PRODUCT SHEET

CBHS INTERNATIONAL HEALTH

OVERSEAS WORKER

TOP HOSPITAL AND MEDICAL POLICY

The CBHS International Health Overseas Worker Top Hospital and Medical policy offers comprehensive, visa-compliant cover for in-hospital services and treatments, as well as emergency ambulance, hospital outpatient and a higher level of out-of-hospital pharmacy benefits.

FEATURES

24/7 HELPLINE

1300 174 537 for medical, interpreter and personal assistance*

ONLINE DOCTOR

Consult a doctor without leaving your home or office

CHOICE NETWORK

Visit a doctor in our network for a low or no gap fee

WHAT'S COVERED?

OUT-OF-HOSPITAL SERVICES

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.

DOCTORS SERVICES

ONLINE/TELEHEALTH DOCTOR SERVICES

For online/telehealth providers we have a preferred provider arrangement with, you'll receive 100% of the agreed rate, except for services where an exclusion applies.

FACE-TO-FACE DOCTOR SERVICES

For face-to-face doctor consults and specialist doctors, receive up to 100% of the MBS Fee, except where an exclusion applies.

HOSPITAL EMERGENCY DEPARTMENT FACILITY FEE

• For non-emergency treatment at a hospital where you are not admitted, you may be charged a facility fee with a the maximum benefit up to $160 from CBHS International Health.

Typical costs for attending a hospital emergency department are significantly higher than $160. You'll need to pay the costs and submit a claim for benefits, which means substantial out-of-pocket costs. Please seek assistance from our online/telehealth doctors or our Choice Network (for face-to-face doctor services) for non-emergency treatment to avoid unnecessary costs.

• For emergency treatment at a hospital where you are admitted, you may be charged a facility fee which is fully covered by your policy, except where an exclusion applies.

MEDICINE

For medicines listed on the Pharmaceutical Benefits Scheme (PBS) and above the co-payment amount, including discharge medicine, you will receive a benefit of up to $75 per script, calculated as follows:

Receipted cost of prescription - PBS co-payment amount = your benefit (up to $75 per script)

For example:

$100 (cost of prescription)	-	**$30** (co-payment example)	=	**$70** (Benefit)

An annual limit of $600 per person per calendar year applies.

	OUT OF HOSPITAL SERVICES	WAITING PERIODS	IMPORTANT INFORMATION
✔	Accident and emergency ambulance services	1 day	
✔	Doctors services	2 months	Up to 100% of the MBS Fee, except where an exclusion applies
✔	Specialists	2 months	Up to 100% of the MBS Fee, except where an exclusion applies
✔	Pathology (e.g. blood tests) and radiology (e.g. X-rays)	2 months	Up to 100% of the MBS Fee, except where an exclusion applies
✔	Prescription medicine (including hospital discharge medicine)	2 months	Up to $75 in benefits, except where an exclusion applies. Limit of $600 per person per calendar year

WHAT'S COVERED?

IN-HOSPITAL SERVICES

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

• **ACCOMMODATION** for overnight and same day for private or shared room in agreement private hospitals and or shared room in non-agreement hospitals and public hospitals (see page 5). If an excess option (see page 5) has been selected, the excess will apply (but does not apply to dependants).

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

• **THEATRE FEES** are covered in agreement private are covered in agreement private hospitals and public hospitals, except for restricted services or where an exclusion applies. Theatre fees 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, except where an exclusion applies.

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.

IN-HOSPITAL SERVICES (CONT.)

	IN-HOSPITAL SERVICES	WAITING PERIODS	IMPORTANT INFORMATION
✔	Hospital accommodation	Waiting periods apply as noted below	Refer to page 5
✔	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 medicines.	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 3
✔	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)	
✔	Pregnancy and birth related services	12 months	Contact us as soon as you know you are pregnant.
✔	Pre-existing conditions (except hospital psychiatric, rehabilitation and palliative care)	12 months	
✔	All other treatments	2 months	
✔	Rehabilitation (including pre-existing conditions)	2 months	
✔	Hospital psychiatric services (including pre-existing conditions)	2 months	
✔	Palliative care (including pre-existing conditions)	2 months	
✔	Weight loss surgery	Weight loss surgery is considered a pre-existing condition	
✘	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) 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)

WHAT'S NOT COVERED?

EXCLUDED SERVICE

For treatments 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 OPTIONS: $0 OR $500

If you choose cover with the $500 excess option, then 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 (excluding 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. Excesses do not apply for any dependants.

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 as agreed between CBHS Corporate Health and the agreement private hospital, except for services where an exclusion applies.

No benefit is payable where an exclusion applies.

Contact us to check if a hospital or day surgery has an agreement with CBHS International Health.

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.

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

WHICH OTHER SERVICES ARE NOT COVERED?

- 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 on 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. When you upgrade your cover, waiting periods may also apply for benefits which you were not previously covered for.

For out-of-hospital services waiting periods, see page 2.
For in-hospital waiting periods, see page 4.

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 for 12 months to be 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.

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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