



The right
to change



COMMONWEALTH
OMBUDSMAN

A guide to transferring health insurance entitlements between health insurers or policies.

THE RIGHT TO CHANGE

If you are considering changing your health insurance cover, this brochure will help explain what you can expect and what you need to do. It also explains the rules that will protect you when you transfer to a new health insurance policy.

CONSUMER PROTECTIONS WHEN YOU CHANGE

Portability

The *Private Health Insurance Act 2007* includes 'portability' rules to protect consumers who want to change to another hospital policy with the same insurer or with another insurer. This means that you will not have to wait the normal waiting periods again before benefits can be paid to you.

To take advantage of the portability rules, you need to make sure that your payments for the policy you are transferring from are up to date. Some insurers will allow a small gap period between the end of your old policy and the start of your new one, but this varies, so you should check with your new insurer for confirmation.

You should also note you may have to wait for any extra benefits or better conditions that apply to your new policy.

The portability rules do not provide similar protection if you change your general treatment (extras) policy. However, most health insurers will give you immediate cover for extras benefits that you had on your previous policy after you transfer. It is up to you to check this with the insurer.

You should also check how any annual limits will operate when you change your extras policy.

Lifetime Health Cover

If you change health insurers, it should not affect your 'Lifetime Health Cover' status, provided you maintain a hospital policy.

Cooling off period

When you join any insurer, or take out a new policy, you should have the details of your new policy explained to you and confirmed in writing. Most insurers offer the benefit of a 30-day cooling off period. This means if you change your mind in the first 30 days after joining, and haven't made a claim for benefits on the new policy, you can request a refund of any contributions you have paid.

Loyalty bonuses

Many insurers offer loyalty bonuses on some of their policies as a reward to longer-term members, such as credits to reduce your hospital excess or higher annual limits for some extras benefits. If you change insurers, loyalty bonuses usually do not carry over to the new insurer. However, it can be worth asking if this can be done.

CHANGING YOUR HOSPITAL POLICY

If you are considering changing your hospital policy, ask these questions for the policy you have and any policy you are considering:

- How long do I have to wait before benefits can be paid?
- If I go to hospital, will I have to pay an excess or make any co-payments?
- Are there any treatments I won't get full hospital benefits for? Ask yourself if you are willing to take the risk of not being fully covered for those treatments.
- Does this insurer have agreements with the private hospitals I might need to attend in my area? If not, you might not get full cover at those hospitals.
- How does the insurer's gap cover scheme work? Find out what you can do to minimise any gap you might have to pay for the doctors' bills when you go to hospital.
- Will this policy exempt me from the Medicare Levy Surcharge? If not, and you are earning over the Surcharge threshold, you might have to pay extra tax on your income.
- How much will this policy cost?

You can also obtain a Standard Information Statement (SIS) from the insurer or online at privatehealth.gov.au for any policy to check the details of the policy yourself.

HOW HOSPITAL POLICY WAITING PERIODS APPLY

These are the maximum waiting periods allowed by law for hospital policies:

- two months for any benefits
- two months for psychiatric care, rehabilitation or palliative care (even if a pre-existing condition)
- 12 months for pre-existing conditions (a condition can be classed as pre-existing even if it hadn't been diagnosed before you joined), and
- 12 months for obstetric treatment (childbirth).

Insurers generally apply the maximum allowable waiting periods to new hospital policies and generally do not waive them. Some insurers might waive the general two month waiting period but will still apply the full 12 month waiting period as normal.

If you have not already served out those waiting periods on your previous policy, the remainder of the waiting period will still apply for all benefits on your new policy. Otherwise, those waiting periods will only apply to any added benefits or better conditions that are available on your new policy.

If you change to a hospital policy that has lower benefits or excludes benefits for some treatments, the lower benefits and/or exclusions will apply immediately.

BENEFIT LIMITATION PERIODS FOR HOSPITAL POLICIES

Some hospital policies have Benefit Limitation Periods for types of hospital treatments, but these only apply to people taking out a new hospital policy.

If you have had hospital insurance with another insurer and transfer to a policy with benefit limitations, the new insurers cannot apply the benefit limitation to you.

Benefit Limitation Periods generally pay a restricted, or basic benefit, for the first two to three years of a new hospital policy.

CHANGING YOUR HOSPITAL POLICY: CASE EXAMPLES

① Example 1

Waiting periods not completed before changing

Joe had a top hospital policy with ABC Health Insurer for eight months. He then changed to the top hospital policy with XYZ Health Insurer. The benefits offered by both insurers' top policy were the same but XYZ is a bit cheaper.

XYZ recognised he had completed the general two month waiting period with ABC Health Insurer—Joe was able to get benefits immediately if he needed hospital treatment for any new injury or condition.

However, Joe needed hospitalisation for a condition where he had symptoms for the past two years. This condition was therefore classified as a pre-existing condition.

The waiting period for pre-existing conditions is 12 months. Under portability rules, XYZ recognised that Joe had already completed eight months of the waiting period—however, Joe still had to complete a further four month waiting period with XYZ before he could be covered for his surgery.

