doctors health fund

Avant mutual

Your Guide to Hospital Cover

This is an important document. Please read it carefully and retain for future reference.

Effective: 1 April 2018

Getting the most from your hospital cover

Hospital cover provides you benefits when you are treated as an admitted private inpatient in a contracted hospital or contracted day-only facility, if your policy covers the procedure.

Inpatient vs outpatient

You are an inpatient when you are admitted into a contracted hospital or contracted day-only facility to receive medical treatment and care.

Services provided outside the hospital admission such as visits to an emergency department, general practitioner or specialists, are not covered by your hospital cover and are known as outpatient services. You may be able to claim a rebate from Medicare for outpatient services.

With all our levels of hospital cover, if your hospital stay involves:

- the payment of an excess; or
- any personal expenses such as telephone calls or newspapers; or
- take home prescribed medication; or
- non health related charges applied by the hospital

then you will be responsible for these expenses and the hospital may ask you for payment on admission and/or discharge.

If you are in hospital for more than 35 days in succession, unless you are an acute care patient, you can expect to pay part of the cost of your hospital accommodation.

All our Hospital products cover you for ambulance nationwide, whether it's for an emergency or medically necessary including when;

- An ambulance is called to attend but you are not subsequently taken to hospital
- It is medically necessary for you to be transported by an ambulance to be admitted to hospital
- You need immediate medical attention at a hospital or other approved facility
- You are an admitted patient and need to be transferred to another hospital

The Hospital and Medical Gap

The gap is the difference between the fee charged by the hospital or the amount the doctor charges for services in hospital, and the amount covered by Medicare and your private health insurer. It is the out of pocket expenses you may pay for your treatment.

The gap occurs for 4 reasons:

1. You have chosen hospital insurance with an excess, exclusions or benefit restrictions
2. You have chosen a hospital that does not have an agreement with Doctors' Health Fund
3. Your doctor's fee is more than the Access Gap Schedule or the AMA list of medical services and fees depending on your level of cover; this is called the medical gap
4. You have incurred in-patient charges for items not covered under our health insurance hospital policies such as newspapers

Doctors' Health Fund provides benefits to cover some or all of the medical gap between the MBS fee and the fee charged by the doctor, depending on your level of cover. The next section outlines how your gap is covered under our hospital cover options.

Top Cover for hospital – unique to us, with benefits based on AMA List of medical services and fees

Our premium hospital cover, Top Cover, includes medical gap cover that pays benefits on medical services listed in the Medicare Benefit Schedule, meaning

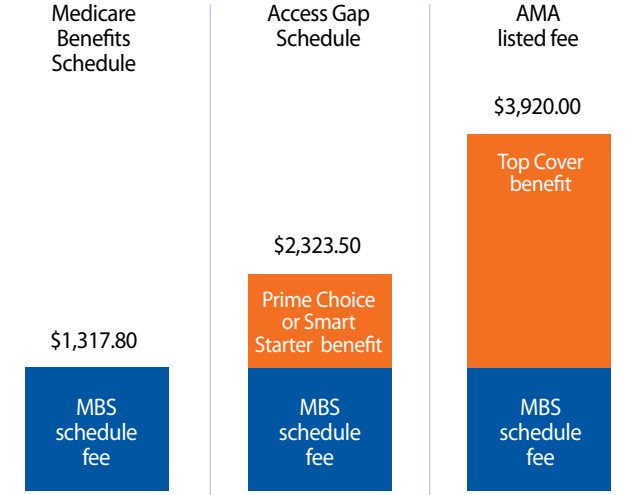
- You will have **no** out-of-pocket expenses when the doctor charges the AMA List of medical services and fees or less
- You will need to pay the difference if your doctor charges you above the AMA List of medical services and fees

Access Gap Cover - High performance, widely accepted gap cover

Our Prime Choice and Smart Starter hospital covers include the Access Gap Cover scheme. A participating doctor agrees to bill for their services according to the scheme's schedule for each medical service item and the rules regarding co-payments which can be charged directly to the patient. Co-payments by patients are not allowed to exceed $400 per service or $800 on management of labour and delivery.

