Defence Health

Fund Rules

1 July 2024

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Introduction

1. Rules Arrangement

These Rules consist of:
a) the General Conditions in Rules A to G; and
b) the Schedules.

Health Benefits Fund

A2.1 Name
Defence Health Limited (ACN 008 629 481) ("Defence Health") is a Private Health Insurer and administers a Health Benefits Fund, the affairs of which are separately recorded ("the Fund").

A reference in the Rules to Defence Health means either Defence Health as a Private Health Insurer, the Fund, or both, depending on the context.

A2.2 Purpose of the Fund
To protect the health of those who protect our country.

A2.3 Purpose of the Rules
These Rules set out the arrangements for Membership of, and the payment of Benefits by, Defence Health.

A2.4 Policies
Defence Health may supplement the Rules with Policies that are not inconsistent with the Rules.

A3 Obligations to Insurer

A3.1 A person applying for admission to the Fund shall comply with the requirements of the Fund and give full and complete disclosure on all matters required by the Fund.

A3.2 The Policy Holders shall inform the Fund of any Membership details, including changes to such details, in the manner and within the time prescribed in these Rules.

A3.3 All Insured Persons are bound by the Rules and Policies as amended from time to time.

A4 Governing Principles

The operation of the Fund and the relationship between the Fund and each Insured Person is governed by:

a) the Private Health Insurance legislation, including subordinate legislation;
b) the Rules;
c) the Constitution of Defence Health; and
d) the Policies.

A5 Use of Funds

A5.1 Financial Control

Defence Health shall:

a) keep proper accounts and records of the transactions and affairs of the Fund
b) ensure that all payments from the Fund are correctly made and properly authorised, and
c) maintain adequate control over:
    (i) the assets in the custody of the Fund; and
    (ii) the incurring of liabilities by the Fund.

A5.2 Audit

Defence Health shall arrange for its accounts and records to be audited by a registered company auditor each year.

A5.3 Income to be Credited to the Fund

Defence Health shall credit to the Fund:

a) all Premiums paid by Policy Holders, and
b) all other income arising from the conduct of the business of the Fund.

A5.4 Drawings on the Fund

Defence Health may draw on the Fund only:

a) to pay Benefits in accordance with these Rules;
b) to make payments to the Private Health Insurance Risk Equalisation Trust Fund;
c) to make investments for the health insurance business;
d) to pay for a purpose specified in the Private Health Insurance Act; and
e) for any other purpose directly related to the business of the Fund.

A6 No Improper Discrimination

Defence Health will comply with the principle of community rating as prescribed in the Private Health Insurance Act unless it has been permitted to do otherwise under any legislative or regulatory instrument, or in any condition of registration.

A7 Changes to Rules

A7.1 Amendments to the Rules

Defence Health may amend the Rules in accordance with the Private Health Insurance Act.

A7.2 Overriding Waiver

Defence Health may, in Nominated Circumstances, or where it would be unconscionable to apply them, waive the application of particular Rules at its discretion, provided that the waiver does not reduce the relevant Policy Holder's entitlement to Benefits.

The waiver of a particular Fund Rule in a given circumstance does not require Defence Health to waive the application of that Rule in any other circumstance.

A7.3 Notification to Policy Holders

7.3.1 Whenever Defence Health amends a Rule such that:

(a) it will or may be detrimental to the interests of an Insured Person under a Product; and

(b) will require an update to the Private Health Information Statement for that Product

Defence Health shall inform all Adults insured by that Product of the change within a reasonable time of the change taking effect and also provide them with an updated Private Health Information Statement for that Product.

7.3.2 Whenever Defence Health amends the Rules such that they will or may be detrimental to an Insured Person, other than as provided in 7.3.1, insured under that Product it shall give reasonable prior notice before the change takes effect.

A8 Dispute Resolution

A8.1 Insured Person Complaints

8.1.1 An Insured Person may make a complaint to Defence Health at any time.

8.1.2 Defence Health will make reasonable endeavours to respond to complaints quickly and efficiently and will not charge a fee for such a service.

A8.2 Commonwealth Ombudsman

8.2.1 The Commonwealth Ombudsman ("Ombudsman") is available to assist Insured Persons who have been unable to resolve issues with the Fund.

8.2.2 Nothing in these Rules prevents an Insured Person from approaching the Ombudsman at any time.

A9 Notices

A9.1 Correspondence

Defence Health shall send any necessary correspondence to one of either the most recently advised postal address, fax number, telephone or e-mail address of the relevant Policy Holder.

A9.2 Availability of Rules to Policy Holders

These Rules are available to Policy Holders on request. The Rules are also available on the Defence Health website.

A10 Winding Up

If on the winding-up (which includes dissolution) of the Fund there remains any assets after satisfaction of all the Fund's debts and liabilities, those assets shall not be paid to or distributed among the Policy Holders, but shall be distributed in accordance with the Private Health Insurance Act.

B Interpretations and Definitions

B1 Interpretation

These Rules shall be interpreted so as not to conflict with the Constitution of the Fund.

Any terms used in these Rules and also in the Constitution shall have the same meaning in these Rules as they bear in the Constitution.

Unless otherwise specified, the meanings attached to the words and expressions in the Private Health Insurance Act shall apply to these Rules.

Words in the singular number shall include the plural and words in the plural shall include the singular.

B2 Definitions

Access Gap or Access Gap Cover means the scheme used by the Fund for the payment of medical Benefits in excess of the Medicare Benefits Schedule to provide no Gap or known Gap Benefit.

Accident means an unplanned or unforeseen event leading to bodily injuries caused solely and directly by external means and requiring immediate Treatment from a Recognised Provider. It does not include unforeseen Conditions attributable to medical causes.

Accidental Injury Benefit means admissions for Clinical Categories that are Restricted or Excluded Services under your Hospital Product and will be treated as Included Services in relation to any non-Compensable Accident occurring after commencement of the Product. Treatment must be sought from a registered practitioner with 72 hours and any required hospitalisation must occur within 180 days of the Accident. With the exception of the change of Included Services for this Benefit as above, the other rules of operation of your Product apply.

ADF or **Australian Defence Forces** or **Defence Forces** means the arms of the Defence Force referred to in the Defence Act 1903 (Cth).

Admitted Patient means a person who is formally admitted to a Hospital for the purposes of Hospital Treatment. This definition:

(a) includes a newborn Child who:
  (i) occupies a bed in a Special Care Unit, or
  (ii) is the second or subsequent Child of a multiple birth, but

(b) excludes:
  (i) any other newborn Child whose mother also occupies a bed in the Hospital, and
  (ii) an employee of a Hospital receiving Treatment in their own quarters.

Adult means an Insured Person who is not a Dependent Child, Dependent Student or Dependent Non-student.

Ambulance Benefit means the Benefit payable to a Member for an Ambulance Treatment, or, at the discretion of Defence Health, the provision of a Benefit for an ambulance subscription to a State or Territory government ambulance service in the State or Territory of residence of the Member. Should a Member incur an out of pocket expense for an Ambulance Treatment, and this out of pocket expense arises from a shortfall between the entitlements received under an

ambulance subscription and the Benefit that would be payable by Defence Health for an Ambulance Treatment if no ambulance subscription existed, then Defence Health will pay a Benefit amounting this difference.

Ambulance Treatment means transport and medical Treatment services provided by a registered ambulance service accredited and engaged by a Federal, State or Territory government within Australia, and is approved by Defence Health. It does not include transport services between hospitals, repatriation to or from a state for non-clinically necessary reasons, or services by patient transport vehicles.

Approved Appliance means an appliance, device, etc. approved by Defence Health from time to time for payment of Benefit purposes.

Arrears means the amount of unpaid Premiums of a Policy Holder represented by the period prior to the current date.

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

Benefit means any amount payable for a product or service provided to a Policy Holder in respect of Insured Persons to assist in treating, managing or preventing diseases, injuries or conditions or which is incidental thereto, in accordance with the Constitution and the Rules.

Benefit Year means the period from 1 July to 30 June.

Board means the members of the Board of Directors of Defence Health appointed in accordance with the Constitution.

Child means one of the following:
(a) a natural Child (including a newborn Child)
(b) an adopted Child
(c) a foster Child, or
(d) a step-Child (that is, a natural, adopted or foster Child of the person's Partner).

Children Only Membership is the Membership Category defined at C1.1(c).

Claim means a claim for a Benefit.

Clinical Category has the same meaning as in the (Complying Product) Rules 2015

Clinically Relevant in relation to a procedure or service means one that is:
(a) performed or rendered by a Medical Practitioner, Dental Practitioner or Optometrist or other Recognised Provider and
(b) generally accepted in the relevant profession as being necessary for the appropriate Treatment of the Patient.

Closed Product has the same meaning as in the Private Health Insurance Act.

Combined Cover means a Cover that combines Hospital Treatment and General Treatment as set out in Schedule J.

Compensation means:

(a) a payment by way of damages

(b) a payment (other than a payment of Fund Benefits) under a scheme of insurance or compensation provided for by a law of a State or Territory including the National Disability Insurance Scheme.

(c) a payment, whether with or without admission of liability, in settlement of a claim for damages or of a claim under a scheme referred to in (b)

(d) a payment by way of damages (or, whether with or without admission of liability, in settlement of a claim for damages) for professional negligence in relation to a claim for payment referred to in (a), (b) or (c), or

(e) any other payment that, in the opinion of Defence Health, is a payment in the nature of Compensation or damages.

Condition means any actual or perceived state of health for which Treatment is sought.

Constitution means the Constitution of Defence Health as amended from time to time.

Consultation means an attendance on a Patient by a Recognised Provider or Hospital, in a manner approved by Defence Health.

Continuous Hospitalisation has the same meaning as in Fund Rule E2.13.

Contribution means the premium payable by Policy Holders for the products offered by the Fund in accordance with the Constitution and the Rules.

Contribution Group means a group of Policy Holders approved for the purposes of Rule D1.2.

Cosmetic Surgery means surgical procedures that:

(a) are not Clinically Relevant, or

(b) do not meet the eligibility conditions for the payment of Medicare Benefits, or

(c) are of a plastic or reconstructive nature that are not listed in the Commonwealth Medicare Benefits Schedule.

Couples Membership is the Membership Category defined at C1.1(b).

Cover means a defined group of Benefits payable, subject to relevant Rules, in respect of approved expenses incurred by a Policy Holder or other Insured Persons under a Cover.

Date of Joining or transfer to the Fund in relation to a Policy Holder means the date from which that person's Contributions commenced.

Date of registration or change of Membership Cover or status in relation to a Policy Holder means the date of notification, provided it is received by the Fund within 30 days of that date. If not received within that period, the effective date will be the date of receipt by the Fund.

Delegated Authority means the assignment of responsibility by the Policy Holder to an authorised representative to carry out specific actions as determined by Defence Health on behalf of the Policy Holder.

Dental Practitioner means a person registered or licensed under a law of a State or Territory as a dental practitioner, dentist, dental surgeon, specialist dentist, advanced dental technician, clinical dental technician or dental prosthetist.

Dependant means a resident of Australia who is:
(a) the Policy Holder's Partner;
(b) the Policy Holder's Dependent Child;
(c) the Policy Holder's Dependent Student;
(d) the Policy Holder's Dependent Non-student; or,
(e) subject to the Private Health Insurance Act, any other person who has been determined by Defence Health as being dependent upon a Policy Holder.

Dependent Child means a person who:
(a) is the Child of the Policy Holder;
(b) is aged under 18 years; or
(c) is a **Non-classified Dependent**; and
(d) does not have a Partner.

Dependent Non-student means a person who:
(a) is the Child of the Policy Holder;
(b) is aged between 21 and 24 (inclusive);
(c) is not receiving full time education at a school, college or university; and
(d) does not have a Partner.

Dependent Student means a person who:
(a) is the Child of the Policy Holder;
(b) is aged between 21 and 24 (inclusive);
(c) is receiving full time education at a school, college or university; and
(d) does not have a Partner.

Excess means an amount of money a Member agrees to pay towards a hospital admission, same day or overnight, before Benefits are payable.

Excluded Service means services for which Benefits are not payable.

Family Membership is the Membership Category defined at C1.1(f).

Family Plus Membership is the Membership Category defined at C1.1(g).

Full-time Serving means people who are members of the Permanent forces rendering full-time service or a pattern of service other than full-time, who are subject to the same service obligations as members rendering full-time service. Full Time Service shall have a corresponding meaning.

Full time Study means a course of study at a secondary school or tertiary college which is at least three quarters of the normal full-time work load or deemed by Defence Health as being full time study.

Fund means the Health Benefits Fund operated by Defence Health, unless the context refers to another Health Benefits Fund.

Gap means the amount of money payable above the Medicare Benefits Schedule payments made under a Medical Purchaser Provider Agreement, Hospital Purchaser Provider Agreement or other scheme.

Gap Cover Scheme means an arrangement where a Medical Practitioner agrees to raise charges for Hospital Treatment and associated Professional Services in accordance with the permitted charges under that scheme. The Fund will cover Members for all, known as No Gap, or all but a specified amount or percentage of that charge, known as Known Gap, where Medicare benefits are payable.

General Benefits are amounts paid by Defence Health for, or towards, the costs of approved General Treatment.

General Cover means any cover approved by Defence Health that is not Hospital Cover and is in respect of General Treatments.

General Treatment has the same meaning as in the Private Health Insurance Act, and is Treatment that is intended to manage or prevent a disease, injury or condition that is not Hospital Treatment.

Health Benefits Fund has the same meaning as in the Private Health Insurance Act.

Health Services Entitlements means health services funded or part-funded through a health service funding body or source, such as the Department of Veterans' Affairs (DVA).

Hearing Aid means an appliance approved by Defence Health that is designed to improve a person's hearing.

Home Nursing means nursing by a duly Registered Nurse in the Policy Holder's home or some other place when such nursing is approved by Defence Health.

Hospital has the same meaning as in the Private Health Insurance Act.

Hospital Cover has the same meaning as in the Private Health Insurance Act, and is a Policy that covers Hospital Treatment.

Hospital Purchaser Provider Agreement (HPPA) means an agreement entered into between Defence Health and a Hospital.

Hospital Psychiatric Services has the same meaning as in the Private Health Insurance (Complying Product) Rules 2015.

Hospital Service means professional attention or any other item in respect of which Benefits are payable from a Hospital Cover.

Hospital-Substitute Treatment has the same meaning as in the Private Health Insurance Act, that substitutes for an episode of hospitalisation.

Hospital Treatment has the same meaning as in the Private Health Insurance Act, and is Treatment that is intended to manage or prevent a disease, injury or condition that is provided at or with the direct involvement of a Hospital.

Included Services means services for which Benefits are payable.

Independent Private Practice means a professional practice (whether sole, partnership or group) that is self-supporting. This means that its accommodation, facilities and services are not provided or subsidised by another party such as a Public Hospital or publicly funded facility.

Initial Consultation means the first consultation in which a Recognised Provider will diagnose and assess a Patient for Treatment related to a specific Condition.

Insured Person means a person insured under a Defence Health Policy or where the context permits, a person insured under a health insurance policy from another Private Health Insurer. Insured People shall have a corresponding meaning.

Lifetime Health Cover has the same meaning as in the Private Health Insurance Act.

Medical Practitioner means a person who:
(a) is registered or licensed as a Medical Practitioner under a law of a State or Territory, and
(b) satisfies the provider eligibility requirements for the payment of Medicare Benefits.

Medical Purchaser Provider Agreement (MPPA) means an agreement between Defence Health and a Medical Practitioner.

Medicare Benefits Schedule (MBS; or Commonwealth Medicare Benefits Schedule (CMBS)) means the 'Medicare Benefits Schedule Book' published by the Department of Health and Aged Care and includes any updates and Supplements to the Schedule published from time to time.

Member Priority network means a network of providers in a particular modality who are approved by Defence Health and who provide Insured Persons with different benefits to other providers in that modality.

Member means a person who is the Policy Holder or another person insured under a Policy of the Fund.

Membership means Membership of the Fund.

Membership Category is defined at C1.1.

Minimum Benefits are equal to the minimum Hospital Benefits determined by the Rules of the Private Health Insurance Act.

Minister means the Federal Minister or their delegate with the powers vested in the Minister by the Private Health Insurance Act.

Month means calendar month.

Nominated Circumstances means events beyond the control of the Fund including acts of God, civil or military authority, pandemics (whether called by an Australian government or relevant world authority), acts or threats of terrorism, civil disturbance, war, riot, strike or labour dispute, fires, floods or acts of government, or other like circumstance.

Non-classified Dependent means a person who:

(a) is the Child of the Policy Holder;
(b) is aged between 18 and 20 (inclusive); and
(c) does not have a Partner.

Nursing Home Type Patient has the same meaning as in the Private Health Insurance (Benefit Requirements) Rules, and means a patient who has been provided with Hospital Treatment for a continuous period exceeding 35 days and is then provided with accommodation and nursing care as an end in itself as part of a continuous period of hospitalisation.

Open Product means a Hospital Treatment Product, General Treatment Product, or Combined Treatment Product that a new or existing Member can join.

Optometrist means a person registered or licensed as an Optometrist or optician under a law of a State or Territory.

Out-Patient means a Patient of a Hospital who is not an Admitted Patient.

Overnight Stay means a period of time in a Hospital that spans both daylight hours and midnight.

Partner means a person who normally lives with the Policy Holder on a bona fide permanent domestic basis and includes a person to whom the Policy Holder is legally married.

PBS means the Pharmaceutical Benefits Scheme.

PBS Item means any drug listed in the Pharmaceutical Benefits Schedule.

Pharmaceutical Benefits Schedule means the Schedule of Pharmaceutical Benefits (Commonwealth Department of Health and Aged Care).

Policies mean a private health insurance policy of the Fund.

Policy Holder means a person who is eligible to be a policy holder of Defence Health and pays Contributions in relation to a health insurance policy. A Policy Holder is deemed to be the owner of the health insurance contract between the Policy Holder and Defence Health. In situations other than where the Fund is bound to take instructions from the Policy Holder, a reference in the Rules to Policy Holder can, at the discretion of Defence Health, with the exception of termination of the policy, be extended to all Insured Persons under the Policy Holder's Cover.

Pre-existing Condition means an ailment, illness or condition, the signs or symptoms of which were considered to be in existence at any time during the six months ending on the day on which the Policy Holder or the Dependants of the Policy Holder joined the fund or upgraded to a higher level of Cover. The consideration shall be by a Medical Practitioner appointed by the

fund who shall examine information furnished by the Insured Person's Medical Practitioner who treated the illness or condition, and other material relevant to the Claim for Benefits.

Premiums (or Contributions) mean an amount of money a Policy Holder is required to pay to Defence Health in respect of a specified period of Cover.

Private Health Insurance Act means the Private Health Insurance Act 2007 (Cth) and the Private Health Insurance (Prudential Supervision) Act 2015 (Cth) as amended from time to time and any legislative instruments made under these Acts.

Private Health Insurance Rules means the rules for which provision is made in the Private Health Insurance Act.

Private Health Insurance Ombudsman has the same meaning as in the Private Health Insurance Act.

Private Health Insurer has the same meaning as in the Private Health Insurance Act.

Private Hospital has the same meaning as in the Private Health Insurance Act.

Private Practice means a practice operated on an independent and self-supporting basis either as a sole, partnership or group practice but not under an arrangement or agreement with, or the subsidy by, another party for the provision of accommodation, facilities or services.

Private Room means, for the purposes of a private room in a public hospital, a room in a hospital that is suitable for one single admitted adult patient.

Product means any of the Defence Health products, which are complying health insurance products under the Private Health Insurance Act.

Professional Attention has the same meaning as in the Health Insurance Act.

Professional Service has the same meaning as in the Health Insurance Act.

Program means a specified group of services or Treatments that is:
(a) provided at a Hospital, and
(b) recognised by Defence Health for the purpose of paying Benefits.

Prosthesis means:
(a) in relation to a Hospital Cover: a surgically implanted item fitted in association with a medical procedure at a Hospital and listed as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules, or
(b) in relation to a General Cover: an external appliance or device approved by Defence Health, normally associated with a physical replacement of some part of the human body.

Public Hospital has the same meaning as in the Private Health Insurance Act.

Public Patient means an Admitted Patient of a Public Hospital who receives Treatment without charge.

Recognised Provider means a provider recognised by Defence Health for the purpose of paying Benefits.

Recognition Criteria, in relation to Providers recognised under these Rules, means:
(a) the provider provides facilities, physical or for services described under Rule E4.3 remote, that meet the standards determined or recognised by Defence Health, and
(b) any other criteria that Defence Health considers reasonable.

Registered Nurse means a person registered as a nurse with the Nurses Board or relevant authority of the State or Territory in which they practise.

Registered Podiatric Surgeon means a person who holds current specialist registration in the specialty of podiatric surgery under the National Law.

Reservist means a person who is actively serving in the Army Reserve, Air Force Reserve or Naval Reserve of Australia, with a Service Category (SERCAT) of 3, 4 or 5.

Restricted Access Group means the Defence Health Ltd Restricted Access Group as defined in these rules.

Restricted Service means a service or Treatment in respect of which the Benefit payable under a specified Hospital Cover is the relevant Minimum Benefit.

Retained Age-Based Discount Policy has the meaning described in the Private Health Insurance (Complying Product) Rules.

Rules means the Rules defined in clause A1 and made by the Board pursuant to the powers conferred by the Constitution.

Same-Day means a period of hospitalisation that commences and finishes on the same date.

Second Tier Benefits has the same meaning as in the Private Health Insurance Act.

Schedule means any of the schedules attached to these Rules.

School Accident means an Accident which causes an injury to a Dependant who is a pre-school, primary or secondary school student while attending, or traveling to or from, school or an organised school activity.

Single Membership is the Membership Category defined at C1.1(a).

Single Parent Family Membership is the Membership Category defined at C1.1(d).

Single Parent Family Plus Membership is the Membership Category defined at C1.1(e).

Special Care Unit means a unit of a Hospital approved by Defence Health for the purpose of providing special care, and includes facilities such as intensive care units, critical care units, coronary care units, and high dependency nursing care units.

Private Health Information Statement is a summary of product features and contains the information and form of words as prescribed by the Private Health Insurance Act.

Subsequent Consultation means, in the reasonable opinion of Defence Health, a consultation for the same Condition in which a Recognised Provider provides additional Treatment to a Patient after an Initial Consultation.

Suspension means the temporary discontinuation of a Membership in accordance with these Rules.

Treatment means:

(a) in respect of Hospital Covers: Hospital Services and Hospital Treatment, and
(b) in respect of General Covers: services and items for which Benefits are payable under these Rules. To avoid doubt, a 'service' excludes any Treatment that is not provided by the provider personally or under the direct supervision of the provider.

Waiting Period means a period during which, except in the case of an Accident to a Policy Holder or his Dependants, Fund Benefits are not payable as defined in Rule F3.

C1 General Conditions of Membership

C1.1 Membership Categories

Defence Health may from time to time offer Products to the following combinations of Insured Persons (**Membership Categories**):

(a) the Policy Holder only (**Single Membership**);
(b) the Policy Holder and their Partner (**Couples Membership**);
(c) two or more Dependent Children, Dependent Students or Dependent Non-students (**Children Only Membership**);
(d) the Policy Holder and one or more Dependent Children or Dependent Student (**Single Parent Family Membership**);
(e) the Policy Holder and at least one Dependent Non-student and any number of Dependent Students or Dependent Children (**Single Parent Family Plus Membership**);
(f) the Policy Holder and their Partner and at least one Dependent Children or Dependent Student (**Family Membership**);
(g) the Policy Holder and one or more Dependent Non- student and any number of Dependent Children or Dependent Students (**Family Plus Membership**).

C1.2 Levels of Cover

A person may be admitted as a Policy Holder in respect of the following Covers:

(a) any one level of Combined Cover;
(b) any one level of General Cover;
(c) any defined combination of one level of Combined Cover with one level of General Cover;
(d) any other Covers determined by Defence Health from time to time.

All Insured People under the same Membership shall:

(a) belong to the same membership category, and
(b) have the same Cover or Covers.

C1.3 Change of Membership Details

Policy Holders are required to advise Defence Health of any changes to Membership details within two months of such changes. Suspensions cannot be made retrospectively unless with the approval of the Fund. Defence Health is not obliged to allow any changes to have effect greater than two months prior to the date advised.

Changes in Membership details may include, but are not limited to:

(a) changes of address of the Policy Holder;
(b) change of contact details such as telephone or email address;
(c) change of Australian residency status;
(d) change of method of payment of Contribution;
(e) change of method of receipt of payments of Benefits;
(f) a Dependant no longer being a Dependant;
(g) change of name;
(h) a Dependent Child who ceases, goes to part-time or defers study;
(i) change of Partner.

C2 Eligibility for Membership

C2.1 Defence Health Restricted Access Group

(a) The only persons to whom complying health insurance products are or will be available (the Restricted Access Group) are:
  (i) persons who are already insured with the Company immediately before the commencement of the Private Health Insurance (Registration) Rules 2007 (No 2); and
  (ii) persons who are or were:
    - a member of an arm of the Defence Force as referred to in the Defence Act 1903 (Cth); or
    - an employee of the Department of Defence or an entity which has a reporting obligation to, or is within the portfolio responsibility of, the Minister for Defence or a Minister Assisting such Minister or a Parliamentary Secretary to either Minister (such Department and entities collectively called "the Bodies"); or
    - an employee of:
      - a contractor to any of the Bodies; or
      - a prescribed agency (as referred to in the Financial Management and Accountability Act 1997 (Cth)) or a Commonwealth authority or Commonwealth company (as referred to in the Commonwealth Authorities and Companies Act 1997 (Cth)) or other entity, which agency, authority, company or entity supplies goods or services to any of the Bodies; and
  (iii) who is or was involved in supplying goods or services to any of the Bodies; and
  (iv) persons who are or become officers or employees (including contractors) of the Company; and
  (v) the partners and dependent children of Principal Insureds; and
  (vi) the former partners and adult children of Principal Insureds; and
  (vii) the siblings, grandchildren and parents of Principal Insureds; and
  (viii) the partners and dependent children of persons who are the adult children of Principal Insureds; and
  (ix) the partners and dependent children of persons who are the siblings of Principal Insureds.

(b) The Company is prohibited from issuing a complying health insurance product to a person who does not belong to the Restricted Access Group.

(c) The Company is prohibited from ceasing to insure a person for the reason that the person has ceased to belong to the Restricted Access Group.

(d) The Company is prohibited from adding new persons to the Restricted Access Group in addition to the persons included in the group by the operation of this Constitution, the Private Health Insurance Act and legislative instruments made under the Private Health Insurance Act.

C2.2 Proof of Eligibility

The Fund may request information from the Policy Holder or their employer at the time of joining the Fund, prior to or after becoming a Policy Holder, to validate eligibility for Membership to the Fund. The Fund may rely upon the advice of the person wishing to join as to their eligibility.

C2.3 Continuation of Membership

C2.3.1 A person who is eligible for Membership under Rule C2.1 and who, as a member of the Australian Defence Force, has health services provided by or through the Australian Defence Force, will have all Waiting Periods waived if an application to join is made within 60 days of the date of discharge.

C2.3.2 A person eligible for Membership under Rules C2.1 may apply to rejoin. All Waiting Periods will apply unless the application to rejoin is made within 60 days of the date of ceasing to be an Insured Person.

C2.4 Dual Membership: Different Funds

(a) An Insured person to a Hospital Cover with another Fund is not eligible to be an Insured Person to a Hospital Cover with Defence Health.

(b) Subject to Defence Health's discretion, an Insured Person to a General Cover with another Fund is not eligible to be an Insured Person to a General Cover with Defence Health.

(c) Subject to these Rules, a person may be an Insured Person to both Defence Health and another fund, where Hospital Cover is held with one fund and General Cover is held with the other fund.

(d) At the absolute discretion of Defence Health, this Rule C2.4 may be altered in circumstances where Dependent Children, Dependent Students and Dependent Non-students of a Policy Holder need to be covered both under a private health insurance cover of a Policy Holder and the Policy Holder's estranged Partner.

C2.5 Dual Memberships: Other

A person cannot take out two Hospital Covers or two General Covers with the Fund.

C2.6 State of Residence

(a) A Policy Holder may hold Membership only in respect of the Policy Holder's State of residence.

(b) Defence Health may transfer a Policy Holder's Membership to the Cover corresponding to the Policy Holder's State of residence.

(c) Defence Health may waive this Rule at its discretion.

C2.7 Minimum Age of Policy Holders

Unless Defence Health otherwise determines, a person must be aged 18 or over to be a Policy Holder.

C3 Dependants

C3.1 Dependants Previously Insured

A person who ceases to be a Dependant of a Policy Holder of Defence Health or any other Fund and is eligible to join Defence Health in their own right, may join Defence Health as a Policy Holder without any additional Waiting Periods, provided:

(a) the new Cover is no higher than the existing Cover,

(b) the person applies for Membership within 60 days of ceasing to be a Dependant.

C4 Membership Applications

C4.1 Application for Admission to Membership

A person who is eligible for Membership, may apply for Membership by:

(a) lodging with Defence Health an application in an approved form; and,

(b) payment of the appropriate Contribution.

C4.2 Non Acceptance of Application for Admission to Membership

Defence Health may refuse any application for admission as a Policy Holder to the Fund where the applicant does not satisfy the requirements of the Rules. When any application for Membership is refused, the applicant is to be advised of the reasons for refusal.

C4.3 Newborn and adopted Children

A newborn or adopted Child may be added to a Membership without Waiting Periods, provided the newborn or adopted Child is added no later than 60 days after their date of birth or date of adoption.

C4.4 Cooling Off Period

A 30 day cooling off period applies to all Memberships. Premiums are fully refundable if a Policy Holder decides to cancel the Membership within the first 30 days of its commencement providing no Claims have been made during that time.

C5 Duration of Membership

Membership Commencement Date

Membership commences on:

(1) the date on which an application is lodged with Defence Health; or

(2) where Defence Health agrees, a later date nominated in the application; or

(3) where Defence Health agrees, for new members and changes in cover, in its absolute discretion, an earlier date nominated in the application.

C6 Transfers

C6.1 Transfers from Other Funds within 60 days – Waiting Periods

When a member of another Fund transfers to Defence Health with a break in coverage of 60 days or less, Defence Health may apply all relevant Waiting Periods:

(a) to any Benefits under the Defence Health Cover that were not provided under the previous Cover

(b) to the difference (if any) between the Benefit payable by Defence Health in respect of a service and that payable by the previous Fund as at the date of service

(c) to the unexpired portions of any Waiting Periods not fully served under the previous Cover.

