

MEMBER GUIDE

October 2026



**Latrobe
Health
Services**

This information is current as of 1 October 2026. This is important information. Please read and retain for future reference.

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WELCOME

Congratulations on choosing health insurance with Latrobe Health Services. You're now part of a community of more than 115,000 members who trust us to help look after their health and wellbeing.

To get the most from your membership, take a little time to read through this guide and understand your cover. If your circumstances change or you have any questions along the way, we're here to help.

For over 75 years, we've backed the health and wellbeing of our members and communities.

In 1991, we established Maryvale Private Hospital, Gippsland's only private hospital providing surgical and acute medical services. We also support and sponsor initiatives that strengthen community health and wellbeing, including The Latrobe Health Services Foundation, Shane Warne Legacy health checks, natural disaster assistance and programs that back local small businesses.

We're a member owned, not-for-profit health fund that exists for our members. That means our focus is on supporting you and delivering value, not generating profits for shareholders.

We're here to help you make informed decisions about your health cover, with practical guidance and support whenever you need it. And we're pretty proud of that.

About this Member Guide

This guide is designed to help you get the most from your Latrobe Health Services membership.

Inside, you'll find practical information about your cover, how it works and how to navigate the health system with confidence. If you need a hand, we're here to help.

Our Customer Experience team can talk you through any tricky bits, and you can choose the way you'd like to get in touch.

Prefer to speak with someone face to face? Visit one of our Member Experience Hubs across Gippsland. For locations and opening hours, visit latrobehealth.com.au.

*You can also call us on **1300 362 144**. Our Customer Experience team is ready to help with any questions about your membership.*

Our commitment to you

We're committed to keeping things clear, honest and straightforward. We'll communicate openly about your cover so you can make informed decisions with confidence.

If we make changes to your cover, we'll let you know at least **30 days in advance** for basic changes and **60 days in advance** for any detrimental changes.

We know we won't always get everything right. If something isn't as it should be, please let us know. We'd welcome the opportunity to discuss the issue and put things right. You can also use our formal complaints process. See the Feedback and Complaints section on page 29 for details.

About your Policy Documents

Your policy documents explain what your cover includes and how it works. They include:

- **Product summary** – key details about your chosen cover
- **Member Guide** – information about your membership, private health insurance, the health system, and using your product
- **Private Health Insurance Information Statement (PHIS)**
- **Fund rules** – legal rules and definitions that apply to your membership and cover. These are available on our website.

If your circumstances change or you're unsure about anything, please let us know.

Private patients' hospital charter

The Private Patients' Hospital Charter explains what it means to be a private patient in a public hospital, private hospital or day hospital.

It also outlines what you can do if you have a concern about your medical treatment or private health insurance.

For more information, visit [health.gov.au](https://www.health.gov.au).



GOVERNMENT SURCHARGES AND INCENTIVES

Private Health Insurance Rebate

The Australian Government's Private Health Insurance Rebate can help reduce the cost of your health insurance. Your rebate entitlement depends on your age and income and is reviewed each year.

You can nominate your rebate entitlement to help avoid a tax liability if your circumstances change. Simply log-in to your online Member Services account, Latrobe Health Services app or give us a call.

For more information on rebate tiers, please visit privatehealth.gov.au.

Medicare Levy Surcharge

The Medicare Levy Surcharge is an additional tax that may apply to high-income earners without eligible private hospital cover. It applies to singles, couples and families, varies based on income, and is paid in addition to the Medicare Levy.

Extras cover alone won't exempt you from the surcharge, **you need to have eligible hospital cover to avoid it.**

If your hospital cover has a \$1,000 excess, you'll still have to pay the Medicare Levy Surcharge.

For information about your individual circumstances, contact your accountant, financial planner or the Australian Taxation Office at ato.gov.au.

For more information on income thresholds, visit privatehealth.gov.au or consult your tax/financial adviser.

Lifetime Health Cover

Lifetime Health Cover is an Australian Government initiative encouraging people to take out private hospital cover earlier in life and maintain it throughout their lifetime.

If you don't have hospital cover by **1 July following your 31st birthday**, you may pay a Lifetime Health Cover loading when you take out cover later. The loading is 2% for each year you delay joining, up to 70%. After **10 continuous years of hospital cover**, the loading is removed.

Lifetime Health Cover doesn't apply to Extras cover or ambulance memberships. If you were born before 1 July 1934, you don't pay a Lifetime Health Cover loading.

Special rules apply if you:

- are an Australian citizen living overseas when you turned 31.
- served in the Australian Defence Force or the Australian Antarctic Division.
- are an immigrant or refugee.
- are an Ex-Norfolk Island resident.
- are no longer entitled to a Department of Veterans' Affairs Gold Card.

If you think a special rule may apply to you, please contact us. We'll let you know what information is needed to confirm your eligibility.

For more information, please visit privatehealth.gov.au.

Age-based discount

If you're between **18 to 29**, you may be eligible for an age-based discount of up to 10%. The discount is based on your age when you join and stays in place until you turn 41. It then reduces by 2% each year until it reaches zero.

For more information please visit privatehealth.gov.au.



ABOUT YOUR PRIVATE HEALTH INSURANCE

There are two types of private health insurance products and you can have either or both:

- **Hospital cover** helps when you are admitted to a hospital for an operation or an illness.
- **Extras cover** helps with the cost of services such as dental, physiotherapy and optical.

Private health insurance provides you with options, choices and control over your health care. Depending on your cover, you may be able to choose your doctor, avoid public hospital waiting lists and access treatment in private hospitals.

Private health insurance works alongside Medicare, Australia's public healthcare system. Medicare helps cover the cost of many medical services, public hospital treatment and some medicines, and is funded through the Medicare Levy paid by most Australian taxpayers.

Under Medicare, your choice of hospitals and health providers is generally limited to the public hospital system. Mid-to-high-income earners without private health insurance may also pay the Medicare Levy Surcharge.

Hospital cover is available in Gold, Silver and Bronze tiers, with a range of excess options.

Waiting periods explained

When you first take out or upgrade your cover, you may need to serve waiting periods before you can start claiming on services.

Hospital

- **2 months:** hospital psychiatric treatment, rehabilitation, and palliative care
- **2 months:** accident-related admissions for clinical categories included in the product
- **12 months:** pregnancy and birth
- **12 months:** pre-existing conditions.

Extras Cover

Waiting periods range from **2 to 12 months**, depending on the service.

Both hospital and extras waiting periods apply to:

- new members
- existing members upgrading their level of cover
- members changing from a single membership to a family membership following the birth of a baby
- new members transferring from other funds and upgrading to a higher level.

Pre-existing conditions

A condition, illness or ailment may be considered pre-existing if you had signs or symptoms in the **six months before, or on the day you joined** Latrobe Health Services, even if no diagnosis had been made before your cover started.

The same rules apply if you've upgraded your cover or reduced your excess. In these cases, the assessment considers the six months before the change took effect.

To determine whether a condition is pre-existing, a medical expert reviews information from your doctor and any other relevant claim details. If the condition is found to be pre-existing, a **12-month waiting period** applies to services related to that condition from the date your cover started or changed.

This rule applies to new members, members upgrading their cover or reducing their excess, and any adult dependants or children added to a policy. If you upgrade, you'll only serve waiting periods for services not covered under your previous cover, or for a lower excess.

Upgrading your cover

If you upgrade your cover, waiting periods may apply to higher benefits, including:

- benefits payable for services that weren't covered under your previous cover
- lower hospital excess or co-payment
- services with a higher benefit under your new cover
- higher annual or personal limits.

During any waiting period for higher benefits, existing members and members transferring from another fund are entitled to the nearest Latrobe Health equivalent cover, provided they have already served the relevant waiting periods before upgrading or transferring their cover.

Your responsibility

For hospital admissions during the first **12 months of your cover**, or within the first **12 months of an upgrade**, you'll need to provide **two medical certificates**. One must be completed by your usual GP and the other by your treating specialist.

We'll use these certificates and any other relevant claim information to determine whether your condition is pre-existing. This assessment may also involve consultations with your medical practitioners.

Before you're admitted to a private hospital, it's important to wait until we've made this determination. If your condition is found to be pre-existing, waiting periods may apply and you may incur significant costs.

