Going to HOSPITAL

If you or a family member need to go to hospital, it will ease your mind if you understand what your GU Health membership covers.

At GU Health we want to make sure your experience as one of our members is as positive as possible. Planning your hospital admission in advance and familiarising yourself with the conditions of your cover can help you to understand what to expect when going to hospital.

Inpatient or outpatient?

When you go to hospital and you're admitted as a patient, any service you receive is referred to as an inpatient service. If you're not admitted (this includes emergency room services) or you receive a medical service outside of hospital, this is classified as an outpatient service. GU Health will only provide hospital benefits when you're admitted as an inpatient.

How your hospital cover works

The key thing you'll want to know is how much your hospital admission may cost you.

Depending on your level of cover, your hospital accommodation and theatre fees are typically covered in either a public hospital or a partner private hospital (including day and overnight stays for services where you're admitted).

Some levels of cover provide cover for all public and private hospitals Australia wide, so it's important to refer to *Your Plan Information* for details specific to your plan.

To reduce the cost of your regular hospital contributions, you or your employer may choose to select a cover option with an excess. Please see 'What is an excess?'

What is an excess?

An excess is only paid if you or anyone on your membership is admitted into hospital as a private patient. Generally, an excess is paid once in an excess year for each person on the membership. Alternatively it might be applied to the first two hospitalisations on your family membership before it's capped. This will depend on your individual cover.

Some covers waive the excess for same-day admissions or for children or student dependants. Please refer to *Your Plan Information* or log in to Online Member Services for further details about the excess arrangements that apply to your particular level of cover. A hospital excess is payable on the hospital component but not the medical component of your cover.

It's worthwhile finding out if you have a 'hospital excess'. If you do, and you have not already paid it in your current membership year, you may be required to pay this fee to the hospital prior to your admission. GU Health will then cover the remaining cost of your accommodation directly with the hospital.

Fees you may have to pay

You'll be responsible for paying for any extras if they're unrelated to your healthcare or not included in your cover, such as telephone, internet and television access.

You'll also need to make sure you're choosing the right hospital for your treatment by searching our list of partner private hospitals

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through the 'Find a hospital' search on our website or by calling your Member Relations Team.

The agreements we have with partner private hospital mean that you'll be covered for 100 per cent of accommodation and theatre fees, less any excess that you may be required to pay based on your level of cover. A small number of hospitals may also charge a fixed daily fee. If this is the case, the hospital should inform you of this fee when you arrange your booking.

At hospitals where no agreement exists (non-partner private hospitals), you'll only receive restricted benefits for the cost of your hospital services.

There will also be a benefit limit of $300 per person per membership year for in-hospital pharmaceutical drugs. Please refer to the section on 'Restricted benefits' in *Your Membership Guidelines* for details.

We recommend that you check to ensure your hospital is listed as a partner private facility before commencing your hospital treatment. We have agreements with most private hospitals throughout Australia, and you can log onto guhealth.com.au and use the 'Find a provider' search function, or contact your Member Relations Team for details.

What are the benefits of being a private patient?

Being admitted into hospital as a private patient doesn't have to be a costly experience, especially when you have health cover with GU Health. Medicare covers 75 per cent of the Medicare Benefit Schedule (MBS) fee for medical costs, and any in-hospital medications provided by the government under the Pharmaceuticals Benefit Scheme (PBS).

Provided there are no exclusions or restrictions under your specific cover, we'll pay the remaining 25 per cent so you'll be covered for 100 per cent of the MBS fee. If your costs exceed the MBS fee, GU Health's Access Gap Cover scheme may help. Please see 'What's GU Health Access Gap Cover Scheme?'

Partner private hospitals

To make sure you're getting the best possible deal, we have contracts in place with hospitals that specify how much they can charge for accommodation and other services. These agreements help to reduce your out-of-pocket expenses.

Our partner (or agreement) private hospitals have an arrangement with us so that you're covered for 100 per cent of your accommodation and other services when you go to hospital.

