Hospital A Excess (Gold)

Hospital A Excess (Gold) covers a wide range of hospital services and treatments for ultimate peace of mind.

Closed to new members and transfers

CBHS
Health Cover for the CommBank Family

Hospital services

This policy includes cover for	
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.

✗ Exclusion (not covered).

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

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 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.

Co-payment and excess

Hospital A Excess (Gold) has both a daily co-payment and an overnight excess component.

Daily co-payment	$70 per day each time a member is admitted to hospital (excluding overnight stays) up to a maximum of 6 days per person or 12 days per family per calendar year.
Overnight excess	$350 per person for overnight admissions with a maximum of $700 for family/couple/sole parent memberships per calendar year.

Ambulance

Hospital A Excess (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.

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.

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

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

*** *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 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 Single cover, all waiting periods will be waived 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 cover

CBHS
Health Cover for the CommBank Family

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
- **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 is 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 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 Extras cover)
- 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.

Medicare Benefits Schedule Fees	
75% covered by Medicare	Up to 25% covered by CBHS

- 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)*