See the example below to compare the different medical benefit outcomes under each gap cover scheme.

Example: Medical services benefits for a knee reconstruction, item no. 49542 as of April 2018.



Medicare Benefits Schedule fee payable for a knee reconstruction.

Prime Choice & Smart Starter maximum benefit for a knee reconstruction in NSW (the benefit varies by State).

Includes Medicare benefit plus the Access gap benefit.

Top Cover maximum benefit for a knee reconstruction.

Includes Medicare benefit plus the AMA gap benefit.

Contracted No-Gap Cover

Our no-gap contractual arrangements with most pathology and radiology providers apply to all our hospital insurance products. The delivery of services by these contracted providers will have no out-of-pocket expenses.

Exclusions, Excesses and Restrictions

Please ensure that you understand whether or not exclusions, restrictions, limits or excesses apply to your chosen level of cover.

An explanation of each of these is provided below to assist.

Exclusions	By excluding some medical conditions or healthcare services from the cover provided, the cost of health insurance can be reduced. However, you will not be able to claim benefits when you have these conditions treated or services performed. Think realistically about your personal situation and the relevance of those procedures to you.
Excesses	Is an amount you agree to pay before your health insurance starts to pay for your hospital accommodation costs. Check whether the excess is paid once a year or per hospital visit. Consider whether you will be able to manage the cost of the excess if you go to hospital. An excess on health insurance will reduce its cost. Your excess (if you have one) will vary depending on your cover. Check your hospital cover details in your Welcome letter to find out if an excess will apply. If you have an excess, it will apply to same day procedures as well as overnight admissions. If you are unsure how your excess applies please give us a call on **1800 226 126**.
Benefit Restrictions	Some conditions may have treatment restrictions. An example is under our Smart Starter hospital cover, psychiatric services are limited to delivery as a private patient in a public hospital in a shared room. Check any benefit restrictions carefully to understand the potential impact to you.

When you're having a baby

If you are planning to have children you should check that your hospital cover includes obstetrics. These are the services associated with pregnancy and the birth of a baby.

All our Hospital covers have a 12-month waiting period for making claims for all in-patient services related to an obstetrics admission unless you are switching from another fund to a comparable cover with us and have already served your waiting period.

After the birth, you need to contact Doctors' Health Fund to add each child to your membership within two months from the date of their birth. This means moving to a family membership if you are not already on that level of cover. This will ensure your child does not serve any additional waiting periods.

Pre-existing medical conditions

A waiting period applies to new members with pre-existing ailments. This waiting period also applies to existing members who have recently upgraded their level of hospital cover.

If the ailment, illness or condition is considered pre-existing:

- new members must wait 12 months for any hospital benefits
- members transferring/upgrading to a higher hospital cover must wait 12 months to get the higher hospital benefits

A pre-existing ailment is one where signs or symptoms of your ailment, illness or condition, in the opinion of a medical practitioner appointed by the health fund (not your own doctor), existed at any time during six months preceding the day on which you purchased your hospital insurance or upgraded to a higher level of hospital cover.

The only person authorised to decide that ailment is pre-existing is the medical practitioner appointed by Doctors' Health Fund. The fund medical practitioner must, however, consider any information regarding signs and symptoms provided by your treating medical practitioner(s).

The next few pages of this guide provide the detail you need to understand about your choice of hospital cover and what waiting periods may apply before you can make a claim.

Take the time to go through this in detail and call us on 1800 226 126 if you have any questions or wish to review your cover.

Top Cover Hospital

Top Cover Hospital is unique as it includes a medical gap benefit that pays up to the AMA list of services and fees.

