

Insure? Not Sure?



Your quick guide to private health insurance

Australia's health system offers a comprehensive range of public and privately funded health services. You can choose whether to have Medicare cover only or a combination of Medicare and private health insurance.

This booklet explains the Australian health system to you in simple terms. It will help you make decisions about how best to meet your health insurance needs.

Insure? Not sure? has been prepared by the Private Health Insurance Administration Council (PHIAC), an independent, Australian Government body within the health system.

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General information

Health care can be expensive. As the basis of Australia's health care system, Medicare covers many health care costs. Private health insurance provides additional cover for some services not covered by Medicare.

What Medicare provides

Australia's Medicare system is available to all permanent residents. Norfolk Island does not participate in the Medicare program, however Australian citizens who have been living in Australia and move to Norfolk Island from the mainland will be eligible for Medicare on return visits for up to a period of five years. The Medicare system has three parts: hospital, medical and pharmaceutical.

Hospital

If you choose to be a Medicare (public) patient, you can be treated, at no charge, in a public hospital by a doctor appointed by the hospital. You cannot choose your own doctor.

Medical

In hospital - under Medicare, you can be treated as a public patient in a public hospital, at no charge, by a doctor appointed by the hospital. Medicare will cover you for 75% of the MBS (Medical Benefits System) fee for medical costs associated with being a private patient in a hospital.

Out of hospital - Medicare will reimburse 85% of the MBS fee for your treatment. If your doctor direct bills Medicare, you will not have to pay anything.

Pharmaceutical

Under the Pharmaceutical Benefits Scheme (PBS) you pay only part of the cost of most prescription medicines purchased at pharmacies. The rest of the cost is covered by PBS. The Government decides how much you pay towards the cost of PBS medicines.

Ambulance Cover

Medicare does **not** cover the cost of emergency ambulance services. If you want cover for this service, you must arrange it yourself.

When you are a private patient in a hospital

As a private patient - whether you are insured or not - you have the right to choose your own doctor, and decide whether you will go to a public or a private hospital that your doctor attends. You may also have more choice as to when you are admitted to hospital.

When you are a private patient, in either a public or private hospital, you will be charged for the hospital accommodation and the medical and other services you receive. Private health insurance may cover some or all of these charges.

When you are a private patient treated in a hospital, whether public or private, Medicare will refund 75% of the MBS fee for your medical practitioners' services.

As a private patient in either a public or private hospital you may need to pay some or all of the costs for a range of services such as:

- hospital accommodation
- theatre fees
- intensive care
- drugs, dressings and other consumables
- prostheses (surgically implanted)
- diagnostic tests
- pharmaceuticals and
- doctors' services.

Treatment as a private patient in a private hospital can be very expensive. Private health insurance will cover some or all of these costs.

What private health insurance covers

If you have private health insurance, you are covered against some or all of the costs of being a private patient in either a public or private hospital. Alternatively, you are free to choose to be treated as a public patient in a public hospital, at no charge.

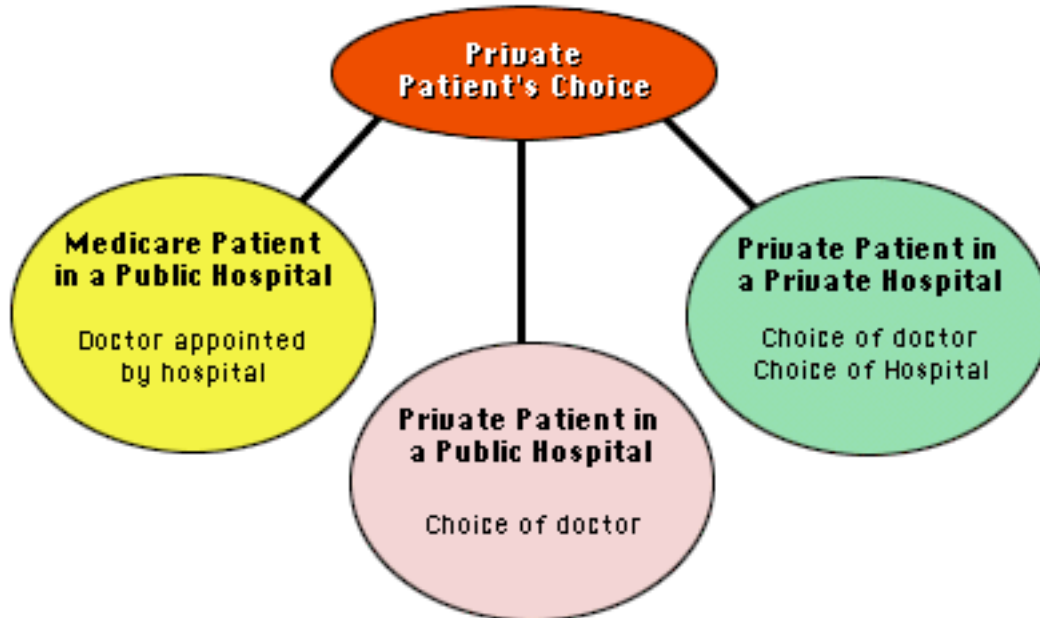
There are many private health insurance policies to choose from. These policies will cover either some or all of the cost of your hospital care and allow you to choose your own doctor or specialist.

