COMMONWEALTH OMBUDSMAN

HEALTH INSURANCE INSIDER

Issue #8 – March 2016

Decoding private health insurance - Common Phrases in Australian Private Health Insurance

Private health insurance, like many other industries, has its own language and its own set of industry terms and jargon. Some common phrases like "cover" or "emergency" have a more specific or complex meaning in private health insurance than they do in everyday usage. This bulletin will explain some of the more commonly used and misunderstood expressions in plain language.

"Cover"

What does it mean to be "covered" or to be "fully covered" in Australian private health insurance? A common perception is that if you are "covered" for a particular service, then you won't have to pay anything out of your own pocket - but in private health insurance, this isn't the case.

When a service is "covered" it means that it is included on your policy and your health insurer will pay the benefit appropriate for that service. However, it does not automatically mean that you will have no costs to pay yourself – if the cost of the service should happen to be more than the benefit paid by your insurer, then you will pay the difference.

Hospital cover: If your insurer will "cover" your hospital admission, then this generally means they are paying for your hospital fee in any hospital for which they have an agreement, and a set portion of your medical fees. However, it's still necessary for you to check with your fund, hospital and doctors about potential out-of-pocket costs – you may have to pay an excess to the hospital or contribute towards the hospital fee in a non-agreement hospital; and you may have extra fees for the doctors if they charge over the Medicare Benefits Schedule fee for any given service. When you are a private patient, doctors have the right to charge more than what is covered by your insurer and by Medicare, so whenever possible always ask your doctors for quotes before proceeding. This includes your surgeon, assistant surgeon, and anaesthetist.

Extras cover: If a service is "covered" on your extras cover, such as dental or physiotherapy, then your insurer will usually pay either a set benefit or a percentage of the cost of the service. Anything above the set benefit or percentage benefit is your cost to pay. Ask your service provider for a quote and check with your health insurer to find out how much will be covered and how much you will need to pay yourself.

"Basic" hospital cover

Many people are under the impression that a "basic" hospital policy may not cover some of the more expensive elective items, like assisted reproductive services or gastric banding, but will still cover what they consider to be essential services or that they will be covered if they have a medical emergency.

What many people don't realise is that basic hospital policies can potentially restrict or exclude almost any medical service, with the most basic ones excluding all but a few medical services – even as few as ten services or less.

Sometimes people are surprised to find that they aren't covered for services they consider essential or "basic" such as:

- chemotherapy for cancer treatment
- heart attacks and cardiac-related treatment
- removal of skin cancers or cysts, and the repair of such surgeries
- nerve repair, for example after an injury to a hand or a finger
- diagnostic procedures such as colonoscopies or gastroscopies, or
- gynaecological services such as treatment for endometriosis.

While you may consider it unlikely that you would ever need a hospital admission, you should always check carefully about what is and isn't included on your policy. Try to check your policy once every year or two years, and always review any letters or emails sent to you by your insurer in case your policy has changed.

"Top" hospital cover

What does it mean to have a "top" hospital cover? Some people purchase the highest possible hospital cover their insurer offers and have the expectation that if they need to go to hospital, they won't need to pay anything out of their own pocket.

However, the real reason why a hospital policy is sometimes called "top" cover is because it will cover you in hospital for more services than the insurer's other, cheaper, offerings. A top policy won't exclude or restrict (pay minimum benefits: see below) any items in the range of services which Medicare lists to be medically necessary.

As explained above, to be "covered" for something doesn't mean that you will have no expenses. There is always the potential that you may have to pay extra if your doctor charges a "gap fee" or, less commonly, if you are admitted to a hospital which doesn't have an agreement with your health insurer.

Before going to hospital, always check with your health insurer for more information, and ask your doctors for written estimates of fees so you know how much extra you may have to pay.

"Restricted benefits" and "minimum benefits"

Some hospital insurance policies only provide "restricted benefits" or "minimum benefits" for certain services. Sometimes this level of benefit is also called the "default benefit".

Cardiac surgery, obstetrics, gastric banding, and hip and knee replacements are some of the more commonly restricted items, but potentially any service can be restricted. By choosing to have only restricted benefits for certain items, the cost of your insurance is reduced.

The major difference is how your hospital fees are covered. The "restricted benefit" or "minimum benefit" rate is enough to cover the cost of being a private patient in a shared room at a public hospital. But if you have a single room or go to a private hospital, then you cover the difference in cost, which can be thousands of dollars.

If you only receive "restricted benefits" then you will have considerable out-of-pocket expenses if you go to a private hospital. Before deciding to go to a private hospital for a restricted service, always check with your health insurer for more information, and ask the hospital and doctors for written quotes so you know how much you will have to pay.

"Accident"

Some basic hospital policies will cover injuries only if they are incurred as the result of an accident. However, the definition of "accident" varies from insurer to insurer and there is no definition which applies across the whole industry.

