

hospital **b excess** *(closed to new members and transfers)*

hospital **b excess** is for those seeking a sense of security, with some restricted benefits on services and procedures you are less likely to need like pregnancy.

what's covered?

- ✓ **Accommodation** for overnight, same day and intensive care for private or shared room in agreement private and public hospitals (excluding restricted services*)
- ✓ **Theatre 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 all services eligible for benefits from Medicare up to Medicare Benefits Schedule (MBS) Fee. Members have their **choice of doctor/surgeon** in a public or 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 prostheses list issued under Private Health Insurance legislation
- ✓ **Pharmacy** covers most drugs related to the reason for your admission in agreement private hospitals
- ✓ **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers
- ✓ **Boarder accommodation** covers 100%, up to \$160 per admission, if not included in hospital agreement
- ✓ **Hospital Services** where a Medicare benefit is payable (excluding restricted services*)

waiting periods

hospital waiting periods	calendar months
Pre-existing condition, pregnancy related services	12 months
All other treatments	2 months
Accidents, injuries and emergencies Emergency ambulance transport	1 day

co-payment and excess

hospital **b excess** has both a daily co-payment and an overnight excess component.

daily co-payment	\$100 per day each time a member is admitted to hospital (excluding overnight stays)
overnight excess	\$350 per person for overnight admissions with a maximum of \$700 for family/couple/sole parent memberships per calendar year

what's not covered?

- ✗ If member is admitted into a private hospital for restricted services 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 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 drugs may be eligible for benefits from your Extras cover)
- ✗ Aids not covered in hospital agreement (may be eligible for benefits from your 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

exclusions

For treatment listed as an exclusion there is no benefit payable and member 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. The following services are excluded from this cover.

- ✗ Cosmetic Services

*restricted benefits (services) not fully covered

The services listed below, 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 fees together with the difference between the Minimum Default Benefit and the bed charge raised by the hospital.

The services listed below are also eligible for hospital benefits in a public hospital at a shared room rate. Public hospitals do not raise charges for theatre use.

- ▶ major eye surgery services (corneal transplant, cataract surgery, other lens related surgery services)
- ▶ joint replacement services (hip, knee, ankle and shoulder)
- ▶ pregnancy related services
- ▶ assisted reproductive services (e.g. IVF)
- ▶ sterilisation and reversal of sterilisation services
- ▶ cardiothoracic services
- ▶ bariatric (gastric banding, sleeve gastrectomy, gastric by-pass) services
- ▶ psychiatric services
- ▶ rehabilitation and palliative care services
- ▶ plastic and reconstructive surgery services
- ▶ services for which a Medicare benefit is not payable

understanding your hospital cover

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

If a member has 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.

A pre-existing condition is an ailment or illness for which the signs or symptoms were evident up to 6 months before a 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 – that doctor, however, will have regard to any information provided by the member's doctor.

Members must also wait for 12 months to be covered for pre-existing conditions where they upgrade their cover.

ambulance

hospital b excess includes cover for emergency ambulance services when transported directly to a hospital or treated at the scene due to an accident or medical emergency. Transport must be provided by a State Government ambulance service or a private ambulance service recognised by CBHS (such as 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 and TAS are the only states covered under their State based ambulance schemes.

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 hospitals

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 fees, intensive and coronary 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 an excess or are admitted for a restricted 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 MBS fee, while Medicare pays the other 75%. If charges are more than the MBS fee, then a gap payment arises.

medicare benefits schedule fee	
75% covered by Medicare	up to 25% covered by CBHS

Services that do not attract a benefit from Medicare will be subject to restricted benefits only. 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 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.**

adding your 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.

family cover	singles cover
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 cover within two calendar months of the birth.

This upgrade must take effect from the date your baby was born.

This information must be read in conjunction with your CBHS Health Benefit Fund Rules, available at cbhs.com.au. Please read carefully and retain for future reference.