1 April 2022

Bronze Plus Essential Hospital $350 Excess Combined Cover

Closed product only available to members who currently hold this cover

If you're young and healthy, this is a great introductory level of cover at a budget-friendly price. Avoid paying for the high-cost services that young people just aren't likely to need. This is part of a combined Hospital and Extras package.

Bronze Plus Essential Hospital $350 Excess Combined Cover is a closed cover. Members who held this cover as of 1 April 2020 are entitled to continue under this cover, but no new Bronze Plus Essential Hospital Combined Cover memberships can be purchased.

What does Bronze Plus Essential Hospital Combined Cover 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 Hospital cover. You'll also see information on the things you are not covered for (exclusions) and the things you are only covered for in a public hospital (restrictions), as well as the waiting periods that apply before you can make different types of claims.

Your Hospital cover pays benefits on five types of costs:

1. Private or public hospital of your choice
With Hospital cover, you're up to 100% covered for all of the hospital's costs when you are treated in any private hospital that Transport Health has a contract with. You are also covered in all public hospitals across Australia. 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. Some hospitals may also charge administration fees.

Transport Health has contracts with most private hospitals and day surgeries in Australia, so you're covered around the country. You can see which private hospitals Transport Health has a contract within the members' area of our website.

It is important to choose one of the hospitals listed because if you choose to be treated in a private hospital that we don't have a contract with, you will be left with substantial out-of-pocket hospital costs. These can add up to many thousands of dollars.

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 Hospital cover. You should check with the hospital prior to your admission what your out-of-pocket expenses will be.

2. Doctors fees
When you are treated as an inpatient in hospital, your doctors' fees are shared between Medicare, your Hospital cover and yourself.

Medicare will reimburse you for 75% of the Medicare Benefits Schedule (MBS) fee and your Hospital cover pays the remaining 25%. Any amount your doctor chooses to charge above the MBS fee is an out-of-pocket cost you will be responsible for paying.

Your Hospital cover gives you access to a gap cover program that can help you to reduce or eliminate any out-of-pocket costs by making certain arrangements with your doctors before you go into hospital. This is called Medicover. You can see which doctors currently participate in Transport Health's Medicover program on our website under 'Members' and 'Find a doctor'. You can read more about Medicover in our Medicover factsheet, which is also on our website under 'Members' and 'Medicover'.

3. Implanted prosthesis
Most prostheses you receive in relation to your treatment in hospital are fully covered, but there are a few restrictions on the types of products we can pay for. These generally apply to items that are not covered by the government's Prostheses List.

To limit any potential out-of-pocket costs, ask your doctor which prosthesis is best for you and if there is a no-gap option available.

4. In-hospital pharmaceuticals
Most pharmaceuticals you receive in relation to your treatment in hospital are fully covered, but there are a few restrictions on the types of pharmaceuticals we can pay for. These generally apply to items that are not covered or restricted by the government's Pharmaceutical Benefits Scheme (PBS) and approved under the Therapeutic Goods Administration.

To limit any potential out-of-pocket costs, ask your doctor which pharmaceutical is best for you and if there is a no-gap option available.

5. Ambulance transportation
Your level of ambulance cover is based on the State or Territory the policy is held in so if you or any of the people listed on your membership live in a different State or Territory to the residential address of the policy, you will need to contact our team to check what level of cover you presently have. You'll find full details over the page.

How do you make a Hospital cover claim?

PLANNED HOSPITAL STAYS

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 best.

2. Make sure that you have served your waiting periods
When you take out Hospital cover for the first time, re-join after letting your cover lapse, 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 Hospital cover are shown over the page. If you're not sure whether or not you've served your waiting periods, please call 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 Hospital cover, you are covered for any in-hospital treatment that Medicare pays a benefit on, with the exception of:

- Heart and vascular system
- Back, neck and spine
- Plastic and reconstructive surgery (medically necessary)
- Cataracts
- Joint replacements
- Dialysis for chronic kidney failure
- Pregnancy and birth
- Assisted reproductive services
- Weight loss surgery
- Insulin pumps.

Each of these treatments is excluded from this level of cover. If you wish to be covered for these services, please contact our member care team. Please note waiting periods will apply if you choose to upgrade your cover.

You have restricted cover for:

- Rehabilitation
- Hospital psychiatric services

If you wish to be fully covered for these services in a private hospital, please contact our member care team. Please note waiting periods will apply if you choose to upgrade your cover.

When you are booking your hospital stay, the hospital will ask you for the details of your cover and will call us to confirm that you are covered for the procedure you are having. They'll also confirm your membership is paid up to date.