Depending on your level of cover, in most cases, you'll be covered for all in-hospital charges for eligible services provided as part of your in-hospital treatment including:

- accommodation for overnight or same-day stays
- operating theatre, intensive care and labour ward fees
- supplied pharmaceuticals approved by the Pharmaceutical Benefits Scheme (PBS)
- allied services provided by the hospital including physiotherapy, occupational therapy and dietetics
- dressings and other consumables
- surgically-implanted prostheses (e.g. a cardiac stent) up to the minimum approved benefit in the Government Prostheses List. To avoid any out-of-pocket expenses, we suggest discussing prosthesis choices with your specialist before going to hospital.

What's GU Health's Access Gap Cover scheme?

When you're treated by a doctor in a hospital or day surgery, your procedure will attract a Medicare item number.

These item numbers have a scheduled fee attached to them which states the maximum GU Health and Medicare can pay for the procedure. Medicare will cover 75 per cent of the fee, and GU Health the remaining 25 per cent.

If the practitioner who is treating you charges more than this fee, you may have to pay the difference between the practitioner's charge for the item number and the scheduled fee.

This means that even if you have the most comprehensive hospital cover, you could still be up for some out-of-pocket expenses when it comes to your in-hospital medical bills.

Normally, any remaining amount above the MBS fee is charged to you. For example, if your surgeon or anaesthetist chooses to bill above the MBS fee for a service, Medicare and GU Health will be unable to cover that extra cost.

However, if they agree to participate in GU Health's Access Gap Cover scheme we'll pay above the MBS fee, up to the access gap cover amount specified in GU Health's Access Gap Cover benefits schedule.

The result is that your potential expenses could be reduced or, in many cases, eliminated completely. This is because the GU Health Access Gap Cover benefit amount is more than the amount set out in the MBS. If you've experienced out-of-pocket expenses in the past it's probably because your practitioner didn't participate in access gap cover.

What's not included under access gap cover?

Keep in mind that your practitioner has the discretion to choose, on a case-by-case basis, whether they'd like to participate in the scheme, so make sure you ask them about this during your consultation.

If there's still an outstanding amount even after your doctor has chosen to take part in access gap cover – referred to as 'known gap' – ask for the details of this amount in writing before your procedure. This is known as Informed Financial Consent. Please see the section on 'Informed Financial Consent' for more information.

Access gap cover doesn't cover costs such as hospital excess, or services such as blood tests and x-rays provided by pathologists and radiologists.

How to claim access gap cover

We've made it easy for you to find a doctor who's previously participated in access gap cover through the 'Find a provider' search option on our website guhealth.com.au. Doctors that appear on the list do not automatically provide a no-gap or known gap service. They may choose to make this decision on a case-by-case basis, so you must ask the doctor if they will participate in the scheme for each admission you arrange.

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If a doctor agrees to participate, they may send their bill directly to us. If the doctor gives the bill directly to you, and they have charged under access gap cover, it's important that you send your claim directly to us for processing – don't send it to Medicare first.

If an access gap claim is processed by Medicare first, we may not be able to pay above the MBS fee and cover the agreed gap.

Please keep in mind that GU Health's Access Gap Cover will only cover services provided during your hospital stay. Any consultations before and after your hospital stay won't be covered under the scheme, including any administration and booking fees that may be charged.

Informed Financial Consent

Your treating doctor has a responsibility to provide you with Informed Financial Consent, which is a document outlining all the charges and out-of-pocket expenses you may incur, before you're admitted to hospital.

It's your responsibility to ensure you understand all the potential costs before your admission to hospital and to discuss your treatment with the hospital and doctor/s.

We recommend you contact your Member Relations Team before going to hospital and/or before you undertake any treatment so that you understand your benefits and learn how you may be able to minimise or avoid out-of-pocket expenses.

If you're a non-resident, please refer to *Your Plan Information* for details of the level of cover provided. If your cover pays less than 100 per cent of the cost, you may also experience out-of-pocket expenses associated with the medical gap.

Restricted benefits

If you choose a product with restricted benefits (also called default or minimum benefits), you'll only be covered for admission into a shared room in a public hospital for those services.