If you're planning treatment, please contact us before admission for a benefit estimate.

Cooling-off period

Changed your mind? If you cancel your cover within 30 days of starting or changing your cover, we'll refund the premiums you've paid, provided no claims have been made.

If a claim has been made, the cooling-off period is void and no longer applies.

Payment options

To make your payments as easy, you can pay in one of several ways.

- **Direct debit:** payments are automatically deducted from your nominated bank account, Mastercard or VISA. Depending on your payment frequency, you may be eligible for a discount. Payment options include weekly, fortnightly, monthly, quarterly, half-yearly and yearly.
- **BPAY®:** pay anytime through your bank's online, mobile or phone banking service
- **By phone:** pay using Mastercard or VISA. Call us on **1300 362 144** or register online
- **Post BillPay:** pay online, by phone, or in person at Australia Post
- **In person:** visit a Member Experience Hub. For details of opening hours and locations, visit latrobehealth.com.au

To keep your cover active, make sure your payments stay up to date. If your premiums are more than 60 days overdue, your cover will be cancelled and waiting periods will apply if you rejoin.

If you're experiencing financial difficulty, please get in touch. We understand that circumstances can change, and we'll talk through your options and do our best to find a solution that works for you.

*Please call us on **1300 362 144** and speak with a member of our Customer Experience team.*

Having a baby?

If you have a **single membership**, you'll need to upgrade to a **single parent membership** within 6 months of your baby's birth.

If you have a **couple or family membership**, you'll need to register your newborn within 12 months of their birth.

A newborn isn't covered under a single membership. If you're planning a pregnancy, please contact us for advice about your health insurance.

Written confirmation of the expected delivery date from your treating obstetrician is required. If you have a family membership, newborn babies are automatically covered, subject to applicable waiting periods.

- **Non-admitted baby:** a newborn less than nine days old is not an 'admitted patient'. Any medical bills resulting from consultation for the baby don't qualify for benefits from Latrobe Health Services. This includes fees for procedures such as circumcision. Medicare will rebate 85% of the Medicare Benefits Schedule fee.
- **Admitted baby:** a hospital can't charge for a newborn unless the baby has been admitted to a neonatal facility by a paediatrician for treatment of a medical condition. In these circumstances, any medical bills resulting from consultation for the baby may qualify for benefits from Latrobe Health Services.

- **Multiple births:** under the National Health Act 1953, second or subsequent babies are considered inpatients. Any excess or co-payment that applies to your hospital cover will also apply to the baby's admission.
- **Private midwife:** you can claim a benefit of up to \$450 for a registered midwife attending a birth in a private hospital. The midwife must be in private practice and can't be employed by the hospital.

Children/dependants

At Latrobe Health, your children are defined as dependants on your policy (not including your spouse):

- **Dependant child** aged 0-17 years
- **Dependant non classified** aged 18-20 years (not married or in a de facto relationship)
- **Dependant student** aged 21-31 years (not married or in a de facto relationship, is undertaking full-time study at a recognised training facility)
- **Dependant non-student** aged 21-31 years (not married or in a de facto relationship). An adult dependant extension is available only on selected products and an additional premium applies. Independent tax advice is recommended.

Separated Members

On a couple or family membership, both the primary member and the spouse have equal authority to access membership information and make changes to the cover.

If your relationship circumstances change, it's your responsibility to let us know as soon as possible so we can update your membership details and help protect your personal information and privacy.

Out-of-Pocket costs

When you're admitted to hospital, you'll be charged separately for medical fees by your doctor, medical specialist, surgeon, anaesthetist, radiologist or pathologist. These fees are in addition to your accommodation and theatre fees.

Effective 1 October 2025, Latrobe Health Services participates in the **AHSA Access Gap Cover Scheme**.

The AHSA Access Gap Cover Scheme helps minimise or avoid out-of-pocket costs for eligible in-hospital medical services when your treating doctor participates.

If your doctor uses this scheme, you may:

- have **no gap** to pay, or
- pay a **known gap**, with a maximum of \$800 for obstetric admissions and \$500 for other hospital admissions.

Not all doctors participate in the scheme, and those who do may not use it for every patient or treatment.

If your doctor doesn't use the scheme and sends you an invoice, submit the claim to Medicare and Latrobe Health Services. We'll pay the benefits you're entitled to under your cover.

If you receive bills or charges you don't understand, such as administration, booking or equipment fees, please send us a copy of the account. We're happy to help you understand what you're being charged for.

Medicare and Latrobe Health Services together pay up to 100% of the Medicare Benefits Schedule (MBS) fee for eligible in-hospital medical services.

Medicare pays 75% of the MBS fee and Latrobe Health Services pays the remaining 25%.

One or more of your providers may charge above the MBS fee, which can result in out-of-pocket costs.

Your provider should explain any costs you'll need to pay before your admission. This is known as Informed Financial Consent.

If you're planning a hospital admission, contact us before your treatment with your MBS item numbers and any quoted fees. We can explain your benefits and help you understand any likely out-of-pocket costs.

You can read more about out-of-pocket costs on our website. Look for the **Going to Hospital** guides in the publications and forms section. You can always give us a call on **1300 362 144**.

Transferring from another fund

When you transfer to Latrobe Health Services from another health fund, you won't need to serve waiting periods you've already completed with your previous fund.

If you upgrade your cover, waiting periods will apply to services not covered by your previous fund, or where your previous fund paid a lower benefit. Your membership must be paid up to date when you transfer.

If there's a gap of **less than 30 days** between funds, we can pay claims once we've received a clearance certificate from your previous fund. Until then, your new membership card won't work.

Any excess or co-payment paid with your previous fund can't be transferred. You'll need to pay any excess or co-payment that applies to your cover.

Any extras claims made with your previous fund during the same calendar year will count towards your annual limits with Latrobe Health Services.

A gap of more than 30 days will mean you have to serve all waiting periods again.

International fund transfer

Transferring from a recognised international health fund must be made within 30 days of returning to Australia. You'll need to provide proof of entry to validate your entry date.

This may include a boarding pass, airline ticket, or Border Force entry stamp card in your passport.

Documents needed for transfers

To complete your transfer, please provide the following documents as soon as possible (attached to your welcome letter or email):

- **Private Health Insurance Rebate form** (to determine any rebate that applies to your cover).
- **Clearance certificate** from your previous health fund.

If you've already provided this information over the phone with one of our Customer Experience team members, there's nothing more you need to do.

Suspension of your membership

Life can bring unexpected challenges, opportunities, and planned changes.

If you're experiencing financial hardship or travelling overseas, you may be able to suspend your membership and keep the membership benefits and rights, including waiting periods you've already served.

To be eligible to suspend your membership, you must:

- have been a Latrobe Health Services member for **at least 12 months**
- have had an active membership for **at least 6 months** since any previous period of suspension.

Suspending your membership may affect your Medicare Levy Surcharge obligations.

We recommend seeking independent financial advice.

Financial hardship

If you're experiencing financial hardship, such as illness, unemployment or the death of a family member, you may be eligible to suspend your membership.

If approved, please note:

- suspensions are in 3-month increments
- while your membership is suspended, you can't make claims and your membership can't be reactivated before the suspension period ends
- you can suspend your membership for a maximum of 12 months over your lifetime.

Overseas travel

If you're travelling overseas, you may be able to suspend your membership while you're away.

To apply for a suspension:

- let us know that you want to suspend your membership before you leave Australia
- provide documentation showing your departure and return dates.

Please note:

- the minimum suspension period is 14 days and the maximum suspension period is two years
- if you return early, you can reactivate your membership by providing proof of re-entry to Australia
- you can't make claims while your membership is suspended.

Annual premium rise

Latrobe Health Services is a not-for-profit health insurer. We return 86 cents in every \$1 paid in premiums as benefits and work hard to keep premium increases as low as possible.

Across the private health insurance industry, premium changes generally take effect on 1 April each year.

Cover we don't provide

Membership for non-residents of Australia

We don't offer a dedicated overseas visitor health insurance product. If you're not eligible for full Medicare benefits, the cover we can offer you will be limited, and you'll have out-of-pocket costs for treatment and services.

