

Know your
rights & responsibilities
as a private patient in hospital

Private patients'
hospital charter

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Purpose of the Private Patients' Hospital Charter

The Private Patients' Hospital Charter is a free guide to what it means to be a private patient receiving hospital treatment. It also sets out what you can expect from:

- the doctor (or doctors) providing your treatment
- the hospital that provides your treatment
- your health insurer.

The charter also provides information about what to do if you have a problem with your medical treatment or your private health insurance. A poster and a flyer with information about the charter are also available.

The charter is available on the internet at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-privatehealth-consumers-charter-index.htm

Additional copies (booklet, poster and flyer)

Free copies of this booklet, the flyer and poster are available from the Department of Health and Ageing by e-mailing privatehealth@health.gov.au or telephoning (02) 6289 9853 (24-hour answering machine).

Community languages

Some information about the charter is also available in other languages on the Department of Health and Ageing web site at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-privatehealth-consumers-charter-index.htm

Planning your hospital health care

Public patient or private patient?

One of the first steps in planning for your care in hospital is to decide whether you wish to be treated as a public patient or a private patient.

What does it mean to be a public patient?

Under Medicare, Australian residents and 'eligible persons' from some countries with reciprocal health care agreements who choose to be admitted as a public patient are entitled to free treatment in a public hospital, including free accommodation, doctor's services, diagnostic tests and medications (but excluding personal expenses such as TV hire or telephone calls). Public patients are treated by doctors appointed by the hospital.

What does it mean to be a private patient?

A private patient can either be self-funded (that is, pays all the costs except those medical costs covered by Medicare) or have private health insurance. Depending on your circumstances, if you choose to be a private patient you may receive treatment in a public hospital or a private hospital.

A private patient in a public hospital

Being a private patient in a public hospital means you may have a choice of doctor if that doctor is available and has rights of private practice at the hospital. Depending on your illness or condition and your needs, this may or may not be the same doctor who would have been allocated to you by the hospital as a public patient.

As a private patient in a public hospital, you may be charged for a range of services which could include:

- hospital accommodation
- doctor's services (including diagnostic tests)
- surgically implanted prostheses (e.g. artificial hips)
- personal expenses such as TV hire and telephone calls.

The hospital and the treating doctor should, where possible, advise you about the services for which you will be billed. Ask them if you are not sure.

Planning your hospital health care

A private patient in a private hospital

Depending on the circumstances, being a private patient in a private hospital allows you to choose the doctor who treats you at a time and in circumstances that suits you. This is provided your doctor has an arrangement with that hospital to treat private patients and that the hospital you have chosen is able to provide the services you will need.

As a private patient in a private hospital, you may be charged for a variety of services which could include:

- care in intensive/critical care units
- doctors' services (including diagnostic tests)
- operating theatre fees
- allied health services (e.g. physiotherapy)
- dressings, medications/drugs, other consumables

- surgically implanted prostheses (e.g. artificial hips)
- personal expenses such as TV hire and telephone calls.

The hospital and the treating doctor should, where possible, advise you about the services for which you will be billed.

Private health insurance

Types of health insurance cover

You may purchase private health insurance to cover all or some of your health care costs as a private patient.

Private health insurance covers two types of treatment:

- hospital treatment
- general treatment.

Hospital treatment

Cover for hospital treatment helps with the cost of medical treatment such as hospital accommodation and doctors' charges for hospital treatment services. This applies when you are receiving treatment from a public or private hospital. Depending on your hospital cover, it may also cover the payment of benefits for treatments in other places, such as dialysis or chemotherapy undertaken in your home.

General treatment (also known as ancillary or extras cover)

Cover for general treatment helps with the cost of some treatments that can be done at a place

other than a hospital. Your doctor will discuss this type of treatment with you if it is an option for you. This cover also helps with the cost of treatment that is not covered by Medicare, such as physiotherapy, dental treatment and optical treatments and lenses. General treatment also covers disease management and prevention programs.

Selecting private health insurance

Generally, the more extensive the health insurance cover, the higher the price (premium). When choosing your private health insurance, it is important to make sure it suits your particular needs, as well as your budget.

