KickStart (Basic Plus)

A cost-effective Hospital and Extras cover tailored for those seeking a handpicked selection of common services like dental and optical, without the need for pregnancy-related coverage.

CBHS
Health Cover for the CommBank Family

Get to know KickStart (Basic Plus)

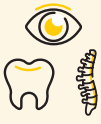
Co-payments help keep premiums affordable

Includes accident-related treatment & medical emergencies

Cover for common treatments for young singles & couples in private hospital

Joint reconstructions included

Hernia & appendix cover



Extras for dental, optical, physio, chiro, & massage

Hospital component

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

R *Restricted benefits*
✓ *Covered in private agreement hospitals and public hospitals*
✗ *Exclusion.*

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).

~For dental surgery performed by a dentist rather than a medical practitioner we only pay benefits towards hospital charges. If the surgery is performed by a medical practitioner and Medicare benefits are payable, we will pay benefits towards the hospital and medical charges. Benefits towards a dentist may be payable from your Extras coverage.

Understanding your Hospital component

CBHS
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Exclusions

For treatment listed as an exclusion, CBHS does not pay a benefit. Please review the exclusions on this cover and always check with CBHS to see if you are covered before having treatment.

Restricted benefits

The services listed as restricted benefits are only eligible for Minimum Benefits prescribed by private health insurance legislation. These benefits relate to accommodation only and are generally similar to hospital bed charges for a shared room in a public hospital. They are unlikely to cover the fees charged for a private room in a public hospital, or private hospital accommodation. Theatre fees are not covered and members may incur large out-of-pocket (gap) expenses.

Accident-related treatment

If you require hospital treatment as a result of an accident, our Accident-related treatment will supersede any Exclusions or Restricted benefits you have on your cover and you'll receive benefits as if the hospital treatment was a covered service.

Please note that specific criteria apply - see previous page or refer to our Fund Rules.

Daily co-payment

This Hospital cover includes a $70 daily co-payment, which helps you to reduce the cost of your hospital premiums.

A **co-payment** means that when you are admitted to hospital (same-day or overnight) you will pay the $70 daily co-payment each day you're in hospital up to a maximum of six days per person, or 12 days per family per calendar year.

For this product, the co-payment applies to all members on the policy including dependants.

Ambulance

This Hospital cover includes cover for emergency ambulance services when transported directly to hospital or treated at the scene due to a medical emergency. We only pay benefits towards 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, if you upgrade your cover, you must wait for 12 months to be covered for pre-existing conditions.

Waiting periods

Service	Calendar months
Pre-existing conditions (except for hospital psychiatric services, rehabilitation and palliative care)	12 months
Pregnancy and birth	12 months
Hospital psychiatric services*, rehabilitation and palliative care	2 months
Accident-related treatment**, emergency ambulance transport	1 day
All other treatments	2 months

** Once you have served the two-month waiting period, you can choose to upgrade your cover (once in a lifetime) and access the higher benefits for hospital psychiatric treatment associated with that cover, without serving an additional waiting period.*

*** 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.*

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, we'll waive all waiting periods for your baby as long as you notify CBHS within two calendar months of the birth.
- If you have single cover, we'll waive all waiting periods for your baby if you upgrade to family or sole parent cover within two calendar months of the birth. The upgrade must take effect the date your baby was born.

Understanding your Hospital component

CBHS
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What's covered?

- **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 and imaging. Covered for included services eligible for benefits from Medicare up to Medicare Benefits Schedule (MBS) fee. Have your 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 an agreed amount in excess of the MBS fee which reduces or eliminates your out-of-pocket medical expenses (e.g. surgeons, anaesthetists, pathology and imaging fees.)
- **Surgically implanted medical devices and human tissue products** to at least the minimum benefit specified in the Prescribed List of Medical Devices and Human Tissue Products 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 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
- **Hospital services** where a Medicare benefit is payable (for included services only). It's essential to check the MBS item number prior to your procedure, to confirm if the treatment falls under a category which included in your policy.