With private health insurance, you may insure against some or all of the costs of health services not covered by Medicare, such as:

- hospital expenses (theatre fees or accommodation) in either a public or private hospital
- some or all of the medical costs Medicare does not cover
- dental treatment
- ambulance
- chiropractic treatment
- home nursing
- podiatry
- physiotherapy, occupational, speech and eye therapy
- glasses and contact lenses
- prostheses and
- other ancillary services.

You can purchase insurance for ancillary benefits on its own or together with hospital insurance. Ask any health fund for details of their policies.

Your options as a privately insured patient



Ambulance cover

Medicare does not cover the cost of emergency or other ambulance services. You can arrange ambulance cover yourself from the ambulance authority in your State. Alternatively, you can arrange it with your health fund.

Health funds may pay or reimburse you for all or part of your annual subscription to your State ambulance authority or the costs associated with transportation. If you take out a hospital insurance policy in New South Wales or the Australian Capital Territory, you will find your health fund premium includes this cover *

*If you are a pensioner or a low income earner in these states, your premium may be reduced because you are entitled to free ambulance cover.

Nursing home type patients

If you are in hospital for more than 35 days in succession you will be regarded as a nursing home type patient (NHTP) unless your doctor specifies otherwise. Generally, all NHTPs have to pay part of the cost of hospital accommodation. The *National Health Act 1953* does not allow health funds to insure for this part of the cost.

Health fund arrangements to cover 'the gap'

The 'medical gap' is the difference between the doctor's fee for services provided in hospital and the combined Medicare benefit and health insurance benefit. Unless your health fund has a gap cover arrangement in place with your doctor which will cover all of your doctor's charge, you will have to contribute towards the cost of the treatment out of your own pocket.

Health funds are also able to negotiate agreements with hospitals to fully or partially cover other charges related to hospital treatment, such as accommodation.

It is important that you contact your health fund before you receive hospital treatment to check whether the fund has an agreement with your hospital and whether your doctor is participating in the fund's gap cover arrangements. You should also ask your doctor(s) and hospital for an estimate of their costs and how much will not be covered by your health fund. Your health fund should also be able to assist with calculating likely out-of-pocket costs.

Hospitals that have agreements with health funds submit to the fund a single account for hospital services provided. Doctors participating in gap cover arrangements with health funds also usually forward all accounts to the fund. If you have a policy that requires you to pay part of the hospital or medical costs, the hospital or doctor will bill you directly.

Hospitals that have agreements with your health fund and doctors participating in your fund's gap cover arrangements should, whenever possible, inform you before providing a medical service in hospital, of any amount you will have to pay.

You should be aware that if you have a health insurance product that has an excess or co-payment provision you will have to pay some of the cost of hospital treatment out of your own pocket even if your hospital has an agreement with your fund and your doctor is participating in the fund's gap cover arrangements. Further information on excesses and co-payments is provided in the section 'Types of health insurance cover.'

If you have any problems or complaints that cannot be resolved satisfactorily with your health fund, you can have the problem fully examined by the Private Health Insurance Ombudsman. You should always try to resolve the problem with your fund before going to the Ombudsman.

Surcharges and incentives

Lifetime Health Cover

Lifetime Health Cover is a Government initiative that recognises the length of time a person has had hospital cover with a registered health fund. People who take out hospital cover earlier in life and maintain their hospital cover, will pay lower premiums throughout their life compared to someone who joins when they're older. Lifetime Health Cover commenced on 1 July 2000.

To lock in the lowest premiums for life under Lifetime Health Cover, a person needs to take out hospital cover with a registered fund by the 1st of July following their 31st birthday. If a person does not have hospital cover on the 1st of July following their 31st birthday and decides to take out hospital cover later in life, they will pay a 2% loading on top of their premium for every year they are aged over 30. For example, someone who first takes out hospital cover at age 40 will pay 20% more than someone who first took out hospital cover at age 30. The maximum loading allowed is 70%.

Under Lifetime Health Cover, health fund members are able to drop their private health insurance cover for a cumulative period of 24 months in their lifetime without affecting their loading. For every 365 days without cover after that, the person's loading will increase by 2%. You can also apply to your health fund to suspend your cover and at the discretion of your fund, this period of suspension counts as periods with private health insurance.

