

Essential Hospital

Information about your policy



▶ **Effective 1 November 2011**

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Contacting ahm?

Visit ahm.com.au and register for online services to manage your cover online and access a range of information on healthy living.



**Find us
on Facebook**

facebook.com/ahm.health.insurance

As soon as you've registered you'll be able to:

- claim for most paid extras online
- check your benefit limits
- change your level of cover
- view and update your personal information
- search for a GapCover Doctor or partner hospital or day surgery
- access information on healthy living including dental and eyecare health
- register for our e-newsletter and more



Private Health Insurance Code of Conduct

ahm adheres to the Private Health Insurance Code of Conduct. This is a self-regulatory code that promotes informed relationships between private health insurers, consumers, agents and brokers.

Our documents display the PHI Code of Conduct logo. This shows that ahm complies with the Code and has been authorised by the Code Compliance Committee to use the logo. If you'd like more information about the Code – or if you'd like your own copy of the Code – call one of our friendly staff on 134 246 or go to ahm.com.au



About Essential Hospital cover

This document includes important information about your cover and benefit entitlements. It also provides you with a step-by-step guide that explains what you need to do if you have to go to hospital and how to access programs and services designed to better manage your health.

Please read this document carefully and keep it in a safe place for future reference.

If you're unsure of anything, please call us on 134 246

Your ahm hospital cover gives you choices that you can't get with Medicare. ahm provides you with benefits for:

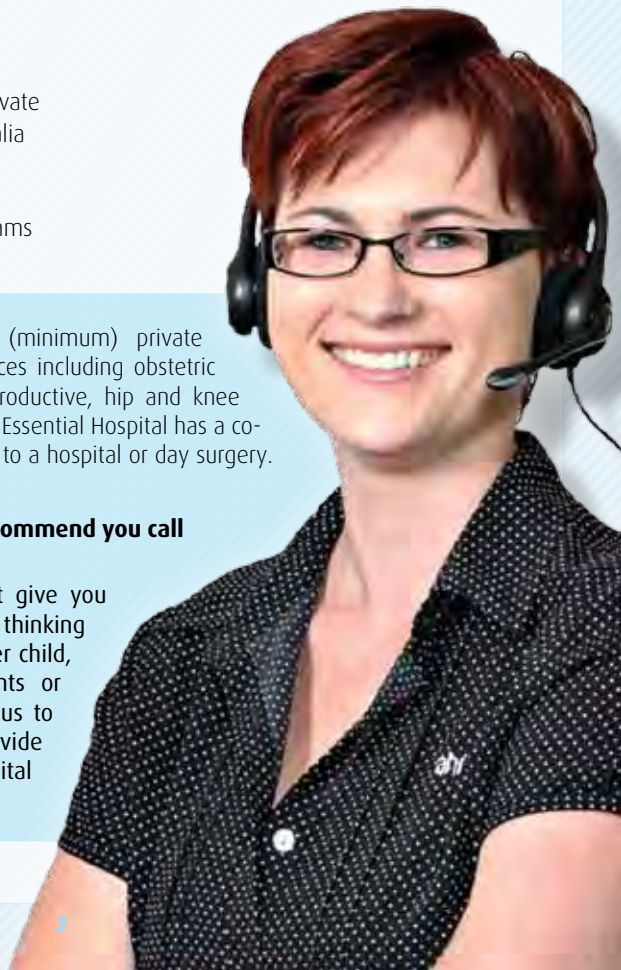
- ▶ Hospital services
- ▶ Ambulance transport
- ▶ Medical gap
- ▶ Hospital accommodation at most private and all public hospitals across Australia
- ▶ Disease prevention programs
- ▶ Chronic disease management programs

Essential Hospital pays a default (minimum) private hospital benefit for a number of services including obstetric related services including assisted reproductive, hip and knee joint replacements and gastric banding. Essential Hospital has a co-payment which applies when admitted to a hospital or day surgery.

There are no exclusions.

If you need to go to hospital, we recommend you call us first.

