



PUTTING YOU BACK IN THE PICTURE OF HEALTH

HOSPITAL
GUIDE

**UNI
HEALTH** 

We're for the educators



We're for the educators

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PRIVACY POLICY

UniHealth respects your privacy and is committed to managing and protecting your personal and health-related information in accordance with relevant legislation in Australia. If you would like to find out more about UniHealth's privacy policy, visit unihealthinsurance.com.au/privacy

GOING TO HOSPITAL? THINGS YOU SHOULD KNOW

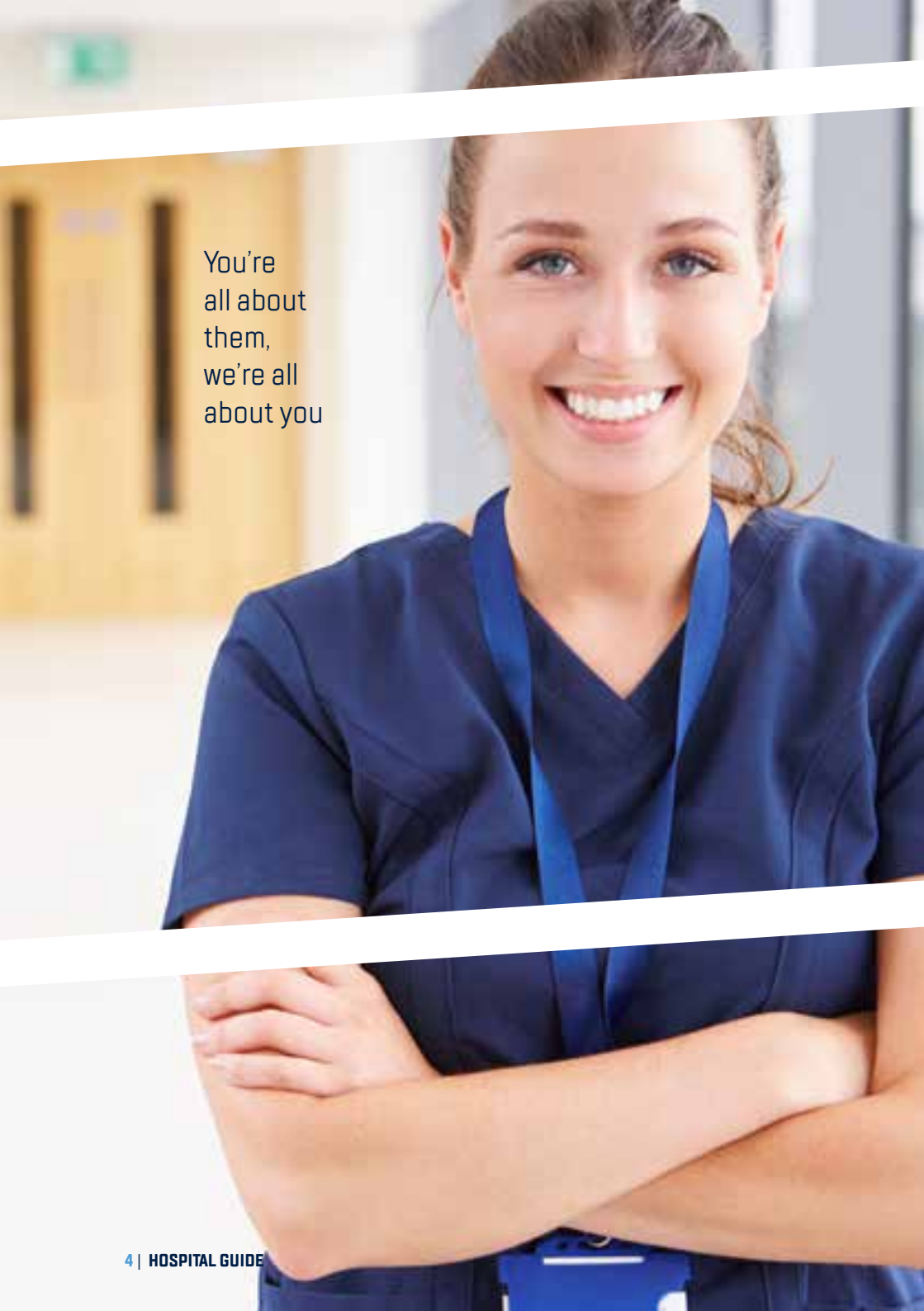
Going to hospital can be a stressful time for many, especially when it comes to understanding how the hospital system works and knowing what you are and aren't covered for.