If you're admitted into a private facility, the benefit we will pay is equal to the lowest cost of a shared room in a public hospital. This means you could face significant out-of-pocket expenses if you are admitted to a private hospital.

We won't pay a benefit for intensive or coronary care, labour ward, or theatre fees in a private hospital or private day centre. If you wish to be covered in a private hospital, we recommend you consider purchasing a more comprehensive level of cover.

Restricted benefits may also apply in instances where you're undergoing a treatment which isn't listed under the MBS. This may include plastic and cosmetic surgery and surgery by an accredited podiatrist. Please refer to *Your Plan Information* for details of benefits included under your level of cover.

Multiple procedures

If you have more than one operative procedure during one theatre admission, or within one day, the procedure with the highest Medicare Benefits Schedule (MBS) fee will determine the classification of the admission, which will influence the level of benefits you'll receive. This means that if you don't have an appropriate level of cover, you may incur a higher out-of-pocket expense. Contact your Member Relations Team before your admission to understand the full extent of your benefit entitlements.

Continuous hospitalisation

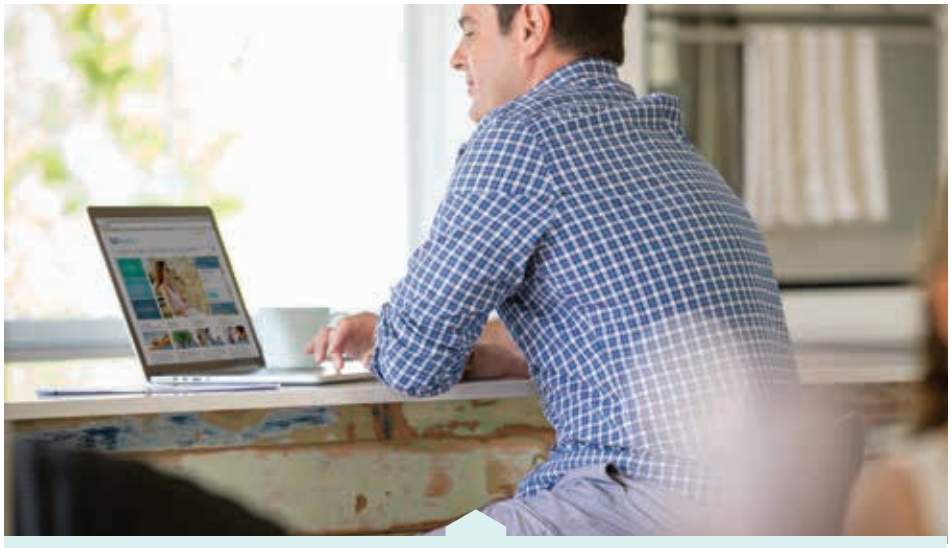
If you're discharged from hospital and then re-admitted again within seven days – to the same hospital or a different hospital for the same or related condition – the two admissions are regarded as one continuous hospitalisation. If your cover has a hospital excess, you may not have to pay the excess for the second admission.

Accidental injury

An accidental injury is when an injury occurs as a result of an unintentional, unexpected action or event and requires treatment by a registered medical practitioner.

Pharmaceutical Benefits Scheme

The Pharmaceutical Benefits Scheme (PBS) is funded by the Federal Government and subsidises the cost of pharmaceuticals. Benefits are only paid for pharmaceutical items that are essential to your care and approved under the PBS for use in Australia as part of the standard treatment. You'll also need to pay the current PBS amount, which is a portion of the cost, before you can claim the remaining cost under your cover.



Ask GU Health

It's a good idea to contact us to discuss the following questions:

- Is the hospital I'm going to a partner private hospital? If no, how will this affect my benefits?
- Have I served my waiting periods? If no, what does that mean for me? (A waiting period is a limited period of time when you or your family will not receive benefits for certain treatments.)
- Is this an excluded Medicare Item for which I am being hospitalised? If yes, what does that mean?
- Do I have a hospital excess? If so, how much? When do I pay this?
- Am I covered for ambulance?