IMPORTANT: Essential Hospital won't give you the level of cover you need if you are thinking about starting a family, having another child, need hip or knee joint replacements or any gastric banding procedures. Call us to discuss health cover options that provide a more comprehensive private hospital benefit for these services.



















About your cover

The following are examples of the most common services we pay benefits for. There are more services we pay for than we can include here so make sure you call us before you go to hospital or have any treatment to confirm the benefits you'll receive.

What you're covered for

 Accommodation* private or shared room	 Surgically implanted prostheses we'll cover the cost of any No Gap prostheses, and the minimum benefit for Gap Permitted prostheses
 Operating theatre*	 Ambulance transport
 Intensive care*	 Travel and accommodation related to a hospitalisation (see page 18)
 Major eye surgery	 Disease prevention and chronic disease management
 Dialysis	 Medical gap
 Psychiatric services	<ul style="list-style-type: none">· the difference between Medicare Benefits and the Medicare Benefits Schedule (MBS) fee for inpatient services· if your doctor participates in GapCover and charges the agreed fee, we'll cover the difference between the Medicare Benefits Schedule fee and the agreed amount (see page 10).
 Rehabilitation	
 Palliative care	
 Cardio-thoracic procedures including open heart and bypass surgery and other invasive cardiac procedures such as angiograms and stents	

* Except for restricted services

Where you're covered

We'll cover you when treated at a:

- ▶ Partner private hospital
- ▶ Partner day surgery
- ▶ Public hospital
- ▶ Non agreement hospital *Default (minimum) benefit only (see definition, page 24)*

Restricted services

We pay the default (minimum) benefit only for restricted services and services not covered by Medicare in either a private or public hospital. Restricted services include:

- ▶ Hip and knee joint replacements (full or partial)
- ▶ Pregnancy related services/obstetrics
- ▶ Assisted reproductive services (eg. IVF and GIFT)
- ▶ Male and female sterility reversals
- ▶ Any gastric banding surgery and associated surgery
- ▶ Podiatric surgery
- ▶ Cosmetic surgery where not considered medically necessary
- ▶ Services not covered by Medicare unless otherwise specified
- ▶ Services where Medicare doesn't pay a benefit (eg. where patient is not Medicare eligible).

Exclusions

If a service is excluded it means we pay no benefits for it.

There are **no exclusions** on Essential Hospital.

BLUE interim, YELLOW reciprocal or no Medicare card

If you have a blue interim, yellow reciprocal or no Medicare card, some of the benefits outlined in this policy document may not be available to you (see Medicare eligibility, page 25). Please call us to check your cover before going to hospital.

What isn't covered

- ▶ Charges above the MBS fee (unless your doctor agrees to participate in GapCover)
- ▶ Charges above the MBS fee if your doctor charges more than the agreed GapCover fee
- ▶ Charges above the minimum benefit for Gap Permitted prostheses
- ▶ Labour ward
- ▶ Private room accommodation for restricted services
- ▶ Operating theatre charges for restricted services
- ▶ Intensive care accommodation for restricted services
- ▶ Personal items including non-local phone calls, faxes, TV, internet and newspapers
- ▶ Take home bandages and dressings
- ▶ Any medication that you take home or that wasn't related to your hospitalisation

What isn't covered continued...

- ▶ Service providers such as physiotherapists or occupational therapists who aren't directly employed by the hospital you're treated in – if you have an extras policy with ahm that covers these services, you may be entitled to claim a benefit towards the cost
- ▶ Cover for the full cost of your accommodation or theatre fees if you attend a private hospital where a contract has been declined or cancelled or for restricted services in either a private or public hospital. Check with us on 134 246 before you go to hospital
- ▶ Treatment that is subject to a waiting period if you haven't served the relevant waiting period
- ▶ Some high cost Non PBS drugs – the hospital should advise you if these drugs won't be paid for by ahm through 'Informed Financial Consent'
- ▶ Medical costs for services not covered by Medicare unless otherwise specified (see Default benefit definition, page 24)
- ▶ Charges for medical services where Medicare doesn't pay a benefit (eg. for a person without a Medicare entitlement or restricted entitlement)
- ▶ Any medical, hospital or ambulance services received overseas or purchased outside Australia, including online purchases from overseas companies.

