

Basic Hospital

'Our budget hospital cover – giving you private treatment in a public hospital'



At this level of cover you receive treatment in a **public hospital** as a private patient. This means that you can choose your own doctor and have shared room accommodation. Remember, theatre fees are not covered under Basic Hospital and there is limited cover for private room accommodation. Basic Hospital is designed for treatment in a public hospital, if you are admitted to a private hospital, be prepared for significant out-of-pocket expenses.

What are you covered for?

Service	Benefit
Shared room in a public hospital	100% cover* up to the Federal Government Default Benefit
Private room in a public or private hospital	Limited cover*
Theatre fees, including: <ul style="list-style-type: none"> - procedure room - labour ward 	Not covered
In-hospital medical services, including: <ul style="list-style-type: none"> - specialist doctor - anaesthetist - pathology - radiology 	100% cover of the Medicare Benefits Schedule (MBS) Fee PLUS the Access Gap Cover Scheme is available to minimise any out-of-pocket gap costs.
Surgically implanted prosthesis	100% cover for No-Gap Prosthesis List Items

* For Basic Hospital benefits, the **Federal Government Default Benefit** is applied. This is the amount of benefit determined by the Federal Government as the minimum amount private health insurers must pay for accommodation in public hospitals. Default Benefits are payable only towards the cost of hospital accommodation and provide no cover for other hospital charges such as labour ward or operating theatre costs. Default Benefits will not cover the full cost of treatment in private hospitals or in day hospital facilities, and you will be left with significant out-of-pocket expenses. Please call us on 1300 368 390 if you would like to know if the Default Benefit applies to any treatment you anticipate.

Basic Hospital cover does not provide any advantage in relation to public hospital waiting lists.

What's not covered?

- ✗ Surgeon's fees for podiatric surgery (benefits available under our Complete Ancillary product)
- ✗ Services for which Medicare pays no benefit e.g. cosmetic surgery
- ✗ Services while a membership is in arrears
- ✗ Services incurred before waiting periods are served (including any service for a pre-existing condition)
- ✗ Services received as an outpatient, such as in the Emergency department or visit to your General Practitioner
- ✗ Services where there is an entitlement under compensation insurance
- ✗ Services claimed over 2 years after the service date
- ✗ Services provided in countries outside of Australia

Waiting periods	
Accidents requiring hospital treatment, not related to a pre-existing condition	No waiting period
Ambulance	No waiting period
Obstetrics (pregnancy)	12 Months
Treatment relating to a pre-existing condition	12 Months
All other services	2 Months

On joining hospital cover for the first time, waiting periods must be served before benefits will be paid. If you have upgraded your hospital cover, waiting periods will apply before the higher benefits will be paid.

More detail continued over page →

Other features

- ✓ Choose your own doctor and **public** hospital
- ✓ Access to the Federal Government Rebate as a reduced premium
- ✓ Exemption from the Medicare Levy Surcharge
- ✓ Exemption from Lifetime Health Cover penalties if joining before age 31
- ✓ Ambulance Cover for residents of NSW & ACT (for other states the ambulance cover is available under the General Treatment Products)

Pre-Existing Conditions

If you are suffering from a medical condition, illness or ailment at the time of commencing or upgrading hospital cover there will be a 12-month waiting period before hospital benefits can be paid on claims relating to that condition.

A pre-existing condition is defined as an ailment or illness where, in the opinion of a medical practitioner, the signs or symptoms existed at any time during the six months before, or on the day which a member joins private health insurance or upgrades to a higher level of cover.

Going to hospital?

As soon as possible before your hospital treatment;

- ✓ Contact us to confirm what you are covered for and to check if any waiting periods still apply, and
- ✓ Talk to your hospital and doctor for an estimate of any costs that are not covered by Medicare or by private health insurance.

The most common cost not covered by Medicare or by private health insurance, referred to as a “Gap”, is the portion of the in-hospital medical services fees that are greater than the Medicare Benefits Schedule (MBS) Fee.