People who were born on or before 1 July 1934 are exempt from Lifetime Health Cover and are able to join a health fund at any time in the future and pay the same premium as someone who takes out cover at age 30.

There are provisions and grace periods in place for Australians who were overseas or resident in another country on their 31st birthday or at the time Lifetime Health Cover was introduced, which may be applicable to you. Recent migrants to Australia and refugees may also receive a grace period before the Lifetime Health Cover loading comes into effect. The grace period that applies for New Zealanders is slightly different from the grace period that applies for other migrants.

For Lifetime Health Cover purposes, time spent on Norfolk Island is classified as time spent overseas and this can have different effects depending on the actual dates you were resident on Norfolk Island.

If you were a member of the Australian Defence Forces (ADF) on 1 July 2000, under Lifetime Health Cover you were granted a certified age at entry of 30. After discharge from the ADF, you will have 24 months under the period of absence rules, to join a health fund and still pay the base rate premium.

A recent amendment to the *National Health Act 1953* extends protection from the application of Lifetime Health Cover to persons issued with a Department of Veterans' Affairs (DVA) Gold Card from 1 July 2004. If you held a Gold Card at any time since 1 July 1999, and the card was subsequently withdrawn by the DVA, you may claim the period you held the card as a period with private health insurance. If you held a Gold card on 1 July 2000, you will generally have a Lifetime Health Cover certified age of entry of 30.

For more information about Lifetime Health Cover, check with your health fund or visit the Commonwealth Department of Health and Ageing web site at <http://www.health.gov.au>

Medicare levy surcharge (MLS)

The Medicare levy surcharge has been in place since 1 July 1997 with the aim of encouraging high income earners to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system.

The Medicare levy surcharge is an additional 1% surcharge of taxable income imposed on high income earners, who are eligible for Medicare but who do not have an appropriate level of hospital insurance with a registered health fund. The Medicare levy surcharge is in addition to the normal 1.5% Medicare levy.

Who must pay the Medicare levy surcharge?

You have to pay the surcharge if you are a high-income earner and you do not have a private hospital insurance policy with a low front-end deductible or excess.

High-income is defined as:

- a single person with an annual taxable income greater than \$50,000; or
- a family or couple with a combined taxable income greater than \$100,000. The family income threshold increases by \$1,500 for each dependent child after the first.

Low front end deductible or excess is defined as:

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

You must also pay the Medicare levy surcharge if you are a prescribed person* with a taxable income over the threshold, and have any dependents who are not prescribed persons and who are not covered by a low front-end deductible hospital insurance policy with a registered health fund.

* Generally, you will know if you are a prescribed person. If you need more information on prescribed persons, call the Australian Taxation Office (ATO) Helpline on 13 28 61.

Your dependents in relation to the Medicare levy surcharge

Providing you contribute to their maintenance (including child support payments), your dependents are:

- your spouse
- any of your children who are under 16 years of age, or
- any of your student children who are under 25 years of age.

This Medicare levy surcharge is in addition to the normal 1.5% Medicare Levy.

You do not have to pay the surcharge if:

- your taxable income is below the income threshold
- your taxable income is over the income threshold and you have hospital insurance for you and all of your dependents with a low front-end deductible with a registered health fund
- you are normally exempt from the Medicare levy because you are a prescribed person and you do not have any dependents. Your taxable income is not considered in this case
- you are a high income earner who had already purchased a hospital insurance product with a front-end deductible or excess greater than \$500 for singles or \$1,000 for families/ couples, on or before 24 May 2000. In this case you will continue to be exempt from the surcharge while ever you maintain continuous membership to the same hospital table.

Notes about the surcharge

To be exempt from the surcharge, your hospital cover must be held with a registered health benefits organisation (health fund) that covers some or all of the fees and charges for a stay in hospital. Information as to whether your health fund is registered can be obtained from the Private Health Insurance Administration Council (PHIAC) by phoning their office on 02 6215 7900 or visiting their website at www.phiac.gov.au.

Ancillary or extras cover does not constitute private patient hospital cover for the purposes of the surcharge.

Low front end deductible or excess

Your front end deductible or excess must be equal to or less than \$500 per annum for single policies or \$1,000 per annum for families/ couples to be considered a low front end deductible or excess.

For more information

For more information about the Medicare levy surcharge, contact the Australian Taxation Office (ATO) by:

- calling the A Fax From Tax line - 13 28 60
- calling the ATO Helpline - 13 28 62
- visiting the ATO Internet Home Page - <http://www.ato.gov.au>

Federal Government Rebate on private health insurance

The Australian Government introduced the Federal Government Rebate initiative in January 1999.

For every dollar that you contribute to your private health insurance premium, the Government will give you back 30 cents.

