KickStart (Basic Plus)

An affordable package cover for the fit and healthy, because accidents do happen! Get covered for the things you may need like dental and optical, without the things you don't, like pregnancy.

Hospital component

EXAMPLE HOSPITAL PROCEDURES at participating private and public hospitals - accommodation, operating theatre, intensive care	
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	R
Ear, nose and throat	R
Kidney and bladder	R
Digestive system	R
Gastrointestinal endoscopy	R
Chemotherapy, radiotherapy and immunotherapy for cancer	R
Skin	R
Breast surgery (medically necessary)	R
Diabetes management (excluding insulin pumps)	R
Miscarriage and termination of pregnancy	R
Gynaecology	R
Male reproductive system	R
Eye (not cataracts)	R
Blood	R
Back, neck and spine	R
Implantation of hearing devices	R
Dialysis for chronic kidney failure	R
Insulin pumps	R
Pain management	R
Pain management with device	R
Sleep studies	R
Cataracts	R
Heart and vascular system	R
Lung and chest	R
Plastic and reconstructive surgery (medically necessary)	R
Rehabilitation	R
Hospital psychiatric services	R
Palliative care	R
Pregnancy and birth	R
Assisted reproductive services	R
Joint replacements	R
Weight loss surgery	R
Podiatric surgery (provided by a registered podiatric surgeon)	✗
Cosmetic services	✗
Services for which a Medicare benefit is NOT payable	✗

✓ Covered in private agreement hospitals and public hospitals.

R Restricted benefits.

Additional services covered above the minimum requirements.

✗ Exclusion (not 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.

^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).

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.

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.

Daily co-payment

A daily co-payment of $70 applies to KickStart (Basic Plus). This means that if you go 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.

Ambulance

KickStart (Basic Plus) 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?

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 WAITING PERIODS	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
Accidents***, 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.*

Understanding your hospital component

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 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, 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
- ✓ **Better Living Programs** information available at **cbhs.com.au/member-health/better-living-programs**
- ✓ **Hospital Substitute Treatment** information available at **cbhs.com.au/tools-and-support/Wellbeing-and-fitness/hospital-substitute-treatment**

What's not covered?

- ✗ No benefits are payable for hospital or medical treatment for excluded services
- ✗ 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
- ✗ 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)
- ✗ 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)
- ✗ MRI's when you are a non-admitted hospital patient
- ✗ 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 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 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.**

KickStart (Basic Plus) extras component	WAITING PERIODS	OVERALL LIMITS	BENEFIT PERIOD
DENTAL*			
Preventative Dental	2 months	Unlimited	calendar year
General Dental		$675	
Major Dental			
Periodontic (gum treatment)	6 months		calendar year
Endodontic (root canal treatment)			
OPTICAL			
Prescribed optical appliances	6 months	$230	calendar year
THERAPIES			
Physiotherapy	2 months	$250	calendar year
Chiropractic			
Osteopathy			
Clinical psychology		$250	
Dietitian		$100	
ALTERNATIVE THERAPIES			
Oriental therapies - *Acupressure, Acupuncture, Chinese Herbal Medicine Consultation, Chinese Massage, Traditional Chinese Medicine Consultation*	2 months	$200	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	$100	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)		$200	

** 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

Covered for a great range of extras

KickStart (Basic Plus) provides members a range of Extras limits suitable for the young and healthy. By selecting KickStart (Basic Plus), you are covered for common things like dental and optical and a range of therapies and general health benefits.

Benefit period

Each group of services within Extras and Package covers have an overall limit on the amount you can claim. 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).

How do my extras benefits work?

CBHS Extras benefits for KickStart (Basic Plus) are based on 100% of the cost the provider charges you, up to a maximum claimable amount (the set benefit per service) which is capped by an overall limit. See next page for detailed examples of maximum claimable amounts.

Waiting periods

EXTRAS WAITING PERIODS	CALENDAR MONTHS
Prescribed optical appliances, periodontics, endodontics	6 months
All other services	2 months

CBHS Wellness Benefits

CBHS Wellness Benefit is a program to assist members in managing their health and wellbeing. CBHS Wellness Benefit covers you for a variety of health checks and programs designed to assist you in better managing your health and wellbeing.

Health Checks^

CBHS provides with 90% of the cost of a variety of health checks (when the service is not eligible for a Medicare benefit) up to the annual limit depending on the level of cover (see below for limits). Health checks included are:

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

Health Management

A series of programs are available for eligible members who can receive a benefit of up to 90% of the cost up to the annual limit on these programs:

- ✓ Quit smoking programs[1]
- ✓ Weight management programs[1]
- ✓ Stress management courses[1]
- ✓ Gym membership[2]
- ✓ Personal training[2]

WELNESS BENEFITS	AMOUNT
Health Checks	$100
Health Management	$100
Gym Membership or Personal Training	$115 (sublimit $100 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 HEALTH | choice network

The CBHS Choice Network is a group of over 5,000 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**

Recognised providers

In addition to our choice network, we pay benefits for services provided by recognised providers in accordance with the CBHS Health Benefit Fund Rules and the applicable Government regulations. Various types of providers are deemed to be recognised providers based on the services which they offer.

For more information about this criteria, please visit **cbhs.com.au/tools-and-support/find-a-provider/recognised-providers**

#	ITEM DESCRIPTION	
	Maximum claimable amounts CBHS pays this percent of the total cost up to the maximum claimable amount per service and up to the overall limit in each benefit period.	100%
DENTAL		
Preventative dental		
011	Examination	$40
022	X-ray	$23
114	Removal of calculus - first visit	$55
121	Fluoride	$20
General dental		
322	Surgical removal of a tooth	$167
323	Surgical removal of a tooth (including bone)	$185
324	Surgical removal of a tooth (including bone and tooth division)	$200
531	Adhesive restoration (filling), 1 surface posterior tooth	$75
532	Adhesive restoration (filling), 2 surfaces posterior tooth	$100
533	Adhesive restoration (filling), 3 surfaces posterior tooth	$110
Major dental		
222	Root planing - per tooth	$24
415	Complete chemo mechanical preparation of root canal - one canal	$110
416	Complete chemo mechanical preparation of root canal - each additional canal	$55
417	Root canal obturation - one canal	$105
418	Root canal obturation - each additional canal	$50
OPTICAL		
110	Frames	100% of cost for one complete optical appliance up to the annual limit
212	Single vision lens pair	
312	Bifocal lens pair	
412	Trifocal lens pair	
512	Multifocal lens pair	
852	Contact lenses	
THERAPIES		
	Physiotherapy (initial/subsequent)	$40 / $30
	Chiropractic (initial/subsequent)	$40 / $40
	Osteopathy (initial/subsequent)	$40 / $30
	Clinical psychology (initial/subsequent)	$50 / $50
	Dietitian (initial/subsequent)	$75 / $42
ALTERNATIVE THERAPIES		
	Oriental therapies - *Acupressure, Acupuncture, Chinese Herbal Medicine Consultation, Chinese Massage, Traditional Chinese Medicine Consultation*	$26
	Massage therapies - *Deep Tissue Massage, Lymphatic Drainage, Myotherapy, Remedial Massage, Sports Massage, Swedish Massage, Therapeutic Massage*	$26
GENERAL HEALTH		
	Blood glucose accessories	70%
	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)	$75

This information must be read in conjunction with your CBHS Health Benefit Fund Rules, available at cbhs.com.au. Please read carefully and retain for future reference.