CBHS
Health Cover for the CommBank Family

CBHS Health Fund Limited

Health Benefit Fund Rules

1 November 2026

Contents

A INTRODUCTION **4**

A1 Rules Arrangement *4*
A2 Health Benefits Fund *4*
A3 Obligations to Insurer *4*
A4 Governing Principles *4*
A5 Use of Funds *5*
A6 No Improper Discrimination *5*
A7 Changes to Rules *5*
A8 Dispute Resolution *5*
A9 Notices *6*
A10 Winding Up *6*
A11 Other *6*

B INTERPRETATION AND DEFINITIONS **6**

B1 Interpretation *6*
B2 Definitions *7*
B3 Other *15*

C MEMBERSHIP **16**

C1 General Conditions of Membership *16*
C2 Eligibility for Membership *16*
C3 Dependants *17*
C4 Membership Applications *17*
C5 Condition of Membership *18*
C6 Transfers *18*
C7 Cancellation of Membership *20*
C8 Termination of Membership by member *21*
C9 Temporary Suspension of Membership *21*
C10 Other *22*

D CONTRIBUTIONS **23**

D1 Payment of Contributions *23*
D2 Contribution Rate Changes *23*
D3 Contribution Discounts *24*
D4 Lifetime Health Cover *24*
D5 Arrears in Contributions *24*
D6 Other *25*

E BENEFITS **25**

E1 General Conditions *25*
E2 Hospital Treatment *26*
E3 General Treatment *29*
E4 Other *29*

F LIMITATION OF BENEFITS **30**

F1 Co Payments *30*
F2 Excesses *30*
F3 Waiting Periods *30*
F4 Exclusions *31*
F5 Benefit Limitation Periods *31*
F6 Restricted Benefits *31*
F7 Compensation Damages and Provisional Payment of Claims *32*
F8 Other *32*

G CLAIMS **32**

G1 General *32*
G2 Other *32*
I1 TOP EXTRAS **33**
I2 INTERMEDIATE EXTRAS **38**
I3 ESSENTIAL EXTRAS **42**
I4 EMERGENCY AMBULANCE ONLY **46**
J1 KICKSTART (BASIC PLUS) **48**
J2 COMPREHENSIVE HOSPITAL (GOLD) **55**
J3 LIMITED HOSPITAL (BRONZE PLUS) **60**
J4 BASIC PLUS HOSPITAL **66**
J6 STEPUP (BRONZE PLUS) **71**
J7 LIVELIFE (GOLD) **78**
J8 HOSPITAL A EXCESS (GOLD) **86**
J9 HOSPITAL B EXCESS (BRONZE PLUS) **91**
J11 PRESTIGE (GOLD) **97**
J12 FLEXISAVER (BASIC PLUS) **105**
J13 ACTIVE HOSPITAL (SILVER PLUS) **112**
J14 COMPLETE GOLD HOSPITAL **117**
J15 ADVANCED SILVER PLUS HOSPITAL **122**
J16 EVERYDAY SILVER PLUS HOSPITAL **127**
J17 VALUE BRONZE PLUS HOSPITAL **132**
J18 STARTER BASIC PLUS HOSPITAL **137**
K SCHEDULE CONTRIBUTION RATES **142**
L OVERSEAS VISITORS HEALTH COVER **143**

L1 OVERVIEW OF PRODUCTS *143*
L2 OVERSEAS WORKER TOP HOSPITAL AND MEDICAL *146*
L3 OVERSEAS WORKER MID HOSPITAL AND MEDICAL *150*
L4 OVERSEAS WORKER BASE HOSPITAL *155*
L5 CBHS OVERSEAS VISITORS HEALTH COVER *159*

A INTRODUCTION

A1 RULES ARRANGEMENT

These **Rules** set out:

Part A – the general principles and operating environment of the **Fund**;
Part B – how to read the **Rules**, including the meaning of terms;
Part C – who can be a **Member**, and on what basis;
Part D – the cost of membership contributions, and conditions on payment of contributions;
Part E – the **Benefits** we offer under different kinds of health cover;
Part F – conditions on the **Benefits** we offer, including **Excesses** and **Waiting Periods**;
Part G – requirements for making a claim for **Benefits**;
Part I – detailed schedules of our **Extras Benefits** cover;
Part J – detailed schedules of our combined **Hospital Benefits** and **Extras Benefits** covers.
Part K – Schedule Contribution Rates
Part L – Overseas Visitors Health Cover Schedules

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

A4 GOVERNING PRINCIPLES

(a) The **Fund** is established and maintained under the **Constitution** of CBHS.
(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**.
(c) 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 Complaints Handling and Disputes Resolution Policy.
(b) **Members** may make a complaint about any aspect of their membership at any time.
(c) **Members** can obtain information about the Complaints Handling and Disputes Resolution Policy at www.cbhs.com.au or by calling Member Services 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, 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.

"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" means either **Oriental and Natural 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" or "**Blood Glucose Accessories**" 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 8:00am 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.

"Child" includes:

i. a biological child
ii. an adopted child
iii. a foster child
iv. a stepchild
v. a child being cared for under guardianship arrangements.

"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.

"Contribution Group" means a group of persons determined by CBHS at its discretion.

"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 **Policy Holders.**

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

"Dependant" means a person who is either a **Dependant Child**, a **Student Dependant** or a **Non-Student Dependant.**

"Dependant Child" means a person who is a **Child** of a **Policy Holder** aged 0 to 17 (inclusive) and does not have a **Partner**.

"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 **Policy Holders** and one or more **Dependant Child** and/or **Student Dependant**.

"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 hospitalisation prescribed in **Rule J6, J7, J11** and **J14.**

"**Gazetted Rates**" means, in relation to Hospital **Benefits** for an **Overseas Visitor** who is a Medicare ineligible patient, the rates determined, recommended or published by the relevant health authority (or individual hospital, where applicable) in each State and Territory for the treatment of Medicare ineligible patients.

"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 ultrasound), 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 may be taken to be approved by CBHS if it is certified by a **Medical Practitioner** or a **Recognised Provider**. A program may involve any one or more of the following: **Yoga**, **Pilates**, **Gym Membership** or **Personal Training**.

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

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

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

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

"Hospital Substitute Treatment" means Hospital Substitute Treatment as defined in the **Act**.

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

"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 Alexander technique, deep tissue massage, lymphatic drainage, myotherapy, remedial massage and sports massage.

"Medical Adviser" means a qualified **Medical Practitioner** appointed by CBHS to give technical advice on professional matters.

"Medical Devices and Human Tissue Products" means medical devices and human tissue items in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules,* as updated from time to time.

"Medical Emergency" means an acute injury or illness which poses an immediate or imminent risk to the **Member's** life for which a **Member** is admitted to Hospital via an Accident and Emergency Department.

"**Medical Practitioner**" means a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student) but does not include a person whose registration has been suspended or cancelled.

"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 Aged Care which was applicable at the time the service was rendered.

"Member" means a **Policy Holder** or **Dependant.**

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

"Minimum 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** of a **Policy Holder** aged 18 to 30 (inclusive) and:

i. does not have a **Partner**; and
ii. is not a full-time student (at least 15 contact hours per week) at a school, college, or university or a first or second year apprentice.

"Non-Student Dependant Family Membership" means a membership that includes two **Policy Holders** and one or more **Non-Student Dependant** and/or **Dependant Child** and/or **Student Dependant.**

"Non-Student Dependant Sole Parent Membership" means a membership that includes one **Policy Holder** and one or more **Non-Student Dependant** and/or **Dependant Child** and/or **Student Dependant**.

"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 and Natural Therapy" means a service or treatment provided by a **Recognised Provider** in acupressure, acupuncture, Chinese herbal medicine consultation, Chinese massage, traditional Chinese medicine consultation, naturopathy, shiatsu and western herbalism consultation.

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

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

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

"Overseas Worker" means a person who is applying for or who has been granted a visa subject to visa condition 8501 requiring the person to have and maintain adequate health insurance cover for the whole of their stay in **Australia**.

"OVHC Policy" means Overseas Visitors Health Cover policy.

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

"Oxygen and Related Apparatus" means oxygen cylinders, masks, cylinder connections and cylinder refills that are provided upon referral of a **Recognised Provider** and recognised by CBHS 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" means a person who lives with another person in a marital or de facto relationship.

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

"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; 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 provided by a **Recognised Provider** and approved by CBHS from time to time and received as part of a **Health Management Program**.

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

"Policy Holder" means a person who is insured under a complying health insurance policy issued by CBHS and who is not a **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 and Birth" 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 one **Policy Holder** and one or more Dependant **Child** and/or **Student Dependant**.

"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 person who is a **Child** of a **Policy Holder** aged 18 to 30 (inclusive) and:

i. does not have a **Partner**; and
ii. is a full-time student (at least 15 contact hours per week) at a school, college or university or a first or second year apprentice.

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

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

"Usual, Customary and Reasonable Charge" means in relation to a service rendered by a **Recognised Provider**, the usual or customary fee charged for that service by other similarly qualified practitioners or a reasonable charge for that service as determined by CBHS 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**.

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

B3 OTHER

C MEMBERSHIP

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) (closed to new **Members** and transfers)
2) Active Hospital (Silver Plus) (closed to new **Members** and transfers)
3) Limited Hospital (Bronze Plus) (closed to new **Members** and transfers)
4) Basic Plus Hospital (closed to new **Members** and transfers)
5) KickStart (Basic Plus) (including **Extras Benefits** cover)
6) StepUp (Bronze Plus) (including **Extras Benefits** cover) (closed to new **Members** and transfers)
7) Prestige (Gold) (including **Extras Benefits** cover) (closed to new **Members** and transfers)
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) (closed to new **Members** and transfers)
16) Complete Gold Hospital
17) Advanced Silver Plus Hospital
18) Everyday Silver Plus Hospital
19) Value Bronze Plus Hospital
20) Starter Basic Plus Hospital
21) Overseas Worker Top Hospital and Medical (closed to new **Members** and transfers)
22) Overseas Worker Mid Hospital and Medical (closed to new **Members** and transfers)
23) Overseas Worker Base Hospital (closed to new **Members** and transfers)
24) Overseas Visitors Health Cover (closed to new **Members** and transfers)

- 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.

