Australian Government
Private Health Insurance Ombudsman

CHOOSING A HEALTH INSURANCE POLICY

hospital cover

When choosing a health insurance policy, you need to think about your own health needs and those of your family. Here are the important questions to ask about any hospital policy.

waiting periods before payment of benefits

Most insurers will require you to complete a set period of membership, known as a *Waiting Period*, before you are covered for certain benefits.

Most insurers will apply the following Waiting Periods when you start your cover:

- A 2-month wait for psychiatric care, rehabilitation or palliative care (whether or not for a pre-existing condition).
- A 12-month wait for benefits on any *Pre-existing Conditions*.
- A 12-month wait for benefits for obstetric treatment (pregnancy).
- A general 2-month wait for any benefits.

If you upgrade your cover, most insurers will apply waiting periods for items you were not covered for on your previous policy.

Your insurer should tell you which waiting periods will apply when you join as a new member or change your existing cover. If you are a member of a health fund and cancel your policy, waiting periods will apply when you rejoin.

Some hospital policies also have *Benefit Limitation Periods* for some types of hospital treatment. Benefit Limitation Periods may apply for up to 1, 2 or 3 years on top of the normal 12 month waiting periods. During this period, the insurer will only pay a limited benefit towards specified services.

Pre-existing Conditions
A Pre-existing Condition is defined by law as any ailment, illness or condition that you had signs or symptoms of during the 6 months prior to taking out hospital cover or upgrading to a higher level of cover.

This rule applies even if you and your doctor did not know you had this condition or if the condition was not diagnosed. If you anticipate any hospital admission within the first 12 months of joining or upgrading your health insurance, you should contact your insurer straight away to check if you will be covered

For more information on Waiting Periods, you can refer to our brochure.

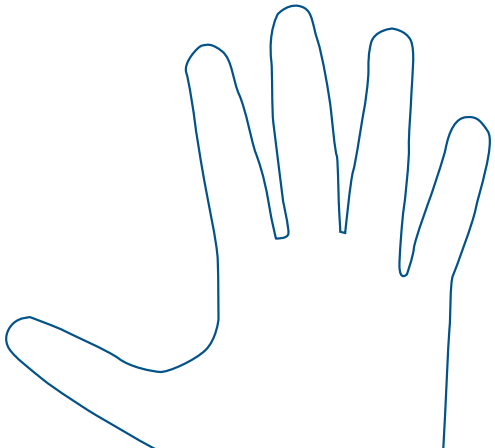
treatments that won't get full hospital benefits

Some hospital insurance policies exclude certain treatments from benefits or permanently restrict the amount of benefits they will pay for certain treatments.

If a policy has *Exclusions*, the insurer will not pay any benefits for the treatments listed as exclusions.

If a policy has *Restrictions*, the insurer will only pay a limited benefit for the treatments listed as restricted. You are likely to have significant out of pocket expenses.

Make sure you know which treatments are excluded or restricted, and that you are prepared to take the risk of not being fully covered for those treatments.



