Comprehensive Hospital (Gold)

Comprehensive Hospital (Gold) cover offers the highest level of hospital cover available, and is designed for those who want cover for unexpected situations.

Hospital component

EXAMPLE HOSPITAL PROCEDURES at participating private and public hospitals - accommodation, operating theatre, intensive care	
Emergency ambulance transport	✓
Accident related treatment^ after joining	✓
Tonsils, adenoids and grommets	✓
Joint reconstructions	✓
Hernia and appendix	✓
Dental surgery	✓
Bone, joint and muscle	✓
Brain and nervous system	✓
Ear, nose and throat	✓
Kidney and bladder	✓
Digestive system	✓
Gastrointestinal endoscopy	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	✓
Skin	✓
Breast surgery (medically necessary)	✓
Diabetes management (excluding insulin pumps)	✓
Miscarriage and termination of pregnancy	✓
Gynaecology	✓
Male reproductive system	✓
Eye (not cataracts)	✓
Blood	✓
Back, neck and spine	✓
Implantation of hearing devices	✓
Dialysis for chronic kidney failure	✓
Insulin pumps	✓
Pain management	✓
Pain management with device	✓
Sleep studies	✓
Cataracts	✓
Heart and vascular system	✓
Lung and chest	✓
Plastic and reconstructive surgery (medically necessary)	✓
Rehabilitation	✓
Hospital psychiatric services	✓
Palliative care	✓
Pregnancy and birth	✓
Assisted reproductive services	✓
Joint replacements	✓
Weight loss surgery	✓
Podiatric surgery (provided by a registered podiatric surgeon)	O
Cosmetic services	✗
Services for which a Medicare benefit is NOT payable	R

✓ Covered in private agreement hospitals and public hospitals.

R Restricted benefits.

Additional services covered above the minimum requirements.

O Indicates benefits for accommodation at Minimum Benefits in relevant PHI (Benefit Requirements) Rules and prostheses benefits based on items listed by the Minister of Health. No benefit for medical or theatre costs.

A Benefit is not payable in respect of a service that was rendered to a Member if the service can be claimable from any other source.

^Accident related treatment means treatment provided in relation to an Accident that occurs after a Member joins the Fund and the Member provides documented evidence of seeking treatment from a Health Care Provider within seven days of the Accident occurring. If Hospital Treatment is required, the Member must be admitted to a Hospital within 180 days of the Accident occurring. Any additional Hospital Treatment (after the initial 180 days) will be paid as per the level of Benefits payable on the Member's chosen level of cover (if applicable).

Exclusion

For treatment listed as an exclusion there is no benefit payable and members will incur significant out-of-pocket expense for these services. Please review the exclusions on this cover and always check with CBHS to see if you are covered before receiving treatment.

Restricted benefits

The services listed as restricted benefits when provided in a private hospital, are eligible for Minimum Default Benefits prescribed by private health insurance legislation. These benefits relate to hospital bed charges and are unlikely to cover the fees charged for a private hospital admission. Members may incur large out-of-pocket expenses for theatre.

Co-payment or Excess

This hospital cover gives you the choice of $0, $70 or $100 co-payment OR a $750 excess. By agreeing to pay a co-payment or excess you can reduce the cost of your hospital cover.

If you choose a co-payment, it means that when you go into hospital you will pay the relevant daily co-payment each day that you are hospitalised up to a maximum of six days per person or 12 days per family per calendar year. Co-payment does not apply to any dependants on the policy.

If you choose an excess, it means that when you go into hospital (same-day or overnight) you will pay the excess amount directly to the hospital. The excess is only payable once per person up to a maximum of twice per couple/family membership per calendar year. Excesses do not apply to any dependants on the policy.

Ambulance

Comprehensive Hospital (Gold) includes cover for emergency ambulance services when transported directly to hospital or treated at the scene due to a medical emergency. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (e.g. Royal Flying Doctor Service). Residents of WA are also eligible to claim a benefit for non-emergency ambulance transport services up to a maximum of $5,000 per person per calendar year.

