March 2021

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**. 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. Remember, theatre fees are not covered under Basic Hospital and there is limited cover for private room accommodation.

What You Are 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: - Procedure room - Labour ward	Not covered
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

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 private hospital accommodation and provide no cover for other hospital charges such as labour ward or operating theatre costs (private hospital charges). 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.*
Note: 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
- ✕ Services for which Medicare pays no benefit e.g. cosmetic surgery & laser-eye 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/ Specialist
- ✕ 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

Other Features

- ✓ The Mental Health waiting period exemption for higher benefit is available to each insured person on a hospital policy once in their lifetime and will apply from the beginning of a current admission if the election (fund was notified) was made within 5 days of admission, if not from the date of the election (fund notification received) where;
  - The 2 month psychiatric/rehabilitation period has been served
  - It is for psychiatric or drug and alcohol related treatment
- ✓ 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 Ancillary Products)

Waiting Periods

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.

Waiting Periods	
Accidents requiring hospital treatment, not related to a pre-existing condition	No Waits
Ambulance (for NSW, ACT)	No Waits
Obstetrics (pregnancy)	12 Months
Treatment relating to a pre-existing condition	12 Months
All other services including Psychiatric and Rehabilitation	2 Months

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 treatment and to check if any waiting periods 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.

In-Hospital Medical Services And Using The Access Gap Cover

These are the medical services you receive while admitted as an in-patient in 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 occurs.

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.

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 $500 per item ($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. **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 which doctors have previously used **Access Gap Cover** and to check which hospitals are contracted with ACA Health at acahealth.com.au.

Having A Baby?

- Make sure you have family cover at least 2 months before the baby is born to ensure waiting periods are served so that 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 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 has set a Prosthesis List with gap and no gap items. You and your surgeon will be able to choose from this list a prosthesis that is most appropriate for you. If you agree to a prosthesis which has a gap, you will need 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 that the details are accurate and are giving the hospital authority to claim from us on your behalf. From there on, we take care of the rest! The benefit will be forwarded to the hospital as payment of the account, or if you have paid the account yourself, the benefit will be sent directly to you.

Medical Claims

Doctors using the Access Gap Cover Scheme will usually bill ACA Health direct. We will claim from Medicare on your behalf and send the payment directly to your 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-imbursement 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.

If we receive an account for services that are not covered, we will return the account unpaid.

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.