Going to hospital

Peoplecare Love people

Going to hospital can be a stressful time & we're here to give you a hand.

We've put together a bunch of info for you – from things to ask your doctor to how billing works. We've even included a checklist to help you keep on track.

It's always best to get in touch with us before going to hospital, we'll be able to tell you exactly what you're covered for and if you've got any waiting periods.

Your level of cover

There are a few important things to keep in mind when it comes to your hospital cover. All of our hospital products exclude cosmetic surgery and services not covered by Medicare.

Gold hospital or Premium Hospital (Gold)^

These are our top level of hospital covers which gives you private hospital cover for most services - perfect if you like to be ready for anything. You can choose our Premium (Gold) Hospital cover with or without an excess.

All our other hospital covers Basic Plus, Bronze, Silver, Silver Plus, Public (Basic)^, Basic (Basic Plus)^ & Mid (Basic Plus)^

There are some services that you have restricted cover for. This means you're covered as a private patient in a public hospital or you're admitted to a private hospital for these restricted services you'll have large out-of-pocket costs.

There are some services that aren't covered on your hospital cover, these are called exclusions. If you're admitted as a private patient for any of these services, you'll have to pay the full cost yourself.

^These hospital products are closed to new members.

Not sure if the procedure you're having is restricted or excluded?

Please see page following pages or a list of services and info on if they are covered, restricted or excluded on each of our covers.

The best way to be sure you're covered is to ask your doctor for the Medicare item numbers for any procedures you're having, then just give us a buzz and we'll be able to tell you whether or not you're covered.

Waiting periods

If you're new to hospital cover or have recently upgraded your cover, you might have to serve some waiting periods. They are:

Hospital services	Waiting period
• Hospitalisation related to an accident • Services covered by another fund (when transferring directly to a similar level of cover)	No waiting period
• Ambulance	1 day
• All other services, except for those listed below • Upgrading your cover • Health programs • Rehabilitation, psychiatric services and palliative care • Hospital substitution programs	2 months
• Pregnancy & birth • Pre-existing conditions	12 months

What are you covered for?

Look for your level of cover below to see what services you're covered for.

✔ = Included ✘ = Excluded
R = Restricted

Clinical Categories^	Waits*	Basic Plus	Bronze	Silver	Silver Plus	Gold
Rehabilitation	2 months	R	R	R	✔	✔
Hospital psychiatric services	2 months	R	R	R	R	✔
Palliative care	2 months	R	R	R	✔	✔
Brain and nervous system	2 months	✘	✔	✔	✔	✔
Eye (not cataracts)	2 months	✘	✔	✔	✔	✔
Ear, nose and throat	2 months	✘	✔	✔	✔	✔
Tonsils, adenoids and grommets	2 months	✔	✔	✔	✔	✔
Bone, joint and muscle	2 months	✘	✔	✔	✔	✔
Joint reconstructions	2 months	✔	✔	✔	✔	✔
Kidney and bladder	2 months	✘	✔	✔	✔	✔
Male reproductive system	2 months	✘	✔	✔	✔	✔
Digestive system	2 months	✘	✔	✔	✔	✔
Hernia and appendix	2 months	✔	✔	✔	✔	✔
Gastrointestinal endoscopy	2 months	✘	✔	✔	✔	✔
Gynaecology	2 months	✔	✔	✔	✔	✔
Miscarriage and termination of pregnancy	2 months	✔	✔	✔	✔	✔
Chemotherapy, radiotherapy and immunotherapy for cancer	2 months	✘	✔	✔	✔	✔
Pain management	2 months	✘	✔	✔	✔	✔
Skin	2 months	✘	✔	✔	✔	✔
Breast surgery (medically necessary)	2 months	✘	✔	✔	✔	✔
Diabetes management (excluding insulin pumps)	2 months	✘	✔	✔	✔	✔
Heart and vascular system	2 months	✘	✘	✔	✔	✔
Lung and chest	2 months	✘	✘	✔	✔	✔
Blood	2 months	✘	✘	✔	✔	✔
Back, neck and spine	2 months	✘	✘	✔	✔	✔
Plastic and reconstructive surgery (medically necessary)	2 months	✘	✘	✔	✔	✔
Dental surgery	2 months	✔	✘	✔	✔	✔
Podiatric surgery (provided by a registered podiatric surgeon)	2 months	✘	✘	✔	✔	✔
Implantation of hearing devices	2 months	✘	✘	✔	✔	✔
Cataracts	2 months	✘	✘	✘	✔	✔
Joint replacements	2 months	✘	✘	✘	✔	✔
Dialysis for chronic kidney failure	2 months	✘	✘	✘	✔	✔
Pregnancy and birth	12 months	✘	✘	✘	✘	✔
Assisted reproductive services	2 months	✘	✘	✘	✘	✔
Weight loss surgery	2 months	✘	✘	✘	✘	✔
Insulin pumps	2 months	✘	✘	✘	✔	✔
Pain management with device	2 months	✘	✘	✘	✔	✔
Sleep studies	2 months	✘	✘	✘	✔	✔
Common services	2 months	✔	✔	✔	✔	✔
Support services	2 months	✔	✔	✔	✔	✔
Ambulance	1 day	✔	✔	✔	✔	✔

