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INTRODUCTION

A1 Rules Arrangement

These Rules set out:

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

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

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

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

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

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

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

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

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

(j) Part K – contribution rates.

A2 Health Benefits Fund

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

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

A3 Obligations to Insurer

A3.1 Provision of information

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

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

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

A3.2 Obligations relating to Compensable Injuries

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

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

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

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

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

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

A4 Governing Principles

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

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

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

A5 Use of Funds

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

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

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

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

A6 No Improper Discrimination

A 6.1 CBHS Corporate not to engage in Improper Discrimination

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

A7 Changes to Rules

A7.1 General Changes to Rules

(a) CBHS Corporate may, subject to its Constitution and the Act, change these Rules at any time.
(b) CBHS Corporate shall notify Members about changes to the Rules in accordance with the Act.
(c) Changes to the Rules will not apply to an admission to Hospital which was already booked at the time the change was notified to Members.
(d) If:
    i. a Member is undergoing a course of treatment; and
    ii. a change to the Rules would have a detrimental effect on the Member in relation to that treatment;

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

A7.2 Waiver of Rules in Specific Cases

(a) CBHS Corporate may waive the application of particular Rules at its sole discretion, as long as the waiver is not detrimental to a Member or inconsistent with the Act.
(b) CBHS Corporate may waive the application of particular Rules by making an ex-gratia payment of a Benefit in accordance with an ex-gratia payment policy approved by the Board.
(c) If CBHS Corporate waives the application of particular Rules on one occasion, this does not bind CBHS Corporate to waive those Rules on any other occasion.

A8 Dispute Resolution

(a) CBHS Corporate offers an internal dispute resolution process to Members through its Complaint Handling Policy and Procedures.
(b) Members may make a complaint about any aspect of their membership at any time.
(c) Members can obtain information about the Complaint Handling Policy and Procedures at www.cbhscorporatehealth.com.au or by calling Member Care or email help@cbhscorp.com.au
(d) Members, or people seeking to become Members, can also complain to the Private Health Insurance Ombudsman (PHIO) about matters arising out of, or in connection with a private health insurance policy. The PHIO is a Commonwealth Government official who is independent of private health insurers.

A9 Notices

A9.1 Correspondence with Members

(a) CBHS Corporate shall direct its correspondence with Members to the most recently advised postal address, fax number or e-mail address for the Policy Holders in relation to the membership.
(b) Where the Rules require CBHS Corporate to notify a Member, or give the Member a notice, CBHS Corporate has satisfied that requirement if it has complied with Rule A9.1 (a) above.

A9.2 Availability of Rules

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

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

A10 Winding Up

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

B INTERPRETATION AND DEFINITIONS

B1 Interpretation

B1.1 General

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

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

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

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

(e) Unless otherwise stated in these Rules, a reference to a person, including a Member, includes the person's executors, administrators, successors and permitted assigns for the purposes of any right, obligation or benefit of the person.

(f) A reference to, or to a provision in, a statute or legislative instrument includes a reference to the statute or instrument as amended, re-enacted, remade or substituted from time to time

(g) A reference to a particular Minister, Department or Government Agency includes a reference to a different or renamed Minister, Department or Government Agency which deals with matters relevant to these rules.

(h) In these Rules headings are inserted for ease of reference only and do not form part of the Rules and do not affect the construction of the Rules.

(i) If a word or phrase is defined, any other grammatical form of that word or phrase (including the use of a plural) has a corresponding meaning.

B1.2 Continuity of the Rules

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

B2 Definitions

In these Rules unless the contrary intention appears:

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

"Accident" means an injury inflicted as a result of unintentional, unexpected actions or events which requires treatment by a medical practitioner, Hospital or dentist (as the context requires), but excludes pregnancy.

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

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

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

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

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

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

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

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

measured over Any 3 Years or Any 5 Years, shall become available again on the third or fifth anniversary (whichever is relevant) of the date when the service or treatment was provided or the goods received.

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

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

"Australia" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Dietetic Service" means:

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

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

"Emergency Ambulance" means an ambulance service that consists of transporting a seriously ill person to a Hospital by a State Government Ambulance Service or an ambulance service

recognised by CBHS Corporate in order to receive urgently needed treatment. This includes transportation from the scene of an Accident or the scene of a medical event such as a heart attack or stroke, but does not include transportation to Hospital for the routine management of an ongoing medical condition or transportation between hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Health Management" means:

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

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

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

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

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

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

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

"Hypnotherapy Service" means a hypnotherapy service or treatment conducted by a Recognised Provider.

"Improper Discrimination" means discrimination defined in section 55-5 of the Act.

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

"Limit per Service" under a level of extras cover means the maximum amount of Benefit which CBHS Corporate will pay in respect of a claim for a particular type of service (as specified in the benefits tables maintained by CBHS Corporate in its database).

"Massage Therapy" means a service or treatment provided by a Recognised Provider in alexander technique, aromatherapy, Bowen therapy, deep tissue massage, Feldenkrais,

lymphatic drainage, Myotherapy, remedial massage, Rolfing, sports massage, Swedish massage and therapeutic massage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"PBS" means the Commonwealth Pharmaceutical Benefits Scheme.

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

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

"Pharmaceuticals" means a substance which:

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

But does not include a substance which:

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

“Physiology Service” means an exercise physiology service or treatment provided by a Recognised Provider.

“Physiotherapy Service” means a physiotherapy service or treatment provided by a Recognised Provider.

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

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

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

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

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

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

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

“Product” has the same meaning as in the Act.

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

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

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

“Restricted Access Group” means the group defined in Rule C2.1.

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

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

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

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

"State" means a State or Territory of Australia.

