basic hospital

A basic level of hospital cover designed for those who just want the basics. It is designed for those who want the option of choosing their own doctor and receiving treatment as a private patient in a shared room in a public hospital.

what's covered

- ✔ **Accommodation** for overnight, same day and intensive care for a shared room as a private patient in a public hospital. We will also pay an amount for accommodation in a private hospital or private room of a public hospital – this amount will be the minimum amount specified by applicable legislation
- ✔ **Theatre fees and labour ward fees** are not raised in a public hospital
- ✔ **Medical expenses related to providers** for services while admitted in hospital e.g. fees from doctors, surgeons, anaesthetists, radiologists, pathology, imaging etc. 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** 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 prosthesis** to at least the minimum benefit specified in the prosthesis list issued under Private Health Insurance legislation
- ✔ **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers
- ✔ **Chronic Disease Management Programs** information available under the membership/services and benefits tab at **www.cbhs.com.au**
- ✔ **Hospital Substitute Treatment** information available under the membership/services and benefits tab at **www.cbhs.com.au**

limited cover for private hospital accommodation

If a member is admitted to a private hospital under Basic Hospital cover members may only receive benefits similar to a public hospital shared room rate which can result in substantial out-of-pocket expenses.

Basic Hospital Cover is not sufficient for private hospital treatment as you may incur significant out-of-pocket expenses.

what's not covered?

- ✘ If member is admitted into an agreement or non-agreement private hospital, benefits are payable only at the minimum rate specified by law – accordingly substantial out of pocket expenses can be incurred.
- ✘ Hospital services received within policy waiting periods
- ✘ Nursing home type patient contribution, respite care or nursing home fees
- ✘ High cost, experimental or non TGA approved drugs
- ✘ Take home/discharge drugs (non-PBS may be eligible for benefits from CBHS Extras cover)
- ✘ Treatments where no Medicare benefits are available
- ✘ Aids not covered in hospital agreement (may be eligible for benefits from CBHS 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
- ✘ Labour ward fees in an agreement and non agreement private hospital
- ✘ Fees raised by public hospitals that exceed Minimum Default Benefits set by the Department of Health and Ageing for shared room accommodation

hospital waiting periods	calendar months
Pre-existing condition, pregnancy and related services	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 an unintentional, unexpected action or event that requires treatment by a medical practitioner, but excludes pregnancy.

Excesses

You can reduce the cost of your Basic Hospital cover by agreeing to pay an excess of $500. This means that when you go into hospital you will pay the first $500 in respect to charges raised by a hospital. This excess is per person up to a maximum of $1000 per family membership per calendar year.

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 hospital policies cover 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.

**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 the service and to check if any waiting periods apply
- Obtain a quote from your treating doctor/surgeon

claiming your benefits

non-admitted medical services

Claims for medical services provided in a hospital, day surgery, 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 x-rays (radiology), 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 you have selected to pay a co-payment or have restricted cover) 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 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 will 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 for admitted hospital medical services

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 direct. 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.**

adding your 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.

family cover	singles cover
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 cover **within two calendar months of the birth.**

This upgrade must take effect from the date your baby was born.

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.

Private Health Insurance Code of Conduct
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