CH1

Corporate Gold Hospital Choice Members

Product summary

Available to employees of a company that has a partnership agreement with Latrobe Health Services

Product features	
Co-payment (per person per admission)	$30 same-day admissions $70 per day for overnight admissions capped at $490 per admission
Co-payment payable for children	No
Emergency ambulance	Yes

Co-payment

This product has a daily co-payment that is a non-refundable amount of money that you pay towards the cost of services before benefits are payable when admitted into a hospital. If hospitalised, the co-payment is $30 for a same-day admission or $70 per day for an overnight admission and is capped at $490 per admission.

What's covered?

This product includes cover for accommodation in a participating private hospital, theatre fees, Medicare-approved prostheses and pharmaceuticals (excluding experimental and high-cost non-PBS drugs).

What's not covered?

Charges for medical services when you are not an inpatient, including radiology, pathology and costs associated with treatment at a private hospital emergency department, are not covered.

Treatment for pre-existing conditions (other than hospital psychiatric services, rehabilitation or palliative care) within the 12-month waiting period is not covered.

Limited benefits are paid for inpatient treatments that are not covered by Medicare, which include but are not limited to cosmetic procedures, dental surgery, podiatry surgery and prostheses associated with a surgery not covered by Medicare.

Out-of-pocket costs

Under this product, you may have to pay out-of-pocket costs above what you get from Medicare and Latrobe. Before you go to hospital, you should ask your doctors, hospital and Latrobe about any out-of-pocket costs that may apply to you.

What does this mean?

✓ = Covered

This product covers all 38 clinical categories and has no restrictions or exclusions.

N/A - not applicable

Note:

Please read and retain for future reference. This product summary is not a complete description of your cover. Further details can be found in your Latrobe Health Services Member Guide, fund rules, Online Member Service, Latrobe app or call 1300 362 144 to check what you are covered for before receiving treatment.

Latrobe HEALTH SERVICES

Your product includes hospital treatment for these clinical categories
✓ **Rehabilitation** – treatment to improve and restore function
✓ **Hospital psychiatric services** – mental health conditions
✓ **Palliative care** – treatment for terminal illness and end of life care
✓ **Brain and nervous system** – stroke, brain or spinal cord tumours
✓ **Eye (not cataracts)** – retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye
✓ **Ear, nose and throat** – damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer
✓ **Tonsils, adenoids and grommets** – hospital treatment of the tonsils, adenoids and insertion or removal of grommets
✓ **Bone, joint and muscle** – carpal tunnel, fractures, hand surgery, joint fusion, bone spurs, osteomyelitis and surgery for bone cancer
✓ **Joint reconstructions** – torn tendons, rotator cuff tears and damaged ligaments
✓ **Kidney and bladder** – kidney stones, adrenal gland tumour and incontinence
✓ **Male reproductive system** – male sterilisation, circumcision and prostate cancer
✓ **Digestive system** – gallstones, irritable bowel syndrome, haemorrhoids
✓ **Hernia and appendix** – hernia operations and appendicitis
✓ **Gastrointestinal endoscopy** – colonoscopy and gastroscopy
✓ **Gynaecology** – endometriosis, polycystic ovaries, repairs post childbirth
✓ **Miscarriage and termination of pregnancy**
✓ **Chemotherapy, radiotherapy and immunotherapy (for cancer)**
✓ **Pain management** – treatment of chronic pain NOT with a device
✓ **Skin** – surgery to remove melanoma, other skin lesions and wound repair
✓ **Breast surgery (medically necessary)** – breast lesion, breast tumours
✓ **Diabetes management (excluding insulin pumps)** – stabilisation
✓ **Dental surgery** – removal of wisdom teeth, dental implants
✓ **Lung and chest** – lung cancer, respiratory conditions, asthma, pneumonia
✓ **Blood** – blood clotting disorder, bone marrow transplants
✓ **Heart and vascular system** – heart attack, stents, varicose veins
✓ **Back, neck and spine** – sciatica, prolapsed discs, curvature of spine
✓ **Plastic and reconstructive surgery (medically necessary)** – burns, skin grafts
✓ **Podiatric surgery (provided by a registered podiatric surgeon)**
✓ **Implantation of hearing devices** – Cochlear implants
✓ **Cataracts** – replacement of eye lens
✓ **Joint replacements** – full or partial replacement of joints
✓ **Dialysis of chronic kidney failure** – filtering blood through a machine
✓ **Insulin pumps** – treatment of diabetes with a pump that delivers insulin
✓ **Pain management with device** – insertion of a device to manage pain
✓ **Sleep studies** – investigation of sleep apnoea and snoring
✓ **Pregnancy and birth** – treatment before, during and after having a baby
✓ **Assisted reproductive services** – treatment to assist conception
✓ **Weight loss surgery** – surgical treatment of obesity

Hospital waiting periods	
1 day	Emergency ambulance
2 months	Psychiatric services, rehabilitation and palliative care
	All other hospital services, including accident-related treatment (for clinical categories included in the product)
12 months	Pre-existing conditions (excluding hospital psychiatric services, rehabilitation and palliative care)
	Pregnancy and birth

Singles Extras

Product summary

PS

This product is closed and no longer available

What's covered?

We pay benefits on the services listed below when:

- the provider is in private practice in Australia and is approved by Latrobe
- all goods and services are supplied within Australia
- claims are made within two years of the date of service
- the service is provided once per day (you cannot claim the same service twice in the same day, e.g. physio).

Services	Description	Benefit	Annual Limit	Waiting period
General dental Items as per dental schedule	Periodic oral examination	$24.20	$400 per person $800 per membership	3 months
	Scale and clean	$46.40		
	Simple tooth extraction	$34.40		
	Adhesive restoration (filling 1 surface)	$50.20		
	Mouth guard (supplied by a dentist or dental technician)	$80 per person		
Optical	Spectacles and repairs	$130	$130 per person	12 months
	Contact lenses			
	Prescription sunglasses			
Group physiotherapy / hydrotherapy	Group sessions	$9	$250 per person $500 per membership Combined limit	2 months
Physiotherapy	Consultation	$27 initial $22 subsequent		
Chiropractic		$26 initial $19 subsequent		
Chiropractic X-ray (one per person)	X-ray consultation	$28 per person		
Osteopathy	Consultation	$25 initial $17 subsequent		
Ambulance membership fee		$44 family $22 single		2 months
Pharmaceuticals (compounded medicine excluded)	Includes most prescribed items not subsidised by the government. Benefits will be paid after the PBS standard subsidy charge has been deducted	$25 per script	$150 per person $300 per membership	2 months

Latrobe HEALTH SERVICES

Note: *Please read and retain for future reference. This product summary is not a complete description of your cover. Further details can be found in your Latrobe Health Services Member Guide, fund rules, Online Member Service, Latrobe app or call 1300 362 144 to check what you are covered for before receiving treatment.*

Member Guide

1 January 2024

This information is current as of 1 January 2024

This is important information. Please read and retain for future reference.