We've created this Hospital Guide to simplify the experience so that you're prepared from pre-admission to discharge.

This Guide will provide you with an overview of the benefits available to you based on your level of Hospital cover, questions to ask your doctor or specialist, helpful information on preparing for your hospital admission and discharge, as well as the process of making a claim.

Let us help take the stress out of your next hospital visit so that you can focus on what's most important, your health.



A close-up portrait of a young woman with brown hair tied back, wearing blue medical scrubs. She is smiling broadly, showing her teeth, and has her arms crossed. The background is a blurred hospital hallway with a wooden door and a green exit sign.

You're
all about
them,
we're all
about you

UNDERSTAND YOUR COVER

It's important to understand the level of Hospital cover you have with UniHealth before being admitted to hospital. UniHealth has three types of Hospital cover – Top, Mid and Basic – and one Combined cover – StarterPak. Each level of Hospital cover will determine the benefits you are entitled to during your hospital stay.

Before going to hospital consider the following:

WHAT TREATMENT OR PROCEDURE WILL YOU BE RECEIVING?

Your doctor or specialist will provide you with the name of the procedure and the relevant Medicare item numbers before going to hospital. Knowing this is a part of your Informed Financial Consent, the right to know the full cost of your treatment and what your out-of-pocket expenses may be prior to admission.

WHAT IS YOUR LEVEL OF HOSPITAL COVER?

Do you have Top, Mid or Basic level of Hospital cover or StarterPak? You can find out your Hospital cover by logging on to Online Member Services at unihealthinsurance.com.au/members

DO YOU HAVE AN EXCESS ON YOUR HOSPITAL COVER?

If you have Top Hospital 300 or 500, Mid Hospital or Basic Hospital cover, you will have an excess to pay towards your hospital admission. Check the table on page 6 to see if your Hospital cover includes an excess.



HOSPITAL COVER	EXCESS PAYABLE
TOP HOSPITAL	No excess.
TOP HOSPITAL 300	<p>\$300 per person, per calendar year.</p> <p>The excess is paid once per person, per calendar year to a maximum of twice per membership for Family and Couple memberships.</p> <p>This is only payable when admitted to a private hospital.</p> <p>The excess does not apply to child dependants under the age of 21.</p>
TOP HOSPITAL 500	<p>\$500 per person, per calendar year.</p> <p>The excess is paid once per person, per calendar year to a maximum of twice per membership for Family and Couple memberships.</p> <p>This is only payable when admitted to a private hospital.</p> <p>The excess does not apply to child dependants under the age of 21.</p>
MID HOSPITAL 300	<p>\$300 per person, per calendar year.</p> <p>The excess is paid once per person, per calendar year to a maximum of twice per membership for Family and Couple memberships.</p> <p>This is payable when admitted to a private or public hospital as a private patient.</p> <p>The excess does not apply to child dependants under the age of 21.</p>
MID HOSPITAL 500	<p>\$500 per person, per calendar year.</p> <p>The excess is paid once per person, per calendar year to a maximum of twice per membership for Family and Couple memberships.</p> <p>This is payable when admitted to a private or public hospital as a private patient.</p> <p>The excess does not apply to child dependants under the age of 21.</p>
BASIC HOSPITAL	<p>\$300 per person, per calendar year.</p> <p>The excess is paid once per person, per calendar year to a maximum of twice per membership for Family and Couple memberships.</p> <p>This is payable when admitted to a private or public hospital as a private patient and applies to all people on the policy.</p>
STARTERPAK	No excess.

WHAT ARE THE WAITING PERIODS FOR MY HOSPITAL COVER?

WAITING PERIODS

Waiting periods apply to:

- new members to private health insurance
- existing UniHealth members who upgrade to a higher level of cover or reduce their level of excess (in this case you will need to serve the relevant waiting period for the higher benefit entitlement)
- members who transfer from another health fund who have not already completed the required waiting periods or are transferring to a higher level of cover.

HOSPITAL WAITING PERIODS

Pre-existing conditions (see right)	12 months
Pregnancy and birth-related services	9 months
All other hospital services	2 months
Psychiatric, rehabilitation and palliative care	2 months
Emergency ambulance transport	1 day
Non-emergency ambulance transport	1 day

Once you hold your Hospital cover for 12 continuous months, all the required waiting periods will be served.

You can check your waiting periods by logging on to Online Member Services available at unihealthinsurance.com.au/members

PRE-EXISTING CONDITIONS

A 12 month waiting period applies to all pre-existing conditions except psychiatric, palliative care and rehabilitation, which are covered by the normal two month waiting period.