What's not covered?

- No benefits are payable for hospital or medical treatment for exclusions
- If a member is admitted into a private hospital for restricted services, benefits are payable only at the minimum rate specified by law. These benefits might be similar to that of a public hospital shared room rate, and may not be sufficient to cover admissions in a private hospital
- Nursing home type patient contribution, respite care or nursing home fees
- Take home/discharge drugs (non-PBS drugs may be eligible for benefits from Extras cover)
- Hospital services received within policy waiting periods
- Services claimed over 24 months after the service date
- Services provided in countries outside of Australia
- Medical devices and human tissue products used for cosmetic procedures, where a Medicare benefit is not payable
- Ambulance transfers between hospitals (for residents in VIC, SA and NT)

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
- Ask for 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, you may only receive benefits similar to a public hospital **shared room rate** which can result in substantial out-of-pocket expenses. By choosing 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 Services on **1300 654 123.**

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 you have in a hospital or day surgery facility as an admitted patient.

Advantages of Access Gap Cover

- You will receive an estimate of doctors' fees before your treatment – no bill shock
- Your doctor/s can claim directly from CBHS on your behalf
- You don't have to worry about claiming from Medicare – we do that for you.

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 pays 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. **Please don't take the account to Medicare or pay it yourself first, as we won't be able to reimburse you at the Access Gap Cover rate.**

More about how benefits work

Non-admitted medical services

Health funds in Australia can't pay benefits for medical services provided in a hospital, day surgery, private or doctor's rooms as a non-admitted patient. This includes, but is 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 and/or are admitted for a restricted or excluded service) you will 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 there will be an out-of-pocket (or 'gap') payment for you.

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

Services where a Medicare benefit is not payable, are not eligible for any benefits from CBHS. This means that you may face significant out-of-pocket expenses for both hospital and medical services.

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

Understanding your Extras component

CBHS
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	Waiting periods	Overall limits	Benefit period
Dental*			
Preventative dental	2 months	Unlimited	calendar year
General dental			
Major dental		Combined limit of $675	
Periodontic (gum treatment)	6 months		calendar year
Endodontic (root canal treatment)			
Optical			
Prescribed optical appliances	6 months	$230	calendar year
Therapies			
Physiotherapy	2 months	Combined limit of $250	calendar year
Chiropractic			
Osteopathy			
Clinical psychology		$250	
Dietitian		$100	
Alternative therapies			
Oriental therapies - *Acupressure, Acupuncture, Chinese Herbal Medicine Consultation, Chinese Massage, Traditional Chinese Medicine Consultation*	2 months	Combined limit of $200	calendar year
Massage therapies - *Deep Tissue Massage, Lymphatic Drainage, Myotherapy, Remedial Massage, Sports Massage, Swedish Massage, Therapeutic Massage*			
General health			
Blood glucose accessories	2 months	$100	calendar year
Non-Pharmaceutical Benefits Scheme drugs requiring a prescription by law. (100% less the current prescribed PBS co-payment for general patients up to the maximum claimable benefit)		$200	

** Benefits are not payable for Do-It-Yourself (DIY) dentistry including whitening kits, aligners and occlusal splints. Please contact us to confirm whether a benefit is payable.*

How do my Extras benefits work?

CBHS Extras benefits are based on the cost the provider charges you, up to a maximum claimable amount (the set benefit per service). This is capped by an overall limit. See next page for detailed examples of maximum claimable amounts.

Most limits are based on per person per calendar year, unless otherwise stated in our Extras table.

CBHS wellness benefits

CBHS wellness benefits cover you for a variety of health checks and programs designed to help you better manage your health and wellbeing.

Wellness benefits	Overall limit
Health checks	$100
Health management	$100
Gym membership or personal training	$115 (sublimit $100 for personal training)

Health checks^

CBHS pays benefits towards a variety of health checks (when the service is not eligible for a Medicare benefit) up to the overall limit. Health checks included are:

- ✓ Breast examination
- ✓ Bone density test
- ✓ Skin cancer screening
- ✓ Bowel/prostate cancer screening
- ✓ Eye screening

Health management

Eligible members can take advantage of a series of programs, with benefits up to your overall health management limit.

