

Private Hospital

'Our quality hospital cover – at a discounted rate'



At this level of cover you receive the same level of protection and benefits as Deluxe Hospital cover, however a co-payment from your own pocket applies if you actually go into hospital. A co-payment is a daily amount that you pay to contribute to your accommodation and theatre fees in a hospital or day surgery facility... we take care of the rest!

What are you covered for?

Service	Benefit	Co-payment by member
Private hospital accommodation, including: - Intensive care - Hospital in the Home or hospital-substitute treatment - In-hospital psychiatric treatment - In-hospital rehabilitation treatment	100% cover* with contracted private hospitals & day facilities in Australia. (Limited to 100 days per calendar year. Basic Hospital default accommodation rates apply thereafter.)	\$40 per day - shared room or \$70 per day - private room
Theatre fees, including: - procedure room - labour ward	100% cover*	\$80 per theatre visit
In-hospital medical services, including: - 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	

* 100% cover applies to private hospitals when they are contracted with the fund through the Australian Health Service Alliance (AHSa). This does involve most licensed private hospitals and day facilities in Australia. To view the hospitals contracted with the fund, you can go to our website www.acahealth.com.au and use the Hospital Search. Please refer to our Policy Booklet for rates paid to non-contracted hospitals.

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 their 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.

Other features

- ✓ Choose your own doctor and private 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 Ancillary 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 appointed by the Fund, 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 neo-natal intensive care unit, are the subsequent baby in a multiple birth, or are in hospital without their mother). 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.

Early discharge options

ACA Health is proud to offer the Member Support Program to help you transition more easily from hospital to home, making an early discharge possible without the worry of what will happen when you get home.

The member support program can be accessed through our participating hospital network. The hospital will organise the services and support you may need through visits by registered nurses to help you recover at home. Your treating doctor and nursing staff will determine whether you require this assistance. To find out if the program is available at the hospital of your choice and for more information, call toll free: 1800 653 316

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-imburement 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?

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...Because We Care