Excess	NIL
Waiting periods	The benefits available under this cover are only payable for services received after serving the relevant waiting period. Waiting periods apply when you're new to private health insurance or you purchase cover with higher benefits or conditions. ■ None for accidents ■ 1 day for ambulance ■ 2 month waiting period on psychiatric services when getting cover for the first time ■ None on psychiatric services when upgrading cover. Waiting period can be waived only once a lifetime ■ 2 months for rehabilitation and palliative care, and all other treatments ■ 12 months for pre-existing conditions ■ 12 months for obstetrics
Inclusions	All in-patient hospital services where a Medicare benefit is payable (unless stated otherwise).
Exclusions	None for services eligible for Medicare benefits.
Benefit Restrictions	Plastic and reconstructive surgery. When chosen for cosmetic reasons, only default hospital accommodation benefits apply and no medical or prostheses benefits are paid.
Ambulance	National cover for emergency and medically necessary ambulance services when: ■ An ambulance is called to attend but you are not subsequently taken to hospital ■ It is medically necessary for you to be transported by an ambulance to be admitted to hospital ■ You need immediate medical attention at a hospital or other approved facility ■ You are an admitted patient and need to be transferred to another hospital
Accommodation	In a contracted private hospital or contracted private day-only facility, as a private patient, all costs of accommodation are covered. In non-contracted hospitals or day-only facilities and public facilities the lowest contracted benefit is paid and you can expect to have out-of-pocket expenses.
Hospital services	All costs are covered for theatre and labour ward services while you are an in-patient in a contracted hospital.
Medical services AMA Gap Cover	The cost of doctors' services delivered while an in-patient is covered by our premium gap cover. Medicare pays 75% of the Medicare Benefit Schedule and your Fund benefits pay the remainder up to the AMA list of medical services and fees (after you have served the relevant waiting period). You pay any amount charged above the AMA list of medical services and fees.
Pharmaceuticals	In a contracted private hospital or contracted private day-only facility all costs of PBS pharmaceuticals related to the condition being treated are covered, and the cost of non-PBS items related to the condition being treated are covered as per the contract with the hospital. In non-contract hospitals or day-only and public facilities you can expect to have out-of-pocket expenses.
Prostheses	Covers 100% of the minimum benefit specified for government approved prostheses.
Travel and Accommodation	Up to $100 per day for travel and accommodation where a doctor certifies the need for a parent, spouse or child to be with a member in hospital more than 200kms from home. An annual limit of $1,000 applies.

Examples of potential out-of-pocket expenses under Top Cover if you go to hospital:

- Personal items such as newspapers and television hire
- Prostheses cost if charged above the minimum benefit
- The difference charged by your doctor above the AMA list of medical services and fees

Prime Choice Hospital Cover

This level of hospital cover is comparable to the top cover offered by many other health funds and includes excess payment options to help reduce the cost of premiums.

Excess	Single memberships: NIL excess or $500 per admission/per calendar year. Family, couple or single-parent memberships: NIL excess or $1,000 per calendar year (up to a max of $500 per admission). $500 of the excess is paid per admission until the full amount of excess is paid for the year. The total excess amount applies to the entire membership, not for each person covered by the membership.
Waiting periods	The benefits available under this cover are only payable for services received after serving the relevant waiting periods. Waiting periods apply when you're new to private health insurance or you purchase cover with higher benefits or conditions. ■ None for accidents ■ 1 day for ambulance ■ 2 month waiting period on psychiatric services when getting cover for the first time ■ None on psychiatric services when upgrading cover. Waiting period can be waived only once a lifetime ■ 2 months for rehabilitation and palliative care, and all other treatments ■ 12 months for pre-existing conditions ■ 12 months for obstetrics
Inclusions	All in-hospital services where a Medicare benefit is payable (unless stated otherwise).
Exclusions	None for services eligible for Medicare benefits.
Benefit restrictions	Plastic and reconstructive surgery. When chosen for cosmetic reasons, only default hospital accommodation benefits apply and no medical or prostheses benefits are paid.
Ambulance	National cover for emergency and medically necessary ambulance services when: ■ An ambulance is called to attend but you are not subsequently taken to hospital ■ It is medically necessary for you to be transported by an ambulance to be admitted to hospital ■ You need immediate medical attention at a hospital or other approved facility ■ You are an admitted patient and need to be transferred to another hospital
Accommodation	In a contracted private hospital or contracted private day-only facility as a private patient all costs of accommodation are covered after the excess is paid. In non-contract hospitals and day-only and public facilities you can expect to have out-of-pocket expenses. You can find a contracted hospital on our website at www.doctorshealthfund.com.au
Hospital services	After the excess is paid all costs are covered for theatre and labour ward services while you are an in-patient at a contracted private hospital or day-only facility.
Medical services Gap Cover	The cost of doctors' services delivered while you are an admitted patient can be covered by the Access Gap Cover scheme which reduces or eliminates your medical services out-of-pocket expenses. When your doctor agrees to participate in the Access Gap Cover scheme the Fund covers the scheme's scheduled amount for your treatment. The doctor may choose to charge you a payment above the scheme's scheduled amount. This may be no more than $400 per service, or for the birth of a child no more than $800 for the management of labour and delivery. Most pathology and radiology providers have contracts with us, so while you are an admitted patient most of these services will have no out-of-pocket expenses. To find doctors who participate in the Access gap scheme you can use the Doctor Search facility at www.doctorshealthfund.com.au
Pharmaceuticals	In a contracted private hospital or contracted private day-only facility all costs of PBS pharmaceuticals related to the condition being treated are covered, and the cost of non-PBS items related to the condition being treated are covered as per the contract with the hospital. In non-contract hospitals or day-only and public facilities you can expect to have out-of-pocket expenses.
Prostheses	Covers 100% of the minimum benefits specified for government approved prostheses.
Travel and Accommodation	Up to $70 per day for travel and accommodation where a doctor certifies the need for a parent, spouse or child to be with a member in hospital more than 200kms from home. An annual limit of $800 applies.