*Anything within the above table that is a pre-existing condition has a 12-month waiting period except for psychiatric, rehab and palliative care which have a 2-month waiting period and ambulance which has a 1-day waiting period.

Please note the following products are closed to new members.

✔ = Included ✘ = Excluded **R** = Restricted

Clinical Categories	Waiting Period*	Public Hospital (Basic)	Basic Hospital (Basic Plus)	Mid Hospital (Basic Plus)	Premium Hospital (Gold)
Rehabilitation	2 months	R	R	R	✔
Hospital psychiatric services	2 months	R	R	R	✔
Palliative care	2 months	R	R	R	✔
Brain and nervous system	2 months	R	✔	✔	✔
Eye (not cataracts)	2 months	R	✘	R	✔
Ear, nose and throat	2 months	R	✔	✔	✔
Tonsils, adenoids and grommets	2 months	R	✔	✔	✔
Bone, joint and muscle	2 months	R	✔	✔	✔
Joint reconstructions	2 months	R	✔	✔	✔
Kidney and bladder	2 months	R	✔	✔	✔
Male reproductive system	2 months	R	✔	✔	✔
Digestive system	2 months	R	✔	✔	✔
Hernia and appendix	2 months	R	✔	✔	✔
Gastrointestinal endoscopy	2 months	R	✔	✔	✔
Gynaecology	2 months	R	✔	✔	✔
Miscarriage and termination of pregnancy	2 months	R	✔	✔	✔
Chemotherapy, radiotherapy and immunotherapy for cancer	2 months	R	✔	✔	✔
Pain management	2 months	R	✔	✔	✔
Skin	2 months	R	✔	✔	✔
Breast surgery (medically necessary)	2 months	R	✔	✔	✔
Diabetes management (excluding insulin pumps)	2 months	R	✔	✔	✔
Heart and vascular system	2 months	R	✘	R	✔
Lung and chest	2 months	R	✘	R	✔
Blood	2 months	R	✔	✔	✔
Back, neck and spine	2 months	R	✘	✘	✔
Plastic and reconstructive surgery (medically necessary)	2 months	R	✘	✘	✔
Dental surgery	2 months	R	✔	✔	✔
Podiatric surgery (provided by a registered podiatric surgeon)	2 months	R	✔	✔	✔
Implantation of hearing devices	2 months	R	✔	✔	✔
Cataracts	2 months	R	✘	R	✔
Joint replacements	2 months	R	✘	R	✔
Dialysis for chronic kidney failure	2 months	R	✘	R	✔
Pregnancy and birth	12 months	R	✘	R	✔
Assisted reproductive services	2 months	R	✘	R	✔
Weight loss surgery	2 months	R	✘	✘	✔
Insulin pumps	2 months	R	✔	✔	✔
Pain management with device	2 months	R	✔	✔	✔
Sleep studies	2 months	R	✔	✔	✔
Common services	2 months	R	✔	✔	✔
Support services	2 months	R	✔	✔	✔
Ambulance	1 day	✔	✔	✔	✔

*Anything within the above table that is a pre-existing condition has a 12-month waiting period except for psychiatric, rehab and palliative care.