(c) a person who was insured with CBHS Corporate Health Pty Ltd before 1 June 2026 constitutes a group of persons for the purposes of section 7(a) of the Private Health Insurance (Registration) Rules and 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

(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 first named **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**.
(c) If CBHS cancels a membership under **Rule C7**, that termination takes effect in accordance with **Rule C7.2**.
(d) Subject to compliance with the **Rules** and **Constitution** of CBHS, a person may maintain membership as a **Dependant**, for so long as they remain a **Dependant**.
(e) Subject to compliance with the **Rules** and **Constitution** of CBHS, a person may maintain membership as a **Policy Holder** until he or she dies.
(f) **Benefits** may be payable after a **Member** dies for services rendered whilst the **Member** was alive.

C6 TRANSFERS

C6.1 Persons transferring from 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).**
(vii) any **Member** has, in the opinion of CBHS, engaged in inappropriate behaviour including acting in an unreasonable or vexatious manner.

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 60 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 continuous 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 12 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 contributions 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 will 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 12 months 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 an **Excess**, or limitation prior to the commencement of the suspension; and
   ii. reactivate the membership on the end date of the period of suspension;
   then CBHS 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) A period during which a membership is suspended is not included for the purposes of completing any **Waiting Periods** that are to be served.

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 **Dependants** 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 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.

D1.5 Forfeited Contributions

(a) On cancellation or termination of membership, if an amount of contributions is credited to the membership which is less than the daily rate of contribution for the applicable cover (that is, the fortnightly rate of contributions divided by 14), the amount is forfeited.

D2 CONTRIBUTION RATE CHANGES

CBHS may amend the fortnightly contribution rates, 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**. This may include offering a discount to any **Contribution Group**.
(b) If CBHS chooses to offer **Age-based Discount**, then it will apply as per the table below:

Person's age at discount assessment date	Percentage
18 or older, but under 26	10%
26	8%
27	6%
28	4%
29	2%

(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.

Persons age for period of cover	Percentage discount for that period
18 or older, but under 41	the person's base percentage
41	the person's base percentage minus 2%
42	the person's base percentage minus 4 %
43	the person's base percentage minus 6%
44	the person's base percentage minus 8%
45 or older	zero

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**.
(c) 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.
(d) CBHS may refuse to accept outstanding contributions for a membership if that membership has lapsed.
(e) A membership lapses when it has been in arrears for a continuous period of more than two months.

D6 OTHER

E BENEFITS

E1 GENERAL CONDITIONS

E1.1 When a Benefit is not payable

(a) A **Benefit** is not payable in respect of a service that was rendered to a **Member** if:

i. the costs of that service were incurred by the **Member's** employer; or

ii. the **Member** obtained the service in connection with:

(A) employment; or

(B) application for employment; or

(C) an industrial undertaking or profession; or

(D) a life insurance examination; or

(E) other non-treatment function; or

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

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

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

vi. the service is claimable from Medicare;

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

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

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

x the medical service 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**.

(c) 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 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 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 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.

(c) If an eligible **Member** receives a surgically implanted medical device and human tissue product for which a Medicare benefit is payable, and that medical device and human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules* as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Hospital Benefit** payable for that medical device and human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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 (hospital psychiatric services)

A **Member** who holds a policy with **Hospital Benefits** which are restricted to **Minimum Benefits** for hospital psychiatric services and who has served a **Waiting Period** of 2 months, may upgrade their policy to receive full **Benefits** payable for hospital 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 and Part J 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 or Schedule L (hospital products or packaged products) may be in 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 or Schedule L (hospital products or packaged products) 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 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 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 **Co-payment** in accordance with Rule J1 10, J2 10, J3 10, J6 10, J7 10, J8 10, J9 10, J13 10 or J14 10 as set out in the relevant **Rules** may apply to the **Benefit** payable.

F2 EXCESSES

An **Excess** in accordance with Rule J2 11, J4 11, J8 11, J9 11, J12 11, J14 11, J15 11, J16 11, J17 11, J18 11, L2.3, L3.3 and L4.3 as set out in that relevant **Rules** may apply to the **Benefit** payable.

F3 WAITING PERIODS

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

(b) Except as otherwise provided in **Rules C6** and **C9**, the time served against a **Waiting Period** for a **Benefit** is calculated by reference to the continuous period of time that a **Member** has held his or her current level of cover with CBHS.

(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 and birth, 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**: Hospital psychiatric services, 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 Benefits** for hospital psychiatric services and has served a **Waiting Period** of 2 months, the **Member** may upgrade their policy to receive full **Benefits** payable for hospital 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**
vii. Advanced Silver Plus Hospital as described at **Rule J15 14**
viii. Everyday Silver Plus Hospital as described at **Rule J16 14**
ix. Value Bronze Plus Hospital as described at **Rule J17 14**
x. Starter Basic Plus Hospital as described at **Rule J18 14**
xi. Overseas Workers Top Hospital and Medical as described at **Rule L2.5**
xii. Overseas Workers Mid Hospital and Medical as described at **Rule L3.5**
xiii. Overseas Workers Base Hospital as described at **Rule L4.5.**

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 **Rul**e **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**;
(vii) Hospital 'a' Excess (Gold) as described in **Rule J8 13**;
(viii) Hospital 'b' Excess (Bronze Plus) as described in **Rule J9 13;**
(ix) Prestige (Gold) as described in **Rule J11 13;**
(x) FlexiSaver (Basic Plus) as described in **Rule J12 13**;
(xi) Active Hospital (Silver Plus) as described in **Rule J13 13**;
(xii) Complete Gold Hospital as described in **Rule J14 13**;
(xiii) Advanced Silver Plus Hospital as described in **Rule J15 13**;
(xiv) Everyday Silver Plus Hospital as described in **Rule J16 13**;
(xv) Value Bronze Plus Hospital as described in **Rule J17 13**;
(xvi) Starter Basic Plus Hospital as described in **Rule J18 13;**
(xvii) Overseas Workers Mid Hospital and Medical as described in **Rule L3.4;** and
(xviii) Overseas Workers Base Hospital as described in **Rule L4.4.**

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**.

I1 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

II 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.

II 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.

II 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 100% of the cost of service up to any relevant **Limit per Service** and the overall limit for the relevant period specified below.

SERVICE	OVERALL LIMIT	EXTENDS FOR
Preventative Dental Services (2 months waiting period)	Unlimited	Not applicable
Dental (2 months waiting period) Fillings, consultations & examinations, x-rays and extractions or surgical dental	Unlimited	Not applicable
Dental (6 month waiting period)		
Periodontics	$630	Calendar Year
Endodontics	$660	Calendar Year
Inlays, onlays, facings, veneers	$1,440	Any 5 years
Dentures and implants	$1,350	Any 5 years
Occlusal therapy	$920	Lifetime
Dental (12 month waiting period)		
Orthodontia	$2,800	Lifetime
Crown and bridges	$3,000	Any 5 years

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

I1 6 OPTICAL

(a) For an **Optical Service**, a **Member** may claim a **Benefit** of 100% 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 100% 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 100% 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 100% 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 100% 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 100% 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 ORIENTAL AND NATURAL THERAPIES

(a) Benefits for **Oriental and Natural Therapy** are paid under **Alternative Therapy** as detailed in **Rule I1 12** Alternative Therapies.

I1 14 SPEECH THERAPY

(a) 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**.

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 100% 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 100% 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

(a) Benefits for naturopathy are paid under **Alternative Therapy** as detailed in **Rule I1 12** Alternative Therapies.

I1 19 ACUPUNCTURE

(a) Benefits for **Acupuncture** are paid under **Alternative Therapy** as detailed in **Rule I1 12** Alternative Therapies.

I1 20 OTHER THERAPIES

(a) For **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 $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 100% 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 100% 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** (including **Yoga** and **Pilates**, but 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 $100 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 $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 100% of the cost of service, up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Artificial Aids	$1,000	Any 3 years
Audiology Services	$360	Calendar Year
Orthoptic Therapy Services	$455	Calendar Year
Oxygen and Related Apparatus	$500	Calendar Year

Vitamin Therapy	$250	Calendar year
Hypnotherapy Service	$360	Calendar Year
Physiology Services	$360	Calendar Year
Nursing Services	$2,800	Calendar Year

(b) For the following, a **Member** may claim a **Benefit** of 100% of the cost up to the overall limits for the relevant period specified below.

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

Travelling and Accommodation Expenses

(a) For Travelling and Accommodation Expenses, a **Member** may claim a **Benefit** of 100% 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 a160km 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 I1 27 (d)** and **(e)**) and 100% 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.

I2 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 100% of the cost of service up to any relevant **Limit per Service** and the overall limits below.

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

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

I2 6 OPTICAL

(a) For **Optical Service**, a **Member** may claim a **Benefit** of 100% 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 100% 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 100% 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 100% 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 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $300 in a **Calendar Year**.

I2 13 ORIENTAL AND NATURAL THERAPIES

(a) Benefits for **Oriental and Natural Therapy** are paid under **Alternative Therapy** as detailed in **Rule I2 12** Alternative Therapies

I2 14 SPEECH THERAPY

Not available on this product.

I2 15 ORTHOTICS

(a) **Benefits** for orthotics are paid under the **Artificial Aids** benefits as detailed in the **Rule I2 27.**

I2 16 DIETETICS

(a) 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**.

I2 17 OCCUPATIONAL THERAPY

Not available on this product.

I2 18 NATUROPATHY

(a) Benefits for naturopathy are paid under **Alternative Therapy** as detailed in **Rule I2 12** Alternative Therapies.

I2 19 ACUPUNCTURE

(a) Benefits for **Acupuncture** are paid under **Alternative Therapy** as detailed in **Rule I2 12** Alternative Therapies.