C6.2 Transfers from Other Funds Outside 60 days

When a member of another Fund transfers to Defence Health with a break in coverage of greater than 60 days, the person will be treated as a new Member for all purposes.

C6.3 Cover Changes Within Defence Health

(a) A Policy Holder may apply to transfer from one product to another product by applying to Defence Health in a form approved by Defence Health. Defence Health may accept or reject such an application.

(b) If an application for transfer is rejected, it shall be for non-compliance with these Rules and the reasons for rejection will be given.

(c) If Defence Health accepts an application, it may require the Policy Holder to comply with such conditions as set out in these Rules.

(d) Where a Policy Holder transfers to a different Defence Health Cover, during any Waiting Period applicable to the new Cover, Benefits are payable at the level of the previous Cover or the new Cover, whichever are the lesser.

C6.4 Previous Benefits May be Taken into Account

(a) Subject to other Rules, where a Policy Holder transfers from another fund or to a different Defence Health Cover, any relevant Benefits that have been paid in a specified time period under the previous Cover may be taken into account in determining the Benefits payable under the new Cover.

(b) 'Any relevant Benefits' include, but are not limited to, Benefits that are subject to an annual or other limit or a maximum number of days of Hospitalisation.

C7 Cancellation of Membership

C7.1 Cancellation of Membership

Subject to (e):

(a) a Policy Holder may cancel their Membership entirely

(b) a Policy Holder may remove any Dependants from their Membership

(c) the Policy Holder's Partner or a Dependant aged at least 16 years of age may leave the Membership, and

(d) a Dependant aged under 16 years of age may leave the Membership with the agreement of the Policy Holder.

(e) Unless otherwise permitted by Defence Health, the above actions:

  (i) must be authorised by the Policy Holder in the manner approved by the Fund

  (ii) may not have retrospective effect, and

  (iii) must be in accordance with any other arrangements specified by Defence Health.

C7.2 Refunds of Premiums

Subject to the Private Health Insurance Act, Defence Health may refund that portion of any premium paid more than 12 months in advance.

C8 Termination of Membership

C8.1 Termination of Membership Where an Insured Person Acts Improperly

(a) Where in Defence Health's opinion an Insured Person has obtained or attempted to obtain an improper advantage, for themselves or for any other Policy Holder or for any Insured Person, Defence Health, subject to the Private Health Insurance Act may terminate the relevant Membership immediately, by written notice to the Policy Holder.

(b) For the purposes of this Fund Rule, 'improper advantage' means any advantage, monetary or otherwise, to which an Insured Person is not entitled under the Rules.

C8.2 Termination of Membership due to Arrears

Defence Health may terminate a Membership where a Policy Holder is in Arrears in their Membership by more than 60 days.

C8.3 Termination for other Reasons

(a) In any circumstance other than as specified in this Rule C8, Defence Health may terminate a Membership.

(b) If Defence Health invokes this Fund Rule, it shall:

  (i) provide the Policy Holder with at least two months' notice in writing including a reason for the termination, and

  (ii) refund any Premiums paid in advance as at the date of the termination.

C8.4 Non-Payment of Benefits

The Fund is not obliged to pay any Benefits or continue Membership or Cover if a Membership is in Arrears or an application form or a Claim form contains false or inaccurate information.

C9 Temporary Suspension of Membership

C9.1 Suspension of Membership Policy

Subject to this Rule 9, Defence Health may permit a Policy Holder to suspend their Membership, or in circumstances of overseas travel, continuous Full-time Service or imprisonment, to suspend individual Members other than the Policy Holder from their Membership after 12 months of Membership. A Policy Holder with two different types of Cover (i.e. Hospital and General) may not suspend one Cover without also suspending the other.

C9.2 Criteria and Time Limits

Subject to the Lifetime Health Cover provisions of the Private Health Insurance Act, a Membership may be suspended in the following circumstances:

(a) Financial hardship - While experiencing financial hardship, a Policy Holder may apply to suspend their Membership for a minimum period of three months and a maximum period of 12 months. Each Policy Holder is permitted a maximum of three hardship Suspensions in a lifetime. However, in Nominated Circumstances, or where it is unconscionable or impractical to apply the Rules, exceptions to these Rules may be approved by Defence Health in its absolute discretion. Defence Health may do this by varying this Rule C9.2 (a) to permit one or more of the following exceptions:

   i. Suspensions within the first 12 months of Membership, for a maximum period prescribed by the Fund at its discretion;
   ii. Suspensions within 12 months of a previous suspension of a Membership, for a maximum period prescribed by the Fund at its discretion;
   iii. Additional suspensions beyond the lifetime maximum, for a maximum period prescribed by the Fund at its discretion.

(b) Overseas travel - for a minimum of 28 days and a maximum of two years, where a Policy Holder is, or individual Members of the Policy are, overseas.

(c) Continuous Full-time Service – for a minimum of 28 days and a maximum of two years, where a Policy Holder is, or individual Members of the Policy are, undertaking a period of continuous Full-time Service. In the case of a Full-time Serving Policy Holder or a policy held by the Partner of a Full-time Serving person who is on continuous full-time military service overseas a maximum of three years applies. Defence Health may exercise its discretion in allowing a longer period of Suspension, for example to the length of the continuous Full-time Service.

(d) Imprisonment – for a minimum of 28 days and a maximum of two years, where a Policy Holder is, or individual Members of the Policy, are imprisoned. The supply of documentation issued by the sentencing Court or State or Territory correctional services department is required.

(e) Any other circumstances, including Nominated Circumstances, Defence Health may permit from time to time in its absolute discretion.

C9.3 Membership to be Current

A Membership may not be suspended unless the Premiums have been paid up to the date of Suspension.

C9.4 Arrangements during Suspension Period

During the period in which a Policy Holder or individual Members of the Policy are suspended:

(a) Benefits are not payable for Treatment received by the Policy Holder and Dependants, or individual Members of the Policy who are suspended and

(b) The period does not count for any purpose in relation to the Insured Person, including Waiting Periods.

C9.5 Minimum Period between Suspensions

Unless Defence Health in its absolute discretion agrees to the contrary, a Membership may be suspended only where the following minimum periods have elapsed since the reactivation from a previous Suspension for the same reason:

(a) No minimum period – Continuous Full-time Service

(b) Six months – overseas travel

(c) 12 months – all other allowable circumstances.

C9.6 Documentation to be Provided

A Policy Holder who wishes to suspend or reactivate a Membership must provide all relevant documentation in support of their application that Defence Health may specify.

C9.7 Reactivation to Occur within 30 days

Where the relevant reason for Suspension ceases to apply, or the maximum period of Suspension has been reached:

(a) if the Policy Holder reactivates the Membership within 30 days, continuity of previous Coverage will apply, but

(b) if reactivation occurs later than 30 days, the Policy Holder will be considered a new Policy Holder for all purposes.

C9.8 Benefit Restitution

The Fund may suspend a Membership where restitution is being sought in situations described in Rule E1.8 (a) and (e) with the following effect:

(a) A Policy Holder is not entitled to Benefits from the Fund during a period of Suspension.

(b) The Policy Holder is responsible for ceasing allotment payments.

(c) The Fund is responsible for ceasing direct debit payments.

(d) Contributions received during the Membership Suspension may be applied towards the amount of restitution.

(e) Provided the applicable full Waiting Periods have been served as prescribed by Rule F3 prior to the date of commencing Suspension and restitution is successful within three months, or after three months from the date of the initial request and prior to termination, the Policy Holder will be eligible for the Benefits under the product for which they are contributing from the date their Membership is restored from Suspension.

(f) Where the Recovery is successful and Contributions have been paid during the Suspension period, Contributions may be applied from the date the Suspension is lifted.

(g) Where restitution is unsuccessful after 3 months from the date of the initial request for payment, the Fund may terminate the Membership in accordance with Rule C8.

D Contributions

D1 Payment of Contributions

D1.2 Premiums Payable for each Product

Premiums payable for each Product can be found on Private Health Information Statements, located at www.privatehealth.gov.au. Premiums are relevant at the date of viewing or downloading.

D1.2 Contribution Groups

Defence Health may at its discretion approve any group of Policy Holders as a Contribution Group for the purposes of sub paragraph 66-5 (3)(e) of the Private Health Insurance Act.

D1.3 Premiums Payable in Advance

(a) All Premiums are payable in advance.

(b) For all Covers, the available advance payment periods are:

- (i) Payment by credit card: monthly, quarterly, half-yearly and yearly
- (ii) Payment by direct debit (other than by credit cards): fortnightly, monthly, quarterly, half-yearly and yearly, and
- (iii) Invoices: quarterly, half-yearly and yearly.

(c) Defence Health may, in its absolute discretion, accept premium payments for amounts less than the advance payment periods outlined in Rule D1.3(b).

(d) Defence Health may, in its absolute discretion, pass onto Policy Holders any bank charges associated with payment of premiums by credit or debit cards.

D1.4 Premiums Limited to 12 Months in Advance

(a) A Policy Holder (or person paying on their behalf) may not make a payment of Premiums that would cause the period of cover to exceed 12 months in advance of the date of payment.

(b) Defence Health will either decline to accept any payment tendered, or part thereof, or refund any amount received that would otherwise breach (a).

(c) Where a change to a Cover pursuant to rule D2.2 and D2.3 occurs and results in the Premium being paid more than 12 months in advance from the date of payment, Defence Health may in its absolute discretion, refund any portion of the Premium that is in excess of 12 months in advance from the date of payment.

(d) Defence Health may waive this Fund Rule at its discretion.

D2 Contribution Rate Changes

D2.1 Premiums May be Changed

Defence Health may change the Premium for any Cover in accordance with the requirements set out in the Private Health Insurance Act, and subject to Rules D2.2 and D2.3

D2.2 Rate Protection

(a) Subject to Rules D1.4 and D2.3, where Premiums have been accepted in advance, the Premium applicable at the time of receipt by Defence Health will apply for the full period of prepayment.

(b) For the purposes of this Fund Rule, the rate protection in clause D2.2(a) above also applies in situations of Cover change.

A Cover change includes:

- (i) the addition or removal of a Cover

(ii) a change in Cover
(iii) a change in the risk equalisation jurisdiction of the Cover, or
(iv) a change of Membership Category resulting in a change in Premiums.

For clarity, where a Cover change is made during the pre-paid period, the Premium paid for the new Cover is the one that applied for that new Cover when the pre-payment was made.

D2.3 When Rate Protection Does Not Apply

The rate protection referred to in rule D2.2 does not apply in the following circumstances:

(a) Where a suspended Membership is reactivated, the Premium current as at the date of the reactivation applies to the Cover from that date.

(b) Where a change in Cover to a Product that did not exist at the time Premiums were paid in advance, the Premium current as at the date of the Cover change applies to the Membership from that date.

D3 Contribution Discounts

D3.1 Discounts on Contribution Group Premiums

(a) Where a Policy Holder is a member of a Contribution Group, Defence Health may allow Premiums to be discounted by up to the amount permitted under the Private Health Insurance Act and may be limited in duration.

(b) Documentary evidence may be requested as proof of membership of a Contribution Group. If documentation is not provided in a timeframe specified by Defence Health, a Policy Holder may forfeit any applicable Premium discount.

(c) Defence Health may, from time to time, apply a time-limited discount during a Nominated Circumstance for Policy Holders in a Contribution Group.

D3.2 Promotional discounts

From time to time Defence Health may offer a promotional discount to a person who is taking out cover for the first time with Defence Health. The promotion will be provided in the first year after the person purchases the policy and will not be greater than the amount permitted under the Private Health Insurance Act

D4 Lifetime Health Cover

D4.1 Lifetime Health Cover Premiums

The Premiums payable by a Policy Holder will be increased by a nominated percentage where required under the Lifetime Health Cover provisions in the Private Health Insurance Act. Defence Health will remove any loading on the amount of premiums payable by a Member once Hospital cover has been held for a continuous period of 10 years, which has only been interrupted by permitted days as specified in the Private Health Insurance Act.

D5 Arrears in Contributions

D5.1 Memberships in Arrears

A Membership (other than a suspended Membership) is 'in Arrears' or in 'a period of Arrears' whenever the date to which Premiums have been paid is earlier than the current date.

D5.2 Treatment During Arrears

(a) Benefits are not payable for Treatment provided to an Insured Person during a period of Arrears. Defence Health may waive this Fund Rule at its discretion.

(b) Subject to Rules D5.3 and D5.4, a Policy Holder may regain an entitlement to Benefits for such Treatment by paying all outstanding Premiums including the minimum amount of advance Premiums relevant to the Policy Holder, as specified in Fund Rule D1.3.

D5.3 Maximum Period of Arrears

When a period of Arrears exceeds 60 days, Defence Health may terminate a Membership with immediate effect without written notice to the Policy Holder.

D5.4 Reinstatement of a Terminated Membership

Where a Membership has been terminated under Fund Rule D5.3, Defence Health has discretion to reinstate the Membership at the request of the Policy Holder, with continuity of entitlements, subject to the payment of all Premiums as required under Fund Rule D5.2(b).

D6 Other

D6.1 Sponsored Memberships

Defence Health may refuse to accept Premiums where a third party seeks to pay them on behalf of a Policy Holder.

E1 General Conditions

E1.1 Treatment to be provided by Recognised Providers

Benefits are payable only where Treatment is provided by a Recognised Provider. Defence Health recognises the following providers:

(a) Hospitals (as defined in these Rules), and

(b) General providers who are:

  (i) in Independent Private Practice,

  (ii) for each relevant class of service or Treatment, satisfy all applicable Recognition Criteria;

  (iii) in relation to Alternative Therapies, recognised by the Australian Regional Health Group; and

  (iv) approved by Defence Health in its absolute discretion.

E1.2 Providers who fail to meet Recognition Requirements

Where Defence Health has reasonable grounds to believe that at the time the services were provided:

(a) at premises or facilities that do not meet the definition of Hospital as set out in Fund Rules, or

(b) by a General provider who is not in Independent Private Practice, or does not meet a relevant Recognition Criterion,

Defence Health will decline to pay Benefits in respect of any Claim.

E1.3 Recognised Providers who cease to meet Recognition Requirements

Where Defence Health has reasonable grounds to believe that at the time the services were provided:

(a) a Hospital has ceased to meet the definition as set out in these Rules, or

(b) a Recognised General Provider has ceased to be in Independent Private Practice, or has ceased to meet any Recognition Criterion,

Defence Health may:

(c) decline to pay Benefits in respect of any Claim, and

(d) suspend or cancel the provider's recognition for the purpose of paying Benefits.

E1.4 No Benefit payment unless permitted by legislation

Irrespective of anything else contained in these Rules, Defence Health will not pay a Benefit to Insured Persons for a Treatment that does not meet the standards in the Private Health Insurance (Accreditation) Rules, unless it has been permitted to do otherwise under any legislative or regulatory instrument, or in any condition of registration.

E1.5 Benefit Reductions

Benefits may be reduced in the following circumstances:

(a) where the charge is lower than the Benefit that would otherwise have been payable, the Benefit shall be reduced to the amount of the charge

(b) where a Benefit is claimable from another source for the same service, the Defence Health Benefit may be reduced by the amount claimable from the other source, and

(c) where in the opinion of Defence Health the charge is higher than the provider's usual charge for the service, Defence Health may assess the Claim as if the provider's usual charge had applied.

E1.6 Hospital-Substitute Treatments

Benefits will not be payable for Hospital-Substitute Treatments where a Medicare benefit of 85% or more of the schedule fee is claimed for the Treatment.

E1.7 Providers Treating Themselves, Family Members, and Business Partners and Family

(a) Subject to (b), Benefits are not payable for Treatment rendered by a provider to:
  (i) the provider's Partner, Dependants, parents, siblings, or business partner, or
  (ii) the provider themselves, or
  (iii) the Partner or Dependants of the provider's business partner.

(b) Defence Health may at its discretion pay Benefits in these cases in respect of the invoiced cost of materials required in connection with any Treatment.

E1.8 Exclusion of Benefits

Benefits are not payable in the following cases:

(a) in respect of any Treatment or service occurring within the Waiting Periods;
(b) in respect of any Treatment or service during a period when Contributions are in Arrears until Contributions are no longer in Arrears
(c) in respect of any Treatment or service during a period when a Policy Holder or individual Members on a Policy are suspended;
(d) in respect of any Treatment or service for which no fee was charged;
(e) if a Membership application or Claim form contains false or misleading information.

E1.9 Benefit Assessment

The Fund may request information from an Insured Person or their health service provider prior to or after the disbursement of Benefits. Information requested will be directly related to a Claim where the Insured Person has made a declaration requesting Benefit entitlement to be paid to the Policy Holder or their health service provider.

Such information may include but is not limited to:

(a) Prescriptions
(b) Signed receipts
(c) Invoices
(d) Treatment plans
(e) Medical/Patient records, and
(f) Appointment schedule.

E1.10 Benefit Restitution

The Fund may seek restitution of monies where:

(a) A Claim contains false or misleading information
(b) A Claim is incorrectly assessed
(c) A Claim is paid after the termination date of the Membership; or
(d) Information is received after the Claim has been paid which establishes that the Benefit should not have been paid, such as, but not limited to, a Member who has a Health Services Entitlement, where restitution may be sought in line with Fund Rule F7.7.

E1.11 Limitations on Consultations provided on the Same Day

The Fund has limitations on Consultations provided on the same day.

(a) Where an Insured Person has two or more Consultations for the same type of service or Treatment on the same day, Benefits are payable where the Consultations are relating to two separate conditions. This is limited to a maximum of two services on any one day, unless specified elsewhere.

(b) Where an Insured Person has two Consultations with the same provider on the same day, Benefits are payable where:
   (i) two different types of services are provided; and
   (ii) the provider is qualified to provide both types of services.
   This is limited to a maximum of two services on any one day, unless specified elsewhere.

E2 Hospital Treatment

E2.1 Hospital Benefits Payable according to the Schedules

The Benefits payable in respect of Hospital Treatment and the conditions relevant to those Benefits are set out in the Fund Rules and associated Schedules.

E2.2 Same-Day Patients

Benefits for Same Day Hospital accommodation are payable only where the Insured Person is an Admitted Patient or where a Benefit is applicable under a Hospital Purchaser Provider Agreement with that Hospital.

E2.3 Day Hospital Facilities

Benefits for Admitted Patients of Day Hospital Facilities are payable in accordance with guidelines the Private Health Insurance Act.

E2.4 Patient Classification: Principles

(a) Benefits for accommodation in Private Hospitals are payable according to the classification of the Patient.

(b) Patients are classified in accordance with the Private Health Insurance Act. The classifications are:
   (i) An advanced surgical patient;
   (ii) A surgical patient;
   (iii) An obstetric patient;
   (iv) A psychiatric patient;
   (v) A rehabilitation patient, or
   (vi) Other (Medical)

(c) Defence Health may permit further sub-classifications of Patients when not inconsistent with the Private Health Insurance Act.

E2.5 Patient Classification: Surgical and Advanced Surgical Patients

Subject to Fund Rule E2.11, the Benefit payable under the surgical and advanced surgical classifications applies:

(a) from the date of admission, where the operative procedure is performed on the first or second day of admission, or

(b) from the date of the procedure, where the operative procedure is performed on the third day of admission or later.

E2.6 Patient Classification: Obstetric Patients

(a) The Obstetric classification applies only where childbirth occurs following the mother's admission to a Hospital.

(b) Where labour resulting in childbirth commenced before admission, the Obstetric classification applies from the date of admission.

(c) Where labour commenced after admission, the Obstetric classification applies from the earliest of:

  (i) the date on which labour commenced, or

  (ii) the date on which an obstetric procedure took place, or

  (iii) any other date that Defence Health may at its absolute discretion specify.

(d) Defence Health has a further discretion to pay Benefits additional to those provided in (b) and (c).

E2.7 Patient Classification: Rehabilitation Patients

Benefits for rehabilitation patients are payable subject to the following conditions:

(a) Treatment must be supported by a rehabilitation certificate (i.e. A certificate in a form approved by Defence Health to the effect that the patient is in need of a special rehabilitation program to recover from an Acute Catastrophic Illness or Injury), and

(b) a further rehabilitation certificate is required:

  (i) for each period specified in any certificate issued under a Hospital Purchaser Provider Agreement where Treatment as a rehabilitation patient beyond 35 days is provided, and

  (ii) for any subsequent readmission as a rehabilitation patient that does not constitute Continuous Hospitalisation.

E2.8 Hospital Psychiatric Services

Hospital Psychiatric Services shall have:

(a) once-per-lifetime upgrade benefits as described in these Rules and the Private Health Insurance (Complying Product) Rules 2015; and

(b) the same portability, waiting periods, and retrospective cover as is prescribed by the Private Health Insurance (Complying Product) Rules 2015.

E2.9 Patient Classification: Counting of Days

(a) The day on which a person became an Admitted Patient and the day of discharge are counted as one day for the purpose of assessing Benefits payable.

(b) Days spent in a special unit (such as an intensive care, critical care, coronary care, or high dependency nursing care unit) do not interrupt the counting of days in relation to the patient classification on entering the unit. To avoid doubt, Benefits payable upon discharge from the special unit will be paid at the classification applicable upon entering the unit, after taking into account any days spent in the unit.

E2.10 Patient Classification: Multiple Procedures

Subject to Fund Rule E2.11, where a patient undergoes more than one operative procedure during the one theatre admission, the procedure with the highest fee in the Medicare Benefits Schedule determines the patient's classification.

E2.11 Patient Classification: Subsequent Procedures

Where a patient undergoes a subsequent operative procedure during the same period of Hospitalisation:

(a) where the procedure results in the patient having a higher classification, the patient's classification increases from the date of the procedure, and

(b) where the procedure would otherwise have resulted in the patient moving to a lower classification, the patient's classification is unchanged.

E2.12 Special Care Unit Patients

The higher Benefits for patients of special care units are payable only for periods during which the patient occupies a bed in a facility approved by Defence Health for this purpose.

E2.13 Continuous Hospitalisation

(a) Where an Admitted Patient is discharged, and within seven days is admitted to the same or a different Hospital for the same or a related Condition, the two admissions are regarded as forming one period of Continuous Hospitalisation. A longer period may be applicable as defined in individual Hospital Purchaser Provider Agreements.

(b) In the case where the Hospitals are different, Benefits at the advanced surgical, surgical or obstetric levels are payable in respect of the later admission only if an appropriate procedure is rendered following that admission.

E2.14 Agreements with Doctors and Hospitals

Subject to Rule E4.2, Defence Health may enter into Medical Purchaser Provider Agreements or Hospital Purchaser Provider Agreements.

E2.15 Gap Cover Arrangements

The schedules referred to in Fund Rule E4.2 shall provide that the Benefits under Gap Cover arrangements are payable subject to the following conditions:

A Medical Practitioner who provides Hospital Services under a Gap Cover Scheme shall give the Insured Person (or Policy Holder where appropriate) written advice of any amount the Insured Person can reasonably be expected to pay for those services.

(1) If possible the advice shall be given before such services are provided, or otherwise as soon as practical, and

(2) the recipient of the advice shall acknowledge receipt of the advice, and

(3) any financial interest the practitioner may have in products or services recommended or provided to the Insured Person are specified.

E2.16 Pharmaceuticals in Hospitals

(a) Where a Hospital Cover includes Benefits for PBS Medications supplied to an admitted patient of a Hospital, the Benefit will meet the full cost of the pharmaceutical if it is directly related to the Treatment of the Condition for which the Insured Person was admitted.

(b) The 'full cost' referred to in (a) includes the Patient co-payment, and any special or Patient Contribution, brand premium or therapeutic group premium otherwise payable by the Patient under the Pharmaceutical Benefits Scheme.

(c) Benefits for non-PBS medications supplied to an Admitted Patient of a Hospital are payable in accordance with the agreement with the Hospital if:

(i) the Benefit is specifically included in the agreement with the Hospital, and

(ii) the pharmaceutical is directly related to the Treatment of the Condition for which the Insured Person is admitted.

E3 General Treatment

E3.1 General Benefits Payable According to the Schedules

The Benefits payable in respect of General Treatments, and the conditions relevant to those Benefits, are set out in the Schedules. General Treatment Benefits are not payable where a Medicare benefit has been or is available to be claimed.

E3.2 Agreements with General Treatment Providers

Defence Health may, from time to time, enter into agreements with providers of General Treatment. The Benefits that apply under these agreements may differ from, and will take precedence over, those shown in general information about Products. Specific information about Benefits is available by contacting Defence Health.

E4 Other

E4.1 Ex-Gratia Benefits

Subject to the Private Health Insurance Act, Defence Health may pay Benefits on an ex-gratia basis, at its discretion.

E4.2 Providers

(a) Subject to Fund Rule E2.15, details of Benefits payable by Defence Health, Benefit conditions, and dates of effect for agreements or arrangements made under this Fund Rule for each Provider are contained in separate schedules maintained by Defence Health.

(b) Subject to (c), and unless otherwise specified in these Rules, the payment of Benefits for Treatment provided by Providers is subject to all relevant Rules.

(c) Defence Health may pay a lower Benefit than as set out in a Schedule if:

  (i) the Benefit is payable for Treatment provided under an agreement referred to in Fund Rule E2.14; and

  (ii) the Insured Person is not subject to any increase in their out-of-pocket expenses for that Treatment.

E4.3 Remote provision of Treatment

(a) Benefits are payable for General Treatment rendered remotely for the following services, subject to other provider Recognition Criteria:

  (i) Dietetics

  (ii) Psychology

  (iii) Speech Therapy

  (iv) Physiotherapy

  (v) Exercise Physiology, and

  (vi) Occupational Therapy.

(b) Other benefits may be payable for services rendered remotely in Nominated Circumstances at the sole discretion of Defence Health.

F Limitation of Benefits

F1 Co Payments

This Rule is left intentionally blank.

F2 Excesses

Excesses: Definition and Explanation
The amount of the Excess and relevant limits and conditions are specified in the Schedule relevant to the Policy Holder's Cover.

F3 Waiting Periods

F3.1 Independence of Waiting Periods
Where more than one Waiting Period applies to a Benefit, each Waiting Period is served independently of any other.

F3.2 Waiver of Waiting Periods
(a) Defence Health may at its discretion waive or reduce any Waiting Period.
(b) The waiver or reduction of a Waiting Period has no effect on:
    (i) any other Waiting Period, or
    (ii) any other Fund Rule applicable to the same service.

F3.3 Waiver in Case of Accidents
Defence Health may at its discretion waive the two-month Waiting Period in Rules F3.4 and F3.5 for Treatment required as the result of an Accident occurring within the two-month period.

F3.4 Waiting Periods: Hospital Treatments
The following Waiting Periods apply to a Benefit for Hospital Treatment or Hospital-Substitute Treatment (where relevant to the Policy Holder's Cover):
(a) Pregnancy and birth - 12 months
(b) Treatment for Pre-Existing Conditions (as provided in Rules F3.6 to F3.8) other than the Treatments covered by paragraph (c) - 12 months
(c) All rehabilitation, hospital psychiatric services and palliative care regardless of whether it is a Pre-Existing Condition - 2 months
(d) All other services and items - 2 months.
(e) If you are on a hospital policy which provides restricted services for psychiatric care, you can upgrade without having to serve additional waiting period to access higher benefits for psychiatric care in a private hospital. This exemption applies only once per lifetime and can only be accessed if you have already completed an initial two months of membership on any level of hospital Product.

F3.5 Waiting Periods: General Treatments

The following Waiting Periods apply to Benefits under General Treatments for the services shown (where relevant to the Policy Holder's Cover):

(a) All services and items except those listed below – 2 months

(b) Laser Refractive Eye Surgery – 12 months

(c) For the supply of medically prescribed health appliances including, mobility aids, blood pressure monitor, TENS machine, splints and braces, orthopaedic shoes, foot orthoses, compression garments, non-cosmetic prostheses, nebulisers and spacers, blood glucose monitors, PAP machines, hearing aids and joint fluid replacement - 12 months

(d) Major dental Treatments including periodontics, oral surgery, endodontics, crowns and bridge work, high cost dentistry and prosthodontics - 12 months

(e) Orthodontic Treatments - 12 months

(f) Midwifery – Home /registered Hospital birthing facility delivery – 12 months

F3.6 Pre-Existing Condition (PEC): Waiting Period

(a) Defence Health may refuse or reduce Benefits in respect of a Pre-Existing Condition that is the subject of Treatment within the first twelve months of Membership of any Hospital Cover.

(b) To avoid doubt, this Fund Rule also applies where an Insured Person transfers to another Cover which provides higher Benefits for the relevant Treatment.

F3.7 PEC: Information from Treating Practitioner(s)

Subject to the Private Health Insurance Act:

(a) Defence Health may appoint a medical or other relevant practitioner to determine whether or not a Condition for which Treatment has been provided and Benefits have been claimed is a Pre-Existing Condition.

(b) A practitioner appointed under (a) shall take into account:

  (i) information provided by the practitioner(s) who treated the Insured Person in the six months ending on the day of becoming an Insured Person or changing their Cover, and

  (ii) any other material that Defence Health considers is relevant to the Claim.

(c) Defence Health may suspend consideration of a Claim until such time as:

  (i) the Insured Person (or Policy Holder where appropriate) authorises the release of the information referred to in (b), and

  (ii) this information has been provided to the Fund, and

  (iii) the relevant practitioner referred to in (a) has reviewed the information referred to in (b), and

  (iv) the Fund is in receipt of the PEC report from the relevant practitioner referred to in (a).

(d) The PEC report from the relevant practitioner referred to in (a) will determine whether the Pre-Existing Condition Waiting Period will be applied.

F3.8 PEC Waiting Period Not to Apply Where the Fund Alters the Cover

(a) Where Defence Health has changed the terms of a Cover, any higher or additional Benefits now available to existing Insured Person of the Cover are not subject to an additional Pre-Existing Condition Waiting Period.

(b) This Fund Rule has no effect on any other Waiting Period or condition that applies to a newly available Benefit.