Some insurers have conditions relating to how soon treatment was sought after an injury occurred and what type of medical attention was provided. For example, some policies specify that you need to seek treatment from a hospital accident & emergency ward within 48 hours of an injury occurring. Insurers assess claims for accident benefits based on the records from the time of the incident occurred, and generally do not pay benefits for injuries that only showed to be a problem days or weeks later.

So check the terms and conditions of your policy carefully to make sure you understand how your policy works, and contact your insurer if you have any questions or if any aspect is unclear.

If you do need to go to hospital but don't have time to confirm with your insurer if you are covered before going to hospital, then be aware that you will become responsible for the full costs if you nominate to go to hospital as a private patient and your insurer later refuses the claim.

Please note you can always nominate to be admitted to a public hospital as a public patient, even if you have private insurance. If you to a public hospital as a public patient, the cost is covered by Medicare.

There are also many policies which don't include or exclude treatments on the basis of whether they are caused as a result of an accident, but instead on the nature of the treatment itself (e.g. all knee surgeries covered, whether or not as a result of an accident). While such policies may have a higher premium, they may be worth considering because they don't impose such strict conditions.

"Emergency Ambulance"

Most policies include cover for emergency ambulance services. But when is an ambulance service an "emergency ambulance" service? For many people, the two would seem to be one and the same – there would be no need to call an ambulance if it wasn't an emergency.

However, from a health insurance perspective, not all ambulance services are the same. Private health insurance "emergency ambulance cover" often pays for fewer services than ambulance subscriptions offered by state based ambulance organisations. For example, some policies only cover you if you need a transport to hospital, meaning that you are not covered for "call-outs" when the ambulance is called and you are treated at the scene.

Non-emergency transports are another type of ambulance service which isn't always covered. Examples of non-emergency transports can include transfers between hospitals, or transports from hospital to home.

Most policies also have restrictions regarding private ambulance services (as opposed to state ambulance services). Private ambulance services aren't automatically included so if possible, check with your insurer.

Check the terms and conditions of your policy carefully to make sure you understand how your ambulance cover works, and contact your insurer if you have any questions or if any aspect is unclear.

"Equivalent" policies

When you are shopping around for a new policy or transferring from one insurer to another, you may ask for an "equivalent" policy, or perhaps your insurance broker or new insurer will assure you that you have transferred to an "equivalent" policy. However, because health insurers have different rules and benefits, it is almost impossible to say a policy is 100% equivalent to another.

Some policies can be similar, but not exactly the same from insurer to insurer. The more exclusions or restrictions that apply to any one hospital policy, the more likely it is that no exact equivalent policy exists. This is also true for general treatment policies, which may pay benefits at different rates per service or have different annual benefit limits, even when they cover the same services.

So it's important to check the details of any new policy yourself, to make sure that you understand what is and isn't included, and how benefits are paid under the terms of your new insurer. "Equivalent" policies are often similar to one another, but you may prefer one policy to another based on your individual needs.

Recent and Upcoming Events in Private Health Insurance

March 2016

- **Health Fund Annual Premium Increase Letter** – Look for a letter from your health fund, as they are required to notify you of any increase in your premium. Make sure you read all information sent by your fund, as there may be other changes to your policy in addition to the price increase. This is a good time for you to review your policy.
- **Changes to the Private Health Insurance Rebate** – rebate contributions will change from 1 April. Contact your health fund or check back on Privatehealth.gov.au for more information.
- **PHIO's State of the Health Funds Report** – How does your health fund measure up? This annual report from the Ombudsman compares the performance and service delivery of Australia's health insurance providers. The reports are published on **www.ombudsman.gov.au** and you can also find key performance information about each health fund on **www.privatehealth.gov.au**.

April 2016

- **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.ombudsman.gov.au**

June 2016

- **Considering buying hospital insurance? Recently turned 31?** – If you answered yes to either of these questions, then you should be aware that for most Australian residents it's cheaper to buy hospital insurance before the end of the financial year. Under the Lifetime Health Cover (LHC) rules, you can buy hospital insurance at the lowest rates if you purchase before the 1 July following your 31st birthday. If you're already over 31, then you should be aware that each financial year it will become more expensive to purchase hospital insurance for the first time.

July 2016

- **Tax statements.** – Look for a tax statement from your health fund confirming your level and duration of cover for the previous financial year. Your tax statement details may be required for your income tax return.

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 planning a family and going to hospital in our factsheets and brochures:

- **The Right to Change**
- **10 Golden Rules of Private Health Insurance**
- **Health Insurance Insider #1 – Reviewing your policy**

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 **info@privatehealth.gov.au**

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1300 362 072 and **phio.info@ombudsman.gov.au**

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