I2 20 OTHER THERAPIES

Not available on this product.

I2 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

I2 22 HEARING AIDS

Not available on this product.

I2 23 PREVENTION HEALTH MANAGEMENT

a. For **Health Checks**, a **Member** may claim a **Benefit** of 100% 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** (including **Yoga** and **Pilates**, but 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 $100 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 $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 DEAT

H FUNERAL EXPENSES

Not available on this product.

I2 27 OTHER SPECIAL

(a) For the following, 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.

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

I3 ESSENTIAL EXTRAS

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 100% of the cost of service up to any relevant **Limit per Service** and the overall limits below.

Service	Overall Limit	Extends for
Preventative Dental Services ***(2 month waiting period)***	$210	Calendar Year

Dental (2 month waiting period) Fillings, consultations & examinations, x-rays and extraction or surgical dental	$170	
Dental (6 month waiting period) Periodontic, endodontic, Inlays, onlays, facings, dentures, implants and occlusal therapy	Not Covered	Not Applicable
Dental (12 month waiting period) Orthodontia, Crown and bridges	Not Covered	

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

I3 6 OPTICAL

(a) For **Optical Service**, a **Member** may claim a **Benefit** of 100% 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 100% 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 100% 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 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $200 in a **Calendar Year**.

I3 13 ORIENTAL AND NATURAL THERAPIES

(a) Benefits for **Oriental and Natural Therapy** are paid under **Alternative Therapy** as detailed in **Rule I3 12** Alternative Therapies

I3 14 SPEECH THERAPY

Not available on this product.

I3 15 ORTHOTICS

Not available on this product.

I3 16 DIETETICS

(a) 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**.

I3 17 OCCUPATIONAL THERAPY

Not available on this product.

I3 18 NATUROPATHY

(a) Benefits for naturopathy are paid under **Alternative Therapy** as detailed in **Rule I3 12** Alternative Therapies.

I3 19 ACUPUNCTURE

(a) Benefits for **Acupuncture** are paid under **Alternative Therapy** as detailed in **Rule I3 12** Alternative Therapies.

I3 20 OTHER THERAPIES

Not available on this product.

I3 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

I3 22 HEARING AIDS

Not available on this product.

I3 23 PREVENTION HEALTH MANAGEMENT

a. For **Health Checks**, a **Member** may claim a **Benefit** of 100% 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** (including **Yoga** and **Pilates**, but 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 $100 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 $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 100% of the cost of service up to the overall limit of $100 in a **Calendar Year.**

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

I4 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

Not available on this product.

I4 8 CHIROPRACTIC

Not available on this product.

I4 9 NON PBS PHARMACEUTICALS

Not available on this product.

I4 10 PODIATRY

Not available on this product.

I4 11 PSYCHOLOGY AND COUNSELLING

Not available on this product.

I4 12 ALTERNATIVE THERAPIES

Not available on this product.

I4 13 ORIENTAL AND NATURAL THERAPIES

Not available on this product.

I4 14 SPEECH THERAPY
Not available on this product.

I4 15 ORTHOTICS
Not available on this product.

I4 16 DIETETICS
Not available on this product.

I4 17 OCCUPATIONAL THERAPY
Not available on this product.

I4 18 NATUROPATHY
Not available on this product.

I4 19 ACUPUNCTURE
Not available on this product.

I4 20 OTHER THERAPIES
Not available on this product.

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

I4 22 HEARING AIDS
Not available on this product.

I4 23 PREVENTION HEALTH MANAGEMENT
Not available on this product.

I4 24 AMBULANCE TRANSPORTATION
If a **Member**:

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

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

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

I4 25 ACCIDENT COVER
Not available on this product.

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

I4 27 OTHER SPECIAL
Not available on this product.

J1 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 Hour**s 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 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 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 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 PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

J1 10 CO PAYMENTS

A **Co-payment** of $70 per day of hospitalisation per **Calendar Year** (maximum of 6 days per person and 12 days per **Couple, Sole Parent or Family Membership**) 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 surgical podiatrist)
- 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.

Service	Overall Limit	Extend for
Preventative Dental ***(2 month waiting period)***	Unlimited	Calendar Year
Dental ***(2 month waiting period)*** Fillings, consultations & examinations, x-rays and extractions or surgical dental	$675	
Dental ***(6 month waiting period)***		
Periodontics		
Endodontics		

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 ORIENTAL AND NATURAL THERAPIES

Benefits for **Oriental and Natural Therapy** are paid under **Alternative Therapy** as detailed in **Rule J1 24** Alternative Therapies.

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

Benefits for naturopathy are paid under **Alternative Therapy** as detailed in **Rule J1 24** Alternative Therapies.

J1 31 ACUPUNCTURE

Benefits for **Acupuncture** are paid under **Alternative Therapy** as detailed in **Rule J1 24** Alternative Therapies.

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 100% of the cost of service, up to any relevant **Limit per Service** and the overall limit of $100 in a **Calendar Year**.
b. For **Health Management** (including **Yoga** and **Pilates**, but 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 $100 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 $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.**

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

J1 40 HOSPITAL-SUBSTITUTE TREATMENT

See **Rule E4.2**.

J2 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

This product is closed for new **Members** and transfer from 1 August 2024.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 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 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 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 medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health*

Insurance (Medical Devices and Human Tissue Products) Rules, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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 reasonably 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 **Dependants**); 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 **Dependants)** 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 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 ORIENTAL AND 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**.

J3 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

This product is closed for new **Members** and transfer from 1 August 2024.

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

(b) 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 medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product

is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

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 **Dependants)**; 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 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 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 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). [Plastic surgery that is medically necessary relating to the treatment of a skin-related condition is covered under the category 'Skin'. For example: melanoma, minor wound repair and abscesses.]
- Pregnancy and birth
- Assisted reproductive services
- Joint replacements
- Weight loss surgery
- Podiatric surgery (provided by a registered surgical podiatrist)
- 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

Not available on this product.

J3 23 PSYCHOLOGY AND COUNSELLING

Not available on this product.

J3 24 ALTERNATIVE THERAPIES
Not available on this product.

J3 25 ORIENTAL AND 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**.

J4 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

This product is closed for new **Members** and transfer from 1 August 2024.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 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 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 PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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 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 surgical podiatrist)
- 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 ORIENTAL AND 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**.

J6 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

This product is closed for new **Members** and transfer from 1 August 2024.

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 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.

(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**.

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 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 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 PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

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 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 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 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) [Plastic surgery that is medically necessary relating to the treatment of a skin-related condition is covered under the category 'Skin'. For example: melanoma, minor wound repair and abscesses.]
- Joint replacements
- Weight loss surgery
- Podiatric surgery (provided by a registered surgical podiatrist)
- 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 100% of the cost of service up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Service	Overall Limit	Extends for
Preventative Dental Services (2 month waiting period)	Unlimited	Not applicable

Dental (2 month waiting period) Fillings, consultations & examinations, x-rays and extractions or surgical dental	$350	Calendar Year
Dental (6 month waiting period)	$900	
Periodontics		Calendar Year
Endodontic		Calendar Year
Inlays, onlays, facings, veneers		Any 5 years
Dentures and Implants		Any 5 years
Occlusal Therapy		Lifetime
Dental (12 month waiting period)		
Crowns & Bridges		Any 5 years
Orthodontics	Lifetime Limit $1,400	Lifetime

(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 100% 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 100% 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 100% 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 ORIENTAL AND NATURAL THERAPIES

Benefits for **Oriental and Natural Therapy** are paid under **Alternative Therapy** as detailed in **Rule J6 24** Alternative Therapies.

J6 26 SPEECH THERAPY

See **Rule J6 32.**

J6 27 ORTHOTICS

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

J6 28 DIETETICS

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

J6 29 OCCUPATIONAL THERAPY

See **Rule J6 32.**

J6 30 NATUROPATHY

Benefits for naturopathy are paid under **Alternative Therapy** as detailed in **Rule J6 24** Alternative Therapies.

J6 31 ACUPUNCTURE

Benefits for **Acupuncture** are paid under **Alternative Therapy** as detailed in **Rule J6 24** Alternative Therapies.

J6 32 OTHER THERAPIES

A **Member** may claim a Benefit of 100% 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 100% 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** (including **Yoga** and **Pilates**, but 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 $100 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 $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 100% of the cost of the service, up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Artificial Aids	$150	**Calendar year**

(b) For the following, a **Member** may claim a **Benefit** of 100% of the cost of the service and the overall limits for the relevant period specified below.

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

J6 40 HOSPITAL-SUBSTITUTE TREATMENT

See **Rule E4.2**.

J7 LIVELIFE (GOLD)

J7 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J7 1 TABLE NAME OR GROUP OF TABLE NAMES

LiveLife (Gold)

J7 2 ELIGIBILITY

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

This is a:

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

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 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 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 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 medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

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 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 100% of the cost of service up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

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

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

J7 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**.

J7 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.**

J7 20 CHIROPRACTIC

For **Chiropractic Services and Osteopathy 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 $1,000 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 100% 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 100% 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 100% 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 ORIENTAL AND NATURAL THERAPIES

Benefits for **Oriental and Natural Therapy** are paid under **Alternative Therapy** as detailed in **Rule J7 24** Alternative Therapies.

J7 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**.

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 100% 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 100% 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

Benefits for naturopathy are paid under **Alternative Therapy** as detailed in **Rule J7 24** Alternative Therapies.

J7 31 ACUPUNCTURE

Benefits for **Acupuncture** are paid under **Alternative Therapy** as detailed in **Rule J7 24** Alternative Therapies.

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 100% 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 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** (including **Yoga** and **Pilates**, but 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.**

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 100% of the cost of the service, up to any relevant **Limit per Service** and the overall limits for the relevant period specified below.