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

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

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

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

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

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

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

C MEMBERSHIP

C1 General Conditions of Membership

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

1) Single Membership;
2) Couple Membership;
3) Family Membership; and
4) Sole Parent Membership.

CBHS Corporate offers the following levels of cover:

1) Gold Hospital ($0 and $500 Excess)
2) Silver Hospital ($0 and $500 Excess)
3) Bronze Hospital ($500 Excess)
4) Gold Extras
5) Silver Extras
6) Bronze Extras
7) Ambulance Cover

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

C2 Eligibility for Membership

C2.1 Membership Eligibility: General

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

C3 Dependants

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

(b) If:

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

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

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

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

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

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

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

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

C4 Membership Applications

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

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

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

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

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

C5 Duration of Membership

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

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

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

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

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

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

C6 Transfers

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

(a) If a person:

i. is a Member of a Non-CBHS Corporate Health Fund; and

ii. applies for membership of this Fund within one calendar month of leaving the Non-CBHS Corporate Health Fund; and

iii. CBHS Corporate accepts the application for membership;

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

(b) In taking into account the amount of time a person has held cover with a Non-CBHS Corporate Health Fund when determining whether Waiting Periods have been served, CBHS Corporate will also consider:
 i. the level of benefits payable by the Non-CBHS Corporate Health Fund and scope of the coverage under the policy held by the person; and
 ii. the level of Benefits payable by this Fund and scope of coverage under the policy chosen by the person.

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

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

(d) Where the level of Benefits payable and the scope of coverage of the policy with the Non-CBHS Corporate Health Fund is lower than the level of Benefits payable and the scope of coverage of this Fund then:
 i. CBHS Corporate will count the amount of time a person held the level of cover with the Non-CBHS Corporate Health Fund as time served against the Waiting Period for that portion of the Benefits which are equivalent to the Benefits payable under the policy with the Non-CBHS Corporate Health Fund; and
 ii. CBHS Corporate may apply the full Waiting Period for Benefits payable in relation to that portion of the cover which is in excess to the Benefits payable under the policy with the Non-CBHS Corporate Health Fund.
 iii CBHS Corporate may apply the full Waiting Period for Extras Benefits in excess of Extras Benefits previously held under the Non-CBHS Corporate Health Fund.

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

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

(a) If:
 (i) a Member has transferred to CBHS Corporate from a Non-CBHS Corporate Health

Fund; and

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

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

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

(b) If a Member:

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

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

then any claims made under the Non-CBHS Corporate Health Fund in respect of Extras Benefits that are subject to the limitation shall be taken to be accrued and applied under the policy with this Fund for the purposes of calculating any overall limit on the amount of Extras Benefits payable by this Fund under the policy in the respective period. Where a Member is serving a Waiting Period under Rule C6.1(a), the Waiting Period is included in calculating the Calendar Year or Lifetime periods.

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

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

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

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

(b) If:

(i) a Member has transferred between policies within the Fund; and

(ii) the original policy held by the Member included the same or similar Excess or Co-payment as the policy transferred to; and

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

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

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

then any claims made under the original policy in respect of Extras Benefits that are subject to the limitation shall be taken to be accrued and applied under the policy transferred to for the purposes of calculating any overall limit on the amount of Extras Benefits payable under the policy transferred to in the respective period.
Where a Member is serving a Waiting Period under Rule C6.3(a), the Waiting Period is included in calculating a Calendar Year, Any 3 years, Any 5 years or Lifetime periods.

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

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

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

(b) In taking into account the amount of time a person has held the previous cover when determining whether Waiting Periods have been served, CBHS Corporate will also consider whether a Benefit is payable for a particular service under both types of cover.
(c) If a Benefit is payable for a service under both types of cover, then CBHS Corporate shall take into account the amount of time a person has held the previous cover when determining whether any Waiting Period required under these Rules for that service has been served.
(d) If a Benefit was not payable for a service under the previous cover, but is payable under the new cover, then CBHS Corporate may apply in full any Waiting Period required for that Benefit under these Rules.
(e) If:
   i. CBHS Corporate initiates a transfer of a Member's membership; and
   ii. the Member has paid an Excess or Co-payment or claimed a Benefit subject to a limitation under the previous cover;

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

C7 Cancellation of Membership

C7.1 Grounds for cancellation

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

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

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

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

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

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

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

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

C7.2 Date of effect of cancellation

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

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

C7.3 Treatment of excess contributions

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

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

C8 Termination of Membership

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

  i notice in writing to CBHS Corporate; or

  ii by telephone advice to CBHS Corporate.

  If a Policy Holder terminates their membership by telephone advice, CBHS Corporate will

confirm the termination by notice in writing to the Policy Holder.

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

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

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

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

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

C9 Temporary Suspension of Membership

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

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

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

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

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

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

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

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

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

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

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

(h) If the Member:

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

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

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

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

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

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

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

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

C10 Other

C10.1 Privacy

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

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

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

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

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

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

D CONTRIBUTIONS

D1 Payment of Contributions

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

(a) Contributions (other than contributions for Emergency Ambulance only cover) may be paid by or on behalf of Policy Holders on a fortnightly, monthly, quarterly, half yearly or annual

basis. Contributions shall be paid in advance unless they are paid in accordance with Rule D1.1(b)(i).

(b) Contributions may be paid:
   i. through the payroll deduction scheme if arranged by CBHS Corporate; or
   ii. by direct debit; or
   iii. by any other arrangement authorised by CBHS Corporate from time to time.

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

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

(b) Contributions may be paid:
   i. through the payroll deduction scheme if arranged by CBHS Corporate; or
   ii. by direct debit; or
   iii. by any other arrangement authorised by CBHS Corporate from time to time.