There are two tools that may help you select and compare private health insurance policies:

- Standard Information Statements (SISs). These provide key summary information for each policy in a set format. You can get a copy of the SIS for each policy you are interested in from the relevant health insurer.

Private health insurance

- A government web site administered by the Private Health Insurance Ombudsman (www.PrivateHealth.gov.au). This web site has useful information on private health insurance and SISs for all private health insurance products available from all health insurers. The web site also has a search facility to provide you with a list of private health insurance policies that may meet your needs.

Health insurers will be able to provide you with further details of the policies you think may be right for you.

If you consider changing health insurers make sure you are aware what you are entitled to, including if any waiting periods apply.

You should regularly check your cover to make sure it meets your changing needs.

What costs does your private health insurance cover?

As a private patient with private health insurance, all your hospital treatment and medical bills may be covered by your insurance, or you may have to pay an amount out of your own pocket. The amount you will have to pay, if anything, depends on your type and level of cover. It also depends on what arrangements your health insurer has with the hospital you are going to and your treating doctor.

Out-of-pocket expenses (gaps)

Your private health insurance may not cover you for the entire cost of a stay in hospital. Before you go to hospital, you should ask your doctor, health insurer and the hospital you are going to whether you will have to pay any out-of-pocket expenses and, if so, how much this is likely to be.

There is a “Gap Checklist” that provides you with a useful list of questions to ask your treating doctor(s), health insurer and hospital. This is available from health insurers or can be downloaded at www.PrivateHealth.gov.au.

Private health insurance

Medical costs

When you receive medical treatment in hospital as a private patient, Medicare pays 75 per cent of the Medicare Benefits Schedule (MBS) fee for the service of the doctors who treat you in hospital and your health insurer pays the remaining 25 per cent of the MBS fee, provided you have cover for hospital treatment.

If your doctor charges above the MBS fee your health insurer may be able to cover some or all of this additional cost. This will depend on the gap cover arrangements that your health insurer has in place and whether your doctors participate in those arrangements.

Before you go to hospital you should contact your health insurer to find out about the gap cover arrangements they have in place and whether they apply to your policy. You should also ask your doctors whether they participate in your health insurer's gap cover arrangements and whether you will have any out-of-pocket medical costs for the treatment you are receiving in hospital.

Remember in most cases there will be more than one doctor involved in a hospital procedure

so it is important to find out about the charges associated with each specialist.

In certain circumstances, you may be referred by your general practitioner to a specialist clinic at a public hospital. If the clinic provides public and private services, you are entitled to be seen by a hospital appointed specialist, free of charge as a public patient.

If your general practitioner refers you to a specialist who has a private practice in rooms at a public hospital or a private hospital, you are not an admitted patient of the hospital and will only receive 85 per cent of the MBS fee from Medicare. You will also not be able to claim any amount from your health insurer because the law does not permit health insurers to provide any benefits for consultations and diagnostic services that do not normally require hospital treatment.

You are entitled to and should always ask your doctor for an estimate in advance of the costs of your treatment. Your health insurer will be able to advise you on whether you have cover for treatment provided out of hospital and if so, what treatments are covered.

Private health insurance

Hospital costs

The benefits paid by your health insurer for hospital treatment will depend on the type of cover you purchase. It will also depend on whether your insurer has an agreement in place with the hospital in which you choose to be treated. When there is an agreement you will have either no out-of-pocket expenses or you will be provided with details of your out-of-pocket expenses.

If you have a hospital policy with an excess or co-payment you will have to pay the amount you have agreed to under your policy. If you have a policy that has exclusions you should also check that the treatment you are having is covered under your policy.

You are entitled to and should always ask your hospital or health insurer for an estimate in advance of the costs of your treatment.

Emergency department treatment

If you go to an emergency department of a public hospital, you should be treated free of charge as a public patient, even if you have private health insurance.

If you go to an emergency department of a private hospital, you are not an admitted patient of the hospital. You will only be admitted to hospital if you are transferred to a hospital ward.