Waiting periods

When you take out private hospital cover or change your level of cover, you'll have to wait a set time before you can claim for services and benefits you weren't previously covered for.

Where benefits are greater on your new level of cover, we'll pay the benefit at the amount on your previous level of cover until the waiting period is served.

1
day

- Hospital treatment as a result of an accident
- Ambulance
- Disease prevention programs
- Chronic disease management programs
- Travel and accommodation

2
months

- Hospital treatment (where there's no pre-existing conditions)
- Rehabilitation, psychiatric and palliative care (regardless of whether pre-existing)
- Doctor health checks and Healthy Heart checks

12
months

- Pre-existing conditions
- Obstetrics, pregnancy and birth related conditions in a public or private hospital
- Disease management appliances
- Speech processor and insulin pump replacements

Pre-existing conditions

A pre-existing condition is an ailment, illness or condition that in the opinion of a Medical Practitioner appointed by ahm, the signs or symptoms of that ailment, illness or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy or changed their cover.

The appointed Medical Practitioner is the only person authorised to decide if an ailment is pre-existing. They must consider any information that was provided by the medical practitioner who treated the ailment, illness or condition.

Assuming that we receive all the information required from your treating medical practitioner(s), we'll need 5 working days to make the assessment so you should allow this into your timeline when you agree to a hospital admission date.

If you're admitted into hospital without confirming your benefit entitlements and your condition is subsequently determined as pre-existing, you'll be required to pay any hospital and medical charges not covered by Medicare.

If you're admitted to hospital for an emergency, we may not have time to assess if the pre-existing rule applies. As a result you may have to pay for all or some of the hospital and medical charges if:

- you've held your current level of hospital cover with us for less than 12 months,
- you're admitted to hospital and choose to be treated as a private patient, and
- your condition is later determined to be pre-existing.



Going to hospital

Not everyone needs to go to hospital but if you do, we can help you prepare by providing you with the information you need to know. You should always call us before you go to hospital so that we can confirm your benefit entitlements.

Before you go to hospital

Use this checklist to make sure you have the right information about your treatment and the costs involved before you go to hospital.

Before you go to hospital

- Ask your doctor/specialist about your condition, where you will be treated, how long you will be in hospital, what treatment you are having and what are the costs involved.
- Ask your doctor/specialist if they participate in ahm's GapCover scheme to minimise your out-of-pocket medical expenses (refer to pages 10-11 for more information).
- Call our service centre on 134 246 to check benefit entitlements, any co-payments you'll need to pay, hospital eligibility and to confirm that you've served any applicable waiting periods. We can also answer other questions you may have about your hospitalisation.

Have you served your waiting periods?

You'll need to have served your waiting periods before receiving full benefits for the services covered on your policy. A full list of waiting periods can be found on page 6.

- Make sure you understand what pre-existing conditions are and confirm that your waiting periods have been served.

What treatment are you having?

It's important that you understand your treatment, how much it will cost and how much you will have to pay towards it.

Informed Consent is your right to know exactly what is involved with your treatment.

Make sure you ask for:

- A full explanation of the procedure and any likely complications or prostheses involved;
- If there are other treatment options;
- How long you will take to recover; and
- How long you will have to wait for test results.

What happens on admission to hospital?

If you're taken by ambulance

- Your hospital policy provides full cover for medically necessary ambulance transportation.
- If it's an emergency, you'll be taken to the nearest Accident and Emergency Department.

If your doctor referred you to a specialist for treatment

- Ask your doctor to refer you to a specialist who participates in GapCover. You can check our website to find out which doctors in your area participate.
- Make sure you ask your doctor to provide you with an estimate of medical fees so you know your costs up front.

