Prestige

Prestige is CBHS' premium level of cover, offering an extensive range of hospital services and generous extras benefits to help you get the most out of life.

Prestige hospital component

what's covered?

- ✔ **Accommodation** for overnight, same day and intensive care covered 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, radiologists, 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, pathology, imaging fees etc)
- ✔ **Surgically implanted prostheses** to at least the minimum benefit specified in the prostheses list 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
- ✔ **Emergency ambulance transport** for an accident or medical emergency by approved ambulance providers
- ✔ **Hospital Services** where a Medicare benefit is payable (excluding restricted services*)
- ✔ **Chronic Disease Management Programs** information available under the membership/services and benefits tab at **cbhs.com.au**
- ✔ **Hospital Substitute treatment** information available under the membership/services and benefits tab at **cbhs.com.au**

gap assist#

To further help you reduce your out-of-pocket expenses as a result of hospitalisation, Prestige also includes a medical gap benefit called Gap Assist, $200 per person per calendar year towards out-of-pocket expenses.

#All hospital services provided in a public hospital are eligible for Minimum Default Benefits. These benefits are stipulated by the Department of Health and Ageing and listed in the relevant Private Health Insurance (Benefit Requirement) Rules. Some public hospitals may charge above the Minimum Default Benefit for shared room accommodation. Please note that fees charged in excess of Minimum Default Benefits are an out-of-pocket expense and are not eligible for reimbursement under CBHS policies.

what's not covered?

- ✘ If a member is admitted into a non-agreement private hospital, 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 (non-PBS drugs may be eligible for benefits from your Extras cover)
- ✘ Aids not covered in hospital agreement (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
- ✘ Fees raised by public hospitals that exceed Minimum Default Benefits set by the Department of Health and Ageing for shared room accommodation

*restricted benefits (services) not fully covered

The services listed below, 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 fees together with the difference between the Minimum Default Benefit and the bed charge raised by the hospital.

The services listed below are also eligible for hospital benefits in a public hospital at a shared room rate. Public hospitals do not raise charges for theatre use.

- ▶ cosmetic surgery
- ▶ podiatry surgery
- ▶ laser eye surgery
- ▶ other services for which a Medicare benefit is not payable

waiting periods

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

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

understanding Prestige 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

Prestige includes 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 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/doctors consultations.

hospital claims

Hospitals will bill CBHS directly. If you are required to contribute to your admission (for example a co-payment or 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 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 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.

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.**

option to keep a non-student dependant on your cover

CBHS Prestige allows you to keep a non-student dependant up to the age of 25 on your cover, providing they meet the non-student dependent criteria, available at cbhs.com.au.

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.

Access to Best Doctors®

For over 20 years Best Doctors® has provided access to leading medical minds from around the world so you can be sure you have the right diagnosis and treatment plan. Today, their network consists of more than 53,000 experts in over 450 specialities and subspecialities. For more information please visit **cbhs.com.au/bestdoctors**

Prestige extras component

description	70% 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)	$35-$45	unlimited	calendar year
X-ray (022)	$28		
Removal of plaque (111)	$41		
Removal of calculus (114,115)	$65-$70		
Fluoride application (121)	$30		
Mouthguard (151,153)	$130-$150		
Fissure sealing (161)	$27		
general dental *(2 month waiting period)*			
Fillings	$61-$140	unlimited	calendar year
Consultations and examinations	$28-$40		
X-rays	$21-$42.80		
Extractions or surgical dental	$50-$255		
major dental *(6 month waiting period)*			
Periodontic (gum treatment)	$24-$260	$700	calendar year
Endodontic (root canal treatment)	$7.50-$180	$700	
Inlays/onlays/facings/veneers	$360	$1440	any 5 years
Dentures and implants	$20-$810	$1500	
Occlusal therapy	$17-$260	$920	lifetime
major dental *(12 month waiting period)*			
Orthodontia	70%	$3200	lifetime
Crowns and bridges	$10-$720	$3500	any 5 years
prescribed optical appliances* *(6 month waiting period)*			
frames			
Frames	$140	$450	calendar year
lenses			
Single vision (pair) (212)	$130		
Bifocal (pair) (312)	$140		
Trifocal vision (pair) (412)	$150		
Multifocal (pair) (512)	$210		
contact lenses			
Contact lenses (852)	$220		
therapies* *(2 month waiting period)*			
Physiotherapy (initial/subsequent)	$61/$43	$900	calendar year
Chiropractic (initial/subsequent)	$61/$40	$1000	
Osteopathy (initial/subsequent)	$61/$35		
Hypnotherapy	$80	$360	
Occupational therapy	$61/$35	$800	
Speech therapy (initial/subsequent)	$95/$46	$1850	
Clinical psychology	$30-$140	$500	
Ante natal/post natal physiotherapy	70%	$105	
Podiatry (excl. artificial aids: e.g. orthotics)	$30-$50	$400	
Audiology	$60	$360	
Eye therapy	$60	$455	
Dietician	$15-$75	$360	
alternative therapies* *(2 month waiting period)*			
Natural therapies Buteyko, Herbal Medicine Consultations, Homeopathy, Naturopathy, Nutrition	$33	$1000	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			

description	70% of the cost up to the per service benefit below	overall limits	benefit period
general health* (2 month waiting period)			
Blood glucose accessories	70%	$320	calendar year
Home visits by registered nurse	$120 (>4 hrs) $80 (<4 hrs)	$2800	
Non-pharmaceutical benefits scheme drugs requiring a prescription by law	100% less the current government prescribed PBS co-payment up to $150 per prescription	$1000	calendar year
Travel and accommodation+	50% of the cost for accommodation (on single room rate), airfare, train, bus or 15c per kilometre car.	$500	per membership per calendar year
health care aids (12 month waiting period) – referred by a doctor and recognised by CBHS			
Artificial aids	$10-$1500	$1500	any 3 years
Hearing aids	70%	$2200	
Blood pressure monitor, nebuliser, glucometer	70%	$500	

+Travel is only payable for a patient who requires essential medical and dental treatment, where it is not available at a facility within a 160km round trip of the member's home. In order to claim travel a patient must be visiting a specialist and will require a referral letter. Excludes Ronald McDonald house

** 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.*

CBHS wellnessbenefit

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)	$300	calendar year
Bone density tests		
Skin cancer screening		
Bowel/prostate cancer screening		
Eye screenings		
health management*		
Quit smoking programs[2]	$200	calendar year
Weight management programs[2]		
Stress management courses[2]		
Yoga[1]		
Pilates[1]		
Gym membership/personal training[1]	$230 ($200 sub limit on personal training)	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 website. 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 Prestige extras cover

how do my extras benefits work?

CBHS Extras benefits for Prestige are based on 70% of the cost the provider charges you (with the exception of our Wellness Benefits whichare 90%) of the cost the provider charges you, up to a set benefit per service which is capped by an overall limit.

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.

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).

waiting periods

extras waiting periods	calendar months
Crowns and bridges, orthodontia, artificial aids, healthcare appliances, oxygen apparatus and hearing aids	12 months
Prescribed optical appliances, periodontics, endodontics, inlays, onlays, facings, dentures and implants	6 months
All other services	2 months

CBHS choicenetwork

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% (rather than a benefit of 70% of the cost of the service from a non-Choice Network provider) 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.