CBHS HEALTH FUND

FlexiSaver (Basic Plus)

Effective 1st April 2019

An entry level package for the young healthy singles and couples, designed to give the flexibility to use extras overall limit on service needed the most while saving money by accepting to have exclusions on hospital treatments not needed at this stage of life.

FlexiSaver (Basic Plus) Hospital component

EXAMPLE HOSPITAL PROCEDURES at participating private and public hospitals - accommodation, operating theatre, intensive care	
Emergency ambulance transport	✓
Accident related treatment^ and medical emergencies 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	R
Hospital psychiatric services	R
Palliative care	R
Pregnancy and birth	✗
Assisted reproductive services	✗
Joint replacements	✗
Weight loss surgery	✗
Podiatric surgery (provided by a registered podiatric surgeon)	✗
Cosmetic services	✗
Services for which a Medicare benefit is NOT payable	✗

✓ Covered in private agreement hospitals and public hospitals.

R Restricted benefits.

Additional services covered above the minimum requirements.

✗ Exclusion (not covered).

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.

Exclusion

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.

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.

Excess payable: $500

An excess is a nominated amount you agree to pay upfront in respect to charges raised by a hospital for overnight or same day admission. The total excess is payable once per person per calendar year up to a maximum of twice for couples policy.

Ambulance

All packages include 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 Queensland and Tasmania are covered by their state based Ambulance schemes.

Waiting periods

HOSPITAL WAITING PERIODS	CALENDAR MONTHS
Pre-existing condition	12 months
All other treatments	2 months
Accidents, medical emergency and ambulance	1 day

^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 7 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).

Understanding your FlexiSaver (Basic Plus) hospital component

What's covered for included services?

- ✓ **Accommodation** for overnight, same day and intensive care covered for private or shared room in agreement private and public hospitals
- ✓ **Medical expenses related to providers** for services while admitted in hospital e.g. fees from doctors, surgeons, anaesthetists, radiologists, pathology, imaging etc. Covered for 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
- ✓ **Boarder accommodation** covers 100%, up to $160 per admission, if not included in hospital agreement
- ✓ **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers

What's not covered?

- ✗ No benefits are payable for hospital or medical treatment and associated costs for excluded services
- ✗ If a member is admitted into a non-agreement private hospital for services covered by this product, 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
- ✗ Aids not covered in hospital agreement
- ✗ Services claimed over 24 months after the service date
- ✗ Services provided in countries outside of Australia
- ✗ Prostheses used for excluded services
- ✗ 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 for shared room accommodation

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.

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/doctors consultations.

Hospital claims

Hospitals will bill CBHS directly. If you are required to contribute to your admission (for example an excess) 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 are excluded and no benefits are payable by CBHS. 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.**

FlexiSaver (Basic Plus) extras cover#

DESCRIPTION	WAITING PERIODS	PER SERVICE BENEFIT	OVERALL LIMIT	BENEFIT PERIOD
Preventative dental (e.g. oral examinations, x-ray, scale and clean, mouthguards)	2 months	55% of the cost of service	$700 (sublimit of $150 for optical)	calendar year
General Dental (e.g. fillings, extractions or surgical dental)				
Optical (e.g. frames, prescription lens, contact lens)	6 months			
Physiotherapy	2 months			

 # 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.

Understanding your FlexiSaver (Basic Plus) Extras cover

How do my extras benefits work?

Extras benefits for FlexiSaver (Basic Plus) are based on 55% of the cost the provider charges you up to any relevant sublimit with combined overall limit per calendar year. Below is one example of how the Extras benefits work, depending on the service fee the dentist charges.

- Dentist fee = $40
- 55% of service fee = $22
- Benefit payable = $22

Benefit period

Each group of services within extras covers have an overall limit on the amount you can claim. The overall limits are based on per person per calendar year.

Dental Choice Network

The dental Choice Network is a group of dental service providers who have committed to reducing or removing the gap for **selected preventative dental** services that you would usually pay between the dentist's charges and the CBHS benefit. By choosing to use a dentist in the network you will have no out-of-pocket expenses for these selected services.

Optical Choice Network

By visiting an optical Choice Network provider, you may receive benefits up to 100% of the cost of services, **optical frames, lenses and contact lenses** up to the maximum per service and overall limits. These services may also be subject to known gaps, where you will know in advance the out-of-pocket expenses you may incur.

Manage your cover online

You can manage your membership online, visit our website at **cbhs.com au**. Some of the services available to you are:

- Update your personal details
- Check progress of a claim
- Check your extras limits
- Submit a claim online

View claims history and much more!

Want More Cover?

Alternatively, if you don't think that FlexiSaver (Basic Plus) is quite right for you, we offer a range of Hospital, Extras and Ambulance Cover which can be taken out separately or combined to create your own package of health cover.

For more information visit our website at cbhs.com.au or contact Member Care on 1300 654 123.

Private Health Insurance Code of Conduct™

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.