Saver Bronze+ Hospital & Extras 65

At Navy Health, we know it's important for you to receive good value. Saver Bronze+ Hospital & Extras 65, is combined health cover, providing you with private hospital and extras insurance in one product.

Hospital excess

Saver Bronze+ Hospital & Extras 65 comes with a $500 excess only. This excess helps to reduce the cost of your premiums and applies to the cost of in-patient hospitalisation in either a private, public or day hospital facility.

Excess payments do not apply to hospital admissions for dependants. The excess applies to the cost of in-patient hospitalisation in either a private, public or day hospital facility.

For families and couples the excess is payable per admission, up to the family maximum of 2 adult admissions in any rolling 12 month period. For singles the excess is only payable once in any rolling 12 month period (once the excess is paid in full).

Restrictions and exclusions

For services that are listed as restricted, you can only be treated as a private patient in a public hospital. If you are treated anywhere else such as a private hospital, you will be significantly out of pocket.

For services that are listed as excluded, no benefits are payable.

General treatment (extras)

As a member of Saver Bronze+ Hospital & Extras 65, you'll be rewarded with more benefits. You'll receive 65% back on the most widely used extras services. That's up to $1500 worth of extras value per person, per year.

Waiting periods for general treatment items are detailed in this product sheet and need to be read carefully in conjunction with the conditions of the selected cover.

The benefit year for General Treatment (Extras) at Navy Health is July 1 to June 30.

Hospital Cover

Included treatments and surgeries	Restrictions	Exclusions
• Blood • Bone, joint and muscle • Brain and nervous system • Breast surgery (medically necessary) • Chemotherapy, radiotherapy and immunotherapy for cancer • Dental surgery • Diabetes management (excluding insulin pumps) • Digestive system • Ear, nose and throat • Eye (not cataracts) • Gastrointestinal endoscopy • Gynaecology • Hernia and appendix • Implantation of hearing devices • Joint reconstructions • Kidney and bladder • Lung and chest • Male reproductive system • Miscarriage and termination of pregnancy • Pain management • Palliative care • Plastic and reconstructive surgery (medically necessary) • Podiatric surgery (provided by a registered podiatric surgeon) • Skin • Tonsils, adenoids and grommets	• Hospital psychiatric services • Rehabilitation	• Assisted reproductive services • Back, neck and spine • Cataracts • Dialysis for chronic kidney failure • Heart and vascular system • Insulin pumps • Joint replacements • Pain management with device • Pregnancy and birth • Services not recognised by Medicare • Sleep studies • Weight loss surgery

Ambulance cover
100% benefit for ambulance services within Australia provided by a state/territory registered ambulance service.

Extras

65% benefit on	Annual limit (per person)	Waiting period
• Chiropractic, osteopathy, physiotherapy	$300 ($600 per family)	2 months
• General & major dental	$600	2 & 12 months
• Natural therapies	$200 ($400 per family)	2 months
• Non-PBS Pharmacy	$200	2 months
• Optical	$200	6 months

NAVY HEALTH

A Members Health Fund

What's covered during my hospital admission?

- Medical treatments not requiring surgery and other investigative procedures
- Day surgery
- Overnight accommodation (private room where available)
- Special care unit accommodation (e.g. intensive care)
- Operating theatre fees
- Allied health services (e.g. physiotherapy, occupational therapy)
- Pharmaceuticals approved by the Pharmaceutical Benefits Scheme
- Ward-drugs and sundry medical supplies (e.g. painkillers, dressings)
- Nursing care
- Patient meals

Out of pocket costs

The Australian Government sets a Medicare Benefits Schedule (MBS) fee for most services. Procedures recognised by Medicare will have an MBS 'item number' and fee. However doctors can charge their patients more than the MBS fee if they choose to do so. Medicare and Navy Health cover the cost of the MBS fee and any extra amount charged by the doctor is known as your out of pocket cost.

MBS fee breakdown

- Medicare pays 75% of the MBS fee for in-hospital treatment as a private patient. Navy Health will pay the remaining 25% of the MBS fee.
- Medicare pays 85% of the MBS fee for out-of-hospital services. Australian private health insurers do not provide benefits for out-of-hospital services

Example:

Sally is going to hospital to receive treatment for Medicare item number 12345 which has a set MBS fee of $1000. However Sally's doctor, Dr Smith, will be charging $1200 to provide this treatment. In this instance, Medicare will pay $750 (75% of the MBS fee), Navy Health will pay $250 (the remaining 25% of the MBS fee) meaning Sally will have to pay Dr Smith the extra $200. This is Sally's out of pocket cost.

How can I reduce my costs?

You can ask your doctor if they will participate in a gap cover scheme. Gap cover schemes allow health insurers to provide benefits for their members to cover some or all of the gap.

Things to note:

- There is no requirement for any doctor to participate in an insurer's gap cover scheme
- You should always ask your health insurer and your doctor's office about your gap cover benefits before you are treated
- If there is going to be an amount left for you to pay, the doctor is required to advise you of this before you agree to be treated, wherever practical
- To find specialists that may participate in the Navy Health gap scheme go to navyhealth.com.au/providers

When are benefits not payable?

- If the service forms any part of a payment from Workers' Compensation, Third Party or any other liability provision, Navy Health reserves the right to seek full reimbursement on any benefits paid in these circumstances
- When doctors submit medical claims two years after the date of service, unless approved by Medicare Australia for benefits
- The services are performed, or the products used are purchased, outside of Australia
- During a period of suspension or when the membership is not paid up-to-date
- During waiting periods
- Where treatment or surgery is excluded on your level of cover
- When you are treated in a private hospital for a restricted service
- Where you are issued with take home pharmaceuticals
- Where treatment occurs at a non contracted private or day hospital
- When the service does not have an assigned Medical Benefits Schedule (MBS) item number

Waiting periods

Hospital benefits are payable after two months of membership on the selected level of cover, with the following exceptions:

- 12 months for pre-existing conditions - this is defined as any condition, illness, or ailment that you had signs or symptoms of during the six months before you joined a hospital policy or upgraded to a higher hospital policy.
- 12 months for Pregnancy and birth and Assisted reproductive services - to be covered, the mother's hospital admission needs to take place after the 12 month waiting period has been completed.
- Two months for psychiatric care, rehabilitation, and palliative care, even for a pre-existing condition - this can include treatment of post-natal depression, eating disorders, and drug and alcohol rehabilitation, amongst other treatments.

If you are adding or upgrading your hospital cover, you will need to complete waiting periods for the new or upgraded items.

Treatment for accidents

This covers the hospital treatment that occurs as a direct result of an unforeseen event which causes injury.

Private Health Insurance Code of Conduct™