Changes to the *Private Health Insurance Incentives Act 1998* made with effect from 1 April 2005, provide an increase in the private health insurance Rebate from 30% to 35% for people aged between 65 and 69 years, and to 40% for people aged over 70 years.

All Australians who are eligible for Medicare and who are members of a registered health fund are eligible for the Rebate – no matter what your level of cover, income or type of membership.

How to claim the Rebate

In order to claim the Rebate, your health insurance policy must be with a health fund registered under the *National Health Act 1953*.

In addition, all of the people covered by the policy must be eligible to claim benefits under Medicare.

There are three ways to claim the Rebate:

- ask your registered health fund to provide the Rebate as a premium reduction
- receive a direct payment from the Government through your local Medicare office
- claim it back on your tax return, using a statement your health fund will provide at the end of the financial year

If your employer has paid your premium on your behalf, you are entitled to claim the Rebate.

For more information

Consumers can seek further information the Federal Government Rebate by visiting the Commonwealth Department of Health and Ageing web site at <http://www.health.gov.au>

About private health insurance

Private health insurance is provided through organisations registered under the *National Health Act 1953*. The financial performance of registered health funds is monitored by PHIAC, an independent Australian Government body, to ensure solvency and capital adequacy requirements are met.

A health insurance fund is registered either as:

- an open membership organisation (anyone can apply to join), or
- a restricted membership organisation (available only through specific employment groups, professional associations or unions).

Health funds follow a principle known as 'community rating'. Under this principle, the premiums charged by the funds do not vary according to your age (other than age at entry for Lifetime Health Cover), gender, state of health or the size of your family. For example, a single, healthy 20-year-old and a single, unwell 60-year-old will both pay the same premium for the same cover. However, the cost of premiums for similar cover may vary between funds.

Private health insurance is different from trauma and disability insurance. These insurances are 'risk-rated' rather than 'community-rated' and generally offer lump-sum payments in the event of specific illness or loss. They are not a substitute for private health insurance.

Membership

There are four categories of membership:

- **single membership** provides cover only for the person named as the member on the application form (the contributor).
- **family membership** provides cover for the contributor, one other adult and one or more dependent children.
- **couple membership** provides cover for the contributor and one other person who is not a dependent child of the contributor.
- **single parent family membership** provides cover for the contributor and one or more dependent children.

'Dependent children' are defined as the contributor's unmarried dependent children, step-children and foster children who are under 18 years of age. This age limit extends to 25 if the 'dependent child' is a full-time student, and depends on the contributor for maintenance and support.

Health funds are not required to offer all types of cover to all categories of membership.

Standard waiting periods for pre-existing ailment/s or illness

When you decide to take out or upgrade private health insurance, you may already be unwell. You may have what is referred to as a pre-existing ailment or illness. Under the *National Health Act 1953*, a health fund may impose a 12-month waiting period on benefits for hospital treatment where it should have been reasonably apparent to either the contributor or a medical practitioner who conducts an examination, that there was a pre-existing ailment in the six months prior to joining a hospital table or upgrading to a higher level of cover.

It is important to check this with your health fund prior to your admission to hospital. Remember, your health fund will need at least a week or so to advise you about whether the pre-existing ailment 12-month waiting period applies.

Even if you are already ill, health funds must allow you to purchase any type of cover. If a fund refuses you membership, you may appeal to the Minister for Health and Ageing.

What is the exact definition of a pre-existing ailment?

A pre-existing ailment is an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the 6 months prior to the member joining a hospital table or upgrading to a higher level of cover.

In forming an opinion about whether or not an illness was pre-existing, the health fund appointed medical practitioner who makes the decision, must take into account information provided by your own doctor.

If you require hospital treatment, but you have less than 12 months membership on your current hospital table, a 12-month waiting period could apply if your condition was determined to be pre-existing.

Waiting periods

When you join a health fund or increase your level of cover, you may have to wait some time before your insurance becomes effective. This protects you and others in your fund by ensuring no contributor makes a large claim shortly after joining a fund, and then drops their membership. This 'hit and run' behaviour results in increased premiums for everyone.

There is usually no waiting period if you need hospital or medical treatment because of an accident that happens after you join the fund.

The Government sets the maximum time that health funds are able to make members wait until they can claim benefits for hospital treatment. These maximums are:

- 12 months for pre-existing ailments
- 12 months for obstetric cases; and
- 2 months in all other circumstances

The Government does not regulate waiting periods for benefits payable under ancillary tables. These waiting periods are set by individual health funds and you should make sure you are aware of ancillary benefit waiting periods that apply to your fund.

Waiting periods applying to new-borns

If you have a single membership and are expecting a child, you may need to transfer to a family membership or a single parent family membership. If you want your child to be insured from the time of birth, you may have to transfer to the new policy two months before your child is born. Ask your fund to explain its policy on new-borns.