Residents of QLD are covered Australia wide by their state based ambulance schemes.

Residents of TAS are covered by state based ambulance schemes except in QLD and SA. You may be able to claim for services not covered by your state scheme under your CBHS Hospital cover.

What are pre-existing conditions and why are they important?

A pre-existing condition is defined as an ailment, illness, or condition where the signs or symptoms existed at any time in the period of six months ending on the day on which the person became insured by a policy. It is the opinion of the CBHS appointed doctor that determines whether the signs or symptoms were in existence in the six-month period. However, when making the determination, CBHS' doctor will have regard to any information provided by the member's doctor.

If you have a pre-existing condition, a waiting period of 12 months will apply before we will pay hospital or medical benefits towards any treatment for that condition.

Also, where a member upgrades their cover, they must wait for 12 months to be covered for pre-existing conditions.

Waiting periods

HOSPITAL WAITING PERIODS	CALENDAR MONTHS
Pre-existing conditions (except for hospital psychiatric services, rehabilitation and palliative care)	12 months
Pregnancy and birth	12 months
All other treatments	2 months
Accidents*, emergency ambulance transport	1 day

**Accident means an unexpected or unforeseen event caused by an external force or object resulting in an injury to the body which requires treatment by a medical practitioner, Hospital or dentist (as the context requires) but excludes pregnancy.*

Keep your non-student dependants covered

This product provides an option to keep your non-student dependants under 31 years of age, on your cover, providing they meet the non-student dependant criteria. An additional contribution amount will apply. More information is available at **cbhs.com.au.**

Understanding your hospital component

What's covered for included services?

- ✓ **Accommodation** for overnight, same day and intensive care for private or shared room in agreement private and public hospitals
- ✓ **Theatre and labour ward fees** covered in agreement private hospitals (excluding restricted services)
- ✓ **Medical expenses related to providers** for services while admitted in hospital e.g. fees from doctors, surgeons, anaesthetists, pathology, imaging etc. Covered for included services eligible for benefits from Medicare up to Medicare Benefits Schedule (MBS) fee. Members have their choice of doctor/surgeon in a public and private hospital. CBHS will cover the difference between the Medicare benefit and the MBS fee for services provided as an admitted patient to a hospital
- ✓ **Access Gap Cover** is where a provider chooses to participate under an arrangement with the fund. CBHS covers up to 100% of an agreed amount in excess of the MBS fee which reduces or eliminates your out-of-pocket medical expenses (i.e. surgeons, anaesthetists, pathology, imaging fees etc.)
- ✓ **Surgically implanted prostheses** to at least the minimum benefit specified in the prosthesis list issued under Private Health Insurance legislation
- ✓ **Pharmacy** covers most drugs related to the reason for your admission in agreement private hospitals
- ✓ **Boarder accommodation** covers 100%, up to $160 per admission, if not included in hospital agreement. This applies to a member assisting with the care of another member on the same membership
- ✓ **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers
- ✓ **Hospital services** where a Medicare benefit is payable (for included services only)
- ✓ **Better Living programs** information available at **cbhs.com.au/member-health/better-living-programs**
- ✓ **Hospital Substitute Treatment** information available at **cbhs.com.au/tools-and-support/Wellbeing-and-fitness/hospital-substitute-treatment**

What's not covered?

- ✗ No benefits are payable for hospital or medical treatment for excluded services
- ✗ If member is admitted into a non-agreement private hospital benefits are payable only at the minimum rate specified by law. These benefits may only provide a benefit similar to a public hospital shared room rate. These benefits may not be sufficient to cover admissions in a non-agreement private hospital
- ✗ Hospital services received within policy waiting periods
- ✗ Nursing home type patient contribution, respite care or nursing home fees
- ✗ Take home/discharge drugs (non-PBS may be eligible for benefits from Extras cover)
- ✗ Aids not covered in hospital agreement (may be eligible for benefits from Extras cover)
- ✗ Services claimed over 24 months after the service date
- ✗ Services provided in countries outside of Australia
- ✗ Prostheses used for cosmetic procedures, where no Medicare benefit is payable
- ✗ Ambulance transfers between hospitals (for residents in VIC, SA and NT)
- ✗ Fees raised by public hospitals that exceed Minimum Default Benefits set by the Department of Health and Ageing for shared room accommodation

Adding a new baby to your membership

When notifying CBHS of a new addition to your family you will need to provide your baby's full name, date of birth and gender.