F4 Exclusions

F4.1 Benefit Exclusions

(a) Unless expressly provided for in these Rules, Benefits are not payable:

(i) for Claims for services rendered while the Membership is suspended or, Premiums are in Arrears until Premiums are no longer in Arrears or

(ii) for Claims for services rendered outside Australia or for items purchased or hired from overseas suppliers, including where the supplier does not have a registered Australian Business Number or

(iii) any Treatment for which, in Defence Health's opinion, you may receive any Compensation, damages, or benefits from another source (even if the Compensation, damages, or benefits are stated to exclude any medical expenses) or

(iv) for Claims for Treatment rendered by a provider other than a Recognised Provider or

(v) for pharmaceuticals that are available under the Pharmaceutical Benefits Scheme (PBS) or

(vi) for contraceptives for the purpose of contraception or

(vii) where an application form for Membership or Claim Form contains false or inaccurate information or

(viii) for services rendered in an aged care service or

(ix) Treatment for which no Medicare Benefits are payable, including any Cosmetic Surgery or experimental or clinical trials of pharmaceuticals or devices.

or

(x) where the Treatment is otherwise excluded by the operation of a Rule.

F4.2 Non-Resident Insured Persons

Benefits to Insured Persons who are Non-Residents of Australia are limited by their Medicare entitlements.

F5 Benefit Limitation Periods

No benefit limitation periods apply to any Covers.

F6 Restricted Benefits

A Cover may restrict Benefits for Hospital Treatment as detailed in the associated Schedules to these Rules.

F7 Compensation Damages and Provisional Payment of Claims

F7.1 Definitions

In Fund Rule F7:

(a) a reference to a Claim (other than a Claim for Benefits) includes a reference to a demand or action

(b) a reference to an injury includes a Condition (including an ailment or injury) for which Benefits would or may otherwise be, payable by Defence Health for expenses incurred in relation to its Treatment, and

(c) a reference to a Member receiving Compensation includes:

(i) Compensation paid to another person at the direction of the Insured Person, and

(ii) Compensation paid to another Insured Person on the same Membership in connection with an injury suffered by the Insured Person.

F7.2 Obligations of an Insured Person

Subject to Fund Rule F7.8, an Insured Person who has, or may have, a right to receive Compensation in relation to an injury, must:

(a) inform Defence Health as soon as the Insured Person knows or suspects that such a right exists

(b) inform Defence Health of any decision of the Insured Person to Claim for Compensation

(c) include in any Claim for Compensation the full amount of all expenses for which Benefits are, or would otherwise be, payable

(d) take all reasonable steps to pursue the Claim for Compensation to Defence Health's reasonable satisfaction

(e) keep Defence Health informed of and updated as to the progress of the Claim for Compensation, and

(f) inform Defence Health immediately upon the determination or settlement of the Claim for Compensation.

F7.3 Entitlement to Benefits for an Injury

(a) Subject to Fund Rule F7.5, and unless otherwise permitted under this Fund Rule, Benefits are not payable for expenses incurred in relation to an injury where the Insured Person has received, or may be entitled to receive, Compensation in respect of that injury.

(b) The expenses referred to in (a) include expenses incurred after the Insured Person has received any Compensation.

F7.4 Defence Health may Withhold Payment

Subject to Fund Rule F7.10, where an Insured Person appears to have a right to make a Claim for Compensation in respect of an injury but that right has not been established, Defence Health may withhold payment of Benefits in respect of expenses incurred in relation to that injury.

F7.5 Provisional Payments

(a) Where a Claim for Compensation in respect of an injury is in the process of being made, or has been made and remains unfinalised, Defence Health may in its absolute discretion make a provisional payment of Benefits in respect of expenses incurred in relation to the injury.

(b) In exercising its discretion, Defence Health may consider factors such as unemployment or financial hardship or any other factors that it considers relevant.

(c) A provisional payment is conditional upon the Insured Person signing a legally binding undertaking and acknowledgment supplied by Defence Health, which contains an agreement by the Insured Person, in consideration for the payment:

- (i) to comply with Fund Rule F7.2
- (ii) that it is bound by these Rules
- (iii) to disclose to Defence Health on request, all matters pertaining to the progress of the Claim and details of any determination made or any settlement reached in respect of the Claim
- (iv) to repay to Defence Health the full amount of the provisional payment as a debt immediately repayable upon the award or settlement of the Claim, whether or not the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future for which Fund Benefits are otherwise payable, and
- (v) that Defence Health has specified rights of subrogation whereby Defence Health acquires all rights and remedies of the Insured Person in relation to the Claim.

F7.6 Where Benefits have been paid by Defence Health

(a) Subject to Fund Rule F7.9, where:

- (i) Defence Health has paid Benefits, whether by way of provisional payments or otherwise, in relation to an injury, and
- (ii) the Insured Person has received Compensation in respect of that injury, the Insured Person must repay to Defence Health the full amount that Defence Health paid in relation to the injury, upon the determination or settlement of the Claim for Compensation.

(b) This Fund Rule applies whether or not:

- (i) the determination or settlement sum includes the full amount that Defence Health paid, or
- (ii) the terms of such settlement specify that the sum of money paid under the settlement relates to expenses past or future in respect of which Benefits are otherwise payable, or
- (iii) the relevant Insured Person complied with their obligations under Rule F7.2.

F7.7 Rights of Defence Health

If an Insured Person makes a Claim for Compensation in relation to an injury and fails to:

(a) comply with any obligation in Rules F7.2 or F7.6, or

(b) include in their Claim for Compensation any payments of Benefits by Defence Health in relation to an injury, Defence Health may, without prejudice to its rights (including its broader subrogation rights) in its absolute discretion take any action permitted by law to:

  (i) assume that all expenses in relation to the injury have been met from the Compensation payable or received pursuant to the Claim, and/or

  (ii) pursue the Insured Person for repayment of all Benefits paid by Defence Health in relation to the injury, and/or

  (iii) assume the legal rights of the Insured Person in respect of all or any parts of the Claim.

F7.8 Claim Abandoned

(a) Where an Insured Person has or may have a right to make a Claim for Compensation in respect of an injury, and

(b) where Defence Health reasonably determines that the Insured Person has abandoned or chosen not to pursue the Claim, Benefits are payable (subject to other Rules) if the Insured Person signs a legally-binding undertaking supplied by Defence Health by which the Insured Person agrees, in consideration for the payment of Benefits, not to pursue the Claim.

F7.9 Requirement to Repay Benefits may be Waived

Where, in respect of an Insured Person's Claim for Compensation in relation to an injury:

(a) the Insured Person has complied with Fund Rule F7.2, and

(b) Defence Health has given prior consent to the settlement of the Claim for an amount that is less than the total Benefits paid or which would otherwise have been payable by Defence Health, Defence Health may in its absolute discretion and subject to any conditions that it considers appropriate, determine that the Insured Person need not repay any part or the full amount of the Benefits paid by Defence Health in respect of the injury.

F7.10 Benefits for Expenses Subsequent to Compensation

Defence Health may, in its absolute discretion, pay Benefits where:

(a) expenses have been incurred as a result of:

  (i) a complication arising from an injury that was the subject of a Claim for Compensation, or

  (ii) the provision of service or item for Treatment of an injury that was the subject of a Claim for Compensation, and

(b) that Claim has been the subject of a determination or settlement, and

(c) there is sufficient medical evidence that those expenses could not have been reasonably anticipated at the time of the determination or settlement.

G1 General

G1.1 Form of Claim

Claims for Benefits must:

(a) be made in a manner approved by Defence Health, and

(b) be supported by accounts and/or receipts on the provider's letterhead or showing the provider's official stamp, and showing the following information:

(i) the provider's name, provider number, qualifications and address

(ii) the Patient's full name and address

(iii) the date of service

(iv) the description of the service

(v) tooth numbers when a Dental Treatment has taken place on an individual tooth

(vi) the amount(s) charged, and

(vii) any other information that Defence Health may reasonably request.

G1.2 Documents to Remain Property of Defence Health

All documents submitted in connection with a Claim become the property of Defence Health, unless otherwise agreed by the Fund.

G1.3 Claims to be Lodged Within Two Years

Benefits are not payable where a Claim is lodged more than two years after the date of service. Defence Health may waive this rule at its discretion.

G1.4 Claims to be Paid Within Two Months

Subject to Rules F3.7(c) and G1.3, Defence Health shall, within two months of receipt of a Claim, assess it and pay any Benefits payable under these Rules.

G1.5 Claims to be Paid after Treatment provided

Benefits are only payable after Treatment has been provided.

G1.6 Claims to be assessed having regard to the date of the Treatment

Benefits are only payable after Treatment has been provided.

G1.7 Incorrect or Fraudulent Claims

If a Claim is found to be incorrect or fraudulent, Defence Health may at its discretion:

(a) suspend all Claiming

(b) offset the amount paid against future Claims or premiums

(c) seek repayment of the funds.

G2 Policy Authorities

G2.1 Dependants aged 16 or over
Dependants aged 16 years or more can request Defence Health to take measures to keep their information confidential from other Insured People on the Policy. Given that many General Treatments are subject to limits which are shown to the Policy Holder, the amount and reduction in Claim limit cannot therefore be kept confidential.

G2.2 Policy authorities – self access for Dependants aged 16 or older
Dependants aged 16 or older have the authority to manage their own personal details, make their own claims, and terminate themselves from the Policy.

G2.3 Delegations of authority to Partner
The Policy Holder may delegate to their Partner the same access as the Policy Holder to manage the Policy with the exception of the ability to:
(a) remove the Policy Holder from the Policy, or
(b) terminate the Policy, or
(c) change the Policy Holder.

G2.4 Delegations of authority to Third Parties
The Policy Holder and Insured People on the Policy may delegate their authority to act on a Policy to a non-Insured Adult. The details and operation of this delegation will be determined by Defence Health.

G2.5 Further definition of Authorities and Delegated Authorities
Defence Health may issue further details and clarifications on the authorities provided in this Rule by publishing these details on the Defence Health website.

G3 Other

G3.1 Manner of Benefit Payment
(a) Defence Health may pay Benefits by cheque or electronic funds transfer in accordance with arrangements it determines from time to time.
(b) Defence Health may prescribe the method of payment of Benefits and insist that Benefits be paid using that payment method.

G3.2 Communication with Members
Defence Health may communicate policy or marketing related information with Members by email where an email address has been provided or alternatively in accordance with the individual's communication preference.

I1 Schedule General Treatment Tables

I1 1 Table Name or Group of Table Names

Top Extras

I1 2 Eligibility

This Product is a Closed Product from 1 October 2014. Policy Holders who held this Product on 30 September 2014 can maintain the Product on an ongoing basis only.

I1 3 General Conditions

Policy holders of the Top Extras General Treatment Product can maintain their Product on an ongoing basis only and from 24 July 2023 may combine this Product with an Open Hospital Treatment Product.

I1 4 Loyalty Bonuses

Defence Health does not have any loyalty bonuses on Extras Tables.

I1 5 Dental

1. Benefits Payable
   - (a) The services for which Benefits are payable and the levels of Benefit prescribed are set out in Schedule M – Dental Benefit Schedule attached to these Rules as adjusted from time to time.
   - (b) The maximum amount of Benefit payable against any one service shall be the Benefit listed in Schedule M – Dental Benefit Schedule or, unless specified otherwise, 100% of the actual cost of the individual service, whichever is the lesser amount.
   - (c) Subject to available limits on Benefits, Dependent Children, Dependent Students and Non-student Dependents are entitled to one mouth guard per Benefit Year at 100% of the cost. For clarity, this refers to the provision, by a dental practitioner, of item 151 or 153 in Schedule M – Dental Benefit Schedule.
   - (d) Members are entitled to preventive dental at 100% of the cost, once per financial year, subject to claim frequency and annual item limits, when provided by a Member Priority network dental practitioner.

2. Benefit Limits
   - (a) Where a service limit applies against any one service / requisite the number of services per person per Benefit Year is listed in Schedule M – Dental Benefit Schedule.
   - (b) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Major Dental will be limited to $850 per person per Benefit Year.
   - (c) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Orthodontics will be limited to $800 per person per Benefit Year.

I1 6 Optical

1. Optical appliance benefits payable
   (a) When provided by a Member Priority network provider:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

   (b) When provided by any other registered Optometrist or Ophthalmologist in Private Practice:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

2. Benefit Limit
   The maximum optical appliance benefit per person per Benefit Year is $255.

Notes:
1. The Benefits shown above are payable up to 100% of cost.
2. Benefits are payable when prescribed by a registered Optometrist or Ophthalmologist in Private Practice.
3. Benefits are not payable for Sunglasses.
4. Benefits are only payable where sight correction or adjustment to the lens is clearly shown on the prescription form.
5. The prescription and account or receipt of payment must be submitted to the Fund with any Claim.
6. For determining entitlements to optical Benefits, the date the appliance was supplied is used to calculate the Benefit payable.

I1 7 Physiotherapy

1. Physiotherapy benefits payable
   (a) For services by registered physiotherapists in Private Practice:

per Initial Consultation	$50
per Subsequent Consultation	$39
per Ante / Post Natal class attendance (max. 10 per Benefit Year)	$20
full day Ante Natal class	$200

   (b) For services relating to pelvic floor muscles performed by registered physiotherapists in Private Practice holding post graduate qualifications specialising in pelvic floor muscle training: $39
   (c) For services relating to lymphoedema performed by registered physiotherapists in Private Practice registered as a Category 1 Practitioner with the Australasian Lymphology Association: $40

Benefit Limit
Limit per person per Benefit Year $550

2. Group Therapy Benefits
For Group Therapy services by registered physiotherapists in Private Practice:
Per group therapy session $17

Benefit Limit
For Group Therapy services a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies & Other Special General Treatment (Health and Wellbeing)

I1 8 Chiropractic

1. Benefits
For services (including Osteopathic) for manipulative Treatment by registered practitioners in Private Practice:
per Initial Consultation $45
per Subsequent Consultation $32
per Xray (maximum of 2 per Benefit Year) $40
2. Benefit Limit
Limit per person per Benefit Year $450

I1 9 Non PBS Pharmaceuticals

1. Benefits
For prescriptions filled by a registered pharmacist in Private Practice when the prescription is ordered by a medical or dental practitioner on legal prescriptions:
per prescription – a Benefit of 100% of the balance remaining after the Insured Person has paid the normal charge for a PBS prescription to a maximum of $80 per prescription.

Notes:

1. Benefits are only payable for prescription medicines or drugs that are classified as Schedule 4 (S4) or Schedule 8 (S8) of the national classification system administered by the Therapeutic Goods Administration of the Department of Health and Aged Care.
2. Benefits are not payable for any prescription medicines or drugs that could have been prescribed under the PBS, products which can be purchased without a prescription or products not related to a medical condition.
3. Benefits are not payable for drugs or products prescribed or supplied to Patients at Private Hospitals or day Hospital facilities.
4. Benefits are not payable for vitamins, minerals and supplements.
5. Benefits are not payable for nicotine e-cigarettes or nicotine vaping products.

2. Benefit Limit
Limit per person per Benefit Year $500

I1 10 Podiatry

1. Benefits
   For services by registered practitioners (including chiropody) in Private Practice:

per Initial Consultation	$45
per Subsequent Consultation	$32

2. Benefit Limit

Limit per person per Benefit Year	$300

I1 11 Psychology

1. Benefits
   For Consultations by registered psychologists in Private Practice when approved by the Fund:

per Initial Consultation	$80
per Subsequent Consultation	$70
per attendance at family therapy	$35
per attendance at group therapy	$25

2. Benefit Limit

Limit per person per Benefit Year	$400

Psychology treatment that has been, or is available to be claimed through Medicare cannot be covered.

I1 12 Alternative Therapies

1. Benefits
   For consultations for Acupuncture, myotherapy and remedial massage where the provider is recognised by the Australian Regional Health Group, and for consultations for Exercise Physiology performed by a Recognised Provider in Private Practice:

per Initial Consultation	$31
per Subsequent Consultation	$27

   Note: Benefits are not payable on any prescribed medications, herbal or dietary preparations.

2. Benefit Limit
   For Alternative Therapy services a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies & Other Special General Treatment (Health and Wellbeing)

I1 13 Natural Therapies

Refer to I1 12 Alternative Therapies.

I1 14 Speech Therapy

1. Benefits

For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$85
per Subsequent Consultation	$45
per attendance at group therapy	$30

Note: The Consultation must be for Speech Therapy services for the Insured Person who has the speech impediment.

2. Benefit Limit

Limit per person per Benefit Year	$500

I1 15 Orthotics

Refer to I1 21 Non Surgically Implanted Prostheses and Appliances.

I1 16 Dietetics

1. Benefits

For Consultations by registered practitioners in Private Practice when approved by the Fund:

per Initial Consultation	$50
per Subsequent Consultation	$30

Benefits are not payable for generic weight reducing courses or programs.

2. Benefit Limit

Limit per person per Benefit Year	$250

I1 17 Occupational Therapy

1. Benefits

For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$65
per Subsequent Consultation	$40
per attendance at group therapy	$20

2. Benefit Limit

Limit per person per Benefit Year	$500

I1 18 Naturopathy

This clause is left intentionally blank.

I1 19 Acupuncture

Refer to I1 12 Alternative Therapies.

I1 20 Other Therapies

1. Eye Therapy
   (a) Benefits
   For services by registered practitioners in Private Practice:

per Initial Consultation	$50
per Subsequent Consultation	$35
per attendance at group therapy	$10

   (b) Benefit Limit

Limit per person per Benefit Year	$500

2. Audiology
   (a) Benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$60
per Subsequent Consultation	$40

   (b) Benefit Limit

Limit per person per Benefit Year	$200

I1 21 Non Surgically Implanted Prostheses and Appliances

Appliances:
Medically Prescribed Health Appliances
Limit of $1000 per person per Benefit Year

When recommended by a physiotherapist, chiropractor, osteopath, podiatrist, chiropodist, occupational therapist, psychologist, psychiatrist or medical practitioner (unless specified otherwise) for a medical condition.

Includes the following subcategories:

1. Nebuliser and spacer
   100% of cost with a limit of $250 per person
   Replacement/additional nebulisers are not claimable within 3 years of previous supply.

2. Blood Glucose Monitors
   100% of cost with a limit of $400 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

3. Positive Airway Pressure Machines (e.g. CPAP, VPAP, APAP, BiPAP etc.)
   100% of cost with a limit of $1,000 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

4. Foot Orthoses
   100% of cost with a limit of $220 per person per Benefit Year
   Custom-made or fitted foot orthoses specifically crafted to meet the needs of a particular individual, including heat moulded orthotics. Must be provided by a specialist orthotic practitioner. Excludes over the counter orthotics.

5. Blood Pressure monitor
100% of cost with a limit of $250 per person
Replacement/additional aids are not claimable within 3 years of previous supply.

6. TENS machine
100% of cost with a limit of $250 per person
Replacement/additional aids are not claimable within 3 years of previous supply.

7. Splints and Braces
100% of the cost with a limit of $250 per person
Knee, leg, spinal, lumbar, sacral, wrist, ankle braces, splints and surgical corsets.

8. Orthopaedic shoes
100% of the cost with a limit of $250 per person
Custom made shoes by a specialist shoemaker for identifiable foot deformities.

9. Compression garments
100% of the cost with a limit of $250 per item
Benefits are claimable for TGA approved, purpose-made garments that aid burn management, post surgical recovery, lymphoedema treatment and deep vein thrombosis prevention.

10. Non-cosmetic prostheses
100% of the cost with a limit of $1000 per person
(a) External breast prostheses following a mastectomy – limit $250 per person.
(b) Wigs following a medical condition – limit $250 per person.
(c) Artificial eyes – limit $1000 per person subject to replacement or additional items not claimable within 3 years of previous supply.

11. Epipen
100% of the cost with a limit of $100 per person

12. Appliance maintenance
100% of the cost with a limit of $100 per person
Repair to foot orthoses and hearing aids, and accessories needed to maintain the function of medical appliances, including masks and tubing for PAP machines and TENS machine electrodes and leads.

13. Rental of appliance
100% of the cost with a limit of $150 per person
The rental of oxygen cylinders, soft collars and any other appliance listed under medically prescribed health appliances, including toilet seat risers, shower chairs and continuous passive movement machines (CPM).

14. Hearing aids
100% of the cost with a limit of $1000 per person
Replacement/additional aids are not claimable within 3 years of previous supply.

15. Mobility aids
100% of the cost with a limit of $1000 per person

Wheelchairs, crutches, walking frames, walking sticks, rolling walkers, seat riser cushions, reachers and adjustable canes. Benefits are not payable for motorised scooters or recliner lift chairs.
Replacement/additional aids are not claimable within 3 years of previous supply.

16. Non-sight correcting Irlen lenses
100% of the cost with a limit of $90 per person
Sight correcting Irlen lenses are payable under optical (Rule I1 6).

I1 22 Hearing Aids

Refer to I1 21 Non Surgically Implanted Prostheses and Appliances.

I1 23 Prevention Health Management

This clause is left intentionally blank.

I1 24 Ambulance Transportation

The Ambulance Benefit is payable.

I1 25 Accident Cover

School Accident

(a) Benefits
A top-up benefit for meeting any gap payments for Treatments (excluding Professional Services for which a Medicare Benefit is payable) incurred as a result of an Accident to a Dependent Child, at school, school activity or travelling to or from school, provided that the costs of such services do not exceed the usual and customary charges and/or schedule fees are not payable from any other source, and are Claimed within 2 years of the date of the Accident.

(b) Benefit Limit
Benefits for 100% of eligible costs up to $600 per Dependent Child per Benefit Year.

I1 26 Accidental Death Funeral Expenses

This clause is left intentionally blank.

I1 27 Other Special

1. Laser Refractive Eye Surgery
   For laser refractive eye surgery performed in a recognised day surgery centre registered with the state.
   100% of the cost with a limit of $1000 per person every two Benefit Years.

2. Home Nursing
   (a) Benefits
   For home visits by a Registered Nurse in Private Practice to attend a person with a serious medical condition approved by the Fund but not including nursing benefits that are a substitute for hospitalisation:

per visit	$32

   (b) Benefit Limit
   Benefits are not payable for a nurse/housekeeper during convalescence.

Limit per person per Benefit Year	$1,000

3. Health and Wellbeing
   (a) Benefits

Bowel screening tests	$80
Kidney function tests	$80
Mole mapping	$80
Bone density tests	$80
Mammograms	$80
Specialist eye tests	$80
Heart tests	$80
Quit smoking program	$80
Nicotine replacement therapy products	$80

   (b) Benefit Limit
   For Health and Wellbeing Benefits, a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing)

Notes:
1. The Benefits shown above are payable at up to 100% of cost.
2. Only the health screening tests listed and quit smoking programs and nicotine replacement therapy products approved by Defence Health are payable.
3. Benefits are not payable where the health screening test has been, or is available to be claimed through Medicare. Benefits are not payable for any prescribed nicotine replacement therapy products or medications subsidised under the Pharmaceutical Benefits Scheme.
4. Only health screening tests conducted by recognised providers are subject to benefit payments. No benefit is payable for tests conducted by a General Practitioner. Quit smoking medications prescribed by a doctor and not subsidised under the Pharmaceutical Benefits Scheme are payable under I1 9 Non PBS Pharmaceuticals.

I2 Schedule General Treatment Tables

I2 1 Table Name or Group of Table Names

Standard Extras

I2 2 Eligibility

This Product is a Closed Product from 1 October 2014. Policy Holders who held this Product on 30 September 2014 can maintain the Product on an ongoing basis only.

I2 3 General Conditions

Policy holders of the Standard Extras General Treatment Product can maintain their Product on an ongoing basis only and from 24 July 2023 may combine this Product with an Open Hospital Treatment Product.

I2 4 Loyalty Bonuses

This clause is left intentionally blank.

I2 5 Dental

1. Benefits Payable
   - (a) The services for which Benefits are payable and the levels of Benefit prescribed are set out in Schedule M – Dental Benefit Schedule attached to these Rules as adjusted from time to time.
   - (b) The maximum amount of Benefit payable against any one service shall be the Benefit listed in Schedule M – Dental Benefit Schedule or, unless specified otherwise, 100% of the actual cost of the individual service, whichever is the lesser amount.

2. Benefit Limit
   - (a) Where a service limit applies against any one service / requisite the number of services per person per Benefit Year is listed in Schedule M – Dental Benefit Schedule.
   - (b) An overall dental maximum of $400 applies per person per Benefit Year.

I2 6 Optical

1. Optical appliance benefits payable
   - (a) When provided by a Member Priority network provider:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

(b) When provided by any other registered Optometrist or Ophthalmologist in Private Practice:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

2. Benefit Limit
The maximum optical appliance benefit per person per Benefit Year is $150

Notes:
1. The Benefits shown above are payable up to 100% of cost.
2. Benefits are payable when prescribed by a registered Optometrist or Ophthalmologist in Private Practice.
3. Benefits are not payable for Sunglasses.
4. Benefits are only payable where sight correction or adjustment to the lens is clearly shown on the prescription form.
5. The prescription and account or receipt of payment must be submitted to the Fund with any Claim.
6. For determining entitlements to optical Benefits, the date the appliance was supplied is used to calculate the Benefit payable.

I2 7 Physiotherapy

1 (a) Benefit

per Initial Consultation	$30
per Subsequent Consultation	$22
Ante/Post Natal class (maximum of 10 per person per Benefit Year)	$10
Full day ante/post natal class	$100

(b) Benefit Limit

Limit per person per Benefit Year	$450

These benefits are applicable for physiotherapy, chiropractic and osteopathic treatment and the limits are combined.

2. Group therapy Benefits
For Group Therapy services by registered physiotherapists in Private Practice:

Per group therapy session	$10

Benefit Limit
For Group Therapy services a combined limit of $150 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) & Alternative Therapies

I2 8 Chiropractic

Refer to I2 7 Physiotherapy.

I2 9 Non PBS Pharmaceuticals

1. Benefits

For prescriptions filled by a registered pharmacist in Private Practice when the prescription is ordered by a medical or dental practitioner on legal prescriptions:
per prescription – a Benefit of 100% of the balance remaining after the Insured Person has paid the normal charge for a PBS prescription to a maximum of $50 per prescription.

Notes:

1. Benefits are only payable for prescription medicines or drugs that are classified as Schedule 4 (S4) or Schedule 8 (S8) of the national classification system administered by the Therapeutic Goods Administration of the Department of Health and Aged Care.
2. Benefits are not payable for any prescription medicines or drugs that could have been prescribed under the PBS, products which can be purchased without a prescription or products not related to a medical condition.
3. Benefits are not payable for drugs or products prescribed or supplied to Patients at Private Hospitals or day Hospital facilities.
4. Benefits are not payable for vitamins, minerals and supplements.
5. Benefits are not payable for nicotine e-cigarettes or nicotine vaping products.

2. Benefit Limit

Limit per person per Benefit Year	$250

I2 10 Podiatry

This clause is left intentionally blank.

I2 11 Psychology

This clause is left intentionally blank.

I2 12 Alternative Therapies

(a) Benefits

For consultations for Acupuncture, myotherapy and remedial massage where the provider is recognised by the Australian Regional Health Group.

per Initial Consultation	$19
per Subsequent Consultation	$15

Note:
Benefits are not payable on any prescribed medications, herbal or dietary preparations.

(b) Benefit Limit
For Alternative Therapy services a combined limit of $150 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) & Alternative Therapies

I2 13 Natural Therapies

This clause is left intentionally blank.

I2 14 Speech Therapy

This clause is left intentionally blank.

I2 15 Orthotics

This clause is left intentionally blank.

I2 16 Dietetics

This clause is left intentionally blank.

I2 17 Occupational Therapy

This clause is left intentionally blank.

I2 18 Naturopathy

Refer to I2 12 Alternative Therapies.

I2 19 Acupuncture

Refer to I2 12 Alternative Therapies.

I2 20 Other Therapies

This clause is left intentionally blank.

I2 21 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

I2 22 Hearing Aids

This clause is left intentionally blank.

I2 23 Prevention Health Management

This clause is left intentionally blank.

I2 24 Ambulance Transportation

The Ambulance Benefit is payable.

I2 25 Accident Cover

This clause is left intentionally blank.

I2 26 Accidental Death Funeral Expenses

This clause is left intentionally blank.

I2 27 Other Special

This clause is left intentionally blank.

I3 Schedule General Treatment Tables

I3 1 Table Name or Group of Table Names

Premier Extras

I3 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group

I3 3 General Conditions

This section is left intentionally blank

I3 4 Loyalty Bonuses

Defence Health does not have any loyalty bonuses on Extras Tables.

I3 5 Dental

1. Benefits Payable
   - (a) The services for which Benefits are payable and the levels of Benefit prescribed are set out in Schedule M – Dental Benefit Schedule attached to these Rules as adjusted from time to time.
   - (b) The maximum amount of Benefit payable against any one service shall be the Benefit listed in Schedule M – Dental Benefit Schedule or, unless specified otherwise, 100% of the actual cost of the individual service, whichever is the lesser amount.
   - (c) Subject to available limits on Benefits, Dependent Children, Dependent Students and Non-student Dependents are entitled to one mouth guard per Benefit Year at 100% of the cost. For clarity, this refers to the provision, by a dental practitioner, of item 151 or 153 in Schedule M – Dental Benefit Schedule.
   - (d) Members are entitled to preventive dental at 100% of the cost, twice per financial year, subject to claim frequency and annual item limits, when provided by a Member Priority network dental practitioner.
2. Benefit Limits
   - (a) Where a service limit applies against any one service / requisite the number of services per person per Benefit Year is listed in Schedule M – Dental Benefit Schedule.
   - (b) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Major Dental will be limited to $1100 per person per Benefit Year.
   - (c) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Orthodontics will be limited to $1000 per person per Benefit Year.

I3 6 Optical

1. Optical appliance benefits payable

(a) When provided by a Member Priority network provider:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

(b) When provided by any other registered Optometrist or Ophthalmologist in Private Practice:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

2. Benefit Limit

The maximum optical appliance benefit per person per Benefit Year is $300.

Notes:

1. The Benefits shown above are payable up to 100% of cost.
2. Benefits are payable when prescribed by a registered Optometrist or Ophthalmologist in Private Practice.
3. Benefits are not payable for Sunglasses.
4. Benefits are only payable where sight correction or adjustment to the lens is clearly shown on the prescription form.
5. The prescription and account or receipt of payment must be submitted to the Fund with any Claim.
6. For determining entitlements to optical Benefits, the date the appliance was supplied is used to calculate the Benefit payable.

