PRODUCT SHEET

CBHS INTERNATIONAL HEALTH

OVERSEAS WORKER

BASE HOSPITAL POLICY

The CBHS International Health Overseas Worker Base Hospital policy offers basic, affordable, visa-compliant cover for in-hospital services and treatments, as well as emergency ambulance.

This policy does not cover any hospital outpatient services where you have not been admitted to hospital, or any out-of-hospital medical services. It does, however, cover emergency department facility fees where attendance leads to admission into hospital.

FEATURES

24/7 HELPLINE

1300 174 537 for medical, interpreter and personal assistance*

WHAT'S COVERED?

ACCIDENT AND EMERGENCY AMBULANCE SERVICES

• Accident and emergency ambulance services when transported directly to a hospital or treated at the scene due to an accident or medical emergency.

	EMERGENCY SERVICES	WAITING PERIODS
✔	Accident and emergency ambulance services	1 day

Non-emergency ambulance services are not covered.

HOSPITAL EMERGENCY DEPARTMENT FACILITY FEES

• For non-emergency treatment at a hospital you may be charged a facility fee, however where you are not admitted or an exclusion applies, no benefit is payable. This means there will be substantial out-of-pocket costs.

• For emergency treatment at a hospital where you are admitted, you may be charged a facility fee. This is covered in full where it leads to an admission into public hospital (or up to $160 if admitted into a private hospital), except where an exclusion applies. No benefit payable where an exclusion applies.

IN-HOSPITAL SERVICES

When you're admitted to hospital, the types of benefits we may pay include:

- **ACCOMMODATION** for overnight and same-day in a private or shared room in agreement private hospitals is covered at the agreed rate except benefits for restricted services which are reduced to Minimum Benefits. For non agreement private hospitals, Minimum Benefits are payable. For public hospitals, benefits are paid at Gazetted Rates. No benefits are payable where an exclusion applies. An excess of $500 (see page 4) will apply.

- **BOARDER ACCOMMODATION** covers 100%, up to $160 per admission, if not included in hospital agreement.

- **THEATRE FEES** are covered in agreement private hospitals and public hospitals, except for restricted services or services where an exclusion applies. Benefits for a restricted service at an agreement private hospital are not covered, and at public hospitals are paid at Gazetted Rates. Theatre fee benefits at a non-agreement private hospital are not covered.

- **SUPPLIED PHARMACEUTICALS** listed on the Pharmaceutical Benefits Scheme (PBS) Schedule and provided as part of your in-hospital medical care.

- **MEDICAL EXPENSES** for services provided by doctors, surgeons, specialist doctors, anaesthetists, and relevant health professionals while admitted in hospital. Covered for all services eligible for benefits from Medicare up to 100% of the Medicare Benefits Schedule (MBS) Fee. No benefits are payable where an exclusion applies.

Check with your doctor or specialist what they will charge, and contact us to confirm what you are covered for, before your procedure, day surgery or hospital admission.

For more information about which types of hospital services are covered, please read the CBHS International Health Rules available at cbhsinternationalhealth.com.au

WHAT'S COVERED?

	IN-HOSPITAL SERVICES	WAITING PERIODS	IMPORTANT INFORMATION
✓	Accident and emergency ambulance services	1 day	
✓	Hospital accommodation	Waiting periods apply as noted below	Refer to page 4
✓	Boarder accommodation	Waiting periods apply as noted below	Up to $160 per admission, if not included in hospital agreement
✓	Hospital treatment (inpatient) - doctors, surgeons, specialist doctors, anaesthetists, relevant health professionals and medicine	2 months (except for pre-existing conditions and pregnancy which have a 12 month waiting period)	Up to 100% of the Medicare Benefits Schedule (MBS) Fee. See CBHS International Health - Overseas Visitor Fund Rules for complete information.
✓	Theatre fees	Waiting periods apply as noted below	Refer to page 2
✓	Pathology (e.g. blood tests) and radiology (e.g. x-rays)	2 months (except for pre-existing conditions and pregnancy which have a 12 month waiting period)	Up to 100% of the MBS Fee.
✓	Hospital emergency department facility fee for attendance that leads to an admission into hospital	Waiting periods apply as noted below	• 100% of the Gazetted Rate for public hospitals • Up to $160 for private hospitals
✗	Hospital emergency department facility fee for attendance that does not lead to an admission		Not covered
✓	Pre-existing conditions (except hospital psychiatric, rehabilitation and palliative care)	12 months	
✓	All other treatments	2 months	
R	Weight loss surgery	Weight loss surgery is considered a pre-existing condition	
R	Rehabilitation (including pre-existing conditions)	2 months	
R	Hospital psychiatric services (including pre-existing conditions)	2 months	
R	Palliative care (including pre-existing conditions)	2 months	
R	Pregnancy and birth-related services	12 months	Contact us as soon as you know you are pregnant
✗	Assisted reproductive services including but not limited to in-vitro fertilisation, sterilisations and reversals		
✗	Elective cosmetic services or laser eye surgery		
✗	Medicines not on the Pharmaceutical Benefits Scheme (PBS) Schedule and experimental or high-cost drugs		
✗	Non-admitted psychiatric and psychology services		
✗	Transplants of stem cells, bone marrow and an organ		
✗	Other services for which a Medicare benefit is not payable, e.g. laser eye surgery or podiatric surgery		

Legend

- ✓ Covered (Included service)
- ✗ Not Covered (Excluded service)
- **R** Restricted benefits

WHAT'S NOT COVERED?