Latrobe HEALTH SERVICES

Contents

Welcome

About this Member Guide 4
Our commitment to you 4
About your policy documents 4
Private Patients' Hospital Charter 5

Government surcharges and incentives

Private health insurance rebate 5
Medicare Levy Surcharge 5
Lifetime Health Cover 6
Age-based discount 6

About your private health insurance

Waiting periods explained 7
- Hospital 7
- Extras 7

Pre-existing conditions 7
Your responsibility 8
Cooling-off period 8
Payment options 8
Upgrading your cover 8
Having a baby? 9
- Children/Dependants 9

Out-of-pocket costs 10
Transferring from another fund 10
- International fund transfer 10
- Documents needed for transfers 10

Suspension of your membership 11
- Financial hardship 11
- Overseas travel 11

Annual premium rise 11
Cover we don't provide 11
- Membership for non-residents of Australia 11
- Travelling 11

Hospital admissions

Choose your medical specialist (doctor) 12
Choose your hospital 12
- Participating private hospitals 12
- Non-participating private hospitals 12
- Public hospitals 12

Accommodation charges 13
- Nursing home-type patients in a recognised private or public hospital 13
- Private room fees for day admissions 13

Inpatient services (in hospital) 13
- Hospital tests 13

Excess or co-payments 14
Supported discharge 14
Before you receive treatment 14

Ambulance

VIC, SA, NT or WA 15
NSW and ACT members 16
Queensland members 16
Tasmanian members 16

This is important information. Please read and retain for future reference.

Thank you for choosing Latrobe

Understanding clinical categories

Restricted cover even if included as a clinical category 17
- Dental surgery 17
- Podiatry surgery 17
- Cosmetic surgery (not included in any clinical category) 17
- Surgically implanted prostheses 18
- Other non-Medicare-covered treatments 18
- Respite care 18
- Allied health service providers 18
- Exceptional funding 18
- New technologies 18
- Commonwealth Prostheses List, non-implanted medical devices 18
- Consumables and non-implanted medical devices (not on Commonwealth Prostheses List) 18
- High-cost drugs 18
- Hormone treatment 18
- Cell storage 18
- Outpatient attendance 19
- Overseas treatment 19
- Personal items 19

Making a claim

Medical 20
- My Gov 20
- Medicare 20

Extras 20
Receipts 21
Compensation from other sources 21

When to contact us

Access/update your personal details Receipts 22
Upgrade of cover 22
Planning hospital treatment 22
Who can make changes to my policy? 22

Feedback and complaints

How to lodge a complaint 23
Feedback process 23
Code of Conduct 23

Privacy Policy

Your privacy is important to us 24
- Who is collecting my personal sensitive information? 24
- Why is my personal and sensitive information being collected? 24
- What happens if my personal and sensitive information is not collected? 24
- Who will you disclose my personal and sensitive information to? 24
- Is any of my personal or sensitive information disclosed to overseas recipients? 24
- How can I access my personal information or make a complaint? 24

Fund rules 25

Definitions 26

This is important information. Please read and retain for future reference.

Welcome!

Congratulations for choosing Latrobe Health Services insurance.

You're now part of an 81,000-strong family that trusts Latrobe to help manage its health.

We've been part of the community for 70 years.

In 1991, we established Gippsland's only surgical and acute medical private hospital, Maryvale Private. We support and sponsor community health and wellbeing projects, such as the community COVID support, natural disaster support and encouragement to local small businesses.

Latrobe is a Members Own Health Fund, which means we exist to benefit and support our members. In short, we're not here to make a profit, we're here to guide, much as a friend would. And we're pretty proud of that.

About this Member Guide

Our Member Guide is a handy 'how to' for getting the most out of your Latrobe membership. It'll help you understand your cover and how to work your way around the health system in general.

Our Customer Experience team is available to help you work through any tricky bits and you get to choose how you want to communicate with us.

Call us on 1300 362 144 – our Customer Experience team members are here to assist you.

Come visit us at a Member Experience Hub – hubs are located in Gippsland (Warragul, Bairnsdale, Traralgon and Moe) and offer personal, face-to-face support and assistance.

Send an email to info@lhs.com.au

Our commitment to you

We will use HEART in all our communications, to empower and build trust and connections with all our members.

If we change any part of your cover, we promise to tell you about it with at least 30 days' notice for basic changes and 60 days' notice for any detrimental changes.

→ We sometimes get things wrong and make mistakes. We have a formal complaints process (see page 22), but please talk to us first about any issue as we would love the opportunity to discuss and correct our mistake.

About your policy documents

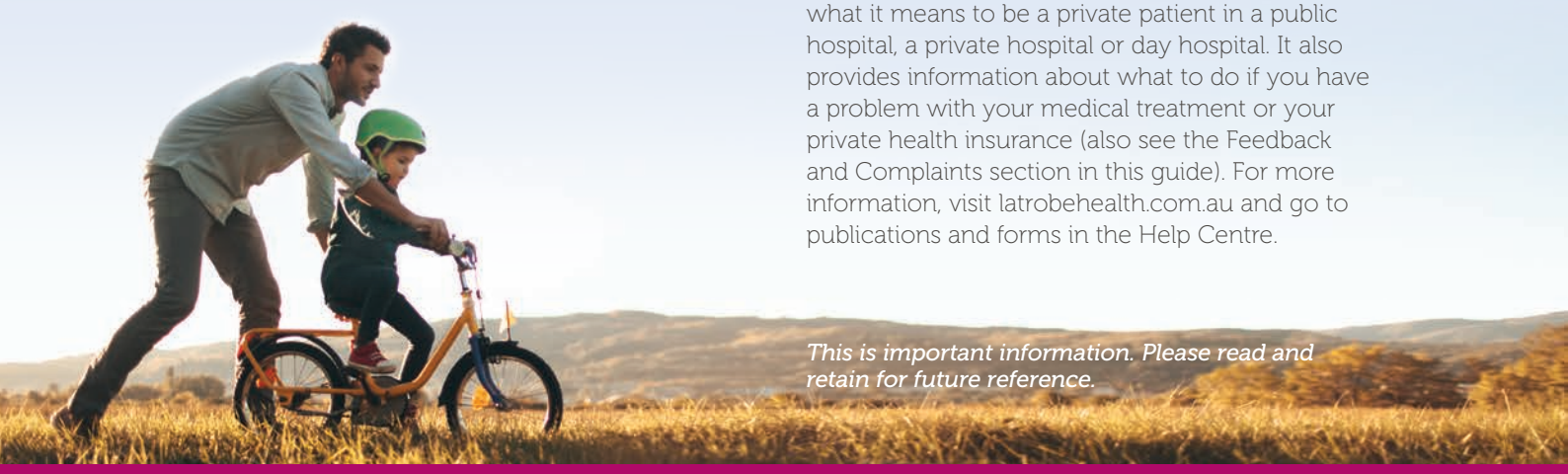
Your cover is detailed in your policy documents. These include the:

- product summary, which has specific details about the product you choose
- Member Guide, which contains the general details that apply about Latrobe, private health insurance, the health system and how to use your product
- Private Health Insurance Information Statement (PHIS)
- fund rules, which detail top-level legal information. The fund rules are available on our website.