What should I do if I'm going to hospital?

At the doctor's... 1

Ask your doctor if they'll take part in the Access Gap scheme, which means you'll have low or no out-of-pocket costs. If you do have out-of-pockets, you'll know exactly what they'll be before you go to hospital.

You should also talk about Informed Financial Consent (IFC) with your doctor. This is where they'll go through all of their fees and explain what can be claimed through Medicare, what can be claimed through us and what out-of-pocket costs you'll have. There's more info about this on the checklist we've included in this pack.

You'll also find a nifty list on the back page to help keep track of everything. Remember to write down the Medicare item numbers (they have 5 digits) for any procedures you're having, that way we'll be able to give you a better idea of what your out-of-pocket costs will be.

Give us a buzz 2

Once you've seen your doctor, give us a call to run through what you're covered for.

We'll let you know:

- what your level of cover is
- if you've got any waiting periods to serve
- your excess (if you've got one)
- what options we can offer to help you recover

We know how complicated hospitals and health cover can be, so if you've got any questions at any time just get in touch. We're here to help!

Before your hospital stay 3

The hospital will contact us to confirm your level of cover before you're admitted. This is also a good time to go through the hospital checklist we've included in this pack to help you get organised.

During your hospital stay 4

If you've got an excess on your cover, the hospital will ask you to pay it up-front – either before your stay or when you're admitted to hospital. If you use any additional services while you're in hospital (like TV or take-home medications), you'll need to pay for them before you're discharged. You should be able to get a list of any additional charges beforehand.

Some hospitals might charge a compulsory $25 incidentals fee for overnight stays. This covers things like wi-fi & pay TV. This is usually separate to the rest of your hospital bills, and you'll need to pay for this one yourself.

Did you know that we also offer hospital services in your home? If your doctor agrees, you might be able to leave hospital early and recover at home. Give us a buzz on 1800 808 690 or head to peoplecare.com.au/myhealth for more info.

Public or private?
Having private hospital cover means you can choose whether you want to be treated as a private or public patient. If you go to a public hospital, you'll be asked to sign a 'patient election form', which tells the hospital whether you want to be admitted as a private or public patient. Having private hospital cover doesn't mean that you can't or shouldn't ever go publicly. You have the right to be fully covered by Medicare as a public patient - it's completely up to you how you'd like to be admitted.

Going to public hospital as a private patient? Public hospital waiting lists apply, so check with your doctor and the hospital.

For more info on public vs private admissions, head to peoplecare.com.au/publicvsprivate.

After your hospital stay 5

Once you're home from hospital, you might start getting bills from your doctors (including your surgeon, assisting doctors and anaesthetists), pathologists and radiologists.

We've put together a breakdown of the billing process for you on the next page, but here are the basics:

- The hospital will automatically bill us for your accommodation, theatre fees and any prostheses

- If your doctor is taking part in the Access Gap scheme, they'll send their bills straight to us. We'll send you a benefit statement to let you know what we've paid on your behalf and you won't have to do anything else.

- Any additional charges from the hospital (like TV or take-home items) need to be paid before you leave hospital. If you've got extras cover, you might be able to claim for some pharmacy items.

Where do the bills go?

Hospital bills

These include fees for things like accommodation, theatre a

If you have **Gold or Premium (Gold) Hospital** cover, your hos
private hospital.

If you have **Public Hospital (Basic)** cover, your hospital bills a
only. If you're admitted to a private hospital you'll have larg
whether you are a public or a private patient, so check thes

If you have **any other cover** with us, your hospital bills are co
services are 'restricted' (only covered on a restricted benefit
'excluded services'). If you're admitted as a private patient f
full cost yourself.