A pre-existing condition is an illness, ailment or condition where the signs or symptoms of which, in the opinion of the Fund Medical Advisor or other relevant medical practitioner appointed by UniHealth, existed at any time during the six months before taking out private health insurance or transferring to a higher level of cover. This rule applies to:

- new members to private health insurance
- existing members who upgrade to a higher level of cover or reduce their level of excess.

We may require your referring doctor and specialist to provide us with information so that we can determine whether or not your condition is pre-existing.

DOES YOUR HOSPITAL COVER HAVE RESTRICTED OR EXCLUDED 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 prosthesis list items.

If you choose to be treated:

- in a private hospital – the benefits we pay will not cover all hospital costs resulting in significant out-of-pocket expenses

- in a public hospital as a private patient – you may have an out-of-pocket expense to pay in the event that the minimum benefit is less than what your chosen public hospital charges

Regardless of where you're treated, the hospital should advise you before you are admitted or have treatment, and seek your consent about any out-of-pocket expenses you'll need to pay. This is known as Informed Financial Consent.

HOSPITAL COVER

TOP HOSPITAL

You are covered for any procedure where Medicare pays a benefit.

TOP HOSPITAL 300

You are not covered for any procedures where Medicare pays no benefit including cosmetic surgery and laser eye surgery. There are no other restrictions on these levels of cover.

TOP HOSPITAL 500

MID HOSPITAL 300

You are covered for any procedure where Medicare pays a benefit as a private patient in a private hospital except for a number of restricted services.

MID HOSPITAL 500

For restricted services we will pay the minimum default benefit for a shared room in a public hospital as set out by the Federal Government. These include:

- pregnancy and birth-related services
- infertility treatments
- hip, knee, shoulder and ankle replacements
- coronary care and cardiothoracic procedures
- dialysis procedures and treatments
- cataract and eye lens procedures
- bariatric surgery
- psychiatric, rehabilitation and palliative care.

You are not covered for any procedures where Medicare pays no benefit including cosmetic surgery and laser eye surgery.

If you choose to be treated in a private hospital, the benefits we pay will not cover all hospital costs resulting in significant out-of-pocket expenses.

BASIC HOSPITAL

You are only covered in a private hospital for the following four key services:

- removal of tonsils and adenoids
- knee and shoulder investigations and reconstructions
- appendicitis treatment
- hernias

For all other services where Medicare pays a benefit, we will pay the minimum default benefit for a shared room in a public hospital. If you choose to be treated in a public hospital as a private patient, 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.

If you choose to be treated in a private hospital, the benefits we pay will not cover all hospital costs resulting in significant out-of-pocket expenses.

STARTERPAK

You are only covered in a private hospital for the following five key services:

- removal of tonsils and adenoids
- knee and shoulder investigations and reconstructions
- appendicitis treatment
- hernia
- accidents (see below).

You are not covered in a public or private hospital for the following services:

- pregnancy and birth-related services
- infertility treatments
- joint replacement (hip and knee)
- coronary care and cardiothoracic procedures
- dialysis procedures and treatments
- glaucoma and eximer laser eye surgery
- sterilisation and reversal of sterilisation
- procedures where Medicare pays no benefit, e.g. cosmetic surgery.

For all other services where Medicare pays a benefit, we will pay the minimum default benefit for a shared room in a public hospital. 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.

If you choose to be treated in a private hospital, the benefits we pay will not cover all hospital costs resulting in significant out-of-pocket expenses.

NON-MEDICARE BENEFIT SERVICES

Services such as surgical podiatry, laser eye surgery and cosmetic surgery (that do not attract a benefit from Medicare) will result in significant out-of-pocket expenses, regardless of your level of Hospital cover.

ACCIDENTS

Accident means an injury to the body inflicted as a result of unintentional, unexpected actions or events caused by an external force or object,

which occurred in Australia and after joining the Fund that requires, within seven days of the accident, in-patient hospital treatment by a recognised medical practitioner, health care provider or dentist, but excludes pregnancy. Benefits are payable for the initial in-patient hospital treatment for injuries resulting from the accident, as well as ongoing in-patient hospital treatment where the services are provided within 180 days of the date of the accident and which form part of the initial course of treatment covered by the Fund.

Inspiring
good
health



GET A QUOTE

Before you go into hospital you should obtain a quote from the doctor or specialist involved in your hospitalisation (e.g. surgeon, anaesthetist, assisting surgeon or pathologist) so you will be aware of any unexpected costs.