→ You'll get the best from your membership if you make an effort to understand this information and check in with us regularly or when your circumstances change.

Private Patients' Hospital Charter

The Private Patients' Hospital Charter is a guide to what it means to be a private patient in a public hospital, a private hospital or day hospital. It also provides information about what to do if you have a problem with your medical treatment or your private health insurance (also see the Feedback and Complaints section in this guide). For more information, visit latrobehealth.com.au and go to publications and forms in the Help Centre.



This is important information. Please read and retain for future reference.

Government surcharges and incentives

Private health insurance rebate

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

You can nominate your rebate entitlement to avoid a tax liability if your circumstances change. Simply log-in to your Online Member Services account or give us a call.

The rebate tiers are effective 1 April 2021. For more information on rebate tiers, please visit privatehealth.gov.au

Medicare Levy Surcharge

The Medicare Levy Surcharge is an extra tax paid by high income earners without private hospital insurance. It applies to singles, couples and families. The surcharge varies depending on your taxable income and is in addition to the Medicare Levy, which is paid by most Australian taxpayers.

An extras product without an appropriate hospital insurance product will not provide an exemption to the surcharge. If you have a hospital product with an excess of $1000 you will still have to pay the surcharge.

For further information regarding your specific circumstances for either the rebate or surcharge please contact your accountant, financial planner or the Australian Taxation Office at ato.gov.au.

Medicare Levy Surcharge income thresholds				
Income threshold	Base tier	Tier 1	Tier 2	Tier 3
Singles	Up to $93,000	$93,001 – $108,000	$108,001 – $144,000	$144,001+
Families	Up to $186,000	$186,001 – $216,000	$216,001 – $288,000	$288,001+
Medicare Surcharge	0.0%	1.0%	1.25%	1.5%

The income threshold tiers are effective from 1 July 2023. For more information on income thresholds, please visit privatehealth.gov.au or consult your tax/financial adviser. Alternatively, you can calculate your income by using the calculator at ato.gov.au.

Lifetime Health Cover

Lifetime Health Cover is an Australian Government initiative designed to encourage people to take out private hospital insurance at a younger age and maintain it throughout their lifetime.

You have until 1 July after your 31st birthday to take out private hospital cover; otherwise, you may be required to pay a loading on your private health insurance when you do decide to buy it. The loading is 2% for each year you delay joining to a maximum of 70%. After 10 continuous years of coverage, the loading is removed.

Lifetime Health Cover does not apply to extras products or ambulance memberships.

This is important information. Please read and retain for future reference.

Government surcharges and incentives

If you were born before 1 July 1934 you are not affected and you do not pay a loading.

Special rules apply to:

- Australian citizens living overseas when they turned 31
- people in the Australian Defence Force or the Australian Antarctic Division
- immigrants and refugees
- ex-Norfolk Island residents
- people no longer entitled to a Veteran's Affairs Gold Card.

If you believe you may be eligible for the special rules, please contact us. It is important to note that in each of these categories, documentation will be required to validate your status. For more information please visit privatehealth.gov.au.

Age-based discount

Age-based discounts are applicable on selected health products for members aged 18 to 29. The discount can be quite substantial, depending on your age, and is locked in until you reach age 41, at which point it reduces by 2% each year until it reaches zero. For more information please visit privatehealth.gov.au.

This is important information. Please read and retain for future reference.

About your private health insurance

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

- **hospital cover** – for when you are admitted to a hospital for an operation or an illness
- **extras cover** – for services such as dental, physiotherapy and optical.

Private health insurance sits alongside Medicare, Australia's publicly funded health care system. Medicare is designed to provide affordable medical services, hospital treatment and prescription medicines. It is publicly funded by taxpayers through the Medicare Levy. Mid to high-income earners without private health insurance pay the Medicare Levy Surcharge. Under Medicare, your choice of hospitals and health providers is limited to the public hospital system.

Private health insurance provides you with options, choice and control over your health care. Hospital cover, available as Gold, Silver and Bronze options with a range of excess choices, allows you to choose your doctor or surgeon, when you are treated, and gives access to both private and public hospitals.

Waiting periods explained

In the first 12 months of your new Latrobe health insurance product you may need to serve 'waiting periods' before you can use your cover.

Hospital

Two months: hospital psychiatric treatment, rehabilitation, palliative care.

Two months: accident-related admissions for clinical categories included in the product.

12 months: pregnancy and birth.

12 months: pre-existing conditions.

Extras

For extras, the waiting periods range from two to 12 months.

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 for the birth of baby
- new members transferring from other funds and upgrading to a higher level of cover.

Pre-existing conditions

If you had signs or symptoms of a condition, illness or ailment during the six months before or on the day you joined Latrobe Health Services (or in the six months before you upgraded to a higher level of cover or reduced your excess), this means the condition was 'pre-existing' even if no diagnosis was made before your cover started.

Latrobe Health Services will have a medical expert look at information from your doctor and any other relevant claim details to decide whether your condition was pre-existing. If it was, a 12-month waiting period will apply to services related to that condition from your policy start date.

This rule applies to all new members, members upgrading their cover or reducing their excess, and to other adult dependants and children you've added to a policy. If you upgrade, you only serve waiting periods for any new services that you weren't covered for previously or a reduced excess if you've chosen to lower it.

This is important information. Please read and retain for future reference.

About your private health insurance

Upgrading your cover

Higher benefits relate to:

- benefits payable for services that were not part of your previous product
- a change in hospital insurance to a lower excess or co-payment
- services for which a higher benefit is payable under your new cover
- services for which there is a higher annual/personal limit.

During waiting periods for higher benefits, existing members and members who have transferred from another fund are entitled to the nearest Latrobe-equivalent cover, provided they have served our required waiting periods before upgrading or transferring their cover.

Your responsibility

For any hospital admission occurring during the first 12 months of cover or upgraded cover, you will be asked to have two medical certificates completed – one by your usual GP and one by your treating specialist.

We need these certificates to make a determination about your pre-existing medical condition status. This determination may also involve consultation with your medical practitioners.

We strongly advise that you do not proceed with an admission to a private hospital until the determination has been made as you may be liable for considerable costs should the condition be deemed as pre-existing.

If you are planning treatment it is essential that you contact us for a benefit estimation before you are admitted to hospital.

Cooling-off period

If you cancel your cover within 30 days of starting or changing your cover, we will refund the premiums you have paid provided no claims have been made. If a claim has been made, the cooling-off period is void.

Payment options

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

- **Direct debit:** payments are automatically debited from your nominated bank account, Mastercard or VISA credit card and may attract a discount depending on the payment frequency. Payment period options are weekly, fortnightly, monthly, quarterly, half yearly and yearly.
- **BPay:** fast easy and at any time of the day or night.
- **By phone:** using Mastercard or VISA. Call us on 1300 362 144 (8.30am to 6pm AEST, Monday to Friday) or register online at latrobehealth.com.au
- **Post BillPay:** options to pay by internet, phone or in person at any Australia Post office.
- **In person:** visit one of our hubs, located in Warragul, Bairnsdale, Traralgon and Moe. For details of opening hours and locations, visit latrobehealth.com.au.