Health insurers do not cover the medical fees and charges for services provided in private hospital emergency departments. Fees for private hospital emergency departments are covered by Medicare as services to non-admitted patients at 85 per cent or 100 per cent of the MBS fee depending on whether you are treated by a specialist or a general practitioner. If tests are required in the emergency department (e.g. blood tests or X-rays), the gap between the MBS fee and the amount charged cannot be covered by your health insurer.

Private health insurance

Many private hospitals charge a facility fee for attendance at their emergency department to help off-set the cost of establishing and running this high cost facility. Depending on the type of cover you have, your health insurer may provide benefits covering a facility fee.

In an emergency, it is very unlikely there will be enough time to provide you with an estimate of out-of-pocket expenses prior to your admission. However, you should be advised of these costs as soon as you are well enough.

Having a baby in hospital

When you have a baby in a private hospital as a private patient you are an admitted patient of the hospital but generally your newborn baby is not an admitted patient. The newborn (who is nine days old or less) will only be an admitted patient of the hospital if the baby:

- is admitted to an Australian Government approved neonatal intensive care unit; or
- is the second or subsequent baby born in a multiple birth; or
- is in hospital without the mother.

If your baby is not an admitted patient of the hospital he or she may not be covered by your private health insurance policy. This means if, for example, you elect to have your baby seen by a doctor, Medicare pays the first 85 per cent of the MBS fee and you must meet all costs not covered by Medicare.

You should talk to your health insurer as early as possible in your pregnancy to find out what their rules are about obstetrics and newborn babies. You should also ask the hospital and your doctor about any services for which you will be billed.

Long-stay patients

If you are in hospital for a long time you may become a nursing home type patient. Your doctor, the hospital you are in and your private health insurer will consider how long you require acute care (that is, care for a short-term illness or health problem).

If you would like more information about the arrangements for long-stay patients, please talk to your hospital or health insurer.

Private health insurance

Waiting periods

When you take out private health insurance or upgrade your existing hospital cover, you may have to wait before you can claim for some services. The maximum waiting periods allowed under legislation are:

- 2 months for palliative care, rehabilitation and psychiatric treatment
- 12 months for treatments relating to other pre-existing ailments
- 12 months for obstetric treatments
- 2 months for all other treatments.

Health insurers can waive or reduce these waiting periods but they cannot increase them.

Check with your health insurer before you receive hospital treatment whether you are currently subject to a waiting period for that treatment.

Waiting periods for general treatment may vary between products and health insurers. You should check the waiting periods on general treatment carefully when choosing your health insurance insurer and product.

Pre-existing conditions

When you take out private health insurance or upgrade your existing cover for hospital treatment, you may have to wait up to 12 months before you can claim benefits for hospital treatment for a pre-existing ailment.

A pre-existing ailment is an ailment, illness or condition, the signs or symptoms of which existed at any time during the six months before the day on which you joined or upgraded to a higher level of cover for hospital treatment. Whether a condition is 'pre-existing' is determined by a doctor appointed by the health insurer.

It is unnecessary for a doctor to have diagnosed the condition, simply that signs and symptoms were in existence. In making this judgement, however, the insurer-appointed doctor must take into account the medical evidence presented by the doctor treating you.

Private health insurance

This means that if you have less than 12 months membership of your current hospital cover and you need hospital treatment, you should confirm with your insurer whether or not the pre-existing ailment waiting period applies to you. *It is important you do this before you are admitted to hospital receive hospital treatment, if possible.*

Insurers will need a few days to make this assessment, so contact your insurer as soon as you know you need hospital treatment.

Hospital-in-the-home

Some hospitals are able to provide your treatment outside hospital, such as in your home, where the hospital has an agreement with your insurer to provide benefits for these types of services. These types of treatment are a direct substitute for the treatment that would have been provided to you if you had stayed within the hospital.

If you receive these treatments the hospital will manage your care and arrange for services prescribed by your doctor to be provided to you.

You should check if your health insurance covers this type of treatment.