ACCESS GAP COVER

Access Gap Cover (AGC) is a billing scheme that aims to reduce or eliminate out-of-pocket expenses for medical services received in hospital as an in-patient.

AGC allows us to pay above the scheduled fee for services provided to you as an in-patient. Doctors can choose to participate in AGC on a patient-by-patient basis so contact your doctor to discuss if they are willing to treat you under this arrangement.

If your doctor or specialist agrees to bill you under this arrangement, you will experience either reduced or nil out-of-pocket expenses for in-patient medical charges. If they charge above the AGC fee you will be able to establish the 'known gap' that you will have to pay before you receive treatment.

If your doctor chooses to participate in AGC, they must provide you with a written estimate of fees for the cost of the services.

If you have any questions about AGC, contact us on **1300 367 906**. You can also visit our website for a list of doctors who have previously participated in the scheme with UniHealth.

KNOW THE RIGHT QUESTIONS TO ASK

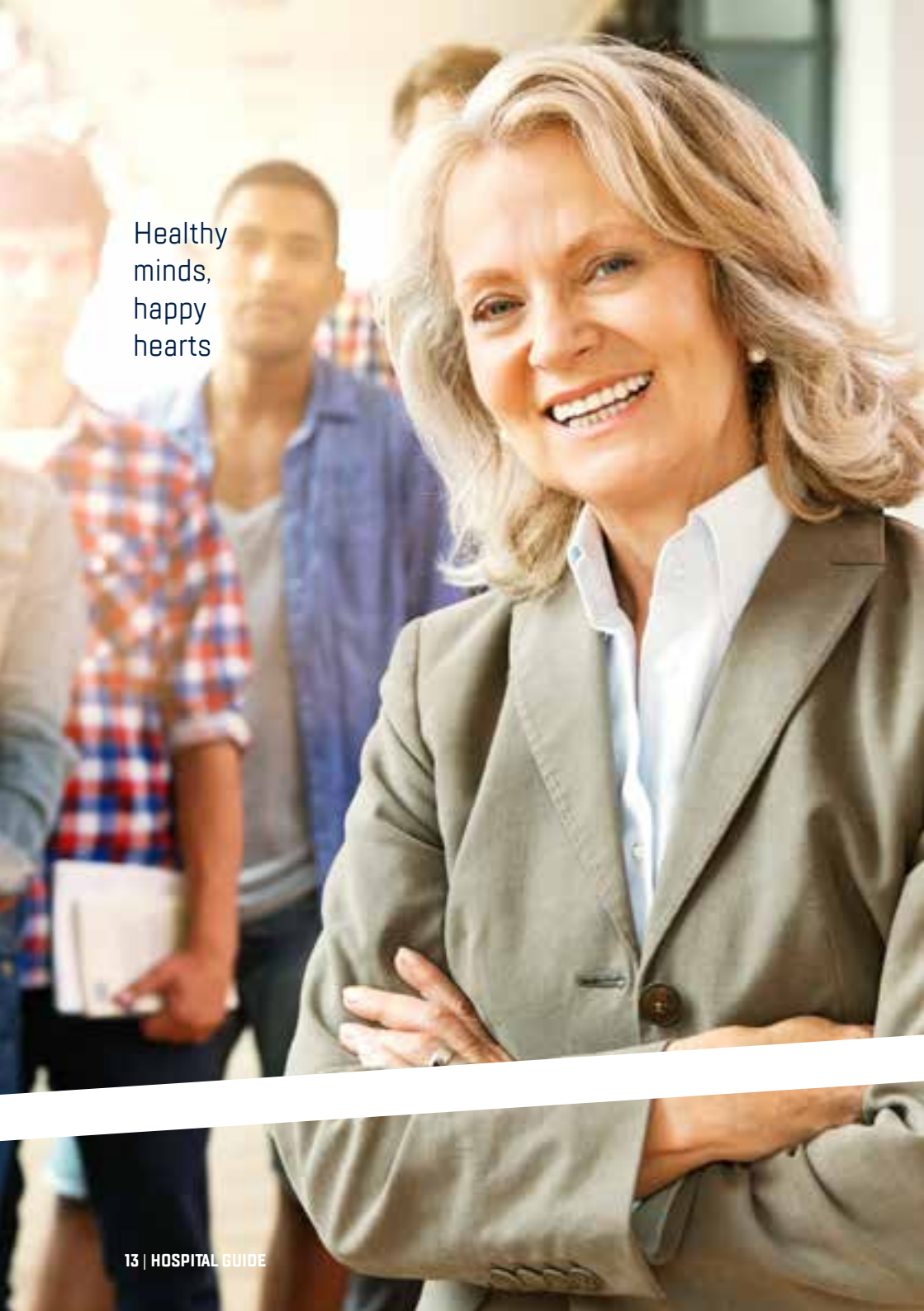
Before going to hospital you should ask your doctor or specialist for information about what your treatment could cost and what out-of-pocket costs you can expect.