Transferring between funds

You can transfer from one health fund to another, for the same or a lower level of benefits, without serving additional waiting periods.

The fund to which you transfer may impose waiting periods before you are eligible for any new or higher benefits on your new policy.

The fund to which you transfer must give you credit for the waiting periods you have already served.

Benefits paid by the previous fund may be taken into account by your new fund when it determines your annual benefit limits.

Transferring between funds will not affect your Lifetime Health Cover entitlements provided that you transfer from hospital cover with your existing health fund to hospital cover with the new health fund.

Suspending your membership

Most funds will let you waive, defer or suspend your membership if you are away from Australia for a certain period of time specified by your fund. Suspension may also be permitted under other conditions, such as periods of unemployment. Ask your fund what conditions apply.

You will not be paid benefits for services used or treatment provided while your membership is suspended. Similarly, the time for which your membership is suspended cannot count towards any waiting or qualifying periods.

Suspending your membership with the agreement of your health fund will not affect your Lifetime Health Cover entitlements.

When you start paying contributions again, your benefit entitlements will continue on the same basis as before your membership was suspended.

Notifying members of changes to fund rules

Health funds change rules and premium prices from time to time. As a result, funds are required to tell their members, in writing, about any change that:

- adversely affects the scope, level or nature of benefits, or
- increases the cost of premiums

Paying your contributions

Paying in advance

Generally, you must pay contributions at least one month in advance unless payments are made under a payroll deduction scheme or by direct debit.

The maximum period for which you may pay in advance is usually 12 months. Some funds offer a 'rate protection' policy under which, if you have paid in advance, you will not have to pay extra if rates are increased during the period for which you have paid. For example, if you pay your premium in advance for 12 months, and there is a rate increase after four months, with rate protection, you will not have to pay the increased rate until your 12 months of cover ends.

When no 'rate protection' policy applies, the fund will ask you to pay the balance owing on the new rates, or reduce the length of time your payment covers. When you are advised of rate increases, check whether the increase will affect the length of time your advance payment covers.

Discounts on premiums

Generally, you may get discounts for contributions paid in advance on a half-yearly or yearly basis. You may also receive a discount if your contributions are automatically deducted from your salary, wages or bank or credit card accounts.

Unpaid contributions

Your private insurance will lapse - meaning you are not insured - if you are more than two months behind in paying your contributions.

Some funds may not accept payment of arrears in excess of two months. In such cases they may impose further waiting periods when you resume contributions.

Cancelling your membership

If you decide to cancel your membership, your fund should pay back any contributions you have paid in advance. The fund may deduct a small administration charge.

Benefits you will receive

The amount of benefits you receive for hospital or medical treatment will depend on the type of cover you purchase, and whether you have chosen to contribute to the costs of your hospital treatment in exchange for paying a lower premium.

The amount of benefits you will receive also depend on the hospital and doctor you choose and whether the hospital has an agreement with your fund and the doctor is participating in the fund's gap cover arrangements.

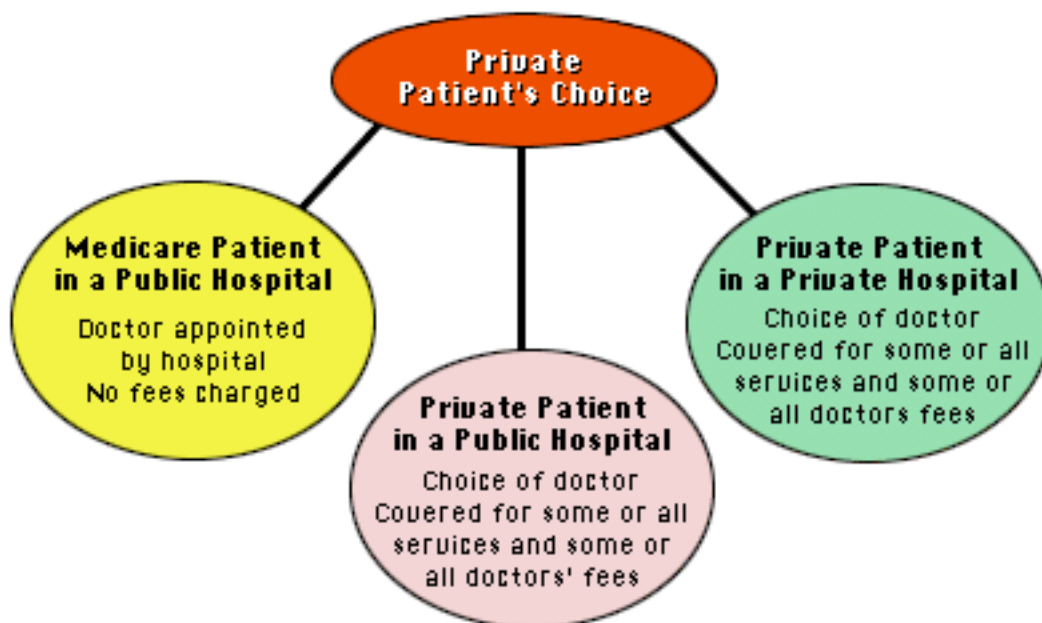
When your health fund has an agreement with your hospital and your doctor is participating in the fund's gap cover arrangements, you are less likely to face out-of-pocket costs. If you choose to go to a hospital that does not have an agreement with your fund, you may face significant out-of-pocket costs.