What is a pre-existing condition?

A pre-existing condition is one which is considered to have shown signs or symptoms up to six months prior to joining or increasing your level of hospital cover, irrespective of diagnosis. Pre-existing conditions are subject to a 12 month waiting period, meaning benefits may not be paid for these conditions until the appropriate level of cover has been held for 12 months. Claims for pre-existing conditions made within waiting periods may be referred to GU Health's consulting doctor for approval prior to payment.

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In order to qualify for cover, the accident must have occurred after you joined GU Health and you must not to be eligible to claim benefits from a third party for your injuries.

The definition of 'accident' excludes accidental illness, injuries arising from surgical procedures, pregnancy, injuries or illnesses induced by alcohol, drug dependence and aggravation of a pre-existing condition.

Emergency room treatment

Treatment received in an emergency department (whether public or private), that doesn't result in an admission, is classified as an outpatient service.

Under our residential covers, benefits are not paid for this type of treatment or for any facility fees which may be charged in private hospital emergency rooms.

If you're a non-resident, benefits are paid in line with the outpatient benefit entitlements which may be available under your particular level of cover. Please refer to *Your Plan Information*.

Emergency admissions

In an emergency, we may not have time to determine if your condition is pre-existing prior to your admission. If you have less than 12 months membership on your current cover, you may need to pay for some or all of the hospital and medical charges if you're admitted to a public or partner private hospital and choose to be treated as a private patient and we later determine that your condition was pre-existing. In addition, the hospital may not be in a position to follow the full Informed Financial Consent process (please see the section on 'Informed Financial Consent'), and you may experience unexpected out-of-pocket expenses as a result of being treated as a private patient.

To avoid this, you may prefer to be admitted as a public patient in emergency situations.

Once the emergency treatment is carried out you may then choose to be re-admitted as a private patient (if required). In such instances we strongly recommend that you:

- ensure the hospital is a partner private hospital
- obtain Informed Financial Consent so you understand any potential out-of-pocket expenses
- contact your Member Relations Team to ensure your level of cover is sufficient for the service/treatment you require. Private hospital emergency room fees are not covered under any resident cover options. If you're a non-resident and are covered for outpatient services, please refer to the outpatient services section of *Your Plan Information*.

Your hospital checklist

1. Call us to discuss your cover including any waiting periods, exclusions, restrictions or excess.
2. Contact the hospital to see if you'll have to pay your excess before you're admitted.
3. Talk to your GP about selecting an appropriate specialist.
4. Talk to your specialist about your condition, treatment options and any out-of-pocket expenses and obtain any relevant Medical Benefits Scheme (MBS) item numbers and Informed Financial Consent.
5. Make sure that you understand the anaesthetist's charges and the charges of any other health professionals associated with your in-hospital treatment.
6. Mention our Hospital Care at Home program to your specialist, as it could be considered as an option for your after-care.
7. Learn about GU Health's Access Gap Cover scheme, designed to reduce or eliminate your out-of-pocket medical expenses, and ask your specialist and any other health professionals associated with your in-hospital treatment if they'll participate.
8. Choose your hospital – selecting one of GU Health's partner private hospitals or day facilities can reduce your out-of- pocket hospital expenses.
9. Ask your hospital about any fixed fees they may have.
10. Prepare for your stay by deciding what to take and following any preparation instructions from your doctor.
11. Have your GU Health Member Card ready to take with you to the hospital.

Please make sure you read the *Your Membership Guidelines* booklet in conjunction with *Your Cover at a Glance* and *Your Plan Information*, which you would have received in your *GU Health Welcome Pack*.

For further information about your GU Health cover or any queries relating to this document, please contact your GU Health Member Relations Team on **1800 249 966** or email **corporate@guhealth.com.au**.

Updated August 2015. The information contained within this document is current from the publication date and is subject to change.
If you're planning a treatment for which you anticipate a benefit from GU Health, contact us in advance to confirm your benefit entitlement.

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