Factsheet

Healthy Start

Latrobe HEALTH SERVICES

This information is current as of 1 July 2020.

Hospital

Have a question?
Call us on 1300 362 144

Accident and extras

This is a hospital and extras package with hospital cover for accidents only in a Participating Private Hospital and basic extras cover.

Healthy start hospital

- You are covered in a shared or private room at a Participating Private Hospital for treatment of injuries directly relating to an accident. You are covered for the treatment of these injuries for up to six months from the date of the accident.
- Significant out-of-pocket expenses will be incurred for any admission to a private hospital that is not a direct result of an accident.
- You are covered for treatment by your own doctor or specialist in a shared or single room at a public hospital for all 38 Clinical Categories as classified under legislation.

Going to hospital?

Call us on 1300 362 144 before treatment to find out how much of the cost we'll handle (benefit amount) and help you understand the out-of-pocket costs involved.

Thank you for choosing Latrobe.

Please read and retain for future reference

Hospital

What's covered in a private hospital - accident treatment only

An accident is defined as a sudden, unplanned and unexpected event caused by any external force resulting in acute physical injury requiring immediate treatment.
An acute physical injury is defined as damage to a body part caused by a single traumatic event. Aggravation of an existing condition or injury, pregnancy, any medical conditions or injury resulting from surgical operations is not considered to be an accident.

The accident must have occurred after joining Latrobe, with treatment sought at an emergency department, or from a medical practitioner or an Australian Health Practitioner Regulation Agency (AHPRA) registered allied health provider within 14 days of the accident.

A Latrobe Accident Form must be submitted within 21 days of the accident and treatment is coverable for up to six months from the date of the accident. Please contact us for a copy of this form go to Publications and Forms under Help Centre on our website.

All treatment must be directly related to the injury sustained at the time of the accident.
If your injury was a result of an accident at work or in a registered motor vehicle and is eligible for compensation, we will require reimbursement from Workcover, TAC or any other compensation source for any claims paid.

Accommodation

You are covered for your room, theatre, intensive care, labour and recovery ward fees, medicines and drugs clinically required as part of your treatment while in hospital.

In a Participating Private Hospital, you have the choice of a private or shared room. Private rooms are subject to availability.

Inpatient services

To be eligible for hospital benefits you must be an inpatient admitted for treatment that has a Medicare item number allocated and a Medicare benefit is payable.

Doctors' fees raised for treatment in a private hospital emergency department will be covered if the treatment results in an inpatient admission. Any facility fees raised for treatment in a private hospital emergency department are not claimable through Medicare or Latrobe.

Medical Gap cover

Medicare pays 75% of the Medicare Benefit Schedule fee for in-hospital medical charges and Latrobe pays the remaining 25%.

Surgically implanted prostheses

All prostheses are covered in accordance with the Commonwealth Prostheses Listing.

Electronic services

The cost of TV hire and local phone calls are included at Participating Private Hospitals.

Limited benefits apply for any other admissions to a private hospital.

What's covered in a public hospital

Limited cover in a shared ward or single room in a public hospital for all clinical categories and accidents.

Accommodation

You are covered in a shared ward or single room in a public hospital for all clinical categories and accidents. In a public hospital, single rooms are subject to availability. If you choose a s ingle room, you may incur out-of-pocket expenses.

If you elect to be admitted to a single room in a public hospital, we will pay a benefit equal to the Department of Health's shared-ward accommodation rate in a public hospital plus an additional amount of up to $80 per night. Out-of-pocket costs may be incurred if the public hospital charges above this rate. Please contact us if you find yourself in the unlikely position where this has occurred.

In public hospitals there is no charge for theatre, intensive care, labour, recovery ward fees, medicines and drugs clinically required as part of your inpatient treatment.

Hospital

Your choice of treating doctor or specialist

You are covered for treatment by your own doctor or specialist for all admissions in a shared or single room at a public hospital for all 38 Clinical Categories classified under legislation. However, public hospitals cannot guarantee choice of doctor.

Surgically implanted prostheses

All prostheses are covered in accordance with the Commonwealth Prostheses List.