Well in advance of receiving treatment you should check with your health fund on whether there is an agreement in place with your hospital and whether your doctor is participating in the fund's gap cover arrangements. You should also ask your doctor(s) and hospital for an estimate of their costs and how much will not be covered by your health fund. Your health fund should also be able to assist with calculating likely out-of-pocket costs.

You can ask any health fund about the hospitals that have agreements with that fund and doctors who are participating in the fund's gap cover arrangements.

If you have ancillary cover you need to be aware that the benefits health funds will pay for ancillary services may be 'capped', and some services might not be covered at all.

Your benefit options as a privately insured patient



Time limit

You should lodge any claims within two years of the date of the service however, some funds may allow claims to be lodged after two years. Check with your fund. The claim form must be signed by you or your spouse in the case of memberships other than single.

Ineligible claims

Benefits will generally not be paid:

- if you will be paid compensation by a third party
- for certain ancillary services provided by someone not recognised by your fund or if you are not covered for ancillary benefits
- if you put false or inaccurate information on your claim form
- if you are more than two months behind with your contributions
- if you claimed benefits for services provided while your membership in the fund was suspended
- if the service provider is directly related to you - that is, if he or she is your spouse, parent, child or sibling, or
- if your claim is made two or more years after the date of service

Prostheses

Surgically implanted prostheses, such as a lens for a cataract surgery, a stent for cardiac surgery or an artificial hip or knee component during a hip/knee replacement, are sometimes required during a medical procedure. For every medical procedure covered by the Medicare Benefits Schedule (MBS) requiring a surgically implanted prostheses, clinicians have determined at least one clinically suitable prosthesis that must be covered by health funds at no additional cost to you (called a 'no-gap' prosthesis).

From mid-2005, there may be some prostheses available which cost more than the 'no-gap' ones. If you choose to use one of these prostheses, you will have to pay the difference between the 'no-gap' amount and the total amount charged by the supplier for the prosthesis.

For each procedure, you should ask your health fund how much it will pay for a particular prosthesis, and whether you will have any 'gap' to pay.

Don't forget that if your private health insurance policy has exclusions – where you can't claim for some services, for example joint replacements – then you won't be able to claim for any prostheses provided as part of these services, either.

Private Patients' Hospital Charter

To help you understand what you can expect from your health fund, doctor and hospital, a Private Patients' Hospital Charter is available. It will assist you with some of the important questions you may need to ask those involved with your health care.

Copies of the Charter are available from health funds, the Department of Health and Ageing and the Private Health Insurance Administration Council (PHIAC).

Private Health Insurance Ombudsman

If you have a problem with your health insurance arrangements, you should first discuss it directly with your health fund.

If you are unable to reach a satisfactory agreement with your fund, contact the Private Health Insurance Ombudsman on the toll free Hotline number 1800 640 695.

Types of private health insurance cover

There are two types of private health insurance cover available:

- hospital cover, and
- ancillary (or extras) cover

While hospital cover helps with the cost of in-hospital treatment by your doctor and other costs like hospital accommodation, ancillary cover provides benefits for services such as physiotherapy, dental and optical treatment.

You are able to take out either one of these types of private health insurance cover on their own, and most health funds offer packaged products that provide cover for both hospital and ancillary services.

There are various types of private health insurance hospital cover that you can purchase. Some health fund policies will give you full cover against the costs of hospital accommodation and in-hospital medical charges. Others, for which you will pay lower premiums, will require you to meet part of the costs. You can elect to pay a lower premium in return for agreeing not to be covered for some conditions, or to only receive limited benefits for a certain condition, or to pay a set amount towards the cost of your hospital treatment.

You could elect to pay a lower premium and take out a hospital cover policy with one or more of the following features:

- **an exclusion for a particular condition or conditions**

If your policy features an exclusion for a particular condition, you are not covered for treatment as a private patient in a public or private hospital for that condition. For example, if you purchase a private health insurance policy that excludes maternity, hip replacements and knee replacements, and you go into hospital as a private patient for one of these conditions, your health fund will not pay any benefits towards your hospital and medical costs.