excesses or co-payment for hospital visits

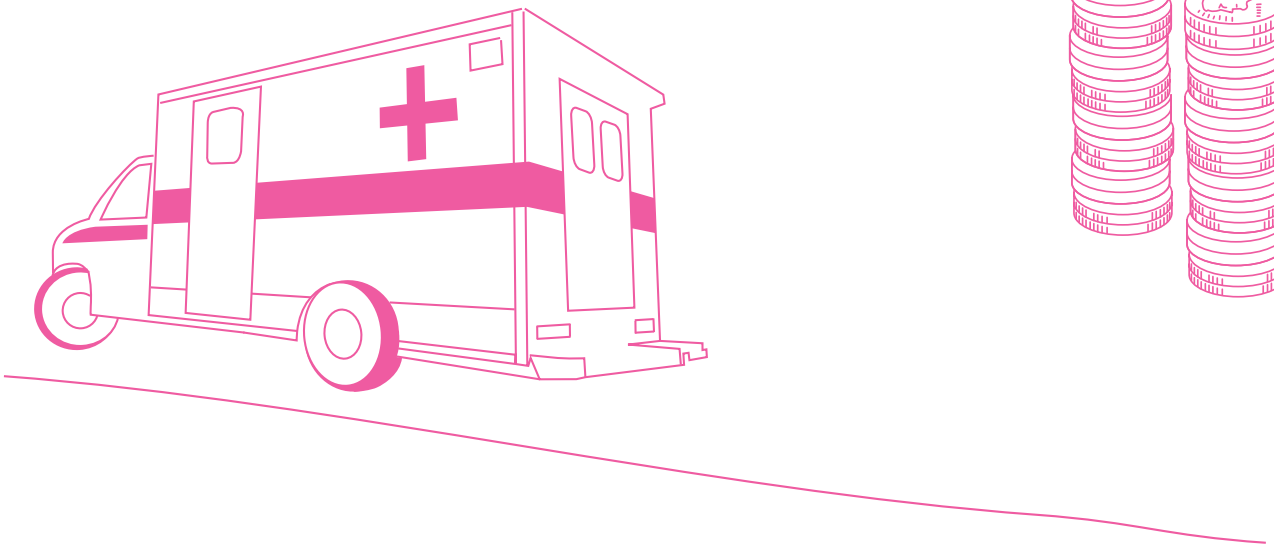
Most insurers will offer you the option of paying an excess or co-payment, in return for reduced membership premiums. If you nominate a high excess or co-payment, then you will have a lower premium than someone with no excess or co-payment.

An *Excess* is a lump sum you pay towards your hospital admission before the insurer will pay its benefits.

A *Co-payment* is an amount you agree to pay each time the insurer pays benefits for you. Normally a co-payment is payable for each day of hospitalisation up to a maximum annual amount or per admission amount.

You need to check the amount of any excess or co-payments, when they apply, and if there is a limit on how much you'd have to pay.

Please note, if you chose an excess of over $500 per person there may be tax implications depending on your earnings (see below).



agreements between insurers and private hospitals

It is important to check that your insurer has agreements with private hospitals in your area or other private hospitals you might attend. Each insurer has a different network of agreement hospitals, and some insurers will specialise only in certain areas or certain states.

When there is an agreement, you will have either no out-of-pocket expenses or you will be provided with details of your out-of-pocket expenses.

If you are treated at a private hospital that your insurer doesn't have an agreement with, you may have to meet a considerable amount of the cost yourself.

The website www.privatehealth.gov.au has a list of agreement hospitals for all insurers or you can phone your health fund to check which hospitals are covered.

"gap" payments and coverage for doctor's fees in hospital?

The government sets a Medicare Benefits Schedule (MBS) fee for most medical services. The MBS fee is used to work out how much Medicare will pay. However, doctors can charge more than the MBS fee if they wish, and many do.

If your doctor charges above the MBS fee, you may have to pay the difference between the MBS fee and the doctor's charge. This extra amount is known as the "gap."

You are entitled to ask your doctor how much this gap will be before you have treatment. Agreeing to known treatment costs upfront is called "informed financial consent".

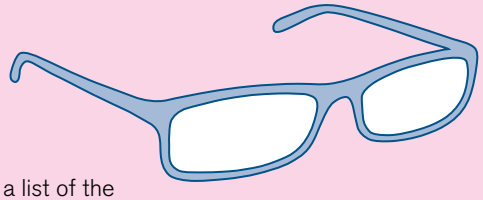
Your insurer can provide extra benefits to help cover this gap if they have an agreement with the doctor or the doctor decides to participate in the insurer's "gap cover" scheme. Ask your doctor(s) whether he or she will bill you under your insurer's "gap cover" scheme. Ask your insurer how much of the doctor's bill their gap scheme will cover.

For more information on Doctors' Bills, you can refer to our brochure.

general treatment cover

General treatment policies (also known as *ancillary* or *extras* cover) provide benefits for ancillary services such as physiotherapy, dental and optical treatment.

Here are some key steps in selecting a health insurance product to cover extras.



- Make a list of the sorts of services you are likely to want to use. (For example: dental, orthodontics, optical, natural therapies, etc.)
- Check that the policy you are considering pays benefits for those services.
- Ask what waiting periods apply for each of the types of service you might use.
- Ask how much of the cost of each service the insurer's benefits will cover.
- Find out what annual limits apply and check when the annual limits are reset.
- Find out if the limits will increase over time if you stay with the insurer.