If you have family cover, all waiting periods will be waived for your baby as long as you notify CBHS within two calendar months of the birth.

If you have singles cover, all waiting periods will be waived for your baby if you upgrade to family cover or sole-parent family cover within two calendar months of the birth. The upgrade must take effect the date your baby was born.

Going into hospital

- Contact us to confirm what you are covered for and to check if any waiting periods apply
- Check if your hospital has an agreement with CBHS
- Obtain a quote from your treating doctor/surgeon

Access to private hospital

CBHS holds agreements with an extensive range of Australian private hospitals and day surgeries. These agreements ensure hospital fees including bed fees, theatre and labour ward and intensive care fees are covered when admitted as a patient to hospital (subject to your level of cover).

For charges incurred in a non-agreement hospital members may only receive benefits similar to a public hospital **shared room rate** which can result in substantial out-of-pocket expenses. Should you choose a hospital that holds an agreement with CBHS, you reduce, if not eliminate, out-of-pocket expenses for hospital fees.

To check if your hospital holds an agreement, visit our website at **cbhs.com.au** or contact Member Care on **1300 654 123**.

Claiming your benefits

Non-admitted medical services

Claims for medical services provided in a hospital, day surgery, private emergency facility or doctors rooms as a non-admitted patient must be submitted directly to Medicare only. These services include, but are not limited to imaging, blood tests (pathology) and specialist/doctor consultations.

Hospital claims

Hospitals will bill CBHS directly. If you are required to contribute to your admission (for example you have selected to pay a co-payment or excess and are admitted for a restricted or excluded service) you will be required to pay this directly to the hospital. Please check with the hospital whether you have to pay this upon admission or if they will bill you.

Admitted hospital medical services*

We pay up to 25% of the Medicare Benefits Schedule (MBS) fee, while Medicare pays the other 75%. If charges are more than the MBS fee, then a gap payment arises.

MEDICARE BENEFITS SCHEDULE FEES	
75% covered by Medicare	Up to 25% covered by CBHS

Services that do not attract a benefit from Medicare will not incur any benefits. This means that you may face significant out-of-pocket expenses for both hospital and medical services.

- Doctors will give you an account for their services. Take this account to Medicare first
- Complete a Two-Way claims form in order for Medicare to forward your claim to CBHS for the Fund benefit to be paid

** A member will incur substantial out-of-pocket expenses if they are not entitled to Medicare benefits (i.e. Non-Australian Residents).*

Access Gap Cover

Many people admitted to hospital as private patients can find themselves faced with out-of-pocket expenses, or 'gaps'.

Access Gap Cover (AGC) is a medical gap cover arrangement designed to minimise or eliminate out-of-pocket expenses for medical procedures conducted in hospitals or day surgery facilities as an admitted patient.

Advantages of Access Gap Cover

- As a patient, you will receive an estimate of doctors fees prior to your treatment
- Doctors may claim directly from CBHS on your behalf (including the Medicare benefit)
- No more Medicare queues

Go to **cbhs.com.au** for more information on Access Gap Cover or to search for Access Gap Cover participating doctors.

Doctors using Access Gap Cover will usually bill CBHS directly. CBHS claims the Medicare benefit on your behalf and sends payment, including the Medicare and Fund benefits, directly to your doctor. If your doctor sends the account to you, please forward it on to CBHS, clearly identifying it is to be claimed through Access Gap Cover. **Do not take accounts to Medicare first.**