Everyday Silver Plus Hospital

A mid-level Hospital cover offering the comfort of knowing there's coverage for treatments such as heart and vascular, and rehabilitation services. We've excluded high-cost services such as pregnancy and joint replacement to help keep things more cost-effective.

CBHS
Health Cover for the CommBank Family

Get to know Everyday Silver Plus Hospital



A mid-level Hospital cover with economical premiums



Includes heart & vascular system



Access to rehabilitation services



Coverage for kidney, bladder & digestive system included



Male reproductive system cover included



Designed with younger families in mind

Hospital services

This policy includes cover for	
Hospital psychiatric services	R
Palliative care	R
Rehabilitation	✓
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	✓
Gastrointestinal endoscopy	✓
Back, neck and spine	✓
Blood	✓
Brain and nervous system	✓
Breast surgery (medically necessary)	✓
Chemotherapy, radiotherapy and immunotherapy for cancer	✓
Diabetes management (excluding insulin pumps)	✓
Digestive system	✓
Eye (not cataracts)	✓
Gynaecology	✓
Kidney and bladder	✓
Lung and chest	✓
Male reproductive system	✓
Miscarriage and termination of pregnancy	✓
Pain management	✓
Skin	✓
Sleep studies	✓
Heart and vascular system	✓
Implantation of hearing devices	✓
Plastic and reconstructive surgery (medically necessary)	✓
Cataracts	✗
Dialysis for chronic kidney failure	✗
Insulin pumps	✗
Joint replacements	✗
Pain management with device	✗
Assisted reproductive services	✗
Pregnancy and birth	✗
Weight loss surgery	✗
Podiatric surgery (provided by a registered surgical podiatrist)	O
Cosmetic services	✗
Services for which a Medicare benefit is NOT payable	✗

R *Restricted benefits*

✓ *Covered in private agreement hospitals and public hospitals*

✗ *Exclusion*

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

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.

Understanding Everyday Silver Plus Hospital

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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.

Excess options

An excess helps you reduce the cost of your Hospital cover. This Hospital cover gives you the choice of a $500 or $750 excess. An excess is an amount you pay towards the cost of your hospital admission before CBHS pays a benefit.

When you are admitted to hospital (same-day or overnight) you will pay the excess amount directly to the hospital. You only pay the excess once per person up to a maximum of twice per couple/family membership per calendar year. You won't need to pay an excess for dependants on your policy.

Ambulance

This Hospital cover includes 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
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.

Keep your non-student dependants covered

This product allows you to keep your non-student dependants under 31 years of age, on your cover, if they meet the non-student dependant criteria. An additional contribution amount will apply. More information is available at **cbhs.com.au.**

Understanding Everyday Silver Plus Hospital

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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 up to 100% of 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
- **Boarder accommodation** covers 100%, 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
- **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers
- **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 you're admitted into a non-agreement private hospital, benefits are payable only at the minimum rate specified by law. The benefit might be 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 drugs 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
- 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)

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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 emergency facility or doctor's rooms as a non-admitted patient. 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 if you have selected to pay an excess 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 on 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)*

Members Health FUND ALLIANCE

Private Health Insurance Code of Conduct

This product information sheet is current as at 1 November 2026 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.