Examples of potential out-of-pocket expenses under Prime Choice Cover if you go to hospital:

- Personal items such as newspapers and television hire
- Prostheses cost if charged above the minimum benefit
- Your Excess (if applicable)
- If your doctor does not wish to participate in the Access Gap Scheme, the difference between the charge and the Medical Benefit Schedule fee

Smart Starter Hospital Cover

This is an economical entry level hospital cover with some exclusions and benefit restrictions. It is available only on singles and couples memberships.

Excess

Single memberships - up to $500 per calendar year.
Couples memberships - up to $1,000 per calendar year.

An excess of $500 is paid per hospital admission until the full amount of excess is paid for the calendar year. The total excess amount applies to the entire membership not each person covered by the membership.

Waiting periods

The benefits available under this cover are only payable for services received after serving the relevant waiting periods. Waiting periods apply when you're new to private health insurance or you purchase cover with higher benefits or conditions.

- None for accidents
- 1 day for ambulance
- 2 month waiting period on psychiatric services when getting cover for the first time
- None on psychiatric services when upgrading cover. Waiting period can be waived only once a lifetime
- 2 months for rehabilitation and palliative care, and all other treatments
- 12 months for pre-existing conditions

Inclusions

All in-hospital services where a Medicare benefit is payable (unless stated otherwise).

Exclusions

No benefits are paid for:

- Pregnancy related services
- Assisted reproductive services
- Sterilisation and reversal of sterilisation
- Hip and knee replacements and revisions
- Cataract and glaucoma treatment
- Gastric banding and obesity surgery
- Plastic surgery and other services which are excluded from Medicare coverage
- Spinal surgery not related to an accident
- Hearing loss related services
- Diabetes related services

Benefit restrictions

These services are limited to delivery as a private patient in a public hospital in a shared room:

- Cardiothoracic surgery
- Psychiatric services
- Dialysis for chronic renal failure
- Rehabilitation services following cardiothoracic, psychiatric, hip and knee replacement and revisions

Ambulance

National cover for emergency and medically necessary ambulance services when:

- An ambulance is called to attend but you are not subsequently taken to hospital
- It is medically necessary for you to be transported by an ambulance to be admitted to hospital
- You need immediate medical attention at a hospital or other approved facility
- You are an admitted patient and need to be transferred to another hospital

Accommodation

In a contracted private hospital or contracted private day-only facility, all costs of accommodation are covered after the excess is paid.