Item	Overall Limit	Extends for
Artificial Aids	$1,500	Any 3 years
Audiology Services	$360	Calendar Year
Orthoptic Therapy Services	$455	Calendar Year

Oxygen and Related Apparatus	$500	Calendar Year
Vitamin Therapy	$250	Calendar year
Hypnotherapy Service	$360	Calendar Year
Physiology Services	$360	Calendar Year
Nursing Services	$2,800	Calendar Year

(b) For the following, a **Member** may claim a **Benefit** of 100% of the cost of the service and the overall limits for the relevant period specified below.

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

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 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 **Membe**r; and

ii. that treatment is not available at a facility within a160km 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 J7 39 (d)** and **(e)**) and 100% 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 the policy on costing private car travel during **Business Hours** from the CBHS office.

J7 40 HOSPITAL-SUBSTITUTE TREATMENT

See **Rule E4.2**.

J8 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 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 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 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 medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

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 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 ORIENTAL AND 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 PROSTHESES 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**.

J9 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 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 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 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 PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

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 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 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 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) [Plastic surgery that is medically necessary relating to the treatment of a skin-related condition is covered under the category 'Skin'. For example: melanoma, minor wound repair and abscesses.]
- Pregnancy and birth
- Assisted reproductive services
- Joint replacements
- Weight loss surgery
- Podiatric surgery (provided by a registered surgical podiatrist)
- 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 ORIENTAL AND 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.

J9 39 OTHER SPECIAL GENERAL TREATMENT

Not available on this product.

J9 40 HOSPITAL-SUBSTITUTE TREATMENT

See **Rule E4.2**.

J11 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

This product is closed for new **Members** and transfer from 1 August 2024.

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 contribution. 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 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 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 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 medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

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 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.

Service	Overall Limit	Extends for
Preventative Dental Services (2 month waiting period)	Unlimited	Not applicable
Dental (2 month waiting period) Fillings, consultations & examinations, x-rays and extractions or surgical dental	Unlimited	Not applicable
Dental (6 month waiting period)		
Periodontics	$700	Calendar Year
Endodontics	$700	Calendar Year
Inlays, onlays, facings, veneers	$1,440	Any 5 years
Dentures and implants	$1,500	Any 5 years

Occlusal therapy	$920	Lifetime
Dental (12 month waiting period)		
Orthodontia	$3,200	Lifetime
Crown and bridges	$3,500	Any 5 years

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

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**, 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 ORIENTAL AND NATURAL THERAPIES

Benefits for **Oriental and Natural Therapy** are paid under **Alternative Therapy** as detailed in **Rule J11 24** Alternative Therapies.

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

Benefits for naturopathy are paid under **Alternative Therapy** as detailed in **Rule J11 24** Alternative Therapies.

J11 31 ACUPUNCTURE

Benefits for **Acupuncture** are paid under **Alternative Therapy** as detailed in **Rule J11 24** Alternative Therapies.

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** (including **Yoga** and **Pilates**, but 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.

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

(B) For the following, a **Member** may claim a **Benefit** of 100% of the cost of the service and the overall limits for the relevant period specified below.

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

(C) Travelling and Accommodation Expense

(a) For Travelling and Accommodation Expenses, a **Member** may claim a **Benefit** of 100% of the cost calculated in accordance with **Rule 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 **Membe**r; and

ii. that treatment is not available at a facility within a160km 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) Other Services

A person on a policy under this **Product** will be entitled to use other programs and services as available at the time, and which may change from time to time.

J11 40 HOSPITAL-SUBSTITUTE TREATMENT

See **Rule E4.2**.

J12 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

This product is closed for new **Members** and transfer from 1 August 2024.

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 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. 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 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)**.

J12 7 NON PBS PHARMACEUTICALS

Not available on this product.

J12 8 SURGICALLY IMPLANTED PROSTHESES

(a) If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*

(b) No benefits are payable for surgically implanted medical device or human tissue product 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 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.

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 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.

Service	Overall Limit	Extends for
Preventative Dental Services (2 month waiting period) *(e.g. oral examinations, x-ray, scale and clean, mouth guards)*	$700 (combined for preventative dental, general dental, optical and physiotherapy)	**Calendar Year**
General Dental (2 month waiting period) *(e.g. fillings, extractions or surgical dental)*		

(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 ORIENTAL AND 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 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

See **Rule E4.2**.

J13 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

This product is closed for new **Members** and transfer from 1 August 2024.

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 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 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 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 PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) 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 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.

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 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 Benefits**.

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

J14 COMPLETE GOLD HOSPITAL

J14 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J14 1 TABLE NAME OR GROUP OF TABLE NAMES

Complete Gold Hospital $0 Excess
Complete Gold Hospital $100 Co-payment
Complete Gold Hospital $500 Excess
Complete Gold Hospital $750 Excess

J14 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under products in **Rule J14 1**.

This is a:

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

J14 3 GENERAL CONDITIONS

(a) 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 contribution. Any policy which includes a **Non-Student Dependant** will be a "non-student policy" as defined by the *Private Health Insurance (Complying Product) Rules*.

J14 4 HOSPITAL TREATMENT PAYMENTS

J14 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J14 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum 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.

J14 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 J14 4.2(a)**, then the amount of **Benefits** payable is the **Minimum Benefits** for that service, or such higher amount agreed between CBHS and the **Hospital** on a one off basis.

J14 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 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.

J14 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 J14 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.

J14 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**.

J14 7 NON PBS PHARMACEUTICALS

Not available on this product.

J14 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*.

J14 9 NURSING HOME TYPE PATIENTS

(a) If:
  (i) a **Member** has been hospitalised for a continuous period of 35 days; and
  (ii) 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 Benefits**. **Minimum Benefits** only payable in relation to **Hospital** accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

(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.

J14 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 **Dependants**); and
  (ii) the amount of the **Co-payment** is:
    (A) $100 per day of hospitalisation per **Calendar Year** (maximum of 6 days per person and 12 days per **Couple Membership, Sole Parent Membership, Family Membership, Non-Student Dependant Sole Parent Membership** or **Non-Student Dependant Family Membership**).

J14 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 (with exception of **Dependants**).

(c) If you choose $500 **Excess**, then the amount of **Excess** payable by any **Member** covered is $500 per person 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, Family Membership, Non-Student Dependant Sole Parent Membership** or **Non-Student Dependant 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 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, Family Membership, Non-Student Dependant Sole Parent Membership** or **Non-Student Dependant Family Membership** - $1500 per **Calendar Year**

J14 12 BENEFIT LIMITATION PERIODS

Not applicable.

J14 13 RESTRICTED BENEFITS

The following services have restricted benefits:

Podiatric surgery (provided by a registered surgical podiatrist): If **Member** is admitted to a **Hospital** for podiatric surgery (provided by a registered surgical podiatrist), then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J14 14 EXCLUSIONS

The following services are excluded (not covered):

- Services for which a Medicare benefit is not payable (e.g., cosmetic services, laser eye surgery)

J14 15 LOYALTY BONUSES

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

J14 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**.

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

J14 17 DENTAL

J14 18 OPTICAL

J14 19 PHYSIOTHERAPY

J14 20 CHIROPRACTIC

J14 21 NON PBS PHARMACEUTICALS

J14 22 PODIATRY

J14 23 PSYCHOLOGY AND COUNSELLING

J14 24 ALTERNATIVE THERAPIES

J14 25 ORIENTAL AND NATURAL THERAPIES

J14 26 SPEECH THERAPY

J14 27 ORTHOTICS

J14 28 DIETETICS

J14 29 OCCUPATIONAL THERAPY

J14 30 NATUROPATHY

J14 31 ACUPUNCTURE

J14 32 OTHER THERAPIES

J14 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

J14 34 HEARING AIDS

J14 35 PREVENTION HEALTH MANAGEMENT

J14 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.

J14 37 ACCIDENT COVER

J14 38 ACCIDENTAL DEATH FUNERAL EXPENSES

J14 39 OTHER SPECIAL GENERAL TREATMENT

J14 40 HOSPITAL-SUBSTITUTE TREATMENT

J15 ADVANCED SILVER PLUS HOSPITAL

J15 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J15 1 TABLE NAME OR GROUP OF TABLE NAMES

Advanced Silver Plus Hospital $500 Excess
Advanced Silver Plus Hospital $750 Excess

J15 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under products in **Rule J15 1**.

This is a:

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

J15 3 GENERAL CONDITIONS

(a) 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 contribution. Any policy which includes a **Non-Student Dependant** will be a "non-student policy" as defined by the *Private Health Insurance (Complying Product) Rules*.

J15 4 HOSPITAL TREATMENT PAYMENTS

J15 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J15 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum 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.

J15 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 J15 4.2(a)**, then the amount of **Benefits** payable is the **Minimum Benefits** for that service, or such higher amount agreed between CBHS and the **Hospital** on a one off basis.

J15 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 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.

J15 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 J15 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.

J15 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**.

J15 7 NON PBS PHARMACEUTICALS

Not available on this product.

J15 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products)(Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*.

J15 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 Benefits**. **Minimum Benefits** only payable in relation to Hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

(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.

J15 10 CO PAYMENTS

Not applicable.

J15 11 EXCESSES

The **Excess** applies to all **Members** covered by the membership (with exception of **Dependants**).

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

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

J15 12 BENEFIT LIMITATION PERIODS

Not applicable.

J15 13 RESTRICTED BENEFITS

The following services have restricted benefits:

- 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 Benefits** for accommodation only.
- Podiatric surgery (provided by a registered surgical podiatrist): If a **Member** is admitted to a **Hospital** for podiatric surgery (provided by a registered surgical podiatrist), then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J15 14 EXCLUSIONS

The following services are excluded (not covered):

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

J15 15 LOYALTY BONUSES

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

J15 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**.

