we're **family**

KickStart

An affordable package cover for the young, 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.

KickStart hospital component

what's covered?

✔ **Private or Public Hospital accommodation & services** includes overnight, same day, intensive care* and theatre fees. Cover is provided for a private or shared room in a private (agreement) or public hospital for the following services:

- accidents and medical emergencies;
- the investigation, repair or reconstruction of bones and tissues of a knee, hip or shoulder; and
- the removal of wisdom teeth, tonsils, adenoids or the appendix

All other services in any hospital are eligible for restricted benefits. Restricted benefits are payable only at the minimum rate specified by law and may only provide a benefit similar to a public hospital shared room rate.

Restricted benefits may not be sufficient to cover admissions in a private hospital.

**Theatre and labour ward fees are not charged in a public hospital*

✔ **Medical expenses related to providers** for services while admitted in hospital e.g. fees from doctors, surgeons anaesthetists, pathology, imaging etc. Covered for all services eligible for benefits from Medicare up to Medicare Benefits Schedule (MBS) Fee. Members have their **choice of doctor/ surgeon** in a public or 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, pathologists, 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 an agreement private hospital

✔ **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers

what's not covered?

✘ 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

✘ 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

daily co-payment

A daily co-payment of $70 applies to KickStart. This means that if you go into hospital you will pay $70 for every day that you are there, up to a maximum of 6 days per person or 12 days per couple in a calendar year. So, if you are admitted to hospital for two days, you will pay a co-payment of $140.

waiting periods

hospital waiting periods	calendar months
Pre-existing condition	12 months
All other treatments	2 months
Accidents^, injuries and emergencies Emergency ambulance transport	1 day

^Accident means an injury inflicted as a result of unintentional, unexpected actions or events that require treatment by a medical practitioner, but excludes pregnancy.

we're family

understanding your KickStart hospital cover

what are pre-existing conditions and why are they important?

If a member has 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.

A pre-existing condition is an ailment or illness for which the signs or symptoms were evident up to 6 months before a 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 – that doctor, however, will have regard to any information provided by the member's doctor.

Members must also wait for 12 months to be covered for pre-existing conditions where they upgrade their cover.

emergency ambulance

All package covers include 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 (such as Royal Flying Doctor Service).

Residents of QLD and TAS are the only states covered under their state based ambulance schemes.

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 fees, intensive and coronary 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 our Member Care Centre 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/doctors consultations.

hospital claims

Hospitals will bill CBHS directly. If you are required to contribute to your admission (for example a co-payment or are admitted for a restricted 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 MBS fee, while Medicare pays the other 75%. If charges are more than the MBS fee, then a gap payment arises.

medicare benefits schedule fee	
75% covered by Medicare	up to 25% covered by CBHS

Services that do not attract a benefit from Medicare will be subject to restricted benefits only. 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 extras component

description	100% of the cost up to the per service benefit below	overall limits	benefit period
dental*			
preventative dental *(2 month waiting period)*			
Oral examinations (011,012,013)	$23-$40	unlimited	calendar year
X-ray (022)	$23		
Removal of plaque (111)	$30		
Removal of calculus (114,115)	$42-$47		
Fluoride application (121)	$18.50		
Mouthguard (151,153)	$62-$65		
Fissure sealing (161)	$23		
general dental *(2 month waiting period)*			
Fillings	$49-$115	$675	calendar year
Consultations and examinations	$28.50-$35.50		
X-rays	$20-$36.50		
Extractions or surgical dental	$50-$180		
major dental *(6 month waiting period)*			
Periodontic (gum treatment)	$24-$190		calendar year
Endodontic (root canal treatment)	$35-$180		
prescribed optical appliances* *(6 month waiting period)*			
Frames	1 complete optical appliance	$230	calendar year
Lenses			
Contacts			
therapies* *(2 month waiting period)*			
Physiotherapy (initial/subsequent)	$40/$30	$250	calendar year
Chiropractic (initial/subsequent)	$40/$30		
Osteopathy (initial/subsequent)	$40/$30		
Clinical psychology	$50	$250	
Dietician	$15-$75	$100	
alternative therapies* *(2 month waiting period)*			
Natural therapies Buteyko, Herbal Medicine Consultations, Homeopathy, Naturopathy, Nutrition	$26	$200	calendar year
Oriental therapies Acupressure, Acupuncture, Chinese Herbal Medicine Consultation, Chinese Massage, Kinesiology, Reflexology, Shiatsu, Traditional Chinese Medicine Consultation			
Massage therapies Alexander Technique, Aromatherapy, Bowen Therapy, Deep Tissue Massage, Feldenkrais, Lymphatic Drainage, Myotherapy, Remedial Massage, Rolfing, Sports Massage, Swedish Massage, Therapeutic Massage			
general health* *(2 month waiting period)*			
Blood glucose accessories	100%	$100	calendar year
Non-pharmaceutical benefits scheme drugs requiring a prescription by law	100% less the current government prescribed PBS co-payment up to $150 per prescription	$200	calendar year

** A Benefit is not payable in respect of a service that was rendered to a Member if the services can be claimable from any other source.*

wellness benefit

CBHS Wellness Benefits cover you for a variety of health checks and programs designed to assist you in better managing your health and wellbeing.

wellness benefits *(2 month waiting period)*	Benefits are 90% of the cost up to maximum category limit	
	overall limit	benefit period
health checks*		
Breast examinations (e.g. mammograms/x-rays)	$100	calendar year
Bone density tests		
Skin cancer screening		
Bowel/prostate cancer screening		
Eye Screenings		
health management*		
Quit smoking programs[2]	$100	calendar year
Weight management programs[2]		
Stress management courses[2]		
Yoga[1]		
Pilates[1]		
Gym membership/personal training[1]	$115/$100	calendar year

[1] *CBHS can only pay a benefit for gym membership/personal trainer/pilates/yoga where the gym/personal trainer/yoga/pilates service is provided as part of a health management program, certified by your GP or a recognised provider confirming that the gym/personal trainer/yoga/pilates program is a health management program. Approval form is available from CBHS. Please note that GP consultations are not covered by CBHS.*

[2] *Must be approved by CBHS.*

** A Benefit is not payable in respect of a service that was rendered to a Member if the services can be claimable from any other source.*

understanding your KickStart extras cover

how do my extras benefits work?

CBHS Extras benefits for KickStart are based on 100% of the cost the provider charges you (with the exception of our Wellness Benefits which are 90% of the cost the provider charges you), up to a set benefit per service which is capped by an overall limit.

Below is one example of how the Extras benefits work, depending on the service fee the dentist charges.

- Dentist fee = $40
- 100% of service fee = $40, however the service limit is ($28.50)
- Benefit payable = $28.50

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 3 and 5 year period are entitled to have the benefit renewed on the same date which the service was performed respectively.

waiting periods

extras waiting periods	calendar months
Prescribed optical appliances, periodontics, endodontics.	6 months
All other services	2 months

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 of 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 what out-of pocket expenses you may incur.

manage your cover online

You can manage your membership online, visit our website at **cbhs.com.au**

Some of the services available to you are:

- Update your personal details
- Check progress of a claim
- Check your extras limits
- Submit a claim online

View claims history and much more!

want more cover?

Alternatively, if you don't think that KickStart is quite right for you, we offer a range of Hospital, Extras and Ambulance Covers which can be taken out separately or combined to create your own package of health cover.

For more information visit our website at **cbhs.com.au** or contact our Member Care Centre on **1300 654 123**.

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.

v1_01/14

Private Health Insurance Code of Conduct