I3 7 Physiotherapy

1. Physiotherapy benefits payable

(a) For services by registered physiotherapists in Private Practice:

per Initial Consultation	$64
per Subsequent Consultation	$51

(b) For services relating to pelvic floor muscles performed by registered physiotherapists in Private Practice holding post graduate qualifications specialising in pelvic floor muscle training: $72

(c) For services relating to lymphoedema performed by registered physiotherapists in Private Practice registered as a Category 1 Practitioner with the Australasian Lymphology Association: $97

Benefit Limit

Limit per person per Benefit Year	$850

2. Group Therapy Benefits
(a) For Group Therapy services by registered physiotherapists in Private Practice:
Per group therapy session $25

Benefit Limit
For Group Therapy services a combined limit of $400 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

I3 8 Chiropractic

1. Benefits
For services (including Osteopathic) for manipulative Treatment by registered practitioners in Private Practice:

per Initial Consultation	$57
per Subsequent Consultation	$43
per Xray (maximum of 2 per Benefit Year)	$60

2. Benefit Limit

Limit per person per Benefit Year	$750

I3 9 Non PBS Pharmaceuticals

1. Benefits
For prescriptions filled by a registered pharmacist in Private Practice when the prescription is ordered by a medical or dental practitioner on legal prescriptions:
per prescription – a Benefit of 100% of the balance remaining after the Insured Person has paid the normal charge for a PBS prescription to a maximum of $100 per prescription.

Notes:
1. Benefits are only payable for prescription medicines or drugs that are classified as Schedule 4 (S4) or Schedule 8 (S8) of the national classification system administered by the Therapeutic Goods Administration of the Department of Health and Aged Care.
2. Benefits are not payable for any prescription medicines or drugs that could have been prescribed under the PBS, products which can be purchased without a prescription or products not related to a medical condition.
3. Benefits are not payable for drugs or products prescribed or supplied to Patients at Private Hospitals or day Hospital facilities.
4. Benefits are not payable for vitamins, minerals and supplements.
5. Benefits are not payable for nicotine e-cigarettes or nicotine vaping products.

2. Benefit Limit

Limit per person per Benefit Year	$500

I3 10 Podiatry

1. Benefits

   For services by registered practitioners (including chiropody) in Private Practice:

per initial Consultation and Treatment	$54
per subsequent Treatment	$40

2. Benefit Limit

   A combined limit of $1300 limit per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I3 11 Psychology

1. Benefits

   For Consultations by registered psychologists in Private Practice when approved by the Fund:

per Initial Consultation	$122
per Subsequent Consultation	$107
per attendance at family therapy	$62
per attendance at group therapy	$42

2. Benefit Limit

   A combined limit of $1300 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

Psychology treatment that has been, or is available to be claimed through Medicare cannot be covered.

I3 12 Alternative Therapies

1. Benefits

   For consultations for Acupuncture, myotherapy and remedial massage where the provider is recognised by the Australian Regional Health Group:

per Initial Consultation	$39
per Subsequent Consultation	$35

   Note: Benefits are not payable on any prescribed medications, herbal or dietary preparations.

2 Benefit Limit

   For Alternative Therapy services a combined limit of $400 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

I3 13 Natural Therapies

This clause is left intentionally blank

I3 14 Speech Therapy

1. Benefits

   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$110
per Subsequent Consultation	$62
per attendance at group therapy	$47

   Note: The Consultation must be for Speech Therapy services for the Insured Person who has the speech impediment.

2. Benefit Limit

   A combined limit of $1300 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I3 15 Orthotics

Refer to I3 21 Non Surgically Implanted Prostheses and Appliances.

I3 16 Dietetics

1. Benefits

   For Consultations by registered practitioners in Private Practice when approved by the Fund:

per Initial Consultation	$74
per Subsequent Consultation	$42

   Benefits are not payable for generic weight reducing courses or programs.

2. Benefit Limit

   A combined limit of $1300 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I3 17 Occupational Therapy

1. Benefits

   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$94
per Subsequent Consultation	$57
per attendance at group therapy	$32

2. Benefit Limit

   A combined limit of $1300 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I3 18 Naturopathy

This clause is left intentionally blank

I3 19 Acupuncture

Refer to I3 12 Alternative Therapies.

I3 20 Other Therapies

1. Eye Therapy benefits
   For services by registered practitioners in Private Practice:

per Initial Consultation	$67
per Subsequent Consultation	$57

2. Audiology benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$82
per Subsequent Consultation	$62

3 Antenatal and Postnatal services benefits
For antenatal and postnatal services provided by a recognised midwife or physiotherapist in private practice:

per visit/class	$50
per full day antenatal class	$500

4. Exercise Physiology benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$51
per Subsequent Consultation	$31

A combined limit of $1300 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

5. Exercise Physiology Group Therapy
For Exercise Physiology Group Therapy services by registered practitioners in Private Practice $17

Benefit Limits
For Exercise Group Therapy services a combined limit of $400 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

I3 21 Non Surgically Implanted Prostheses and Appliances

Appliances:
Medically Prescribed Health Appliances

Limit of $1500 per person per Benefit Year

When recommended by a physiotherapist, chiropractor, osteopath, podiatrist, chiropodist, occupational therapist, psychologist, psychiatrist or medical practitioner (unless specified otherwise) for a medical condition.
Includes the following subcategories:

1. Nebuliser and spacer
   100% of cost with a limit of $300 per person
   Replacement/additional nebulisers are not claimable within 3 years of previous supply.

2. Blood Glucose Monitors
   100% of cost with a limit of $500 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

3. Positive Airway Pressure Machines (e.g. CPAP, VPAP, APAP, BiPAP etc.)
   100% of cost with a limit of $1250 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

4. Foot Orthoses
   100% of cost with a limit of $300 per person per Benefit Year
   Custom-made or fitted foot orthoses specifically crafted to meet the needs of a particular individual, including heat moulded orthotics. Must be provided by a specialist orthotic practitioner. Excludes over the counter orthotics.

5. Blood Pressure monitor
   100% of cost with a limit of $300 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

6. TENS machine
   100% of cost with a limit of $300 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

7. Splints and Braces
   100% of the cost with a limit of $300 per person
   Knee, leg, spinal, lumbar, sacral, wrist, ankle braces, splints and surgical corsets.
8. Orthopaedic shoes
   100% of the cost with a limit of $300 per person
   Custom made shoes by a specialist shoemaker for identifiable foot deformities.

9. Compression garments
   100% of the cost with a limit of $300 per item
   Benefits are claimable for TGA approved, purpose-made garments that aid burn management, post surgical recovery, lymphoedema treatment and deep vein thrombosis prevention.

10. Non-cosmetic prostheses
    100% of the cost with a limit of $1250 per person
    (a) External breast prostheses following a mastectomy – limit $300 per person.
    (b) Wigs following a medical condition – limit $300 per person.

(c) Artificial eyes – limit $1250 per person subject to replacement or additional items not claimable within 3 years of previous supply.

11. Epipen
100% of the cost with a limit of $150 per person

12. Appliance maintenance
100% of the cost with a limit of $100 per person
Repair to foot orthoses and hearing aids, and accessories needed to maintain the function of medical appliances, including masks and tubing for PAP machines and TENS machine electrodes and leads.

13. Rental of appliance
100% of the cost with a limit of $200 per person
The rental of oxygen cylinders, soft collars and any other appliance listed under medically prescribed health appliances, including toilet seat risers, shower chairs and continuous passive movement machines (CPM).

14. Hearing aids
100% of the cost with a limit of $1500 per person
Replacement/additional aids are not claimable within 3 years of previous supply.

15. Mobility aids
100% of the cost with a limit of $1000 per person
Wheelchairs, crutches, walking frames, walking sticks, rolling walkers, seat riser cushions, reachers and adjustable canes. Benefits are not payable for motorised scooters or recliner lift chairs.
Replacement/additional aids are not claimable within 3 years of previous supply.

16. Non-sight correcting Irlen lenses
100% of the cost with a limit of $100 per person
Sight correcting Irlen lenses are payable under optical (Rule I3 6).

17. Joint fluid replacement
100% of the cost for approved Joint replacement fluid with a limit of $300 per person.

I3 22 Hearing Aids

Refer to I3 21 Non Surgically Implanted Prostheses and Appliances.

I3 23 Prevention Health Management

This clause is left intentionally blank.

I3 24 Ambulance Transportation

The Ambulance Benefit is payable.

I3 25 Accident Cover

School Accident

(a) Benefits

A top-up benefit for meeting any gap payments for Treatments (excluding Professional Services for which a Medicare Benefit is payable) incurred as a result of an Accident to a Dependent Child, at school, school activity or travelling to or from school, provided that the costs of such services do not exceed the usual and customary charges and/or schedule fees are not payable from any other source, and are Claimed within 2 years of the date of the Accident.

(b) Benefit Limit

Benefits for 100% of eligible costs up to $800 per Dependent Child per Benefit Year.

I3 26 Accidental Death Funeral Expenses

This clause is left intentionally blank.

I3 27 Other Special

1. Laser Refractive Eye Surgery

   For laser refractive eye surgery performed in a recognised day surgery centre registered with the state.

   100% of the cost with a limit of $1500 per person every two Benefit Years.

2. Health and Wellbeing

   (a) Benefits

Bowel screening tests	$180
Kidney function tests	$180
Mole mapping	$180
Bone density tests	$180
Mammograms	$180
Specialist eye tests	$180
Heart tests	$180
Quit smoking program	$180
Nicotine replacement therapy products	$180

   (b) Benefit Limit

   For Health and Wellbeing Benefits, a combined limit of $400 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

Notes:

1. The Benefits shown above are payable at up to 100% of cost.
2. Only the health screening tests listed and quit smoking programs and nicotine replacement therapy products approved by Defence Health are payable.
3. Benefits are not payable where the health screening test has been, or is available to be claimed through Medicare. Benefits are not payable for any prescribed nicotine

replacement therapy products or medications subsidised under the Pharmaceutical Benefits Scheme.

4. Only health screening tests conducted by recognised providers are subject to benefit payments. No benefit is payable for tests conducted by a General Practitioner. Quit smoking medications prescribed by a doctor and not subsidised under the Pharmaceutical Benefits Scheme are payable under I3 9 Non PBS Pharmaceuticals.

I4 Schedule General Treatment Tables

I4 1 Table Name or Group of Table Names

Value Extras

I4 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group.

I4 3 General Conditions

This section is left intentionally blank

I4 4 Loyalty Bonuses

Defence Health does not have any loyalty bonuses on Extras Tables.

I4 5 Dental

1. Benefits Payable
   - (a) The services for which Benefits are payable and the levels of Benefit prescribed are set out in Schedule M – Dental Benefit Schedule attached to these Rules as adjusted from time to time.
   - (b) The maximum amount of Benefit payable against any one service shall be the Benefit listed in Schedule M – Dental Benefit Schedule or, unless specified otherwise, 100% of the actual cost of the individual service, whichever is the lesser amount.
   - (c) Subject to available limits on Benefits, Dependent Children, Dependent Students and Non-student Dependents are entitled to one mouth guard per Benefit Year at 100% of the cost. For clarity, this refers to the provision, by a dental practitioner, of item 151 or 153 in Schedule M – Dental Benefit Schedule.
   - (d) Members are entitled to preventive dental at 100% of the cost, once per financial year, subject to claim frequency and annual item limits, when provided by a Member Priority network dental practitioner.

2. Benefit Limits
   - (a) Where a service limit applies against any one service / requisite the number of services per person per Benefit Year is listed in Schedule M – Dental Benefit Schedule.
   - (b) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Major Dental will be limited to $900 per person per Benefit Year.
   - (c) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Orthodontics will be limited to $800 per person per Benefit Year.

I4 6 Optical

1. Optical appliance benefits payable
   (a) When provided by a Member Priority network provider:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

   (b) When provided by any other registered Optometrist or Ophthalmologist in Private Practice:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

2. Benefit Limit
   The maximum optical appliance benefit per person per Benefit Year is $255

Notes:
1. The Benefits shown above are payable up to 100% of cost.
2. Benefits are payable when prescribed by a registered Optometrist or Ophthalmologist in Private Practice.
3. Benefits are not payable for Sunglasses.
4. Benefits are only payable where sight correction or adjustment to the lens is clearly shown on the prescription form.
5. The prescription and account or receipt of payment must be submitted to the Fund with any Claim.
6. For determining entitlements to optical Benefits, the date the appliance was supplied is used to calculate the Benefit payable.

I4 7 Physiotherapy

1. Physiotherapy benefits payable
   (a) For services by registered physiotherapists in Private Practice:

per Initial Consultation	$52
per Subsequent Consultation	$39

   (b) For services relating to pelvic floor muscles performed by registered physiotherapists in Private Practice holding post graduate qualifications specialising in pelvic floor muscle training: $39
   (c) For services relating to lymphoedema performed by registered physiotherapists in Private Practice registered as a Category 1 Practitioner with the Australasian Lymphology Association: $81

Benefit Limit

Limit per person per Benefit Year	$600

2. Group Therapy Benefits

(a) For Group Therapy services by registered physiotherapists in Private Practice:

Per group therapy session	$18

Benefit Limit

For Group Therapy services a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment

I4 8 Chiropractic

1. Benefits

For services (including Osteopathic) for manipulative Treatment by registered practitioners in Private Practice:

per Initial Consultation	$45
per Subsequent Consultation	$32
per Xray (maximum of 2 per Benefit Year)	$42

2. Benefit Limit

Limit per person per Benefit Year	$550

I4 9 Non PBS Pharmaceuticals

1. Benefits

For prescriptions filled by a registered pharmacist in Private Practice when the prescription is ordered by a medical or dental practitioner on legal prescriptions:
per prescription – a Benefit of 100% of the balance remaining after the Insured Person has paid the normal charge for a PBS prescription to a maximum of $80 per prescription.

Notes:

1. Benefits are only payable for prescription medicines or drugs that are classified as Schedule 4 (S4) or Schedule 8 (S8) of the national classification system administered by the Therapeutic Goods Administration of the Department of Health and Aged Care.
2. Benefits are not payable for any prescription medicines or drugs that could have been prescribed under the PBS, products which can be purchased without a prescription or products not related to a medical condition.
3. Benefits are not payable for drugs or products prescribed or supplied to Patients at Private Hospitals or day Hospital facilities.
4. Benefits are not payable for vitamins, minerals and supplements.
5. Benefits are not payable for nicotine e-cigarettes or nicotine vaping products.

2. Benefit Limit

Limit per person per Benefit Year	$400

I4 10 Podiatry

1. Benefits

For services by registered practitioners (including chiropody) in Private Practice:

per Initial Consultation	$45
per Subsequent Consultation	$32

2. Benefit Limit
   A combined limit of $900 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I4 11 Psychology

1. Benefits
   For Consultations by registered psychologists in Private Practice when approved by the Fund:

per Initial Consultation	$87
per Subsequent Consultation	$72
per attendance at family therapy	$35
per attendance at group therapy	$27

2. Benefit Limit
   A combined limit of $900 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

Psychology treatment that has been, or is available to be claimed through Medicare cannot be covered.

I4 12 Alternative Therapies

1. Benefits
   For consultations for Acupuncture, myotherapy and remedial massage where the provider is recognised by the Australian Regional Health Group.

per Initial Consultation	$31
per Subsequent Consultation	$27

   Note: Benefits are not payable on any prescribed medications, herbal or dietary preparations.

2. Benefit Limit

For Alternative Therapy services a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment

I4 13 Natural Therapies

Refer to I4 12 Alternative Therapies.

I4 14 Speech Therapy

1. Benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$92
per Subsequent Consultation	$47
per attendance at group therapy	$32

   Note: The Consultation must be for Speech Therapy services for the Insured Person who has the speech impediment.
2. Benefit Limit
   A combined limit of $900 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I4 15 Orthotics

This clause is left intentionally blank.

I4 16 Dietetics

1. Benefits
   For Consultations by registered practitioners in Private Practice when approved by the Fund:

per Initial Consultation	$57
per Subsequent Consultation	$31

   Benefits are not payable for generic weight reducing courses or programs.

2. Benefit Limit
   A combined limit of $900 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I4 17 Occupational Therapy

1. Benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$72
per Subsequent Consultation	$42
per attendance at group therapy	$22

2. Benefit Limit
   A combined limit of $900 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

I4 15 Orthotics

This clause is left intentionally blank.

I4 18 Naturopathy

This clause is left intentionally blank.

I4 19 Acupuncture

Refer to I4 12 Alternative Therapies.

I4 20 Other Therapies

1. Eye Therapy benefits
   For services by registered practitioners in Private Practice:

per Initial Consultation	$62
per Subsequent Consultation	$42

2. Audiology benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$69
per Subsequent Consultation	$47

3 Antenatal and Postnatal services benefits
For antenatal and postnatal services provided by a recognised midwife or physiotherapist in private practice:

per visit/class	$30
per full day antenatal class	$300

4. Exercise Physiology benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$29
per Subsequent Consultation	$23

A combined limit of $900 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

5. Exercise Physiology Group Therapy
For Exercise Physiology Group Therapy services by registered practitioners in Private Practice
$13

Benefit Limit
For Exercise Group Therapy services, a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy), Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment.

I4 21 Non Surgically Implanted Prostheses and Appliances

Appliances:
Medically Prescribed Health Appliances
Limit of $1000 per person per Benefit Year
When recommended by a physiotherapist, chiropractor, osteopath, podiatrist, chiropodist, occupational therapist, psychologist, psychiatrist or medical practitioner (unless specified otherwise) for a medical condition.

Includes the following subcategories:

1. Nebuliser and spacer
   100% of cost with a limit of $250 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

2. Blood Glucose Monitors
   100% of cost with a limit of $400 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

3. TENS machine
   100% of cost with a limit of $250 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

4. Orthopaedic shoes
   100% of the cost with a limit of $250 per person
   Custom made shoes by a specialist shoemaker for identifiable foot deformities.

5. Epipen
   100% of the cost with a limit of $100 per person

6. Appliance maintenance
   100% of the cost with a limit of $100 per person
   Repair to foot orthoses and hearing aids, and accessories needed to maintain the function of medical appliances, including masks and tubing for PAP machines and TENS machine electrodes and leads.

7. Rental of appliance
   100% of the cost with a limit of $150 per person
   The rental of oxygen cylinders, soft collars and any other appliance listed under medically prescribed health appliances, including toilet seat risers, shower chairs and continuous passive movement machines (CPM).

8. Hearing aids
   100% of the cost with a limit of $1000 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

9. Non-sight correcting Irlen lenses
   100% of the cost with a limit of $90 per person
   Sight correcting Irlen lenses are payable under optical (Rule I4 6).

I4 22 Hearing Aids

Refer to I4 21 Non Surgically Implanted Prostheses and Appliances.

I4 23 Prevention Health Management

This clause is left intentionally blank.

I4 24 Ambulance Transportation

The Ambulance Benefit is payable.

I4 25 Accident Cover

School Accident

(a) Benefits

A top-up benefit for meeting any gap payments for Treatments (excluding Professional Services for which a Medicare Benefit is payable) incurred as a result of an Accident to a Dependent Child, at school, school activity or travelling to or from school, provided that the costs of such services do not exceed the usual and customary charges and/or schedule fees are not payable from any other source, and are Claimed within 2 years of the date of the Accident.

(b) Benefit Limit

Benefits for 100% of eligible costs up to $600 per Dependent Child per Benefit Year.

I4 26 Accidental Death Funeral Expenses

This clause is left intentionally blank.

I4 27 Other Special

1. Health and Wellbeing

(a) Benefits

Bowel screening tests	$100
Kidney function tests	$100
Mole mapping	$100
Bone density tests	$100
Mammograms	$100
Specialist eye tests	$100
Heart tests	$100
Quit smoking program	$100
Nicotine replacement therapy products	$100

(b) Benefit Limit

For Health and Wellbeing Benefits, a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

Notes:

1. The Benefits shown above are payable at up to 100% of cost.
2. Only the health screening tests listed and quit smoking programs and nicotine replacement therapy products approved by Defence Health are payable.
3. Benefits are not payable where the health screening test has been, or is available to be claimed through Medicare. Benefits are not payable for any prescribed nicotine replacement therapy products or medications subsidised under the Pharmaceutical Benefits Scheme.
4. Only health screening tests conducted by recognised providers are subject to benefit payments. No benefit is payable for tests conducted by a General Practitioner. Quit smoking medications prescribed by a doctor and not subsidised under the Pharmaceutical Benefits Scheme are payable under I4 9 Non PBS Pharmaceuticals.

I5 Schedule General Treatment Tables

I5 1 Table Name or Group of Table Names

Essentials Extras

I5 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group.

I5 3 General Conditions

This section is left intentionally blank

I5 4 Loyalty Bonuses

This clause is left intentionally blank.

I5 5 Dental

1. Benefits Payable
   - (a) The services for which Benefits are payable and the levels of Benefit prescribed are set out in Schedule M – Dental Benefit Schedule attached to these Rules as adjusted from time to time.
   - (b) The maximum amount of Benefit payable against any one service shall be the Benefit listed in Schedule M – Dental Benefit Schedule or, unless specified otherwise, 100% of the actual cost of the individual service, whichever is the lesser amount.
2. Benefit Limit
   - (a) Where a service limit applies against any one service / requisite the number of services per person per Benefit Year is listed in Schedule M – Dental Benefit Schedule.
   - (b) An overall dental maximum of $500 applies per person per Benefit Year.

I5 6 Optical

1. Optical appliance benefits payable
   - (a) When provided by a Member Priority network provider:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

   - (b) When provided by any other registered Optometrist or Ophthalmologist in Private Practice:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%

Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

2. Benefit Limit
The maximum optical appliance benefit per person per Benefit Year is $170

Notes:

1. The Benefits shown above are payable up to 100% of cost.
2. Benefits are payable when prescribed by a registered Optometrist or Ophthalmologist in Private Practice.
3. Benefits are not payable for Sunglasses.
4. Benefits are only payable where sight correction or adjustment to the lens is clearly shown on the prescription form.
5. The prescription and account or receipt of payment must be submitted to the Fund with any Claim.
6. For determining entitlements to optical Benefits, the date the appliance was supplied is used to calculate the Benefit payable.

I5 7 Physiotherapy

1 Physiotherapy benefits payable

(a) For services by registered physiotherapists in Private Practice:

per Initial Consultation	$36
per Subsequent Consultation	$26

(b) For services relating to lymphoedema performed by registered physiotherapists in Private Practice registered as a Category 1 Practitioner with the Australasian Lymphology Association: $52

Benefit Limit
A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

2. Group Therapy Benefits
(a) For Group Therapy services by registered physiotherapists in Private Practice:
Per group therapy session $12

Benefit Limit
For Group Therapy services a combined limit of $200 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies & Other Therapies (Exercise Physiology – Group Therapy)

I5 8 Chiropractic

(a) Benefit

per Initial Consultation	$36
per Subsequent Consultation	$26

(b) Benefit Limit
A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

I5 9 Non PBS Pharmaceuticals

1. Benefits
For travel vaccination prescriptions filled by a registered pharmacist in Private Practice when the prescription is ordered by a medical practitioner on legal prescriptions:
per prescription– a Benefit of 100% of the balance remaining after the Insured Person has paid the normal charge for a PBS prescription to a maximum of $50 per prescription.

Notes:
1. Benefits are not payable for any travel vaccination prescriptions which could have been prescribed under the PBS, products that can be purchased without a prescription or products not related to a medical condition.
2 Benefits are not payable for drugs or products prescribed or supplied to Patients at Private Hospitals or day Hospital facilities.

2. Benefit Limit
A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

I5 10 Podiatry

This clause is left intentionally blank.

I5 11 Psychology

This clause is left intentionally blank.

I5 12 Alternative Therapies

1. Benefits
For consultations for Acupuncture, myotherapy and remedial massage where the provider is recognised by the Australian Regional Health Group.

per Initial Consultation	$21
per Subsequent Consultation	$17

Note: Benefits are not payable on any prescribed medications, herbal or dietary preparations.

2. Benefit Limit
For Alternative Therapy services a combined limit of $200 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies & Other Therapies (Exercise Physiology – Group Therapy)

I5 13 Natural Therapies

This clause is left intentionally blank.

I5 14 Speech Therapy

This clause is left intentionally blank.

I5 15 Orthotics

This clause is left intentionally blank.

I5 16 Dietetics

This clause is left intentionally blank.

I5 17 Occupational Therapy

This clause is left intentionally blank.

I5 18 Naturopathy

Refer to I5 12 Alternative Therapies.

I5 19 Acupuncture

Refer to I5 12 Alternative Therapies.

I5 20 Other Therapies

This clause is left intentionally blank.

I5 21 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

I5 22 Hearing Aids

This clause is left intentionally blank.

I5 23 Prevention Health Management

This clause is left intentionally blank.

I5 24 Ambulance Transportation

The Ambulance Benefit is payable.

I5 25 Accident Cover

This clause is left intentionally blank.

I5 26 Accidental Death Funeral Expenses

This clause is left intentionally blank.

I5 27 Other Special

1. Exercise Physiology benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$20
per Subsequent Consultation	$16

Benefit Limit
A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

2. Exercise Physiology Group Therapy
For Exercise Physiology Group Therapy services by registered practitioners in Private Practice
$8

Benefit Limit
For Exercise Group Therapy services, a combined limit of $200 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy), Alternative Therapies & Other Therapies (Exercise Physiology – Group Therapy)

J1 Schedule Combined Hospital Treatment and General Treatment Tables

J1 1 Table Name or Group of Table Names

Top Hospital Gold
Top Hospital Gold 250
Top Hospital Gold 300
Top Hospital Gold 400
Top Hospital Gold 500
Top Hospital Gold 800

J1 2 Eligibility

This is a Closed Product closed from 1 October 2014. Policy Holders who held this Product on 30 September 2014 can maintain the Product on a continuous basis only.

1. Single Memberships include:
   (a) Top Hospital Gold
   (b) Top Hospital Gold 250 or
   (c) Top Hospital Gold 400.

2. Couples Membership, Family Membership and Single Parent Family Membership include:
   (a) Top Hospital Gold
   (b) Top Hospital Gold 300
   (c) Top Hospital Gold 500 or
   (d) Top Hospital Gold 800.

J1 3 General Conditions

Policy holders of the Top Hospital Gold Product can maintain their Product on an ongoing basis only and from 24 July 2023 may combine this Product with an Open General Treatment Product.

J1 4 Hospital Treatment Payments

Providing a hospital admission is not related to an Excluded Service described in rule J1 14, or a Restricted Service described in rule J1 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)

At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:

(a) 10% above the Minimum Benefit as defined under the Private Health Insurance Act; and

(b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital

When the Insured Person elects to be treated as a Private Patient, the Fund will pay:

(a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and

(b) an additional $80 per day when admitted to a private room.

J1 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J1 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:

(a) Medicare pays 75% of the Medicare scheduled fee; and

(b) The Fund will pay 25% of the Medicare scheduled fee.

J1 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J1 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J1 7 Non PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J1 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J1 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J1 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J1 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J1 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J1 10 Co Payments

Defence Health does not apply co-payments.

J1 11 Excesses

(a) The Top Hospital Gold Cover is Excess free.
(b) Policy Holders contributing to the following Covers will pay an Excess once per Membership, per Benefit Year. The Excess applicable is:
    (i) Top Hospital Gold 250 - $250 Excess
    (ii) Top Hospital Gold 300 - $300 Excess
    (iii) Top Hospital Gold 400 - $400 Excess
    (iv) Top Hospital Gold 500 - $500 Excess
    (v) Top Hospital Gold 800 - $800 Excess
(c) This Excess is applied in both public and Private Hospitals.
(d) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(e) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(f) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J1 12 Benefit Limitation Periods

No benefit limitation periods apply.

J1 13 Restricted Services

There are no Restricted Services defined for this product.

J1 14 Excluded Services

There are no Clinical Categories defined as Excluded Services for this Product

J1 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J1 16 Other Special Hospital Treatment

A Benefit is payable where the primary procedure is performed by a Registered Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee. Podiatric surgery performed by a Registered Podiatric Surgeon will attract hospital treatment benefits at the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

J1 17 Dental

This clause is left intentionally blank.

J1 18 Optical

This clause is left intentionally blank.

J1 19 Physiotherapy

This clause is left intentionally blank.

J1 20 Chiropractic

This clause is left intentionally blank.

J1 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J1 22 Podiatry

This clause is left intentionally blank.

J1 23 Psychology

This clause is left intentionally blank.

J1 24 Alternative Therapies

This clause is left intentionally blank.

J1 25 Natural Therapies

This clause is left intentionally blank.

J1 26 Speech Therapy

This clause is left intentionally blank.

J1 27 Orthotics

This clause is left intentionally blank.

J1 28 Dietetics

This clause is left intentionally blank.

J1 29 Occupational Therapy

This clause is left intentionally blank.

J1 30 Naturopathy

This clause is left intentionally blank.

J1 31 Acupuncture

This clause is left intentionally blank.

J1 32 Other Therapies

This clause is left intentionally blank.

J1 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J1 34 Hearing Aids

This clause is left intentionally blank.

J1 35 Prevention Health Management

A benefit is payable for approved specialised programs at private facilities.

J1 36 Ambulance Transportation

The Ambulance Benefit is payable.

J1 37 Accident Cover

This clause is left intentionally blank.

J1 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J1 39 Other Special General Treatment

1. Home Nursing
   Towards charges for approved Home Nursing by a Registered Nurse in Private Practice when deemed appropriate by a Medical Practitioner, a Benefit of $70 per day to $1800 per person per Benefit Year for insured persons

2. Midwifery
   Towards charges for services by a registered midwife nurse in Private Practice and accredited with Defence Health.
   (a) For ante natal / post natal care a Benefit of $40 per pre-natal visit and up to $80 per post-natal visit subject to a $500 limit per person per Benefit Year
   (b) For a confinement / delivery at home or in a registered Hospital birthing facility (except in cases where a Medical Practitioner is required to intervene and take over the delivery) for insured persons a Benefit of up to $1000.

J1 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J1.14, Defence Health will pay the following:

1. Hospital Substitute Programs
Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs
These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J2 Schedule Combined Hospital Treatment and General Treatment Tables

J2 1 Table Name or Group of Table Names

Public Hospital Basic Plus

J2 2 Eligibility

This Product is a Closed Product from 1 October 2014. Policy Holders who held this Product on 30 September 2014 can maintain the Product on an ongoing basis only.

J2 3 General Conditions

1. The Public Hospital Basic Plus Product was able to be combined with the Top Extras (Schedule I1) General Treatment Product or Standard Extras (Schedule I2) General Treatment Product. Policy Holders who held one of these covers on 30 September 2014 can maintain their cover on an ongoing basis only.

J2 4 Hospital Treatment Payments

Providing a hospital admission is not related to an Excluded Service described in rule J2 14, or a Restricted Service described in rule J2 13, Defence Health will pay the following:

1. Public Hospital
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory.

2. Private Hospital Including Day Hospital Facilities
   At Private Hospitals the Fund will pay 10% above the Minimum Benefit for accommodation as defined under the Private Health Insurance Act.

