Member Care 1300 654 123
Manage your cover online at cbhs.com.au

limited hospital

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

Example hospital procedures at participating private and public hospitals - accommodation, operating theatre, intensive care	
Emergency ambulance transport	✔
Accident related treatment^ after joining	✔
Dental services, removal of tonsils, adenoids, appendix	✔
Investigation, repair or reconstruction of bones and tissues of a knee, hip or shoulder that have been damaged as a result of physical trauma	✔
Removal of kidney stones & gall stones	✔
Colonoscopies, gastroscopies	✔
Cancer treatment (e.g. radiotherapy, chemotherapy)	✔
Brain surgery	✔
Back surgery (e.g. spinal fusion, discectomy)	✔
Cochlear implant surgery and bone anchored hearing devices	✔
Insulin pump procedures	✔
Renal dialysis	✔
Major eye surgery (including cataract surgery, glaucoma surgery and corneal grafts/transplants)	R
Hip and knee joint replacement	R
Other joint replacement	R
Pregnancy related services	R
Assisted reproductive services (e.g. IVF, GIFT)	R
Cardiothoracic services (heart and lung related)	R
Bariatric services – all including revision and reversal procedures (e.g. gastric banding, sleeve gastrectomy)	R
Psychiatric services	R
Rehabilitation services	R
Palliative care services	R
Sterilisation and reversal of sterilisation	R
Cosmetic services	✘
Plastic and reconstructive surgery services	R
Other services for which a Medicare benefit is not payable	R
All other inpatient services receiving a Medicare benefit	✔

✔ Covered ✘ Exclusion (not covered) **R** Restricted Benefits (not fully 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.

daily co-payment

You can **reduce the cost** of your Limited Hospital cover by agreeing to pay a daily co-payment of $70 or $100. This 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 6 days per person or 12 days per family per calendar year. Co-payment does not apply for any dependant children on the policy.

ambulance

Limited Hospital 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 Queensland and Tasmania are covered by their state based Ambulance schemes

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

Pre-existing condition means an ailment or illness the signs or symptoms of which, in the opinion of the Medical Adviser, or other relevant health care practitioner appointed by CBHS to give advice on such matters, having regard to any information furnished by the Member's Health Care Provider providing the treatment and any other relevant information furnished in respect of the claim for Benefit, existed at any time in the period of six months ending on the day on which the person became insured under the policy and the commencement of contributions for the Benefit.

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.

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

waiting periods

hospital waiting periods	calendar months
Pre-existing condition, pregnancy related services	12 months
All other treatments	2 months
Accidents, emergency ambulance transport	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 hospital cover

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 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

✔ **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 (for included services only)

✔ **Chronic Disease Management Programs** information available under the membership/services and benefits tab at **cbhs.com.au**

✔ **Hospital Substitute Treatment** information available under the membership/services and benefits tab at **cbhs.com.au**

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 notifiying 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 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.**