Who gets the bill? Most of the time, your hospital will send the bi
statement to let you know it's paid. The only thing you'll have to pay fo
one) and any additional services you've used (like TV). If your hospital bill does get sent to you, just send it on to
us and we'll take care of the rest!

Medical bills

These are bills from doctors, specialists, surgeons, anaesthetists, pathologists, radiologists, etc.

Who gets the bill? If your doctor is taking part in the Access Gap scheme, they'll send their bills straight to us and all you'll have to pay is the gap (which your doctor will tell you about before you go to hospital).

If they're not taking part in Access Gap, you'll be sent their bills directly. If you've been sent a medical bill, you'll need to take it to Medicare first. Medicare pays 75% of the Medicare Scheduled Fee. Once Medicare has paid their benefit, send the bill to us and we'll pay the remaining 25% of the Medicare Scheduled Fee.

If you doctor has charged more than the Medicare Scheduled Fee, you'll have what's called a 'gap payment'. This is your out-of-pocket cost and your doctor should tell you what that'll be before you go to hospital.

What's a Medicare scheduled fee?

Medicare sets a fee for all medical services – this is their suggested cost (think of it like a Recommended Retail Price). Medicare pays 75% of this scheduled fee and your private hospital cover pays the remaining 25% of that fee while you're admitted to hospital.

We can't pay towards services that aren't done in the hospital (known as out-patient services), but Medicare pays 85% of the Scheduled Fee in these cases.

It's really important to know that doctors and healthcare providers can charge above the Medicare scheduled fees for both in-hospital and out-patient services. If they do, you'll have an out-of-pocket (or 'gap') cost.

Other bills

These are for additional services during your hospital stay (like TV, newspapers, a double bed, extra meals etc.). You'll pay for the full cost of these yourself.

Who gets the bill? You'll usually get the bill for this while you're still in hospital and need to pay it before you're discharged. If not, it'll be sent straight to you and you'll pay the full cost yourself.

Out-of-pocket costs

It's important to remember that you might have out-of-pocket costs for hospital stays, even if you're on our Premium (Gold) or Gold Hospital covers. These can include:

- your excess (if you have one)
- anything your doctor charges over the Medicare Scheduled Fee (which you should've already had the heads-up about from your doctors)
- any additional services while you're in hospital (like TV)
- pharmacy items that you're given to take home with you. If you've got extras cover we might be able to pay a benefit towards these.

Our tip: if you're taking your bills to Medicare first, fill in a two-way claim form (included in this pack) and Medicare will send your bills straight to us once they've paid their bit.

Love keeping track

If you like being organised, this list is for you. It's handy to have with you when you visit your doctor to jot down everything that you'll be expected to pay.

One of the most important things to take note of is the Medicare item numbers. You'll find these 5-digit numbers on your bills (or by asking your doctor). Each medical service has a Medicare item number, and each item number has a set Medicare Scheduled Fee – anything your doctor charges above that fee will be an out-of-pocket cost payable by yourself.

REMEMBER: private hospital cover (together with Medicare) is there to cover you for 100% of the Medicare Scheduled Fee for in-hospital services – with Medicare paying 75% and us taking care of the remaining 25%. Your private hospital cover also covers the cost of your accommodation, prostheses and theatre fees while you're in hospital.

Expected bills	Item number(s)	TOTAL	Medicare scheduled fee (MSF)	You (out-of-pocket)	Medicare	Peoplecare
eg. Consult with anaesthetist, less than 15 minutes	17610	$87.00	$65.00	$22.00 (Above the MSF)	$48.75 (75% of MSF)	$16.25 (25% of MSF with Hospital cover)

Hospital name:

Phone number:

Dates of stay:

My level of cover:

My excess:

Membership number:

Recovering at home

We love giving our members more options, so we've got some great **hospital substitute programs** that could get you out of hospital sooner and recovering at home (if your doctors approve).

And the best part?

They're all **free** with some of our Hospital covers! For more info, head to **peoplecare.com.au/myhealth** or give us a buzz on:

1800 808 690

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