3. Theatre Fees and Labour Ward Costs
   No benefits for theatre fees nor labour ward costs are payable.

4. COVID-19 related illness inclusion
   Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health, per the following:
   (i) Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.
   (ii) Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)

At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:

(a) 10% above the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and

(b) no benefits for theatre fees nor labour ward costs are payable.

J2 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J2 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
   (a) Medicare pays 75% of the Medicare scheduled fee; and
   (b) The Fund will pay 25% of the Medicare scheduled fee.

J2 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Defence Health will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J2 7 Non PBS Pharmaceuticals

Defence Health will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J2 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J2 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J2 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J2 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J2 10 Co Payments

Defence Health does not apply co-payments.

J2 11 Excesses

This product is Excess free.

J2 12 Benefit Limitation Periods

No benefit limitation periods apply.

J2 13 Restricted Services

Minimum Benefits apply to all Clinical Categories

J2 14 Excluded Services

There are no Clinical Categories defined as Excluded Services for this Product.
The following Hospital Treatments are Excluded Services:

J2 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J2 16 Other Special Hospital Treatment

A Benefit is payable where the primary procedure is performed by a Registered Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee.

J2 17 Dental

This clause is left intentionally blank.

J2 18 Optical

This clause is left intentionally blank.

J2 19 Physiotherapy

This clause is left intentionally blank.

J2 20 Chiropractic

This clause is left intentionally blank.

J2 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J2 22 Podiatry

This clause is left intentionally blank.

J2 23 Psychology

This clause is left intentionally blank.

J2 24 Alternative Therapies

This clause is left intentionally blank.

J2 25 Natural Therapies

This clause is left intentionally blank.

J2 26 Speech Therapy

This clause is left intentionally blank.

J2 27 Orthotics

This clause is left intentionally blank.

J2 28 Dietetics

This clause is left intentionally blank.

J2 29 Occupational Therapy

This clause is left intentionally blank.

J2 30 Naturopathy

This clause is left intentionally blank.

J2 31 Acupuncture

This clause is left intentionally blank.

J2 32 Other Therapies

This clause is left intentionally blank.

J2 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J2 34 Hearing Aids

This clause is left intentionally blank.

J2 35 Prevention Health Management

This clause is left intentionally blank.

J2 36 Ambulance Transportation

The Ambulance Benefit is payable.

J2 37 Accident Cover

This clause is left intentionally blank.

J2 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J2 39 Other Special General Treatment

Midwifery
Towards charges for services by a registered midwife nurse in Private Practice and accredited with Defence Health.
(a) For ante natal / post natal care a Benefit of $40 per pre-natal visit and up to $80 per post-natal visit subject to a $500 limit per person per Benefit Year
(b) For a confinement / delivery at home or in a registered Hospital birthing facility (except in cases where a Medical Practitioner is required to intervene and take over the delivery) for insured persons a Benefit of up to $1000.

J2 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J2 14, Defence Health will pay the following:

1. Hospital Substitute Programs

Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs
These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J6 Schedule Combined Hospital Treatment and General Treatment Tables

J6 1 Table Name or Group of Table Names

ADF Top Hospital Gold
ADF Top Hospital Gold 250
ADF Top Hospital Gold 300
ADF Top Hospital Gold 400
ADF Top Hospital Gold 500
ADF Top Hospital Gold 800

J6 2 Eligibility

This Product is a Closed Product from 1 October 2014. Policy Holders who held this Product on 30 September 2014 can maintain the Product on an ongoing basis only.

1. Single Memberships include:
   (a) ADF Top Hospital Gold
   (b) ADF Top Hospital Gold 250 or
   (c) ADF Top Hospital Gold 400.

2. Single Parent Family Memberships include:
   (a) ADF Top Hospital Gold
   (b) ADF Top Hospital Gold 300
   (c) ADF Top Hospital Gold 500 or
   (d) ADF Top Hospital Gold 800.

3. Children Only Memberships include ADF Top Hospital Gold only.

J6 3 General Conditions

Policy holders of the Top Hospital Gold Product can maintain their Product on an ongoing basis only and from 24 July 2023 may combine this Product with an Open General Treatment Product.

J6 4 Hospital Treatment Payments

Providing a hospital admission is not related to an Excluded Service described in rule J6 14, or a Restricted Service described in rule J6 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)

At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:

(a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and

(b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital

When the Insured Person elects to be treated as a Private Patient, the Fund will pay:

(a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and

(b) an additional $80 per day when admitted to a private room.

J6 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J6 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:

(a) Medicare pays 75% of the Medicare scheduled fee; and

(b) The Fund will pay 25% of the Medicare scheduled fee.

J6 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J6 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J6 7 Non PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J6 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J6 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J6 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J6 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J6 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J6 10 Co Payments

Defence Health does not apply co-payments.

J6 11 Excesses

(a) The ADF Top Hospital Gold Cover is Excess free.
(b) Policy Holders contributing to the following Covers will pay an Excess once per Membership, per Benefit Year. The Excess applicable is:
    (i) ADF Top Hospital Gold 250 - $250 Excess
    (ii) ADF Top Hospital Gold 300 - $300 Excess
    (iii) ADF Top Hospital Gold 400 - $400 Excess
    (iv) ADF Top Hospital Gold 500 - $500 Excess
    (v) ADF Top Hospital Gold 800 - $800 Excess
(c) This Excess is applied in both public and Private Hospitals.
(d) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(e) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(f) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J6 12 Benefit Limitation Periods

No benefit limitation periods apply.

J6 13 Restricted Services

There are no Restricted Services defined for this product.

J6 14 Excluded Services

The following Hospital Treatments are Excluded Services: Treatments not recognised by Medicare: Defence Health will make no payments for hospital services, medical services,

pharmaceuticals, surgically implanted prostheses, or Nursing Home Type Patient payments where the Treatment is not a clinically necessary Hospital Treatment recognised by Medicare.

J6 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J6 16 Other Special Hospital Treatment

Podiatric surgery performed by a Registered Podiatric Surgeon will attract hospital treatment benefits at the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

J6 17 Dental

This clause is left intentionally blank.

J6 18 Optical

This clause is left intentionally blank.

J6 19 Physiotherapy

This clause is left intentionally blank.

J6 20 Chiropractic

This clause is left intentionally blank.

J6 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J6 22 Podiatry

This clause is left intentionally blank.

J6 23 Psychology

This clause is left intentionally blank.

J6 24 Alternative Therapies

This clause is left intentionally blank.

J6 25 Natural Therapies

This clause is left intentionally blank.

J6 26 Speech Therapy

This clause is left intentionally blank.

J6 27 Orthotics

This clause is left intentionally blank.

J6 28 Dietetics

This clause is left intentionally blank.

J6 29 Occupational Therapy

This clause is left intentionally blank.

J6 30 Naturopathy

This clause is left intentionally blank.

J6 31 Acupuncture

This clause is left intentionally blank.

J6 32 Other Therapies

This clause is left intentionally blank.

J6 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J6 34 Hearing Aids

This clause is left intentionally blank.

J6 35 Prevention Health Management

A benefit is payable for approved specialised programs at private facilities.

J6 36 Ambulance Transportation

The Ambulance Benefit is payable.

J6 37 Accident Cover

This clause is left intentionally blank.

J6 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J6 39 Other Special General Treatment

1. Home Nursing
   Towards charges for approved Home Nursing by a Registered Nurse in Private Practice when deemed appropriate by a Medical Practitioner, a Benefit of $70 per day to $1400 per person per Benefit Year for insured persons.

2. Midwifery
   Towards charges for services by a registered midwife nurse in Private Practice and accredited with Defence Health.
   (a) For ante natal / post natal care a Benefit of $20 per pre-natal visit and up to $40 per post-natal visit subject to a $240 limit per person per Benefit Year
   (b) For a confinement / delivery at home or in a registered Hospital birthing facility (except in cases where a Medical Practitioner is required to intervene and take over the delivery) for insured persons a Benefit of up to $55

J6 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J6 14, Defence Health will pay the following:

1. Hospital Substitute Programs
   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs
   These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J7 Schedule Combined Hospital Treatment and General Treatment Tables

J7 1 Table Name or Group of Table Names

ADF Public Hospital Basic Plus

J7 2 Eligibility

This Product is a Closed Product from 1 October 2014. Policy Holders who held this Product on 30 September 2014 can maintain the Product on an ongoing basis only.

J7 3 General Conditions

The ADF Public Hospital Basic Plus Product was able to be combined with the Top Extras (Schedule I1) General Treatment Product or Standard Extras (Schedule I2) General Treatment Product. Policy Holders who held one of these covers on 30 September 2014 can maintain their cover on an ongoing basis only.

J7 4 Hospital Treatment Payments

Providing a hospital admission is not related to an Excluded Service described in rule J7 14, or a Restricted Service described in rule J7 13, Defence Health will pay the following:

1. Public Hospital Basic Plus
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory.

2. Private Hospital Including Day Hospital Facilities
   At Private Hospitals the Fund will pay the Minimum Benefit for accommodation as defined under the Private Health Insurance Act.

3. Theatre Fees and Labour Ward Costs
   No benefits for theatre fees nor labour ward costs are payable.

4. COVID-19 related illness inclusion
   Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health per the following:
   (iii) Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.
   (iv) Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)

At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:

(a) 10% above the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and

(b) no benefits for theatre fees nor labour ward costs are payable.

J7 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J7 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
   (a) Medicare pays 75% of the Medicare scheduled fee; and
   (b) The Fund will pay 25% of the Medicare scheduled fee.

J7 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Defence Health will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J7 7 Non PBS Pharmaceuticals

Defence Health will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J7 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J7 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J7 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J7 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J7 10 Co Payments

Defence Health does not apply co-payments.

J7 11 Excesses

This product is Excess free.

J7 12 Benefit Limitation Periods

No benefit limitation periods apply.

J7 13 Restricted Services

Minimum Benefits apply for all Clinical Categories.

J7 14 Excluded Services

There are no Clinical Categories defined as Excluded Services for this Product

J7 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J7 16 Other Special Hospital Treatment

This clause is left intentionally blank.

J7 17 Dental

This clause is left intentionally blank.

J7 18 Optical

This clause is left intentionally blank.

J7 19 Physiotherapy

This clause is left intentionally blank.

J7 20 Chiropractic

This clause is left intentionally blank.

J7 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J7 22 Podiatry

This clause is left intentionally blank.

J7 23 Psychology

This clause is left intentionally blank.

J7 24 Alternative Therapies

This clause is left intentionally blank.

J7 25 Natural Therapies

This clause is left intentionally blank.

J7 26 Speech Therapy

This clause is left intentionally blank.

J7 27 Orthotics

This clause is left intentionally blank.

J7 28 Dietetics

This clause is left intentionally blank.

J7 29 Occupational Therapy

This clause is left intentionally blank.

J7 30 Naturopathy

This clause is left intentionally blank.

J7 31 Acupuncture

This clause is left intentionally blank.

J7 32 Other Therapies

This clause is left intentionally blank.

J7 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J7 34 Hearing Aids

This clause is left intentionally blank.

J7 35 Prevention Health Management

This clause is left intentionally blank.

J7 36 Ambulance Transportation

The Ambulance Benefit is payable.

J7 37 Accident Cover

This clause is left intentionally blank.

J7 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J7 39 Other Special General Treatment

Midwifery
Towards charges for services by a registered midwife nurse in Private Practice and accredited with Defence Health.
(a) For ante natal / post natal care a Benefit of $20 per pre-natal visit and up to $40 per post-natal visit subject to a $240 limit per person per Benefit Year
(b) For a confinement / delivery at home or in a registered Hospital birthing facility (except in cases where a Medical Practitioner is required to intervene and take over the delivery) for insured persons a Benefit of up to $550.

J7 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J7 14, Defence Health will pay the following:

1. Hospital Substitute Programs
   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs

These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J14 Schedule Combined Hospital Treatment and General Treatment Tables

J14 1 Table Name or Group of Table Names

Premier Hospital Gold
Premier Hospital Gold 250
Premier Hospital Gold 500

J14 2 Eligibility

This Product is a Closed Product from 1 December 2017. Policy Holders who held this Product on 30 November 2017 can maintain the Product on an ongoing basis only.

J14 3 General Conditions

Policy holders of the Premier Hospital Gold Product can maintain their Product on an ongoing basis only and from 24 July 2023 may combine this Product with an Open General Treatment Product.

J14 4 Hospital Treatment Payments

Providing a hospital admission is not related to an Excluded Service described in rule J14 14, or a Restricted Service described in rule J14 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay:
   (a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
   (b) an additional $80 per day when admitted to a private room.

J14 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J14 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
   (a) Medicare pays 75% of the Medicare scheduled fee; and
   (b) The Fund will pay 25% of the Medicare scheduled fee.

J14 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J14 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J14 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J14 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J14 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J14 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J14 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J14 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J14 10 Co Payments

Defence Health does not apply co-payments.

J14 11 Excesses

(a) The Premier Hospital Gold Cover is Excess free.
(b) Policy Holders contributing to the following Covers will pay an Excess once per Adult, per Benefit Year. The Excess applicable is:
    (i) Premier Hospital Gold 250 - $250 Excess
    (ii) Premier Hospital Gold 500 - $500 Excess
(c) This Excess is applied in both public and Private Hospitals.
(d) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(e) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(f) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J14 12 Benefit Limitation Periods

No benefit limitation periods apply.

J14 13 Restricted Services

There are no Restricted Services defined for this product.

J14 14 Excluded Services

There are no Clinical Categories defined as Excluded Services for this Product.

J14 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J14 16 Other Special Hospital Treatment

A Benefit is payable where the primary procedure is performed by a Registered Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee. Podiatric surgery performed by a Registered Podiatric Surgeon will attract hospital treatment benefits at the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

J14 17 Dental

This clause is left intentionally blank.

J14 18 Optical

This clause is left intentionally blank.

J14 19 Physiotherapy

This clause is left intentionally blank.

J14 20 Chiropractic

This clause is left intentionally blank.

J14 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J14 22 Podiatry

This clause is left intentionally blank.

J14 23 Psychology

This clause is left intentionally blank.

J14 24 Alternative Therapies

This clause is left intentionally blank.

J14 25 Natural Therapies

This clause is left intentionally blank.

J14 26 Speech Therapy

This clause is left intentionally blank.

J14 27 Orthotics

This clause is left intentionally blank.

J14 28 Dietetics

This clause is left intentionally blank.

J14 29 Occupational Therapy

This clause is left intentionally blank.

J14 30 Naturopathy

This clause is left intentionally blank.

J14 31 Acupuncture

This clause is left intentionally blank.

J14 32 Other Therapies

This clause is left intentionally blank.

J14 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J14 34 Hearing Aids

This clause is left intentionally blank.

J14 35 Prevention Health Management

A benefit is payable for approved specialised programs at private facilities.

J14 36 Ambulance Transportation

The Ambulance Benefit is payable.

J14 37 Accident Cover

This clause is left intentionally blank.

J14 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J14 39 Other Special General Treatment

1. Home Nursing

Towards charges for approved Home Nursing by a Registered Nurse in Private Practice when deemed appropriate by a Medical Practitioner, a Benefit of $90 per day to $1800 per person per Benefit Year for insured persons.

2. Midwifery

Up to $1500 is available towards charges by a registered midwife in Private Practice and accredited with Defence Health for the confinement/delivery at home or in a registered Hospital birthing facility. In cases where a Medical Practitioner is required to intervene and take over the delivery Benefits will be provided to the Medical Practitioner, not the Midwife.

J14 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J14 14, Defence Health will pay the following:

1. Hospital Substitute Programs

   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs

   These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J15 Schedule Combined Hospital Treatment and General Treatment Tables

J15 1 Table Name or Group of Table Names

Value Hospital Silver Plus 250
Value Hospital Silver Plus 500

J15 2 Eligibility

This Product is a Closed Product from 1 September 2019. Policy Holders who held this Product on 31 August 2019 can maintain the Product on an ongoing basis only.

J15 3 General Conditions

Policy holders of the Value Hospital Silver Plus Product can maintain their Product on an ongoing basis only and from 24 July 2023 may combine this Product with an Open General Treatment Product.

J15 4 Hospital Treatment Payments

J15 4.1 Accidental Injury Benefit
The Accidental Injury Benefit is payable provided that proof that the occurrence of the Accident and documentary evidence of admission to Hospital or to the emergency department of a Hospital is provided to Defence Health upon request.

J15 4.2 Complications
The Fund may, in its absolute discretion, pay Benefits where expenses have been incurred as a result of a complication arising from the Treatment of an Included Service described in rule J15 4.1.

J15 4.3 Hospital payments
Providing a hospital admission is not related to an Excluded Service described in rule J15 14, or a Restricted Service described in rule J15 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
When the Insured Person elects to be treated as a Private Patient, the Fund will pay:
(a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
(b) an additional $80 per day when admitted to a private room.

4. COVID-19 related illness inclusion
Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health. This Rule overrides the Restricted and Excluded Services outlined in Rules J15 13 and J15 14. Benefits for Private Hospital and Day Surgery admissions will be payable in accordance with Rules J15 4.3(1) and (2). Benefits for Public Hospital admissions will be payable in accordance with Rule J15 4.3(3).

J15 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J15 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
(a) Medicare pays 75% of the Medicare scheduled fee; and
(b) The Fund will pay 25% of the Medicare scheduled fee.

J15 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J15 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J15 7 Non PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J15 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J15 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J15 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J15 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J15 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J15 10 Co Payments

Defence Health does not apply co-payments.

J15 11 Excesses

(a) Policy Holders contributing to the following Covers will pay an Excess once per Adult, per Benefit Year. The Excess applicable is:
  (i) Value Hospital Silver Plus 250 - $250 Excess
  (ii) Value Hospital Silver Plus 500 - $500 Excess
(b) The Excess is applied in both public and Private Hospitals.
(c) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(d) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(e) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J15 12 Benefit Limitation Periods

No benefit limitation periods apply.

J15 13 Restricted Services

Minimum Benefits apply for the following Clinical Categories:
(a) Hospital Psychiatric Services

J15 14 Excluded Services

The following Clinical Categories are Excluded Services:

(a) Assisted Reproductive Services
(b) Cataracts
(c) Weight Loss Surgery
(d) Joint Replacements
(e) Dialysis for Chronic Kidney Failure
(f) Treatments not recognised by Medicare: Defence Health will make no payments for hospital services, medical services, pharmaceuticals, surgically implanted prostheses, or Nursing Home Type Patient payments where the Treatment is not a clinically necessary Hospital Treatment recognised by Medicare.

J15 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J15 16 Other Special Hospital Treatment

A Benefit is payable where the primary procedure is performed by a Registered Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee. Podiatric surgery performed by a Registered Podiatric Surgeon will attract hospital treatment benefits at the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

J15 17 Dental

This clause is left intentionally blank.

J15 18 Optical

This clause is left intentionally blank.

J15 19 Physiotherapy

This clause is left intentionally blank.

J15 20 Chiropractic

This clause is left intentionally blank.

J15 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J15 22 Podiatry

This clause is left intentionally blank.

J15 23 Psychology

This clause is left intentionally blank.

J15 24 Alternative Therapies

This clause is left intentionally blank.

J15 25 Natural Therapies

This clause is left intentionally blank.

J15 26 Speech Therapy

This clause is left intentionally blank.

J15 27 Orthotics

This clause is left intentionally blank.

J15 28 Dietetics

This clause is left intentionally blank.

J15 29 Occupational Therapy

This clause is left intentionally blank.

J15 30 Naturopathy

This clause is left intentionally blank.

J15 31 Acupuncture

This clause is left intentionally blank.

J15 32 Other Therapies

This clause is left intentionally blank.

J15 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J15 34 Hearing Aids

This clause is left intentionally blank.

J15 35 Prevention Health Management

This clause is left intentionally blank.

J15 36 Ambulance Transportation

The Ambulance Benefit is payable.

J15 37 Accident Cover

This clause is left intentionally blank.

J15 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J15 39 Other Special General Treatment

1. Home Nursing

Towards charges for approved Home Nursing by a Registered Nurse in Private Practice when deemed appropriate by a Medical Practitioner, a Benefit of $70 per day to $750 per person per Benefit Year for insured persons.

2. Midwifery

Up to $750 is available towards charges by a registered midwife in Private Practice and accredited with Defence Health for the confinement/delivery at home or in a registered Hospital birthing facility. In cases where a Medical Practitioner is required to intervene and take over the delivery Benefits will be provided to the Medical Practitioner, not the Midwife.

J15 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J15 14 the following Benefits are payable:

1. Hospital Substitute Programs
   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs
   These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J16 Schedule Combined Hospital Treatment and General Treatment Tables

J16 1 Table Name or Group of Table Names

Essentials Hospital Basic Plus 250
Essentials Hospital Basic Plus 750

J16 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group. This product is only available for Single Memberships or Couples Memberships.

J16 3 General Conditions

This section is left intentionally blank.

J16 4 Hospital Treatment Payments

J16 4.1 Included services
A Hospital Benefit will be provided for Hospital Treatment related to one of the following clinical categories as outlined by the Department of Health and Aged Care:

(a) Tonsils, adenoids and grommets
(b) Dental surgery
(c) Hernia and appendix
(d) Bone, joint and muscle
(e) Joint reconstructions
(f) Gastrointestinal endoscopy

J16 4.2 Accidental Injury Benefit
The Accidental Injury Benefit is payable provided that proof that the occurrence of the Accident and documentary evidence of admission to Hospital or to the emergency department of a Hospital is provided to Defence Health upon request.

J16 4.3 Complications
The Fund may, in its absolute discretion, pay Benefits where expenses have been incurred as a result of a complication arising from the Treatment of an Included Service described in rule J16 4.1.

J16 4.4 Hospital payments
Providing a hospital admission is related to an Included Service described in rule J16 4.1, and is not related to a Restricted Service described in rule J16 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)

At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
When the Insured Person elects to be treated as a Private Patient, the Fund will pay:
   (a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
   (b) an additional $80 per day when admitted to a private room.

4. COVID-19 related illness inclusion
Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health. This Rule overrides the Restricted and Excluded Services outlined in Rules J16 13 and J16 14. Benefits for Private Hospital and Day Surgery admissions will be payable in accordance with Rules J16 4.4(1) and (2). Benefits for Public Hospital admissions will be payable in accordance with Rule J16 4.4(3).

J16 5 Medical Services Payments while admitted

Providing a hospital admission is related to an Included Service described in rule J16 4.1 or a Restricted Service described in rule J16 13, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
   (a) Medicare pays 75% of the Medicare scheduled fee; and
   (b) The Fund will pay 25% of the Medicare scheduled fee.

J16 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is related to an Included Service described in rule J16 4.1 or a Restricted Service described in rule J16 13, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J16 7 Non PBS Pharmaceuticals

Providing a hospital admission is related to an Included Service described in rule J16 4.1 or a Restricted Service described in rule J16 13, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J16 8 Surgically Implanted Prostheses

Providing a hospital admission is related to an Included Service described in rule J16 4.1 or a Restricted Service described in rule J16 13, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J16 9 Nursing Home Type Patients

Providing a hospital admission is related to an Included Service described in rule J16 4.1 or a Restricted Service described in rule J16 13, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J16 10 Co Payments

Defence Health does not apply co-payments.

J16 11 Excesses

(a) Policy Holders contributing to this Cover will pay an Excess once per Adult per Benefit Year. The Excess applicable is:
  (i) Essentials Hospital Basic Plus 250 - $250 Excess
  (ii) Essentials Hospital Basic Plus 750 - $750 Excess
(b) This Excess is applied in both public and Private Hospitals.
(c) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(d) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J16 12 Benefit Limitation Periods

No benefit limitation periods apply.

J16 13 Restricted Services

Minimum Benefits apply for the following Clinical Categories:

(a) Hospital Psychiatric Services
(b) Rehabilitation
(c) Palliative Care

J16 14 Excluded Services

Hospital Benefits are payable only on hospital admissions related to an Included Service described in rule J16 4.1 or a Restricted Service described in rule J16 13. All other Clinical Categories are excluded.

J16 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J16 16 Other Special Hospital Treatment

This clause is left intentionally blank.

J16 17 Dental

This clause is left intentionally blank.

J16 18 Optical

This clause is left intentionally blank.

J16 19 Physiotherapy

This clause is left intentionally blank.

J16 20 Chiropractic

This clause is left intentionally blank.

J16 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J16 22 Podiatry

This clause is left intentionally blank.

J16 23 Psychology

This clause is left intentionally blank.

J16 24 Alternative Therapies

This clause is left intentionally blank.

J16 25 Natural Therapies

This clause is left intentionally blank.

J16 26 Speech Therapy

This clause is left intentionally blank.

J16 27 Orthotics

This clause is left intentionally blank.

J16 28 Dietetics

This clause is left intentionally blank.

J16 29 Occupational Therapy

This clause is left intentionally blank.

J16 30 Naturopathy

This clause is left intentionally blank.

J16 31 Acupuncture

This clause is left intentionally blank.

J16 32 Other Therapies

This clause is left intentionally blank.

J16 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J16 34 Hearing Aids

This clause is left intentionally blank.

J16 35 Prevention Health Management

This clause is left intentionally blank.

J16 36 Ambulance Transportation

The Ambulance Benefit is payable.

J16 37 Accident Cover

This clause is left intentionally blank.

J16 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J16 39 Other Special General Treatment

This clause is left intentionally blank.

J16 40 Hospital-Substitute Treatment

This clause is left intentionally blank.

J17 Schedule Combined Hospital Treatment and General Treatment Tables

J17 1 Table Name or Group of Table Names

ADF Total Package Gold
ADF Total Package Gold 250
ADF Total Package Gold 500

J17 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group. Designed for ADF Full-time Serving and Reservist Members.

J17 3 General Conditions

This section is left intentionally blank.

J17 4 Hospital Treatment Payments

Providing a hospital admission is not related to an Excluded Service described in rule J17 14, or a Restricted Service described in rule J17 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay:
   (a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
   (b) an additional $80 per day when admitted to a private room.

J17 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J17 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
   (a) Medicare pays 75% of the Medicare scheduled fee; and
   (b) The Fund will pay 25% of the Medicare scheduled fee.

J17 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J17 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J17 7 Non PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J17 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J17 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J17 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J17 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J17 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J17 10 Co Payments

Defence Health does not apply co-payments.

J17 11 Excesses

(a) The ADF Total Package Gold is Excess free.
(b) Policy Holders contributing to the following Covers will pay an Excess once per Adult, per Benefit Year. The Excess applicable is:
    (i) ADF Total Package Gold 250 - $250 Excess
    (ii) ADF Total Package Gold 500 - $500 Excess
(c) This Excess is applied in both public and Private Hospitals.
(d) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(e) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(f) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J17 12 Benefit Limitation Periods

No benefit limitation periods apply.

J17 13 Restricted Services

There are no Restricted Services defined for this product.

J1 14 Excluded Services

There are no Clinical Categories defined as Excluded Services for this Product

J17 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J17 16 Other Special Hospital Treatment

1. Podiatric Surgery

A Benefit is payable where the primary procedure is performed by a Registered Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee. Podiatric surgery performed by a Registered Podiatric Surgeon will attract hospital treatment benefits at the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

2. Boarder fee for Full-time Serving person

Where a Hospital Purchaser Provider Agreement includes a boarder fee benefit, this will also be payable for the uncovered Full-time Serving person.

J17 17 Dental

1. Benefits Payable
   - (a) The services for which Benefits are payable and the levels of Benefit prescribed are set out in Schedule M – Dental Benefit Schedule attached to these Rules as adjusted from time to time.
   - (b) The maximum amount of Benefit payable against any one service shall be the Benefit listed in Schedule M – Dental Benefit Schedule or, unless specified otherwise, 100% of the actual cost of the individual service, whichever is the lesser amount.
   - (c) Subject to available limits on Benefits, Dependent Children, Dependent Students and Non-student Dependents are entitled to one mouth guard per Benefit Year at 100% of the cost. For clarity, this refers to the provision, by a dental practitioner, of item 151 or 153 in Schedule M – Dental Benefit Schedule.
   - (d) Members are entitled to preventive dental at 100% of the cost, twice per financial year, subject to claim frequency and annual item limits, when provided by a Member Priority network dental practitioner.

2. Benefit Limit
   - (a) Where a service limit applies against any one service / requisite the number of services per person per Benefit Year is listed in Schedule M – Dental Benefit Schedule.
   - (b) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Major Dental will be limited to $950 per person per Benefit Year.
   - (c) Benefits paid on services categorised in Schedule M – Dental Benefit Schedule as Orthodontics will be limited to $800 per person per Benefit Year.

J17 18 Optical

1. Optical appliance benefits payable

(a) When provided by a Member Priority network provider:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

(b) When provided by any other registered Optometrist or Ophthalmologist in Private Practice:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

2. Benefit Limit

The maximum optical appliance benefit per person per Benefit Year is $255

Notes:

1. The Benefits shown above are payable up to 100% of cost.
2. Benefits are payable when prescribed by a registered Optometrist or Ophthalmologist in Private Practice.
3. Benefits are not payable for Sunglasses.
4. Benefits are only payable where sight correction or adjustment to the lens is clearly shown on the prescription form.
5. The prescription and account or receipt of payment must be submitted to the Fund with any Claim.
6. For determining entitlements to optical Benefits, the date the appliance was supplied is used to calculate the Benefit payable.

J17 19 Physiotherapy

1. Physiotherapy benefits payable

(a) For services by registered physiotherapists in Private Practice:

per initial Consultation and Treatment	$59
per subsequent Treatment	$41

(b) For services relating to pelvic floor muscles performed by registered physiotherapists in Private Practice holding post graduate qualifications specialising in pelvic floor muscle training: $63

(c) For services relating to lymphoedema performed by registered physiotherapists in Private Practice registered as a Category 1 Practitioner with the Australasian Lymphology Association: $85

Benefit Limit

Limit per person per Benefit Year $850

2. Group Therapy Benefits
(a) For Group Therapy services by registered physiotherapists in Private Practice:
Per group therapy session $20

Benefit Limit
For Group Therapy services a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

J17 20 Chiropractic

1. Benefits
For services (including Osteopathic) for manipulative Treatment by registered practitioners in Private Practice:
per Initial Consultation $47
per Subsequent Consultation $33
per Xray (maximum of 2 per Benefit Year) $45

2. Benefit Limit
Limit per person per Benefit Year $750

J17 21 Non PBS Pharmaceuticals

1. Benefits
For prescriptions filled by a registered pharmacist in Private Practice when the prescription is ordered by a medical or dental practitioner on legal prescriptions:
per prescription – a Benefit of 100% of the balance remaining after the Insured Person has paid the normal charge for a PBS prescription to a maximum of $80 per prescription.