In non-contracted hospitals or day-only facilities the lowest contracted benefit is paid and you can expect to have out-of-pocket expenses. You can find a contracted hospital on our website at www.doctorshealthfund.com.au

Hospital services

After the excess is paid all costs are covered for theatre services while you are an in-patient at a contracted hospital or contracted day-only facility.

Medical services gap cover

The cost of doctors' services delivered while you are an admitted patient can be covered by the Access Gap Cover scheme which reduces or eliminates your medical services out-of-pocket expenses.

When your doctor agrees to participate in the Access Gap Cover scheme the Fund covers the scheme's scheduled amount for your treatment. The doctor may choose to charge you a payment above the scheme's scheduled amount. This may be no more than $400 per service. To find doctors who participate in this gap scheme you can use the Doctor Search facility at www.doctorshealthfund.com.au

Pharmaceuticals

In a contracted private hospital or day-only facility, or a public hospital as a private patient, all costs of PBS pharmaceuticals related to the condition being treated are covered, and the cost of non-PBS items related to the condition being treated are covered as per the contract with the hospital.

In non-contract hospitals and day-only facilities the lowest contracted benefit is paid and you can expect to have out-of-pocket expenses.

Prostheses

Covers 100% of the minimum cost specified for government approved prostheses.

Travel and Accommodation

Up to $70 per day for travel and accommodation where a doctor certifies the need for a parent, spouse or child to be with a member in hospital more than 200kms from home. An annual limit of $500 applies.

Examples of potential out of pocket expenses under Smart Starter Cover if you go to hospital:

- Your excess
- Personal items such as newspapers and television hire
- Prostheses cost if charged above the minimum benefit
- If your doctor does not wish to participate in the Access Gap Scheme, the difference between the charge and the Medical Benefits Schedule fee

Going to Hospital?

Let us make it as easy as possible for you, so you can focus on your health and recovery.

Call us before you go to hospital on **1800 226 126** and we'll talk you through planning your visit, what's covered, how to minimise costs and how to claim costs.

You should take your membership card with you if you are going to hospital.

Hospital charges

If you go to hospital there will be a number of charges relating to your treatment. The hospital will charge for your accommodation and use of its facilities (even if you do not stay overnight).

Your doctor and other practitioners (such as pathologists or anaesthetists) will charge for the medical services they provide while you are an in-patient.

In most cases when you are discharged from hospital Doctors' Health Fund will settle your accommodation account directly with the hospital.

Whatever your level of hospital cover, your doctors should always submit the bills for your treatment in hospital directly to Doctors' Health Fund.

The most efficient way to make medical services claims is direct billing. You don't have to go to Medicare. Doctors' Health Fund processes the entire claim for you including the claim to Medicare.

If you are covered by our Prime Choice or Smart Starter hospital covers and your doctors have agreed to treat you under the Access Gap Cover scheme, but they send their bills to you, check they have been marked as Access Gap Cover accounts and submit them to Doctors' Health Fund with a claim form. A claim form can be obtained from our website at www.doctorshealthfund.com.au

Send your claim to:

The Doctors' Health Fund Pty Ltd.
PO Box Q1749
Queen Victoria Building
Sydney NSW 1230

Claims for hospital services are **not** payable where:

- they are submitted more than 2 years after the date of service of the claimed treatment;
- the provider is not qualified to supply the treatment under the Fund Rules;
- the patient and the treating practitioner are related;
- the policy is unfinancial or suspended at the date of service;
- the relevant waiting periods have not been served at the date of service;
- an amount is, or a right exists for an amount to be, paid or payable from a third party in relation to the claim;
- the service was for health screening, superannuation entry or employer requested health check;
- false or inaccurate information is supplied;
- the service is excluded or restricted on your cover;
- the date of service was prior to the patient joining the fund, or after the patient left the fund;
- the treatment was supplied outside of Australia;
- the treatment does not meet the standards and requirements of the Private Health Insurance Act 2007 or its associated instruments;
- the treatment was not delivered in person;
- the treatment has not yet been supplied;
- there was no legally enforceable debt raised for the supply of the treatment.

Contact us

Phone
1800 226 126
Monday to Friday
8:30 am to 6:00 pm AEDT/AEST

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