FlexiSaver (Basic Plus)

An entry-level package with cover for emergencies like accidents and broken bones. Put your Extras benefits towards preventative and general dental, optical and physio.

Closed to new members and transfers as of 1 August 2024

CBHS
Health Cover for the CommBank Family

Hospital component

This policy includes cover for	
Emergency ambulance transport	✓
Accident related treatment^ and medical emergencies 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	R
Hospital psychiatric services	R
Palliative care	R
Pregnancy and birth	✗
Assisted reproductive services	✗
Joint replacements	✗
Weight loss surgery	✗
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.

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 below 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.

Excess payable: $500

An excess is a nominated amount you agree to pay upfront in respect to charges raised by a hospital for overnight or same day admission. The total excess is payable once per person per calendar year up to a maximum of twice for a Couple policy.

Ambulance

All packages include 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.

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.*

^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
Health Cover for the CommBank Family

What's covered?

- **Accommodation** for overnight, same day and intensive care covered for private or shared room in agreement private and public hospitals
- **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
- **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
- **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers

What's not covered?

- No benefits are payable for hospital or medical treatment and associated costs for exclusions
- If a member is admitted into a non-agreement private hospital for services covered by this product, 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
- Aids not covered in hospital agreement
- Services claimed over 24 months after the service date
- Services provided in countries outside of Australia
- Medical devices and human tissue products used for excluded services
- Ambulance transfers between hospitals (for residents in VIC, SA and NT).

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.

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)*

Understanding your Extras component

Extras cover#*	Waiting periods	Per service benefit	Overall limit	Benefit period
Description				
Preventative dental (e.g. oral examinations, x-ray, scale and clean, mouthguards)	2 months	55% of the cost of service	$700 (sublimit of $150 for optical)	calendar year
General dental (e.g. fillings, extractions or surgical dental)				
Optical (e.g. frames, prescription lens, contact lens)	6 months			
Physiotherapy	2 months			

 # 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.

**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?

Extras benefits for FlexiSaver (Basic Plus) are based on 55% of the cost the provider charges you up to any relevant sublimit with combined overall limit per calendar year. Below is one example of how the Extras benefits work, depending on the service fee the dentist charges.

- Dentist fee = $40
- 55% of service fee = $22
- Benefit payable = $22

Benefit period

Each group of services within Extras covers has an overall limit on the amount you can claim. The overall limits are based on per person per calendar year.

Want more cover?

Is the FlexiSaver (Basic Plus) package not quite right for you? We offer a range of Hospital and Extras covers to choose from. You can take them separately, or mix and match the perfect combination for your needs.

For more information, visit our website at cbhs.com.au or contact Member Services on 1300 654 123.

CBHS choice network

Dental Choice Network

The dental Choice Network is a group of dental service providers who have committed to reducing or removing the gap for **selected preventative dental** services that you would usually pay between the dentist's charges and the CBHS benefit. By choosing to use a dentist in the network you will have no out-of-pocket expenses for these selected services.

Optical Choice Network

By visiting an optical Choice Network provider, you may receive benefits up to 100% of the cost of services, **optical frames, lenses and contact lenses** up to the maximum per service and overall limits. These services may also be subject to known gaps, where you will know in advance the out-of-pocket expenses you may incur.

Manage your cover online

You can manage your membership online at **cbhs.com au**. Some of the services available to you:

- Update your personal details
- Check progress of a claim
- Check your Extras limits
- Submit a claim online
- View claims history and much more!