Travelling

We don't cover medical or hospital treatment received, or products purchased, outside Australia. This includes treatment received on a cruise ship, even if it remains in Australian waters. If you're planning to travel, we recommend taking out travel insurance.



HOSPITAL ADMISSIONS

Choose your medical specialist (doctor)

Your GP can refer you to a specialist and help you explore the options that are right for you. You can also do your own research and discuss potential specialists with your GP before making a decision.

If your referral includes a doctor's name, you can use it with a different doctor, provided they're in the same specialty.

Questions to ask the specialists:

- Do you participate in the Access Gap Scheme?
- Will my treatment be billed as a No Gap or a Known Gap service? If there is a Known Gap, what will that gap be?
- What are the item numbers for my treatment?
- Will any other doctors be involved in my care and send me a bill? Do they participate in the Access Gap Scheme?
- Will you bill Latrobe Health Services directly?
- Will I need any prosthesis or medical devices?
- What hospitals can I be admitted to?
- Is there anything I need to do to prepare for my treatment?
- Should I continue taking my usual medications?

Choose your hospital

Most specialists work across a range of different hospitals, so you may have a choice about where you're treated. Understanding the different hospital types can help you make an informed decision.

Participating private hospitals

Latrobe Health Services has agreements with participating private hospitals and day hospital facilities across Australia, helping ensure the full cost of your hospital accommodation is covered.

A list of participating private hospitals is available in the Help Centre on our website: latrobehealth.com.au/globalassets/publications/participating-private-hospitals-list.pdf.

These agreements provide fixed accommodation and theatre benefits, helping you get more value from your cover. At participating private hospitals, the cost of TV hire and local phone calls is included. You can choose a private or shared room during your stay.

| *Private rooms are subject to availability.*

Non-participating private hospitals

If you choose to be treated at a non-participating private hospital, your treatment may not be fully covered, and you could have significant out-of-pocket costs.

If you're planning treatment at a non-participating hospital, we strongly encourage you to contact us before your admission.

Public hospitals

You can choose to be treated as a **private patient in a public hospital**. This allows you to choose your treating doctor, but it won't allow you to avoid the public hospital waiting list. Before treatment, it's a good idea to contact the hospital to understand likely waiting times.

It's important to know that:

- you don't have to be admitted as a private patient
- hospital staff can't require or pressure you to be a private patient
- benefits are paid in line with Australian Government default benefits when treated as a private patient in a public hospital.

If you choose a **single room in a public hospital**, we'll pay the Department of Health shared ward accommodation rate, plus up to **\$80 per night** in all states except NSW. If the hospital charges more than this, you may have out-of-pocket costs. Please contact us if this happens.

In NSW public hospitals, all private health insurers pay the published NSW rate for single-room accommodation. There should be no out-of-pocket costs for single-room accommodation, excluding any applicable excess or co-payment. Please contact us if this is not your experience.

Government funding covers theatre fees and additional costs associated with critical care services.

As a private patient, the doctors involved in your treatment may charge separate medical fees, and a gap fee may be payable.

Accommodation charges

You're covered for accommodation, theatre, intensive care, labour and recovery ward fees, and clinically required medicines and drugs while admitted to a participating private hospital. For admissions longer than 35 consecutive days, your cover continues when your doctor provides an ongoing **Acute Care Certificate**.

Nursing home-type patients in a recognised private or public hospital

Latrobe Health Services will pay a nursing home-type patient default benefit as set by the Australian Government Department of Health, when:

- a hospital stay has exceeded 35 days; and
- the treating doctor has deemed that acute hospital care is no longer required; and
- discharge to home is not appropriate; and
- a nursing home placement isn't available.

The treating hospital may charge the patient an additional fee. This fee is not claimable from Latrobe Health Services or Medicare.

Private room fees for day admissions

All same-day admissions are paid at a shared-room rate.

Inpatient services (in hospital)

To receive hospital benefits, you must be admitted as an inpatient to a recognised public or private hospital. The treatment must:

- be in a clinical category included in your cover
- have a Medicare item number, and
- be eligible for a Medicare benefit.

Doctors' fees for treatment in a private hospital emergency department are covered only if the treatment results in an inpatient admission.

Facility fees charged in a private hospital emergency department aren't claimable through Medicare or Latrobe Health Services.

The decision about whether a treatment requires admission to hospital is a clinical decision made by the treating medical team and the hospital, not by Latrobe Health Services. Some treatments may require the hospital to provide formal certification to support those clinical decisions.

Hospital tests

Blood tests and X-rays provided in hospital are often delivered by organisations independent of the hospital.

We have agreements with most in-hospital pathology and radiology providers, meaning almost 100% of eligible services are provided with no gap payments for members.

Charges for medical services when you're not admitted to hospital aren't covered, including pathology, radiology and costs associated with treatment in a private hospital emergency department.

Excess or co-payments

If your cover includes an excess or co-payment, you'll need to pay an agreed amount towards the cost of your hospital admission.

An excess is payable by adults once, each calendar year.

A co-payment is paid for every adult admission and is capped at a maximum of seven days.

Some older products (no longer available for sale) also apply excesses and co-payments to dependant admissions.

Refer to your Product Summary for details.

Your excess or co-payment details can be found in the 'policy details' section of the Latrobe Health Services app, in the Online Member Services Portal or call us on 1300 362 144.

Supported discharge

When no alternative arrangements have been made, Latrobe Health Services has a **Supported Discharge Program (SDP)** designed to provide short-term assistance and support while you recover from a recent hospital stay.

SDPs are not an entitlement under your cover and are only considered when no inpatient rehabilitation or outpatient physiotherapy at the hospital has been planned.

Each situation is considered based on individual circumstances and in consultation with the member receiving treatment, the referring health service provider and the treating medical practitioner.

- home based nursing care, and
- home based Rehabilitation/Home based respite care.

Members should be advised to discuss their options prior to discharge with the 'Discharge Co-ordinator' at the hospital or for more information prior to their admission email sdp@lhs.com.au.

Before you receive treatment

Before receiving treatment, check with us first. We can help confirm what's covered, whether your provider is recognised, and whether any out-of-pocket costs may apply.

For hospital admissions, have your Medicare Benefits Schedule item numbers and any fees your doctor or specialist has quoted. For more information about your cover before admission, call **1300 362 144** or email info@lhs.com.au.

For extras policies, please contact us to confirm your provider is a registered Australian health provider in private practice. Benefits are paid for one-on-one consultations and group physiotherapy.



AMBULANCE COVER

Ambulance services aren't covered by Medicare, and ambulance cover requirements vary by state and territory.

If you're covered by an applicable state or territory ambulance scheme, including any reciprocal arrangements, or by another eligible third-party scheme, that cover will apply instead of your policy's emergency ambulance cover.

Unlimited emergency ambulance transport and emergency callouts are included in a range of Latrobe Health Services products. You can find this information in the product features table in your product summary.

Product features	
Excess options (per person per calendar year)	\$250, \$500, \$750
Excess payable for children	No
Available without extras	Yes
Emergency Ambulance	Yes

**Table included for demonstration purposes only and does not represent individual cover.*

Emergency ambulance means unplanned transport needed to provide immediate medical attention. Whether transport is considered an emergency is determined by the attending paramedic and is usually recorded on the account.

Emergency ambulance cover includes:

- unlimited emergency transport to the closest clinically appropriate hospital by road, air or water, with no limits on distance travelled, services used each year or total transport costs
- Australia-wide *emergency* ambulance transport. *Non-emergency* transfers from interstate to your home state aren't covered

- call-out fees for onsite emergency care, even if transport to hospital isn't required
- a 1-day waiting period
- applicable for all recognised ambulance service providers (see Definitions page 33)
- emergency ambulance cover doesn't include non-emergency transfers from interstate to your home state.

Non-emergency ambulance

transportation such as transfer from one private hospital to another hospital or transport from hospital to home is not included, even if it is deemed medically necessary.

Closer look State by State

VIC, SA, NT, or WA

These states and territories offer ambulance service subscription that provide cover for emergency ambulance transport and medically necessary non-emergency transport. Each state sets its own eligibility rules and subscription fees.

If your Latrobe Health Services product doesn't include unlimited emergency ambulance cover (check your Product Summary), or if medically necessary non-emergency ambulance transport is important to you, you may wish to consider a subscription with your state ambulance service.