If you are changing your extras cover to another insurer, your new insurer can make you serve waiting periods - but many don't. It is worth asking if the insurer will waive or reduce any waiting periods.

All insurers operate their extras covers quite differently so you should always re-check the benefits as well as any annual limits and how they work. It is worth asking if the new insurer will match any extra limits you might have built up with your old insurer.

However loyalty bonuses – for example, higher benefits after 5 years of membership – are generally not transferable between insurers.

exemptions from the 1% extra medicare levy

Most Australian taxpayers pay a Medicare Levy of 1.5% in their income tax.

However, if your taxable income is above a certain threshold, you will have to pay an extra 1% Medicare Levy Surcharge unless you have an approved hospital cover with a registered health insurer.

If you are in this situation, you need to make sure that the policy you are considering will exempt you from the extra levy.

To avoid the Surcharge, you must have a hospital policy which covers you and your dependants, and which has a low excess. The excess must be:

- Equal to or less than $500 per annum for single policies, or
- Equal to or less than $1,000 per annum for families/couples.

The Surcharge threshold is indexed annually. In the 2010-11 financial year, the threshold will be $77,000 for single persons and $154,000 for families. For current information, check www.privatehealth.gov.au or contact the Australian Taxation Office.

lifetime health cover

Lifetime Health Cover is designed to encourage people to take out hospital cover early in their life and keep it. Health insurers are therefore required to charge extra to people who join a hospital policy after the age of 31. (There are some special rules for new residents and people who were overseas when they turned 31.)

The extra charge is 2% on top of the normal premium for each year you are over 30 years of age. For example:

- If you don't take out hospital insurance until you are 40 you'll pay an extra 20%.
- If you wait until you are 50 it's an extra 40%.

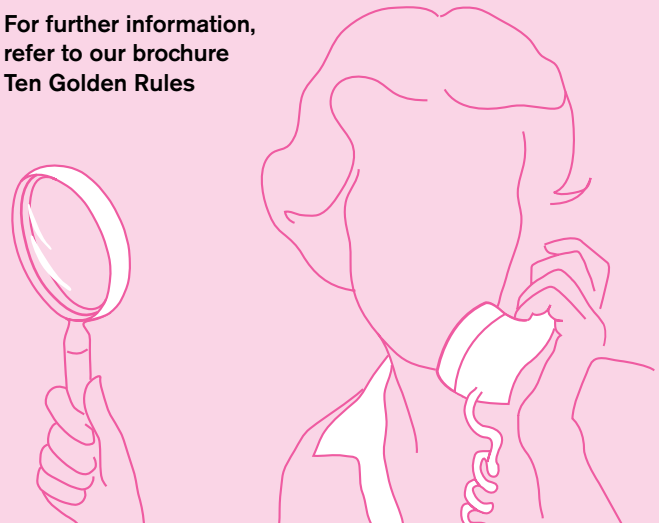
The Lifetime Health Cover loading no longer applies once you have paid it for a period of 10 continuous years.

For more information on Lifetime Health Cover visit www.privatehealth.gov.au or ask your health fund.

making the most of your health insurance (and avoid problems)

- Consider choosing the highest level of hospital cover you can afford: Choose a higher excess rather than a restriction, to save money on premiums.
- Keep your membership payments up to date: It is your responsibility to make sure you keep your premium payments up to date. If you get too far behind in your payments (usually 2 months or more) the insurer can cancel your policy and refuse to pay you any benefits. If your policy is cancelled waiting periods may apply to you when you rejoin.
- Contact your insurer if you're going to hospital: If you are going to hospital as a private patient, contact your insurer to check that you'll be covered for the hospital bill and any doctor's bills, and how much you'll have to pay yourself. Ask your doctor to give you the Medicare item numbers he or she will be using before you contact your insurer.
- Read the information your insurer sends you carefully: Important information about your policy will be sent in a personalised letter and should not be ignored.
- Check your policy every year: Make sure you are covered for the services and treatments you may need.
- Tell your insurer: If you change address, add a partner or add a child.

For further information, refer to our brochure Ten Golden Rules



more information

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