Notes:
1. Benefits are only payable for prescription medicines or drugs that are classified as Schedule 4 (S4) or Schedule 8 (S8) of the national classification system administered by the Therapeutic Goods Administration of the Department of Health and Aged Care.
2. Benefits are not payable for any prescription medicines or drugs that could have been prescribed under the PBS, products which can be purchased without a prescription or products not related to a medical condition.
3. Benefits are not payable for drugs or products prescribed or supplied to Patients at Private Hospitals or day Hospital facilities.
4. Benefits are not payable for vitamins, minerals and supplements.

5. Benefits are not payable for nicotine e-cigarettes or nicotine vaping products.

2. Benefit Limit

Limit per person per Benefit Year	$400

J17 22 Podiatry

1. Benefits

For services by registered practitioners (including chiropody) in Private Practice:

per Initial Consultation	$47
per Subsequent Consultation	$33

2. Benefit Limit

A combined limit of $1000 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

J17 23 Psychology

1. Benefits

For Consultations by registered psychologists in Private Practice when approved by the Fund:

per Initial Consultation	$102
per Subsequent Consultation	$77
per attendance at family therapy	$37
per attendance at group therapy	$32

2. Benefit Limit

A combined limit of $1000 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

Psychology treatment that has been, or is available to be claimed through Medicare cannot be covered.

J17 24 Alternative Therapies

1. Benefits

For consultations for Acupuncture, myotherapy and remedial massage where the provider is recognised by the Australian Regional Health Group.

per Initial Consultation	$31
per Subsequent Consultation	$27

Note: Benefits are not payable on any prescribed medications, herbal or dietary preparations.

Benefit Limit

For Alternative Therapies a combined limit of $300 per person per Benefit Year applies.

It Includes Physiotherapy (Group Therapy), Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

J17 25 Natural Therapies

Refer to J17 24 Alternative Therapies.

J17 26 Speech Therapy

1. Benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$107
per Subsequent Consultation	$52
per attendance at group therapy	$37

   Note: The Consultation must be for Speech Therapy services for the Insured Person who has the speech impediment.

2. Benefit Limit
   A combined limit of $1000 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

J17 27 Orthotics

Refer to J17 33 Non Surgically Implanted Prostheses and Appliances.

J17 28 Dietetics

1. Benefits
   For Consultations by registered practitioners in Private Practice when approved by the Fund:

per Initial Consultation	$59
per Subsequent Consultation	$33

   Benefits are not payable for generic weight reducing courses or programs.

2. Benefit Limit
   A combined limit of $1000 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

J17 29 Occupational Therapy

1. Benefits
   For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$85
per Subsequent Consultation	$45

per attendance at group therapy $27

2. Benefit Limit

A combined limit of $1000 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

J17 30 Naturopathy

Refer to J17 24 Alternative Therapies.

J17 31 Acupuncture

Refer to J17 24 Alternative Therapies.

J17 32 Other Therapies

1. Eye Therapy benefits
   For services by registered practitioners in Private Practice:
   per Initial Consultation $65
   per Subsequent Consultation $45

2. Audiology benefits
   For Consultations by registered practitioners in Private Practice:
   per Initial Consultation $72
   per Subsequent Consultation $52

3 Antenatal and Postnatal services benefits
   For antenatal and postnatal services provided by a recognised midwife or physiotherapist in private practice:
   per visit/class $40
   per full day antenatal class $400

4. Exercise Physiology benefits
   For Consultations by registered practitioners in Private Practice:
   per Initial Consultation $30
   per Subsequent Consultation $24

A combined limit of $1000 per person per Benefit Year applies. It includes Podiatry, Psychology, Speech Therapy, Dietetics, Occupational Therapy and Other Therapies (Eye Therapy, Audiology, Antenatal & Postnatal Services and Exercise Physiology).

5. Exercise Physiology Group Therapy
   For Exercise Physiology Group Therapy services by registered practitioners in Private Practice $14

Benefit Limit
For Exercise Group Therapy sessions, a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy), Alternative Therapies, Other Therapies

(Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing).

J17 33 Non Surgically Implanted Prostheses and Appliances

Appliances:
Medically Prescribed Health Appliances
Limit of $1000 per person per Benefit Year

When recommended by a physiotherapist, chiropractor, osteopath, podiatrist, chiropodist, occupational therapist, psychologist, psychiatrist or medical practitioner (unless specified otherwise) for a medical condition.

Includes the following subcategories:

1. Nebuliser and spacer
   100% of cost with a limit of $300 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

2. Blood Glucose Monitors
   100% of cost with a limit of $400 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

3. Positive Airway Pressure Machines (e.g. CPAP, VPAP, APAP, BiPAP etc.)
   100% of cost with a limit of $1,000 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

4. Foot Orthoses
   100% of cost with a limit of $300 per person per Benefit Year
   Custom-made or fitted foot orthoses specifically crafted to meet the needs of a particular individual, including heat moulded orthotics. Must be provided by a specialist orthotic practitioner. Excludes over the counter orthotics.

5. Blood Pressure monitor
   100% of cost with a limit of $250 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

6. TENS machine
   100% of cost with a limit of $250 per person
   Replacement/additional aids are not claimable within 3 years of previous supply.

7. Splints and Braces
   100% of the cost with a limit of $250 per person
   Knee, leg, spinal, lumbar, sacral, wrist, ankle braces, splints and surgical corsets.
8. Orthopaedic shoes
   100% of the cost with a limit of $300 per person
   Custom made shoes by a specialist shoemaker for identifiable foot deformities.

9. Compression garments
   100% of the cost with a limit of $250 per item

Benefits are claimable for TGA approved, purpose-made garments that aid burn management, post surgical recovery, lymphoedema treatment and deep vein thrombosis prevention.

10. Non-cosmetic prostheses

100% of the cost with a limit of $1000 per person

(a) External breast prostheses following a mastectomy – limit $250 per person.
(b) Wigs following a medical condition – limit $250 per person.
(c) Artificial eyes – limit $1000 per person subject to replacement or additional items not claimable within 3 years of previous supply.

11. Epipen

100% of the cost with a limit of $150 per person

12. Appliance maintenance

100% of the cost with a limit of $100 per person

Repair to foot orthoses and hearing aids, and accessories needed to maintain the function of medical appliances, including masks and tubing for PAP machines and TENS machine electrodes and leads.

13. Rental of appliance

100% of the cost with a limit of $150 per person

The rental of oxygen cylinders, soft collars and any other appliance listed under medically prescribed health appliances, including toilet seat risers, shower chairs and continuous passive movement machines (CPM).

14. Hearing aids

100% of the cost with a limit of $1000 per person

Replacement/additional aids are not claimable within 3 years of previous supply.

15. Mobility aids

100% of the cost with a limit of $1000 per person

Wheelchairs, crutches, walking frames, walking sticks, rolling walkers, seat riser cushions, reachers and adjustable canes. Benefits are not payable for motorised scooters or recliner lift chairs.

Replacement/additional aids are not claimable within 3 years of previous supply.

16. Non-sight correcting Irlen lenses

100% of the cost with a limit of $90 per person

Sight correcting Irlen lenses are payable under optical (Rule I4 6).

J17 34 Hearing Aids

Refer to J17 33 Non Surgically Implanted Prostheses and Appliances.

J17 35 Prevention Health Management

A benefit is payable for approved specialised programs at private facilities.

J17 36 Ambulance Transportation

The Ambulance Benefit is payable.

J17 37 Accident Cover

School Accident

(a) Benefits

A top-up benefit for meeting any gap payments for Treatments (excluding Professional Services for which a Medicare Benefit is payable) incurred as a result of an Accident to a Dependent Child, at school, school activity or travelling to or from school, provided that the costs of such services do not exceed the usual and customary charges and/or schedule fees are not payable from any other source, and are Claimed within 2 years of the date of the Accident.

(b) Benefit Limit

Benefits for 100% of eligible costs up to $600 per Dependent Child per Benefit Year.

J17 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J17 39 Other Special General Treatment

1. Home Nursing

Towards charges for approved Home Nursing by a Registered Nurse in Private Practice when deemed appropriate by a Medical Practitioner, a Benefit of $100 per day to $2000 per person per Benefit Year for insured persons.

2. Midwifery

Up to $2000 is available towards charges by a registered midwife in Private Practice and accredited with Defence Health for the confinement/delivery at home or in a registered Hospital birthing facility. In cases where a Medical Practitioner is required to intervene and take over the delivery Benefits will be provided to the Medical Practitioner, not the Midwife.

3. Laser Refractive Eye Surgery

For laser refractive eye surgery performed in a recognised day surgery centre registered with the state.

100% of the cost with a limit of $1000 per person every two Benefit Years.

4. Health and Wellbeing

(a) Benefits

Bowel screening tests	$120
Kidney function tests	$120
Mole mapping	$120
Bone density tests	$120
Mammograms	$120
Specialist eye tests	$120
Heart tests	$120
Quit smoking program	$120
Nicotine replacement therapy products	$120

Benefit Limit
For Health and Wellbeing Benefits, a combined limit of $300 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies, Other Therapies (Exercise Physiology – Group Therapy) & Other Special General Treatment (Health and Wellbeing)

Notes:

1. The Benefits shown above are payable at up to 100% of cost.
2. Only the health screening tests listed and quit smoking programs and nicotine replacement therapy products approved by Defence Health are payable.
3. Benefits are not payable where the health screening test has been, or is available to be claimed through Medicare. Benefits are not payable for any prescribed nicotine replacement therapy products or medications subsidised under the Pharmaceutical Benefits Scheme.
4. Only health screening tests conducted by recognised providers are subject to benefit payments. No benefit is payable for tests conducted by a General Practitioner. Quit smoking medications prescribed by a doctor and not subsidised under the Pharmaceutical Benefits Scheme are payable under J17 21 Non PBS Pharmaceuticals.

J17 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J17 14, Defence Health will pay the following:

1. Hospital Substitute Programs
   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs
   These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J18 Schedules Combined Hospital Treatment and General Treatment Tables.

J18 1 Table Name or Group of Table Names

ADF Essentials Package Basic Plus 250

J18 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group. Designed for ADF Full-time Serving and Reservist Members. It is only available for Single Memberships or Couples Memberships.

J18 3 General Conditions

This clause is left intentionally blank.

J18 4 Hospital Treatment Payments

J18 4.1 Included services

A Hospital Benefit will be provided for Hospital Treatment related to one of the following clinical categories as outlined by the Department of Health and Aged Care:

(a) Tonsils, adenoids and grommets
(b) Dental surgery
(c) Hernia and appendix
(d) Bone, joint and muscle
(e) Joint reconstructions
(f) Gastrointestinal endoscopy

J18 4.2 Accidental Injury Benefit

The Accidental Injury Benefit is payable provided that proof that the occurrence of the Accident and documentary evidence of admission to Hospital or to the emergency department of a Hospital is provided to Defence Health upon request.

J18 4.3 Complications

The Fund may, in its absolute discretion, pay Benefits where expenses have been incurred as a result of a complication arising from the Treatment of an Included Service described in rule J18 4.1.

J18 4.4 Hospital payments

Providing a hospital admission is related to an Included Service described in rule J18 4.1, and is not related a Restricted Service described in rule J18 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
(a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
(b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
When the Insured Person elects to be treated as a Private Patient, the Fund will pay:
(a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
(b) an additional $80 per day when admitted to a private room.

4. COVID-19 related illness inclusion
Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health. This Rule overrides the Restricted and Excluded Services outlined in Rules J18 13 and J18 14. Benefits for Private Hospital and Day Surgery admissions will be payable in accordance with Rules J18 4.4(1) and (2). Benefits for Public Hospital admissions will be payable in accordance with Rule J18 4.4(3).

J18 5 Medical Services Payments while admitted

Providing a hospital admission is related to an Included Service described in rule J18 4.1 or a Restricted Service described in rule J18 13, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
(a) Medicare pays 75% of the Medicare scheduled fee; and
(b) The Fund will pay 25% of the Medicare scheduled fee.

J18 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is related to an Included Service described in rule J18 4.1 or a Restricted Service described in rule J18 13, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J18 7 Non PBS Pharmaceuticals

Providing a hospital admission is related to an Included Service described in rule J18 4.1 or a Restricted Service described in rule J18 13, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J18 8 Surgically Implanted Prostheses

Providing a hospital admission is related to an Included Service described in rule J18 4.1 or a Restricted Service described in rule J18 13, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J18 9 Nursing Home Type Patients

Providing a hospital admission is related to an Included Service described in rule J18 4.1 or a Restricted Service described in rule J18 13, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J18 10 Co Payments

Defence Health does not apply co-payments.

J18 11 Excesses

(a) Policy Holders contributing to this Cover will pay an Excess once per Adult per Benefit Year. The Excess applicable is $250 Excess.
(b) This Excess is applied in both public and Private Hospitals.
(c) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(d) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J18 12 Benefit Limitation Periods

No benefit limitation periods apply.

J18 13 Restricted Services

Minimum Benefits apply for the following Clinical Categories:

(a) Hospital Psychiatric Services
(b) Rehabilitation
(c) Palliative Care

J18 14 Excluded Services

Hospital Benefits are payable only on hospital admissions related to an Included Service described in rule J18 4.1 or a Restricted Service described in rule J18 13. All other Clinical Categories are excluded.

J18 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J18 16 Other Special Hospital Treatment

This clause is left intentionally blank.

J18 17 Dental

1. Benefits Payable
   (a) The services for which Benefits are payable and the levels of Benefit prescribed are set out in Schedule M – Dental Benefit Schedule attached to these Rules as adjusted from time to time.
   (b) The maximum amount of Benefit payable against any one service shall be the Benefit listed in Schedule M – Dental Benefit Schedule or, unless specified otherwise, 100% of the actual cost of the individual service, whichever is the lesser amount.

2. Benefit Limits
   (a) Where a service limit applies against any one service / requisite the number of services per person per Benefit Year is listed in Schedule M – Dental Benefit Schedule.
   (b) An overall dental maximum of $500 applies per person per Benefit Year.

J18 18 Optical

1. Optical appliance benefits payable

(a) When provided by a Member Priority network provider:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

(b) When provided by any other registered Optometrist or Ophthalmologist in Private Practice:

Single vision lenses	100%
Ground single vision lenses	100%
Bi-focal lenses	100%
Multi-focal lenses	100%
Frames and repairs	100%
Contact lenses	100%

2. Benefit Limit

The maximum optical appliance benefit per person per Benefit Year is $170

Notes:

1. The Benefits shown above are payable up to 100% of cost.
2. Benefits are payable when prescribed by a registered Optometrist or Ophthalmologist in Private Practice.
3. Benefits are not payable for Sunglasses.
4. Benefits are only payable where sight correction or adjustment to the lens is clearly shown on the prescription form.
5. The prescription and account or receipt of payment must be submitted to the Fund with any Claim.
6. For determining entitlements to optical Benefits, the date the appliance was supplied is used to calculate the Benefit payable.

J18 19 Physiotherapy

1 Physiotherapy benefits payable

(a) For Services by registered physiotherapists in Private Practice:

per Initial Consultation	$37
per Subsequent Consultation	$27

(b) For services relating to lymphoedema performed by registered physiotherapists in Private Practice registered as a Category 1 Practitioner with the Australasian Lymphology Association: $54

Benefit Limit

A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

2. Group Therapy Benefits

(a) For Group Therapy services by registered physiotherapists in Private Practice:
Per group therapy session $14

Benefit Limit
For Group Therapy services a combined limit of $200 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies & Other Therapies (Exercise Physiology – Group Therapy)

J18 20 Chiropractic

(a) Benefit
per Initial Consultation $37
per Subsequent Consultation $26

(b) Benefit Limit
A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

J18 21 Non PBS Pharmaceuticals

1. Benefits
For travel vaccination prescriptions filled by a registered pharmacist in Private Practice when the prescription is ordered by a medical practitioner on legal prescriptions:
per prescription – a Benefit of 100% of the balance remaining after the Insured Person has paid the normal charge for a PBS prescription to a maximum of $50 per prescription.
Notes:
    1. Benefits are not payable for any travel vaccination prescriptions which could have been prescribed under the PBS, products which can be purchased without a prescription or products not related to a medical condition.
    2 Benefits are not payable for drugs or products prescribed or supplied to Patients at Private Hospitals or day Hospital facilities.

2. Benefit Limit
A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

J18 22 Podiatry

This clause is left intentionally blank.

J18 23 Psychology

This clause is left intentionally blank.

J18 24 Alternative Therapies

1. Benefits
   For consultations for Acupuncture, myotherapy and remedial massage where the provider is recognised by the Australian Regional Health Group.

per Initial consultation	$21
per Subsequent Consultation	$17

   Note: Benefits are not payable on any prescribed medications, herbal or dietary preparations.

2. Benefit Limit
   For Alternative Therapy services a combined limit of $200 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies & Other Therapies (Exercise Physiology – Group Therapy)

J18 25 Natural Therapies

This clause is left intentionally blank.

J18 26 Speech Therapy

This clause is left intentionally blank.

J18 27 Orthotics

This clause is left intentionally blank.

J18 28 Dietetics

This clause is left intentionally blank.

J18 29 Occupational Therapy

This clause is left intentionally blank.

J18 30 Naturopathy

Refer to J18 24 Alternative Therapies.

J18 31 Acupuncture

Refer to J18 24 Alternative Therapies.

J18 32 Other Therapies

4. Exercise Physiology benefits
For Consultations by registered practitioners in Private Practice:

per Initial Consultation	$20
per Subsequent Consultation	$17

A combined limit of $450 per person per Benefit Year applies. It includes Physiotherapy, Chiropractic, Non PBS Pharmaceuticals and Other Therapies (Exercise Physiology).

2. Exercise Physiology Group Therapy session
For group therapy sessions by registered practitioners in Private Practice $9

Benefit Limit
For Exercise Group Therapy sessions a combined limit of $200 per person per Benefit Year applies. It Includes Physiotherapy (Group Therapy) Alternative Therapies & Other Therapies (Exercise Physiology – Group Therapy)

J18 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J18 34 Hearing Aids

This clause is left intentionally blank.

J18 35 Prevention Health Management

This clause is left intentionally blank.

J18 36 Ambulance Transportation

The Ambulance Benefit is payable.

J18 37 Accident Cover

This clause is left intentionally blank.

J18 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J18 39 Other Special General Treatment

This clause is left intentionally blank.

J18 40 Hospital-Substitute Treatment

This clause is left intentionally blank.

J19 Schedule Combined Hospital Treatment and General Treatment Tables

J19 1 Table Name or Group of Table Names

Ultimate Hospital Gold
Ultimate Hospital Gold 250
Ultimate Hospital Gold 500

J19 2 Eligibility

Ultimate Hospital Gold and Ultimate Hospital Gold 250 are Closed Products from 8 January 2020. Policy Holders who held this product on 7 January 2020 can maintain the Product on an ongoing basis only.

Ultimate Hospital Gold 500 is an Open Product and is available to persons in the Restricted Access Group.

J19 3 General Conditions

This section is left intentionally blank.

J19 4 Hospital Treatment Payments

Providing a hospital admission is not related to an Excluded Service described in rule J19 14, or a Restricted Service described in rule J19 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay:
   (a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
   (b) an additional $80 per day when admitted to a private room.

J19 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J19 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
   (a) Medicare pays 75% of the Medicare scheduled fee; and
   (b) The Fund will pay 25% of the Medicare scheduled fee.

J19 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J19 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J19 7 Non PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J19 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J19 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J19 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J19 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J19 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J19 10 Co Payments

Defence Health does not apply co-payments.

J19 11 Excesses

(a) The Ultimate Hospital Gold Cover is Excess free.
(b) Policy Holders contributing to the following Covers will pay an Excess once per Adult, per Benefit Year. The Excess applicable is:
    (i) Ultimate Hospital Gold 250 - $250 Excess
    (ii) Ultimate Hospital Gold 500 - $500 Excess
(c) This Excess is applied in both public and Private Hospitals.
(d) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(e) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(f) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J19 12 Benefit Limitation Periods

No benefit limitation periods apply.

J19 13 Restricted Services

There are no Restricted Services defined for this product.

J19 14 Excluded Services

There are no Clinical Categories defined as Excluded Services for this Product

J19 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J19 16 Other Special Hospital Treatment

A Benefit is payable where the primary procedure is performed by a Registered Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee. Podiatric surgery performed by a Registered Podiatric Surgeon will attract hospital treatment benefits at

the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

J19 17 Dental

This clause is left intentionally blank.

J19 18 Optical

This clause is left intentionally blank.

J19 19 Physiotherapy

This clause is left intentionally blank.

J19 20 Chiropractic

This clause is left intentionally blank.

J19 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J19 22 Podiatry

This clause is left intentionally blank.

J19 23 Psychology

This clause is left intentionally blank.

J19 24 Alternative Therapies

This clause is left intentionally blank.

J19 25 Natural Therapies

This clause is left intentionally blank.

J19 26 Speech Therapy

This clause is left intentionally blank.

J19 27 Orthotics

This clause is left intentionally blank.

J19 28 Dietetics

This clause is left intentionally blank.

J19 29 Occupational Therapy

This clause is left intentionally blank.

J19 30 Naturopathy

This clause is left intentionally blank.

J19 31 Acupuncture

This clause is left intentionally blank.

J19 32 Other Therapies

This clause is left intentionally blank.

J19 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J19 34 Hearing Aids

This clause is left intentionally blank.

J19 35 Prevention Health Management

A benefit is payable for approved specialised programs at private facilities.

J19 36 Ambulance Transportation

The Ambulance Benefit is payable.

J19 37 Accident Cover

This clause is left intentionally blank.

J19 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J19 39 Other Special General Treatment

1. Home Nursing

Towards charges for approved Home Nursing by a Registered Nurse in Private Practice when deemed appropriate by a Medical Practitioner, a Benefit of $100 per day to $2000 per person per Benefit Year for insured persons.

2. Midwifery

Up to $1700 is available towards charges by a registered midwife in Private Practice and accredited with Defence Health for the confinement/delivery at home or in a registered Hospital birthing facility. In cases where a Medical Practitioner is required to intervene and take over the delivery Benefits will be provided to the Medical Practitioner, not the Midwife.

J19 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J19 14, Defence Health will pay the following:

1. Hospital Substitute Programs

   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs

   These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J20 Schedule Combined Hospital Treatment and General Treatment Tables

J20 1 Table Name or Group of Table Names

Everyday Hospital Bronze Plus 500
Everyday Hospital Bronze Plus 750

J20 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group. This product is a Retained Age-Based Discount Policy.

J20 3 General Conditions

This section is left intentionally blank

J20 4 Hospital Treatment Payments

J20 4.1 Included services

A Hospital Benefit will be provided for Hospital Treatment related to one of the following clinical categories as outlined by the Department of Health and Aged Care:

(a) Brain and nervous system
(b) Eye (not cataracts)
(c) Ear, nose and throat
(d) Tonsils, adenoids and grommets
(e) Dental surgery
(f) Hernia and appendix
(g) Bone, joint and muscle
(h) Joint reconstructions
(i) Kidney and bladder
(j) Male reproductive system
(k) Digestive system
(l) Gynaecology
(m) Miscarriage and termination of pregnancy
(n) Chemotherapy, radiotherapy and immunotherapy for cancer
(o) Pain management
(p) Skin
(q) Gastrointestinal endoscopy
(r) Breast surgery (medically necessary)
(s) Diabetes management (excluding insulin pumps)
(t) Blood
(u) Lung and chest
(v) Back, neck and spine
(w) Podiatric surgery (provided by a registered podiatric surgeon)
(x) Sleep studies

J20 4.2 Accidental Injury Benefit
The Accidental Injury Benefit is payable provided that proof that the occurrence of the Accident and documentary evidence of admission to Hospital or to the emergency department of a Hospital is provided to Defence Health upon request.

J20 4.3 Complications
The Fund may, in its absolute discretion, pay Benefits where expenses have been incurred as a result of a complication arising from the Treatment of an Included Service described in rule J20 4.1.

J20 4.4 Hospital payments
Providing a hospital admission is related to an Included Service described in rule J20 4.1, and is not related to a Restricted Service described in rule J20 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay:
   (a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
   (b) an additional $80 per day when admitted to a private room.

4. COVID-19 related illness inclusion
   Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health. This Rule overrides the Restricted and Excluded Services outlined in Rules J20 13 and J20 14. Benefits for Private Hospital and Day Surgery admissions will be payable in accordance with Rules J20 4.4(1) and (2). Benefits for Public Hospital admissions will be payable in accordance with Rule J20 4.4(3).

J20 5 Medical Services Payments while admitted

Providing a hospital admission is related to an Included Service described in rule J20 4.1 or a Restricted Service described in rule J20 13, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
   (a) Medicare pays 75% of the Medicare scheduled fee; and
   (b) The Fund will pay 25% of the Medicare scheduled fee.

J20 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is related to an Included Service described in rule J20 4.1 or a Restricted Service described in rule J20 13, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J20 7 Non PBS Pharmaceuticals

Providing a hospital admission is related to an Included Service described in rule J20 4.1 or a Restricted Service described in rule J20 13, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J20 8 Surgically Implanted Prostheses

Providing a hospital admission is related to an Included Service described in rule J20 4.1 or a Restricted Service described in rule J20 13, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J20 9 Nursing Home Type Patients

Providing a hospital admission is related to an Included Service described in rule J20 4.1 or a Restricted Service described in rule J20 13, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J20 10 Co Payments

Defence Health does not apply co-payments.

J20 11 Excesses

(a) Policy Holders contributing to the following Covers will pay an Excess once per Adult, per Benefit Year. The Excess applicable is:
  (i) Everyday Hospital Bronze Plus - $500 Excess
  (ii) Everyday Hospital Bronze Plus - $750 Excess
(b) The Excess is applied in both public and Private Hospitals.
(c) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(d) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(e) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J20 12 Benefit Limitation Periods

No benefit limitation periods apply.

J20 13 Restricted Services

Minimum Benefits apply for the following Clinical Categories:
(a) Hospital Psychiatric Services
(b) Rehabilitation
(c) Palliative Care

J20 14 Excluded Services

Hospital Benefits are payable only on hospital admissions related to an Included Service described in rule J20 4.1 or a Restricted Service described in rule J20 13. All other Clinical Categories are excluded.

J20 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J20 16 Other Special Hospital Treatment

This clause is left intentionally blank.

J20 17 Dental

This clause is left intentionally blank.

J20 18 Optical

This clause is left intentionally blank.

J20 19 Physiotherapy

This clause is left intentionally blank.

J20 20 Chiropractic

This clause is left intentionally blank.

J20 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J20 22 Podiatry

This clause is left intentionally blank.

J20 23 Psychology

This clause is left intentionally blank.

J20 24 Alternative Therapies

This clause is left intentionally blank.

J20 25 Natural Therapies

This clause is left intentionally blank.

J20 26 Speech Therapy

This clause is left intentionally blank.

J20 27 Orthotics

This clause is left intentionally blank.

J20 28 Dietetics

This clause is left intentionally blank.

J20 29 Occupational Therapy

This clause is left intentionally blank.

J20 30 Naturopathy

This clause is left intentionally blank.

J20 31 Acupuncture

This clause is left intentionally blank.

J20 32 Other Therapies

This clause is left intentionally blank.

J20 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J20 34 Hearing Aids

This clause is left intentionally blank.

J20 35 Prevention Health Management

This clause is left intentionally blank.

J20 36 Ambulance Transportation

The Ambulance Benefit is payable.

J20 37 Accident Cover

This clause is left intentionally blank.

J20 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J20 39 Other Special General Treatment

This clause is left intentionally blank.

J20 40 Hospital-Substitute Treatment

This clause is left intentionally blank.

J21 Schedule Combined Hospital Treatment and General Treatment Tables

J21 1 Table Name or Group of Table Names

Core Hospital Silver Plus 500
Core Hospital Silver Plus 750

J21 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group. This product is a Retained Age-Based Discount Policy.

J21 3 General Conditions

This section is left intentionally blank

J21 4 Hospital Treatment Payments

J21 4.1 Accidental Injury Benefit
The Accidental Injury Benefit is payable provided that proof that the occurrence of the Accident and documentary evidence of admission to Hospital or to the emergency department of a Hospital is provided to Defence Health upon request.

J21 4.2 Complications
The Fund may, in its absolute discretion, pay Benefits where expenses have been incurred as a result of a complication arising from the Treatment of an Included Service described in rule J21 4.1.

J21 4.3 Hospital payments
Providing a hospital admission is not related to an Excluded Service described in rule J21 14, or a Restricted Service described in rule J21 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay:

(a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
(b) an additional $80 per day when admitted to a private room.

4. COVID-19 related illness inclusion
Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health. This Rule overrides the Restricted and Excluded Services outlined in Rules J21 13 and J21 14. Benefits for Private Hospital and Day Surgery admissions will be payable in accordance with Rules J21 4.3(1) and (2). Benefits for Public Hospital admissions will be payable in accordance with Rule J21 4.3(3).

J21 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J21 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
(a) Medicare pays 75% of the Medicare scheduled fee; and
(b) The Fund will pay 25% of the Medicare scheduled fee.

J21 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J21 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J21 7 Non PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J21 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J21 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J21 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J21 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J21 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J21 10 Co Payments

Defence Health does not apply co-payments.

J21 11 Excesses

(a) Policy Holders contributing to the following Covers will pay an Excess once per Adult, per Benefit Year. The Excess applicable is:
  (i) Core Hospital Silver Plus 500 - $500 Excess
  (ii) Core Hospital Silver Plus 750 - $750 Excess
(b) The Excess is applied in both public and Private Hospitals.
(c) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(d) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(e) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J21 12 Benefit Limitation Periods

No benefit limitation periods apply.

J21 13 Restricted Services

Minimum Benefits apply for the following Clinical Categories:
(a) Hospital Psychiatric Services

J21 14 Excluded Services

The following Clinical Categories are Excluded Services:
(a) Pregnancy and Birth
(b) Assisted Reproductive Services
(c) Cataracts
(d) Weight Loss Surgery

(e) Joint Replacements
(f) Dialysis for Chronic Kidney Disease
(g) Pain Management with Device

J21 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J21 16 Other Special Hospital Treatment

A Benefit is payable where the primary procedure is performed by an Accredited Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee. Podiatric surgery performed by an Accredited Podiatric Surgeon will attract hospital treatment benefits at the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

J21 17 Dental

This clause is left intentionally blank.