All Latrobe Health Services Extras products include a benefit towards the cost of an eligible state-based ambulance subscription.

In Victoria, members who hold an eligible concession card may be exempt from ambulance transport costs.

If you receive an ambulance invoice, complete the relevant section and return it to Ambulance Victoria to settle the account. In these circumstances, benefits aren't payable under your Latrobe Health Services policy.

NSW and ACT members

If you're a resident of NSW or the ACT with hospital cover, a levy is included in your cover. This entitles you to emergency ambulance transport provided by your home state's ambulance service.

Emergency ambulance transport in Victoria, Western Australia and the Northern Territory is covered through reciprocal arrangements.

In Tasmania, Queensland and South Australia, emergency ambulance transport may be covered through your Latrobe Health Services policy if your product includes unlimited emergency ambulance cover. Check your Product Summary for details.

If you receive an invoice for eligible emergency ambulance transport, send it to us and we'll arrange settlement of the account.

If your product doesn't include unlimited emergency ambulance cover, or if medically necessary non-emergency ambulance transport is important to you, you may wish to consider a standalone ambulance product available in your state or territory. Latrobe Health Services doesn't offer a standalone ambulance product.

Members who hold an eligible concession card may be exempt from ambulance transport costs. If you receive an ambulance invoice, complete the relevant section and return it to the ambulance service provider. In these circumstances, benefits aren't payable under your Latrobe Health Services policy.

Queensland members

If you're a resident of Queensland, your state ambulance service scheme provides Australia-wide ambulance cover. Because this cover is provided through the state scheme, ambulance benefits aren't payable under your Latrobe Health Services policy.

Tasmanian members

If you're a Tasmanian resident, you're covered under the state ambulance service scheme within Tasmania.

When travelling interstate, emergency road ambulance services may be covered through reciprocal arrangements between state ambulance services (excluding Queensland and South Australia). These arrangements can change from time to time.

If you receive emergency ambulance services in Queensland or South Australia, you may be able to claim under your Latrobe Health Services cover if your product includes unlimited emergency ambulance transport. Check your Product Summary for details.

ACCIDENT ADVANTAGE

What is Accident Advantage?

Accidents can happen when you least expect them. **Accident Advantage** may provide cover for treatment that would otherwise be excluded or restricted under your policy.

If you're admitted to hospital under Accident Advantage and meet the criteria below, you won't need to pay your hospital excess.

How Accident Advantage Works

If you're injured in an accident, Accident Advantage may provide cover for related treatment that would normally be excluded or restricted under your hospital cover.

To be eligible:

- you must seek initial treatment from a doctor or emergency department within 72 hours of the accident
- any related hospital admission must occur within 90 days of the accident
- you must submit an Accident Advantage claim form within 21 days of the accident.

When these requirements are met, we'll pay benefits for eligible accident-related treatment, and you won't need to pay a hospital excess for the admission.

How to use Accident Advantage

If you're injured in an accident:

- seek urgent medical attention within 72 hours
- let the hospital know you're a Latrobe Health Services member with Accident Advantage
- complete and submit an Accident Advantage Form to Latrobe Health Services within 21 days of the accident so your hospital excess doesn't apply.

Eligibility

Accident Advantage isn't included in all products. Check your policy documents to see if it's included in your cover.



UNDERSTANDING CLINICAL CATEGORIES

Hospital treatment is grouped into 38 clinical categories, such as brain and nervous system, kidney and bladder, and digestive system. Your Product Summary shows which categories are included in your cover.

If a clinical category isn't included, you aren't covered for treatment in that category as a private patient in a public or private hospital. If a category is restricted, benefits are limited to the Commonwealth-determined minimum benefit in public and private hospitals, which means you may have out-of-pocket costs.

Some treatments, services and tests aren't covered by either Medicare or Latrobe Health Services. If this applies, you'll need to pay the full cost.

Restricted cover even if included as a clinical category

Dental surgery

Some dental procedures, such as wisdom tooth removal, may be performed in hospital rather than at your dentist's clinic.

- 1. Hospital costs if your hospital cover includes the 'Dental' clinical category:** you're covered for the hospital costs associated with dental surgery in a participating private hospital or public hospital.
- 2. Dentist fees:** no benefit is payable for your dentist's fees. If you have appropriate Extras cover, you can claim a benefit for the dental fees.
- 3. Anaesthetist fees:** benefits are payable for anaesthetist fees associated with dental surgery under the Latrobe Health Services Additional Medical Benefits program.

Podiatry surgery

- 1. Hospital costs if your hospital cover includes the podiatry clinical category:** you're covered for some of the hospital costs associated with podiatric surgery in a participating private hospital or a public hospital.
- 2. Podiatrist costs:** no benefit is payable for the podiatrist's fees. You may be able to claim a benefit for these fees if you have appropriate Extras cover.
- 3. Anaesthetist fees:** no benefits are payable for the anaesthetist fees associated with podiatric surgery.
- 4. Prosthesis costs:** a benefit is payable for the cost of any prosthesis listed on the Prescribed List that is associated with podiatric surgery. If you're planning surgery, it's important to contact us first.

Cosmetic surgery (not included in any clinical category)

1. **Hospital cost:** no benefits apply to hospital charges associated with cosmetic surgery in a participating private hospital or public hospital.
2. **Medical cost:** no benefit is payable for the surgeon fees.
3. **Anaesthetist fees:** no benefit is payable for the anaesthetist costs associated with cosmetic surgery.
4. **Prosthesis cost:** no benefit is payable for the cost of any prosthesis associated with cosmetic surgery.

Surgically implanted prostheses

Prostheses listed on the Prescribed List are covered for clinical categories included in your hospital cover. If you or your doctor choose a prosthesis that isn't on the Prescribed List, you may have out-of-pocket costs.

Other non-Medicare-covered treatments

No benefits are paid for inpatient treatment that's not covered by Medicare. No benefit is payable for the cost of any prosthesis associated with non-Medicare-covered surgery. Your specialist can confirm whether Medicare benefits apply to your treatment.

Respite care

Benefits aren't payable for respite care or holiday relief services.

Allied health service providers

If you choose to use your own allied health professional while in hospital instead of the hospital-appointed provider, benefits aren't payable for those services. In a non-participating private hospital, benefits aren't payable for services such as physiotherapy and occupational therapy.

Exceptional funding

Benefits aren't payable for treatments that aren't approved by the Therapeutic Goods Administration (TGA) or for experimental or off-label treatments and devices.

New technologies

New technologies include, but aren't limited to, medicines, devices and treatments. No benefits are payable for services or items that remain in the testing, clinical trial or experimental phase. This includes services or items used for a purpose other than their registered or approved use.

Replacement of Prostheses List, non-implanted medical devices

This includes, but isn't limited to, insulin pumps, speech processors and neurostimulators. These devices won't be replaced during a warranty period or if they are lost, stolen or damaged. Associated consumables aren't covered.

Consumables and non-implanted medical devices (not on Prostheses List)

Benefits aren't payable for robotic consumables and medical devices that aren't listed on the Prostheses List.

High-cost drugs

Benefits aren't payable for drugs that aren't listed on the Pharmaceutical Benefits Scheme (PBS).

Hormone treatment

Costs associated with assisted reproduction services are not covered.

Cell storage

Costs associated with assisted cell storage are not covered.

Outpatient attendance

No benefits are payable for services provided on an outpatient basis. Doctors' fees for treatment in a private hospital emergency department are covered only if the treatment results in an inpatient admission. Private hospital emergency department facility fees aren't covered by Medicare or Latrobe Health Services. No benefits are payable for treatment in a public hospital emergency department.

Overseas treatment

Benefits aren't payable for services, treatment or appliances provided or sourced outside Australia. This includes treatment received on cruise ships, whether inside or outside Australian waters.

Personal items

Benefits aren't payable for:

- wi-fi, pay TV, visitor meals or other personal items
- luxury room surcharges
- bandages and dressings that you take home with you
- medical appliances (such as braces and crutches) that you take home
- medication to take home after your hospital stay
- medication you used prior to your hospital stay.



MAKING A CLAIM

Medical

If your provider participates in the **AHSA Access Gap Cover Scheme**, they'll send their account directly to us. We'll take care of claiming the Medicare portion and pay our benefit directly to the provider, so you'll only need to pay any agreed gap amount.

