LiveLife (Gold)

LiveLife (Gold) is a high level of cover, offering an extensive range of Hospital services and generous Extras benefits to help you get the most out of life.

Closed to new members and transfers

CBHS
Health Cover for the CommBank Family

Hospital component

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 device and human tissue product benefits based on items listed by the Minister of Health. No benefit for medical or theatre costs.

Gap Assist

One of the benefits of LiveLife (Gold) is a medical gap benefit called 'Gap Assist', assistance to help you further reduce your out-of-pocket expenses as a result of hospitalisation. This assistance provides $200 per person per calendar year towards out-of-pocket expenses.

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.

Daily co-payment

A daily co-payment of $70 applies to LiveLife (Gold). This means that if you're admitted into hospital you will pay $70 for every day that you are there, up to a maximum of six days per person or 12 days per family in a calendar year.
So, if you are admitted to hospital for two days, you will pay a co-payment of $140. Co-payment does not apply to any dependant on the policy.

Ambulance

LiveLife (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 Queensland and Tasmania are covered by their state based Ambulance schemes.

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

Hospital services	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 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, 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 from 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 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)*

LiveLife (Gold) Extras component	Waiting periods	Overall limit	Benefit period
Dental*			
Preventative dental	2 months	Unlimited	Calendar year
General dental			
Major dental			
Periodontic (gum treatment)	6 months	$700	Calendar year
Endodontic (root canal treatment)		$700	
Inlays/onlays/facings/veneers		$1,440	Any 5 years
Dentures and implants		$1,500	
Occlusal therapy		$920	Lifetime
Crowns and bridges	12 months	$3,500	Any 5 years
Orthodontia		$3,200	Lifetime
Optical			
Prescribed optical appliances	6 months	$450	Calendar year
Therapies			
Physiotherapy	2 months	$900	Calendar year
Chiropractic		$1,000	
Osteopathy			
Occupational therapy		$800	
Speech therapy		$1,850	
Clinical psychology		$500	
Ante natal/post natal physiotherapy		$105	
Hypnotherapy		$360	
Podiatry (excl. artificial aids: e.g. orthotics, which are covered under artificial aids)		$400	
Audiology		$360	
Eye therapy		$455	
Dietitian		$360	
Exercise physiology		$360	
Alternative therapies			
Oriental therapies - *Acupressure, Acupuncture, Chinese Herbal Medicine Consultation, Chinese Massage, Traditional Chinese Medicine Consultation*	2 months	$1,000	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	$320	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)		$1,000	
Health care aids (referred by a doctor and recognised by CBHS)			
Artificial aids	12 months	$1,500	Any 3 years
Hearing aids		$2,200	
Blood pressure monitor, nebuliser, glucometer		$500	

** 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.*

Understanding your Extras component

CBHS Extras benefits for LiveLife (Gold) 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.

Benefits which attract a three and five year period are entitled to have the benefit renewed on the same date which the service was performed respectively.

Benefits which attract a 'lifetime' period; lifetime means the period commencing on the date the member was first insured and ceases to be insured by CBHS (irrespective of any suspension of membership or other period without cover).

Waiting periods

Extras waiting time	Calendar months
Crowns and bridges, orthodontia, artificial aids, healthcare appliances, and hearing aids	12 months
Prescribed optical appliances, periodontics, endodontics, inlays, onlays, facings, veneers, occlusal therapy, dentures and implants	6 months
All other services	2 months

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.

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 examinations
- Bone density test
- Skin cancer screening
- Bowel/prostate cancer screening
- Eye screenings

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]

Wellness benefits	Amount
Health checks	$300
Health management	$200
Gym membership or personal training	$230 (sublimit $200 for personal training)

^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.

CBHS | choice network

The CBHS Choice Network is a group of dental and optical providers who are committed to providing exceptional treatment to our members while 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**

Home visits by registered nurse

Where you require an in home visit by a registered nurse, CBHS will pay a benefit up to $80 for less than four hours, and up to $120 for more than four hours. An annual benefit limit applies of $2,800 per person.

Travel and accommodation

Another exclusive benefit for our LiveLife (Gold) members, to help offset the cost of travelling long distances to medical appointments. Eligible members can receive a benefit towards the cost for accommodation (single room rate), airfare, train, bus or 15c per kilometre for car travel up to the annual limit of $500.+

+Travel is only payable for a patient who requires essential medical and dental treatment, where it is not available at a facility within a 160km round trip of the member's home. In order to claim travel a patient must be visiting a specialist and will require a referral letter. Excludes Ronald McDonald House.

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	$45
022	X-ray	$28
114	Removal of calculus - first visit	$68
121	Fluoride	$27
General dental		
322	Surgical removal of a tooth	$182
324	Surgical removal of a tooth (including bone and tooth division)	$250
531	Adhesive restoration (filling), 1 surface posterior tooth	$90
532	Adhesive restoration (filling), 2 surfaces posterior tooth	$110
533	Adhesive restoration (filling), 3 surfaces posterior tooth	$135
Major dental		
222	Root planing - per tooth	$30
415	Complete chemo mechanical preparation of root canal - one canal	$136
416	Complete chemo mechanical preparation of root canal - each additional canal	$85
417	Root canal obturation - one canal	$157
418	Root canal obturation - each additional canal	$65
526	Veneer - direct	$260
556	Veneer - indirect	$600
615	Full crown - non metallic - indirect	$750
642	Bridge - direct - per pontic	$380
643	Bridge - indirect - per pontic	$680
711	Complete maxillary denture	$480
712	Complete mandibular denture	$500
719	Complete maxillary and mandibular denture	$750
811	Passive removable appliance - per arch	$3,200
843	Maxillary expansion appliance	$3,200
881	Complete course of orthodontic treatment	$3,200
965	Occlusal splint	$260
Optical		
110	Frames	$140
212	Single vision lens pair	$130
312	Bifocal lens pair	$140
412	Trifocal lens pair	$150
512	Multifocal lens pair	$210
852	Contact lenses	$220
Therapies		
	Physiotherapy (initial/subsequent)	$61 / $43
	Chiropractic (initial/subsequent)	$61 / $40
	Osteopathy (initial/subsequent)	$61 / $35
	Occupational therapy (initial/subsequent)	$61 / $35
	Speech therapy (initial/subsequent)	$95 / $46
	Clinical psychology (initial/subsequent)	$140 / $80
	Ante natal/post natal physiotherapy	100%
	Hypnotherapy	$80
	Podiatry (excl. artificial aids: e.g. orthotics, which are covered under artificial aids) (standard consult)	$35
	Audiology	$60
	Eye therapy	$60
	Dietitian (initial/subsequent)	$75 / $42
	Exercise physiology (initial/subsequent)	$35 / $35
Alternative therapies		
	Oriental therapies - Acupressure, Acupuncture, Chinese Herbal Medicine Consultation, Chinese Massage, Traditional Chinese Medicine Consultation	$33
	Massage therapies - Deep Tissue Massage, Lymphatic Drainage, Myotherapy, Remedial Massage, Sports Massage, Swedish Massage, Therapeutic Massage	$33
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)	$150
Health care aids (referred by a doctor and recognised by CBHS)		
	Artificial aids	$12 - $1,500
	Hearing aids	100%
	Blood pressure monitor, nebuliser, glucometer	100%