J21 18 Optical

This clause is left intentionally blank.

J21 19 Physiotherapy

This clause is left intentionally blank.

J21 20 Chiropractic

This clause is left intentionally blank.

J21 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J21 22 Podiatry

This clause is left intentionally blank.

J21 23 Psychology

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J21 24 Alternative Therapies

This clause is left intentionally blank.

J21 25 Natural Therapies

This clause is left intentionally blank.

J21 26 Speech Therapy

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J21 27 Orthotics

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J21 28 Dietetics

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J21 29 Occupational Therapy

This clause is left intentionally blank.

J21 30 Naturopathy

This clause is left intentionally blank.

J21 31 Acupuncture

This clause is left intentionally blank.

J21 32 Other Therapies

This clause is left intentionally blank.

J21 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J21 34 Hearing Aids

This clause is left intentionally blank.

J21 35 Prevention Health Management

This clause is left intentionally blank.

J21 36 Ambulance Transportation

The Ambulance Benefit is payable.

J21 37 Accident Cover

This clause is left intentionally blank.

J21 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J21 39 Other Special General Treatment

This clause is left intentionally blank.

J21 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J21 14 the following Benefits are payable:

1. Hospital Substitute Programs
   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs

   These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

J22 Schedule Combined Hospital Treatment and General Treatment Tables

J22 1 Table Name or Group of Table Names

Advantage Hospital Silver Plus 500
Advantage Hospital Silver Plus 750

J22 2 Eligibility

This Product is an Open Product and is available to persons in the Restricted Access Group. This product is a Retained Age-Based Discount Policy.

J22 3 General Conditions

This section is left intentionally blank.

J22 4 Hospital Treatment Payments

J22 4.1 Accidental Injury Benefit
The Accidental Injury Benefit is payable provided that proof that the occurrence of the Accident and documentary evidence of admission to Hospital or to the emergency department of a Hospital is provided to Defence Health upon request.

J22 4.2 Complications
The Fund may, in its absolute discretion, pay Benefits where expenses have been incurred as a result of a complication arising from the Treatment of an Included Service described in rule J22 4.1.

J22 4.3 Hospital payments
Providing a hospital admission is not related to an Excluded Service described in rule J22 14, or a Restricted Service described in rule J22 13, Defence Health will pay the following:

1. Private Hospital Including Day Hospital Facilities (Under Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are Hospital Purchaser Provider Agreements in force, the Benefits payable are as set out in the agreement.

2. Private Hospital Including Day Hospital Facilities (No Hospital Purchaser Provider Agreement)
   At Private Hospitals where there are no Hospital Purchaser Provider Agreements in force, the following Benefits are payable:
   (a) the Minimum Benefit as defined under the Private Health Insurance Act and as applied to an Applicable Benefits Arrangement; and
   (b) no benefits for theatre fees nor labour ward costs are payable.

3. Public Hospital
   When the Insured Person elects to be treated as a Private Patient, the Fund will pay:

(a) a Benefit for a shared room accommodation declared for that State or Territory by the respective Health Minister of that State or Territory; and
(b) an additional $80 per day when admitted to a private room.

4. COVID-19 related illness inclusion
Benefits are payable for inpatient hospital treatment for COVID-19 related illnesses at the discretion of Defence Health. This Rule overrides the Restricted and Excluded Services outlined in Rules J22 13 and J22 14. Benefits for Private Hospital and Day Surgery admissions will be payable in accordance with Rules J22 4.3(1) and (2). Benefits for Public Hospital admissions will be payable in accordance with Rule J22 4.3(3).

J22 5 Medical Services Payments while admitted

Providing a hospital admission is not related to an Excluded Service described in rule J22 14, Defence Health will pay the following:

1. Where the Provider has a Medical Purchaser Provider Agreement or participates in the Access Gap Cover Scheme, Benefits are payable in accordance with the Agreement or the Access Gap Cover Scheme.

2. Where the Provider does not have a Medical Purchaser Provider Agreement or does not participate in the Access Gap Cover Scheme, Benefits are payable as follows:
(a) Medicare pays 75% of the Medicare scheduled fee; and
(b) The Fund will pay 25% of the Medicare scheduled fee.

J22 6 Pharmaceutical Benefits Scheme PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J22 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J22 7 Non PBS Pharmaceuticals

Providing a hospital admission is not related to an Excluded Service described in rule J22 14, Defence Health will pay the following:

1. Where Defence Health has a Hospital Purchaser Provider Agreement, the Fund will pay in accordance with that agreement.

2. Where Defence Health does not have a Hospital Purchaser Provider Agreement, the Fund will not pay any Benefit for any pharmaceuticals not included in the accommodation charge.

J22 8 Surgically Implanted Prostheses

Providing a hospital admission is not related to an Excluded Service described in rule J22 14, Defence Health will pay the minimum benefit as described in the Private Health Insurance (Medical Devices and Human Tissue Products) Rules for that kind of Prosthesis.

J22 9 Nursing Home Type Patients

Providing a hospital admission is not related to an Excluded Service described in rule J22 14, Benefits are payable in accordance with the definitions of Nursing Home Type Patients as prescribed under the Private Health Insurance Act.

J22 10 Co Payments

Defence Health does not apply co-payments.

J22 11 Excesses

(a) Policy Holders contributing to the following Covers will pay an Excess once per Adult, per Benefit Year. The Excess applicable is:
  (i) Advantage Hospital Silver Plus 500 - $500 Excess
  (ii) Advantage Hospital Silver Plus 750 - $750 Excess
(b) The Excess is applied in both public and Private Hospitals.
(c) No Excess applies to Hospitalisations of Dependent Children, Dependent Students and Non-student Dependents.
(d) Calculation of the Excess amount will apply to Claims in the order they are processed by the Fund.
(e) Where a Policy Holder's Hospitalisation extends beyond the end of a Benefit Year, the Excess amount for the new Benefit Year will apply to the first subsequent admission of the new Benefit Year.

J22 12 Benefit Limitation Periods

No benefit limitation periods apply.

J22 13 Restricted Services

Minimum Benefits apply for the following Clinical Categories:
(a) Hospital Psychiatric Services

J22 14 Excluded Services

The following Clinical Categories are Excluded Services:
(a) Pregnancy and Birth
(b) Assisted Reproductive Services
(c) Weight Loss Surgery

J22 15 Loyalty Bonuses

Defence Health does not have any loyalty bonuses.

J22 16 Other Special Hospital Treatment

A Benefit is payable where the primary procedure is performed by an Accredited Podiatric Surgeon. The Benefit payable is equivalent to 25% of the relevant MBS item fee. Podiatric surgery performed by an Accredited Podiatric Surgeon will attract hospital treatment benefits at the contracted rate where surgery is performed in an agreement hospital. In non-agreement second tier hospitals second tier default rates will apply.

J22 17 Dental

This clause is left intentionally blank.

J22 18 Optical

This clause is left intentionally blank.

J22 19 Physiotherapy

This clause is left intentionally blank.

J22 20 Chiropractic

This clause is left intentionally blank.

J22 21 Non PBS Pharmaceuticals

This clause is left intentionally blank.

J22 22 Podiatry

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J22 23 Psychology

This clause is left intentionally blank.

J22 24 Alternative Therapies

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J22 25 Natural Therapies

This clause is left intentionally blank.

J22 26 Speech Therapy

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J22 27 Orthotics

This clause is left intentionally blank.

J22 28 Dietetics

This clause is left intentionally blank.

J22 29 Occupational Therapy

This clause is left intentionally blank.

J22 30 Naturopathy

This clause is left intentionally blank.

J22 31 Acupuncture

This clause is left intentionally blank.

J22 32 Other Therapies

This clause is left intentionally blank.

J22 33 Non Surgically Implanted Prostheses and Appliances

This clause is left intentionally blank.

J22 34 Hearing Aids

This clause is left intentionally blank.

J22 35 Prevention Health Management

This clause is left intentionally blank.

J22 36 Ambulance Transportation

The Ambulance Benefit is payable.

J22 37 Accident Cover

This clause is left intentionally blank.

J22 38 Accidental Death Funeral Expenses

This clause is left intentionally blank.

J22 39 Other Special General Treatment

This clause is left intentionally blank.

J22 40 Hospital-Substitute Treatment

Providing the Hospital-Substitute Treatment is not related to an Excluded Service described in rule J22 14 the following Benefits are payable:

1. Hospital Substitute Programs
   Defence Health has agreements with a number of approved health care providers to deliver services such as wound management, IV therapy, administration of blood products and ambulatory sleep studies in your home. These services are not available in all areas.

2. Chronic Disease Management Programs
   These provide telephone based support that is focused on keeping an Insured Persons recovery on track. They have been designed for Insured Persons who have had an appropriate hospital admission or meet program-specific criteria and who have been assessed by Defence Health as being suitable for these programs.

M1 Other

DENTAL BENEFIT SCHEDULE

Item	Description	Service limit	Category	Step	Top Extras	Standard Extras	ADF Total Package Gold	ADF Essentials Package Basic Plus	Premier Extras	Value Extras	Essentials Extras
011	Comprehensive oral examination	1 per financial year	Preventive	1	$34.40	$30.60	$37.20	$32.00	$44.00	$37.00	$30.20
012	Periodic oral examination	2 per financial year	Preventive	1	$35.40	$30.00	$37.60	$32.40	$45.00	$37.60	$30.80
013	Oral examination – limited	2 per financial year	Preventive	1	$25.00	$19.20	$29.60	$23.00	$32.00	$27.00	$22.00
014	Consultation	2 per financial year	Preventive	1	$33.40	$27.40	$37.00	$31.40	$44.00	$36.60	$30.60
015	Consultation – extended (30 minutes or more)		Preventive	1	$49.00	$41.20	$51.60	$47.00	$61.00	$50.80	$43.60
016	Consultation by referral		General	1	$54.10	$45.60	$56.80	$48.10	$67.60	$56.40	$44.70
017	Consultation by referral – extended (30 minutes or more)		General	1	$62.10	$49.80	$61.30	$52.60	$73.10	$61.10	$49.20
018	Written report (not elsewhere included)		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
019	Referral		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
022	Intraoral radiograph – per exposure		General	1	$21.20	$17.80	$24.20	$19.90	$28.60	$23.30	$18.70
				2	$15.40	$12.40	$0.00	$0.00	$0.00	$0.00	$0.00
026	Cone Beam Computed Tomography – scan acquisition – per appointment	1 per appointment, 2 per financial year	General	1	$79.30	$66.30	$94.30	$77.40	$111.30	$88.00	$74.20
031	Extraoral radiograph – maxillary, mandibular – per exposure	2 per financial year	General	1	$40.90	$43.50	$30.70	$24.20	$36.00	$30.10	$23.10

033	Lateral, antero-posterior, postero-anterior or submento-vertex radiograph of the skull – per exposure	2 per financial year	General	1	$49.40	$43.50	$46.00	$37.30	$54.50	$45.60	$33.90
035	Radiograph of temporomandibular joint – per exposure	2 per financial year	General	1	$51.50	$46.60	$47.10	$40.50	$56.80	$47.10	$38.20
036	Cephalometric radiograph – lateral, antero-posterior, postero-anterior or submento-vertex – per exposure	2 per financial year	General	1	$51.50	$47.70	$47.10	$40.50	$56.80	$47.10	$37.10
037	Panoramic radiograph – per exposure	1 per financial year	General	1	$58.90	$54.10	$56.80	$48.10	$67.60	$56.40	$44.70
038	Hand–wrist radiograph for skeletal age assessment	1 per appointment	General	1	$82.30	$31.80	$35.00	$28.60	$41.60	$34.60	$25.20
039	Computed tomography of the skull or parts thereof	1 per appointment	General	1	$107.10	$97.50	$99.20	$80.80	$116.60	$98.40	$74.20
041	Bacteriological examination		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
042	Culture examination and identification		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
043	Antibiotic sensitivity test		General	1	$65.70	$59.40	$0.00	$0.00	$0.00	$0.00	$0.00
044	Collection of specimen for pathology examination		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
047	Saliva screening test		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
048	Microbiological screening test		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
051	Biopsy of tissue		General	1	$90.10	$77.40	$84.20	$71.00	$100.30	$84.00	$66.60
052	Histopathological examination of tissue		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
053	Cytological investigation		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
055	Blood Collection		General	1	$109.20	$96.50	$0.00	$0.00	$0.00	$0.00	$0.00
056	Haematological examination		General	1	$24.00	$20.10	$0.00	$0.00	$0.00	$0.00	$0.00

057	Procedures to derive biologically active components from a collection of blood.		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
059	Comprehensive head and neck cancer examination and risk assessment		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
061	Pulp testing – per appointment		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
071	Diagnostic model – per model	2 per financial year	General	1	$28.20	$23.30	$30.70	$25.20	$37.30	$30.50	$25.20
072	Photographic records – intraoral – per appointment	1 per financial year	General	1	$15.50	$12.70	$16.50	$13.40	$18.90	$16.30	$12.30
073	Photographic records – extraoral – per appointment	1 per financial year	General	1	$15.50	$12.70	$16.50	$13.40	$18.90	$16.30	$12.30
074	Diagnostic Modelling – physical – per tooth	1 per tooth, per appointment, maximum of 4 per financial year	General	1	$42.80	$14.40	$42.20	$35.60	$50.20	$42.00	$32.90
075	Diagnostic modelling - digital - per tooth	1 per tooth, per appointment, maximum of 4 per financial year	General	1	$21.40	$7.20	$21.20	$17.80	$25.20	$21.00	$16.50
076	Intra-oral evaluation of diagnostic modelling - per tooth or tooth replacement		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
081	Cephalometric analysis – excluding radiographs	1 per financial year	General	1	$28.20	$21.20	$30.70	$24.20	$37.30	$30.50	$22.00
082	Tooth–jaw size prediction analysis	1 per financial year	General	1	$17.20	$12.70	$17.80	$14.40	$21.00	$17.40	$13.40

083	Tomographic analysis	1 per appointment	General	1	$26.10	$22.30	$28.40	$23.10	$29.70	$24.80	$20.80
087	Cone Beam Computed Tomography analysis and/or interpretation – small field of view (less than one complete dental arch)	1 per appointment	General	1	$21.40	$17.70	$22.30	$19.10	$27.60	$21.20	$18.00
088	Cone Beam Computed Tomography analysis and/or interpretation – maxillary or mandibular dentition (single arch)	1 per appointment	General	1	$21.40	$17.70	$22.30	$19.10	$27.60	$21.20	$18.00
089	Cone Beam Computed Tomography analysis and/or interpretation – maxillary and mandibular dentition (both arches)	1 per appointment	General	1	$21.40	$17.70	$22.30	$19.10	$27.60	$21.20	$18.00
090	Cone Beam Computed Tomography analysis and/or interpretation – temporomandibular joints only	1 per appointment	General	1	$21.40	$17.70	$22.30	$19.10	$27.60	$21.20	$18.00
091	Cone Beam Computed Tomography analysis and/or interpretation – orofacial structures	1 per appointment	General	1	$21.40	$17.70	$22.30	$19.10	$27.60	$21.20	$18.00
111	Removal of plaque and/or stain	1 per appointment, 2 per financial year	Preventive	1	$31.60	$28.00	$34.00	$29.20	$40.00	$33.00	$29.80
113	Recontouring and polishing of pre-existing restoration(s) – per tooth	1 per tooth, per appointment, maximum of	Preventive	1	$6.00	$4.60	$6.60	$5.60	$7.60	$6.00	$5.00

		4 per financial year									
114	Removal of calculus – first appointment	2 per financial year	Preventive	1	$66.20	$55.00	$71.40	$61.80	$84.00	$70.80	$60.40
115	Removal of calculus – subsequent appointment	2 per financial year	Preventive	1	$65.60	$53.60	$69.40	$59.80	$81.00	$67.80	$58.40
116	Enamel micro-abrasion – per tooth		Preventive	1	$28.60	$24.00	$27.40	$23.60	$32.60	$27.20	$21.80
117	Bleaching, internal – per application	1 per tooth, per appointment, maximum of 4 per financial year	General	1	$0.00	$0.00	$65.50	$53.00	$77.40	$65.10	$49.20
118	Bleaching, external – per tooth	6 per financial year	General	1	$0.00	$0.00	$15.70	$12.30	$18.90	$15.30	$11.70
119	Bleaching, home application	4 per financial year	General	1	$0.00	$0.00	$30.70	$24.80	$36.70	$30.50	$24.40
121	Topical application of remineralisation agents, one treatment	1 per appointment, 2 per financial year	Preventive	1	$19.00	$14.80	$21.20	$17.80	$24.20	$20.60	$16.40
122	Topical remineralisation agents, home application – per arch	2 per financial year	General	1	$0.00	$0.00	$19.90	$17.60	$24.20	$19.50	$17.60
123	Application of a cariostatic agent - per tooth	1 per tooth, per appointment, maximum of 2 per financial year	Preventive	1	$22.60	$21.00	$19.20	$15.80	$22.00	$18.60	$14.40
131	Dietary analysis and advice		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
141	Oral hygiene instruction		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
142	Tobacco counselling		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

151	Provision of a mouthguard – indirect		General	1	$78.20	$66.80	$89.50	$72.10	$105.80	$88.80	$69.70
153	Bi-maxillary mouthguard – indirect		General	1	$124.70	$115.50	$115.50	$93.90	$132.90	$114.90	$87.10
161	Fissure and/or tooth surface sealing – per tooth	1 per tooth, per appointment	Preventive	1	$24.80	$18.40	$24.80	$21.60	$30.00	$24.40	$21.80
163	Resin Infiltration – per tooth	1 per tooth, per appointment	Preventative	1	$24.80	$18.40	$24.80	$21.60	$30.00	$24.40	$21.80
165	Desensitising procedure – per appointment		General	1	$14.80	$11.20	$15.70	$12.30	$18.90	$15.30	$12.30
171	Odontoplasty – per tooth		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
213	Treatment of acute periodontal infection – per appointment	1 per appointment	General	1	$35.80	$30.50	$42.80	$34.10	$51.30	$42.40	$30.70
221	Clinical periodontal analysis and recording	1 per financial year	General	1	$20.80	$17.00	$22.00	$16.50	$26.30	$21.60	$15.50
222	Periodontal debridement – per tooth		Major	1	$12.70	$9.50	$12.90	$0.00	$16.50	$12.90	$0.00
223	Non-surgical treatment of peri-implant disease – per implant		Major	1	$32.30	$0.00	$36.00	$0.00	$51.90	$36.00	$0.00
231	Gingivectomy – per tooth		Major	1	$67.40	$64.70	$57.70	$0.00	$75.00	$57.70	$0.00
232	Periodontal flap surgery – per tooth		Major	1	$106.60	$88.00	$108.50	$0.00	$148.40	$108.50	$0.00
233	Surgical treatment of peri-implant disease - per implant		Major	1	$102.40	$0.00	$109.20	$0.00	$148.40	$109.20	$0.00
234	Application of biologically active material		Major	1	$102.50	$0.00	$108.10	$0.00	$147.30	$108.10	$0.00
235	Gingival graft – per tooth, implant or extraction socket	1 per tooth, per appointment	Major	1	$212.20	$183.40	$264.20	$0.00	$356.20	$264.20	$0.00

236	Guided tissue regeneration – per tooth or implant		Major	1	$351.90	$327.50	$231.70	$0.00	$312.30	$231.70	$0.00
237	Guided tissue regeneration – membrane removal		Major	1	$250.20	$225.80	$104.10	$0.00	$142.00	$104.10	$0.00
238	Periodontal surgery for crown lengthening – per tooth		Major	1	$108.10	$62.50	$110.00	$0.00	$150.70	$110.00	$0.00
239	Gingival xenograft, per tooth	1 per tooth, per appointment	Major	1	$212.20	$183.40	$264.20	$0.00	$356.20	$264.20	$0.00
241	Root resection – per root		Major	1	$118.70	$109.20	$110.00	$0.00	$150.70	$110.00	$0.00
242	Osseous surgery – per tooth or implant		Major	1	$109.80	$51.90	$174.90	$0.00	$235.30	$174.90	$0.00
243	Osseous graft – per tooth or implant		Major	1	$234.00	$206.70	$248.00	$0.00	$333.50	$248.00	$0.00
244	Osseous graft – block		Major	1	$259.70	$232.10	$272.40	$0.00	$367.00	$272.40	$0.00
245	Periodontal surgery involving one tooth		Major	1	$46.60	$35.00	$51.50	$0.00	$71.70	$51.50	$0.00
246	Maxillary sinus augmentation – trans-alveolar technique – per sinus		Major	1	$355.80	$0.00	$392.20	$0.00	$520.70	$392.20	$0.00
247	Maxillary sinus augmentation – lateral wall approach – per sinus		Major	1	$355.80	$0.00	$394.30	$0.00	$529.20	$394.30	$0.00
250	Active non-surgical periodontal therapy – per quadrant	4 per appointment, 4 per financial year	Major	1	$108.10	$93.30	$113.40	$0.00	$152.60	$113.40	$0.00
251	Supportive periodontal therapy – per appointment	1 per appointment	Major	1	$108.10	$93.30	$113.40	$0.00	$152.60	$113.40	$0.00
311	Removal of a tooth or part(s) thereof		General	1	$75.50	$59.10	$93.90	$74.40	$111.10	$93.30	$73.10

314	Sectional removal of a tooth or part(s) thereof		General	1	$103.50	$84.80	$108.10	$90.50	$127.40	$107.10	$84.00
322	Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division		Major	1	$132.50	$81.60	$124.70	$116.00	$163.70	$124.70	$107.30
324	Surgical removal of a tooth or tooth fragment requiring bone removal and/or tooth division		Major	1	$177.70	$135.70	$166.80	$159.20	$226.40	$166.80	$147.30
331	Alveoloplasty – per segment		Major	1	$84.40	$51.90	$86.10	$0.00	$112.80	$86.10	$0.00
332	Ostectomy – per jaw		Major	1	$62.30	$30.70	$118.30	$0.00	$161.50	$118.30	$0.00
337	Reduction of fibrous tuberosity		Major	1	$190.40	$164.10	$122.50	$0.00	$160.50	$122.50	$0.00
338	Reduction of flabby ridge – per segment		Major	1	$190.40	$203.50	$122.50	$0.00	$160.50	$122.50	$0.00
341	Removal of hyperplastic tissue		Major	1	$188.70	$132.50	$89.00	$0.00	$120.40	$89.00	$0.00
343	Repositioning of muscle attachment		Major	1	$442.70	$396.40	$179.10	$0.00	$241.50	$179.10	$0.00
344	Vestibuloplasty		Major	1	$442.70	$396.40	$256.30	$0.00	$318.60	$234.00	$0.00
345	Skin or mucosal graft		Major	1	$442.70	$396.40	$233.80	$0.00	$297.00	$227.50	$0.00
351	Repair of skin and subcutaneous tissue or mucous membrane		Major	1	$129.30	$124.00	$120.40	$0.00	$159.40	$120.40	$0.00
352	Fracture of maxilla or mandible – not requiring fixation		Major	1	$98.20	$92.20	$81.80	$0.00	$111.70	$81.80	$0.00
353	Fracture of maxilla or mandible – with wiring of teeth or intraoral fixation		Major	1	$568.80	$400.00	$308.70	$0.00	$392.40	$312.90	$0.00
354	Fracture of maxilla or mandible – with external fixation		Major	1	$333.50	$301.30	$319.30	$0.00	$423.20	$319.30	$0.00
355	Fracture of zygoma		Major	1	$453.30	$400.00	$384.10	$0.00	$509.60	$384.10	$0.00

359	Fracture of the maxilla or mandible requiring open reduction		Major	1	$758.50	$400.00	$643.60	$0.00	$855.60	$643.60	$0.00
361	Mandible – relocation following dislocation	1 per appointment	Major	1	$36.70	$30.50	$39.40	$0.00	$54.30	$39.40	$0.00
363	Mandible – relocation requiring open operation		Major	1	$91.20	$81.20	$79.90	$0.00	$104.10	$79.90	$0.00
365	Osteotomy – maxilla	1 per appointment	Major	1	$605.70	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
366	Osteotomy – mandible	1 per appointment	Major	1	$607.80	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
371	Removal of tumour, cyst or scar – cutaneous, subcutaneous or in mucous membrane		Major	1	$106.40	$88.80	$110.00	$0.00	$150.70	$110.00	$0.00
373	Removal of tumour, cyst or scar involving muscle, bone or other deep tissue		Major	1	$197.80	$178.90	$194.40	$0.00	$255.70	$194.40	$0.00
375	Surgery to salivary duct		Major	1	$296.80	$273.10	$122.50	$0.00	$165.80	$122.50	$0.00
376	Surgery to salivary gland		Major	1	$362.10	$329.70	$254.40	$0.00	$340.90	$254.40	$0.00
377	Repair of soft tissue		Major	1	$97.10	$88.80	$73.80	$0.00	$100.90	$73.80	$0.00
378	Surgical removal of foreign body		Major	1	$201.40	$186.80	$114.30	$0.00	$155.00	$114.30	$0.00
379	Marsupialisation of cyst		Major	1	$199.30	$185.50	$113.20	$0.00	$143.30	$113.20	$0.00
381	Surgical exposure of an unerupted tooth – per tooth	1 per tooth, per appointment	Major	1	$174.30	$119.80	$191.20	$0.00	$258.60	$191.20	$0.00
382	Surgical exposure and attachment of device for orthodontic traction	1 per tooth, per appointment	Major	1	$252.30	$231.10	$236.00	$0.00	$312.90	$236.00	$0.00
384	Repositioning of displaced tooth/teeth – per tooth	1 per tooth, per appointment	Major	1	$44.10	$39.20	$43.50	$0.00	$55.50	$43.50	$0.00

385	Surgical repositioning of unerupted tooth – per tooth	1 per tooth, per appointment	Major	1	$168.10	$149.50	$144.80	$0.00	$190.60	$144.80	$0.00
386	Splinting of displaced tooth/teeth – per displaced tooth	1 per tooth, per appointment	Major	1	$100.30	$88.80	$90.10	$0.00	$117.70	$90.10	$0.00
387	Replantation and splinting of a tooth – per avulsed or intentionally removed tooth	1 per tooth, per appointment	Major	1	$106.40	$88.80	$110.00	$0.00	$150.50	$110.00	$0.00
388	Transplantation of tooth or tooth bud	1 per tooth, per appointment	Major	1	$222.00	$196.10	$233.80	$0.00	$315.00	$233.80	$0.00
389	Surgery to isolate and preserve neurovascular tissue		Major	1	$145.90	$123.00	$73.80	$0.00	$99.90	$73.80	$0.00
391	Surgical intervention of a frenum.		Major	1	$134.60	$125.10	$130.60	$0.00	$172.40	$130.60	$0.00
392	Drainage of abscess		Major	1	$94.30	$81.60	$33.30	$0.00	$46.90	$33.30	$0.00
393	Surgery involving the maxillary antrum		Major	1	$369.10	$326.50	$390.70	$0.00	$520.70	$390.70	$0.00
394	Surgery for osteomyelitis	1 per appointment	Major	1	$289.00	$260.80	$276.70	$0.00	$367.00	$276.70	$0.00
395	Repair of nerve trunk		Major	1	$312.70	$273.50	$390.70	$0.00	$504.80	$390.70	$0.00
399	Control of reactionary or secondary post-operative haemorrhage		Major	1	$48.30	$41.30	$11.00	$0.00	$16.50	$11.00	$0.00
411	Direct pulp capping		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
412	Incomplete endodontic therapy (tooth not suitable for further treatment)		Major	1	$53.80	$47.70	$57.50	$0.00	$80.30	$57.50	$0.00
414	Pulpotomy	1 per tooth, per appointment	Major	1	$62.10	$55.10	$50.00	$0.00	$64.00	$50.00	$0.00

415	Complete chemo-mechanical preparation of root canal – one canal	1 per tooth, per appointment	Major	1	$121.50	$98.60	$110.00	$0.00	$150.70	$110.00	$0.00
416	Complete chemo-mechanical preparation of root canal – each additional canal		Major	1	$48.80	$40.30	$37.10	$0.00	$53.40	$37.10	$0.00
417	Root canal obturation – one canal	1 per tooth, per appointment	Major	1	$136.70	$121.90	$117.40	$0.00	$158.20	$117.40	$0.00
418	Root canal obturation – each additional canal		Major	1	$46.60	$40.30	$37.10	$0.00	$53.40	$37.10	$0.00
419	Extirpation of pulp or debridement of root canal(s)	1 per tooth, per appointment	Major	1	$66.80	$58.30	$71.70	$0.00	$98.80	$71.70	$0.00
421	Resorbable root canal filling – primary tooth	1 per tooth, per appointment	Major	1	$93.90	$84.80	$73.80	$0.00	$96.70	$73.80	$0.00
431	Periapical curettage – per root		Major	1	$129.30	$119.80	$122.50	$0.00	$161.50	$122.50	$0.00
				2	$0.00	$0.00	$54.40	$0.00	$74.80	$55.40	$0.00
432	Apicectomy – per root		Major	1	$166.00	$135.70	$155.00	$0.00	$204.80	$155.00	$0.00
				2	$0.00	$0.00	$69.60	$0.00	$95.20	$70.60	$0.00
433	Exploratory periradicular surgery		Major	1	$102.40	$94.30	$79.10	$0.00	$107.90	$79.10	$0.00
434	Apical seal – per canal		Major	1	$153.30	$118.70	$138.40	$0.00	$183.60	$138.40	$0.00
				2	$0.00	$0.00	$65.40	$0.00	$86.60	$65.40	$0.00
436	Sealing of perforation		Major	1	$111.30	$103.90	$81.80	$0.00	$111.70	$81.80	$0.00
437	Surgical treatment and repair of external root resorption – per tooth	1 per tooth, per appointment	Major	1	$126.10	$103.90	$106.20	$0.00	$143.10	$106.20	$0.00