If you're billed directly by your provider, there are two ways to submit your claim:

1. myGov

To register for a myGov account, visit my.gov.au or download the myGov app. You'll need to link your Medicare account and follow the prompts to submit your claim online.

If your claim is approved, you'll receive a Statement of Benefits in your myGov inbox within **7 to 10 days**. If your claim is rejected, you'll be notified by post.

Once you've received your Statement of Benefits, download it and send it to us with a completed Latrobe Health Services claim form.

You can email the documents to info@lhs.com.au or post them to **Reply Paid 41, Morwell VIC 3840**.

If the account is unpaid, Medicare will pay the provider directly and Latrobe Health Services will pay its benefit directly to your nominated bank account. You'll then need to pay the provider and settle the account.

If you've already paid the account, we'll reimburse you directly to your nominated bank account.

2. Medicare

Medicare will ask for your Latrobe Health Services membership details and, once processed, submit the claim to us electronically.

We'll then process our portion of the claim and pay the benefit directly into your nominated bank account. Medicare and Latrobe Health Services will pay claims up to the Medicare Benefits Schedule fee. You can check the progress of your claim through your myGov account.

Please note that due to privacy laws, we're unable to contact Medicare on your behalf.

Extras

Before starting treatment, please contact us to confirm your provider is a registered Australian provider in a private practice. All services must be performed as a one-on-one consultation, except for group physiotherapy or hydrotherapy. Telehealth services are approved for psychology/ counselling, physiotherapy, dietetics/ nutrition, speech pathology, podiatry, occupational therapy, exercise physiology and osteopathy.

Home visits for extras services aren't covered.

You can make claims electronically and pay the gap for services including chiropractic, dental, dietetics, optical, occupational therapy, osteopathic services, physiotherapy, podiatry, psychology and speech therapy. Present your Latrobe Health Services membership card at participating providers.

For services where electronic claiming is not available, you can quickly and easily submit your claim using the Latrobe Health Services app or through your online member area latrobehealth.com.au.

Claiming options

- **Claim online:** claiming through our online member area is quick and easy. Visit latrobehealth.com.au to upload your receipt. Once your claim has been assessed and approved, your benefit will be paid into your nominated bank account within three to five days.
- **Claim on the go:** download the **Latrobe Health Services app**. Track claims, check your benefits and limits, view payment details, update your contact information and find a provider near you.
- **Claim on the spot:** some services can be claimed through HICAPS or HealthPoint with participating providers. Check with your provider and present your membership card to claim your benefit immediately.
- **Mail us your claim:** send your claim to **Latrobe Health Services, Reply Paid 41, Morwell VIC 3840**.
- **Claim directly with Latrobe Health Services:** visit one of our Member Experience Hubs with your receipts. For locations and opening hours, visit latrobehealth.com.au.

Receipts

When making a claim, please submit the original account or receipt, or a clear image or scan of the original.

Accounts/receipts must show:

- the date(s) of service
- the type of service and item number
- the patient's name
- the provider's name and address on official letterhead
- the provider number.

Claims must be submitted within two years of the date of service. Claims received after this time can't be paid, so we encourage you to submit your claim as soon as possible.

Benefits aren't payable where compensation or damages can be claimed from another source.

Compensation from other sources

If you can claim compensation or damages from another source, you won't be able to claim benefits from us for the same treatment. If your claim may involve compensation, we'll contact you to better understand your circumstances.

We'll work with you and your legal team to make sure your treatment isn't delayed while any legal proceedings are being resolved.

We'll ask for an undertaking that any benefits we've paid will be reimbursed if those costs are later accepted as part of a compensation settlement.



WHEN TO CONTACT US

Access/update your personal details

Manage your membership online whenever it suits you. You can update your personal details, pay your membership and access tax statements by accessing your account online at latrobehealth.com.au.

Simply log in, or give us a call. We're more than happy to help.

Upgrade of cover

You can upgrade your cover at any time. You won't need to re-serve waiting periods you've already completed.

However, waiting periods may apply to services that weren't previously included in your cover, as well as lower hospital excesses or higher Extras benefits.

Planning hospital treatment

We recommend contacting us before planned hospital treatment. We can guide you about the type of costs, what to ask your doctors/surgeon about item numbers and other members of the medical team who may bill you, and work out what your Out-of-Pocket costs may be according to the level of cover you have with us.

Who can make changes to my policy?

If you have a couples or family membership, both adults covered by the policy can access membership information and make changes to the cover, including cancelling the policy.

To protect your privacy, we need your permission before discussing your membership with anyone who isn't covered by your policy. If you'd like someone else to help manage your membership, you'll need to provide third-party authority.

You can do this by calling us, completing a Third-Party Authority form on our website, or updating your details through Online Member Services.

FEEDBACK AND COMPLAINTS

We aim to provide an excellent experience for our members. If you're unhappy with the service you've received, we want you to get in touch. We pride ourselves on having one of the highest levels of member satisfaction in the industry.

Providing you with a confidential and free complaint-resolution service is an important part to our commitment to you.

How to lodge a complaint

Contact us:

- **Call us:** 1300 362 144
- **Email us:** info@lhs.com.au
- **Write to us:** Latrobe Health Services, Reply Paid 41, Morwell VIC 3840.
- **Visit us** at a Latrobe Health Services branch. Go to latrobehealth.com.au for hours and locations.

Contact the Private Health Insurance Ombudsman:

A free and independent service to help resolve complaints and issues between members and their health fund.

- **Phone:** 1300 362 072 (select option 4 for private health insurance).
- **Email:** phio.info@ombudsman.gov.au
- **Website:** www.ombudsman.gov.au

Need an interpreter?

Call the Translating and Interpreting Service (TIS) on 131 450 for help in your language.

If you're deaf or have a hearing or speech impairment, you can contact the National Relay Service:

- **TTY users:** type 133 677, then ask for 1300 362 072.
- **Speak and Listen users:** call 1300 555 727, then ask for 1300 362 072.
- **Internet Relay Users:** connect to the National Relay Service, then ask for 1300 362 072.

Feedback process

Your feedback helps us understand what's working and where we can do better.

If you'd like to share feedback about one of our team members or how your Latrobe Health Services cover has supported you, we'd love to hear from you.

Call us on 1300 362 144 or email info@lhs.com.au.

Code of Conduct

The Private Health Insurance Code of Conduct is a voluntary industry code that promotes informed relationships between private health funds, members, agents and brokers. As part of our commitment under the code we will:

- continue to improve standards of practice and service in the private health insurance industry
- provide information to members in plain language
- help members make informed decisions about our health insurance products and services
- provide information about members' rights and obligations
- provide easy access to our internal dispute resolution procedures, which we'll manage in a fair and reasonable manner.

For more information on the Code of Conduct, visit latrobehealth.com.au/member-area/code-of-conduct/.



PRIVACY POLICY

Your privacy is important to us

Protecting your privacy is important to us. Our Privacy Policy outlines our commitment to your privacy and the procedures and systems we have in place to comply with the Australian Privacy Principles and help protect your personal and sensitive information from inappropriate use.

Who is collecting my personal sensitive information?

Your personal and/or sensitive information is collected, used and/or stored by Latrobe Health Services.

Why is my personal and sensitive information being collected?

We collect your personal and sensitive information so we can provide health insurance products and services to you. This includes providing health cover and paying benefits, as well as offering a range of other products and services, either directly or as an agent for other providers, such as ambulance cover.

What happens if my personal and sensitive information is not collected?

We need your personal and sensitive information to provide your health cover and services. If we can't collect this information, we won't be able to establish your membership or provide benefits under your cover.

Who will you disclose my personal and sensitive information to?

We may need to disclose some of your personal and sensitive information to individuals and organisations that provide services to us.

This helps us carry out our functions and activities, and work with providers you've dealt with directly and received services from, such as hospitals, doctors, dentists, optometrists and third-party insurers.

Is any of my personal or sensitive information disclosed to overseas recipients?

Latrobe Health Services does not disclose any personal or sensitive information to overseas recipients.

How can I access my personal information or make a complaint?

