Australian Private Hospitals Association

Am I adequately covered for private hospital care?

Will my private health insurance cover me for private hospital care when I need it?

Some patients are surprised to find that they are not fully covered for the care they need in private hospitals. They may not be covered for things like cardiac surgery, joint replacement or dialysis. If your private health insurance policy contains exclusions or restrictions then you may not be able to access some services in private hospitals.

This brochure, brought to you by the Australian Private Hospitals Association (APHA), explains what is meant by exclusions and restrictions in health insurance policies and how this may affect you. We encourage you to check your policy regularly to ensure that it is current and relevant for your circumstances and that you and your family can access private hospital care when you most need it.

What are exclusions & restrictions?

Exclusions are specific treatments or services not covered by your health insurance policy. Exclusions will be specifically stated on your policy and can include services like eye surgery or major joint surgery. Insurers can exclude any medical service except for psychiatric, rehabilitation services and palliative care. There is no limit to how many different services an insurer can exclude.

Restrictions apply to specific treatments or services that are only partially covered. There are several types of restrictions that can appear on a policy:

- A specific medical service may only be covered to a 'limited extent'. For example you may only be covered in a public hospital for treatment of the restricted service, not a private hospital or the cover you are provided may not meet the full cost of your treatment.
- A specific medical service may be covered only after a certain waiting time known as a 'benefit limitation period'. Once this waiting period is over, you are covered for that service.
- A specific medical service may only be covered for a set number of days of treatment or 'episodes' within a year.
- Sometimes a program of treatment will only be covered if it is first approved by your health fund.

Insurers generally impose the following waiting periods for a policy to be a complying health insurance policy:

- 12 months for all pre-existing conditions (except psychiatric care, rehabilitation or palliative care)
- 12 months for obstetric treatment
- 2 months for psychiatric care, rehabilitation or palliative care *(whether or not for a pre-existing condition)*
- 2 months for any benefit for treatment provided in a hospital.

If you are unsure about waiting times contact your insurer.

My 'peace of mind' checklist:

To make sure that you are adequately covered for treatment in a private hospital, we suggest you:

- Check your policy statement from your health insurer and make sure that you understand any restrictions or exclusions that apply to your policy.
- Make sure you review the Standard Information Statement for the policy you have selected.
- Regularly review your policy to ensure it is relevant to your current circumstances. A policy that you took out some time ago may not be appropriate for your needs now.
- Contact your health insurer with any questions you may have and review or upgrade your policy if you think it necessary.
- Discuss with your doctor if you are unsure which services you may need cover for.
- If your doctor has recommended a particular treatment or hospital admission check, prior to admission, with your doctor, hospital and your health fund, the cover provided and any out of pocket charges that will apply.
- If you find that your policy does not meet your needs, you are entitled to switch to another policy or health fund and have the waiting periods you have already served recognised.

The Private Health Insurance Ombudsman recommends considering taking a higher level of excess, rather than a restriction or exclusion, to save money on premiums.

For more information about private health insurance, visit **www.privatehealth.gov.au.**

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V2 - 08/14