QUESTIONS TO ASK YOUR DOCTOR OR SPECIALIST ABOUT POTENTIAL COSTS

- Do you participate in the Access Gap Cover (AGC) scheme?
- Will the fee you charge be covered under AGC or will I have to pay a 'known gap' amount?
- If there is a gap amount, can you provide me with a quote so I know the exact amount for which I will be out-of-pocket?
- Can you provide me with the relevant Medicare Benefits Schedule (MBS) item numbers, so I can discuss these with UniHealth?

- Will any assisting doctors involved in my medical treatment, including assistant surgeons, radiologists, anaesthetists and pathologists, treat me under AGC? What out-of-pocket expenses, if any, will there be for their services?
- Are you prepared to send the bill to UniHealth directly, so that my Medicare benefit can be claimed on my behalf and payment can be sent back to you?

You can search for a list of doctors and specialists who have utilised AGC in the past at unihealthinsurance.com.au, however this does not guarantee that they will agree to apply this scheme to every patient.

A photograph of a woman with short, wavy, light-colored hair, smiling broadly. She is wearing a grey blazer over a light blue button-down shirt. Her arms are crossed. In the background, several other people are visible, including a man in a blue shirt and another in a red and blue plaid shirt. The scene appears to be an indoor public space, possibly a hospital lobby or a community center.

Healthy
minds,
happy
hearts

STEP 3

CHECK YOUR HOSPITAL HAS AN AGREEMENT

UniHealth holds agreements with an extensive network of private hospitals and day surgeries. These agreements ensure that hospital charges for accommodation, theatre and labour ward, coronary care and intensive care are covered when a member is admitted as an in-patient – subject to their level of cover.

Check if your hospital has an agreement with us by visiting unihealthinsurance.com.au. If your chosen hospital does not have an agreement with us, you will be covered up to the minimum default benefit rate set out by the Federal Government and you will incur significant out-of-pocket expenses.



DETERMINE THE BENEFITS AVAILABLE

1. DO YOU HAVE AN EXCESS ON YOUR HOSPITAL COVER? [SEE PAGE 6]

Yes – go to question 2

No – go to question 3

2. HAVE YOU ALREADY BEEN ADMITTED INTO HOSPITAL THIS CALENDAR YEAR AND PAID YOUR EXCESS?

Yes – your excess is only payable once per person per calendar year. You are not required to pay any further excess this calendar year. Continue to question 3.

No – you will need to pay the relevant excess for your hospitalisation. Go to question 3.

Please note that if you have Top Hospital 300 or 500 you are only required to pay the excess when you are admitted to a private hospital. The excess does not apply to child dependants under the age of 21.

If you have Mid Hospital 300 or 500, the excess is payable when you are admitted to a private or public hospital as a private patient. The excess does not apply to child dependants under the age of 21.

If you have Basic Hospital, the excess is payable when you are admitted to a private or public hospital as a private patient and applies to all people on the policy.

3. IS THE SERVICE OR TREATMENT, RESTRICTED OR EXCLUDED ON MY COVER? [SEE PAGE 8 & 9]

Yes – if the service is restricted, 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 prosthesis list items.

If you choose to be treated in a private hospital, the benefits we pay will not cover all hospital costs resulting in significant out-of-pocket expenses.

If the service is excluded, you are not entitled to any benefits from UniHealth. Contact us on **1300 367 906** for more information. Continue to question 4.

No – go to question 4.

4. DOES YOUR HOSPITAL HAVE AN AGREEMENT WITH UNIHEALTH? [VISIT UNIHEALTHINSURANCE.COM.AU]

Yes – you will be covered for hospital charges relating to accommodation, theatre and labour ward, coronary care and intensive care – subject to level of cover. Continue to question 5.

No – you will have significant out-of-pocket expenses. Please contact us on **1300 367 906** for more information. Continue to question 5.

5. IS YOUR DOCTOR (AND OTHER SPECIALISTS INVOLVED IN YOUR TREATMENT) CHARGING YOU UNDER ACCESS GAP COVER? (SEE PAGES 11 & 12)

Yes – your doctor will have provided you with a written estimate of fees and you should be aware of any out-of-pocket expenses.