If you'd like more information about our Privacy Policy, access the personal information we hold about you, or find out how to make a complaint, please visit:

Go to latrobehealth.com.au and search 'privacy policy', or phone 1300 362 144 or email privacy@lhs.com.au.

FUND RULES

Latrobe Health Services' Fund Rules set out how your membership works. They must comply with relevant government legislation and are available on our website at latrobehealth.com.au.

When you join Latrobe Health Services, you agree to comply with the Fund Rules.



DEFINITIONS

We understand that private health insurance is hard to understand at the best of times, so this document will provide further explanations about key words used within the industry.

Unless the context suggests otherwise, the following defined words and phrases will have the meaning set out below:

'Access Gap Cover (AGC)' means the Medical Gap Cover scheme administered by AHSA on behalf of participating funds. The scheme uses state-based fee schedules and may provide either a No Gap or a Known Gap Benefit.

'Accident' means an unplanned, unintentional, and unexpected event that occurs by chance, by an external force or object, that results in a physical injury requiring immediate treatment or advice for which Benefits may be payable under these Rules.

An Accident does not include:

- a. any illness;
- b. an injury or condition resulting from complications of treatment or surgery;
- c. any injury or condition resulting from the effects of alcohol, or drugs of addiction;
- d. pregnancy; or
- e. the aggravation of an existing physical injury or condition.

'Accident Advantage' means a Benefit that provides top-level hospital Cover for up to 90 days following an Accident, given that initial treatment is sought within a specified timeframe and hospital Admission follows. This Benefit may provide cover for services usually excluded or restricted under standard policies, with required documentation from a Medical Practitioner or hospital.

'Accommodation' means the hospital facilities and services covered under a Member's policy, including meals, bed fees, theatre fees and treatment including nursing care.

'Act' means the *Private Health Insurance Act 2007* and the *Private Health Insurance Rules 2007*, as amended or replaced from time to time.

'Acute Care Certificate' means a certificate, in a form approved and required by Latrobe Health, from a medical provider confirming the need for an Admitted Patient to continue to receive acute hospital care. An Acute Care Certificate is required after 35 days of continuous hospitalisation and remains valid for 30 days.

'Additional Gap Medical Benefits' means the Benefits (if any) payable in respect of medical expenses which are in Excess of the schedule fee and which otherwise meet the requirements of the Fund's No Gap or Known Gap membership, provided always that the medical expenses relate to a Professional Service that:

- a. is rendered to a patient, while Hospital Treatment is provided to that patient in a hospital by a Medical Practitioner with whom the organisation does not have a medical purchaser Provider Agreement that applies to that Professional Service; and
- b. is a Professional Service in respect of which a Medicare Benefit is payable.

'Admission' means the period from when a patient is admitted to a hospital for treatment of a condition or illness until they are discharged from the hospital/ day facility.

'Admitted Patient' means a person who occupies an approved bed in a hospital for the purpose of Hospital Treatment and includes:

- a. a newly born child who occupies an approved bed in an intensive care facility in a hospital, being a facility approved by the Minister for the purpose of the provision of special care; and
- b. where there are two (2) or more newly born Children of the same mother in a hospital and those Children are not Admitted Patients of the hospital by virtue of the preceding paragraph – each such child in Excess of one (1)
- c. an Admitted Patient does not include an Insured Person of the staff of the hospital who is receiving treatment in his or her own quarters or a newly born child whose mother also occupies a bed in the hospital.

'Adult' means a person who is not a Dependant Child, Dependant Non-Classified, Dependant Student or Non-Student Dependant (previously known as an Adult Dependant).

'Allied Health Services' means health services provided by professionals such as physiotherapy, occupational therapy, chiropractic, Podiatry, optometry, psychology, dietetics and Pharmacy, among others.

'Age-based discount' means a discount available on selected hospital policies for persons and/ or their partners aged 18 to 29. The discount is two per cent (2%)

for each year that the person is aged under 30, to a maximum of ten per cent (10%). Provided the person remains under an eligible hospital policy, the discount continues until they turn 41, after which it decreases by two per cent (2%) per year for up to five years. No Age-based Discount is available after the age of 45.

'Ambulance' means a registered road vehicle, boat or aircraft operated by a recognised Ambulance Service Provider and equipped to transport people requiring medical attention.

'Ambulance Transportation – Emergency' means transportation of an unplanned and non-routine nature for the purpose of providing immediate medical attention to a person. The determination of a specific transport as being an Emergency is made by the paramedic employed by a recognised Ambulance Service Provider and recorded on the account. It does not include:

- Ambulance transport from a hospital to your home, or Ambulance transfers between hospitals
- any services which are not operated by the listed recognised Ambulance Service Providers
- any non-emergency services as determined by the recognised Ambulance Service Provider.

'Ambulance Service Provider' means an Ambulance provider recognised by Latrobe Health for the payment of Benefits, including:

- ACT Ambulance Service
- Ambulance Service of NSW
- Ambulance Victoria
- Non-Emergency Patient Transportation NSW

- Queensland Ambulance Service
- South Australia Ambulance Service
- St John Ambulance Service NT
- St John Ambulance Service WA
- Tasmanian Ambulance Service.

'Ambulance Subscription' is a membership taken out with a recognised Ambulance Service Provider who participates in a direct membership scheme – Ambulance Victoria, SA Ambulance Service, St John Ambulance Service NT and WA. The services covered by these memberships are defined by the governing ambulance body.

'Annual Limit' means the maximum amount claimable per person in a calendar year, unless otherwise stated.

'Approved Provider' (recognised provider) means a provider approved by Latrobe Health to provide services for which Benefits may be payable.

'AHPRA' means The Australian Health Practitioner Regulation Agency. AHPRA is responsible for regulating Australia's registered health practitioners.

'APRA' means the Australian Prudential Regulation Authority. APRA is an independent statutory authority that supervises institutions across banking, insurance and superannuation.

'Arrears' means the amount of unpaid Premiums when Premiums are not paid up to the current date.

'Australian Government rebate' means the private health insurance rebate that helps reduce the cost of health insurance. The rebate you are entitled to depends on your income and age and is indexed annually by the Australian Government.

'Australian Health Services Alliance'

(AHSA) means a service company representing a number of small to medium sized private health insurance funds. AHSA provides a range of services including (but not limited to) management of provider relationships, and negotiation of contracts. Latrobe Health joined AHSA as a Member fund on 01/05/2023.

'Australian Regional Health Group'

(ARHG) means a collective of regional health Funds utilised to negotiate Hospital Purchaser Provider Agreements with providers and monitor the registration process of relevant General Treatment providers. Latrobe Health was a member of ARHG until 30/04/2023. Latrobe Health is still part of ARHG for the alternate therapy provider registration and accreditation (General Treatment).

'Basic Hospital Cover' means a hospital membership that includes the minimum Clinical Categories required for a Basic Hospital product under private health insurance legislation.

'Benefit' means the entitlement due to the Principal Member in respect of approved expenses incurred in accordance with the terms of these Fund Rules.

'Bronze Hospital Cover' means a hospital product that includes the Clinical Categories required for a Bronze hospital product under private health insurance legislation.

'Business Partner' means an individual or entity that has entered an arrangement with another individual or entity for a common business purpose.

'Calendar Year' means the period from 1 January to 31 December.

'Cancellation Date' means the date on which the written notice of cancellation is received by the Fund or the last date to which Premiums were paid.

'Clinical Categories' means groups of Hospital Treatments prescribed under private health insurance legislation.

'Children' means all Dependant Children listed on a policy and does not include a Spouse or partner.

'Compensation' means a payment by way of damages, a payment under an insurance or Compensation scheme established by law, or any other payment that the Fund reasonably determines to be in the nature of Compensation or damages.

'Cover' means a defined group of Benefits available under a membership for approved expenses incurred by the Insured Person.

'Consumables and Medical Devices' mean (consumables) items that require regular replacement (e.g. batteries) to keep a medical device (such as a hearing aid) operational. Many medical devices require consumables.

'Co-payment' means an amount payable by an Insured Person towards the cost of Hospital Treatment for each day of an Episode of Care, as specified under the product.

'De facto Relationship' means a relationship between two people (partners) who are not married but live together as a couple on a genuine domestic basis.

'Dental' means services relating to the diagnosis, treatment or care of teeth and oral health.