- ✓ Quit smoking programs[1]
- ✓ Weight management programs[1]
- ✓ Stress management courses[1]
- ✓ Gym membership[2]
- ✓ Personal training[2]

^CBHS is only able to pay a benefit towards selected scans, screenings and tests when they are NOT covered by Medicare. Your GP or provider will be able to advise you if your scan, screen or test meets Medicare criteria for benefits.

1. Must be approved by CBHS

2. CBHS can only pay a benefit for gym membership/personal trainer where the gym/personal trainer service is provided as part of a Health Management Program, certified by your GP or a Recognised Provider confirming that the gym/personal trainer program is a Health Management Program. Approval form is available from the CBHS website. Please note that GP consultations are not covered by CBHS.

Understanding your Extras component

CBHS
Health Cover for the CommBank Family

Examples of services and maximum claimable amount
CBHS pays the total cost up to the maximum claimable amount per service and up to the overall limit in each benefit period.

#	Item description	
Dental		
Preventative dental		
011	Examination	$40
022	X-ray	$23
114	Removal of calculus - first visit	$58
121	Fluoride	$22
General dental		
322	Surgical removal of a tooth	$172
324	Surgical removal of a tooth (including bone and tooth division)	$200
531	Adhesive restoration (filling), 1 surface posterior tooth	$75
532	Adhesive restoration (filling), 2 surfaces posterior tooth	$100
533	Adhesive restoration (filling), 3 surfaces posterior tooth	$110
Major dental		
222	Root planing - per tooth	$24
415	Complete chemo mechanical preparation of root canal - one canal	$110
416	Complete chemo mechanical preparation of root canal - each additional canal	$55
417	Root canal obturation - one canal	$117
418	Root canal obturation - each additional canal	$50
Optical		
110	Frames	100% of cost for one complete optical appliance up to the overall limit
212	Single vision lens pair	
312	Bifocal lens pair	
412	Trifocal lens pair	
512	Multifocal lens pair	
852	Contact lenses	
Therapies		
	Physiotherapy (initial/subsequent)	$40 / $30
	Chiropractic (initial/subsequent)	$40 / $40
	Osteopathy (initial/subsequent)	$40 / $30
	Clinical psychology (initial/subsequent)	$50 / $50
	Dietitian (initial/subsequent)	$75 / $42
Alternative therapies		
	Oriental therapies - *Acupressure, Acupuncture, Chinese Herbal Medicine Consultation, Chinese Massage, Traditional Chinese Medicine Consultation*	$26
	Massage therapies - *Deep Tissue Massage, Lymphatic Drainage, Myotherapy, Remedial Massage, Sports Massage, Swedish Massage, Therapeutic Massage*	$26
General health		
	Blood glucose accessories	100%
	Non-pharmaceutical benefits scheme drugs requiring a prescription by law (100% less the current prescribed PBS co-payment for general patients up to the maximum claimable benefit)	$75

CBHS | choice network

The CBHS Choice Network is a group of dental and optical providers who are committed to reducing or removing the gap for Extras services on selected preventative dental treatments, optical frames, lenses and contact lenses. For more information about the CBHS Choice Network and to find a provider, visit

cbhs.com.au/tools-and-support/find-a-provider

Recognised providers

In addition to our Choice Network, we only pay benefits for services provided by 'recognised providers' in accordance with the CBHS Health Benefit Fund Rules and the applicable Government regulations. For more information on how we classify recognised providers, please visit

cbhs.com.au/tools-and-support/find-a-provider/recognised-providers

Members Health FUND ALLIANCE

Private Health Insurance Code of Conduct

This product information sheet is current as at 29 May 2024 and provides general information and guidance about the policy and is intended as a summary only. This information should be read in conjunction with the CBHS Health Benefit Fund Rules and is subject to change from time to time.