4. Make sure that the hospital you're planning to be treated in is one that Transport Health has a contract with
We have contracts with most private hospitals and day surgeries in Australia, and you're also covered for treatment as a private patient in any public hospital in the country. There is a search facility where you can look up whether the hospital you are planning to go to is contracted with us in the members' area of our website. Please be aware that choosing to be treated in a private hospital that is not contracted with us will leave you with substantial out-of-pocket costs.

5. Ask your doctors if they will use our Medicover
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 that you contact our team for more information about how to request Medicover arrangements when you are planning your hospital stay. You can see which doctors currently participate in Transport Health's Medicover program on our website under 'Members' and 'Find a doctor'. You can read more about Medicover in our Medicover factsheet, which is also on our website under 'Members' and 'Medicover'.

6. Your excess is payable directly to the hospital
Hospital cover comes with an excess. An excess of $350 applies per hospital stay payable once per calendar year per person and a maximum of $700 per year on a couple membership.

The hospital admission staff will let you know whether you need to pay it before you are admitted or at the time of your admission. You can confirm the amount of the excess payable by contacting our team, or contacting the admission staff, who will confirm that information with us prior to your hospital stay.

7. Find out if you're suitable for our Hospital at Home program
Hospital Hospital at Home can help you to get home from hospital sooner, and sometimes avoid a hospitalisation altogether, by providing you with hospital-equivalent treatment and follow-up care in your own home. The program is available for a range of treatments and post-procedure support. If the treatments you need in your home are available, and if you, your doctor and the hospital all agree that it is appropriate for you, then we can help. Ask our team for more information about Hospital at Home.

8. Following your hospital stay
You usually won't see any bills from the hospital as they get sent directly to us, but you will receive bills from all the doctors who treat you.

If your doctors agree to participate in our Medicover, they will send the bill directly to us. With Medicover, your doctors will have either agreed to charge you no gap, or they will have given you a written quote in advance for any out-of-pocket costs. You are responsible for paying any agreed out-of-pocket costs.

If your doctors do not participate in our Medicover, 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.

If the hospital does decide that you need to be admitted, you will be asked if you have private hospital cover. Remember, you're not obligated to declare or to use your private cover if it doesn't suit you – you have the option of choosing to be treated as a public patient under Medicare rather than using your cover.

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Transport Health Pty Ltd ABN 39 099 028 127. 0320/3392

Transport Health

BRONZE PLUS ESSENTIAL HOSPITAL $350 EXCESS COMBINED COVER

Here's what you're covered for:

Private or public hospital costs – contracted private hospitals or public hospitals	
Accommodation	Up to 100% of the cost after you have paid the applicable excess for your membership and provided that your treatment is not related to any of the items listed under the exclusions or restrictions. Depending on availability, this may be either a private or shared room.
Operating theatre / Intensive care	Up to 100% of the cost provided the treatment is not related to any of the items listed under 'exclusions' or 'restrictions'.
Doctors' costs	
Doctor of your choice	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 private 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 people 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 Hospital cover that can help to reduce the likelihood of out-of-pocket costs. With Medicover, you can ask the 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 Medicover, you will either have no out-of-pocket costs or you will know in advance what the costs will be. Please be aware Medicover is not available on restricted services. Please note that doctors usually work in a select few hospitals, which may limit the choice of hospitals 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 prosthesis (lower benefits apply for other prosthesis provided that the prosthesis is not related to any of the items listed under exclusions). We recommend that you contact our member care team to find out exactly what you are covered for before going into hospital.
Pharmaceuticals	100% of the cost of: • TGA and PBS listed pharmacy items directly related to the reason for your hospitalisation, supplied to you during your admission provided they are not listed as a restricted drug. • pharmaceuticals listed on the Commonwealth Exceptional Drug List.
Ambulance attendance and transportation costs	
Ambulance	Benefits for ambulance are paid when the service is provided by a state government operated, authorised or approved ambulance scheme. Residents of VIC, SA, WA, TAS, NT– unlimited cover for emergency ambulance 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. 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 for emergency transportation, and medically necessary non-emergency transportation. Cover applies anywhere in Australia. Contact the QLD state government ambulance provider for more information. *Your level of ambulance cover is based on the state the policy is held in. If you live in a different state to the residential address of the policy please contact our team.
Additional benefits	
Hospital at Home (hospital substitution program)	Where available, offers an alternative to a hospital admission or enables you to leave hospital early and receive treatment in your own home. For more information, enrolment and referral forms, call our member care team on: **1300 806 808** or visit **transporthealth.com.au**
Travel and Accommodation	**Travel:** Benefit is up to $60 per round trip (over 200km). **Accommodation:** Benefit is up to $40 per night. Please speak with our member care team on **1300 806 808** about when these benefits are payable.