438	Hemisection	1 per tooth, per appointment	Major	1	$126.10	$119.80	$98.20	$0.00	$133.30	$98.20	$0.00
445	Exploration and/or negotiation of a calcified canal – per canal, per appointment		Major	1	$44.10	$31.80	$39.20	$0.00	$55.50	$39.20	$0.00
				2	$0.00	$0.00	$16.00	$0.00	$23.80	$17.00	$0.00
451	Removal of root filling – per canal		Major	1	$44.10	$0.00	$39.20	$0.00	$55.50	$39.20	$0.00
				2	$0.00	$0.00	$16.00	$0.00	$23.80	$17.00	$0.00
452	Removal of a cemented root canal post or post crown		Major	1	$102.80	$92.20	$53.60	$0.00	$73.80	$53.60	$0.00
453	Removal or bypassing fractured endodontic instrument		Major	1	$102.80	$92.20	$73.80	$0.00	$100.90	$73.80	$0.00
455	Additional appointment for irrigation and/or dressing of the root canal system – per tooth	1 per tooth, per appointment	Major	1	$54.90	$43.50	$57.50	$0.00	$80.30	$57.50	$0.00
457	Obturation of resorption defect or perforation (non-surgical)	1 per tooth, per appointment	Major	1	$76.30	$64.70	$73.80	$0.00	$96.70	$73.80	$0.00
459	Guided endodontic repair — per tooth	1 per tooth, per appointment	Major	1	$93.30	$75.90	$87.60	$0.00	$116.60	$87.60	$0.00
511	Metallic restoration – one surface – direct	1 per tooth, per appointment	General	1	$53.00	$48.30	$53.60	$46.00	$64.40	$53.60	$42.60
512	Metallic restoration – two surfaces – direct	1 per tooth, per appointment	General	1	$71.40	$60.40	$73.10	$62.30	$87.30	$73.10	$57.90
513	Metallic restoration – three surfaces – direct	1 per tooth, per appointment	General	1	$87.60	$75.30	$93.90	$78.70	$111.10	$93.30	$73.10

514	Metallic restoration – four surfaces – direct	1 per tooth, per appointment	General	1	$93.90	$86.90	$98.20	$82.90	$116.60	$97.90	$76.30
515	Metallic restoration – five surfaces – direct	1 per tooth, per appointment	General	1	$103.50	$95.40	$102.60	$86.30	$122.10	$102.40	$79.50
521	Adhesive restoration – one surface – anterior tooth – direct	1 per tooth, per appointment	General	1	$64.20	$53.60	$71.00	$60.00	$84.00	$70.20	$55.80
522	Adhesive restoration – two surfaces – anterior tooth – direct	1 per tooth, per appointment	General	1	$78.20	$65.70	$84.20	$71.00	$100.30	$84.00	$66.60
523	Adhesive restoration – three surfaces – anterior tooth – direct	1 per tooth, per appointment	General	1	$90.30	$78.20	$102.40	$86.30	$122.10	$102.40	$79.50
524	Adhesive restoration – four surfaces – anterior tooth – direct	1 per tooth, per appointment	General	1	$106.60	$86.50	$112.40	$93.90	$132.90	$111.70	$87.10
525	Adhesive restoration – five surfaces – anterior tooth – direct	1 per tooth, per appointment	General	1	$127.40	$95.20	$139.50	$116.60	$165.60	$139.50	$107.90
526	Adhesive restoration – veneer – anterior tooth – direct	1 per tooth, per financial year	General	1	$139.90	$95.20	$167.90	$139.50	$198.00	$167.10	$129.50
531	Adhesive restoration – one surface – posterior tooth – direct	1 per tooth, per appointment	General	1	$69.50	$58.10	$84.20	$66.80	$100.30	$84.00	$65.50
532	Adhesive restoration – two surfaces – posterior tooth – direct	1 per tooth, per appointment	General	1	$92.00	$79.90	$108.10	$87.30	$127.40	$107.10	$84.00
533	Adhesive restoration – three surfaces – posterior tooth – direct	1 per tooth, per appointment	General	1	$124.20	$103.90	$130.80	$109.00	$154.50	$130.20	$101.30

534	Adhesive restoration – four surfaces – posterior tooth – direct	1 per tooth, per appointment	General	1	$137.20	$115.50	$145.00	$121.10	$170.90	$144.20	$112.10
535	Adhesive restoration – five surfaces – posterior tooth – direct	1 per tooth, per appointment	General	1	$146.10	$126.10	$153.70	$128.70	$181.90	$153.50	$118.70
536	Adhesive restoration – veneer – posterior tooth – direct	1 per tooth, per financial year	General	1	$139.90	$95.20	$167.90	$136.30	$198.00	$167.10	$129.50
541	Metallic restoration – one surface – indirect	1 per tooth, per financial year	Major	1	$179.80	$160.10	$181.30	$0.00	$239.30	$181.30	$0.00
542	Metallic restoration – two surfaces – indirect	1 per tooth, per financial year	Major	1	$330.30	$300.00	$292.80	$0.00	$388.60	$292.80	$0.00
543	Metallic restoration – three surfaces – indirect	1 per tooth, per financial year	Major	1	$390.10	$331.80	$353.60	$0.00	$469.60	$353.60	$0.00
544	Metallic restoration – four surfaces – indirect	1 per tooth, per financial year	Major	1	$442.20	$374.20	$491.20	$0.00	$658.90	$491.20	$0.00
545	Metallic restoration – five surfaces – indirect	1 per tooth, per financial year	Major	1	$491.40	$400.00	$548.00	$0.00	$734.60	$548.00	$0.00
551	Tooth-coloured restoration – one surface – indirect	1 per tooth, per financial year	Major	1	$331.40	$269.20	$317.20	$0.00	$421.00	$317.20	$0.00
552	Tooth-coloured restoration – two surfaces – indirect	1 per tooth, per financial year	Major	1	$405.80	$300.00	$475.10	$0.00	$637.30	$475.10	$0.00
553	Tooth-coloured restoration – three surfaces – indirect	1 per tooth, per financial year	Major	1	$477.20	$395.40	$515.60	$0.00	$691.30	$515.60	$0.00

554	Tooth-coloured restoration – four surfaces – indirect	1 per tooth, per financial year	Major	1	$521.50	$400.00	$556.10	$0.00	$745.40	$556.10	$0.00
555	Tooth-coloured restoration – five surfaces – indirect	1 per tooth, per financial year	Major	1	$547.00	$400.00	$576.40	$0.00	$772.30	$576.40	$0.00
556	Tooth-coloured restoration – veneer – indirect	1 per tooth, per financial year	Major	1	$465.10	$331.80	$515.60	$0.00	$691.30	$515.60	$0.00
571	Adaptation of new restoration to existing removable prosthesis – per tooth	1 per tooth, per appointment	General	1	$18.70	$10.70	$18.00	$14.80	$22.00	$20.10	$12.70
572	Provisional/interim restoration – per tooth	1 per tooth, per appointment	General	1	$38.40	$27.60	$38.40	$29.70	$46.00	$37.90	$30.70
574	Metal band	1 per tooth, per financial year	General	1	$51.90	$43.90	$56.80	$48.10	$67.60	$56.40	$44.70
575	Pin retention – per pin		General	1	$14.80	$8.10	$14.40	$11.20	$17.60	$14.20	$10.00
577	Cusp capping – per cusp		General	1	$16.10	$10.60	$19.90	$15.50	$22.00	$19.70	$15.50
578	Restoration of an incisal corner – per corner		General	1	$31.40	$27.30	$19.90	$18.70	$22.00	$19.70	$17.60
579	Bonding of tooth fragment		General	1	$67.40	$47.30	$87.30	$67.80	$100.30	$87.10	$65.50
586	Preformed Full Crown – metallic - significant tooth preparation	1 per tooth, per appointment	General	1	$106.60	$93.10	$121.10	$98.20	$143.70	$121.10	$93.70
587	Preformed Full Crown – metallic – minimal tooth preparation	1 per tooth, per appointment	General	1	$71.00	$57.80	$81.60	$65.70	$97.50	$76.30	$61.50
588	Preformed Full Crown – tooth-coloured	1 per tooth, per appointment	General	1	$104.40	$84.40	$121.90	$98.60	$143.70	$113.40	$95.40
595	Removal of indirect restoration		General	1	$36.90	$21.00	$58.10	$47.10	$68.90	$57.20	$42.80

596	Recementing of indirect restoration		General	1	$56.40	$46.20	$61.30	$49.40	$73.10	$61.10	$48.10
597	Post – direct		General	1	$65.30	$51.50	$86.30	$70.00	$102.40	$85.90	$64.40
598	Restoration root capping - direct	3 per tooth, per appointment	General	1	$69.10	$60.00	$78.40	$64.70	$92.20	$78.40	$60.00
611	Full crown – polymeric material – indirect	1 per tooth, per financial year	Major	1	$292.30	$241.70	$325.00	$0.00	$437.10	$325.00	$0.00
613	Full crown – ceramic – indirect	1 per tooth, per financial year	Major	1	$687.50	$400.00	$799.50	$0.00	$1,069.80	$799.50	$0.00
615	Full crown – veneered – indirect	1 per tooth, per financial year	Major	1	$714.20	$400.00	$801.60	$0.00	$1,071.90	$801.60	$0.00
618	Full crown – metallic – indirect	1 per tooth, per financial year	Major	1	$617.30	$400.00	$799.50	$0.00	$1,069.80	$799.50	$0.00
625	Post and core for crown – indirect	1 per tooth, per financial year	Major	1	$174.30	$141.00	$191.20	$0.00	$258.90	$191.20	$0.00
627	Preliminary restoration for crown – direct	1 per tooth, per financial year	Major	1	$89.00	$76.30	$85.90	$0.00	$118.30	$85.90	$0.00
629	Post and root cap – indirect	1 per tooth, per financial year	Major	1	$125.70	$109.20	$213.50	$0.00	$287.00	$212.40	$0.00
631	Provisional crown – per tooth	1 per tooth, per appointment	Major	1	$93.90	$82.70	$73.80	$0.00	$96.70	$73.80	$0.00
632	Provisional bridge pontic – per pontic		Major	1	$53.60	$45.60	$29.30	$0.00	$41.30	$29.30	$0.00
633	Provisional implant abutment – per abutment		Major	1	$89.00	$85.90	$85.90	$0.00	$118.30	$85.90	$0.00

634	Provisional implant restoration – per implant abutment	1 per tooth, per appointment	Major	1	$89.00	$85.90	$65.70	$0.00	$90.10	$65.70	$0.00
642	Bridge pontic – direct – per pontic	1 per tooth, per financial year	Major	1	$509.40	$397.50	$317.20	$0.00	$424.60	$317.20	$0.00
643	Bridge pontic – indirect – per pontic	1 per tooth, per financial year	Major	1	$511.60	$400.00	$531.90	$0.00	$713.00	$531.90	$0.00
644	Semi-fixed attachment		Major	1	$128.00	$114.50	$141.40	$0.00	$187.60	$141.40	$0.00
645	Precision or magnetic attachment		Major	1	$123.60	$98.60	$142.50	$0.00	$194.00	$142.50	$0.00
648	Bonded retainer - direct - per tooth		Major	1	$92.00	$79.90	$107.10	$0.00	$127.40	$107.10	$0.00
649	Bonded retainer – indirect – per tooth		Major	1	$114.90	$98.60	$134.40	$0.00	$183.20	$134.40	$0.00
651	Recementing crown or veneer		General	1	$52.60	$40.70	$65.50	$52.60	$78.70	$65.50	$48.10
652	Recementing bridge or splint – per abutment		General	1	$56.40	$49.40	$65.50	$52.60	$78.70	$65.50	$51.30
653	Rebonding of bridge or splint where retreatment of bridge surface is required		General	1	$69.50	$59.40	$75.50	$61.30	$89.50	$74.80	$56.80
655	Removal of crown		General	1	$46.60	$33.10	$47.10	$40.50	$56.80	$47.10	$38.20
656	Removal of bridge or splint		General	1	$56.40	$47.70	$61.30	$49.40	$73.10	$61.10	$49.20
658	Repair of crown or bridge – indirect - per crown or pontic		General	1	$50.00	$40.70	$93.90	$75.50	$111.10	$93.30	$70.00
659	Repair of crown, bridge or veneer – direct – per crown, pontic or veneer		General	1	$59.10	$51.50	$84.20	$67.80	$100.30	$84.00	$62.30
661	Fitting of implant abutment – per abutment		Major	1	$389.00	$204.60	$393.90	$0.00	$529.20	$393.90	$0.00

663	Removal of implant and/or retention device		Major	1	$136.50	$119.80	$142.50	$0.00	$194.00	$142.50	$0.00
664	Fitting of bar for denture – per tooth or implant		Major	1	$166.00	$152.60	$130.60	$0.00	$172.40	$130.60	$0.00
665	Prosthesis with resin base attached to implants – removable – per arch		Major	1	$651.10	$400.00	$799.50	$0.00	$1,069.80	$799.50	$0.00
666	Prosthesis with metal frame attached to implants – fixed – per arch		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
667	Prosthesis with metal frame attached to implants – removable – per arch		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
668	Implant prosthetic screw replacement		Major	1	$24.00	$11.90	$35.40	$0.00	$49.80	$35.40	$0.00
669	Removal and reattachment of prosthesis fixed to implant(s) – per implant		Major	1	$88.00	$82.70	$85.90	$0.00	$118.30	$85.90	$0.00
				2	$0.00	$0.00	$42.00	$0.00	$57.40	$42.00	$0.00
671	Full crown attached to osseointegrated implant – non-metallic – indirect		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
672	Full crown attached to osseointegrated implant – veneered – indirect		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
673	Full crown attached to osseointegrated implant – metallic – indirect		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
678	Diagnostic template		Major	1	$200.30	$179.10	$90.10	$0.00	$122.50	$90.10	$0.00
679	Surgical implant guide		Major	1	$207.80	$182.30	$175.10	$0.00	$231.70	$175.10	$0.00
684	Insertion of first stage of two-stage endosseous implant – per implant		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00

685	Insertion of the first-stage of two-stage maxillofacial endosseous implant - per implant		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
686	Insertion of a one-stage maxillofacial endosseous implant - per implant		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
687	Insertion of a mini-implant - per implant		Major	1	$339.20	$275.60	$318.00	$0.00	$424.00	$318.00	$0.00
688	Insertion of one-stage endosseous implant – per implant		Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
689	Provisional implant		Major	1	$135.70	$123.00	$106.20	$0.00	$144.20	$106.20	$0.00
690	Provisional retention or anchorage device		Major	1	$117.20	$114.10	$90.10	$0.00	$122.50	$90.10	$0.00
691	Second stage surgery of two-stage endosseous implant – per implant		Major	1	$334.50	$302.10	$275.60	$0.00	$362.10	$275.60	$0.00
692	Closure of the screw access chamber		Major	1	$69.10	$60.00	$78.40	$0.00	$92.20	$78.40	$0.00
				2	$32.60	$28.40	$37.00	$0.00	$43.60	$37.00	$0.00
693	Remodelling of a fixed implant prosthesis		Major	1	$307.80	$250.10	$288.60	$0.00	$384.80	$288.60	$0.00
694	Repair or replacement of the ceramic component of an implant metal-ceramic or all ceramic crown or bridge – per prosthetic tooth	1 per tooth, per appointment	Major	1	$50.00	$40.70	$93.30	$0.00	$111.10	$93.30	$0.00
				2	$23.60	$19.20	$44.00	$0.00	$52.40	$44.00	$0.00
695	Cleaning and polishing of an implant prosthesis	2 per financial year	Major	1	$24.60	$18.90	$21.80	$0.00	$29.00	$21.80	$0.00
696	Removal of fractured abutment screw		Major	1	$63.60	$51.70	$59.60	$0.00	$79.50	$59.60	$0.00

711	Complete maxillary denture		Major	1	$476.20	$395.40	$572.40	$0.00	$767.00	$572.40	$0.00
712	Complete mandibular denture	1 per financial year	Major	1	$476.20	$395.40	$572.40	$0.00	$767.00	$572.40	$0.00
713	Provisional complete maxillary denture	1 per financial year	Major	1	$252.90	$0.00	$278.80	$0.00	$375.20	$278.80	$0.00
714	Provisional complete mandibular denture	1 per financial year	Major	1	$252.90	$0.00	$278.80	$0.00	$375.20	$278.80	$0.00
715	Provisional complete maxillary and mandibular dentures	1 per financial year	Major	1	$388.70	$0.00	$428.20	$0.00	$573.50	$428.20	$0.00
716	Metal palate or plate	2 per appointment	Major	1	$269.90	$243.80	$215.60	$0.00	$271.10	$215.60	$0.00
719	Complete maxillary and mandibular dentures	1 every 3 financial years	Major	1	$850.00	$400.00	$950.00	$0.00	$1,100.00	$900.00	$0.00
721	Partial maxillary denture – resin base	1 per financial year	Major	1	$270.70	$225.80	$312.90	$0.00	$421.00	$312.90	$0.00
722	Partial mandibular denture – resin base	1 per financial year	Major	1	$270.70	$225.80	$312.90	$0.00	$421.00	$312.90	$0.00
723	Provisional partial maxillary denture	1 per financial year	Major	1	$171.90	$0.00	$187.60	$0.00	$253.30	$187.60	$0.00
724	Provisional partial mandibular denture	1 per financial year	Major	1	$171.90	$0.00	$187.60	$0.00	$253.30	$187.60	$0.00
727	Partial maxillary denture – custom fabricated metal framework	1 per financial year	Major	1	$520.20	$395.40	$637.30	$0.00	$853.50	$637.30	$0.00
728	Partial mandibular denture – custom fabricated metal framework	1 per financial year	Major	1	$520.20	$395.40	$637.30	$0.00	$853.50	$637.30	$0.00
731	Retainer (clasp) – per tooth		Major	1	$12.30	$10.60	$12.70	$0.00	$19.70	$12.70	$0.00
732	Occlusal rest – per rest		Major	1	$14.80	$12.70	$15.90	$0.00	$18.70	$15.90	$0.00
733	Tooth/teeth (partial denture)		Major	1	$11.90	$7.40	$14.00	$0.00	$21.80	$14.00	$0.00
734	Overlays – per tooth		Major	1	$22.90	$20.10	$24.80	$0.00	$30.50	$24.80	$0.00
735	Precision or magnetic denture attachment		Major	1	$81.00	$54.10	$85.90	$0.00	$118.30	$85.90	$0.00

736	Immediate tooth replacement – per tooth		Major	1	$18.70	$15.90	$15.10	$0.00	$23.10	$15.10	$0.00
737	Resilient lining		Major	1	$102.80	$93.30	$98.20	$0.00	$129.10	$98.20	$0.00
738	Wrought bar		Major	1	$43.50	$40.30	$47.30	$0.00	$66.40	$47.30	$0.00
739	Metal backing of denture teeth – per backing		Major	1	$39.90	$37.10	$27.30	$0.00	$38.20	$27.30	$0.00
741	Adjustment of a denture		Major	1	$18.70	$15.90	$19.10	$0.00	$28.40	$19.10	$0.00
743	Relining – complete denture – processed		Major	1	$152.40	$131.40	$191.20	$0.00	$258.90	$191.20	$0.00
744	Relining – partial denture – processed		Major	1	$133.30	$114.50	$166.80	$0.00	$226.40	$166.80	$0.00
745	Remodelling – complete denture		Major	1	$174.30	$141.00	$207.30	$0.00	$280.50	$207.30	$0.00
746	Remodelling – partial denture		Major	1	$186.10	$141.00	$197.20	$0.00	$266.50	$197.20	$0.00
751	Relining – complete denture – direct		Major	1	$470.60	$400.00	$102.00	$0.00	$139.90	$102.00	$0.00
752	Relining – partial denture – direct		Major	1	$129.30	$121.90	$85.90	$0.00	$118.30	$85.90	$0.00
753	Cleaning and polishing of pre-existing denture	2 per financial year	Major	1	$0.00	$0.00	$8.70	$0.00	$15.50	$8.70	$0.00
754	Denture base modification		Major	1	$49.80	$37.10	$51.50	$0.00	$71.70	$51.50	$0.00
755	Maintenance of overdenture attachment - per attachment	6 per financial year	Major	1	$49.00	$44.50	$53.40	$0.00	$75.00	$53.40	$0.00
				2	$23.20	$21.00	$25.20	$0.00	$35.40	$25.20	$0.00
761	Reattaching pre-existing retainer (clasp) to denture		Major	1	$49.00	$44.50	$53.40	$0.00	$75.00	$53.40	$0.00
762	Replacing/adding retainer (clasp) to denture – per retainer (clasp)		Major	1	$57.70	$47.70	$61.50	$0.00	$85.90	$61.50	$0.00
763	Repairing broken base of a complete denture		Major	1	$49.00	$44.50	$53.40	$0.00	$75.00	$53.40	$0.00
764	Repairing broken base of a partial denture		Major	1	$49.00	$44.50	$53.40	$0.00	$75.00	$53.40	$0.00

765	Replacing and/or adding a new tooth to a denture or implant prosthesis – per tooth		Major	1	$52.60	$47.70	$53.40	$0.00	$75.00	$53.40	$0.00
766	Reattaching an existing tooth to a denture – per denture tooth		Major	1	$47.30	$44.50	$45.20	$0.00	$64.20	$45.20	$0.00
768	Adding a denture tooth to a partial denture to replace an extracted or decoronated tooth - per denture tooth		Major	1	$64.20	$55.10	$69.50	$0.00	$96.70	$69.50	$0.00
769	Repair or addition to metal frame		Major	1	$81.00	$70.00	$85.90	$0.00	$118.30	$85.90	$0.00
771	Tissue conditioning - per application		Major	1	$32.40	$28.00	$31.20	$0.00	$44.70	$31.20	$0.00
772	Splint – resin		Major	1	$204.60	$184.40	$163.00	$0.00	$215.60	$163.00	$0.00
773	Splint – metal – indirect		Major	1	$322.90	$285.10	$187.40	$0.00	$251.20	$187.40	$0.00
775	Characterisation of denture base		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
776	Impression – dental appliance repair/modification	2 per financial year	General	1	$22.00	$17.60	$26.30	$21.00	$31.80	$26.10	$19.70
777	Identification		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
778	Inlay for denture tooth		Major	1	$93.90	$88.00	$73.80	$0.00	$100.90	$73.80	$0.00
779	Surgical guide for an immediate denture		Major	1	$203.50	$179.10	$114.30	$0.00	$153.90	$114.30	$0.00
781	Obturator	2 per financial year	Major	1	$197.60	$197.60	$197.60	$0.00	$265.20	$197.60	$0.00
782	Surgical/interim obturator	2 per financial year	Major	1	$106.00	$86.10	$99.40	$0.00	$132.50	$99.40	$0.00
783	Revision of surgical/interim obturator	2 per financial year	Major	1	$52.60	$42.80	$49.40	$0.00	$65.70	$49.40	$0.00
785	Interim or diagnostic maxillofacial prosthesis		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

786	Mandibular resection prosthesis		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
787	Extra-oral prosthesis - ear		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
788	Extraoral prosthesis – nose		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
789	Extraoral prosthesis - eye		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
790	Adjustment of a maxillofacial prosthesis		Major	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
811	Passive removable appliance – per arch	2 per financial year	Orthodontics	1	$161.60	$147.00	$140.80	$0.00	$167.60	$139.40	$0.00
821	Active removable appliance – per arch	2 per financial year	Orthodontics	1	$296.00	$253.00	$336.00	$0.00	$398.20	$332.40	$0.00
823	Functional orthopaedic appliance – custom fabrication	2 per appointment	Orthodontics	1	$466.60	$393.00	$422.60	$0.00	$500.20	$418.40	$0.00
824	Functional orthopaedic appliance – prefabricated	1 per financial year	Orthodontics	1	$280.00	$0.00	$329.00	$0.00	$390.00	$309.00	$0.00
825	Sequential plastic aligners – per arch		Orthodontics	1	$800.00	$243.00	$800.00	$0.00	$1,000.00	$800.00	$0.00
829	Partial banding – per arch		Orthodontics	1	$279.00	$243.00	$362.00	$0.00	$427.80	$358.20	$0.00
831	Full arch banding – per arch		Orthodontics	1	$800.00	$273.00	$800.00	$0.00	$1,000.00	$800.00	$0.00
833	Removal of banding – per arch	2 per financial year	Orthodontics	1	$83.00	$0.00	$96.00	$0.00	$115.00	$89.00	$0.00
841	Fixed palatal or lingual arch appliance	2 per financial year	Orthodontics	1	$170.60	$144.20	$213.60	$0.00	$254.00	$211.40	$0.00
842	Partial banding for inter-maxillary elastics (vertical and/or cross elastics)	2 per financial year	Orthodontics	1	$170.60	$144.20	$249.20	$0.00	$296.20	$246.60	$0.00
843	Expansion appliance – fixed – per arch	1 per financial year	Orthodontics	1	$251.20	$145.20	$362.00	$0.00	$428.80	$358.20	$0.00
844	Sagittal movement appliance		Orthodontics	1	$251.20	$145.20	$362.00	$0.00	$428.80	$358.20	$0.00
845	Passive appliance – fixed	2 per financial year	Orthodontics	1	$160.60	$148.00	$162.60	$0.00	$194.20	$160.80	$0.00
846	Minor tooth guidance – fixed		Orthodontics	1	$131.00	$118.00	$144.20	$0.00	$172.80	$142.60	$0.00

851	Extraoral appliance	1 per appointment	Orthodontics	1	$169.60	$141.20	$194.80	$0.00	$194.80	$191.80	$0.00
862	Bonding of attachment for application of orthodontic force		Orthodontics	1	$116.00	$100.00	$90.20	$0.00	$101.60	$86.20	$0.00
871	Orthodontic adjustment	1 per appointment	Orthodontics	1	$51.00	$45.00	$56.20	$0.00	$68.60	$55.40	$0.00
872	Reattachment of passive appliance – fixed	1 per appointment	Orthodontics	1	$38.40	$0.00	$49.00	$0.00	$60.00	$45.00	$0.00
873	Repair of passive appliance – fixed	1 per appointment	Orthodontics	1	$60.00	$0.00	$74.00	$0.00	$90.00	$69.00	$0.00
874	Removal of passive appliance – fixed	1 per appointment	Orthodontics	1	$60.00	$0.00	$72.00	$0.00	$89.00	$68.00	$0.00
875	Repair of removable appliance – resin base	2 per financial year	Orthodontics	1	$41.40	$35.00	$60.40	$0.00	$73.80	$59.80	$0.00
876	Repair of removable appliance – clasp, spring or tooth		Orthodontics	1	$41.20	$35.00	$43.20	$0.00	$53.40	$42.60	$0.00
877	Addition to removable appliance – clasp, spring or tooth		Orthodontics	1	$39.60	$35.00	$43.20	$0.00	$53.40	$42.60	$0.00
878	Relining – removable appliance – processed	2 per financial year	Orthodontics	1	$129.00	$115.00	$123.20	$0.00	$143.20	$121.80	$0.00
881	Course of orthodontic treatment		Orthodontics	1	$800.00	$400.00	$800.00	$0.00	$1,000.00	$800.00	$0.00
882	Course of orthodontic treatment with orthognathic surgery		Orthodontics	1	$800.00	$400.00	$800.00	$0.00	$1,000.00	$800.00	$0.00
911	Palliative care – per appointment	1 per appointment	General	1	$28.20	$25.00	$30.70	$24.20	$37.30	$30.70	$25.20
915	After-hours callout	1 per appointment	General	1	$39.00	$25.40	$56.80	$44.90	$67.60	$56.40	$41.60
916	Travel to provide services	1 per appointment	General	1	$38.20	$33.90	$38.40	$32.90	$46.00	$37.90	$30.70
919	Teleconsultation		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
920	Extended teleconsultation - 30 minutes or more		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

921	Teleconsultation by referral		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
926	Individually made tray – medicament(s)		General	1	$81.20	$77.40	$0.00	$0.00	$0.00	$0.00	$0.00
927	Provision of medication/medicament		General	1	$24.00	$22.90	$0.00	$0.00	$0.00	$0.00	$0.00
928	Intravenous cannulation and establishment of infusion	1 per appointment	General	1	$45.60	$25.90	$52.60	$44.90	$62.30	$51.70	$41.60
929	Provision of neuromodulator therapy		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
941	Local anaesthesia		General	1	$19.10	$16.50	$0.00	$0.00	$0.00	$0.00	$0.00
942	Sedation – intravenous – per 30 minutes or part thereof	2 per appointment	General	1	$84.80	$80.60	$84.20	$71.00	$100.30	$84.00	$65.50
943	Relative analgesia – inhalation of nitrous oxide and oxygen mixture - per 30 minutes or part thereof	2 per appointment	General	1	$28.20	$19.30	$34.10	$26.50	$40.50	$33.30	$27.30
944	Relaxation therapy		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
945	Low level laser therapy – per appointment		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
948	Dental acupuncture – per appointment		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
949	Treatment under general anaesthesia/sedation	1 per appointment	General	1	$72.70	$54.90	$75.90	$63.40	$89.50	$74.80	$55.80
961	Minor occlusal adjustment – per appointment	1 per appointment	General	1	$0.00	$0.00	$5.70	$4.70	$5.70	$4.50	$4.70
963	Clinical occlusal analysis, including muscle and joint palpation	1 per financial year	General	1	$48.80	$50.90	$42.80	$37.30	$51.30	$42.40	$33.90
964	Registration and mounting of dental models for occlusal analysis		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

965	Occlusal appliance	1 per financial year	Major	1	$303.20	$236.40	$256.10	$0.00	$345.30	$256.10	$0.00
966	Adjustment of pre-existing occlusal appliance – per appointment	2 per financial year	General	1	$39.90	$36.00	$42.80	$37.30	$51.30	$42.40	$33.90
967	Pantographic tracing	1 per financial year	General	1	$155.40	$127.20	$87.10	$71.00	$103.50	$87.10	$65.50
968	Occlusal adjustment following occlusal analysis – per appointment	1 per appointment	General	1	$63.60	$60.40	$65.50	$55.80	$78.70	$65.50	$51.30
971	Physical therapy for temporomandibular joint and associated structures – per appointment		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
972	Repair/addition – occlusal splint	1 per financial year	General	1	$90.10	$84.80	$78.70	$63.40	$92.60	$78.00	$58.90
981	Splinting and stabilisation – direct – per tooth		General	1	$60.00	$55.10	$56.80	$48.10	$67.60	$56.40	$44.70
982	Enamel stripping – per appointment	1 per appointment	General	1	$22.30	$19.70	$19.90	$18.70	$24.20	$19.70	$17.60
984	Mandibular advancement appliance for diagnosed snoring and obstructive sleep apnoea	1 every 3 financial years	Major	1	$625.40	$400.00	$653.40	$0.00	$875.10	$653.40	$0.00
985	Repair/addition – snoring or sleep apnoea device	1 per financial year	General	1	$65.30	$54.00	$75.30	$61.50	$89.50	$70.00	$57.20
986	Post-operative care not otherwise included		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
987	Recontour tissue – per appointment		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
990	Treatment not otherwise included (specify)		General	1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00