To ensure you are covered you need to keep your payments up to date. If you are more than 60 days' late paying your cover will be cancelled and you will have serve all your waiting periods again.

We do understand that sometimes members may have financial challenges and we can work on a solution with you. Please call us on 1300 362 144 and speak with a member of our Customer Experience team.

This is important information. Please read and retain for future reference.

About your private health insurance

Having a baby?

→ To ensure your newborn is covered from birth, an upgrade of cover from a single membership to a family membership or a single parent membership is required two months before the expected delivery date.

A newborn baby is not covered under your single membership. If you are planning a pregnancy, please contact Latrobe for advice about your health insurance.

Written confirmation of the expected delivery date is required from the treating obstetrician. A family membership automatically covers newborn babies subject to waiting periods being served.

- **Non-admitted baby:** A newborn less than nine days old is not an 'admitted patient'. Any medical bills resulting from consultation for the baby do not qualify for any benefits from Latrobe. This also includes any fees incurred for procedures such as circumcision. Medicare will rebate 85% of the Medicare benefit schedule fee.
- **Admitted baby:** The hospital cannot raise a charge for a newborn unless it has been admitted to a neonatal facility by a paediatrician for the treatment of a medical condition. In these circumstances, any medical bills resulting from consultation to the baby qualify for benefits from Latrobe.
- **Multiple births:** In accordance with the National Health Act 1953, second or subsequent babies are considered as inpatients. In this instance, any excess or co-payment applicable to your selected hospital product will apply to the baby's admission.
- **Private midwife:** A benefit of up to $450 is payable for the attendance of a registered midwife at a birth in a private hospital. The midwife must be in private practice and cannot be an employee of the hospital.

Children/Dependants

At Latrobe your children are defined as dependants on a 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 de facto relationship). An adult dependant extension is available only on selected products and an additional premium applies. Independent tax advice is recommended.

Out-of-pocket costs

When you are admitted to hospital, you will 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.

You will receive 100% of the Medicare Benefit Schedule (MBS) amount towards the payment of these fees from both Medicare and Latrobe. Medicare pays 75% of the Medicare Benefit Schedule fee for in-hospital medical charges and Latrobe pays the remaining 25%. One or more of your providers may choose to charge above the MBS amount; your provider should advise you of any out-of-pocket costs before your admission. This advice is called Informed Financial Consent.

This is important information. Please read and retain for future reference.

About your private health insurance

If you have received Informed Financial Consent, we will pay up to an additional 20% above the schedule fee to assist with reducing your out-of-pocket costs.

→ Please contact us before any planned hospitalisation with the MBS item numbers and fees the doctor will be charging so we can provide you with more information about any out-of-pocket expenses. You can read more about out-of-pocket costs on our website – look for the 'Reducing the Gap' guide in the publications and forms section. See also 'Claiming Details' under 'Members' on the website for more information about claiming your medical fees after a hospital admission.

Transferring from another fund

When transferring into Latrobe from another fund, you do not have to serve waiting periods that you have already served with your previous fund. If you upgrade your cover when transferring to Latrobe, waiting periods will apply to services that were not covered and/or where a benefit was lower with your previous fund. Your membership with your previous fund must be up to date when you transfer.

→ A gap of less than 30 days will mean we can pay claims once we have received a clearance certificate from your previous fund. Until we have received the certificate, your new membership card will not work.

Any excess or co-payment amount paid with your previous fund is not transferable. You will be required to pay any excess or co-payment applicable to your product.

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

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

International fund transfer

A transfer from a recognised international health fund must be made within 30 days of returning to Australia. International movement records will be required to validate your entry date to Australia. This may include a boarding pass, airline ticket or Border Force entry stamp on your passport.

Documents needed for transfers

To make the transfer process as simple as possible we need you to return the following documents as soon as possible (you will find these attached to your welcome letter/email):

- private health insurance rebate form (this determines the rebate level to be applied to your product – if any)
- clearance certificate (from your previous health fund).

If you completed these over the phone with one of our customer experience agents there is nothing further you need to do.

This is important information. Please read and retain for future reference.

About your private health insurance

Suspension of your membership

We understand that unexpected challenges and opportunities happen throughout life. Suspending a membership allows our members to retain all membership benefits and rights including waiting periods that have been served

We allow memberships to be suspended for the following reasons:

- Overseas travel
- Financial hardship

To be eligible for a suspension you must:

- have been a Latrobe member for 12 months or more,
- have been re activated for at least 6 months since the last period of suspension

Any suspension may have an impact on whether you have to pay the Medicare Levy Surcharge (for high income earners). We recommend that you check with your financial adviser.

Financial hardship

- This may apply due to illness, unemployment or the death of a family member.
- Suspensions are in three-month increments.
- Membership cannot be reactivated during the suspension period.
- Claims cannot be made during the suspension period.
- You cannot suspend your membership for more than 12 months in a lifetime.

Overseas travel

You can suspend your membership while you travel overseas.

- Let us know that you want to suspend your membership before you leave Australia.
- Submit documentation with your departure and return dates.
- The minimum period of suspension is 14 days.
- The maximum period of suspension is two years.
- If you return early you can reactive your memberships with proof of re-entry to Australia.
- Claims cannot be made during the suspension period.

Annual premium rise

Latrobe is a not-for-profit health insurer. We return 90 cents in every $1 to our members as benefits paid. We work hard to keep our annual premium increases low. Across the industry this increase occurs on 1st April.

Non Australian Resident and Australian Resident Overseas Travel

Membership for non-residents of Australia

We don't provide a specific overseas visitor product. If you are not eligible for full Medicare benefits, the cover we can offer you will be limited and you will have out-of-pocket costs.

Travelling

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

This is important information. Please read and retain for future reference.

Hospital admissions

Choose your medical specialist (doctor)

Your GP will refer you for specialist care. They will also help you to find the correct specialist for you, but you can also do some research yourself so that you can talk through the options with your GP.

Here's a place to start: https://www.latrobehealth.com.au/help-centre/find-a-provider

Questions to ask the specialists:

- What are the item numbers for my treatment?
- What will you charge me for this treatment?
- What other doctors will be sending me a bill?
- Will you send my bill straight to Latrobe?
- Will I need any prosthesis?
- What hospitals can I be admitted to?
- Is there anything I should do to prepare for my treatment?
- Do I continue to take all my medication?

Choose your hospital

Most specialists visit a range of different hospitals so it is likely you will have a choice of hospital. It is important to understand what the hospital types are.

Participating private hospitals

To ensure that the full cost of your hospital accommodation is covered, Latrobe has agreements with participating private hospitals and day hospital facilities throughout Australia. A comprehensive listing of participating private hospitals is available from the Help Centre on our website: https://www.latrobehealth.com.au/globalassets/publications/participating-private-hospitals-list.pdf

These agreements provide fixed accommodation and theatre benefits, which ensures Latrobe members achieve maximum value. The cost of TV hire and local phone calls are included at participating private hospitals. You also have the choice of a private or shared room. **Private rooms are subject to availability.**

Non-participating private hospitals

Latrobe cannot guarantee full cover if you elect to be treated in a non-participating private hospital and advise that you may incur a large out-of-pocket expense. If you are planning treatment at a non-participating hospital, you are strongly urged to contact us first.