J15 17 DENTAL

J15 18 OPTICAL

J15 19 PHYSIOTHERAPY

J15 20 CHIROPRACTIC

J15 21 NON PBS PHARMACEUTICALS

J15 22 PODIATRY

J15 23 PSYCHOLOGY AND COUNSELLING

J15 24 ALTERNATIVE THERAPIES

J15 25 ORIENTAL AND NATURAL THERAPIES

J15 26 SPEECH THERAPY

J15 27 ORTHOTICS

J15 28 DIETETICS

J15 29 OCCUPATIONAL THERAPY

J15 30 NATUROPATHY

J15 31 ACUPUNCTURE

J15 32 OTHER THERAPIES

J15 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

J15 34 HEARING AIDS

J15 35 PREVENTION HEALTH MANAGEMENT

J15 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.

J15 37 ACCIDENT COVER

J15 38 ACCIDENTAL DEATH FUNERAL EXPENSES

J15 39 OTHER SPECIAL GENERAL TREATMENT

J15 40 HOSPITAL-SUBSTITUTE TREATMENT

J16 EVERYDAY SILVER PLUS HOSPITAL

J16 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J16 1 TABLE NAME OR GROUP OF TABLE NAMES

Everyday Silver Plus Hospital $500 Excess
Everyday Silver Plus Hospital $750 Excess

J16 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under products in **Rule J16 1**.

This is a:

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

J16 3 GENERAL CONDITIONS

(a) 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 contribution. Any policy which includes a **Non-Student Dependant** will be a "non-student policy" as defined by the *Private Health Insurance (Complying Product) Rules*.

J16 4 HOSPITAL TREATMENT PAYMENTS

J16 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J16 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum 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.

J16 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 J16 4.2(a)**, then the amount of **Benefits** payable is the **Minimum Benefits** for that service, or such higher amount agreed between CBHS and the **Hospital** on a one off basis.

J16 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 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.

J16 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 J16 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.

J16 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**.

J16 7 NON PBS PHARMACEUTICALS

Not available on this product.

J16 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*.

J16 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 Benefits**. **Minimum Benefits** only payable in relation to Hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

(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.

J16 10 CO PAYMENTS

Not applicable.

J16 11 EXCESSES

The **Excess** applies to all **Members** covered by the membership (with exception of **Dependants**).

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

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

J16 12 BENEFIT LIMITATION PERIODS

Not applicable.

J16 13 RESTRICTED BENEFITS

The following services have restricted benefits:

- 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 Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.
- 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 Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.
- Podiatric surgery (provided by a registered surgical podiatrist): If a **Member** is admitted to a **Hospital** for podiatric surgery (provided by a registered surgical podiatrist), then the **Benefits** payable for services rendered by the **Hospital** are restricted to **Minimum Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J16 14 EXCLUSIONS

The following services are excluded (not covered):

- Assisted reproductive services
- Cataracts
- Dialysis for chronic kidney failure
- Insulin pumps
- Joint replacements
- Pain management with device
- Pregnancy and birth
- Weight loss surgery
- Services for which a Medicare benefit is not payable (e.g., cosmetic services, laser eye surgery)

J16 15 LOYALTY BONUSES

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

J16 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**.

J16 17 DENTAL

J16 18 OPTICAL

J16 19 PHYSIOTHERAPY

J16 20 CHIROPRACTIC

J16 21 NON PBS PHARMACEUTICALS

J16 22 PODIATRY

J16 23 PSYCHOLOGY AND COUNSELLING

J16 24 ALTERNATIVE THERAPIES

J16 25 ORIENTAL AND NATURAL THERAPIES

J16 26 SPEECH THERAPY

J16 27 ORTHOTICS

J16 28 DIETETICS

J16 29 OCCUPATIONAL THERAPY

J16 30 NATUROPATHY

J16 31 ACUPUNCTURE

J16 32 OTHER THERAPIES

J16 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

J16 34 HEARING AIDS

J16 35 PREVENTION HEALTH MANAGEMENT

J16 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.

J16 37 ACCIDENT COVER

J16 38 ACCIDENTAL DEATH FUNERAL EXPENSES

J16 39 OTHER SPECIAL GENERAL TREATMENT

J16 40 HOSPITAL-SUBSTITUTE TREATMENT

J17 VALUE BRONZE PLUS HOSPITAL

J17 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J17 1 TABLE NAME OR GROUP OF TABLE NAMES

Value Bronze Plus Hospital $500 Excess
Value Bronze Plus Hospital $750 Excess

J17 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under products in **Rule J17 1**.

This is a:

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

J17 3 GENERAL CONDITIONS

(a) 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 contribution. Any policy which includes a **Non-Student Dependant** will be a "non-student policy" as defined by the *Private Health Insurance (Complying Product) Rules*.

J17 4 HOSPITAL TREATMENT PAYMENTS

J17 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J17 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum 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.

J17 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 J17 4.2(a)**, then the amount of **Benefits** payable is the **Minimum Benefits** for that service, or such higher amount agreed between CBHS and the **Hospital** on a one off basis.

J17 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 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.

J17 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 J17 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.

J17 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**.

J17 7 NON PBS PHARMACEUTICALS

Not available on this product.

J17 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*.

J17 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 Benefits**. **Minimum Benefits** only payable in relation to Hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

(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.

J17 10 CO PAYMENTS

Not applicable.

J17 11 EXCESSES

The **Excess** applies to all **Members** covered by the membership (with exception of **Dependants**).

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

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

J17 12 BENEFIT LIMITATION PERIODS

Not applicable.

J17 13 RESTRICTED BENEFITS

The following services have restricted benefits:

- 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 Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.
- 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 Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees..
- 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 Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J17 14 EXCLUSIONS

The following services are excluded (not covered):

- Assisted reproductive services
- Cataracts
- Dialysis for chronic kidney failure
- Heart and vascular system
- Implantation of hearing devices
- Insulin pumps
- Joint replacements
- Pain management with device
- Plastic and reconstructive surgery (medically necessary)
- Podiatric surgery (provided by a registered surgical podiatrist)
- Pregnancy and birth
- Weight loss surgery
- Services for which a Medicare benefit is not payable (e.g., cosmetic services, laser eye surgery)

J17 15 LOYALTY BONUSES

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

J17 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**.

J17 17 DENTAL

J17 18 OPTICAL

J17 19 PHYSIOTHERAPY

J17 20 CHIROPRACTIC

J17 21 NON PBS PHARMACEUTICALS

J17 22 PODIATRY

J17 23 PSYCHOLOGY AND COUNSELLING

J17 24 ALTERNATIVE THERAPIES

J17 25 ORIENTAL AND NATURAL THERAPIES

J17 26 SPEECH THERAPY

J17 27 ORTHOTICS

J17 28 DIETETICS

J17 29 OCCUPATIONAL THERAPY

J17 30 NATUROPATHY

J17 31 ACUPUNCTURE

J17 32 OTHER THERAPIES

J17 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

J17 34 HEARING AIDS

J17 35 PREVENTION HEALTH MANAGEMENT

J17 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.

J17 37 ACCIDENT COVER

J17 38 ACCIDENTAL DEATH FUNERAL EXPENSES

J17 39 OTHER SPECIAL GENERAL TREATMENT

J17 40 HOSPITAL-SUBSTITUTE TREATMENT

J18 STARTER BASIC PLUS HOSPITAL

J18 SCHEDULE COMBINED HOSPITAL TREATMENT AND GENERAL TREATMENT TABLES

J18 1 TABLE NAME OR GROUP OF TABLE NAMES

Starter Basic Plus Hospital $750 Excess

J18 2 ELIGIBILITY

Any person who is eligible to become a **Member** is entitled to be insured under products in **Rule J18 1**.

This is a:

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

J18 3 GENERAL CONDITIONS

(a) 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 contribution. Any policy which includes a **Non-Student Dependant** will be a "non-student policy" as defined by the *Private Health Insurance (Complying Product) Rules*.

J18 4 HOSPITAL TREATMENT PAYMENTS

J18 4.1 General

(a) Levels of **Benefit** payable are subject to **Rule J18 9**.

(b) Where the level of **Benefit** payable for a service is **Minimum 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.

J18 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 J18 4.2(a)**, then the amount of **Benefits** payable is the **Minimum Benefits** for that service, or such higher amount agreed between CBHS and the **Hospital** on a one off basis.

J18 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 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.

J18 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 J18 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.

J18 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**.

J18 7 NON PBS PHARMACEUTICALS

Not available on this product.

J18 8 SURGICALLY IMPLANTED PROSTHESES

If a **Member** receives a surgically implanted medical device or human tissue product for which a Medicare benefit is payable, and that medical device or human tissue product is listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*, as part of receiving an **Admitted Patient** service at a **Hospital**, then the **Benefit** payable for that medical device or human tissue product is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules*.

J18 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 Benefits**. **Minimum Benefits** only payable in relation to Hospital accommodation and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

(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.

J18 10 CO PAYMENTS

Not applicable.

J18 11 EXCESSES

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

The amount of **Excess** payable is $750 per person for overnight or same day admission to a **Hospital** by any **Member** covered up to a maximum of:

i. For **Single Membership** - $750 **per Calendar Year**
ii. For **Couple Membership, Sole Parent Membership, Family Membership, Non-Student Dependant Sole Parent Membership** or **Non-Student Dependant Family Membership** - $1500 **per Calendar Year**

J18 12 BENEFIT LIMITATION PERIODS

Not applicable.

J18 13 RESTRICTED BENEFITS

The following services have restricted benefits:

- 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 Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.
- 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**

Benefits for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

- 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 Benefits** for accommodation only and are not payable in relation to non-accommodation fees including theatre fees and labour ward fees.

J18 14 EXCLUSIONS

The following services are excluded (not covered):

- Assisted reproductive services
- Back, neck and spine
- Blood
- Brain and nervous system
- Breast surgery (medically necessary)
- Cataracts
- Chemotherapy, radiotherapy and immunotherapy for cancer
- Diabetes management (excluding insulin pumps)
- Dialysis for chronic kidney failure
- Digestive system
- Eye (not cataracts)
- Gynaecology
- Heart and vascular system
- Implantation of hearing devices
- Insulin pumps
- Joint replacements
- Kidney and bladder
- Lung and chest
- Male reproductive system
- Miscarriage and termination of pregnancy
- Pain management
- Pain management with device
- Plastic and reconstructive surgery (medically necessary)
- Podiatric surgery (provided by a registered surgical podiatrist)
- Pregnancy and birth
- Skin
- Sleep studies
- Weight loss surgery
- Services for which a Medicare benefit is not payable (e.g., cosmetic services, laser eye surgery)

J18 15 LOYALTY BONUSES

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

J18 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**.