No – you will be covered for 100% of the Medicare Benefits Schedule fee (Medicare pay 75% of the scheduled fee and we pay 25%). If your doctor and other specialists charge above this fee you will have to pay the difference. Ask your doctor and specialists what your expected out-of-pocket expenses will be.

If you have answered all these questions you should have a clear idea of the benefits you can expect to receive from us and the out-of-pocket expenses you may have to pay. If you are still unsure, please contact us on **1300 367 906** for more information.



A happy future
is a healthy
future



PREPARING FOR A HOSPITAL STAY

Being prepared before a hospital stay can reduce some of the worry prior to admission. The following checklists will help to ensure you're organised before your next visit to hospital.

HOSPITAL PRE-ADMISSION CHECKLIST

Remember:

- Your UniHealth membership card
- Your Medicare card
- A complete list of your medicines, preferably from a pharmacist or your GP (you need to take all of your medicines with you, including prescription and non-prescription medicines, health supplements, complementary and over-the-counter medicines. It is important that you tell the hospital admitting doctor exactly what medicines you are taking to support your health)
- Letters from your GP, specialists or other health professionals
- Relevant x-rays or other medical images and test results
- Your hospital bag (include non-slip slippers)
- Hospital pre-admission pack or documents (if available)
- Resources that will help keep your mind active during your hospital stay (books, iPad, music, laptop etc.)
- Advise family and friends that you are going to hospital – they may want to provide support or assistance

OTHER THINGS TO CONSIDER

FOOD AND DRINK

If you are having a surgical procedure or certain investigations, you may be required to fast (stop eating and drinking) for a period of time before. Always follow your doctor's advice about avoiding food and drink before a procedure.

Ask your doctor:

- Do I need to fast before my procedure?
- What time do I need to stop eating and drinking?
- When do I need to stop taking my medicines?
- Are there any medicines I should continue to take?

TESTS

Ask your doctor:

- Do I need to have any tests before my hospital stay? (e.g. blood tests, x-rays)
- Will I need any further tests during my hospital stay?
- What kind of tests?
- What are these tests for?

RESTRICTIONS

There may be some restrictions to your usual activities upon discharge that you need to consider and prepare for before you go into hospital (dietary, cleaning, personal hygiene, travel to medical appointments etc.)

Ask your doctor:

- Are these restrictions long-term or for a short length of time?

HOSPITAL CARE IN THE COMFORT OF YOUR OWN HOME

Hospital substitute services allow you to recover in the comfort of your own home and closer to family and friends who can assist you whilst still being supported by highly trained health professionals.

Hospital substitute services:

- offer excellent evidence-based and high quality services from qualified clinicians
- must be approved and supported by your hospital treating team. It is important to follow the advice of your treating team because they know what is best for you in terms of your condition and recovery
- must substitute a hospital bed day. This means if your doctor wants you to have nursing services or rehabilitation as an in-patient you are not eligible for hospital substitute services as well.

If you are considering nursing or rehabilitation services at home instead of in hospital, call UniHealth on **1300 367 906**.

Hospital substitute services are coordinated by Teachers Healthcare Services.



PREPARING FOR DISCHARGE

GENERAL ADVICE

Ask your treating team if there is any post-operative information available for you to take home about the procedure or medical admission that you have had. This may include:

- What is the doctors preferred after care and expected recovery time?
- What information should I know about my illness or procedure?
- What lifestyle changes can be made to assist my recovery and long-term health?

SYMPTOMS

When you are preparing to go home it's a good idea to know what symptoms to expect. It's also important to know when these symptoms should stop and, if not, what should be done. You may want to ask:

- What symptoms should I expect on discharge?
- What can I do to relieve these symptoms?
- Are these symptoms part of my expected recovery?
- If my symptoms get worse, when should I seek further help?
- Who should I contact, and what happens if symptoms occur after hours?

RESTRICTIONS OR MODIFICATIONS

Ask your treating team if you are required to restrict regular activities (e.g. exercise, flying) or modify anything around your home (e.g. install hand rails or ramps).

MEDICINES

You may be prescribed new medicines while in hospital. You need to be aware of these changes, why they have been made and any possible side effects to monitor when you go home. Your GP also needs to understand your medicine changes.

The hospital will usually provide you with a list of your medicines to take home. Make sure you keep the list in a safe place and show your GP at your first appointment after discharge.

Things you should know about your medicines are:

- name of the medicine
- strength of the medicine
- what the medicine is for
- how much is to be taken and when
- any special instructions (e.g. must be taken with food)
- start date
- when to stop or review.