Public hospitals

You can elect to be treated as a private patient in a public hospital. This allows you to choose your treating doctor, however you won't be able to avoid the public hospital waiting list. If you are planning treatment in a public hospital, you should contact the hospital to confirm the likely waiting times. Please note:

- You are not obliged to be a private patient and you cannot be pressured by hospital staff to be a private patient.
- Benefits are paid in accordance with the Commonwealth-determined default benefits when treated as a private patient in a public hospital.

If you elect to be admitted to a single room in a public hospital, we will pay a benefit equal to the Department of Health's shared-ward accommodation rate in a public hospital plus an additional amount of up to $80 per night. Out-of-pocket costs may be incurred if the public hospital charges above this rate. Please contact us if this has occurred.

This is important information. Please read and retain for future reference.

Hospital admissions

Government funding covers the cost of theatre fees and extra costs associated with critical care services.

Admission as a private patient enables medical providers to bill you for their services and a gap may be payable.

Accommodation charges

You are covered for your room, theatre, intensive care, labour and recovery ward fees, and medicines and drugs clinically required as part of your treatment while in 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 will pay a nursing home-type patient default benefit as set by the Australian Government Department of Health where:

- 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 is not available.

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

Private room fees for day admissions

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

This is important information. Please read and retain for future reference.

Hospital admissions

Inpatient services (in hospital)

To be eligible for hospital benefits, you must be an inpatient admitted to a recognised private or public hospital for treatment that is a clinical category that is included in your cover, has a Medicare item number allocated and a Medicare benefit is payable.

Doctors' fees for treatment in a private hospital emergency department will be covered only if the treatment results in an inpatient admission. Any facility fees for treatment in a private hospital emergency department are not claimable through Medicare or Latrobe.

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

Hospital tests

It may appear that blood tests and X-rays are performed directly by your hospital, but these services are provided by companies independent to the hospital. Fees for these services are classified as medical costs and covered under additional medical benefits by Medicare and Latrobe. There will be out-of-pocket costs associated with these charges. Charges for medical services when you are not an inpatient, including radiology, pathology and costs associated with treatment at a private hospital emergency department, are not covered.

Excess or co-payments

If you have chosen an insurance product that has either an excess or co-payment, you will be required to pay the hospital a certain amount from your own pocket.

→ An excess is payable by adults each calendar year and once the excess is reached no more is required for the rest of the year.

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

It should be noted that our older products (those no longer available for sale) the excess and co-payments will apply to admissions for dependants. Please refer to the product feature table on your product summary for more detail.

Your excess or co-payment details can be found in the 'policy details' section of the Latrobe app, in the Online Member Services Portal or call us on 1300 362 144 (8.30am to 6pm AEST, Monday to Friday).

Supported discharge

Discharge requirements will be discussed with you at the treating hospital. If additional support mechanisms are required, the discharge coordinator will contact Latrobe to discuss these issues further.

Before you receive treatment

Before you access health care, get in touch with us to confirm that your provider is approved and the products and services you are accessing are eligible for benefits under the cover you have.

For hospital admissions, you will need the Medicare Benefit Schedule item numbers and the fees the doctor or medical professional will be charging.

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

This is important information. Please read and retain for future reference.

Ambulance Cover

In Australia, ambulance transportation is not covered by Medicare and ambulance cover requirements varies state to state.

Where cover is provided by an applicable state or territory ambulance scheme (including informal reciprocal arrangements) or a third-party scheme, you'll be covered by the state or territory scheme rather than your policy's emergency ambulance cover.

Unlimited Emergency ambulance transportation and emergency call outs are included in a range of Latrobe products. (This information can be found on the product features table on 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 is defined as transportation of an unplanned and non-routine nature for the purpose of providing immediate medical attention to a person. Whether the transportation is deemed an emergency is determined by the paramedic and usually recorded on the account.

These entitlements are:

• unlimited emergency transport to the closest, clinically appropriate hospital, including transport by road, boat, or air. There is no limit to the km's travelled, the number of times used per year or the total cost of the transport.

• Australia wide **emergency** ambulance transportation, non-**emergency** transfer from interstate to your home state is **not** included.

• includes call out fees for onsite emergency care even if transportation to hospital is not required

• waiting period of 1 day

• applicable for all recognised ambulance service provider (see Definitions page 26)

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 have an ambulance service subscription that provides comprehensive cover for emergency and medically necessary non-emergency ambulance transportation. Each state determines their own business rules and subscription fees. If your product does not include the unlimited emergency ambulance transportation (check your product features table on your product summary) **or** non-emergency (medically necessary) transportation is a consideration for you it is recommended that you consider a membership subscription with your state service.* All Latrobe Extras products include a benefit towards the cost of a state-based ambulance subscription.

This is important information. Please read and retain for future reference.

Ambulance Cover

In Victoria, members with pension and social security entitlements are exempt from the cost of ambulance transportation. You just need to fill in the relevant section on the back of your ambulance invoice and return it to the ambulance service provider to settle the account. In this instance, benefits for ambulance services aren't payable under your Latrobe policy.

**Ambulance Victoria (AV) membership is governed by the AV business rules. Members with dependents over 25 will need their own AV subscription.*

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 levy entitles you to emergency ambulance transport provided by an ambulance service provider within your home state. Any interstate emergency ambulance transportation is either covered by reciprocal agreements in Vic, WA, and NT, or by Latrobe if your product includes the unlimited emergency ambulance transportation in Tas, QLD and SA (check your product features table on your product summary). So, if you get an invoice for emergency-related ambulance transport, send it to us and we'll arrange the settlement of the account.

If your product **does not** include the unlimited emergency ambulance transportation (check your product features table on your product summary) **or** non-emergency (medically necessary) transportation is a consideration for you it is recommended that you consider a standalone ambulance product within your state. Latrobe does not offer a stand-alone ambulance product.

Members with pension and social security entitlements are exempt from the cost of ambulance transportation. You just need to fill in the relevant section on the back of your ambulance invoice and return it to the ambulance service provider to settle the account. In this instance, benefits for ambulance services aren't payable under your Latrobe policy.

Queensland members

If you're a Queensland resident, you're covered under your state ambulance service scheme Australia-wide and benefits for ambulance services aren't payable under your Latrobe policy.

Tasmanian members

If you're a resident of Tasmania, you're covered under your state ambulance service scheme in Tasmania only. In other states (excluding Queensland and South Australia), you're covered under state reciprocal agreements (these can change from time to time) for emergency road ambulance only. If you receive emergency ambulance services from either Queensland or South Australian state government ambulance providers, you can claim under your Latrobe cover if your product includes the unlimited emergency ambulance transportation in QLD and SA (check your product features table on your product summary).

This is important information. Please read and retain for future reference.