J18 17 DENTAL

J18 18 OPTICAL

J18 19 PHYSIOTHERAPY

J18 20 CHIROPRACTIC

J18 21 NON PBS PHARMACEUTICALS

J18 22 PODIATRY

J18 23 PSYCHOLOGY AND COUNSELLING

J18 24 ALTERNATIVE THERAPIES

J18 25 ORIENTAL AND NATURAL THERAPIES

J18 26 SPEECH THERAPY

J18 27 ORTHOTICS

J18 28 DIETETICS

J18 29 OCCUPATIONAL THERAPY

.

J18 30 NATUROPATHY

J18 31 ACUPUNCTURE

J18 32 OTHER THERAPIES

J18 33 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

J18 34 HEARING AIDS

J18 35 PREVENTION HEALTH MANAGEMENT

J18 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.

J18 37 ACCIDENT COVER

J18 38 ACCIDENTAL DEATH FUNERAL EXPENSES

J18 39 OTHER SPECIAL GENERAL TREATMENT

J18 40 HOSPITAL-SUBSTITUTE TREATMENT

K SCHEDULE CONTRIBUTION RATES

Not Used.

L OVERSEAS VISITORS HEALTH COVER

L1 OVERVIEW OF PRODUCTS

L1.1 (A) ELIGIBILITY

1.1.1 These products are open to an eligible **Overseas Visitor**, their **Partner** and/or **Dependant** who:

- Holds or applies for an eligible temporary resident visa sub class to enter **Australia**; and
- Is in reasonable health at the time of the application; and
- Is not concurrently covered by an equivalent or corresponding policy with another insurer

are eligible to become a CBHS Health insured person.

1.1.2 Subject to these **Rules**, and the policy held by the person remaining up to date with contribution payments, CBHS will supply the selected **Product** for the intended duration of the visa being applied for or held.

1.1.3 An **OVHC Policy Holder** who also holds a complying health insurance policy is not entitled to a benefit for a claim on both **Product**. Where a service is covered by an **OVHC Policy** and a complying health insurance policy, the **Benefit** is only claimable on one **Product**.

1.1.4 An **Overseas Visitor** is eligible to join CBHS in the following manner:

(a) If an eligible visa has been granted for the **Overseas Visitor** only, then the **Overseas Visitor** must join CBHS on a **Single Membership**.
(b) If an eligible visa has been granted for the **Overseas Visitor** and a **Partner** as the secondary visa holder, then the **Overseas Visitor** must join CBHS on a **Couple Membership** listing the **Partner** as per the eligible visa.
(c) If an eligible visa has been granted for the **Overseas Visitor** and any **Dependant**, then the **Overseas Visitor** must join CBHS on a **Sole Parent Membership** listing the **Partner** and any **Dependant** as per the eligible visa.
(d) If an eligible visa has been granted for the **Overseas Visitor**, a **Partner** as the secondary visa holder and any **Dependant** then the **Overseas Visitor** must join CBHS on a **Family Membership** listing the **Partner** as per the eligible visa.

L1.1 (B) GENERAL CONDITIONS

Dependants

(a) CBHS may elect not to make a **Product** available to a category of insured that includes **Dependant** children.
(b) An application is required to add a **Dependant** to a policy. The following provisions apply when adding a **Dependant**:
    (i) Where a policy is a **Single Membership**, an upgrade to a **Couple Membership** is required to add the **Partner** as the secondary visa holder, and pay any contribution adjustment;
    (ii) Where a policy is a **Single Membership**, an upgrade to a **Sole Parent Membership** is required to add the **Dependant**, and pay any contribution adjustment;
    (iii) Where a policy is a **Couple Membership**, an upgrade to a **Family Membership** is required to add the **Dependant**, and pay any contribution adjustment;
    (iv) Where a policy is a **Family Membership**, a **Dependant** can be added, subject to paying any contribution adjustment.

Commencement of Policy

(a) Subject to acceptance of an application for OVHC by CBHS, an **OVHC Policy** commences:
  (i) On the date that CBHS confirms that the policy has been accepted; and
  (ii) When the visa start date has passed; and
  (iii) When the policy is up to date with contribution payments.

(b) A minimum payment for the **OVHC Policy** is required at the time of application.
(c) OVHC policies must not be paid more than 12 months in advance.
(d) The effective date of an **OVHC Policy** may be adjusted to align with:
- The date the **OVHC Policy Holder** arrives in **Australia**, where the visa was applied for outside of **Australia**; or
- The visa start date, where the visa was applied for and approved in **Australia**; or
- The following day after transferring from cover provided by another health insurance provider.

(e) If an application we have accepted for an **OVHC Policy** is withdrawn or cancelled prior to arrival in **Australia** or within 30 days of the start date of the policy if the applicant is in **Australia**, CBHS may apply a reasonable administration fee by way of deduction from the contribution paid.
(f) CBHS may define an administration fee from time to time.
(g) The **OVHC Policy** continues until the visa duration expires and while the policy remains up to date with contribution payments unless we are otherwise notified. The **OVHC Policy Holder** must notify CBHS if the visa class changes or expires.
(h) Where a **OVHC Policy Holder** is officially advised that their permanent Australian residency or full Medicare entitlements has been granted, they are no longer eligible to hold an **OVHC Policy** and must:
- Inform CBHS that Medicare entitlement has been granted;
- Cancel their **OVHC Policy**.

L1.2 LIST OF PRODUCTS

CBHS offers the following levels of cover:

1. Overseas Worker Top Hospital and Medical $0 Excess (Closed to new **Members** and transfers from 1 November 2025)
2. Overseas Worker Top Hospital and Medical $500 Excess (Closed to new **Members** and transfers from 1 November 2025)
3. Overseas Worker Mid Hospital and Medical $500 Excess (Closed to new **Members** and transfers from 1 November 2025)
4. Overseas Worker Base Hospital $500 Excess (Closed to new **Members** and transfers from 1 November 2025)

L1.3 HOSPITAL AND MEDICAL BENEFITS

(a) Medical Services Payments - Admitted Patient

Where the **Benefit** is to be calculated, the **Benefit** payable shall be the lower of:
(i) The fee of the **Medical Practitioner** (or other service provider registered with Medicare); or
(ii) 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.

(b) Medical Services Payments - Not Related to a Hospital Admission

A **Benefit** shall be provided for fees that are charged by a **Medical Practitioner** (or other service provider registered with Medicare) for services that are not part of an **Admitted Patient** episode (except psychiatric and psychology services). The **Benefit** shall only be payable where the service provided would have been covered by Medicare had it been provided to the holder of a valid Medicare Card.

The **Benefit** payable shall be as per the Overseas Visitor Health Cover, non-admitted patient medical benefits schedules detailed in these Fund Rules for Medical Services provided by General Practitioners and telehealth consultation services.

(c) Accommodation at Public Hospitals

The **Benefit** payable with respect to accommodation at a **Public Hospital** shall be **Gazetted Rates** for the episode for patients who do not hold a valid Medicare card. No **Benefit** is payable where an **Exclusion** applies.

(d) Accommodation at Non-Agreement Private Hospitals

The **Benefit** payable with respect to accommodation at a non-agreement **Private Hospital** shall be restricted to the **Minimum Benefits**. No **Benefit** is payable where an **Exclusion** applies.

(e) Accommodation at Agreement Private Hospitals

The **Benefit** payable with respect to accommodation at an agreement **Private Hospital** shall be the agreed contract rates, agreed between CBHS and the contracted agreement **Private Hospital**, except for services where restricted benefits or **Exclusion** applies. For accommodation services at an agreement **Private Hospital** where restricted benefits apply, the **Benefit** payable shall be restricted to the **Minimum Benefit**. No **Benefit** is payable where an **Exclusion** applies.

(f) Cooling off period not applicable

These products are not complying health insurance products. Consequently the cooling off period referred to in **Rule C8 (f)** is not applicable.

L1.4 WAITING PERIODS

In accordance with **Rule F3**, the following waiting periods apply to **Overseas Visitor** products:

Waiting periods	**Calendar months**
Pre-existing Condition, **Pregnancy and Birth** services	12 months
All other treatments (including **Pre-existing Condition** relating to hospital psychiatric services, rehabilitation, and palliative care)	2 months
Accidents, emergency ambulance transport	1 day

L1.5 GENERAL EXCLUSIONS

In addition to Rule **E1.1** benefits are not payable for:

- Treatment (or goods) provided in countries outside of **Australia**
- Treatment arranged in advance to arrival in **Australia**
- Services and treatments which are covered by compensation and damage provisions of any kind
- Same treatment or service claimed under more than one **Product**

- Services required for the purpose of gaining a visa or residency (excluded on Overseas Worker Mid Hospital and Medical; and Overseas Worker Base Hospital).

L2 OVERSEAS WORKER TOP HOSPITAL AND MEDICAL

L2.1 PRODUCT NAME

1. Overseas Worker Top Hospital and Medical $0 Excess (Closed to new **Members** and transfers from 1 November 2025).
2. Overseas Worker Top Hospital and Medical $500 Excess (Closed to new **Members** and transfers from 1 November 2025).