'Dental Technician (Advanced)' means a person registered or licensed as a Dental Technician (Advanced) under the law of a State or Territory.

'Dental Practitioner' means a person in private practice registered by the Australian Dental Association.

'Department' means the Australian Government Department of Health and Aged Care.

'Dependant' means a person eligible to be covered under a membership as the Principal Member's:

- spouse or partner (including de facto and same-sex partner)
- own children
- stepchildren
- legally adopted children, and
- children for whom the Principal Member is the legal guardian, provided they meet the eligibility requirements of these Rules.

'Dependant Child' means a Dependant person who is under 18 years of age, and does not have a Spouse or Partner.

'Dependant Non-Classified' means a Dependant person who is between the ages of 18 and 20 who does not have a Spouse or Partner.

'Dependant Student' means a Dependant person who is between the ages 21 and 31 years, does not have a Spouse or Partner, is a Full-Time Student at school, college, or university; and may be living away from home.

'Dependant Non-Student' means a person who is between the ages of 21 and 31, does not have a Spouse or Partner, and is no longer a Full-Time Student Dependant. These Dependents may be working or living away from home.

'Direct debit payment' means an arrangement that allows Premiums to be automatically deducted from a nominated bank account or payment card at agreed intervals. The Direct Debit Customer Service Agreement applies when you pay your Premiums by direct debit. You can find this agreement at latrobehealth.com.au.

'Elective Surgery' means non-emergency surgery, which is medically necessary but can be delayed for at least 24 hours. In the public hospital system, patients waiting for Elective Surgery are assessed by their treating medical professional as Category 1, 2 or 3, per the following definitions:

Category 1: needing treatment within 30 days

Category 2: needing treatment within 90 days

Category 3: needing treatment at some point in the next year.

'Emergency' means a situation where the patient presenting at a hospital or other medical facility is assessed using the Australasian Triage Scale as:

Category 1: immediate treatment

Category 2: treatment within 10 minutes; or

Category 3: treatment within 30 minutes.

'Emergency Ambulance' means Ambulance transport required to provide immediate medical attention in an Emergency. Whether the transportation is classified as an Emergency is determined by the paramedic and generally recorded by the Ambulance Service Provider.

'Episode of Care' means a period of continuous Hospital Treatment, including readmission within a seven (7) day period for treatment of the same ailment, condition, or illness.

'Excess' means an amount of money paid in a calendar year towards the cost of each hospital Episode of Care up to an annual maximum before fund Benefits are payable.

'Exclusions' means services, treatments or Benefits that are not covered under a particular product.

'Federation Products' means the products and packages formerly offered by Federation Health before its merger with Latrobe Health in 2005.

'Full-Time Student' means an Insured Person undertaking full-time study at an educational institution recognised by the Fund.

'Gap Medical Benefits' means the Benefits (if any) payable in respect of medical expenses which are less than, greater than or equal to the schedule fee, provided always that the medical expenses relate to a Professional Service that:

- a. is rendered to a patient, while Hospital Treatment is provided to that patient in a hospital by a Medical Practitioner with whom the organisation does not have a medical purchaser Provider Agreement that applies to that Professional Service; and
- b. is a Professional Service in respect of which a Medicare Benefit is payable.

'General Medical Practitioner' means a general practitioner as defined in section 3 of the *Health Insurance Act 1973*.

'General Treatment' means treatment (including provision of goods and services) that is intended to manage or prevent a disease, injury or condition and is not "Hospital Treatment".

'Gold Card' has the same meaning as in s34-15 of the *Private Health Insurance Act*.

'Gold Hospital Cover' means a hospital product that includes all Clinical Categories required for a Gold hospital product under private health insurance legislation.

'Health Appliances' are external devices, appliances, or aids used to assist people to manage or improve a medical condition, or to help prevent further injury or worsening of a health condition.

Health Appliances do not include foot orthotics, Podiatry orthotics, orthotic appliances, orthopaedic shoes, devices requiring surgical implantation, or ordinary household, fitness, or lifestyle products.

Where an item is specifically defined in these Rules or is covered under another Benefit category of a product, Benefits are payable only under that specific Benefit category and not under Health Appliances.

Examples include:

- blood glucose monitors
- blood pressure monitors
- compression Garments
- CPAP machines (including replacement tubing and masks)
- nebulisers
- asthma spacers
- peak flow meters
- TENS machines
- crutches
- wheelchairs
- hearing aids.

'Health Benefits Fund' means a health Benefits Fund as described within the meaning of s131-10 of the *Private Health Insurance Act*.

'Health Insurance Membership' means a membership that provides specified Benefits for hospital and/ or General Treatment and meets all requirements under s63-10 of the *Private Health Insurance Act*.

'Hearing Glasses (audio-enabled frames)' are devices that incorporate audio or amplification technology within spectacle frames for the purpose of supporting hearing function.

'High-Cost Drugs' means any drugs that are not listed on the Pharmaceutical Benefits Scheme (PBS) and are not eligible for payment of Benefits under these Rules.

'Hospital' a recognised hospital, private hospital or a public hospital as defined under s121-5(5) of the *Private Health Insurance Act*.

'Hospital Purchaser/Provider Agreement (HPPA Agreement)' means a negotiated agreement entered between the Fund and the hospital for cost of Hospital Treatment.

'Hospital Treatment' means treatment, including provision of goods and services, that is intended to manage a disease, injury or condition and is provided at a hospital or arranged with the direct involvement of a hospital.

'Informed Financial Consent' means the medical provider advises you of any out-of-pocket costs before your Admission. This is called Informed Financial Consent.

'Inpatient services' means services provided to an Insured Person as an admitted inpatient in a recognised private or public hospital for treatment in an included clinical category, where a Medicare Item Number applies and a Medicare Benefit is payable.

'Insured Person' means a person covered under a Principal Member's membership with the Fund.

'Insured Person's Year' means a period of 12 months commencing on the date the Insured Person's cover starts and each subsequent 12-month period commencing on the anniversary of that date.

'Item number' means the unique number attached to each Professional Service contained in the Medicare Benefits Schedule (MBS). Each Item Number has a set Benefit. For more information see MBS Online.

'Known Gap' means that a medical provider may charge a Member an out-of-pocket amount up to a maximum amount per Admission. The medical provider must obtain the Member's Informed Financial Consent before providing treatment.

'Latrobe Health' means Latrobe Health Services Limited. ABN 94 137 187 010 (otherwise referred to in these Rules as "Latrobe" or "the Fund").

'Levels of Cover' means those Levels of Cover, or any one of them as the context requires, specified in clause C1.2.

'Lifetime Health Cover Loading' means an additional Premium payable by an Insured Person who does not take out an appropriate hospital cover prior to 1 July following their 31st birthday.

'Lifetime limit' means the maximum Benefit payable for a particular service during a person's lifetime, regardless of any change in cover or health insurer. This information is included on a clearance certificate.

'Limited Benefits' mean that a minimal level of Benefit is paid for a specified Hospital Treatment, or in a Non-participating Private Hospital, or for treatments not covered by Medicare.

'Medical Practitioner' means a person as defined in s3(1) of the *Health Insurance Act 1973* and satisfies the provider eligibility requirements for the payment of Medicare Benefits.

'Medical Benefits Schedule' means the Medicare Schedule of Benefits produced by the Department of Health and Ageing to which all fees and Benefits relate for Inpatient Services.

'Medicare Benefit' means the Medicare Benefit payable within the meaning of Part II of the *Health Insurance Act 1973* with respect to a Professional Service.

'Medicare Levy Surcharge' means an additional tax payable by high income earners beyond the standard Medicare Levy if they do not have qualifying private hospital insurance coverage. This charge is assessed as part of an individual or family's annual tax return.

'Medical Gap Cover' means the arrangement under which Medicare pays 75% of the Medicare Benefit Schedule (MBS) fee for eligible in-hospital medical services and Latrobe Health pay the remaining 25%.

'Medical Purchasing Provider Agreement' means a negotiated agreement entered between the fund and the medical provider for the cost of medical service whilst admitted to hospital for treatment.

'Member' means any person's, Insured Person's or Dependant's covered on a membership.

'Membership year' means a 12-month period commencing on the anniversary of the date the membership commenced.