Restricted cover in a private hospital

There is limited cover for treatment in a private hospital not related to and within six months of an accident.

If you are planning an admission to a private hospital that is not directly related to and within six months of an accident, you will incur significant out-of-pocket expenses and are strongly urged to contact us first.

Hospital costs: limited benefits apply to private hospital charges associated with an admission for treatment that is not directly related to and within six months of an accident.

Medical costs: additional medical benefits are payable.

Prosthesis costs: benefit is payable for the cost of any prosthesis listed on the Commonwealth Prostheses List.

Podiatry surgery

Hospital costs: limited benefits apply to hospital charges associated with podiatric surgery in a Participating Private Hospital or a public hospital.

Podiatrist costs: no benefit is payable for the podiatrist's fees. You may be able to claim a benefit for these fees if you have appropriate extras cover.

Anaesthetist fees: no benefits are payable for the anaesthetist costs associated with podiatric surgery.

Prosthesis costs: benefit is payable for the cost of any prosthesis listed on the Commonwealth Prostheses List that is associated with podiatric surgery.

If you are planning surgery, you are strongly urged to contact us first.

Dental surgery

Some dental surgery is performed in hospital rather than in the dentist's surgery. A common example is the removal of wisdom teeth.

Hospital costs: limited benefits apply to hospital charges associated with dental surgery in a Participating Private Hospital or a public hospital.

Dentist fees: no benefit is payable for the dentist's fees. If you have appropriate extras cover you can claim a benefit for the dental fees.

Anaesthetist fees: benefits are payable for the anaesthetist costs associated with dental surgery. These will be payable in accordance with the Latrobe Additional Medical Benefits program.

Cosmetic surgery

Hospital costs: limited benefits apply to hospital charges associated with cosmetic surgery in a Participating Private Hospital or a public hospital.

Medical costs: no benefit is payable for the surgeon fees.

Anaesthetist fees: no benefits are payable for the anaesthetist costs associated with cosmetic surgery.

Prosthesis costs: no benefit is payable for the cost of any prosthesis associated with cosmetic surgery.

Other non-Medicare covered treatments

Hospital costs: limited benefits are paid for inpatient treatments that are not covered by Medicare.

Medical costs: no benefit is payable for non-Medicare approved procedures. This includes but is not limited to cosmetic procedures and procedures performed by podiatric surgeons.

Prosthesis costs: no benefit is payable for the cost of any prosthesis associated with non-Medicare covered surgery.

Your specialist should be able to confirm if Medicare benefits are payable for your treatment.

Hospital

Hospital tests

Including blood tests, other pathology services and x-rays during a hospital admission.

It may appear that blood tests and x-rays are performed directly by your hospital, but these services are provided by companies independent to the hospital.

Fees for these services are classified as medical costs and covered under additional medical benefits by Medicare and Latrobe. There will be out-of-pocket costs associated with these charges.

Charges for medical services when you are not an inpatient, including radiology, pathology and costs associated with treatment at a private hospital emergency department, are not covered.

New technologies

Including but not limited to medicines, devices or treatments.

There is no cover for any service or item that remains in the testing, clinical trial or experimental phase. This includes any service being used for a purpose other than what it was registered or approved for.

Consumables and medical devices

Robotic consumables and medical devices that are not on the Commonwealth Prostheses List are not covered.

High cost drugs

Any drugs not listed on the Pharmaceutical Benefits Scheme (PBS) are not covered.

Hormone treatment

Costs associated with assisted reproduction services are not covered.

Cell storage

Costs associated with assisted reproduction services are not covered.

Outpatient attendance

No benefits are payable for services provided on an outpatient basis.

Doctors' fees for treatment in a private hospital emergency department will be covered only if the treatment results in an inpatient admission.

Any facility fees for treatment in a private hospital emergency department are not claimable through Medicare or Latrobe.

No benefits are payable for treatment in a public hospital emergency department.

Private room fees for day admissions

All same-day admissions are paid at a shared-room rate.