L2.2 HOSPITAL TREATMENTS AND MEDICAL BENEFITS

Covered Item	Description	Benefits, Exclusions and Restricted Benefits
HOSPITAL BENEFITS		
Accommodation	For overnight and same day accommodation in: • an agreement **Private Hospital** (private or shared room) • a non-agreement **Private Hospital** (shared room) and • a **Public Hospital** (shared room). If an excess option has been selected, the excess will apply (does not apply to **Dependants**).	<u>Agreement Private Hospital</u> The **Benefit** payable shall be paid at agreed contract rates, as agreed between CBHS and the agreement **Private Hospital**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies. <u>Non-agreement Private Hospital</u> The **Benefit** payable shall be restricted to the **Minimum Benefit**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies. <u>Public Hospital</u> The **Benefit** payable shall be paid at **Gazetted Rates**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies.
Operating theatre, labour ward and intensive care fees	Operating theatre, labour ward, and intensive care fees covered in an agreement **Private Hospital,** non-agreement **Private Hospital** and **Public Hospital**.	<u>Agreement Private Hospital</u> The **Benefit** payable shall be paid at agreed contract rates, as agreed between CBHS and the agreement **Private Hospital**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies. <u>Non-agreement Private Hospital</u> No **Benefit** is payable for services rendered at a non-agreement **Private Hospital**, or where an **Exclusion** applies. <u>Public Hospital</u> The **Benefit** payable shall be paid at **Gazetted Rates**, except for services where

		an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies.
Emergency department facility fees	Fees charged by a **Private Hospital** or **Public Hospital** emergency department for attending the facility.	Covered in full where leading to an admission, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies. Where the attendance does not lead to an admission, a maximum benefit of $160 shall by payable, except for services where restricted benefits or **Exclusion** applies.
In-patient supplied pharmaceuticals	Medicines listed on the PBS Schedule and provided as part of an **Admitted Patient** treatment.	Covered in full except for services where an **Exclusion** applies and as otherwise stated below: Note: Other medicines (including experimental or high-cost drugs) may not be covered. Cost of pharmaceuticals supplied upon discharge from hospital will not be covered under **Admitted Patient** supplied pharmaceutical. Discharge medication may be covered under **Non-Admitted Patient** prescription medicine **Benefits**.
Surgically implanted medical devices and human tissue products	At least the minimum **Benefits** specified in Federal Government Prescribed List of Medical Devices and Human Tissue Products.	Covered up to the relevant amount on the Federal Government Prescribed List of Medical Devices and Human Tissue Products except for services where an **Exclusion** applies
ADMITTED PATIENT MEDICAL BENEFITS		
Admitted Patient Medical Expenses	Services provided by doctors, surgeons, or anesthetists in hospital.	If a **Member** receives an **Admitted Patient** service from a **Medical Practitioner** (or service from any other service provider registered with Medicare), then the **Benefit** is 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.
NON-ADMITTED PATIENT MEDICAL BENEFITS		
Medical Services provided by General Practitioners (GP)	Consultation and treatment provided by general practitioners in a face-to-face environment.	Up to 100% of the **Medicare Benefits Schedule Fee**, except for services where an **Exclusion** applies.

Medical Services provided by a telehealth consultation service	Consultation and treatment provided by a **Medical Practitioner** via remote (video and telephone) consultation.	• Services provided by telehealth providers with whom CBHS has entered a preferred provider arrangement: 100% of the agreed rate, except for services where an **Exclusion** applies • Services provided by telehealth providers with whom CBHS does not have a preferred provider arrangement: up to 100% of the **Medicare Benefits Schedule Fee** where a Medicare Benefit Schedule item number is provided, except for services where an **Exclusion** applies
Specialist Doctor	Consultation and treatment provided by specialist doctors.	100% of the **Medicare Benefits Schedule Fee**, except for services where an **Exclusion** applies.
Specialist Services	Medical specialists including pathology, radiology, and medical imaging.	100% of the **Medicare Benefits Schedule Fee** for specialist services including pathology and radiology, except for services where an **Exclusion** applies.
Hospital Non-Admitted Patient medical treatment	Treatment provided at a **Public Hospital Non-Admitted Patient** clinic, including Accident and Emergency, when the insured is not an admitted patient.	Up to 100% of **Medicare Benefits Schedule Fee**, except for services where **Exclusion** applies.
Pharmaceuticals and medicines	Selected pharmacy items prescribed by a doctor or specialist which are **Pharmaceuticals** approved for the condition for which the item is being prescribed.	Selected **Pharmaceutical** items including discharge medications. Benefit of 100% up to $75 of the receipted cost of the prescription less a Co-payment equivalent to the current prescribed **PBS** co-payment for general patients with an overall limit of $600 per person in a **Calendar Year**.
Chronic Disease Management Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
Hospital Substitute Treatment Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
Maternity Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
Mental Health Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
AMBULANCE COVER		

Ambulance cover	Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as Royal Flying Doctor Service). Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per Calendar Year.	Full cover for **Emergency Ambulance**. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per Calendar Year.

L2.3 EXCESS

- Overseas Worker Top Hospital and Medical $0 Excess: No excess payable.
- Overseas Worker Top Hospital and Medical $500 Excess: $500 excess payable.

The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member**

(with exception of **Dependants)** covered up to a maximum of:

i. For **Single Membership** - $500 per **Calendar Year**
ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1,000 per **Calendar Year**

L2.4 RESTRICTED BENEFITS

Not applicable on this product.

L2.5 EXCLUSIONS

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

a) **Non-Admitted Patient** psychiatric and psychology services
b) Assisted reproductive services
c) **Cosmetic services**
d) **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery).

L2.6 OTHER SPECIAL HOSPITAL TREATMENT

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

L2.7 REPATRIATION

The **Benefit** is for one one-way repatriation, per membership per **Calendar Year**, up to a maximum of $10,000 if the **Member** becomes **Terminally Ill** or suffers a life altering injury, including the return of mortal remains.

CBHS reserves to refer applications to a **Medical Advisor** and payment of the benefit shall be on a case-by-case basis and at the absolute discretion of CBHS.

L3 OVERSEAS WORKER MID HOSPITAL AND MEDICAL

L3.1 PRODUCT NAME

1. Overseas Worker Mid Hospital and Medical $500 Excess (Closed to new **Members** and transfers from 1 November 2025).

L3.2 HOSPITAL TREATMENTS AND MEDICAL BENEFITS

Covered Item	Description	Benefits, Exclusions and Restricted Benefits
HOSPITAL BENEFITS		
Accommodation	For overnight and same day accommodation in: • an agreement **Private Hospital** (private or shared room) • a non-agreement **Private Hospital** (shared room) and • a **Public Hospital** (shared room). The excess will apply.	<u>Agreement Private Hospital</u> The **Benefit** payable shall be paid at agreed contract rates, as agreed between CBHS and the agreement **Private Hospital**, except for services where restricted benefits or **Exclusion** applies. Services for restricted benefits at an agreement **Private Hospital** are restricted to the **Minimum Benefit**. No **Benefit** is payable where an **Exclusion** applies. <u>Non-agreement Private Hospital</u> The **Benefit** payable shall be restricted to the **Minimum Benefit**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies. <u>Public Hospital</u> The **Benefit** payable shall be paid at **Gazetted Rates**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies.
Operating theatre, labour ward and intensive care fees	Operating theatre, labour ward, and intensive care fees covered in an agreement **Private Hospital**, non-agreement **Private Hospital** and **Public Hospital**.	<u>Agreement Private Hospital</u> The **Benefit** payable shall be paid at agreed contract rates, as agreed between CBHS and the agreement **Private Hospital**, except for services

		where restricted benefits or **Exclusion** applies. No **Benefit** is payable for services with restricted benefits rendered at an agreement **Private Hospital**, or where an **Exclusion** applies. <u>Non-agreement Private Hospital</u> No **Benefit** is payable for services rendered at a non-agreement **Private Hospital**, or where an **Exclusion** applies. <u>Public Hospital</u> The **Benefit** payable shall be paid at **Gazetted Rates**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies.
Emergency department facility fees	Fees charged by a **Private Hospital** or **Public Hospital** emergency department for attending the facility.	Covered in full where leading to an admission, except for services where an **Exclusion** applies. No **Benefit** shall be payable where an **Exclusion** applies. Where the attendance does not lead to an admission, a maximum benefit of $160 shall be payable, except for services where restricted benefits or **Exclusion** applies.
Admitted Patient supplied pharmaceuticals	Medicines listed on the PBS Schedule and provided as part of an **Admitted Patient** treatment.	Covered in full except for services where an **Exclusion** applies and as otherwise stated below: Note: Other medicines (including experimental or high-cost drugs) may not be covered. **Cost of pharmaceuticals supplied upon discharge** from hospital will not be covered under **Admitted Patient** supplied pharmaceutical. Discharge medication may be covered under **Non-Admitted Patient** prescription medicine **Benefits**.
Surgically implanted medical devices and human tissue products	At least the minimum **Benefits** specified in the Federal Government Prescribed List of Medical Devices and Human Tissue Products.	Covered up to the relevant amount on the Federal Government Prescribed List of Medical Devices and Human Tissue Products except for services where an **Exclusion** applies.
ADMITTED PATIENT MEDICAL BENEFITS		

Admitted Patient Medical Expenses	Services provided by doctors, surgeons, or anesthetists in hospital.	If a **Member** receives an **Admitted Patient** service from a **Medical Practitioner** (or service from any other service provider registered with Medicare), then the **Benefit** is 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.
NON-ADMITTED PATIENT MEDICAL BENEFITS		
Medical Services provided by General Practitioners (GP)	Consultation and treatment provided by general practitioners in a face-to-face environment.	Up to 100% of the **Medicare Benefits Schedule Fee**, except for services where an **Exclusion** applies.
Medical Services provided by a telehealth consultation service	Consultation and treatment provided by a **Medical Practitioner** via remote (video and telephone) consultation.	• Services provided by telehealth providers with whom CBHS has entered a preferred provider arrangement: 100% of the agreed rate, except for services where an **Exclusion** applies • Services provided by telehealth providers with whom CBHS does not have a preferred provider arrangement: up to 100% of the **Medicare Benefits Schedule Fee** where a Medicare Benefit Schedule item number is provided, except for services where an **Exclusion** applies
Specialist Doctor	Consultation and treatment provided by specialist doctors.	100% of the **Medicare Benefits Schedule Fee**, except for services where an **Exclusion** applies.
Specialist Services	Medical specialists including pathology, radiology, and medical imaging.	100% of the **Medicare Benefits Schedule Fee** for specialist services including pathology and radiology, except for services where an **Exclusion** applies.