Understanding clinical categories

Hospital services are provided under 38 'clinical categories'; for example, brain and nervous system, kidney and bladder, and digestive system. Your product summary outlines the clinical categories included in your product. Any category that is not included means that you are **not covered** for treatment as a private patient in a public or private hospital.

Any category that is 'Restricted' means that your cover is **limited** to the Commonwealth-determined minimum benefit in both a public and private hospital. This means you may have out-of-pocket costs.

There are types of treatments and tests where neither Medicare nor Latrobe Health Services pays a benefit and you will be required to pay the full cost.

Restricted cover even if included as a clinical category

Dental surgery

Some dental surgery is performed in hospital rather than in the dentist's surgery. A common example is the removal of wisdom teeth.

1. **Hospital costs if your hospital cover includes the 'Dental' clinical category:** you are covered for the hospital costs associated with dental surgery in a participating private hospital or a public hospital.
2. **Dentist fees:** no benefit is payable for the 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 the anaesthetist costs associated with dental surgery. These will be payable in accordance with the Latrobe Additional Medical Benefits program.

Podiatry surgery

1. **Hospital costs if your hospital cover includes the podiatry clinical category:** you are covered for some of the hospital costs associated with podiatry 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 costs 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 are planning surgery, it is 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 a 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.

This is important information. Please read and retain for future reference.

Understanding clinical categories

Surgically implanted prostheses

All prostheses listed on the Prescribed List are covered for the clinical categories included in your hospital cover. If you or your doctor choose a prosthesis that is not on this list, you may have out-of-pocket expenses.

Other non-Medicare-covered treatments

No benefits are paid for inpatient treatments that are not covered by Medicare. No benefit is payable for the cost of any prosthesis associated with non-Medicare-covered surgery. Your specialist should be able to confirm if Medicare benefits are payable for your particular treatment.

Respite care

No benefits are payable for services provided for respite or holiday relief.

Allied health service providers

There is no cover if you choose to have your own private allied health professional attend to your needs while in hospital rather than the hospital-appointed provider. In a non-participating private hospital, services such as physiotherapy and occupational therapy are not covered.

Exceptional funding

There is no funding available for treatments that are not approved by the Therapeutic Goods Administration (TGA) or that are experimental or 'off label' types of treatments or devices.

New technologies

'New technologies' include but are not limited to medicines, devices and treatments. There is no cover for any service or item that remains in the testing, clinical trial or experimental phase. This includes any service being used for a purpose other than what it was to be registered or approved for.

Replacement of Commonwealth Prostheses List, non-implanted medical devices

This includes but is not limited to insulin pumps, speech processors and neurostimulators. Such devices will not be replaced during any warranty periods or as a result of being lost, stolen or damaged. Any associated consumables are not covered.

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

Robotic consumables and medical devices that are not on the Commonwealth Prostheses List are not covered.

High-cost drugs

Any drugs not listed on the Pharmaceutical Benefits Scheme (PBS) are not covered.

Hormone treatment

Costs associated with assisted reproduction services are not covered.

Cell storage

Costs associated with assisted cell storage are not covered.

This is important information. Please read and retain for future reference.

Understanding clinical categories

Outpatient attendance

No benefits are payable for services provided on an outpatient basis. Doctors' fees for treatment in a private hospital emergency department will be covered only if the treatment results in an inpatient admission. Any facility fees for treatment in a private hospital emergency department are not claimable through Medicare or Latrobe. No benefits are payable for treatment in a public hospital emergency department.

Overseas treatment

No benefits are payable for services, treatment or appliances provided or sourced outside of Australia. This includes treatment on cruise ships inside or outside Australian waters.

Personal items

There is no cover 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.

This is important information. Please read and retain for future reference.

Making a claim

Medical

If your medical providers send their invoices directly to us, we will claim the Medicare portion on your behalf and forward our portion directly to the provider for you. This means you will only be responsible for paying any out-of-pocket costs. If you are billed directly by your provider, there are two options to submit your claim for payment.

1. myGov

To register for a myGov account, go to my.gov.au or download the app. You will need to link your Medicare account through this service and follow the prompts to make an online claim. If the claim is approved, you will be notified with a statement of benefits via your myGov inbox in seven to 10 days. If the claim is rejected, you will be notified by post.

You can download your statement of benefit and email this together with a completed Latrobe claim form to info@lhs.com.au or post these documents to us at Reply Paid 41, Morwell VIC 3840.

If the account is unpaid, Medicare will pay the provider directly and Latrobe will pay its benefit directly to your nominated bank account. You will need make a payment to the provider and settle the account.

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

2. Medicare

Medicare will ask for your Latrobe details and once processed the claim will be submitted to Latrobe electronically. We will process our portion of your claim and the benefit will be deposited directly into your nominated bank account. Medicare and Latrobe will pay claims up to the MBS schedule fee.

Check your myGov account for the progress of your claim.

Please note, due to privacy legislation we are 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 are not 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 membership card at participating providers.

For services where electronic claiming is not available, you can quickly and easily submit your claim using the Latrobe app or on our website at latrobehealth.com.au.

This is important information. Please read and retain for future reference.

Making a claim

Claiming options

- **Claim online** – claiming on our website is quick and easy. Visit latrobehealth.com.au to complete the form and upload your receipt. Your claim will be assessed by our team and once approved your benefit will be paid into your nominated bank account in three to five days.
- **Claim on the go** – Get the Latrobe Health Services app and and start claiming on the go, track claims, check your benefits and limits, see your payment details, update your contact info and find a provider near you.
- **Claim on the spot**– Some services are claimable via HICAPS or HealthPoint with participating providers. Check with your provider and present your card to claim your benefit immediately.
- **Mail us your claim**– Latrobe Health Services, Reply Paid 41, Morwell VIC 3840
- **Claim directly with Latrobe** – bring your receipts to one of our hubs at Bairnsdale, Moe, Traralgon or Warragul. You can find the opening hours and locations at latrobehealth.com.au

Receipts

When making a claim, it's important to submit either the original or an image/scan of the original accounts and receipts

Accounts/receipts must show:

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

Claims must be made within two years of the date of service. Any claims made after this two-year period will be void. Please submit your claims as soon as possible after the service is provided. You cannot claim benefits if compensation and/or damages can be claimed from another source.

Compensation from other sources

You are not entitled to claim benefits from us if compensation and/or damages can be claimed from another source. If your claim appears to involve a potential for compensation we will contact you to further understand your claim. We will work with you and your legal team to make sure your treatment is not delayed while any legal proceedings are being worked out. We will just get an undertaking that we will be reimbursed for any payments we have made that later are accepted as part of any settlement.

This is important information. Please read and retain for future reference.

When to contact us

Access/update your personal details

This is easily done via our website at latrobehealth. com.au; click on the log-in tab. You can pay your membership and access tax statements as well. You can also give us a call.

Upgrade of cover

You may upgrade your cover at any time. You do not have to serve waiting periods that you have already served; however, waiting periods may apply to services that were not previously part of your cover. If you upgrade your cover to a lower excess and higher extras benefits, waiting periods will apply.

