Australian Government
Private Health Insurance Ombudsman

TEN GOLDEN RULES

OF PRIVATE HEALTH INSURANCE

Most people who purchase private health insurance find that they get good service from their health fund and have no problems when they need to use or claim on their insurance.

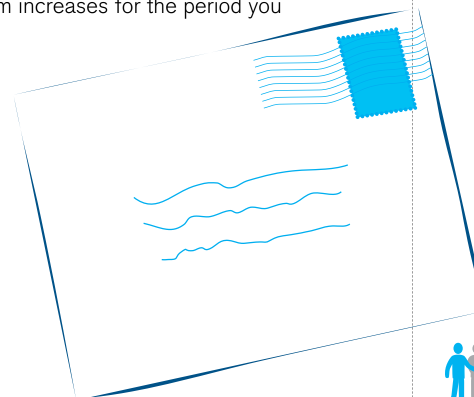
However thousands of people each year seek the Private Health Insurance Ombudsman's help with health insurance problems. The Ombudsman has prepared this list of ten tips to help avoid problems with private health insurance.

1. Keep your premium payments up to date

It is your responsibility to make sure that your premium payments are up to date and you remain financial with your health fund.

Most funds require you to pay your premiums in advance. They will normally allow some leeway if you fall behind in your payments by up to a few weeks. However, funds will not pay benefits toward hospital treatments or general treatment (extras) services unless your premiums are up to date. If you get too far behind in your payments (two months or more) the fund can cancel your policy. If this happens waiting periods may apply to you when you rejoin.

- If you are having difficulty keeping up with your payments because of a temporary problem talk to your fund to see if they will agree to a payment plan.
- If you pay your premiums by a regular direct debit from a credit card or bank account check each bank statement to make sure that the payments have been correctly debited.
- Many funds provide extra incentives for members to pay more than a month in advance (e.g. a year in advance). These incentives can include a discount on your premiums or deferral of any premium increases for the period you have paid in advance.



2. Carefully read any letters or written information from your health fund

Your health fund will generally only send you a letter if there has been some change to your cover or you need to do something. So it is important to read any correspondence from your fund carefully.

Health funds can change the benefits available on your cover at any time, provided they give you reasonable notice of any change. Such changes to benefits will apply to you even if you have paid for your cover in advance.

- Check whether the letter asks you to do anything (like return a form or provide additional information).
- If you are unsure about anything included in the letter or brochure contact your fund for an explanation and tell them the letter was not clear to you.
- Health funds usually write to all members around March of each year to announce changes in premiums. If the fund is making any changes to benefits it will normally include information about these with that letter. So be sure to read the whole letter and any brochures or additional information that might come with it.
- Health funds are required to send standard information statements yearly. These statements provide a summary of your cover. In June /July health funds also send a tax statement which is needed if you are filing a tax return.

3. Let your health fund know about any changes in your circumstances that might effect your cover

Keeping your health fund informed about changes in your circumstances can help to avoid problems when you need to use your health insurance.

Change of address

- To make sure you receive notification of any changes to your cover, notify your health fund if you change your postal address.

Moving interstate

- If you move interstate, this might affect the amount of premiums you pay or even the benefits you are entitled to. For example, cover offered by some funds for ambulance services can vary between states (because of differences in ambulance arrangements in each state).

Going Overseas

- Health insurance policies do not pay benefits for goods received from or services incurred while overseas. You may wish to enquire into taking a separate travel insurance policy to cover yourself overseas. See www.smartraveller.gov.au for more information about travel insurance.
- If you are going overseas for three months or more your health fund rules may allow you to suspend your health insurance policy. This normally means you won't have to serve the normal waiting periods when you recommence your health insurance after returning to Australia. However you must organise this with your fund before you go overseas.

  Some funds will impose waiting periods for certain treatments and conditions when you return. Check the rules about this with your health fund before you go.

  If you suspend your hospital insurance you may become liable for the *Medicare Levy Surcharge* for the period of time that your membership is suspended (depending on your taxable income). Check this with your fund.

  Some funds may allow you to suspend your policy for absences of less than three months.
- If you don't organise to suspend your health insurance policy, while you are away, you will need to keep up your premium payments to make sure you're covered when you return.

Changes in your family circumstances

- If you have family health cover, changes in your family circumstances can affect who is covered on your policy. You should let your fund know of any significant changes (e.g. separation).
- Funds have different rules about cover for older children. Before your child turns eighteen or leaves home you should check with your fund whether they will still be covered on your health insurance.
- If you have a single policy but plan to start a family, check with your fund about when you may need to switch to a family policy. Babies born prematurely or with other health issues usually need to be admitted as patients in their own right. If this happens and you still have only single cover, the baby's hospital costs probably won't be covered by your fund. So contact your fund as soon as possible during your pregnancy to find what you need to do to avoid potential problems.

Change of bank details

- If your health insurance premiums are paid by direct deduction from your bank account or credit card, your health fund will normally need at least two or three weeks notice to change these arrangements.