Hospital Non-Admitted Patient medical treatment	Treatment provided at a **Public Hospital Non-Admitted Patient** clinic, including Accident and Emergency, when the insured is not an admitted patient.	Up to 100% of **Medicare Benefits Schedule Fee**, except for services where **Exclusion** applies.
Pharmaceuticals and medicines	Selected pharmacy items prescribed by a doctor or specialist which are **Pharmaceuticals** approved for the condition for which the item is being prescribed.	Selected **Pharmaceutical** items including discharge medications. Benefit of 100% up to $75 of the receipted cost of the prescription less a Co-payment equivalent to the current prescribed **PBS** co-payment for general patients with an overall limit of $300 per person in a **Calendar Year**.
Chronic Disease Management Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
Hospital Substitute Treatment Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
Maternity Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
Mental Health Program		100% of the cost for **Overseas Worker** approved by CBHS to participate.
AMBULANCE COVER		
Ambulance cover	Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as Royal Flying Doctor Service). Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per Calendar Year.	Full cover for **Emergency Ambulance**. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per Calendar Year.

L3.3 EXCESS

- Overseas Worker Mid Hospital and Medical $500 Excess: $500 excess payable.

  The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:
  i. For **Single Membership** - $500 per **Calendar Year**
  ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1,000 per **Calendar Year**

L3.4 RESTRICTED BENEFITS

If a **Member** is admitted to an agreement **Private Hospital** for any of the services listed below, then the **Benefits** payable for accommodation shall be restricted to the **Minimum Benefit** and no **Benefit** shall be paid for theatre, intensive care or labour ward fees.

a) **Pregnancy and Birth**
b) Rehabilitation
c) Hospital psychiatric services
d) Palliative care
e) Weight loss surgery

Public Hospital

The **Benefit** payable at a **Public Hospital** shall be paid at **Gazetted Rates** for the episode for patients who do not hold a valid Medicare card (irrespective of which service). No **Benefit** is payable where an **Exclusion** applies.

Non-agreement Private Hospital

The **Benefit** payable with respect to accommodation at a non-agreement **Private Hospital** shall be restricted to the **Minimum Benefit** and no **Benefit** shall be paid for theatre, intensive care or labour ward fees (irrespective of which service) or where an **Exclusion** applies.

L3.5 EXCLUSIONS

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

a) **Non-Admitted Patient** psychiatric and psychology services
b) Stem cells, bone marrow transplants
c) Organ transplants
d) Assisted reproductive services
e) **Cosmetic services**
f) **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery).

L3.6 OTHER SPECIAL HOSPITAL TREATMENT

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

L3.7 REPATRIATION

The **Benefit** is for one one-way repatriation, per membership per **Calendar Year**, up to a maximum of $10,000 if the **Member** becomes **Terminally Ill** or suffers a life altering injury, including the return of mortal remains.

CBHS reserves to refer applications to a **Medical Advisor** and payment of the benefit shall be on a case-by-case basis and at the absolute discretion of CBHS.

L4 OVERSEAS WORKER BASE HOSPITAL

L4.1 PRODUCT NAME

1. Overseas Worker Base Hospital $500 Excess (Closed to new **Members** and transfers from 1 November 2025).

L4.2 HOSPITAL TREATMENTS AND MEDICAL BENEFITS

Covered Item	Description	Benefits, Exclusions and Restricted Benefits
HOSPITAL BENEFITS		
Accommodation	For overnight and same day accommodation in: • an agreement **Private Hospital** (private or shared room) • a non-agreement **Private Hospital** (shared room) and • a **Public Hospital** (shared room). The excess will apply.	<u>Agreement Private Hospital</u> The **Benefit** payable shall be paid at agreed contract rates, as agreed between CBHS and the agreement **Private Hospital**, except for services where restricted benefits or **Exclusion** applies. Services for restricted benefits at an agreement **Private Hospital** are restricted to the **Minimum Benefit**. No **Benefit** is payable where an **Exclusion** applies. <u>Non-agreement Private Hospital</u> The **Benefit** payable shall be restricted to the **Minimum Benefits**. No **Benefit** is payable where an **Exclusion** applies. <u>Public Hospital</u> The **Benefit** payable shall be paid at **Gazetted Rates**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies.
Operating theatre, labour ward and intensive care fees	Operating theatre, labour ward, and intensive care fees covered in an agreement **Private Hospital**, non-agreement **Private Hospital** and **Public Hospital**.	<u>Agreement Private Hospital</u> The **Benefit** payable shall be paid at agreed contract rates, as agreed between CBHS and the agreement **Private Hospital**, except for services

		where restricted benefits or **Exclusion** applies. No **Benefit** is payable for services with restricted benefits rendered at an agreement **Private Hospital**, or where an **Exclusion** applies <u>Non-agreement Private Hospital</u> No **Benefit** is payable for services rendered at a non-agreement **Private Hospital**, or where an **Exclusion** applies. <u>Public Hospital</u> The **Benefit** payable shall be paid at **Gazetted Rates**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies.
Emergency department facility fees	Fees charged by a **Private Hospital** or **Public Hospital** emergency department for attending the facility.	<u>Public Hospital</u> Covered in full where attendance leads to an admission into a **Public Hospital**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies. Where the attendance does not lead to an admission, no **Benefit** is payable. <u>Private Hospital</u> Covered up to a maximum of $160 where leading to an admission into a **Private Hospital**, except for services where an **Exclusion** applies. No **Benefit** is payable where an **Exclusion** applies. Where attendance does not lead to an admission, no **Benefit** is payable.
Admitted Patient supplied pharmaceuticals	Medicines listed on the PBS Schedule and provided as part of an **Admitted Patient** treatment.	Covered in full except for services where an **Exclusion** applies and as otherwise stated below: Note: Other medicines (including experimental or high-cost drugs) may not be covered.
Surgically implanted medical devices and human tissue products	At least the minimum **Benefits** specified in the Federal Government Prescribed List of Medical Devices and Human Tissue Products.	Covered up to the relevant amount on the Federal Government Prescribed List of Medical Devices and Human Tissue Products except for services where an **Exclusion** applies.

ADMITTED PATIENT MEDICAL BENEFITS		
Admitted Patient Medical Expenses	Services provided by doctors, surgeons, or anesthetists in hospital.	If a **Member** receives an **Admitted Patient** service from a **Medical Practitioner** (or service from any other service provider registered with Medicare), then the **Benefit** is 100% of the **Medicare Benefits Schedule Fee** that would apply to the service if the service had been provided to the holder of a valid Medicare card.
NON-ADMITTED PATIENT MEDICAL BENEFITS		
No benefits payable for non-admitted patient.		
AMBULANCE COVER		
Ambulance cover	Includes cover for **Emergency Ambulance** services when transported directly to a hospital or treated at the scene due to an **Accident** or **Medical Emergency**. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as Royal Flying Doctor Service). Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per Calendar Year.	Full cover for **Emergency Ambulance**. Residents of WA are also eligible to claim a **Benefit** for **Non-Emergency Ambulance** transport services up to a maximum of $5,000 per person per Calendar Year.

L4.3 EXCESS

- Overseas Worker Base Hospital $500 Excess: $500 excess payable.

  The amount of **Excess** payable is $500 per person per **admission** for overnight or same day admission to a hospital by any **Member** covered up to a maximum of:
  i. For **Single Membership** - $500 per **Calendar Year**
  ii. For **Couple Membership, Sole Parent Membership** or **Family Membership** - $1,000 per **Calendar Year**

L4.4 RESTRICTED BENEFITS

If a **Member** is admitted to an agreement **Private Hospital** for any of the services listed below, then the **Benefits** payable for accommodation shall be restricted to the **Minimum Benefit** and no **Benefit** shall be paid for theatre, intensive care or labour ward fees.

a) **Pregnancy and Birth**
b) Rehabilitation
c) Hospital psychiatric services
d) Palliative care
e) Weight loss surgery

Public Hospital

The **Benefit** payable at a **Public Hospital** shall be paid at **Gazetted Rates** for the episode for patients who do not hold a valid Medicare card (irrespective of which service). No **Benefit** is payable where an **Exclusion** applies.

Non-agreement Private Hospital

The **Benefit** payable with respect to accommodation at a non-agreement **Private Hospital** shall be restricted to the **Minimum Benefit** and no **Benefit** shall be paid for theatre, intensive care or labour ward fees (irrespective of which service) or where an **Exclusion** applies.

L4.5 EXCLUSIONS

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

a) **Non-Admitted Patient** psychiatric and psychology services
b) Stem cells, bone marrow transplants
c) Organ transplants
d) Assisted reproductive services
e) **Cosmetic services**
f) **Hospital** services for which there is no **Medicare Benefit Schedule Fee** payable (for example: podiatric surgery and laser eye surgery).

L4.6 OTHER SPECIAL HOSPITAL TREATMENT

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

L4.7 REPATRIATION

The **Benefit** is for one one-way repatriation, per membership per **Calendar Year**, up to a maximum of $10,000 if the **Member** becomes **Terminally Ill** or suffers a life altering injury, including the return of mortal remains.

CBHS reserves to refer applications to a **Medical Advisor** and payment of the benefit shall be on a case-by-case basis and at the absolute discretion of CBHS.

L5 CBHS OVERSEAS VISITORS HEALTH COVER

L5.1 ELIGIBILITY

This product is closed for new **Members** and transfer from 1 August 2024.

L5.2 PRODUCT DESCRIPTION

The product provides benefits that are similar to a combination of the products Comprehensive Hospital (Gold) (see Schedule J2) and Top Extras (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 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 Benefits** that would be payable to a **Member** covered by the Comprehensive Hospital product.

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

This product is not a complying health insurance product. Consequently the 60 day cooling off period referred to in **Rule C8 (f)** is not applicable.