D1.3 Amount of Payment

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

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

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

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

(e) The amount of contributions payable by Policy Holders on a monthly, quarterly, half yearly or annual basis will be calculated using the fortnightly rate for that cover as follows:
   i. the fortnightly rate will be multiplied by 26 to give the total amount due for a twelve-month period and that amount will then be:
      (A) divided by 12 to determine the monthly rate of contributions; or
      (B) divided by 4 to determine the quarterly rate of contributions; or
      (C) divided by 2 to determine the half yearly rate of contributions; or
      (D) divided by 1 to determine the annual rate of contributions.

D2 Contribution Rate Changes

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

D3 Contribution Discounts

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

D4 Lifetime Health Cover

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

D5 Arrears in Contributions

(a) If a Policy Holder has not met a contribution payment prior to the Paid to Date, then that membership is in arrears.

(b) Any period of arrears is calculated as commencing on the Paid to Date.

(c) CBHS Corporate shall not pay any Benefits for goods or services rendered to a Member during a period in which the membership is in arrears until the outstanding contributions are paid to CBHS Corporate, and CBHS Corporate has accepted them.

(d) CBHS Corporate may refuse to accept outstanding contributions for a membership if that membership has lapsed.

(e) A membership lapses when it has been in arrears for a continuous period of more than two months.

E BENEFITS

E1 General Conditions

E1.1 When a Benefit is not payable

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

- i. the costs of that service were incurred by the Member's employer; or
- ii. the Member obtained the service in connection with:
  - (A) employment; or
  - (B) application for employment; or
  - (C) an industrial undertaking or profession; or
  - (D) a life insurance examination; or
  - (E) other non-treatment function; or
- iii. the service was rendered to the Member as part of care and accommodation in an Aged Care Service; or
- iv. the service was rendered by a person who is not a Recognised Provider; or
- v the service did not meet the standards set out in the *Private Health Insurance (Accreditation) Rules*; or
- vi. the service is claimable from Medicare;
- vii. the Member has not submitted a claim to CBHS Corporate in accordance with Part G;
- viii the services can be claimable from any other source; or
- ix the service is listed as Exclusion; or
- x the medical service has been provided as a non-Admitted Patient (other than hospital substitute treatment); or
- xi the treatment or service was experimental; or

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

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

E1.2 To whom the Benefit is payable

(a) If the Benefit relates to a service which was provided to a Member in accordance with a Purchaser-Provider Agreement or the Access Gap Cover Scheme, then:
   i. the Member is taken to have assigned the right to the payment of the Benefit to the provider; and
   ii. CBHS Corporate shall pay the Benefit directly to the provider.

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

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

E1.3 The amount of Benefit payable

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

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

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

(d) Where a Benefit:
   i. is calculated as a percentage of the receipted cost of a service; and
   ii. the receipted cost of a service appears to CBHS Corporate to be excessive;

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

E1.4 Payment of benefits by mistake

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

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

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

recovered from the Member at law.

E2 Hospital Treatment

E2.1 Treatment for which Hospital Benefits are payable

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

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

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

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

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

(a) CBHS Corporate may enter into a Purchaser-Provider Agreement with a Hospital which (among other things):
   i. sets an amount which the Hospital will accept for particular services rendered to Members; and
   ii. specifies the level of accommodation which the Hospital will provide to Members.

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

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

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

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

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

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

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

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

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

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

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

(c) If:

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

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

(d) If:

  i. an eligible Member receives an Admitted Patient service from a medical practitioner; and
  ii. the medical practitioner has opted to be covered by the Access Gap Cover Scheme in relation to the rendering of that service to that Member;

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

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

i. the balance of the medical practitioner's fee for the service, after the Medicare benefit payable for the services is deducted; or
ii. 25% of the Medicare Benefits Schedule Fee.

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

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

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

E2.6 Level of Hospital Benefits – goods

(a) If a Member:
   i. receives Hospital Pharmaceuticals as part of receiving an Admitted Patient service at a Hospital; and
   ii. CBHS Corporate has a Purchaser-Provider Agreement with the Hospital;

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

(b) A Benefit is only payable in respect of Hospital Pharmaceuticals that are not specified in the Hospital Purchaser-Provider Agreement where the Hospital Pharmaceuticals have been given prior approval by CBHS Corporate.
(c) If an eligible Member receives a surgically implanted prosthesis for which a Medicare benefit is payable, and that prosthesis is listed in the *Private Health Insurance (Prostheses) Rules* as part of receiving an Admitted Patient service at a Hospital, then the Hospital Benefit payable for that prosthesis is at least the minimum, and at most the maximum, amount listed in the *Private Health Insurance (Prostheses) Rules,* depending upon the level of cover held by the Member.

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

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

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

(b) CBHS Corporate will be satisfied that the patient requires further hospitalisation for acute care having regard to:
   i. the attending medical practitioner certifying that the Member needs further hospitalisation for acute care, and
   ii. the attending medical practitioner providing CBHS Corporate with any further information which it reasonably requires.

E3 General Treatment

E3.1 General

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

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

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

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

E3.2 Emergency Ambulance cover

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

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

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

E4 Other

E4.1 Chronic Disease Management Program

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

E4.2 Hospital Substitute Treatment

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

F LIMITATION OF BENEFITS

F1 Co Payments

Not applicable.