② Example 2 **The new policy has some better benefits (lower excess)**

Joan had completed several years of membership on a policy that had an excess of \$500 for each hospital admission. She was then diagnosed with a stomach ulcer, and shortly afterwards decided that she should upgrade to a policy that had a lower excess (\$200).

Joan required hospitalisation in relation to her pre-existing stomach ulcer condition. As she was within the 12 month waiting period for pre-existing conditions following the upgrade, she was therefore required to pay the higher \$500 excess for this hospitalisation.

If Joan had not needed the treatment until 12 months after transferring, the pre-existing condition waiting period on the additional benefits would have been completed and she would have only had to pay the new lower \$200 excess.

③ Example 3 **The new policy has benefit limitation periods**

Jane had a top hospital policy with ABC Health Insurer for five years. She decided to change to a cheaper policy offered by XYZ Health Insurer.

The new policy with XYZ Health Insurer has a two year benefit limitation period applying to psychiatric treatment. (In the first two years of membership, only limited benefits could be paid for any psychiatric treatment at a private hospital.)

As Jane transferred from another hospital policy where she had already completed the two month waiting period for psychiatric benefits, the benefit limitation period did not apply to her. If Jane required psychiatric treatment at a private hospital, she would be entitled to the full benefits for that treatment immediately.

CHANGING YOUR GENERAL TREATMENT (EXTRAS) POLICY

If you are considering changing your general treatment policy, ask these questions for the policy you have and any policy you are considering:

- Does the policy pay benefits for the services I want to use? Make a list of the sorts of services you are likely to want to use (for example dental, orthodontics, optical, physiotherapy, natural therapies, etc.)
- What waiting periods apply for each of the types of service I might use? Ask if the insurer will waive any of those waiting periods because you have previously had an extras policy
- How much of the cost of each service will the insurer benefits cover? If you have old bills or receipts ask how much the insurer would have paid on that bill
- What annual limits apply? Find out the maximum total benefit payable each year and the maximum number of services for which the insurer will pay benefits
- Will the limits increase over time if I stay with the insurer? Ask if you can get any recognition for the time completed on your previous policy
- How much will the policy cost?

You can also obtain a Standard Information Statement (SIS) from the insurer or online at privatehealth.gov.au for any policy to check details of the policy yourself.

HOW GENERAL TREATMENT (EXTRAS) WAITING PERIODS APPLY

Most general treatment policies have different waiting periods for the different types of services that the policies cover. They vary significantly but some examples of typical waiting periods are:

- two months for benefits for general dental services and physiotherapy
- six months for benefits for optical items (glasses or contact lenses)
- 12 months for benefits for major dental procedures such as crowns or bridges, and
- one, two or three years for some high cost procedures such as orthodontics.

If you change to another insurer

If you are changing your general treatment policy to another insurer, most insurers will not need you to serve waiting periods again for the benefits you had on your previous

policy. You should ask the insurer to confirm, in writing or via a recorded phone call, which waiting periods will apply to you, if any.

All insurers operate their general treatment policies quite differently so check the benefits as well as any annual limits and how they work. On transfer, insurers can reduce any annual benefit limits by the amount of benefit already paid to you under your previous policy during that year.

WHAT TO DO WHEN YOU CHANGE INSURERS

- Make sure the premium payments for your old policy are up to date.
- Ask your new insurer to start your new policy from the day after your old policy is paid up to.
- Your old health insurance policy history needs to be sent to your new insurer. You can either ask your new insurer to obtain your previous health insurance details or handle the process yourself. Requests for your transfer or clearance certificates must be completed by your old insurer within 14 days of request.
- If relying on your new insurer to transfer your details, we recommend checking a few weeks later that the old policy details have been sent and the new insurer has loaded the details into your new policy history. It is worth setting a reminder a month later to ensure you do not forget to check your new policy is set up properly.
- If the premiums for your old policy were being deducted from your bank account or credit card, check your next account statements to make sure the deductions have stopped.
- If you have authorised the new insurer to deduct your premiums from your bank account or credit card, check your next account statements to make sure the deductions have started and that the correct amount was deducted.
- Check the paperwork from your new insurer carefully. If you were sold a policy over the phone or at a branch, make sure the policy you purchased matches what you expected. If you have any queries or notice any errors, you should raise this with the insurer within the 30 day cooling off period.
- After 30 days it becomes difficult to correct any problems with the policy you have chosen because the insurer has written to you with the policy details and you are expected to have read them.



MORE INFORMATION

privatehealth.gov.au is where you can find out about private health insurance and search for and compare selected features for all private health insurance policies in Australia.

If you have a complaint or need advice about your health insurance arrangements, contact the Private Health Insurance Ombudsman:

ONLINE

Visit **ombudsman.gov.au** and **privatehealth.gov.au**

EMAIL

phio.info@ombudsman.gov.au

IN WRITING

GPO Box 442, Canberra ACT 2601

PHONE

Call **1300 362 072** between 9am and 5pm (AEDT)
Monday to Friday.

SERVICES AVAILABLE TO HELP YOU MAKE A COMPLAINT

If you are a non-English speaking person, we can help through the Translating and Interpreting Service (TIS) on **131 450**. If you are hearing, sight or speech impaired, a TTY Service is available through the National Relay Service on **133 677**.

THE OMBUDSMAN'S SERVICES ARE FREE