Public Hospital

Public Hospital cover enables you to be treated by the doctor of your choice, however, you are only covered for treatment in a public hospital, not a private hospital. It is a very comprehensive cover, which does not have any treatment exclusions or restrictions.

What does Public Hospital cover you for?
Over the page, you’ll find a comprehensive list of the types of treatments, services and products you can claim under your Public Hospital cover. You’ll also see information on the things you are not covered for as well as the waiting periods that apply before you can make different types of claims.

Your hospital cover pays benefits on four types of costs:

1. Public hospital of your choice
   With Public Hospital, you’re up to 100% covered for all of the hospital’s costs when you are treated in a public hospital. This is for both overnight and same-day procedures. The only costs that won’t be covered are personal services such as television hire, internet access, newspaper delivery etc.
   Please note that some state governments allow public hospitals to charge fees outside the default rate covered by the health funds. These additional charges are not covered by your Public Hospital cover. You should check with the hospital prior to admission what your out-of-pocket expenses will be.

2. Doctors of your choice
   If you choose to be treated in a private hospital you will be left with substantial out-of-pocket hospital costs, which can often add up to many thousands of dollars.

3. Implantated prostheses and in-hospital pharmaceuticals
   Most prostheses and pharmaceuticals are likely to have lower out-of-pocket costs, but you often have no control over the timing of your treatment or the doctors who are appointed to care for you. With public hospital cover, you have the ability to make the choice that suits you.

4. Ambulance transportation
   Transportation. You’ll find full details over our website.

How do you make a hospital cover claim?

1. Decide whether you wish to go private or public
   Having private hospital cover gives you the best of all options when it comes to deciding by whom you want to be treated. You also have the option of choosing not to use your hospital cover and to instead be treated as a public patient. As a private patient, you have more control over the timing of your treatment and can nominate the doctor you wish to treat you, but you may have out-of-pocket costs following the procedure. As a public patient, you are less likely to have any out-of-pocket costs, but you often have no control over the timing of your treatment or the doctors who are appointed to care for you. With private hospital cover, you have the ability to make the choice that suits you.

2. Make sure that you have served your waiting periods
   When you take out hospital cover for the first time, after signing your cover your policy, or when you upgrade to a higher level of cover, you are required to serve waiting periods. This means you must have the cover for a certain period of time before you can claim for some services. All the waiting periods that apply to your Public Hospital cover are shown over the page. If you’re not sure whether or not you’ve served your waiting periods, contact our team to find out.

3. Make sure that the treatment or procedure you’re planning to claim is covered
   If you’re not 100% certain, please ask us. With Public Hospital cover, the simple test of whether something is covered or not is whether Medicare pays a benefit; if Medicare pays, so does Public Hospital. When you are booking your hospital stay, the hospital will ask you for the details of your cover and will contact us to confirm that you are covered for the procedure you’re having. They’ll also to check that your membership is paid up to date.

4. Ask your doctors if they will use our Access Gap cover
   You need to make this arrangement before your hospital stay. If your doctors agree, it means they are willing to accept a set fee for their services that is higher than the MBS fee, but probably less than what they might otherwise charge. This means you are likely to have lower out-of-pocket costs, and in some cases, none at all. We recommend you contact our team for more information about how to request Access Gap cover arrangements when you are planning your hospital stay.

5. Find out if you’re suitable for our Hospital at Home program
   You are responsible for paying any agreed out-of-pocket costs.

6. Following your hospital stay
   You usually won’t see any bills from the hospital, they get sent directly to us, but you may receive bills from all the doctors who treat you.
   If your doctors agreed to participate in our Access Gap cover, send your doctors’ bills to us together with a completed claim form (available to download from our website, or ask our team to email or post one to you). With Access Gap cover, your doctors will have either agreed to charge you no gap, or they will have given you a quote in advance for any out-of-pocket costs you might have. You are responsible for paying any agreed out-of-pocket costs.
   If your doctors do not participate in our Access Gap cover, take your doctors’ bills to a Medicare office. They will pay 75% of the MBS fee and give you a statement that you send to us together with a completed claim form (available to download from our website, or ask our team to email or post one to you). We will pay the remaining 25% of the MBS fee. Any remaining amount is an out-of-pocket cost you are responsible for paying.