Using Access Gap Cover to claim for in-hospital medical services

These are the medical services you receive while an in-patient in a hospital, or approved day facility, and may include services received from your specialist doctor, assisting surgeons, anaesthetist, pathology and radiology.

We are restricted by law to paying 25% of the MBS fee, while Medicare pays the other 75%. If the charges are more than the MBS fee, this is where your gap payment arises.

Medicare Benefits Schedule (MBS) Fee

75% covered by Medicare

25% covered by ACA Health

Portion of the fee above MBS = Gap Payment

OR this can be fully or partially covered by ACA Health where the **Access Gap Cover** Scheme is used

To help avoid or minimise your gap payment, ACA Health offers the **Access Gap Cover** Scheme. If your doctor chooses to participate in the scheme, and bills in accordance with these arrangements, we can pay a higher benefit and you will either:

- ✓ Have ZERO gap expenses, or
- ✓ Have a known gap of up to \$400 (\$800 for obstetrics)

Using Access Gap Cover also makes it much easier for you and the doctor to claim your benefits from Medicare and ACA Health (see “How to claim your benefits”).

It is your doctor’s choice to bill using the Access Gap Cover scheme, and they may do so on a case-by-case basis, so **it’s important to discuss with them before your treatment begins that you would like them to participate in the scheme for you.**

You can search to see which doctors have previously used **Access Gap Cover** and to check which hospitals are contracted with ACA Health at www.acahealth.com.au

Having a baby?

- ✓ Make sure you have family cover at least 2 months before the baby is born to ensure the waiting period is served and the baby will have immediate cover.

Generally, newborn babies are not admitted hospital patients, (unless they are admitted to an approved neonatal intensive care unit, are in hospital without their mother, or are a subsequent baby after the first in a multiple birth). This means that when a baby is treated by a paediatrician in hospital, and the baby is not admitted, the costs can only be claimed from Medicare.

Likewise, only medical services received while a mother is an admitted patient in hospital can be claimed from ACA Health.

Surgically Implanted Prosthesis

These include pacemakers, defibrillators, joint replacements and other devices that are surgically implanted during a stay in hospital. There are often a number of different choices available with any particular prosthesis, which can vary in cost and benefits.

The Department of Health and Aging has created an approved Prosthesis List of items considered appropriate by specialists with the majority as ‘no gap’. This means, you and your surgeon can choose a prosthesis for every Medicare procedure from the prostheses list that will be fully covered by ACA Health with no gap amount to pay. Other, more expensive prostheses may be available for your surgery, and your surgeon may recommend one of these. If you agree to have one of these, you will have to pay the gap amount.

How to claim your benefits

Hospital Claims

At the time of hospitalisation, the hospital will request details of your private health insurer – so keep your membership card handy and present this to the hospital when you are admitted. On discharge, check that all your details on the account are correct and then sign the hospital claim form signifying that you are satisfied the details are correct and giving the hospital authority to claim from us on your behalf. From then on, we take care of the rest! The benefit will be forwarded to the hospital in payment of the account, or if you have paid the account yourself, the benefit will be sent to you.

Medical Claims

Doctors using the Access Gap Cover Scheme will usually bill ACA Health direct. We claim from Medicare on your behalf and send payment directly to the doctor. If the doctor gives you the account, but has stated they are billing using the Scheme, send the account to us – clearly identifying it is to be claimed through Access Gap Cover.

Doctors not using Access Gap Cover will give you the account and it is up to you to claim the Medicare re-imbursalment first. Medicare will issue you a statement which you send, with a signed claim form to ACA Health, for us to pay the remaining 25% of the MBS fee.

This product benefits sheet must be read in conjunction with your ACA Health Policy Booklet. Please read these documents carefully and retain them for your future reference.

Need help with anything?

Please contact us:

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...Because We Care