If you are unsure which conditions are excluded on your policy you should ask your health fund.

- **a front-end deductible (also known as an excess)**

An excess is an amount of money you agree to pay for a hospital stay before health fund benefits are payable. For example, if your policy has an excess of \$200, you will be required to pay the first \$200 of your hospital costs should you go to hospital as a private patient. An excess could apply every time that you go to hospital in a year, or it may be capped at a total amount that you will have to pay in a year. If you are unsure how the excess on your policy works you should ask your health fund.

- **a co-payment**

With a co-payment, you agree to pay an agreed amount each time a service is provided. For example, a policy may have a co-payment clause that requires you to pay the first \$50 for each days hospital accommodation. If your policy has such a co-payment and you were in hospital for 5 days, you would have to pay \$250 ($\50×5). The total amount of co-payment you can pay in a year is often limited to a set maximum amount.

- **restricted benefits**

If your policy has restricted benefits for some conditions you will be covered for treatment as a private patient in a public hospital for these conditions, but will face considerable out-of-pocket costs if you were to be treated in a private hospital for these conditions.

If you are unsure about whether restricted benefits apply to your policy you should ask your health fund.

- **a benefit limitation period**

A benefit limitation period is where you are only entitled to limited benefits for a particular condition or treatment for a set period of time. After that period of time has elapsed you would normally be entitled to full benefits for the condition or treatment. Some benefit limitation periods may commence after standard waiting periods have been served.

If you are unsure about whether a benefit limitation period applies to your policy you should ask your health fund.

- **public hospital table**

Some health funds offer policies that have restricted benefits for all conditions. This policy is sometimes called a public hospital table. Under this policy you will be covered for treatment as a private patient in a public hospital, but will face considerable out-of-pocket costs if you were to be treated in a private hospital.

NOTE: You should regularly review your health insurance needs in case you change your mind about whether you want to be covered for particular conditions and therefore need to upgrade your cover.

Ancillary cover

Ancillary cover is available for a range of non-hospital services such as physiotherapy, optical or dental treatment. Ancillary cover is usually available separately or as an add-on to hospital coverage.

Questions to ask a private health insurance fund

You should know as much as possible about the private health fund you have already joined or are thinking of joining. The following questions address some of the topics that may be of interest to you.

Which hospitals have agreements with this fund?

Which doctors participate in this fund's gap cover arrangements?

When will my insurance cover begin?

When will I be able to claim benefits?

How long do I have to wait to be covered?

What will this give me that Medicare doesn't?

Can I choose my own doctor?

What level of hospital benefits are paid under this cover?

What level of medical benefits are paid under this cover?

Will I be covered for treatment for medical conditions existing before I purchased health insurance?

How do I qualify for benefits?

Under what circumstances will I not be eligible to receive benefits?

What out-of-pocket expenses will I have to pay?

Does the fund offer protection against increases in rates?

What happens if there are increases in rates that I cannot afford?

If I have paid my premiums in advance and there are increases in rates, will I have to pay these increases?

Will I have to satisfy any waiting periods?

Do special limits apply to my ancillary cover?

Can I take out, say, dental cover only for my children and not for my spouse and myself?

Will my hospital cover provide benefits for all procedures or types of treatment?

Which hospital treatments will not be covered by this policy?

Is ambulance cover included with my hospital cover?

Which operations are considered elective?

What other options should I consider?

When did this fund last increase its rates?

Common terms used by private health insurance funds

Accommodation

Accommodation covers meals and a bed in hospital, and includes all hospital-provided services including nursing care. It does not include treatment by doctors or other health professionals.

Ancillary services

Ancillary services are services, such as physiotherapy, speech pathology and podiatry, which are provided by health professionals.

Benefit limitation period

Limited benefits are paid for certain conditions for a specified period of time.

Co-payment

A co-payment is where you agree to pay an agreed amount each time a service is provided. For example, a private health insurance policy may have a co-payment clause that requires you to pay the first \$50 for each day's hospital accommodation.

Dependent

A dependent is defined by each health fund according to their rules.

Generally a dependent is:

- your spouse
- any of your children who are under 18 years of age, and you contribute to their maintenance; or
- any of your student children who are under 25 years of age, and you contribute to their maintenance

Diagnostic tests

Diagnostic tests can include such things as x-rays and bloods tests.

Drugs, dressings and other consumables

Drugs, dressings and other consumables are additional services to support hospital treatment. For example, medications, bandages and crutches, prostheses (surgically implanted) - these include such things as hip replacements, artificial lenses and heart valves.

Elective surgery

Elective surgery is treatment of a condition your doctor considers does not require immediate attention.