Other important questions to ask about your medicines include:

- What has changed and why?
- If some medicines have been stopped whilst in hospital, should they be restarted and, if so, when?
- If some new medicines have commenced, will this continue and, if so, for how long?
- If some medicines are to be discontinued, how do I do this (when my supply or prescription has finished or should I be 'weaned' off them slowly)? It may be dangerous to discontinue some medicines abruptly and therefore you should always follow the advice of your doctor/pharmacist.
- Do any of the medicines I am taking interact with each other (including prescription and non-prescription medicines, health supplements, complementary and over the counter medicines)?

FOLLOW-UP

When you are discharged from hospital it is important to make sure that you have a follow-up appointment booked with the doctor who admitted you into hospital. If you have been treated by more than one specialist or allied health professional, you may need additional follow-up appointments. An appointment with your GP after discharge is also important as it's your GP who coordinates your health care.

DISCHARGE CHECKLIST:

- medicine list
- any new medicines from the hospital pharmacy
- follow up appointments
- discharge care instructions (such as activity restrictions)
- transport home
- personal items/valuables
- a discharge letter for my GP
- signs and symptoms to manage and how to know if things aren't going according to plan
- a list of who to contact if things are not going according to plan.

CLAIMING YOUR BENEFITS

HOSPITAL BILLS

If you are required to pay an excess, you will need to pay this directly to the hospital. Please check with the hospital whether you have to pay this upon admission or if they will bill you at a later date. Hospitals will usually bill the remainder of the account to UniHealth directly.

DOCTOR AND SPECIALIST BILLS

If your doctor participated in the Access Gap Cover (AGC) scheme (see page 11–12)

Generally, AGC bills will be sent directly to UniHealth for payment. If the doctor sends the bill to you, please forward it to us, do not take it to Medicare. We will forward it to Medicare on your behalf once we have processed our portion of your claim.

If your doctor did not participate in the AGC scheme (see pages 11 – 12)

Please take the bill directly to Medicare. Medicare must process the claim before we can provide any benefit. Simply complete the Medicare two-way claim form and Medicare claim form and Medicare will forward it to us once they have processed their part.

UniHealth will pay benefits for your treatment when admitted to hospital (depending on level of Hospital cover) but not for visits to your specialist, tests or scans before or after your hospital stay.

For visits to your specialist before and after you go to hospital:

- Medicare pays 85% of the Medicare Benefits Schedule (MBS) fee.
- You pay the remainder of the account.

For treatment in hospital:

- Medicare pays 75% of the MBS fee.
- UniHealth pays 25% of the MBS fee.

Note: Doctors and specialists may charge above the MBS fee for a service. This will leave you to pay the 'gap' which will be your out-of-pocket expense. The 'gap' is the difference between the fees charged by the doctor or specialist and the MBS fee for the service.



FREQUENTLY ASKED QUESTIONS

1. I am thinking about having a baby – what do I need to know?

When you start planning a family, you need to think about your health cover.

If you want to be covered for obstetrics (pregnancy and birth-related services) in a private hospital with an obstetrician of your choice it's important that you have a Hospital cover that includes these services, such as Top Hospital. A nine month waiting period applies, so ensure that you take out appropriate cover (or upgrade) well before you are pregnant.

Generally, only the mother is admitted as an in-patient in hospital. Babies born without complications are usually treated as an out-patient. This means that expenses relating to your baby may only be claimable through Medicare and no further benefits are available from UniHealth.

A newborn baby is only classified as an in-patient when one or more of the following criteria are met:

- the baby is admitted to an approved neo-natal intensive care facility
- the baby is the second or subsequent born in a multiple birth situation (i.e. twins or triplets)
- the baby is more than 10 days old when still in hospital.

When your baby is born it needs to be added to a Family membership to be eligible for benefits. This may require

you to upgrade to a Family or Single Parent membership.

UniHealth needs to be advised of the name, date of birth and sex within two months of birth for the baby to be covered with no waiting periods.

For more information, please refer to the UniHealth Pregnancy Guide available at unihealthinsurance.com.au

2. Why won't my doctor participate in the Access Gap Cover (AGC) scheme?

It is up to your doctor to decide whether to charge you under the AGC scheme. Even if the doctor has participated in this scheme before it does not automatically guarantee that the doctor will participate in AGC for your treatment. Doctors are free to choose whether they will participate on a patient-by-patient basis. This decision remains solely with the doctor.