Confirm your level of health insurance cover

As soon as you know that you will need hospital treatment, you should if you can:

- ask your health insurer about your level of cover for hospital treatment to make sure your private health insurance does not exclude the procedure you need
- check with your health insurer about the level of accommodation covered by your policy
- ask your health insurer whether waiting periods apply to your cover. If you purchased or upgraded your cover for hospital treatment in the past 12 months, be aware that there is a 12 month waiting period on payment of benefits for hospital treatment for any pre-existing ailments and obstetric conditions
- ask your doctor whether he or she participates in your health insurer's gap cover arrangements
- ask your health insurer whether it has an agreement with the hospital you are going to be treated in

Private health insurance

- ask your hospital, doctor and insurer for an estimate of your hospital treatment medical costs not covered by Medicare or your private health insurance
- ask your doctor or insurer if you will need to make any additional payments for surgically implanted prostheses you may require.

Make sure you allow a few days for the hospital, health insurer and doctor to reply.

What you can expect from your doctor and hospital

Choice of being a public patient or a private patient in a public hospital

You can expect to be asked before or on admission to a public hospital whether you wish to be treated as a private patient or a public patient. You can choose to be admitted to hospital as a public patient even if you have health insurance.

You will be asked to sign a Patient Election Form, which will record your choice. This form should provide a clear and unambiguous explanation of the consequences of your choice. If you are unable to make a choice at the time of admission, you will be asked to make a choice as soon as you or your legal guardian is able to do so. You should make a choice at least before you are discharged from hospital.

You will be treated as a public patient until you make a choice.

Note: If you choose to be a private patient, you may not be able to change to be a public patient unless there are unforeseen circumstances such as complications requiring additional procedures or an extension of your length of stay. Once you

make a private election, you will be regarded as having been a private patient from the time of your admission, even if your election was made some time after your admission.

If you choose to be a public patient, you may not be able to change to a private patient just because a single room has become available.

Obtaining your consent to the treatment

Your doctor should give you a clear explanation of your diagnosis, your treatment and other treatment options available. You should be told that you are able to withdraw from treatment at any stage (with some exceptions). You should also be advised about what each doctor involved in your treatment charges.

In an emergency, where it is not possible to obtain your consent, you will receive treatment and should be informed of any costs as soon as practicable.

Interpreting services/Interpreters are available if you want them.

What you can expect from your doctor and hospital

Advice about seeking other medical opinions

You can ask for referrals for other medical opinions. There will most likely be additional costs associated with doing this that may not be covered by Medicare or your private health insurance.

Visiting rights

You should ask your hospital about visiting rights while you are in hospital. For example, you may wish to ask about:

- facilities for visitors
- rights of family access
- who is considered family
- arrangements for the parents if the patient is a child.

Advice about the likely costs

Before you receive your treatment as a private patient you are entitled to know, and should always ask your doctor, your health insurer and your hospital about, the expected costs of your treatment and any extra money you may have to

pay out of your own pocket, commonly known as a 'gap'.

If treatments do have a gap, you have the right to know what these costs are up-front to help avoid any surprises later on.

Remember that each of the doctors and health care professionals involved in your care will probably charge a fee. Doctors and health care professionals may include medical specialists, surgeons, anaesthetists, physiotherapists, pathologists and radiologists. These fees are additional to the fees the hospital may charge for accommodation and other hospital services.

If your treatment includes a prosthesis, such as a pacemaker or an artificial knee, your doctor should tell you about any out-of-pocket expenses for that prosthesis. Your doctor should tell you about the alternatives with no cost and explain which prosthesis is the most clinically suitable for your treatment.

What you can expect from your doctor and hospital

There is a “Gap Checklist” that provides you with a useful list of questions to ask your treating doctor, health insurer and hospital. This is available from health insurers or may be downloaded at www.PrivateHealth.gov.au.

Confidentiality and access to your medical records

Your personal details will be kept strictly confidential. However, there may be times when information about you needs to be provided to another health worker to assist in your care, or if this is required or authorised by law.

Your health insurer needs access to certain information to allow payments to be made for your medical treatment. You will need to sign a form to agree to this.

Under Freedom of Information legislation, you are entitled to see and obtain a copy of your medical records (with some exceptions or limitations) kept in a public hospital. You can also request that information be corrected if there are mistakes.

You can also approach private hospitals and your doctor to gain access to the medical records they keep about you. *The Privacy Act 1988* provides you with a general right under the National Privacy Principles to access personal information collected about you by the private sector.