Emergency treatment

Emergency treatment occurs when the patient is treated by the medical practitioner within 30 minutes of presentation and the patient is in danger of suffering loss of life, limb, bodily function or mental stability, is in severe pain or is bleeding.

Excess

An excess is an amount that you agree to pay towards the cost of hospital treatment in exchange for lower premium costs. You may be required to pay an excess every time you go to hospital, or only the first time, depending on the private health insurance policy you take out. An excess is also known as a front-end deductible.

Federal Government Rebate

For every dollar that you contribute to your private health insurance premium, the Government will give you back 30 cents. For health fund members aged between 65 and 69 years, this amount increases to 35 cents, and for members aged over 70 years it is 40 cents.

Front-end deductible

See Excess.

Gap

The term 'gap' generally means the difference in the amount that your doctor charges and the amount that is covered by Medicare and your health fund, i.e. the amount that you must pay for your medical services received in hospital.

It can also refer to the difference between what your hospital charges and the amount that is covered by your health fund.

Intensive care

Intensive care is treatment for actual or potential life-threatening illnesses, injuries or complications.

Labour ward fees

Labour ward fees include costs for delivery of babies in a birthing suite.

Lifetime Health Cover

Lifetime Health Cover was introduced on 1 July 2000. Under Lifetime Health Cover, health funds are required to charge members different premiums based on the age they are when they first take out hospital cover. If a person does not have hospital cover on the 1st of July following their 31st birthday and decides to take out hospital cover later in life, they will pay a 2% loading on top of their premium for every year they are aged over 30. For example, someone who first takes out hospital cover at age 40 will pay 20% more than someone who first took out hospital cover at age 30.

Low front end deductible

Your front end deductible (also known as excess) must be equal to or less than \$500 per annum for single policies or \$1,000 per annum for families / couples to be considered a low front end deductible.

MBS fee (Medicare Benefits Schedule fee)

The Government sets a schedule of medical fees – called the Medicare benefits schedule. You can claim a rebate for medical fees whether you are a member of a health fund or not. The rebate is currently 75% of the MBS fee for in-hospital medical fees and 85% of the MBS fee for medical fees incurred out of hospital.

Medical expenses/charges

Medical expenses are charges for medical procedures performed during a hospital stay. This covers items such as surgeons' fees, obstetricians' fees, radiology, pathology and anaesthetists. Medicare pays 75% of the MBS fee for these services.

Medicare levy surcharge (MLS)

Higher income individuals and families who do not have private hospital insurance cover will pay an extra 1% of their taxable income for the Medicare levy surcharge. This is in addition to the normal 1.5% Medicare levy.

Palliative care

Palliative care is provided when a patient's condition is terminal. Such care provides relief of suffering and any enhancement to quality of life that can be achieved.

Pre-existing ailment

A pre-existing ailment is an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund, existed at any time during the 6 months prior to the member joining a hospital table or upgrading to a higher level of cover.

Private patient in a public hospital

You are a private patient in a public hospital if you choose to be treated in a public hospital but retain the right to choose your own doctor. If you do so, you will be charged for hospital accommodation costs and doctors fees. Medicare will cover 75% of the MBS fee for your doctors' charges. If you have private health insurance, your health fund will pay at least the remaining 25% of the MBS fee for your doctor's charges and can pay more if your doctor is participating in your health fund's gap cover arrangements. Your health fund will also cover some or all of your hospital accommodation costs.

Private patient in a private hospital

You must be a private patient to be treated in a private hospital. As a private patient in a private hospital you have the right to choose your own doctor, and you are responsible for all hospital and doctors' services. Medicare will cover 75% of the MBS fee for these doctors' charges. If you have private health insurance, your health fund will pay at least the remaining 25% of the MBS fee for your doctor's charges and can pay more if your doctor is participating in the health fund's gap cover arrangements. Your health fund will also cover some or all of your hospital accommodation costs.

Prostheses (surgically implanted)

Prostheses include such things as hip replacements, artificial lenses and heart valves.

Psychiatric care

You are under psychiatric care if you have a disability and you are taking part in a program designed to improve your functions, retrain you in lost skills or help you to re-establish your place in society.

Public patient

You are a public patient if you choose to be treated in a public hospital under Medicare by a doctor appointed by the hospital.

Rehabilitation care

You are under rehabilitation care if you have a disability and you are taking part in a program designed to improve your physical functions, retrain you in lost skills or help you to re-establish your place in society.

Restricted benefits

Cost for treatment as a private patient in a public hospital will be covered but there will be out of pocket expenses for treatment in a private hospital.

Same-day patient

You are a same-day patient if you are admitted, treated and discharged on the same day.

Theatre fees

Theatre fees are costs for procedures performed in an operating room including those performed in day surgery facilities.