Here's where out-of-pocket costs can come from:

Exclusions – things you are not covered for	• Heart and vascular system • Plastic and reconstructive surgery (medically necessary) • Dialysis for chronic kidney failure • Assisted reproductive services • Insulin pumps.	• Back, neck and spine • Cataracts • Joint replacements • Pregnancy and birth • Weight loss surgery
Restrictions – things you are covered for as a private patient in a public hospital. In a private hospital, you will only receive minimum benefits and will incur significant out-of-pocket expenses.	• Rehabilitation • Hospital psychiatric services.	
Treatments and procedures not covered by Medicare	If the treatment or procedure you're having cannot be claimed under Medicare, your normal cover entitlements won't apply. You will have substantial out-of-pocket costs.	
Admission to a non-contracted hospital	If you receive treatment or procedures in a private hospital that we do not have a contract with, we will pay a 'default benefit' towards your accommodation, but no other benefits for hospital costs are payable. You will have substantial out-of-pocket costs.	
Hospital or medical costs for outpatient treatment	Your Hospital cover can only pay benefits for treatments you receive as an inpatient, that is, when you are admitted as a patient to hospital.	
Private hospital emergency department fees	When you are treated in an emergency department, you are an outpatient (you have not yet been admitted to the hospital). No benefits are payable for outpatient treatment.	
Pharmaceuticals	**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 Hospital cover. **Other Pharmaceuticals** You are not covered for pharmaceuticals that are not TGA approved and listed on the Pharmaceutical benefit scheme.	
Services such as television hire, internet access, purchase of newspapers, purchase of medication not related to the reason for your admission, hospital administration fees	Your Hospital cover does not pay benefits for these additional products or services.	

Waiting periods:

Accidents	1 day	
General services	2 months	
Hospital psychiatric services and rehabilitation, Palliative care	2 months	Cover for psychiatric, rehabilitation and palliative care are restricted to public hospital under this cover. Waiting periods will apply should you choose to upgrade your cover so you are covered in a private hospital.
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 Transport Health or upgrade your existing Transport Health 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 the 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.
Pregnancy and birth	12 months	Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.
Assisted reproductive services	2 months	Pre-existing rule conditions apply. Not covered under this level of cover. Waiting periods will apply should you choose to upgrade for this service.

Read more about your Hospital cover in our online A to Z guide which can be found under 'Your Cover' on our website. You can find a copy of the Private Health Information Statement by visiting PrivateHealth.gov.au. If you have a hospital stay coming up, we strongly recommend that you call us for advice about how to make the most of your Hospital cover, and to confirm that you are covered for the procedure you're having.

Private Health Insurance Code of Conduct

Our industry code of conduct The Private Health Insurance Code of Conduct is a voluntary industry code aimed at delivering better service to health members through clear and complete communication, whether in writing or in person. As a signatory to the code, we are committed to ensuring that our members receive accurate information from properly trained staff, including clear and complete policy documentation, and information on internal and external dispute resolution processes. You can read more about the code at www.privatehealthcareaustralia.org.au

Effective 01 April 2022. Fund rules and policies are subject to change without notice. If a change will adversely affect your membership and/or benefits, we will notify you in writing. Depending on the issue, this may be through a personally addressed letter, via email or through our Pulse Newsletter. While you are making your decision about whether to join Transport Health, and which cover is best for you, it is important that you read (and retain for future reference) this cover guide and any other materials that we might send to you or refer you to. Transport Health Pty Ltd ABN 39 099 028 127 is a registered Health Benefits organisation.

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Transport Health

1 April 2022

Closed product only available to members who currently hold this cover

Combined Extras

Just want to cover the basics each year? This is our most affordable level of Extras cover, ideal for young singles and couples. It is part of a combined Hospital and Extras package.

Combined Extras is a closed cover. Members who held this cover as of 1 April 2020 are entitled to continue under this cover, but no new Combined Extras memberships can be purchased.

What does Combined Extras cover you for?

Over the page, you'll find a comprehensive list of the products, services and treatments you can claim under your Combined Extras cover.

For most items shown, you will also see:

- the maximum benefit you can receive each time you make a claim
- the maximum benefit you can receive each year for the different things you are covered for
- information about the maximum annual benefit for each person covered by the membership
- the waiting periods that apply before you can make a claim.