F2 Excesses

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

F3 Waiting Periods

(a) Except as otherwise provided in Rule C3 (b) and C6, the Waiting Periods apply to all Members.
(b) Except as otherwise provided in Rules C6 and C9, the time served against a Waiting Period for a Benefit is calculated by reference to the continuous period of time that a Member has held his or her current level of cover with CBHS Corporate.
(c) CBHS Corporate may not pay a Benefit for a service to which a Waiting Period applies until the Member has served the Waiting Period in full:
    i. 12 months: Pre-existing Conditions, pregnancy/obstetrics, crowns, bridges, orthodontia, artificial aids, healthcare appliances, oxygen apparatus and hearing aids.
    ii. 6 months: Optical, periodontics, endodontics, facings and dentures.
    iii. 2 months: Psychiatric, rehabilitation, palliative care whether or not there is a pre-existing condition.

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

v. 1 day: Accidents, injuries and emergencies.

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

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

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

no Waiting Period applies to that Member.

F4 Exclusions

Exclusions apply in accordance to:

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

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

(iii) Bronze Hospital as described at Rule J3 14;

F5 Benefit Limitation Periods

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

F6 Restricted Benefits

Restricted benefits apply in accordance to:

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

(ii) Silver Hospital as described at Rule J2 13;

(iii) Bronze Hospital as described at Rule J3 13;

F7 Compensation Damages and Provisional Payment of Claims

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

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

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

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

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

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

(e) If a Member receives a Benefit for services related to treating a condition which later becomes a Compensable Injury, and the amount of compensation sought or received includes an amount for the treatment of the Compensable Injury, then the amount of the

Benefit is a debt owed to CBHS Corporate and CBHS Corporate may recover it at law.

G CLAIMS

G1 General

(a) To make a claim for Benefits a Member shall:
  (i) submit a completed and signed claim in the form required by CBHS Corporate;
  (ii) provide all relevant receipts or accounts relating to the service rendered or good received; and
  (iii) provide any other information or documents to CBHS Corporate which CBHS Corporate reasonably requires to process the claim for Benefits.

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

G2 Other

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

I1 GOLD EXTRAS

I1 SCHEDULE GENERAL TREATMENT TABLES

I1 1 TABLE NAME OR GROUP OF TABLE NAMES
Gold Extras.

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

I1 3 GENERAL CONDITIONS
I1 3.1 Emergency Ambulance Cover

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

I1 3.2 Limits per Service

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

I1 3.3 Special limits on some services

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

(a) Physiotherapy Service;
(b) Chiropractic Service;
(c) Osteopathic Service; and
(d) Massage Therapy.

I1 4 LOYALTY BONUSES
Not applicable on this product.

I1 5 DENTAL

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

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

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

I1 6 OPTICAL

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

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

I1 7 PHYSIOTHERAPY

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

I1 8 CHIROPRACTIC

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

I1 9 NON PBS PHARMACEUTICALS

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

I1 10 PODIATRY

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

I1 11 PSYCHOLOGY AND COUNSELLING

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

I1 12 ALTERNATIVE THERAPIES

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

I1 13 NATURAL THERAPIES

See Rule I1 12 Alternative Therapies.

I1 14 SPEECH THERAPY

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

I1 15 ORTHOTICS

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

I1 16 DIETETICS

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

I1 17 OCCUPATIONAL THERAPY

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

I1 18 NATUROPATHY

See Rule I1 12 Alternative Therapies.

I1 19 ACUPUNCTURE

See Rule I1 12 Alternative Therapies.

I1 20 OTHER THERAPIES

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

I1 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

I1 22 HEARING AIDS

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

I1 23 PREVENTION HEALTH MANAGEMENT

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

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

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

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

I1 24 AMBULANCE TRANSPORTATION

See Rule I1 3.1 Emergency Ambulance Cover.

I1 25 ACCIDENT COVER

Not available on this product.

I1 26 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

I1 27 OTHER SPECIAL

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

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

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

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

Travelling and Accommodation Expenses

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

(b) If a Member:

i. requires essential medical or dental treatment for which a Benefit would be payable under either hospital or extras cover held by the Member; and

ii. that treatment is not available at a facility within a 160km round trip from where the Member lives, then the Member is entitled to claim a Benefit of 50% of the cost of travelling to the nearest facility to receive treatment and back to where the Member lives (calculated in accordance with Rule I1 27 (d) and (e) and 50% of the

costs of accommodation on such travel.

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

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

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

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

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

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

I2 SILVER EXTRAS

I2 SCHEDULE GENERAL TREATMENT TABLES

I2 1 TABLE NAME OR GROUP OF TABLE NAMES

Silver Extras.

I2 2 ELIGIBILITY

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

I2 3 GENERAL CONDITIONS

I2 3.1 Emergency Ambulance

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

I2 3.2 Limits per Service

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

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

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

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

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

ii. during Business Hours from the CBHS Corporate office.

I2 3.3 Special limits on some services

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

(i) Physiotherapy Services;

(ii) Chiropractic Services;

(iii) Osteopathic Services; and

(iv) Massage Therapy.

I2 4 LOYALTY BONUSES

Not applicable on this product.

I2 5 DENTAL

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

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

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

I2 6 OPTICAL

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

(b) For an Optical Service, a Member may claim a Benefit of up to 100% from a Choice Network Provider of the cost of services, of optical frames, lenses and contact lenses up to any relevant Limit per Service and the overall limit of $250 in a Calendar Year.

I2 7 PHYSIOTHERAPY

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

I2 8 CHIROPRACTIC

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

I2 9 NON PBS PHARMACEUTICALS

For non-PBS Pharmaceuticals, a Member may claim a Benefit of 100% of the receipted cost of the prescription in excess of the maximum PBS co-payment up to any relevant Limit per Service and the overall limit of $300 in a Calendar Year.

I2 10 PODIATRY

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

I2 11 PSYCHOLOGY AND COUNSELLING

Not available on this product.

I2 12 ALTERNATIVE THERAPIES

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

I2 13 NATURAL THERAPIES

See Rule I2 12 Alternative Therapies.