'Mental health waiver' means a waiver of the two-month Waiting Period that applies when an eligible Member upgrades from Restricted to Included cover for in-hospital psychiatric treatment, in accordance with Division 78 of the *Private Health Insurance Act 2007*. The Mental Health Waiver can only be used once in a Member's lifetime across any private health insurer.

'Mixed Business Premises' means a premises that provides both health care services and other services that includes but are not limited to retail, beauty, or wellness type services.

'Newborn' means a child aged less than nine days.

'New technologies' mean, but are not limited to, medicines, devices, or treatments.

'Non-participating Private Hospital' means a hospital which does not have a Hospital Purchaser Provider Agreement (HPPA) with the Fund.

'No Gap' means that no out of pocket cost is payable by the Member for an eligible in-hospital medical service.

'Non-surgically implanted prostheses' are artificial body parts that replace missing or non-functional parts of the body without requiring surgical implantation. These devices are typically external and can be worn or attached to the body.

Examples include:

- prosthetic limbs (arms, legs)
- braces (knee, back)
- splints (finger, hand, wrist, arm, elbow)
- prosthetic eyes (ocular prostheses)
- breast prostheses.

'Nursing home-type patients' means a patient who has been in hospital more than 35 days, no longer requires acute hospital care, cannot live independently at home or be looked after at home, and either cannot be placed in a nursing home or a nursing home place is not available.

'Obstetrics' means medical care and treatment related to pregnancy, childbirth and the period immediately following birth.

'Obstetric Condition' means a condition that is listed under Group T4 (Obstetrics) in the Medicare Benefits Schedule.

'Optical' means services related to the provision of glasses, contact lenses, tests and treatments carried out by a registered optometrist or ophthalmologist.

'Orthodontic' means a type of specialist Dental treatment carried out by an orthodontist that diagnoses, prevents and corrects mispositioned teeth and jaws and misaligned bite patterns.

'Outpatient attendance' means treatment received in a hospital emergency department where the patient is not admitted to a bed in the hospital.

'Out-of-Pocket' means the difference between the Benefit payable by the Fund for a treatment or service and the provider's fee, and is payable by the Member.

'Overseas Treatment' means treatments or appliances provided or sourced from outside of Australia. This includes treatment on cruise ships inside or outside Australian waters.

'Participating Private Hospital' means a hospital which has a Hospital Purchaser Provider Agreement with the Fund.

'Pathologist' means a Medical Practitioner who specialises in the provision of pathology services within the meaning of the *Health Insurance Act 1973*.

'Pharmacy' means prescribed drugs and medicines dispensed by a pharmacist and/or travel and allergy vaccines dispensed by a pharmacist or doctor.

'PBS' means the Pharmaceutical Benefits Schedule (PBS) that is a list of all the medicines that receive a government subsidy.

'Non-PBS Pharmaceutical' means a pharmaceutical that is registered for use in Australia by the Therapeutic Goods Administration (TGA) but is not eligible for a government subsidy under the Pharmaceutical Benefits Schedule (PBS).

'Physiotherapy Class Consultation' means a group of clients are provided with a common intervention simultaneously and in most instances clinical notes are not recorded for each person.

'Physiotherapy Group Consultation' means a small group of clients are provided with different interventions concurrently and generally includes;

- a. pre-intervention assessment
- b. individual designed intervention is provided during the session
- c. modification of intervention as appropriate occurs during the session
- d. clinical record keeping.

'Practitioners in Private Practice' means a practitioner who does not:

- a. use any publicly Funded hospital, clinic, health Centre or other such facility, including a facility provided by a

municipal authority for, or in connection with, the provision of a general service for which a Benefit is claimed under the general table; and

- b. receive publicly Funded assistance or support, whether by way of remuneration, subsidy or otherwise, in connection with the provision of the general service.

'Podiatry' is a medical specialty focused on diseases, afflictions and deformities of the foot, ankle and related structures of the lower leg.

'Policy Documentation' is the complete suite of product documents as amended from time to time including but not limited to:

- Product summary
- Member Guide
- Private Health Insurance Statement (PHIS).

'Pre-Existing Condition' means an ailment, illness or condition that, in the opinion of a Medical Practitioner appointed by the Fund, the signs or symptoms of that ailment, illness or condition existed at any time in the period of six (6) months ending on the day on which the Insured Person became insured under the membership (s75-15 of the Act).

'Premium' means the payment to the Fund for health insurance cover for a Principal Member and any Dependant covered under the membership.

'Principal Member' means the person whose name the membership is held and is responsible for the payment of Premiums.

'Private or shared room' in a Participating Private Hospital means you have the choice of a private or shared room when you have a hospital Admission. (Private rooms are subject to availability).

'Private (Single) Room' is a room in a Hospital which is:

- purpose built, comprising of 4 walls and a door
- holds a single bed
- has facility for no more than a single Admitted Patient, and
- includes an ensuite.

In the case of an Admission relating to the birth of a child, the occupancy can be extended to accommodate the patient's support person and the birth child. This room can hold a multi person bed.

'Professional Service or Professional Services' means a Professional Service or Professional Services as defined in the *Health Insurance Act 1973*.

'Radiologist' means a Medical Practitioner who specialises in the provision of radiological services within the meaning of the *Health Insurance Act 1973*.

'Rate Protection' means the payment of Premiums for a defined period of time not exceeding 12 months, in advance of a rate increase that will not require any further payments to cover any difference between the advance payment and the new Premium rate.

'Recognised Provider' (Approved Provider) means a provider of services registered with the appropriate association or organisation to render services to a Member and approved Latrobe Health to render services to its members.

'Reinstatement Date' means the date from which a membership will be reinstated after cancellation subject to rule C7.8.

'Reinstatement' means that Latrobe Health may, at its discretion, reinstate a previously cancelled membership at the request of the Principal Member with continuity of entitlements, subject to the payment of all Premiums as required under the Fund Rules.

'Relevant Change' means a change which is or might be detrimental to the interests of an Insured Person being to the scope, level or amount of treatment, Benefits payable or increases to the Premiums payable by an Insured Person.

'Restricted Benefit' (default Benefit, Commonwealth minimum Benefits) means Benefits payable will be in accordance with the minimum Benefit requirements in the Private Health Insurance (Benefit Requirements) Rules as amended from time to time for shared ward Accommodation in a public hospital.

'Rule Change' means an amendment to these Rules, including the addition, variation, or removal of a Rule.

'Rules' means these Fund Rules, as amended from time to time.

'Silver Hospital Cover' means a hospital product that includes the Clinical Categories required for a Silver hospital product under the private health insurance legislation.

'Simplified and/or Aggregate Billing Arrangement' means a billing arrangement providing Additional Medical Gap Benefits.

'Specialist Medical Practitioner' means a specialist as defined in Section 3 of the *Health Insurance Act 1973*.

'Spouse or Partner' means a person who lives with the Principal Member in a marital or De facto Relationship.

'Suspension' means the temporary discontinuation of a membership in accordance with rule C5.8.

'Surgically Implanted Prosthesis' means an artificial substitute for a missing body part that is surgically inserted into the body during a surgical procedure.

'Termination Date' means the date at which the policy is no longer active, and Benefits are no longer payable.

'TGA' means Therapeutic Goods Administration.

'Transfer Certificate' means a certificate in an approved form providing details of Insured Persons, membership held, and Benefits paid issued under section 99-1 of the *Private Health Insurance Act* to another health insurance fund.

'Transferring Applicant' means a person transferring from another Health Benefits Insurer.

'Two-year claim limitation' means no Benefit is payable for any claim submitted two years or more from the date of Admission or service provision.

'Waiting Period' means a period during which a Member must hold continuous membership under a particular product before the Member has entitlement to receive a Benefit at the level payable on the product.



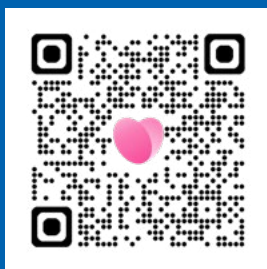
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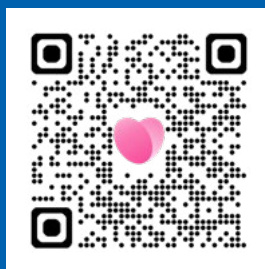
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