On admission to hospital

- The hospital will confirm your cover with us (or may do so prior to your admission).
- The hospital usually requires you to pay your co-payment prior to or on the day of admission. Make sure you have your credit card or money to pay this on the day.
- The hospital will also provide you with an estimate of medical fees. This will detail any additional charges relating to your treatment that aren't covered by us.
- If you like, you can ask for a 'Patient's Code' from the hospital which details your rights and the responsibilities of doctors and the hospital.

What you should know about the doctor's charges

It is important to know exactly what you are covered for if you have to go to hospital. Your doctor or specialist should provide you with an estimate of medical fees so that you know how much your treatment will cost and how much you will have to pay towards it. This will enable you to provide the Informed Financial Consent.

How does ahm's GapCover help me to minimise my out-of pocket expenses?

- The MBS is a list of fees for medical services as defined by the Federal Government. Medicare pays 75% of the MBS fee for inpatient hospital related medical services and private health insurers pay the remaining 25%.
- In some cases, a doctor may charge more than the MBS fee, which may leave you with an out-of-pocket expense which you may have to pay. This is known as the 'Gap' and is the difference between the fees you're charged by the medical providers and the MBS fees for the services they provide. ahm's GapCover is designed to help remove or reduce the medical gap between the MBS fee and what the doctor charges so you pay less for your treatment or pay nothing at all. If your doctor participates in GapCover and charges the agreed fee, we'll cover the difference to the agreed amount.

If your doctor participates in GapCover

- Ask your doctor to provide you with an estimate of medical fees so that you can see upfront exactly how much you'll have to pay before your treatment begins. This estimate enables you to make a fully informed decision about the cost of your treatment prior to giving consent to your doctor.
- We'll pay up to the GapCover agreed fee. Your doctors will send the bills directly to us and we send you a statement detailing how much we've paid so you don't need to worry about filling out any claim forms.
- To ensure GapCover maintains some control over costs, a cap of \$500 per claiming provider above the GapCover agreed fee has been put into place. If you're quoted a charge in excess of this amount, then the GapCover scheme can't be used and you'll have to pay the amount between the MBS fee and the doctor's charge.

If your doctor declines to participate in GapCover

- You should still ask your doctor to provide you with an estimate of medical fees prior to your treatment
- We pay up to the MBS fee set by the Government
- You'll have to pay the amount above the MBS fee
- Doctors involved in your treatment will each bill you separately.

What you should know about the doctor's charges continued

How it works

GapCover scheme	
Doctor charges MBS Fee	
Medicare pays 75%	ahm pays 25%
Doctor charges above MBS	
ahm pays up to the agreed GapCover schedule fee	Member pays up to \$500 per claiming provider
Doctor charges more than \$500 over the GapCover agreed fee	
Member pays balance above MBS fee	

You can access a doctor search facility on the ahm website at ahm.com.au to find a doctor who has registered to participate in the GapCover scheme.

What about Hospital charges?

Your hospital cover means you are covered in full for agreed theatre and accommodation charges, except for restricted services as outlined on page 5 and services not covered or paid by Medicare, unless specified after your co-payment amount is paid at:

- all partner private hospitals and day surgeries; and
- public hospitals.

The hospital will bill ahm directly and we'll send you a statement showing you the benefits we've paid.

What about the prostheses charges?

- ahm covers you for all surgically implanted No Gap prostheses on the Government's Prostheses List.
- We'll also cover the minimum benefit towards the prostheses charge for any Gap Permitted prostheses.
- If you choose a Gap Permitted prosthesis that costs more than the minimum benefit, you'll have to pay the difference between the minimum benefit and the prosthesis charge.

NOTE: There is at least one clinically appropriate No Gap prosthesis available for any procedure you may require so you should discuss the choices with your doctor.

What is a Co-payment

A co-payment is the daily amount that you pay towards the cost of treatment if you go to any hospital or day surgery. It applies to each person covered on your policy and there are set limits for each person per membership year.

How much do you have to pay and when?