I2 14 SPEECH THERAPY

Not available on this product.

I2 15 ORTHOTICS

Not available on this product.

I2 16 DIETETICS

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

I2 17 OCCUPATIONAL THERAPY

Not available on this product.

I2 18 NATUROPATHY

See Rule I2 12 Alternative Therapies.

I2 19 ACUPUNCTURE

See Rule I2 12 Alternative Therapies.

I2 20 OTHER THERAPIES

Not available on this product.

I2 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES

Not available on this product.

I2 22 HEARING AIDS

Not available on this product.

I2 23 PREVENTION HEALTH MANAGEMENT

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

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

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

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

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

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

I2 24 AMBULANCE TRANSPORTATION

See Rule I2 3.1 Emergency Ambulance Cover.

I2 25 ACCIDENT COVER

Not available on this product.

I2 26 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

I2 27 OTHER SPECIAL

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

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

Health Care Appliances	$300	Any 3 years
Artificial Aids	$350	Any 3 years

I3 BRONZE EXTRAS

I3 SCHEDULE GENERAL TREATMENT TABLES

I3 1 TABLE NAME OR GROUP OF TABLE NAMES

Bronze Extras.

I3 2 ELIGIBILITY

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

I3 3 GENERAL CONDITIONS

I3 3.1 Emergency Ambulance

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

I3 3.2 Limits per Service

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

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

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

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

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

I3 3.3 Special limits on some services

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

- (i) Physiotherapy Service;
- (ii) Chiropractic Service;
- (iii) Osteopathic Service; and
- (iv) Massage Therapy.

I3 4 LOYALTY BONUSES

Not applicable on this product.

I3 5 DENTAL

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

<table>
<tr><th>Service</th><th>Overall Limit</th><th>Extends for</th></tr>
<tr><td>Preventative Dental Services

(2 month waiting period)</td><td>$210</td><td rowspan="2">Calendar Year</td></tr>
<tr><td>Dental (2 month waiting period)

Fillings, consultations & examinations, x-rays and extraction or surgical dental</td><td>$170</td></tr>
<tr><td>Dental (6 month waiting period)

Periodontic, endodontic, inlays, onlays, facings, dentures, implants and occlusal therapy</td><td>Not Covered</td><td rowspan="2">Not Applicable</td></tr>
<tr><td>Dental (12 month waiting period)

Orthodontia, Crown and bridges</td><td>Not Covered</td></tr>
</table>

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

I3 6 OPTICAL

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

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

I3 7 PHYSIOTHERAPY

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

I3 8 CHIROPRACTIC

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

I3 9 NON PBS PHARMACEUTICALS
For non-PBS Pharmaceuticals, a Member may claim a Benefit of 100% of the receipted cost of the prescription in excess of the current prescribed maximum PBS co-payment, up to any relevant Limit per Service and the overall limit of $200 in Calendar Year.

I3 10 PODIATRY

Not available on this product.

I3 11 PSYCHOLOGY AND COUNSELLING

Not available on this product.

I3 12 ALTERNATIVE THERAPIES

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

I3 13 NATURAL THERAPIES
See Rule I3 12 Alternative Therapies.

I3 14 SPEECH THERAPY
Not available on this product.

I3 15 ORTHOTICS
Not available on this product.

I3 16 DIETETICS
For Dietetic Services, a Member may claim a Benefit of 70% of the cost of service up to any relevant Limit per Service and the overall limit of $100 in a Calendar Year.

I3 17 OCCUPATIONAL THERAPY
Not available on this product.

I3 18 NATUROPATHY
See Rule I1 12 Alternative Therapies.

I3 19 ACUPUNCTURE
See Rule I1 12 Alternative Therapies.

I3 20 OTHER THERAPIES
Not available on this product.

I3 21 NON SURGICALLY IMPLANTED PROSTHESES AND APPLIANCES
Not available on this product.

I3 22 HEARING AIDS
Not available on this product.

I3 23 PREVENTION HEALTH MANAGEMENT

(a) For Health Checks, a Member may claim a Benefit of 90% of the cost of service, up to any relevant Limit per Service and the overall limit of $200 in a Calendar Year.
(b) For Health Management (not including Gym Membership and Personal Training), a Member may claim a Benefit of 90% of the cost of the service up to any relevant Limit per Service and the overall limit of $100 in a Calendar Year.
(c) For Gym Membership and Personal Training, a Member may claim a Benefit of 90% of the cost of the service up to any relevant Limit per Service. The combined overall limit for Gym Membership and Personal Training is $115 in a Calendar Year. The Limit per Service for Gym Membership is $115 and for Personal Training, $100 in a Calendar Year.
(d) For the purpose of Rule I3 23 (b):
   i. A Benefit is payable in relation to a First Aid Course only where the Member has completed that course.
   ii. A Benefit is payable in relation to a First Aid Kit only where the Member has completed a First Aid Course.

I3 24 AMBULANCE TRANSPORTATION

See Rule I3 3.1 Emergency Ambulance Cover.

I3 25 ACCIDENT COVER

Not available on this product.

I3 26 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

I3 27 OTHER SPECIAL

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

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

I4 AMBULANCE COVER

I4 SCHEDULE GENERAL TREATMENT TABLES

I4 1 TABLE NAME OR GROUP OF TABLE NAMES

Ambulance Cover

I4 2 ELIGIBILITY

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

I4 3 GENERAL CONDITIONS

Ambulance Cover contributions must be paid annually in advance.

I4 4 LOYALTY BONUSES

Not applicable on this product.

I4 5 DENTAL

Not available on this product.

I4 6 OPTICAL

Not available on this product.