Overseas treatment

No benefits are payable for services, treatment or appliances provided or sourced outside of Australia. This includes treatment on cruise ships inside or outside Australian waters.

Out-of-pocket costs

Charges above the Latrobe additional medical benefit scheme are also known as out-of-pocket costs and are not covered.

Personal items

There is no cover for:

- Wi-Fi, pay TV, visitor meals or other personal items
- Luxury room surcharges
- Bandages and dressings that you take home with you
- Medical appliances (such as braces and crutches) that you take home
- Medication to take home after your hospital stay
- Medication you used prior to your hospital stay.

Allied health services

There is no cover if you choose to have your own private allied health professional attend your needs whilst in hospital rather than the hospital-appointed provider.

In a non-participating private hospital, services such as physiotherapy or occupational therapy are not covered.

Hospital

Respite care

No benefits are payable for services provided for respite or holiday-relief basis.

Two year claim limitation

No benefit is payable for any claim submitted two years or greater from date of admission.

Waiting periods

A period of time during which members cannot claim benefits for services received.

Who do they apply to?

- New members
- Existing members upgrading their level of cover
    - Transferring from other funds and upgrading to a higher level of cover
    - Changing from a single membership to a family membership for the birth of a baby

Wait periods

- 12 months for pre-existing conditions
- Two months where no other waiting period applies including:
    - Psychiatric care
    - Rehabilitation
    - Palliative care

Upgrading your cover

Higher benefits relate to:

- Benefits payable for services that were not covered by your previous cover
- A change in hospital cover to one with a lower excess or co-payment
- Services for which a higher benefit is payable under your new cover
- Services for which there is a higher annual/ personal limit.

During these waiting periods, existing members and members who have transferred from another fund are entitled to the nearest Latrobe equivalent cover, provided they have served our required waiting periods before upgrading or transferring their cover.

Excess

Any excess paid with your previous fund is not transferable and will not count towards meeting your excess obligations with Latrobe.

Pre-existing conditions

This refers to any ailment, illness or condition where the signs or symptoms existed, in the opinion of a Latrobe-appointed medical practitioner, at any time in the six months prior to the day you joined or upgraded your cover.

Latrobe's medical practitioner will take into account information provided by your own practitioner who treated the condition. No benefits are paid for the treatment of a pre-existing condition during the first 12 months of starting a new cover.

Your responsibility

For any admission occurring during the first 12 months of cover or upgraded cover, you will be asked to have two medical certificates completed - one from your usual GP and one from your treating specialist.

We need these certificates to make a determination regarding your pre-existing medical condition status. This determination may involve consultation with your medical practitioners also.

We strongly advise that you do not proceed with an admission to a private hospital until the determination has been made as you may be liable for considerable costs should the condition be deemed as pre-existing.

If you are planning treatment it is essential that you contact us for a benefit estimation before you are admitted to hospital.

Having a baby?

To ensure your newborn is covered at birth, an upgrade from a single membership to a family membership is required two months prior to the expected delivery date.

A single membership only covers the person who applied for the membership. A newborn baby is not covered under your single membership. If you are planning a pregnancy, please contact Latrobe for advice.

Written confirmation of the expected delivery date is required from the treating obstetrician.
A family membership automatically covers newborn babies subject to waiting periods being served.

Hospital

Non-admitted baby: A newborn baby, less than nine days old, is not an admitted patient. Any medical bills resulting from consultation to the baby do not qualify for any benefits from Latrobe. This also includes any fees raised for procedures such as circumcision. Medicare will rebate 85% of the Medicare Benefit Schedule fee.

Admitted baby: The hospital cannot raise a charge for a newborn unless it has been admitted to a neonatal facility by a paediatrician for the treatment of a medical condition. In these circumstances, any medical bills resulting from consultation to the baby qualify for benefits from Latrobe.

Multiple births: In accordance with the National Health Act (1953), second or subsequent babies are considered as inpatients. In this instance, any excess or co-payment applicable to your selected hospital product will apply to the baby's admission.

Private midwife: A benefit of up to $450 is payable for the attendance of a registered midwife at a birth in a private hospital. The midwife must be in private practice and cannot be an employee of the hospital.