Treatment with respect and dignity

You can expect to be treated with courtesy and to have your ethnic, cultural and religious practices and beliefs respected.

You can legally discharge yourself at any time (with some exceptions), even against the advice of your doctor or hospital staff. However, if you discharge yourself, you must accept the associated risks and sign a form taking responsibility.

You should treat your health care workers and other patients with respect and courtesy. Staff who attend you should always identify themselves.

What you can expect from your doctor and hospital

Care and support from nurses and allied health professionals

Nurses and allied health professionals (for example, physiotherapists) are a very important part of your treatment in hospital. Nurses provide vital care and support for patients, while allied health professionals provide a variety of services.

You should feel confident to discuss any issues in relation to your treatment or hospital experience with nurses or allied health professionals.

Help doctors and hospital staff provide you with better care

You can help doctors and hospital staff to provide you with better care by:

- letting your doctors and hospital know about any physical or psychological conditions affecting you (for example, allergies)
- providing your doctor with information such as your medical and family history when required

- informing your doctor and hospital about any other treatment you are receiving or medication or complementary medicines you are taking even if they are not prescribed by a doctor. You should take your medicines with you when you go to hospital.

Advice about care after discharge

Before you leave hospital you should expect to be consulted about the continuing care that you may need after you leave hospital. This includes being given information about any care and medication you will need after you have been discharged, as well as any costs. For example, after you have been discharged from hospital you may need:

- medical care
- medication
- home nursing or other community services.

You should also be asked whether you need help with transport home. Some health insurers can help patients arrange their care after discharge.

You should actively participate in the planning of your after-discharge care.

What you can expect from your health insurer

Clear, timely and accurate advice

Your health insurer is able to provide you with information about:

- the types of health insurance cover available, as well as the premiums and benefits of each type of cover, including advice about reviewing your health cover when your needs change
- your level of cover and the likely out-of-pocket expenses, including any excess (see Glossary) or co-payments (see Glossary) that you may face while you are in hospital
- your certified age at entry under the Lifetime Health Cover (see Glossary) arrangement and any periods of absence accrued
- any conditions of the health insurance cover such as waiting periods before benefits are payable, inclusion of newborns, health insurer rules regarding pre-existing ailments or illnesses, and treatment not covered by your health insurance.

Insurers can only provide advice about definite out-of-pocket costs when there is an agreement in place with the relevant doctor(s) or hospital and your treating doctor(s) agree to participate in your health insurer's gap cover arrangements. Insurers should, nevertheless, be able to provide information as to the likely benefit level even in the absence of an agreement.

You can help your health insurer provide you with a better service by:

- obtaining confirmation of your entitlements in writing from your insurer, before going ahead with any treatment
- reviewing your health cover regularly so that it continues to meet your needs.

What you can expect from your health insurer

Reassurance

At any time you can:

- *upgrade* your cover with the same insurer and be advised of any waiting and benefit limitation periods that apply before you are eligible to claim higher benefits; or
- *transfer* from one insurer to another without being faced with any additional waiting periods, provided you are taking out a comparable or lower level of cover with your new insurer.

You may have to serve additional waiting periods if you upgrade your level of cover even if it is with your current insurer.

If you have hospital cover, you can transfer between insurers at the same or a lower level of cover, without serving additional waiting periods. The insurer you transfer to must give you credit for any waiting periods already served.

Check your entitlements with your new health insurer before transferring.

How to make a complaint

Advice on how to comment on or make a complaint about your health carers or hospital

You are entitled to comment or complain about hospital treatment you receive. You should approach the staff caring for you and raise your concerns at the time.

If you have concerns regarding your hospital treatment under your health insurance cover, your health insurer would like to know. You should, however, advise the hospital that provided or arranged your treatment about your concerns first.

If you would like to make a formal statement about the care you received, you should contact or write to the officer responsible for handling complaints at the hospital that provided or arranged your treatment. You should be advised who the Complaints Officer is.

If you would like to make a complaint about your health care or treatment but you are incapacitated, you should be provided with assistance to make the complaint, including the writing down of details about the complaint.

There are a number of complaints bodies listed at the end of this publication that you can approach if you are not satisfied with the manner in which your complaint has been dealt with by the hospital.

