Waiting periods for private health insurance

COMMONWEALTH OMBUDSMAN

PRIVATE HEALTH INSURANCE OMBUDSMAN

A guide for consumers about how and why waiting periods operate, including the rules on pre-existing conditions.

WAITING PERIODS

A waiting period is an initial period of health insurer membership during which no benefit is payable for certain procedures or services. Waiting periods can also apply to any additional benefits when you change (upgrade) your health insurance policy.

In Australia, all health insurers are required by law to provide health insurance for Australian residents regardless of their health status and cannot charge higher premiums based on whether a person is more likely to require treatment.

If there were no waiting periods, people could take out hospital insurance or upgrade to a higher policy only when they knew or suspected they might need hospital treatment. This would lead to much higher premiums for all existing contributors to health insurance.

WAITING PERIODS FOR HOSPITAL COVER

The maximum hospital waiting periods that health insurers can apply are set down in the *Private Health Insurance Act 2007*:

- 12 months for pre-existing conditions—this is defined as any condition, illness, or ailment that you had signs or symptoms of during the six months before you joined a hospital policy or upgraded to a higher hospital policy.
- 12 months for obstetrics (pregnancy)—to be covered, the mother's hospital admission needs to take place after the 12 month waiting period has been completed.
- Two months for psychiatric care, rehabilitation, and palliative care, even for a pre-existing condition—this can include treatment of post-natal depression, eating disorders, and drug and alcohol rehabilitation, amongst other treatments.
- Two months in all other circumstances.

If you transfer from one health insurer to another without a break in cover, you do not need to re-serve hospital waiting periods you have previously completed. However, if you are adding or upgrading your hospital cover, you do need to complete waiting periods for the new or upgraded items.

WAITING PERIODS FOR GENERAL TREATMENT (EXTRAS)

The waiting periods for general treatment, also known as extras or ancillary cover, are set by individual health insurers are not subject to the same laws as hospital cover. They vary significantly from two months to three years, so to find out the waiting periods that apply to you please contact your health insurer. 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
- One, two or three years for some high cost procedures such as orthodontics.

If you transfer from one health insurer to another, most health insurers will not require you to re-serve many waiting periods again. However, loyalty limits and accrued benefits don't necessarily transfer between insurers so check with the individual insurer.

Holding a general treatment (extras) policy does not count towards waiting periods for a hospital policy.

WAIVERS FOR HEALTH INSURANCE WAITING PERIODS

Sometimes insurers will waive some waiting periods as part of a promotion to attract new members. Usually, they only waive or some of the waiting periods for general treatment services. Always check which waiting periods will still apply. It is very rare for insurers to waive the twelve month waiting periods for pre-existing conditions, obstetrics, or major dental.

THE OBSTETRIC (PREGNANCY) WAITING PERIOD

If possible, it is best to plan health insurance for private obstetric treatment early because insurers are usually strict in applying a 12 month waiting period to this service. Almost all insurers apply a 12 month waiting period to hospital benefits for pregnancy services.

You will receive advice on an 'expected delivery' date from your doctor; but if your baby arrives earlier than anticipated and you have not served the 12 month waiting period, health insurers are not required to pay a benefit.

Choose an appropriate policy–many less expensive hospital policy do not cover obstetrics, or pay restricted benefits that only cover you for obstetrics as a private patient in a public hospital.

You will also need to upgrade from a single policy to family policy if you want to ensure your baby is covered at birth in a private facility. Insurers have different rules about when you need to do this, so make sure you check with your insurer as soon as possible.

THE PRE-EXISTING CONDITIONS WAITING PERIOD

A pre-existing condition is defined by law as any condition, illness, or ailment that in the opinion of the health insurer's doctor (not you, or your doctor), you had signs or symptoms of during the six months before you joined a hospital policy, or upgraded to a higher hospital policy.

It is not necessary that you or your doctor knew what your condition was or that the condition had been diagnosed. A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining the hospital policy or upgrading to a higher hospital policy.

Risk factors, including family history of a condition, are not signs or symptoms of a pre-existing condition.

If you are a new holder of a hospital policy, you will not be entitled to any benefits for a pre-existing condition in the first 12 months of membership.

If you already have a hospital policy but have transferred to a higher level of cover, you may only receive the (lower) benefits that you had on your previous level of cover for a pre-existing condition in the first 12 months on your new policy.

WHAT HAPPENS IF I NEED TO GO TO HOSPITAL DURING THE PRE-EXISTING CONDITION WAITING PERIOD?

If you need to be admitted to hospital during your waiting period, you should contact your health insurer straight away to check if you will be entitled to hospital benefits.

Your health insurer should:

- Give you some general advice about the pre-existing condition rule but, at this stage, they cannot tell you whether or not your condition is pre-existing.
- Send you documentation for your doctors to complete and return to the insurer.
- Contact you within five working days of sending them the information, if not contact the insurer and ask if they have made a decision.

If you need to go to hospital urgently, your health insurer might not have enough time before you are admitted to decide whether your condition is pre-existing. This means that you may not know, before you are admitted, whether you will receive any health insurer benefits.

If you proceed with your admission before the health insurer has advised you whether you are entitled to benefits, you may become responsible for all costs associated with the admission.

If you are concerned that you may be liable for your own private hospital treatment and want to look at other options, it is a good idea to check with your doctor for advice. Your doctor is in the best position to advise you if delaying treatment is medically advisable or whether you can opt to use the public system instead.

PRE-EXISTING CONDITIONS–EXAMPLES

Example 1: Pre-existing condition rule applies

- Pam was experiencing nausea and abdominal pain one month before she took out hospital insurance with a health insurer.
- She consulted her GP about the problem shortly after joining the insurer. Her GP referred her to a specialist, who diagnosed gallstones and recommended surgery.
- The doctor appointed by the health insurer determined that symptoms of Pam's condition were in existence in the six months before she joined the insurer. Although Pam's GP had not diagnosed gallstones initially, the symptoms of nausea and pain had been present for some time before Pam saw him or joined the health insurer.
- The insurer advised Pam she would not be eligible for benefits for treatment of the gallstones for the first 12 months of her membership.

Example 2: Pre-existing condition rule does not apply

- Warren had held his hospital policy for three months when he suffered a stroke and was rushed to hospital.
- Warren's treating doctor indicated he had a number of risk factors for stroke, including high blood pressure, but had no signs or symptoms of a condition that lead to the stroke prior to joining the insurer.
- The doctor appointed by the health insurer determined that Warren was eligible to receive benefits for his treatment, because he did not have any signs or symptoms of the stroke prior to joining the insurer.

(Please note that these examples are intended as a guide only. Each case will depend on the individual's particular circumstances.)

MORE INFORMATION AND HOW TO MAKE A COMPLAINT

The Private Health Insurance Ombudsman has a number of other brochures and publications on our websites that may help you to better understand your health insurance.

If you need our help with private health insurance arrangements or have a complaint please refer to our contact information on the back page.

CONTACT US

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

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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