There are a few important things to understand about how your Combined Extras cover works

1. Annual limits

Each type of product, service or treatment has an 'annual limit'. This is the total amount that can be claimed for that particular item in a calendar year. With Combined Extras, annual limits apply 'per person', which means that each person covered by the membership can claim up to that amount. There is also an overarching Extras policy limit, meaning that you will not be entitled to claim the 'per person' limit on all services covered on your policy.

On 31 December of each year, any unused annual limits expire, and they reset again on 1 January. It's not possible to rollover any unused limits from one year to the next, or to transfer 'per person' limits between the people covered by the membership.

2. Registered providers

Benefits are only paid for products, services or treatments provided to you by appropriately qualified practitioners. These are called 'registered providers'.

As a general rule, registered providers include:
Dentists registered with AHPRA (Australian Health Practitioner Regulation Agency)
Registered optometrists or ophthalmologists
Licensed optical dispensers
Natural therapists registered with the Australian Regional Health Group.

Unlike doctors and hospitals, which are monitored by Medicare, there is no one body that ensures only qualified, skilled and experienced practitioners provide the types of treatments covered by extras. By only paying benefits on services you receive from registered providers, we help to ensure that you receive care from properly qualified people.

3. Products, services or treatments purchased in Australia

Health funds are only permitted to pay benefits for products, services or treatments that are purchased in Australia. If you purchase something overseas; order it online and the transaction takes place overseas; or have a treatment or procedure overseas, you are not able to claim benefits for it under your Extras cover.

Please be aware that some overseas online providers may appear to be based in Australia. If you contact us with the name of the provider and the provider number before ordering products online, we can let you know if your purchase will be eligible for a benefit.

4. Claiming costs through Medicare and your Extras cover

A limited number of Extras treatment types can be provided by practitioners with a Medicare provider number, and costs for these services can be claimed under Medicare. You are not able to claim costs for the same treatment from both Medicare and your Extras cover.

How do you make an Extras cover claim?

1. Make sure that the product, service or treatment you're planning to claim is covered

If you're not 100% certain, please ask us. If it's something you've claimed before, but it's been a while since your last claim, check with us to make sure nothing has changed. We can let you know how much you're going to get back, so there'll be no surprises.

2. Make sure that the person you are going to for treatment is a 'registered provider'

You can do that by asking them, or by giving us a call. Any appropriately qualified natural therapist can apply to the Australian Regional Health Group, and if they meet the criteria, can become a registered provider.

3. Make sure that you have served your waiting periods

When you take out Extras cover for the first time, re-join after letting your cover lapse, 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 Combined Extras cover are shown over the page. If you're not sure whether you've served your waiting periods, please ask our team.

4. When you're ready to make a claim, there are two different ways you can go about it

ON THE SPOT

If your practitioner offers the HICAPS claiming facilities, you can use your Transport Health membership card to make an on the spot claim. You'll swipe your Transport Health card through a special terminal when you're about to pay your bill. The information will be sent directly to us, and your claim will be lodged right there on-the-spot. All you pay is any difference between the amount of your Transport Health benefit and the cost of the treatment. Ask your practitioner when you make your appointment if they offer electronic claiming, or visit the HICAPS website (hicaps.com.au) for more information about practitioners that offer these facilities.

SEND US YOUR CLAIM

If on-the-spot claiming is not available, you have two options.

1. Download our free Transport Health Mobile Claims app from the App Store or Play Store.

OR

2. Fill out a claim form, send us your receipts or account, and we'll send you a cheque or drop the money straight into your bank account. You can nominate a bank account when you complete your claim form.

You have up to two years from the date of service to lodge an Extras cover claim. Claims with a service date older than two years are not payable.

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Transport Health

COMBINED EXTRAS

Here's what you're covered for:

	Benefit for each purchase, service or treatment	Annual limit	Waiting period
Dental	70% of the fee charged	$300 per service type $600 per person $180 service limit applies to optical	2 months for general dental 12 months major dental
Optical			6 months
Physiotherapy			2 months
Chiropractic			
Remedial Massage			
Osteopathy			
Travel Vaccinations			

Read more about your Extras cover in online A to Z guide which can be found under 'Your Cover' on our website. You can find a copy of the Private Health Information Statement by visiting PrivateHealth.gov.au

Private Health Insurance Code of Conduct

Our industry code of conduct The Private Health Insurance Code of Conduct is a voluntary industry code aimed at delivering better service to health members through clear and complete communication, whether in writing or in person. As a signatory to the code, we are committed to ensuring that our members receive accurate information from properly trained staff, including clear and complete policy documentation, and information on internal and external dispute resolution processes. You can read more about the code at www.privatehealthcareaustralia.org.au.

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