Intermediate Hospital cover provides a great value mid-level hospital cover ideal for a young or healthy person who doesn’t want to pay for hospital services they’re less likely to need, like pregnancy, IVF, heart surgery, major eye surgery, in-hospital psychiatric care or even a hip or knee replacement. This cover is a cost effective option if you want hospital cover for the majority of hospital treatments but are prepared to have limited or no cover for the hospital services that are restricted and excluded.

**What You Are Covered For**

*This provides a summary of cover and isn’t intended to be a comprehensive list of all the services covered*

- Choice of doctor/hospital
- Public hospital accommodation as a private patient
- Theatre fees
- Intensive care
- Tonsils and adenoids removal
- Gastroscopies
- Gynaecological services
- Joint reconstructions
- Brain surgery
- In-hospital rehabilitation treatment
- Private hospital accommodation
- Back surgery
- Appendix removal
- Colonoscopies
- Grommets in ears
- Hernia repair
- Plastic and reconstructive surgery

**Restricted and excluded services**

**RESTRICTED SERVICES**

If a service is covered as a restricted benefit, this means that you will be covered by your choice of doctor in a shared ward accommodation for public hospital only. If you go to a private hospital/day surgery for a restricted service, you will only receive a minimum benefit and may face large out of pocket costs.

- In-hospital psychiatric treatment
- Cardiac and cardiac related procedures – e.g. open heart surgery
- Major eye surgery - e.g. cataract and eyes lens procedures
- Obstetric related services
- Assisted reproduction services – e.g. IVF
- Gastric banding and obesity surgery
- Dialysis for chronic renal failure
- Knee and hip joint replacements
- Cosmetic surgery
- Mechanical Aids and Appliances – for example CPAP Machines, Hearing Aids etc.

**EXCLUDED SERVICES**

There is no benefit entitlement for hospital treatment for which Medicare pays no benefit e.g. most cosmetic surgery.

**Waiting Periods**

Initial waiting period

- Palliative care, psychiatric, rehabilitation services, and all other hospital treatment/services where there are no pre-existing conditions (excluding accidental injury*) ................................................................. 2 months
- Pre-existing ailments, conditions or illnesses .......................................................................................... 1 year
- Pregnancy related services (including childbirth) and assisted reproductive services .................................. 1 year

* Cover for an accident is immediate provided it is not recoverable from another source such as Worker’s Compensation, third party or other liability provision. Sporting accidents sustained by professional sportspeople in activities relating to their employment, including training and competition are subject to a two month waiting period.
These are the fees that are charged by a doctor, surgeon, anaesthetist or other specialist for any treatment given to you whilst you’re an inpatient in hospital. Private health insurance means that generally you can choose your own doctor and decide whether you will go into a public or private hospital. If you choose private, this may also mean you will have more of a choice of when your procedure will take place.

You are covered for the cost of medical fees up to the Medicare Benefit Schedule (MBS) fee. The MBS fee is the amount set up by the Federal Government for each medical service covered by Medicare. You must be eligible for Medicare in order to be covered up to the MBS fee. If you choose to be treated as a private patient in a hospital (public or private), Medicare will cover you for 75% of the MBS fee for associated medical costs and we will cover the remaining 25%. If your specialist charges more than the MBS fee there will be a ‘gap’ for you to pay. However, the Territory Health Fund Access Gap Agreement can help eliminate or reduce the gap for you if your doctor/s chooses to use it.

Children aged 12 and under are NOT exempt from paying an excess on this product.

**Excess options**

- **$250**
- **$500**

An excess is an amount you agree to pay upfront before a benefit is paid for overnight or same day hospital/day surgery admissions. You can choose to have a $250 or $500 excess. For a single policy regardless of the number of times within the same Membership Year you are hospitalised, you will only need to pay a total excess contribution per Membership Year equivalent to the selected policy excess option. On a family policy, regardless of the number of people covered or the number of times within the same Membership Year these persons are hospitalised, each individual will only be responsible to pay a total excess contribution per Membership Year equivalent to the selected policy excess option. For a family policy the total maximum excess payment obligation per Membership Year for the entire family is limited to an amount equivalent to twice the chosen excess option. This means for an entire family policy a total maximum excess obligation of $500 per Membership Year would apply on a $250 excess option product, or alternatively $1,000 per Membership Year for a $500 excess option.

Medical costs

These are the fees that are charged by a doctor, surgeon, anaesthetist or other specialist for any treatment given to you whilst you’re an inpatient in hospital. Private health insurance means that generally you can choose your own doctor and decide whether you will go into a public or private hospital. If you choose private, this may also mean you will have more of a choice of when your procedure will take place.

You are covered for the cost of medical fees up to the Medicare Benefit Schedule (MBS) fee. The MBS fee is the amount set up by the Federal Government for each medical service covered by Medicare. You must be eligible for Medicare in order to be covered up to the MBS fee. If you choose to be treated as a private patient in a hospital (public or private), Medicare will cover you for 75% of the MBS fee for associated medical costs and we will cover the remaining 25%. If your specialist charges more than the MBS fee there will be a ‘gap’ for you to pay. However, the Territory Health Fund Access Gap Agreement can help eliminate or reduce the gap for you if your doctor/s chooses to use it.

Access Gap Cover

This is a direct billing arrangement between Territory Health Fund and your doctor/s that in most instances eliminates your out-of-pocket expenses for in-hospital doctors’ fees (the gap). If your doctor charges up to the Medicare Benefits Schedule fee or is participating in the Access Gap Cover Scheme, in most cases you will have limited out of pocket costs. For doctors who are not participating in the Access Gap Scheme and are charging above the MBS fee, we will pay the difference between the Medicare benefit and the MBS fee. Any amount above the MBS fee will be the amount you are required to pay and this is referred to as your ‘gap’ fee or out of pocket expenses.

Extra value from your Membership

**EXCLUSIVE UNIT ACCOMMODATION**

Territory Health Fund has self-contained units in both Brisbane and Townsville exclusively available to our Members travelling to those locations for medical treatment. These two bedroom units can be booked at very reasonable rates for an overnight stay or for several weeks, depending on your needs.

Planning a trip to hospital?

If you’re planning any treatment, or have a hospital procedure coming up, we would love to hear from you. If you call us first we can discuss your options, assist with what you’re covered for and check that you have served all waiting periods and you’re all set to go. That way you can be more confident when attending medical appointments and will have a better idea of what to expect when you’re admitted to hospital.

Need more info?

**CALL: 1800 623 893**  **VISIT: territoryhealth.com.au**  **EMAIL: info@territoryhealth.com.au**