

## **1. Read all the fine print before selecting a health policy**

Policies offered by private health funds include conditions, exclusions and explanations in the 'fine print' attached to their brochures and applications forms. Read the 'fine print' before signing. Policies are also called 'tables' or 'products'.

If you do not understand the 'fine print,' ask the health fund to explain. For example, a health insurance policy might exclude important things like heart surgery or hip replacements. Please read your fund's brochure to familiarise yourself with what your health insurance policy covers and what it doesn't. All health insurance products are NOT the same.

## **2. Beware of waiting periods applying to new and upgrading members**

Only treatment for accidents is covered when you first join most health funds or upgrade your health insurance. There are usually three main areas where waiting periods apply before you can make a claim:

- 2 months before new members can make a claim. From time to time private health funds run promotions offering "immediate" cover to new members - this "immediate" cover usually does NOT apply to obstetrics and pre-existing ailments.

- 12 months for obstetrics and maternity claims.

- 12 months for pre-existing ailments and conditions. Funds firmly apply this rule - so, if you're not certain how this may affect your cover, ask the funds staff to explain the rule. Remember, even undiagnosed illnesses may not be covered by your health insurance policy.

Many policies incorporate other waiting periods for 'ancillary' benefits such as dental and optical work; and lengthy waiting periods for some specific medical and surgical procedures, such as cosmetic surgery and IVF.

Note that waiting periods apply to the additional benefits members get when they upgrade their health insurance.

Waiting periods can be extended further by 'benefit limitation periods'.

## **3. Check to see if benefit limitation periods apply**

Some funds impose benefit limitation periods on new members, people transferring from other funds and existing members upgrading their policies. These limitations effectively impose additional waiting periods for the payment of benefits above the default benefit amount. For example, a new member might have to wait for a year before default benefits are paid for certain treatment and then more time before full benefits are paid. (Default benefits are often only about half the fees for accommodation in private hospitals and do not cover theatre and some other costs).

## **4. Contact your fund before receiving treatment or entering hospital**

Contact your health fund before having any treatment or going to hospital. Provide the fund with your membership number, the name of your doctor, details of the hospital and procedure (including the "item numbers" that can be provided by your doctor, dentist or surgeon).

Many health funds have 'agreements' with private hospitals. When you call your fund, ask if you have chosen an 'agreement' hospital. If you have not, you will need to call the

hospital and health fund and ask what your out of pocket expenses will be.

Check about your doctor's fees as well as your hospital fees. Find out how much they will be and how they are to be paid. Many doctors charge fees above the amount you can claim from Medicare and your health fund. Check with your doctors about likely medical costs for treatment in hospital as soon as possible.

## **5. Regularly review your health insurance**

Your family's circumstances may change from time-to-time. Review your health insurance to make sure it still meets your health needs and circumstances. Avoid expensive surprises.

Health funds change the benefits they pay. It is worth checking your health insurance at least once a year and comparing it with other policies offered by your fund and other health insurers in the marketplace.

## **6. Keep payments up to date or your policy will be cancelled**

Your health insurance policy will usually be cancelled if you fail to make payments for two consecutive months. People rejoining after such a cancellation may have to serve all waiting periods again. Some funds do not send reminder notices if your premiums fall behind

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### **You can usually transfer between funds without re-serving waiting periods, but take care**

You can usually switch to a different fund - without having to serve another waiting period - if the switch is to the same level of cover and you have served the appropriate waiting periods with your original health fund.

You will have to serve waiting periods before you qualify for any new or higher benefits the new policy may offer. The new fund will usually limit the benefits it pays to the benefits you were entitled to at the original fund for the first year.

You may also have to serve additional waiting periods with some funds, because of 'benefit limitation periods'. Check the fine print to see if they apply in the new fund of your choice.

Also check whether any accrued benefits, credits or bonus points or 'equity' in your original fund can be transferred to the new one - usually they cannot be transferred. (e.g. orthodontic).

Ask the fund to explain any new waiting periods, benefit limitation periods and your rights about accrued credits.

## **8. Promptly lodge any claims**

Most private health funds won't pay benefits if you make a claim two years after the health service was provided. If legal action or other unforeseen circumstances prevent you from making a claim, contact your fund. The fund may be able to extend the claim period if you let them know beforehand.

## **9. Understand how policy limits, excesses and co-payments are calculated**

Many health insurance policies place a limit on claims, particularly those for "ancillary" benefits such as dental and optical services. For example, you may only be able to claim up to \$750 for fillings or other dental work in any 12-month period.

Many funds have products with excesses. By agreeing to pay the first part of your bill, from anywhere between \$100 and \$1000, you can reduce your premiums.

A few funds require members to pay a daily amount towards their hospitals bills called co-payments.

There are a number of ways that health funds apply limits, excesses and co-payments. It is important for you to understand this before selecting a policy. Ask your fund for details.

#### **10. Many funds do not offer overseas cover**

Many health insurers will not pay for any overseas medical treatment. Other health funds will only make payments at Australian fee levels - which are well below the cost of medical treatment in the USA, Europe and many other countries.

Before leaving Australia, you should ask your health fund if your health insurance policy covers you for overseas medical expenses.

Also, if you suspend your health insurance policy while you are overseas, some funds will impose waiting periods for certain treatment when you return. Check the rules about this with your health fund before you go.

If you require more information on private health insurance matters, please contact your health fund or the Complaints Hotline on 1800 640 695.