Your hospital would also appreciate hearing from you about anything you thought they did particularly well or if you have a suggestion for improvements.

Advice on how to make a complaint about your health insurer

You are entitled to have a complaint satisfactorily addressed by your health insurer when you have concerns about any aspect of the service provided by your health insurer. If you have a complaint you should first formally approach your health insurer and proceed through their complaints handling process.

If you think your health insurer has not dealt with your complaint in a satisfactory manner you can contact the Private Health Insurance Ombudsman (see next page for details).

Contacts for complaints and further information

Complaints

Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman is an independent national body established to deal with enquiries and complaints about private health insurance arrangements.

Level 7
362 Kent Street
SYDNEY NSW 2000

Phone: (02) 8235 8777
Fax: (02) 8235 8778
Toll free: 1800 640 695
Web site: www.phio.org.au
E-mail: info@phio.org.au

The Office of the Federal Privacy Commissioner

The Office of the Federal Privacy Commissioner is an independent national office established to deal with enquiries and complaints about privacy and the handling of personal information. The Privacy Commissioner is able to deal with complaints on the handling of personal information held in the private sector. If you have a complaint, you should raise it with the relevant organisation or individual before bringing it to the Privacy Commissioner.

GPO Box 5218
SYDNEY NSW 2001

Phone: 1300 363 992
(for the cost of a local call anywhere in Australia)
TTY for hearing impaired: 1800 620 241
Fax: (02) 9284 9666
E-mail: privacy@privacy.gov.au
Web site: www.privacy.gov.au

Contacts for complaints and further information

Health care complaints resolution bodies

State and territory complaints resolution bodies are all independent organisations dealing with complaints about health services (such as hospitals, medical centres and nursing homes) and individual health practitioners (such as doctors, nurses, dentists and counsellors).

NEW SOUTH WALES

Health Care Complaints Commission

Phone: (02) 9219 7444

Toll free: 1800 043 159

TTY for hearing impaired: (02) 9219 7555

Web site: www.hccc.nsw.gov.au

VICTORIA

Office of the Health Services Commissioner

Phone: (03) 8601 5200

Toll free: 1800 136 066

TTY for hearing impaired: 1300 550 275

Web site: www.health.vic.gov.au/hsc

QUEENSLAND

Health Rights Commission

Phone: (07) 3234 0272

Toll free: 1800 077 308

TTY for hearing impaired: (07) 3120 5997

Web site: www.hqcc.qld.gov.au

AUSTRALIAN CAPITAL TERRITORY

Human Rights Commissioner

Phone: (02) 6205 2222

TTY for hearing impaired: (02) 6205 1666

Web site: www.hrc.act.gov.au

WESTERN AUSTRALIA

Office of Health Review

Phone: (08) 9323 0600

Toll free: 1800 813 583

Web site: www.healthreview.wa.gov.au

Contacts for complaints and further information

TASMANIA

Complaints Commissioner Office of Health

Phone: (03) 6233 6348 or 1300 766 725

(for the cost of a local call in Australia)

Web site: www.healthcomplaints.tas.gov.au

NORTHERN TERRITORY

Health Complaints Commission

Phone: (08) 8999 1969

Toll free: 1800 806 380

Web site: www.hcsc.nt.gov.au

SOUTH AUSTRALIA

South Australian Health and Community Services Complaints Commissioner

Enquiry Service Mon-Thurs 10am-4pm

Phone: (08) 8226 8666

Toll free: 1800 232 007

Reception: (08) 8226 8652

Web site: www.hcsc.sa.gov.au

Further information

Private Health Insurance Administration Council

The Private Health Insurance Administration Council (PHIAC) is an independent statutory authority that regulates the private health insurance industry. In addition, PHIAC collects and disseminates financial and statistical data regarding health insurers and collects and disseminates information about private health insurance to enable consumers to make informed choices.

Suite 16, Level 1
71 Leichhardt Street
KINGSTON ACT 2604

Phone: (02) 6215 7900

Fax: (02) 6215 7977

E-mail: phiac@phiac.gov.au

Web site: www.phiacc.gov.au

Contacts for complaints and further information

Department of Health and Ageing

Further information about private health insurance is available from the Department of Health and Ageing.