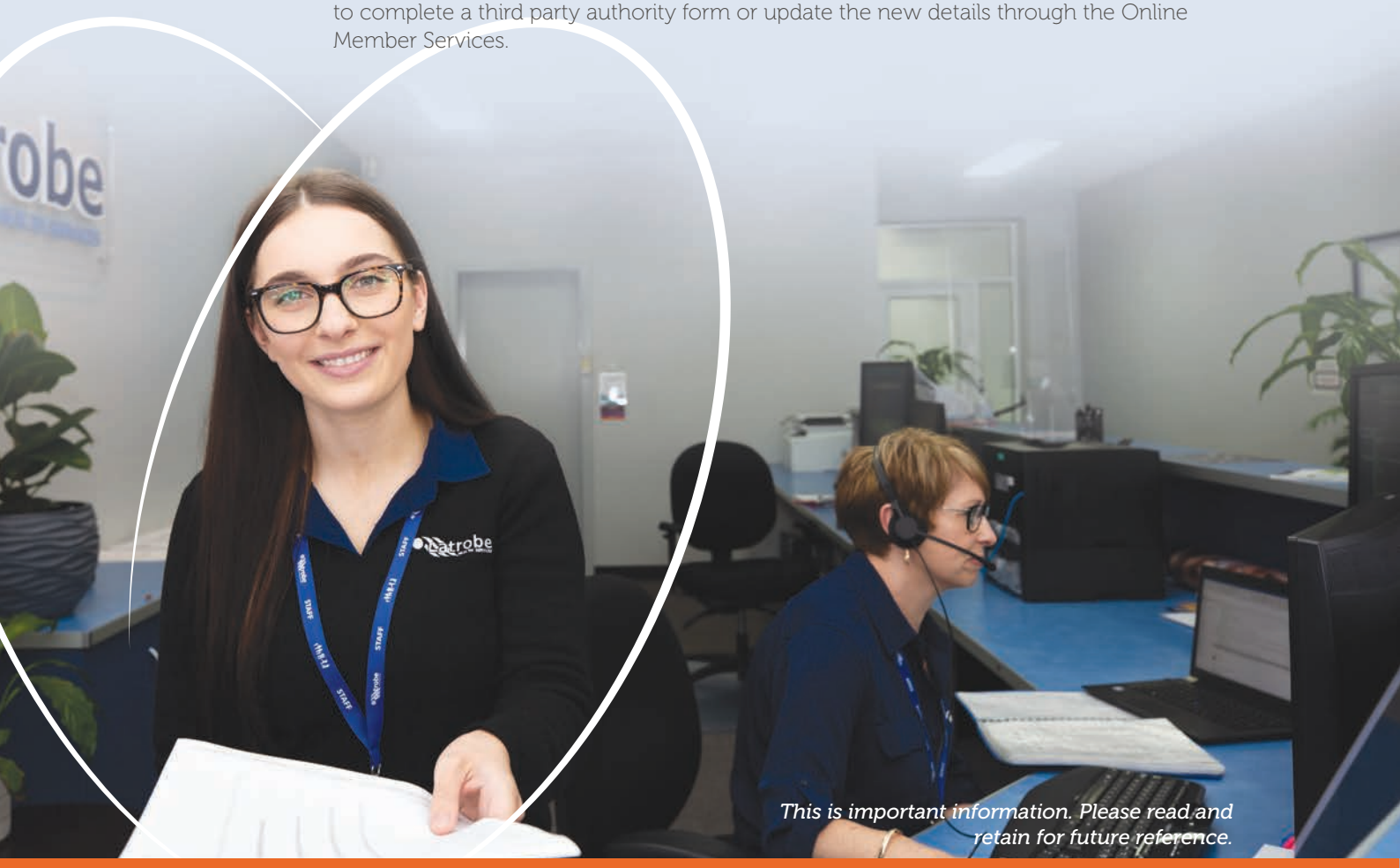
Planning hospital treatment

It's always a good idea to speak with us if you are planning to have treatment in a hospital. 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?

A family or couples membership gives you and your partner equal authority to access information or change your cover, including cancelling your policy.

Due to privacy laws we must have your authority to allow any other person who is not on your policy to access your details or make changes to your membership. If you need to appoint a third party to assist with your membership, please call us, visit our website to complete a third party authority form or update the new details through the Online Member Services.



This is important information. Please read and retain for future reference.

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:

- 1300 362 144 (8.30am to 6pm, Monday to Friday)
- info@lhs.com.au
- Write to the Customer Experience Manager, Latrobe Health Services, Reply Paid 41, Morwell VIC 3840
- Visit a Latrobe hub (10am to 3pm, Monday to Friday).

Contact the Private Health Insurance Ombudsman:

- free and independent services to handle unresolved issues between members and their health fund
- complaints hotline – 1300 362 072 (select option 4 for private health insurance)
- phio.info@ombudsman.gov.au
- www.ombudsman.gov.au

If you are non-English speaking, the Translating and Interpreter Service (TIS) can assist. Please call 131 450.

If you are deaf or have a hearing or speech impairment, please contact the National Relay Service:

- TTY users – 133 677, then ask for 1300 362 072
- speak and listen users – 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

We're always working to improve our service and we love celebrating what we do well. If you have feedback about one of our team or how your Latrobe Health Services cover helped you, please get in touch on 1300 362 144 (8.30am to 6pm, Monday to Friday), or email info@lhs.com.au.

Code of Conduct

The Private Health Insurance Code of Conduct is a self-regulatory code to promote informed relationships between private health funds, members, agents and brokers. As part of our commitment under the code we will:

- continuously improve the standards of practice and service in the private health insurance industry
- provide information to members in plain language
- promote better-informed decisions about our health insurance products and services
- provide information to members on their rights and obligations
- provide members with easy access to our internal dispute resolution procedures, which will be undertaken in a fair and reasonable manner.

Please contact us if you would like a copy of the Code of Conduct, or for more information go to latrobehealth.com.au

This is important information. Please read and retain for future reference.

Privacy Policy

Your privacy is important to us

Latrobe's Privacy Policy details our commitment to your privacy and the procedures and systems that are in place to ensure compliance with the Australian Privacy Principles for protection against inappropriate use of your personal or sensitive information.

Who is collecting my personal sensitive information?

Your personal and/or sensitive information is being 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 to enable us to provide products and services as a health insurer. These may include providing health benefits cover and a range of other products and services that we bring to you either directly or as agents for others such as ambulance cover.

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

If we do not collect your personal and sensitive information, membership with Latrobe and coverage for benefits will not be possible.

Who will you disclose my personal and sensitive information to?

We may be required to disclose some or all of your personal and sensitive information to individuals or organisations who provide services to us.

This assists us in fulfilling our functions and activities with others that you have direct dealings with and who have provided services to you, such as hospitals, doctors, dentists, optometrists and third-party insurers.

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

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

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

For more information about our Privacy Policy, how you can access any information we may hold about you or how a complaint may be lodged, please visit latrobehealth.com.au and search 'privacy policy', or phone 1300 362 144 or email privacy@lhs.com.au.

This is important information. Please read and retain for future reference.

