



Exclusions and Restrictions on Hospital Policies

In the sixth issue of Health Insurance Insider, we look at exclusions and restrictions on hospital policies.

Health insurers develop a variety of policies to meet the needs of a broad range of consumers. There is demand from consumers for more affordable policies, particularly from younger people who may be taking out a policy for the first time and from people who are purchasing health insurance primarily for tax purposes. One way insurers can reduce the cost of a policy is by restricting or excluding certain treatments on the policy.

As a consumer, if you choose to take out a policy that has restrictions or exclusions on some services, you are taking on a higher level of risk in exchange for a lower premium. PHIO's advice to members is to take out a more comprehensive level of hospital cover and choose a higher excess or lower level of extras cover, rather than a restriction or exclusion on the policy.

If you do take out a policy with restrictions or exclusions, make sure you understand what these restrictions mean. PHIO produces a number of Fact Sheets that explain common restrictions – see links at the end of this bulletin. It is also important to review your policy every year, to ensure that it

will continue to meet your needs in future. Health insurers are required to send members a Standard Information Statement once a year. This is a one page summary of the main features of your policy, including restrictions or exclusions. When you receive your SIS is a good time to review your policy and make sure it will meet your needs in the coming year.

It's also important to read all the material your insurer sends you, particularly letters or emails about your cover. Health insurers are permitted to introduce new restrictions or exclusions to existing policies, providing that they inform you in advance and allow you to upgrade your policy without re-serving waiting periods before the change takes effect. The introduction of a new restriction or exclusion to an existing policy is usually done to manage premium costs for members.

If you do receive a letter from your insurer advising that a new restriction or exclusion will be applied to your policy, make sure you contact your insurer, to discuss your options as soon as possible, particularly if you want to retain cover for that service.

What are hospital restrictions or exclusions?

If your policy has **restrictions** for some conditions, you will be covered for treatment for those conditions, **but only to a very limited extent**.

For example, if your policy restricts hip replacement surgery, you will only be covered for this as a private patient in a **public** hospital. In some cases, hospital cover may be limited to shared ward only and will not cover the full cost of a private room in a public hospital.

If you go into hospital as a private patient in a **private** hospital, your health fund will not pay any benefits towards the theatre fees and only a small benefit towards your accommodation fees. This means you will face considerable out-of-pocket costs for your treatment.

If you receive treatment in a private hospital, your health fund and Medicare will still contribute towards your medical fees. This includes, but is not limited to, paying a benefit towards your treating doctor, your anaesthetist, pathology and x-rays, and other medical services you receive in hospital. If any of your treating doctors charge a gap for their services, you will be responsible for paying these costs yourself.

If your policy has **exclusions** for some conditions, you will not be covered at all for treatment as a private patient in either a public or private hospital for those conditions. This means that if you choose to be treated as a private patient, you will be responsible for the full hospital bill and a large portion of the medical fees for services you receive in hospital. This applies in both public and private hospitals if you are admitted as a private patient.

For example, if your policy excludes cardiac services and you go into hospital as a private patient for cardiac surgery, your health fund will not pay any benefits towards your hospital and medical costs. This means you will face considerable out-of-pocket costs for a private patient admission.

If you do elect to be treated as a private patient for an excluded service, Medicare will still pay a small benefit toward your medical fees.



How can restrictions and exclusions affect you?

We can't always foresee what services we will need and when we will need them, so it's important to understand any restrictions or exclusions that apply to your policy. The following is a list of the most common procedures that can be restricted or excluded:

- **Cardiac and cardiac related services:** This can include heart investigations such as angiographies and surgery such as angioplasty, coronary artery bypass, cardio ablation and treatment of coronary heart disease.
- **Plastic and reconstructive surgery:** This is defined as medically necessary treatment that can include skin grafts following burns, surgery to correct congenital abnormalities such as repair of cleft palates or cleft lips, nasal deformities causing breathing problems, surgery following traumatic injuries including the repair of facial bone fractures and breaks, surgery following removal of cancers or tumours such as breast reconstruction following mastectomy, skin grafts and skin flap surgery following tumour removal.
- **Psychiatric services:** This includes drug and alcohol rehabilitation and treatment of mental health issues such as eating disorders, schizophrenia, depression and anxiety.
- **Cataract and eye lens procedures:** Eye surgery to correct impaired vision.
- **Pregnancy and birth related services:** Includes the birth of a baby as well as any hospital admission relating to pregnancy.