Private Health Insurance Branch
MDP 86
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Phone: (02) 6289 9853
(24-hour answering machine).
E-mail: privatehealth@health.gov.au
Web site: www.health.gov.au

Government web site

There is a government web site that provides information on private health insurance and a search facility to help you find private health insurance products to meet your needs. This site is located at www.PrivateHealth.gov.au.

Glossary

Acute care: Short-term care for an illness or health problem.

Benefits: Money or services you may receive from your health insurer.

Charter: A formal document detailing rights and privileges.

Co-payments: A co-payment is an agreed amount paid towards the total cost of each day spent in hospital. For example, you might agree to pay the first \$50 for each day's hospital admission.

Disease management and prevention programs: A disease management program is intended to reduce complications in a person with diagnosed chronic disease. A prevention program is intended

to prevent or delay the onset of chronic disease for a person with multiple risk factors for chronic disease.

Excess: An excess is an amount of money you pay towards the cost of hospital treatment, regardless of the number of days of hospitalisation. For example, your product has an excess of \$300. This means if you go to hospital you pay the first \$300 of hospital charges for your care.

Facility fee: The fee charged by some private hospitals for attendance at their emergency department, to offset the cost of establishing and running a high-cost facility.

General treatment: General treatment is any treatment intended to manage or prevent a disease, injury or condition that is not covered by hospital treatment.

Hospital costs: Costs associated with your hospital treatment, such as nursing and accommodation.

Glossary

Lifetime Health Cover: To encourage people to take out private hospital cover at an early age, the government introduced the Lifetime Health Cover scheme. People who take out hospital cover after 1 July following their 31st birthday, pay more for the same level of cover than those who took out cover before 1 July following their 31st birthday. The cost increases by 2 per cent for each year that a person delays taking out cover. For example, a person who takes out hospital cover when he or she is aged 40 will pay 20 per cent more than a person who takes out cover at age 30. There are special provisions for migrants, for people born before 1 July 1934, and for

Australians who are overseas on the 1 July following their 31st birthday.

Medical costs: Costs associated with the provision of medical services by a doctor.

Medicare Benefits Schedule: The government sets a schedule of medical fees - called the Medicare Benefits Schedule (MBS) - based on a fair price and how much Australia can afford to pay for the total health system. Whether you have private health insurance or are a private patient paying for all your own costs, the government provides a rebate on nearly all medical fees. This rebate is 75 per cent of the MBS fee for professional medical services provided

as part of a privately insured episode of hospital treatment. In the case of services which do not normally require hospital treatment, Medicare can reimburse doctors' fees at either 85 per cent or 100 per cent of the MBS fee depending on whether you are treated by a general practitioner or specialist. Doctors can, however, choose to charge more than the scheduled fee.

Out-of-pocket expenses: The costs you have to pay for hospital treatment that are not covered by Medicare or your health insurer.

Glossary

Pre-existing ailment: An illness or health problem you already have when you decide to take out or upgrade your private health insurance cover. Whether a condition is 'pre-existing' is determined by a doctor appointed by the health insurer.

Prostheses: Prostheses are the manufactured items and human tissue items that are surgically implanted during an episode of hospital treatment. These prostheses do not include items that are not permanently inserted into people, such as artificial limbs, external mammary prostheses or wigs.

Self-funded: As a private patient you are responsible for paying hospital and medical fees connected with your treatment that are not covered by Medicare. You can either pay for costs out of your own pocket or have private health insurance. If you are self-funded you will be required to meet all costs not covered by Medicare. You will be eligible for a 75 per cent rebate of the MBS fee on services covered by Medicare. You will be responsible for paying all other costs.

Waiting periods: When you take out private health insurance or upgrade your existing cover for hospital or general treatment, you may have to wait before you can claim for some services from your health insurer. For example, there is a maximum 12-month waiting period on payment of hospital benefits for any pre-existing ailments and obstetric conditions. Ask your health insurer whether waiting periods will apply to your cover.

For further information call the Department of Health and Ageing on **(02) 6289 9853**
or see **www.PrivateHealth.gov.au**