Navy Health

CORE SILVER+ HOSPITAL

A Members Health Fund

Uniformed or not. A Defence connection through family or business can mean you're eligible.

Serving everyone connected to Defence.

CORE SILVER+ HOSPITAL

Core Silver+ Hospital is a hospital policy that offers you a great balance of coverage and price.

Hospital excess

Core Silver+ Hospital comes with a $500 excess. 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.

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 in a private hospital, you may be significantly out of pocket.

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

Included treatments and surgeries

- Back, neck and spine
- 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
- Heart and vascular system
- Hernia and appendix
- Implantation of hearing devices
- Insulin pumps
- Joint reconstructions
- Kidney and bladder
- Lung and chest
- Male reproductive system
- Miscarriage and termination of pregnancy
- Pain management
- Pain management with device
- Palliative care
- Plastic and reconstructive surgery (medically necessary)
- Podiatric surgery (provided by a registered podiatric surgeon)
- Rehabilitation
- Skin
- Sleep studies
- Tonsils, adenoids and grommets

Restrictions

- Hospital psychiatric services

Exclusions

- Assisted reproductive services
- Cataracts
- Dialysis for chronic kidney failure
- Joint replacements
- Pregnancy and birth
- Services not recognised by Medicare
- Weight loss surgery

Ambulance cover

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

What's covered during my hospital admission?

- In-patient 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.
- In-patient 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 $1,000. However Sally's doctor, Dr Smith, will be charging $1,200 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 **https://navyhealth.com.au/find-a-provider/**.

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 Medicare 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™

Navy Health