I4 7 PHYSIOTHERAPY

Not available on this product.

I4 8 CHIROPRACTIC

Not available on this product.

I4 9 NON PBS PHARMACEUTICALS

Not available on this product.

I4 10 PODIATRY

Not available on this product.

I4 11 PSYCHOLOGY AND COUNSELLING

Not available on this product.

I4 12 ALTERNATIVE THERAPIES

Not available on this product.

I4 13 NATURAL THERAPIES

Not available on this product.

I4 14 SPEECH THERAPY

Not available on this product.

I4 15 ORTHOTICS

Not available on this product.

I4 16 DIETETICS

Not available on this product.

I4 17 OCCUPATIONAL THERAPY

Not available on this product.

I4 18 NATUROPATHY

Not available on this product.

I4 19 ACUPUNCTURE
Not available on this product.

I4 20 OTHER THERAPIES
Not available on this product.

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

I4 22 HEARING AIDS
Not available on this product.

I4 23 PREVENTION HEALTH MANAGEMENT
Not available on this product.

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

If a Member:

(a) receives Emergency Ambulance services; and

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

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

I4 25 ACCIDENT COVER
Not available on this product.

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

I4 27 OTHER SPECIAL
Not available on this product.

J1 GOLD HOSPITAL

J1 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J1 1 TABLE NAME OR GROUP OF TABLE NAMES

1. Gold Hospital $0 Excess
2. Gold Hospital $500 Excess

J1 2 ELIGIBILITY

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

J1 3 GENERAL CONDITIONS

Not applicable on this product.

J1 4 HOSPITAL TREATMENT PAYMENTS

J1 4.1 General

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

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

J1 4.2 Services rendered by a private Hospital

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

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

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

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

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

J1 4.3 Services rendered by a public hospital

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

(b) If a service received by a Member relates to a stay in a single private room of a public Hospital, then the amount of Benefits payable is the amount prescribed by the relevant

State Health Minister, Department or Authority as the chargeable amount for that service.

J1 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

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

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

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

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

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

(b) If:

(i) a Member receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to Rule J1 5(a); and

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

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

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

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

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

J1 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

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

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

and the Hospital.

J1 7 NON PBS PHARMACEUTICALS

Not available on this product.

J1 8 SURGICALLY IMPLANTED PROSTHESES

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

J1 9 NURSING HOME TYPE PATIENTS

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

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

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

J1 10 CO PAYMENTS

Not applicable on this product.

J1 11 EXCESSES

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

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

(c) The amount of Excess payable is $500 per person per admission for overnight or same day admission to a hospital by any Member covered up to a maximum of:
   i. For Single Membership - $500 per Calendar Year

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

J1 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J1 13 RESTRICTED BENEFITS
Not applicable on this product.

J1 14 EXCLUSIONS
The following have Exclusions on this level of cover:

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

J1 15 LOYALTY BONUSES
Not applicable on this product.

J1 16 OTHER SPECIAL HOSPITAL TREATMENT
(a) If not otherwise covered by a Hospital Purchaser-Provider Agreement, then
  (i) the Benefit payable in respect of Boarder Fees is 100% of the cost up to a total of $160 per admission of the Member admitted; and
  (ii) the Benefit payable in respect of Facility Fees is 70% of the cost up to a total of $160.

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

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

J1 17 DENTAL
Not available on this product.

J1 18 OPTICAL
Not available on this product.

J1 19 PHYSIOTHERAPY
Not available on this product.

J1 20 CHIROPRACTIC
Not available on this product.

J1 21 NON PBS PHARMACEUTICALS
Not available on this product.

J1 22 PODIATRY
Not available on this product.

J1 23 PSYCHOLOGY AND COUNSELLING
Not available on this product.

J1 24 ALTERNATIVE THERAPIES

Not available on this product.

J1 25 NATURAL THERAPIES
Not available on this product.

J1 26 SPEECH THERAPY
Not available on this product.

J1 27 ORTHOTICS
Not available on this product.

J1 28 DIETETICS
Not available on this product.

J1 29 OCCUPATIONAL THERAPY
Not available on this product.

J1 30 NATUROPATHY
Not available on this product.

J1 31 ACUPUNCTURE
Not available on this product.

J1 32 OTHER THERAPIES
Not available on this product.

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

J1 34 HEARING AIDS
Not available on this product.

J1 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J1 36 AMBULANCE TRANSPORTATION
Includes cover for Emergency Ambulance services when transported directly to a hospital or treated at the scene due to an Accident or Medical Emergency. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes.

J1 37 ACCIDENT COVER
Not available on this product.

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

J1 39 OTHER SPECIAL GENERAL TREATMENT

Not available on this product.

J1 40 HOSPITAL-SUBSTITUTE TREATMENT

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

J2 SILVER HOSPITAL

J2 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J2 1 TABLE NAME OR GROUP OF TABLE NAMES

1. Silver Hospital $0 Excess
2. Silver Hospital $500 Excess

J2 2 ELIGIBILITY

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

J2 3 GENERAL CONDITIONS

Not applicable on this product.

J2 4 HOSPITAL TREATMENT PAYMENTS

J2 4.1 General

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

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

J2 4.2 Services rendered by a private Hospital

(a) If a service received by a Member is:
   (i) rendered by a Hospital with which CBHS Corporate has a Hospital Purchaser-Provider Agreement; and
   (ii) the Hospital Purchaser-Provider Agreement covers the level of Benefits paid for that kind of service;

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

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

J2 4.3 Services rendered by a public Hospital

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

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

J2 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

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

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

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

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

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

(b) If:

(i) a Member receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to Rule J2 5(a); and

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

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

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

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

J2 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

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

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

J2 7 NON PBS PHARMACEUTICALS

Not available on this product.