3. How does excess work?

Depending on your level of Hospital cover, you may need to pay an excess for your hospital admission (see page 6).

If your level of cover includes an excess, it is only payable once per person per calendar year. This means that if you have an excess of \$500, you will only be required to pay \$500 per calendar year. If the cost of your hospital admission is less than your excess, you will be required to pay the remainder of your excess if you are admitted into hospital in the same calendar year.

For example, a member on Top Hospital 500 is admitted to hospital for the first time in one calendar year, and the total cost of the hospital admission is \$200, the member would only be required to pay an excess of \$200. If that member goes to hospital again during the same calendar year, they will be required to pay up until their \$500 limit is reached.

4. What kinds of things might I have to pay for during my hospital stay?

There are services that you may receive in hospital that are not covered by us. These include:

- telephone and internet usage charges
- TV hire or other items of a non-medical nature
- surgically implanted prostheses not on the Government Prostheses list and non-prosthetic medical devices that may attract out-of-pocket charges. Please contact us for more information
- pharmaceuticals not covered in the agreement with the hospital, including discharge medicine.

5. Am I classified as an in-patient when having chemotherapy or dialysis on a daily basis?

You will be covered for chemotherapy or dialysis received on a daily basis as long as the hospital you are receiving the treatment from has an agreement with UniHealth and admits you as a day patient.

6. What am I covered for when going to the emergency ward of a private hospital?

UniHealth will only pay benefits towards services received as an in-patient in hospital. If you attend a private hospital emergency ward and incur costs as an out-patient (not admitted to hospital), you will not be able to claim benefits for these services from us.

7. Am I covered for medical procedures in my doctor's room rather than a hospital?

If you receive services in your doctor's room, rather than in a day surgery or hospital, you are only entitled to benefits from Medicare. UniHealth cannot pay a benefit for services received outside of a hospital for patients who aren't admitted.

8. Do I have to pay my excess for a day procedure?

Yes.

9. Can I receive benefits towards home nursing after a hospitalisation?

If you have Top Extras cover you may receive some benefits towards home visits by a registered nurse in a private practice. Please contact us on **1300 367 906** for more information.

10. What is a pre-existing condition?

A pre-existing condition is an illness, ailment or condition where the signs or symptoms of which, in the opinion of the Fund Medical Advisor or other relevant medical practitioner appointed by UniHealth, existed at any time during the six months before taking out private health insurance or transferring to a higher level of cover.

This rule applies to:

- new members to private health insurance
- existing members who upgrade to a higher level of cover or reduce their level of excess.

A 12 month waiting period applies to all pre-existing conditions except psychiatric, palliative care and rehabilitation, which are covered by the normal two month waiting period.

It's important to note that a condition can be classed as pre-existing even though a diagnosis may not have been made.

11. Why does UniHealth want me to submit a Pre-existing Condition Certificate Form for my planned hospitalisation?

When joining, upgrading or resuming your cover from suspension, there is a 12 month waiting period for pre-existing conditions. You need to submit a Pre-existing Condition Certificate Form so our Medical Advisor can assess whether or not the condition is pre-existing. For more information, see page 7.

12. What happens if I get taken to hospital in an emergency?

In an emergency situation, you will be taken by ambulance to the nearest accident and emergency department of a public hospital. In this situation you have the right to choose to be treated as a public patient at no charge, by a doctor appointed by the hospital. You are fully covered for the emergency ambulance transportation and services, when provided by a state government service (including state government air ambulance), under UniHealth Hospital and Extras cover (subject to cover limits).

13. Am I covered 100% for prostheses?

In a small number of cases, your doctor or specialist may recommend prostheses that are more expensive than usual which will attract out-of-pocket expenses. If this occurs it's important to ask why it is being recommended to you. Your doctor or specialist has an obligation to advise you of expenses incurred prior to your procedure as part of Informed Financial Consent.



AFTER READING THIS YOU SHOULD BE ABLE TO ANSWER THESE QUESTIONS:

- Am I covered for this procedure or treatment?
- Have I served all of my waiting periods?
- How does Access Gap Cover work and what should I ask my doctor or specialist?
- Does the private or day hospital I am going to have an agreement with UniHealth?
- What out-of-pocket expenses might I have under my Hospital cover?
- Do I have to pay an excess? If so, how much, to who and when?
- What do I need to organise prior to my hospital admission, and once I'm discharged?

If you have any further questions, please contact us on **1300 367 906** or visit **unihealthinsurance.com.au**



UNI HEALTH

We're for the educators



unihealthinsurance.com.au

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