

Premium Package (Gold)

Premium Package (Gold) is CBHS Corporate Health's premium level of cover, offering an extensive range of Hospital services and generous Extras benefits to help you get the most out of life.

Hospital component

This policy includes cover for:	
Emergency ambulance transport	✓
Accident related treatment [^] 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	✓
Hospital psychiatric services	✓
Palliative care	✓
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	✗

- ✓ Covered in private agreement hospitals and public hospitals.
- Additional services covered above the minimum requirements.
- ✗ Exclusion (not covered).
- Indicates benefits for accommodation at Minimum Benefits in relevant PHI (Benefit Requirements) Rules and medical device and human tissue product benefits based on items listed by the Minister of Health. No benefit for medical or theatre costs.

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 Corporate Health to see if you are covered before receiving treatment.

Gap Assist

A unique benefit of Premium Package (Gold) is a medical gap benefit called 'Gap Assist', assistance to help you further reduce your out-of-pocket expenses as a result of hospitalisation. This assistance provides \$200 per person per calendar year towards out-of-pocket expenses.

Access to a second opinion provider

Your cover includes a telehealth second opinion service from some of the best medical minds in Australia and further afield. Covers most illnesses, injuries or diseases and offers alternative treatment options your own doctor might not have considered. A second opinion can also provide peace of mind the original recommendations are the best for you. For more information please contact us.

Ambulance

Premium Package (Gold) 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 Corporate Health (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 Corporate Health appointed doctor that determines whether the signs or symptoms were in existence in the six-month period. However, when making the determination, CBHS Corporate Health's 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 SERVICES	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

[^]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).

^{***} 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.

[~]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.

Keep your non-student dependants covered

This product provides an option to keep your non-student dependants under 31 years of age, on your cover, providing they meet the non-student dependant criteria. An additional contribution amount will apply. More information is available at cbhscorporatehealth.com.au.

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 Corporate Health 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 Corporate Health 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 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 100%, 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
- ✓ **Hospital services** where a Medicare benefit is payable (for included services only). It's essential to check the MBS item number prior to your procedure, to confirm if the treatment falls under a category which is included in your policy.

What's not covered?

- ✗ No benefits are payable for hospital or medical treatment for exclusions
- ✗ If 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 may be eligible for benefits from Extras cover)
- ✗ Aids not covered in hospital agreement (may be eligible for benefits from Extras cover)
- ✗ Services claimed over 24 months after the service date
- ✗ Services provided in countries outside of Australia
- ✗ Medical devices and human tissue products used for cosmetic procedures, where a Medicare benefit is not payable
- ✗ Ambulance transfers between hospitals (for residents in VIC, SA and NT)

Adding a new baby to your membership

When notifying CBHS Corporate Health 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 Corporate Health 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**. 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 Corporate Health
- Obtain a quote from your treating doctor/surgeon

Access to private hospital

CBHS Corporate Health 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 Corporate Health, you reduce, if not eliminate, out-of-pocket expenses for hospital fees.

To check if your hospital holds an agreement, visit our website at cbhscorporatehealth.com.au or contact Member Care on **1300 586 462**.

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 Corporate Health 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 Corporate Health

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 claims form in order for Medicare to forward your claim to CBHS Corporate Health 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 Corporate Health on your behalf (including the Medicare benefit)
- No more Medicare queues

Go to cbhscorporatehealth.com.au or more information on Access Gap Cover or to search for Access Gap Cover participating doctors.

Doctors using Access Gap Cover will usually bill CBHS Corporate Health directly. CBHS Corporate Health 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 Corporate Health, 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.**

Premium Package (Gold) Extras component

	WAITING PERIODS	OVERALL LIMITS	BENEFIT PERIODS
DENTAL			
Preventative dental	2 months	Unlimited	Calendar year
General dental	2 months	Unlimited	Calendar year
Major dental			
Periodontic (gum treatment)	12 months	\$700	Calendar year
Endodontic (root canal treatment)		\$700	
Inlays/onlays/facings/veneers		\$1,440	Any 5 years
Dentures and implants		\$1,500	
Occlusal therapy		\$920	Lifetime
Crowns and bridges		\$3,500	Any 5 years
Orthodontia		\$3,200	Lifetime
OPTICAL			
Prescribed optical appliances	6 months	\$450	Calendar year
THERAPIES			
Physiotherapy	2 months	\$900	Calendar year
Chiropractic		\$1,000	
Osteopathy		\$800	
Occupational therapy		\$1,850	
Speech therapy		\$500	
Clinical psychology		\$105	
Ante natal/post natal physiotherapy		\$360	
Hypnotherapy		\$400	
Podiatry (excl. artificial aids: e.g. orthotics, which are covered under artificial aids)		\$360	
Audiology		\$455	
Eye therapy		\$360	
Dietitian		\$360	
Exercise physiology		\$360	
ALTERNATIVE THERAPIES			
Oriental therapies - Acupressure, acupuncture, Chinese herbal medicine consultation, Chinese massage, traditional Chinese medicine consultation	2 months	\$1,000	Calendar year
Massage therapies - Deep tissue massage, lymphatic drainage, myotherapy, remedial massage, sports massage			
GENERAL HEALTH			
Blood glucose accessories	2 months	\$320	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)		\$1,000	
HEALTH CARE AIDS (referred by a doctor and recognised by CBHS Corporate Health)			
Artificial aids	12 months	\$1,500	Any 3 years
Hearing aids		\$2,200	
Blood pressure monitor, nebuliser, glucometer		\$500	

Understanding your Extras component

Highest level of Extras cover

Premium Package (Gold) provides members with the highest level of Extras limits and benefits of all of our cover types. By selecting Premium Package (Gold), we cover you when you need us most for a long list of Extras and additional benefits.

