July 2023

Silver Plus Hospital

'Our Silver Plus Cover – when you choose to reduce your cover to save money'

With this level of cover, ACA Health pays benefits on Included services and limited benefits on Restricted services (rehabilitation and psychiatric services). There is no benefit payable on Excluded services (refer inside table). There is an excess payable of $750 per person, per calendar year (whether in a private or public hospital) which also applies to child dependants. Call us before you book a treatment and ask about the benefits you can expect to receive and any out-of-pocket expenses you may incur.

What You Are Covered For

Service		Benefit For Included Services	Benefit For Restricted Services
Public hospital accomodation and services, including:	Private room	100% cover* ($750 excess applies per person on the policy, including child dependants)	Not covered
	Shared room (as a private patient)		100% cover* at Federal Government Default Rate ($750 excess applies)
	Surgically implanted Medical Devices and Human Tissue Products**		
Private hospital accomodation and services, including:	Private room	100% cover with contracted private hospitals & day facilities in Australia.* ($750 excess applies)	Not covered
	Shared room		
	Theatre fees (including intensive care fees)		
	Surgically implanted Medical Devices and Human Tissue Products**	100% cover for No-Gap Medical Devices and Human Tissue Product** List Items. ($750 excess applies)	

* *Access Gap Cover Scheme is available with participating doctors to minimise any out-of-pocket gap costs.*

* *For Silver Plus Hospital benefits, the **Federal Government Default Benefit** is applied for restricted services in a Public Hospital. This is the amount of benefit determined by the Federal Government as the minimum amount private health insurers must pay for shared 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 operating theatre costs. Please call us on 1300 368 390 if you would like to know if the Default Benefit applies to any treatment you anticipate.*

*** Formerly known as Prostheses.*

What's Not Covered?

- ✕ **Excluded Services** (Dialysis, joint replacements, pregnancy & related services, assisted reproductive services) **See Inside for more details**
- ✕ Surgeon's fees for podiatric surgery
- ✕ Services for which Medicare pays no benefit e.g. cosmetic surgery & laser-eye surgery
- ✕ Restricted services in a Private Hospital
- ✕ 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
- ✕ Pharmaceutical prescriptions
- ✕ Hospital substitute services (i.e. early discharge program)
- ✕ Labour ward fees
- ✕ Accommodation for nursing home type patients
- ✕ Chronic disease management programs
- ✕ Services claimed over 2 years after the service date
- ✕ Services provided in countries outside of Australia
- ✕ No special assistance
- ✕ Allied health services which are not included in the hospital agreement (where no Ancillary cover exists)

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
- ✓ 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 Ancillary Products). No Ambulance cover for Excluded services.
- ✓ Dependants covered to age 21 (or 25 if eligible fulltime students)

*Note: With this level of cover there is an **excess payable of $750** per person, per calendar year (whether in a private or public hospital) which also applies to child dependants.*

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
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.

Restricted Services

We pay minimum benefits for restricted services. This means that we will pay the minimum default benefit rate for a shared room as set out by the Federal Government, and minimum benefits for Government approved Surgically implanted Medical Devices and Human Tissue Product** list items. If you choose to be treated:

- In a private hospital – there are no benefits payable for these services in a private hospital
- In a public hospital as a private patient in a shared room – you may have an out-of-pocket expense to pay, in the event that the minimum benefit is less than your chosen public hospital charges

Regardless of where you are treated, the hospital should advise before you are admitted into or have treatment in the hospital, of your out-of-pocket expenses that you may incur. Seeking your approval beforehand is known as informed financial consent.

Service	Benefits
Rehabilitation	*All rehabilitation, psychiatric treatments and programs and palliative care are restricted services*
Psychiatric	
Palliative Care	

Note: No benefit is payable for restricted services in a private hospital.

Included Services

This includes all services that are not part of the Excluded services or Restricted services as listed previously.

Going To Hospital?

As soon as possible before your hospital treatment;

- ✔ Contact us to confirm if you are covered for the treatment and 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 is important to discuss with them before your treatment begins that you would like them to participate in the scheme for you.**

Login to the Online Member Portal to search which doctors have previously used Access Gap Cover and to check which hospitals are contracted with ACA health.

How To Claim Your Benefits

*Note: With this level of cover there is an **excess payable of $750** per person, per calendar year (whether in a private or public hospital) which also applies to child dependants.*

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.

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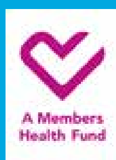
Excluded Services

If a service is excluded, no benefits are payable on the hospital or medical accounts. Excluded services are listed in the table below.

R=Restricted ✔ = Covered X= Not Covered

Silver Plus		
		What's Included
Basic	Rehabilitation	R
	Hospital psychiatric services	R
	Palliative care	R
Bronze	Brain and nervous system	✔
	Eye (not cataracts)	✔
	Ear, nose and throat	✔
	Tonsils, adenoids and grommets	✔
	Bone, joint and muscle	✔
	Joint reconstructions	✔
	Kidney and bladder	✔
	Male reproductive system	✔
	Digestive system	✔
	Hernia and appendix	✔
	Gastrointestinal endoscopy	✔
	Gynaecology	✔
	Miscarriage and termination of pregnancy	✔
	Chemotherapy, radiotherapy and immunotherapy for cancer	✔
	Pain management	✔
	Skin	✔
	Breast surgery (medically necessary)	✔
	Diabetes management (excluding insulin pumps)	✔
Silver	Heart and vascular system	✔
	Lung and chest	✔
	Blood	✔
	Back, neck and spine	✔
	Plastic and reconstructive surgery (medically necessary)	✔
	Dental surgery	✔
	Podiatric surgery (provided by a registered podiatric surgeon)	✔
	Implantation of hearing devices	✔
Gold	Cataracts	X
	Joint replacements	X
	Dialysis for chronic kidney disease	X
	Pregnancy and birth	X
	Assisted reproductive services	X
	Weight loss surgery	X
	Insulin pumps	X
	Pain management with device	✔
	Sleep studies	✔
	Excess	**$750**
	Co-payment (per day)	**$0**



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