Fund rules

Latrobe's fund rules govern all matters to do with your membership. These rules must comply with the relevant government legislation and are available on our website, latrobehealth.com.au. When you apply for a Latrobe membership, you agree to abide by the rules.

This is important information. Please read and retain for future reference.

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:

"Accident" means an unplanned, unintentional, and unexpected event, occurring by chance and caused by external force or object resulting in a physical injury requiring immediate treatment or advice in respect of which benefits are payable under these rules, but excluding:

a) any illness

b) an injury or condition resulting from any complications of treatment or surgery

c) any injury or condition resulting from the effects of alcohol, or drugs of addiction

d) pregnancy

e) the aggravation of an existing physical injury or condition.

"Accommodation" means hospital facilities covered under your applicable 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 from time to time.

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

"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 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 of time when admitted as a patient for a condition or illness into a hospital for treatment until 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" a person who is not a Dependant Child, Dependant Non-Classified, Dependant Student or Non-Student Dependant (previously known as Adult Dependant).

"Allied Health Services" are services such as physiotherapy, occupational therapy, chiropractic, podiatry, optometry, psychology, dietetics and pharmacy (among others).

"Age-based discount" means a discount offered on selected hospital policies for persons and/ or their partners aged between 18 and 29. The discount is two per cent for each year that the person is aged under 30, to a maximum of ten per cent. Providing the person remains on an applicable hospital cover, they are

Definitions

entitled to the discount until they turn 41 at which time the discount will decrease at the rate of two per cent per year for up to five years, so that no age-based discounts are available after the age of 45.

"Ambulance" means a registered road vehicle, boat or aircraft operated by an Ambulance Service Provider and equipped for the transport of persons requiring medical attention.

"Ambulance transportation – emergency" is 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 Latrobe Health Services recognises the following providers for the purposes of paying benefits:

- 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 is 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 of services registered with the appropriate association or organisation to render services to a member and approved by the Latrobe to render services to its members.

"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 whenever the date to which premiums have been paid is earlier than 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 collective of health funds utilised to negotiate hospital purchaser provider agreements with providers.

"Basic Hospital Cover" means a hospital membership that includes the clinical categories that must be covered by a Basic Hospital product.

This is important information. Please read and retain for future reference.

Definitions

"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 membership that covers hospital treatment and covers the treatments in all of the clinical categories required for a bronze membership.

"Business Partner" are individual(s), and individuals that are part of separate entities that have an alliance to work together.

"Calendar Year" starts on 1 January and ends on 31 December annually.

"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 a group of hospital treatments where all services within a group must be included.

"Children" means all dependants named on a policy (not including spouse).

"Compensation" means a payment by way of damages or a payment under a scheme of insurance or compensation provided for by law, or any other payment that in the opinion of the Fund is a payment in the nature of compensation or damages.

"Cover" means a defined group of benefits payables under a membership for approved expenses incurred by the insured person.

"Consumables and medical devices" means (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 a relatively small amount of money paid by the insured person towards the cost of each day in a private hospital per episode of care.

'Defacto Relationship' means when two people (partners) are not married but are living together as a couple on a genuine domestic basis.

"Dental" means of or relating to the teeth and the work of a dentist.

"Dental Technician (Advanced)" means a person registered or licensed under a law of a State or Territory as a dental technician (advanced).

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

"Department" means The Commonwealth Department of Health.

"Dependant" means a person dependant upon the principal member including:

- adult partner (including de facto and same-sex partner)
- own children
- stepchildren
- legally adopted children, and
- children of whom the principal member is the legal guardian who do not have a partner.

"Dependant child" means a dependant person who is aged under 18 years of age who does not have a spouse or partner; or

"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 who does not have a spouse or partner and who is no longer a full-time student dependant. These dependants may be working or living away from home.

This is important information. Please read and retain for future reference.

Definitions

"Direct debit payment" is a method to make your premium payments automatically depending on your premium frequency. 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 transportation of an unplanned and non routine nature for the purpose of providing immediate medical attention to a person. Whether the transportation is deemed an emergency is determined by the paramedic and usually recorded on the account

"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 that certain things are deliberately not covered in a particular policy type

"Full Time Student" means an insured person in 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 membership that covers hospital treatment and covers the treatments in all of the clinical categories required for a gold membership.

"Health Benefits Fund" means a Fund as described in 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*.

This is important information. Please read and retain for future reference.

Definitions

"High-Cost Drugs" means any drugs not listed on the Pharmaceutical Benefits Scheme (PBS) and are not eligible for payment of benefits.

"Hospital" a recognised hospital, private hospital or a 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 you as an admitted inpatient in a recognised private or public hospital for treatment that is in an included clinical category, has a Medicare item number allocated 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 year from the date of commencement of the insured persons membership, or from the anniversary date of the commencement of the insured person.

"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.

"Latrobe" means Latrobe Inc. ABN 95 159 348 533 (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 additional premiums 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 amount that can be claimed on a selected service in a lifetime, even if cover and funds are changed. 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 ss3(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 extra charge 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" is when Medicare pays 75% of the Medicare Benefit Schedule fee for in-hospital medical charges and Latrobe pays the remaining 25%.

"Member" means any person's, insured person's or dependant's covered on a membership.

"Membership year" means a 12-month period starting on the anniversary of the date that the membership commenced.

This is important information. Please read and retain for future reference.

Definitions

"Mental health waiver" means a waiver of the two-month waiting period for an upgrade from 'Restricted services' to 'Included services' for in-hospital psychiatric treatment in accordance with Division 78 of the *Private Health Insurance Act 2007* for an eligible member. 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 baby less than nine days old.

"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 with the Fund.

"Non-surgically implanted prostheses" means a replacement body part not surgically implanted.

"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" is a term used to define information or procedures relating to pregnancy and 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 fund benefit for a treatment or service and the provider's fees 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.

"PBS" (non) means a Pharmaceutical that is registered for use in Australia by the Therapeutic Goods Administration (TGA) but is not on 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.

This is important information. Please read and retain for future reference.

Definitions

"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 financial payment to the Fund, entitling a principal member and dependant(s) to be an insured person of the Fund.

"Prescribed List of Medical Devices and Human Tissue Products (The Prescribed List)" formerly known as the Commonwealth Prothesis List, the Prescribed List identifies the mimimum amount payable by private health insurers for medical devices and products.

"Principal Member" means the person who signs the application 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.)

"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 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.

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Definitions

"Reinstatement" means that Latrobe 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 the changing of these rules by varying or deleting existing rules and by adding new rules.

"Rules" means these rules as amended from time to time.

"Silver Hospital Cover" means a membership that covers hospital treatment and covers the treatments in all of the clinical categories required for a silver membership.

"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 C9.

"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.

Latrobe
HEALTH SERVICES

Keep in touch

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E: info@lhs.com.au

W: www.latrobehealth.com.au

A: download the app

Using the camera on your mobile, scan the QR code and you'll be directed to your app store to download the Latrobe Health Services mobile app

Google Play Store (Android)
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This is important information. Please read and retain for future reference.

The information contained in this brochure is current at the time of issue and replaces all previously published material.