Unplanned hospital stays
   If you are taken to hospital as a result of an accident or emergency, you will more than likely go to a public hospital emergency ward. Most public hospital emergency departments will treat you as a public patient at no cost. Some private hospitals also have emergency departments, and if you attend one of these, you are not covered for the costs. Hospital cover only comes into play when you are admitted, as an inpatient to hospital.

   Having private hospital cover gives you the option of choosing to be treated as a public patient under Medicare rather than using your cover.
Public hospital costs

Accommodation
Up to 100% of the cost of shared room accommodation in a public hospital. If you elect to have a private room, you will have out-of-pocket costs.

Operating theatre / Intensive care / Coronary care
Up to 100% of the cost in a public hospital only.

Doctors’ costs

100% of the Medicare Benefits Schedule (MBS) fee for services provided by doctors in hospital.

When you are treated in hospital, Medicare will pay 75% of the MBS fee for each ‘item’ and hospital cover is only allowed by law to pay the remaining 25%. Doctors are not limited to only charging the MBS fee – and that’s where we can end up with out-of-pocket costs, because the law prevents funds from paying more than 25% of the MBS fee.

We offer a program as part of all our hospital covers that can help to reduce the likelihood of out-of-pocket costs.

With Access Gap cover, you can ask your doctors to charge a set fee based on a different fee schedule, which is higher than the MBS fee but probably not as much as they might otherwise charge. If they agree to use Access Gap cover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. We can give you more information and assistance with this when you are planning your hospital stay.

Please note that doctors usually work in a select few hospitals, which may limit the choice of hospital available to you if you wish to be treated by a particular doctor.

Prostheses and pharmaceutical costs

Prostheses
100% of the cost of government-approved no-gap prostheses (lower benefits apply for other prostheses).

We recommend you contact our member care team to find out exactly what you’re covered for before going into hospital.

Pharmaceuticals
100% of the cost of:
• pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission
• pharmacy items listed on the Commonwealth Exceptional Drugs List.

Ambulance and transportation costs

Ambulance
Residents of VIC, WA, TAS, NT – up to $5,000 per person per year for emergency ambulance transport or transportation in the case of accident or illness. Cover applies anywhere in Australia. Residents of Tasmania are covered by a reciprocal state government ambulance scheme in all states except QLD and SA, so our ambulance cover only applies where the state government scheme does not. You can also purchase additional ambulance cover through a state government ambulance service.

Residents of NSW or the ACT – unlimited cover for emergency transportation, and medically necessary non-emergency transportation. The service must be provided by a state government operated, authorised or approved ambulance service. Cover applies anywhere in Australia. Please contact the fund prior to using any non-emergency patient transportation supplied by a hospital for inter-hospital transfers.

Residents of QLD – unlimited cover under a QLD state government ambulance scheme. Cover applies anywhere in Australia.

Additional benefits available

Hospital at Home (hospital substitution program)
Offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home.

Chronic disease prevention and management program
Helps people self-manage existing or potential chronic diseases (including asthma, diabetes, arthritis, heart disease and others).

Ambulance emergency department fees
When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). Your Public Hospital cover can only pay benefits for treatment you receive as an inpatient, that is, when you are admitted as a patient to hospital.

Discharge pharmaceuticals
These are items prescribed for you to take home after you are discharged from hospital. No benefits are payable for these under your Public Hospital cover, but you may be able to claim under your extras cover.

Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees

Waiting periods:

Accidents
1 day

General services
2 months

Psychiatry, rehabilitation and palliative care
2 months

Pre-existing conditions
12 months

A pre-existing condition is “an ailment or illness, the signs or symptoms of which were in existence at any time during the six months preceding the day on which the member joined the fund or upgraded to a higher level of cover”. If you have a medical condition at the time you join rt, or upgrade your existing rt hospital cover, you may not be immediately covered. If a claim looks like it may relate to a pre-existing condition, a medical advisor or practitioner appointed by us will examine information provided by your doctor/s and any other material relevant to the claim, and will make a determination as to whether the condition is pre-existing or not.

Obstetrics and other pregnancy-related services and treatments
12 months

If you have a hospital stay coming up, we strongly recommend you call us for advice on how to make the most of your hospital cover, and to confirm that you are covered for the procedure you’re having.