EXCLUDED SERVICE

For a treatment listed as an "excluded service", there is no benefit payable, so you may have high out-of-pocket costs to pay. Please review the excluded services on your cover and always check with CBHS International Health to see if you are covered before receiving treatment.

HOSPITAL EXCESS PAYABLE: $500

This policy has an excess amount of $500. This means when you are admitted to hospital, you will need to pay the first $500 of the fees charged by the hospital. This excess is per person (including dependants), per admission, up to a maximum of $500 for Single membership and $1,000 for Couple, Sole Parent Family and Family memberships per calendar year. The excess applies to both same-day and overnight stays.

RESTRICTED BENEFITS

Services for restricted benefits are paid at different rates compared to services with non-restricted benefits.

Benefits for theatre, intensive care and labour ward fees are not payable.

RESTRICTED BENEFITS - HOSPITAL ACCOMMODATION

Public hospital

If you are admitted to a public hospital, benefits are paid at Gazetted Rates, except where an exclusion applies. No benefit is payable where an exclusion applies.

Agreement private hospital

If you are admitted to a private hospital that has an agreement with CBHS International Health, benefits are paid at the agreed rate, except where restricted benefits or an exclusion applies. Services for restricted benefits at an agreement private hospital are restricted to Minimum Benefits. Minimum Benefits will likely result in high out-of-pocket costs.

No benefit is payable where an exclusion applies.

Non-agreement private hospital

If you are admitted to a private hospital that does not have an agreement with CBHS International Health, you will likely have high out-of-pocket costs because benefits are reduced to Minimum Benefits. No benefit is payable where an exclusion applies.

Restricted Benefits: Weight loss surgery/rehabilitation/hospital psychiatric services/palliative care/pregnancy and birth.

Minimum Benefits means the minimum hospital benefit prescribed by the Private Health Insurance (Benefit Requirement) Rules.

We recommend you obtain Informed Financial Consent. **Before you receive your treatment,** you're entitled to ask your doctor, health care provider and hospital about any extra money you may have to pay out of your own pocket, commonly known as a 'gap' payment. Knowing how much your treatment will cost is called Informed Financial Consent.

WHAT'S NOT COVERED? (CONT.)

- Services and pharmacy as an outpatient in hospital or out-of-hospital
- Services received during waiting periods.
- Services claimed more than 24 months after the service date.
- Nursing home type patient contribution, respite care or nursing home fees.
- Aids not covered in a hospital agreement (may be eligible for benefits under separate Extras health cover).
- Surgically implanted medical devices and human tissue products (formerly "Prostheses") used for cosmetic procedures where no Medicare benefit is payable had the service been provided to the holder of a valid Medicare card.
- Ambulance transfers between hospitals (for residents in Victoria, South Australia and the Northern Territory).
- Treatment (or goods) provided in countries outside of Australia.
- Treatment arranged in advance before your arrival in Australia.
- Services and treatments which are covered by compensation and damage provisions of any kind.
- Same treatment or service claimed under more than one health insurance policy.
- Services required for the purpose of gaining a visa or residency.
- Non-emergency ambulance services.
- Ineligible visas.

Understanding your health cover

WAITING PERIODS

Waiting periods apply as soon as your health cover starts, and is a specified period of time that you are not covered for a service or treatment. You can receive benefits listed on your level of cover once you have served the relevant waiting periods.

For in-hospital services waiting periods, see page 3.

WHAT ARE PRE-EXISTING CONDITIONS AND WHY ARE THEY IMPORTANT?

If you have a pre-existing condition, a waiting period of 12 months will apply before you can receive benefits towards any treatment for that condition (unless it relates to:

- Psychiatric
- Rehabilitation or
- Palliative care

that is a pre-existing condition). The waiting period for psychiatric, rehabilitation and palliative care is two months even if it's a pre-existing condition.

A pre-existing condition is an ailment or illness where, in the opinion of our appointed medical adviser, the signs or symptoms were evident up to 6 months before your health cover started. Our medical adviser will consider any information provided by your doctor.

If you upgrade to a higher level of cover, you must also wait 12 months before you're covered for pre-existing conditions for benefits not previously covered.

REPATRIATION

The benefit is for a single one-way repatriation, per membership, per calendar year, up to a maximum of $10,000 if you become terminally ill or suffer a life-altering injury, including the return of mortal remains. Payment of the benefit shall be on a case-by-case basis and at the discretion of CBHS International Health.

CBHS INTERNATIONAL HEALTH

WHAT TO DO WHEN YOU NEED US

Contact us. Anytime. Any day. Any language.

CALL US

1300 174 537*

IN AUSTRALIA

+61 2 8604 3537*

OUTSIDE AUSTRALIA

EMAIL US

ovhc@cbhscorp.com.au

VISIT US

cbhsinternationalhealth.com.au

*CBHS International Health may refer you to third-party providers when you use the medical, interpreter and personal assistance helpline. If you decide to engage a provider, it will be on the basis that CBHS International Health will not be responsible, and you will not hold CBHS International Health responsible, for any liability that may arise from that engagement.

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