J2 8 SURGICALLY IMPLANTED PROSTHESES

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

J2 9 NURSING HOME TYPE PATIENTS

(a) If:

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

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

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

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

J2 10 CO PAYMENTS

Not applicable on this product.

J2 11 EXCESSES

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

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

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

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

J2 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J2 13 RESTRICTED BENEFITS

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

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

J2 14 EXCLUSIONS

The following have Exclusions on this level of cover:

- Hip replacement services
- Knee replacement services
- Other joint replacement services including Ankle and Shoulder replacement services
- Pregnancy and birth related services
- Assisted reproductive services
- All Bariatric services including revision and reversal procedures (e.g. gastric banding, sleeve gastrectomy)
- Cosmetic services
- Hospital services for which there is no Medicare Benefit Schedule Fee payable (for example: podiatric surgery and laser eye surgery)

J2 15 LOYALTY BONUSES

Not applicable on this product.

J2 16 OTHER SPECIAL HOSPITAL TREATMENT

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

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

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

J2 17 DENTAL

Not available on this product.

J2 18 OPTICAL

Not available on this product.

J2 19 PHYSIOTHERAPY
Not available on this product.

J2 20 CHIROPRACTIC
Not available on this product.

J2 21 NON PBS PHARMACEUTICALS
Not available on this product.

J2 22 PODIATRY
Not available on this product.

J2 23 PSYCHOLOGY AND COUNSELLING
Not available on this product.

J2 24 ALTERNATIVE THERAPIES
Not available on this product.

J2 25 NATURAL THERAPIES
Not available on this product.

J2 26 SPEECH THERAPY
Not available on this product.

J2 27 ORTHOTICS
Not available on this product.

J2 28 DIETETICS
Not available on this product.

J2 29 OCCUPATIONAL THERAPY
Not available on this product.

J2 30 NATUROPATHY
Not available on this product.

J2 31 ACUPUNCTURE
Not available on this product.

J2 32 OTHER THERAPIES
Not available on this product.

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

J2 34 HEARING AIDS
Not available on this product.

J2 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J2 36 AMBULANCE TRANSPORTATION

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

J2 37 ACCIDENT COVER

Not available on this product.

J2 38 ACCIDENTAL DEATH FUNERAL EXPENSES

Not available on this product.

J2 39 OTHER SPECIAL GENERAL TREATMENT

Not available on this product.

J2 40 HOSPITAL-SUBSTITUTE TREATMENT

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

J3 BRONZE HOSPITAL

J3 SCHEDULE COMBINED HOSPITAL TREATMENT and GENERAL TREATMENT TABLES

J3 1 TABLE NAME OR GROUP OF TABLE NAMES

Bronze Hospital $500 Excess

J3 2 ELIGIBILITY

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

J3 3 GENERAL CONDITIONS

Not applicable on this product.

J3 4 HOSPITAL TREATMENT PAYMENTS

J3 4.1 General

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

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

J3 4.2 Services rendered by any Hospital

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

J3 5 MEDICAL SERVICES PAYMENTS WHILE ADMITTED

(a) If:

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

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

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

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

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

(b) If:
  (i) a Member receives an Admitted Patient service from a medical practitioner (or service from any other service provider registered with Medicare) which is not subject to Rule J3 5(a); and
  (ii) the medical practitioner (or other service provider registered with Medicare) has opted to be covered by the Access Gap Cover Scheme in relation to the rendering of that service to that Member;

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

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

J3 6 PHARMACEUTICAL BENEFITS SCHEME PBS PHARMACEUTICALS

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

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

J3 7 NON PBS PHARMACEUTICALS

Not available on this product.

J3 8 SURGICALLY IMPLANTED PROSTHESES

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

J3 9 NURSING HOME TYPE PATIENTS

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

  the Member will be classified as a Nursing Home Type Patient and any higher Hospital

Benefits which would otherwise be payable to the Member are reduced to Minimum Default Benefits for a Nursing Home Type Patient.

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

J3 10 CO PAYMENTS

Not applicable on this product.

J3 11 EXCESSES

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

i. For Single Membership - $500 per Calendar Year

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

J3 12 BENEFIT LIMITATION PERIODS

Not applicable on this product.

J3 13 RESTRICTED BENEFITS

All services except for those shown as Exclusions in J3 14 are restricted Benefits only.

J3 14 EXCLUSIONS

The following have Exclusions on this level of cover:

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

J3 15 LOYALTY BONUSES

Not applicable on this product.

J3 16 OTHER SPECIAL HOSPITAL TREATMENT

If a Member:

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

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

J3 17 DENTAL
Not available on this product.

J3 18 OPTICAL
Not available on this product.

J3 19 PHYSIOTHERAPY
Not available on this product.

J3 20 CHIROPRACTIC
Not available on this product.

J3 21 NON PBS PHARMACEUTICALS
Not available on this product.

J3 22 PODIATRY
Not available on this product.

J3 23 PSYCHOLOGY AND COUNSELLING
Not available on this product.

J3 24 ALTERNATIVE THERAPIES
Not available on this product.

J3 25 NATURAL THERAPIES
Not available on this product.

J3 26 SPEECH THERAPY
Not available on this product.

J3 27 ORTHOTICS
Not available on this product.

J3 28 DIETETICS
Not available on this product.

J3 29 OCCUPATIONAL THERAPY
Not available on this product.

J3 30 NATUROPATHY
Not available on this product.

J3 31 ACUPUNCTURE
Not available on this product.

J3 32 OTHER THERAPIES

Not available on this product.

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

J3 34 HEARING AIDS
Not available on this product.

J3 35 PREVENTION HEALTH MANAGEMENT
Not available on this product.

