
CONTRIBUTION RATES

K SCHEDULE CONTRIBUTION RATE

The CBHS fortnightly contribution rates (un-rebated and excluding Lifetime Health Cover Loading) for Tables from 1 April 2019 are as follows:

### Single Fortnightly Contribution Rates

<table>
<thead>
<tr>
<th>SINGLE FORTNIGHTLY</th>
<th>NSW &amp; ACT</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
<th>WA</th>
<th>TAS</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Hospital (Gold)</td>
<td>95.96</td>
<td>102.88</td>
<td>102.88</td>
<td>95.96</td>
<td>85.58</td>
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<td>Hospital A Excess (Gold)</td>
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<td>99.04</td>
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<td>81.34</td>
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<td>Comprehensive Hospital 70 (Gold)</td>
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<td>95.20</td>
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<td>Comprehensive Hospital 100 (Gold)</td>
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<td>82.70</td>
<td>72.88</td>
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<tr>
<td>Comprehensive Hospital $750 Excess (Gold)</td>
<td>81.34</td>
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<td>88.26</td>
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<td>Limited Hospital (Bronze Plus)</td>
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<td>77.88</td>
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<td>Hospital B Excess (Bronze Plus)</td>
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<td>Limited Hospital 70 (Bronze Plus)</td>
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<td>46.46</td>
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<td>Top Extras</td>
<td>40.02</td>
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<td>37.16</td>
<td>35.74</td>
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<td>34.88</td>
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<tr>
<td>Intermediate Extras</td>
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\(^{^\text{a}}\)Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.
Couple Fortnightly Contribution Rates

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^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.
### Family Fortnightly Contribution Rates

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^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.
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<td>3.76</td>
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^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.
### Family Non-Student Dependant Fortnightly Contribution Rates

<table>
<thead>
<tr>
<th>Family Non-Student Dependant</th>
<th>FORTNIGHTLY</th>
<th>NSW</th>
<th>VIC</th>
<th>QLD</th>
<th>SA</th>
<th>WA</th>
<th>TAS</th>
<th>NT</th>
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<tbody>
<tr>
<td>Comprehensive Hospital (Gold)</td>
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<td>239.90</td>
<td>257.22</td>
<td>257.22</td>
<td>239.90</td>
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<tr>
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### Sole Parent Non-Student Dependant Fortnightly Contribution Rates

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<th>Sole Parent Non-Student Dependant</th>
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<th>WA</th>
<th>TAS</th>
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</tbody>
</table>
OVERSEAS VISITORS HEALTH COVER

L SCHEDULE OVERSEAS

L1 SCHEDULE OVERSEAS VISITORS COVER

L1.1 Eligibility

This product shall be open to any person who falls within the Restricted Access Group and who is not eligible to enrol with Medicare for access to any free or subsidised treatment in Australia.

L1.2 Product Description

The product provides benefits that are similar to a combination of the products Comprehensive Hospital (see Schedule J2) and TopExtras (see Schedule I1). Except for the services referred to below, reference should be made to Schedules J2 and I1 for details about the cover provided by this product. The exceptions are:

(a) Medical Services Payments - Admitted Patient

Where the Benefit is to be calculated by reference to provision J2 5(c), 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. 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 a Member on Comprehensive Hospital, receiving that same service, would have only been entitled to restricted benefits (in accordance with J2 13), then the Benefit
payable shall be restricted to the **Minimum Default Benefits** that would be payable to a **Member** covered by the Comprehensive Hospital product.

(d) **Accommodation at Non-Contracted Private Hospitals**

The **Benefit** payable with respect to accommodation at a non-contracted private **Hospital** (to which, but for this provision, rule J2 4.2(b) would have otherwise applied) shall be restricted to the **Minimum Default Benefits** that would be payable to a **Member** covered by the Comprehensive Hospital product.

(e) **Cooling off period not applicable**

This product is not private health insurance. Consequently the 30 day cooling off period referred to in **Rule C8 (f)** is not applicable.