We get that inclusions and exclusions on services can be confusing. Call us to have your questions answered.

Extras explained

Your extras include 'add on' out-of-hospital care services. They include things that Medicare doesn't cover.

Ambulance

We want to assist in emergency health situations. That's why we have included emergency ambulance cover in your extras policy.

Benefits

We pay benefits on products and services provided by a Latrobe approved practitioner in private practice in Australia.

Some good stuff

Budget

This cover is for vital services for those who are budget conscious.

Flexible

Total limits on included allied health and maintenance services will give you flexibility to choose which services you need the most.

Extras

Amount you receive back after using a health service.

Only applies if you are new to health insurance or if you have recently increased your level of cover.

Service	Benefit	Annual limit	Waiting period
General dental			
Diagnostic and most preventative services, extractions and restorations	Limited dental benefits included (benefits as per dental schedule)	$500 per person $2000 per membership	2 months
Major dental			
Treatment resulting from an accident only	$250	$500 per person	12 months
Mouth guard supplied by dentist or dental technician	$80	$80	2 months
Optical			
Spectacles and repairs, contact lenses and prescription sunglasses	$130	$130	6 months
Allied health			
Group physiotherapy / hydrotherapy	$9	$250 total all services per person $500 total all services per membership	2 months
Osteopathy	$22		
Podiatry consultations			
Chiropractic			
Chiropractic x-ray (one per year)	$28		
Physiotherapy	$25		

Annual limit is the maximum amount claimable per person in a calendar year, unless otherwise stated.

Extras

Service	Benefit	Annual limit	Waiting period
Health maintenance			
Pharmaceuticals[1]	$22	Included in 'total all services' (previous page)	2 months
Travel vaccines			
Top up amount to cover additional extras services required in case of accident	100%	$175	12 months
Ambulance services*	2 emergency ambulance transports where necessary		1 day
Ambulance rebate	50% of paid ambulance subscription		2 months

We get that inclusions and exclusions on services can be confusing. Call us to have your questions answered.

The fine print

Ambulance

Emergency Ambulance Cover is included within this policy. You are entitled to two emergency ambulance transports per calendar year. A waiting period of one day is applied to all ambulance benefits with LHS. Where you are covered by an applicable state or territory ambulance scheme (including informal reciprocal arrangements) or third party scheme, costs of ambulance usage will be covered by this scheme and not your policy's Emergency Ambulance Cover.

Where you hold an extras and hospital combination or standalone extras with us and an take out an ambulance subscription, you are entitled to a rebate on the cost of the subscription.

Dental

Dental benefits are paid according to the service, as per the current edition of the Australian Dental Association's Schedule of Dental Services and Glossary (ADA Glossary).

The ADA Glossary restricts certain combinations of items at any one consultation. All dental limits apply to a calendar year, which is from 1 January to 31 December. Please contact us for a benefit quotation before undergoing dental treatment.

Optical

The provision of a benefit for the purchase, repair and replacement of glasses, contact lenses or prescription sunglasses prescribed by a registered optometrist or ophthalmologist.

Pharmacy

Pharmacy benefits include prescribed drugs and medicines dispensed by a pharmacist and/or travel and allergy vaccines dispensed by a pharmacist or doctor.

Benefits are not payable for oral contraceptives, Pharmaceutical Benefit Scheme (PBS) subsidised prescriptions or substances from which they are compounded. The benefit is calculated after deducting the current general patient contribution as defined by the PBS.

Podiatry

Benefits are paid for services provided by a qualified and registered podiatrist in private practice. The amount of benefit paid depends on the service provided and is set out in the Australian Podiatry Association (Vic) current schedule.

Conditions

[1] Conditions apply, please refer to information under pharmacy above.

[*] Emergency ambulance transportation is defined as transportation of an unplanned and non-routine nature for the purpose of providing immediate medical attention to a person. Where you are covered by an applicable state or territory ambulance scheme (including informal reciprocal arrangements) or third-party scheme, costs of ambulance usage will be covered by this scheme.