- **Assisted reproductive services:** Includes infertility services such as In Vitro Fertilisation (IVF) and Gamete intra-fallopian transfer (GIFT).

- **Hip and knee replacements:** Joint replacement surgery.

- **Obesity Surgery:** Including gastric banding and bariatric surgery which is performed to assist in weight management.

What should I do if I need hospital treatment for a service that is listed as restricted or excluded on my level of hospital cover?

PHIO's advice to consumers is that they should contact their insurer ahead of time whenever practicable, to confirm whether they will be covered for a particular surgery, and to provide their fund with the Medicare item numbers from their surgeon where possible.

If you have purchased a policy with exclusions or restrictions and then require these services, you may have to wait to receive these services as a public patient, or upgrade to a higher level of hospital cover and complete a 12-month waiting period for pre-existing conditions to be covered as a private patient. Alternatively, you may choose to pay for the procedure or service yourself to be able to access it as a private patient.





What you can do

PHIO's advice to consumers is to consider taking out a more comprehensive level of hospital cover and choosing a higher level of excess or lower level of extras cover, in preference to an exclusion or restriction on the policy.

Review your policy every year to ensure it will meet your health needs over the coming year, particularly if you are thinking of starting a family or your health needs are changing as you age. A good time to review your policy is when your insurer sends you the Standard Information Statement for your policy. Insurers must send you a Standard Information Statement each year. The Statement is a one page summary of the main features of your policy and it has information about any restrictions or exclusions applying to the policy.

You can also access a copy of your Standard Information Statement on the consumer website, PrivateHealth.gov.au and compare it with Standard Information Statements for other policies you may be interested in purchasing. Standard Information Statements for all health insurance policies sold in Australia by all 34 health insurers are available for viewing and downloading from the website.

You can upgrade your hospital policy to include any services that are currently restricted or excluded on your current policy. Be aware, however, that you will have to wait for 12 months before you are entitled to payment of benefits for these services on your new policy if the treatment you require is for maternity services (obstetrics) or a pre-existing condition. Further information about these waiting periods and how they apply is available in [PHIO's Waiting Periods brochure](#).

Please note that if you upgrade your hospital cover to include psychiatric and rehabilitation treatment, the maximum waiting period is 2 months, even for a pre-existing condition.

If you need more immediate treatment for an excluded or restricted service, you should discuss your treatment options with your doctor.





Recent and Upcoming Events in Private Health Insurance

October 2014

- **PHIO Annual Report:** The Ombudsman's Annual Report will detail the activities undertaken by the PHIO in 2013-14. The report will include case studies, discussion of developments and complaint trends in the industry, as well as PHIO's outlook on the year ahead. The report will be published on www.phio.gov.au
- **Final Lodgement for Income Tax Returns:** You have until 31 October to lodge your income tax return. If you use a registered tax agent you can lodge later than 31 October, but you need to be registered as a client before 31 October to qualify. Your private health insurance tax statement details may be required for your income tax return – you can request your statement or ask for a reprint from your health fund.

November 2014

- **PHIO's Quarterly Bulletin:** The Ombudsman's bulletins keep the industry updated on the most recent health fund complaint statistics and trends in complaint issues. The bulletins are published on www.phio.gov.au

Useful Links and Resources

- **Privatehealth.gov.au:** This is PHIO's consumer website and is Australia's leading independent source of consumer information about private health insurance. To **search a database** of every health insurance policy in Australia, please visit our website.

Find out more about exclusions and restrictions in our factsheets and brochures:

- **Restrictions and Exclusions:** what isn't covered on your policy
- **Mental Health Treatment and Health Insurance:** cover for psychiatric services, rehabilitation and psychology
- **Plastic and Reconstructive Surgery:** items your policy may not cover
- **Waiting Periods:** how and why waiting periods work, including pre-existing conditions

Contact Us

The Private Health Insurance Ombudsman (PHIO) protects the interests of people covered by private health insurance. We provide an independent service to help consumers with health insurance problems and enquiries. The Ombudsman can deal with complaints from health fund members, health funds, private hospitals or medical practitioners. Our services are free of charge.

General Enquiries:

1300 737 299 and website@phio.gov.au

Complaints Hotline:

1800 700 465 and info@phio.gov.au

Websites:

www.phio.gov.au and www.privatehealth.gov.au

Facebook:

Follow us on Facebook at

www.facebook.com/privatehealthgovau

Subscribe

Subscribe to Health Insurance Insider e-mail updates and find copies of all our publications at www.phio.gov.au