Benefit period

Each group of services within Extras and Packaged 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 Corporate Health (irrespective of any suspension of membership or other period without cover).

How do my Extras benefits work?

CBHS Corporate Health Extras benefits for Premium Package (Gold) are based on 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.

Extras waiting periods

EXTRAS SERVICES	CALENDAR MONTHS
Periodontics, endodontics, inlays, onlays, facings, veneers, occlusal therapy, dentures, implants, crowns, bridges, orthodontia, artificial aids, healthcare appliances and hearing aids	12 months
Prescribed optical appliances	6 months
All other services	2 months

CBHS Corporate Health wellness benefits

CBHS Corporate Health wellness benefits cover you for a variety of health checks and programs designed to help you better manage your health and wellbeing.

Health checks[^]

CBHS Corporate Health pays benefits towards a variety of health checks (when the service is not eligible for a Medicare benefit) up to the overall limit. Health checks included are:

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

Health management

Eligible members can take advantage of a series of programs, with benefits up to your overall health management limit.

- ✓ Quit smoking programs¹
- ✓ Weight management programs¹
- ✓ Stress management courses¹
- ✓ Gym membership²
- ✓ Personal training²

WELLNESS BENEFIT	OVERALL LIMIT
Health checks	\$300
Health management	\$200
Gym membership or personal training	\$230 (submit \$200 for personal training)

[^]CBHS Corporate Health 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 Corporate Health

2. CBHS Corporate Health 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 Corporate Health website. Please note that GP consultations are not covered by CBHS Corporate Health.

* CBHS Corporate Health 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.



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 Corporate Health 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 receive benefits of 100% of the cost for all optical **frames, lenses and contact lenses** from a selected range, 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.

Home visits by registered nurse

A benefit is paid where an in home visit is required by a registered nurse, CBHS Corporate Health will pay a benefit of the cost up to \$80 for less than four hours and up to \$120 for more than four hours. An annual benefit limit applies of \$2,800 per person.

Travel and accommodation

Another exclusive benefit for our Premium Package (Gold) members to help offset the cost of traveling long distances to medical appointments. Eligible members can receive a benefit of the cost for accommodation (single room rate), airfare, train, bus or 15c per kilometre for car travel up to the annual limit of \$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.

Examples of services and maximum claimable amount		
CBHS Corporate Health pays the total cost up to the maximum claimable amount per service and up to the overall limit in each benefit period.		
#	Item description	
DENTAL		
Preventative dental		
011	Examination	\$45
022	X-ray	\$28
114	Removal of calculus - first visit	\$68
121	Fluoride	\$27
General dental		
322	Surgical removal of a tooth	\$182
324	Surgical removal of a tooth (including bone and tooth division)	\$250
531	Adhesive restoration (filling), 1 surface posterior tooth	\$90
532	Adhesive restoration (filling), 2 surfaces posterior tooth	\$110
533	Adhesive restoration (filling), 3 surfaces posterior tooth	\$135
Major dental		
222	Root planing - per tooth	\$30
415	Complete chemo mechanical preparation of root canal - one canal	\$136
416	Complete chemo mechanical preparation of root canal - each additional canal	\$85
417	Root canal obturation - one canal	\$157
418	Root canal obturation - each additional canal	\$65
526	Veneer - direct	\$260
556	Veneer - indirect	\$600
615	Full crown - non metallic - indirect	\$750
642	Bridge - direct - per pontic	\$380
643	Bridge - indirect - per pontic	\$680
711	Complete maxillary denture	\$480
712	Complete mandibular denture	\$500
719	Complete maxillary and mandibular denture	\$750
811	Passive removable appliance - per arch	\$3,200
843	Maxillary expansion appliance	\$3,200
881	Complete course of orthodontic treatment	\$3,200
965	Occlusal splint	\$260
OPTICAL		
110	Frames	\$140
212	Single vision lens pair	\$130
312	Bifocal lens pair	\$140
412	Trifocal lens pair	\$150
512	Multifocal lens pair	\$210
852	Contact lenses	\$220
THERAPIES		
	Physiotherapy (initial/subsequent)	\$61 / \$43
	Chiropractic (initial/subsequent)	\$61 / \$40
	Osteopathy (initial/subsequent)	\$61 / \$35
	Occupational therapy (initial/subsequent)	\$61 / \$35
	Speech therapy (initial/subsequent)	\$95 / \$46
	Clinical psychology (initial/subsequent)	\$140 / \$80
	Ante natal/post natal physiotherapy	100%
	Hypnotherapy	\$80
	Podiatry (excl. artificial aids: e.g. orthotics, which are covered under artificial aids) (standard consult)	\$35
	Audiology	\$60
	Eye therapy	\$60
	Dietitian (initial/subsequent)	\$75 / \$42
	Exercise physiology (initial/subsequent)	\$35 / \$35
ALTERNATIVE THERAPIES		
	Oriental therapies - Acupressure, acupuncture, Chinese herbal medicine consultation, Chinese massage, traditional Chinese medicine consultation	\$33
	Massage therapies - Deep tissue massage, lymphatic drainage, myotherapy, remedial massage, sports massage	\$33
GENERAL HEALTH		
	Blood glucose accessories	100%
	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)	\$150
HEALTH CARE AIDS (referred by a doctor and recognised by CBHS Corporate Health)		
	Artificial aids	\$12 - \$1,500
	Hearing aids	100%
	Blood pressure monitor, nebuliser, glucometer	100%

This product information sheet is current as at 1 June 2025 and provides general information and guidance about the policy and is intended as a summary only. This information should be read in conjunction with the CBHS Corporate Health Benefit Fund Rules and is subject to change from time to time.