4. Ask your doctor (or your doctor's staff) for an estimate of fees before receiving treatment

Wherever practical, doctors should provide information to their patients about fees for any proposed treatment and should be prepared to discuss their charges before providing their services. For major treatment in a private hospital this information should preferably be provided in writing. If this information is not provided, it is your right to ask for it before you receive the service or agree to a proposed treatment.

Ask your doctor or your doctor's office staff for the following information -

- What are the Medicare item numbers for the services the doctor is going to perform and what will be the charge for each of these services?
- Does the doctor participate in my health fund's gap cover scheme and will the doctor treat me under this arrangement?
- Will I incur any personal out-of-pocket costs and, if so, about how much can I expect to have to pay?
- Who are the other doctors treating me during the admission and how can I get an estimate of their fees?
- Will the doctor provide me with a written estimate of any costs I'll have to pay so I can consider this when agreeing to the treatment?
- How will the doctor bill me?
- When will I have to pay?

For more information on doctors' bills check out our *Doctors' Bills* brochure.

5. Contact your fund before receiving treatment or entering hospital

Contact your health fund before having any treatment or going to hospital as a private patient. 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).

- Ask the fund what benefits it will pay and how much you are likely to have to pay yourself. (If there is time, ask the fund to confirm this in writing.)
- 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, your out of pocket expenses will probably be higher.

6. Know your limits – for benefits on extras services

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

- There are a number of ways that health funds calculate their benefits and apply their limits. It is important for you to understand this before selecting a policy. Ask your fund for details.
- Funds also have different rules about when annual limits are reset. (Some might operate on a calendar year basis, others on a financial or membership year.) If you know when your limits will restart you may be able to schedule your treatments to get the most out of your health fund benefits.

7. Make any claims promptly

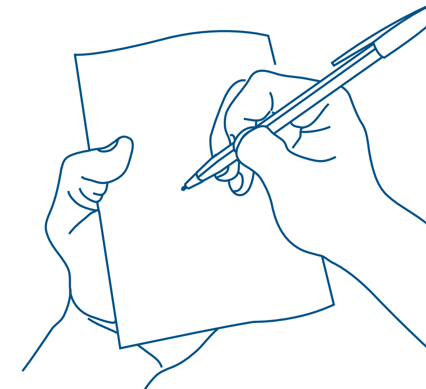
For many services, your hospital, doctor or extras provider can claim your health fund benefit and deduct it from your bill. If not, you may have to pay the full bill and claim a refund of some of the bill from your health fund.

- It is safer to make any claims for health fund benefits as soon as possible after receiving treatment. This reduces the risk of misplacing receipts or accounts and your benefit is paid sooner.
- If you are claiming by post it is a good idea to keep a copy of any accounts or receipts you send to your fund.
- 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 unforseen circumstances are likely to prevent you from making a claim in time, contact your fund. The fund may be able to extend the claim period if you let them know beforehand.

8. Make a note of important advice

If you contact your fund by telephone for advice on your cover, make a written note of any information provided to you, together with the time and date and the name or reference number provided to you.

If you are going to rely on the advice and it is important to you, let the health fund staff know this and ask for confirmation in writing, if possible.



9. Regularly review your health insurance

Your family's circumstances may change from time to time. Review your health insurance regularly to make sure it still meets your health needs and circumstances. For example if you chose a restricted cover designed for young people, as you get older you will need to consider whether you still want lower benefits for any of the restricted treatments. (The types of treatments restricted on some of these products include things like obstetrics or cardiac surgery.)

Health funds can change the benefits they pay and the services which are included on your policy. 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.

10. If you decide to change funds, make sure you understand the new product before changing

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. For any pre-existing conditions, 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. For example, if you choose a product with a lower excess you will normally have to serve waiting periods before the lower excess applies.
- You only have a limited time to change between funds without losing continuity of your waiting periods. Check this with your new fund - some funds allow a break of up to two months but others may only allow one day.
- 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. accrued orthodontic limits).
- Make sure you read all the documents you receive from the fund within your first month of membership. If there's anything you don't understand, contact the fund.
- More Information: see our brochure *The Right to Change* or visit www.PrivateHealth.gov.au

more information

The Private Health Insurance Ombudsman has a number of other brochures and publications for consumers on private health insurance issues.

- **The State of the Health Funds Report - Consumer Guide**
  (The Ombudsman's annual assessment of the comparative performance of health funds and advice on selecting a health insurance product)
- **The Right to Change**
  (What you need to know when changing your health insurance arrangements)
- **Doctors' Bills**
  (If you're not sure what to do about your doctor's bill.)
- **Making a Complaint**
  (When you need our help with a health insurance problem)
- **About Our Service**
  (The Private Health Insurance Ombudsman's service charter)
- **Health Insurance Choice**
  (Choosing a health insurance policy.)
- **Health Insurance Insider**
  (Your consumer guide to health insurance.)

These are available on our website or can be provided on request.

www.PrivateHealth.gov.au

A site where you can find out about private health insurance, search for and compare selected features for all private health insurance products offered in Australia.

If you need our help with private health insurance arrangements telephone our Hotline: **1800 640 695**, email us at **info@phio.gov.au**, or check out our web site at **www.phio.gov.au**

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