J3 36 AMBULANCE TRANSPORTATION
Includes cover for Emergency Ambulance services when transported directly to a hospital or treated at the scene due to an Accident or Medical Emergency. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS Corporate (such as Royal Flying Doctor Service). Residents of QLD and TAS are covered under their state based ambulance schemes.

J3 37 ACCIDENT COVER
Not available on this product.

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

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

J3 40 HOSPITAL-SUBSTITUTE TREATMENT
See Rule E4.2 which sets out the benefits that may be payable towards Hospital Substitute Treatment.

K CONTRIBUTION RATES

K SCHEDULE CONTRIBUTION RATE

The CBHS Corporate fortnightly contribution rates (un-rebated and excluding Lifetime Health Cover Loading) from July 2016 are as follows:

Single Fortnightly Contribution Rates

Single FORTNIGHTLY	NSW & ACT	NT	QLD	SA	TAS	VIC	WA
Gold Hospital $0 Excess	$103.84	$77.54	$110.76	$93.70	$106.16	$110.30	$85.84
Gold Hospital $500 Excess	$82.62	$67.38	$89.08	$79.84	$85.84	$90.00	$72.00
Silver Hospital $0 Excess	$90.00	$73.38	$99.24	$85.38	$90.00	$103.84	$76.16
Silver Hospital $500 Excess	$78.92	$61.84	$83.08	$73.84	$82.62	$85.38	$66.46
Bronze Hospital $500 Excess	$43.84	$36.92	$48.46	$48.46	$50.76	$46.62	$43.84
Gold Extras	$47.54	$34.62	$46.16	$53.08	$33.70	$46.16	$41.54
Silver Extras	$27.70	$25.38	$24.00	$25.38	$23.08	$27.70	$25.38
Bronze Extras	$14.76	$14.76	$14.76	$15.70	$13.84	$14.76	$14.30
Ambulance Cover^	$2.30	$2.30	$2.30	$2.30	$2.30	$2.30	$2.30

Couple Fortnightly Contribution Rates

Couple FORTNIGHTLY	NSW & ACT	NT	QLD	SA	TAS	VIC	WA
Gold Hospital $0 Excess	$207.68	$155.08	$221.52	$187.40	$212.32	$220.60	$171.68
Gold Hospital $500 Excess	$165.24	$134.76	$178.16	$159.68	$171.68	$180.00	$144.00
Silver Hospital $0 Excess	$180.00	$146.76	$198.48	$170.76	$180.00	$207.68	$152.32
Silver Hospital $500 Excess	$157.84	$123.68	$166.16	$147.68	$165.24	$170.76	$132.92
Bronze Hospital $500 Excess	$87.68	$73.84	$96.92	$96.92	$101.52	$93.24	$87.68
Gold Extras	$95.08	$69.24	$92.32	$106.16	$67.40	$92.32	$83.08
Silver Extras	$55.40	$50.76	$48.00	$50.76	$46.16	$55.40	$50.76
Bronze Extras	$29.52	$29.52	$29.52	$31.40	$27.68	$29.52	$28.60
Ambulance Cover^	$4.60	$4.60	$4.60	$4.60	$4.60	$4.60	$4.60

^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.

Family Fortnightly Contribution Rates

Family FORTNIGHTLY	NSW & ACT	NT	QLD	SA	TAS	VIC	WA
Gold Hospital $0 Excess	$207.68	$155.08	$221.52	$187.40	$212.32	$220.60	$171.68
Gold Hospital $500 Excess	$165.24	$134.76	$178.16	$159.68	$171.68	$180.00	$144.00
Silver Hospital $0 Excess	$180.00	$146.76	$198.48	$170.76	$180.00	$207.68	$152.32
Silver Hospital $500 Excess	$157.84	$123.68	$166.16	$147.68	$165.24	$170.76	$132.92
Bronze Hospital $500 Excess	$87.68	$73.84	$96.92	$96.92	$101.52	$93.24	$87.68
Gold Extras	$95.08	$69.24	$92.32	$106.16	$67.40	$92.32	$83.08
Silver Extras	$55.40	$50.76	$48.00	$50.76	$46.16	$55.40	$50.76
Bronze Extras	$29.52	$29.52	$29.52	$31.40	$27.68	$29.52	$28.60
Ambulance Cover^	$4.60	$4.60	$4.60	$4.60	$4.60	$4.60	$4.60

Sole Parent Fortnightly Contribution Rates

Sole Parent FORTNIGHTLY	NSW & ACT	NT	QLD	SA	TAS	VIC	WA
Gold Hospital $0 Excess	$181.74	$135.70	$193.84	$163.96	$185.76	$193.04	$150.24
Gold Hospital $500 Excess	$144.58	$117.92	$155.88	$139.74	$150.24	$157.50	$126.00
Silver Hospital $0 Excess	$157.50	$128.42	$173.66	$149.42	$157.50	$181.74	$133.26
Silver Hospital $500 Excess	$138.12	$108.24	$145.38	$129.24	$144.58	$149.42	$116.30
Bronze Hospital $500 Excess	$76.74	$64.62	$84.80	$84.80	$88.84	$81.58	$76.74
Gold Extras	$83.20	$60.58	$80.76	$92.88	$58.96	$80.76	$72.70
Silver Extras	$48.46	$44.42	$42.00	$44.42	$40.38	$48.46	$44.42
Bronze Extras	$25.84	$25.84	$25.84	$27.46	$24.24	$25.84	$25.04
Ambulance Cover^	$4.04	$4.04	$4.04	$4.04	$4.04	$4.04	$4.04

^Ambulance Cover has to be paid annually in advance unless it is combined with an Extras cover.