Essential Hospital	
What you pay	\$250 for same day or 1 night stay per person or \$500 for two or more nights stay per person
Limits per membership year	\$500 per person

Where will you be treated?

When you go to hospital you can choose where you're treated and whether you are treated as a private or public patient.

If you're treated as a private patient, ahm has agreements in place with the majority of private hospitals and day surgeries throughout Australia. These agreements guarantee your cover for agreed theatre and accommodation charges (excluding restricted services) as outlined in your policy. You can find a list of Partner Private hospitals on our website ahm.com.au

The table below outlines your choices.

Day only surgery	<ul style="list-style-type: none">• you'll be able to choose your own doctor• you'll need to pay any co-payment that applies• a default benefit applies to restricted services• we'll cover all agreed theatre and accommodation charges• you'll be admitted to hospital and discharged on the same day
Private patient in a private hospital	<ul style="list-style-type: none">• you'll be able to choose your own doctor• you'll need to pay any co-payment that applies• a default benefit applies to restricted services• we'll cover all agreed theatre and accommodation charges
Private patient in a public hospital	<ul style="list-style-type: none">• you'll be able to choose your own doctor• you'll need to pay any co-payment that applies• a default benefit applies to restricted services• we'll cover all agreed theatre and accommodation charges
Non-agreement hospitals or day surgeries	<ul style="list-style-type: none">• you'll be significantly out-of-pocket• you'll need to pay any co-payment that applies• a default benefit only applies on all services
Public patient in a public hospital	<ul style="list-style-type: none">• you'll go on a waiting list for your treatment and be treated by the next available doctor• Medicare covers your doctor and hospital fees

After you have been to hospital

Your doctor may advise you to see other healthcare providers following your hospital visit. If you have ahm Extras cover, you will be able to claim benefits for services such as a physiotherapist to aid in your recovery. For more information on our ahm Extras, call our service centre on 134 246.



Looking after your health with ahm's Health Management Programs

Your ahm hospital policy provides you with access to programs and services designed to help you achieve and maintain good health and manage or prevent disease and health risks. Some of these services include health risk assessments, health coaching and help managing chronic conditions.

The following pages detail what's available to you for each ahm health management program. In most cases, any benefits associated with the programs will be paid on your behalf directly to the service provider (like we do with hospital claims) so you won't need to complete a claim form.

You'll also see a range of other benefits in this section designed to help you (and your family) with your ongoing good health. This includes disease management appliances, a travel and accommodation benefit, benefits for insulin pump and speech processor replacements, doctor health checks and Healthy Heart checks.

Some of the programs are subject to eligibility, limitations and your doctor's approval. There is a one day waiting period for the disease prevention and chronic disease management programs and normal waiting periods apply to other programs (see page 6). ahm pays 100% of the cost for all eligible programs and services. You must be 18 years or older to participate.

If you're eligible to participate in a program just call 134 246 and ask to speak with a health consultant.

Disease prevention programs

Benefit

ahm's Health Risk Assessment

This is a questionnaire-based assessment of your current health and lifestyle. The assessment provides you with a Wellness profile including your Health Age, any major health risks you're likely to encounter and advice on preventative measures.

- If your assessment reveals the potential risk of major disease a health consultant may call you or you can call ahm to enrol in our Health Coaching program.

Participation: The assessment can only be completed online and you must be 18 years or older to complete the assessment.
ahm.com.au/healthsurvey

ahm pays 100% of the cost

ahm's Health Coaching

Health Coaching is a six month support program to help you improve or maintain your health or manage a condition to prevent chronic disease where a risk factor is present.

This program involves a series of telephone calls made by qualified clinicians including dietitians, exercise physiologists and occupational therapists.

- It helps you to make the changes needed to improve your health through motivation and behavioural change
- You'll be provided with information specific to your health goals and needs
- You can use ahm's online diary for setting and tracking goals and access a library of health features and recipes.

Services include:

- Consultation to set health goals
- Over the phone support.

Participation: If you're 18 years or older, just call us on 134 246 to enrol in the program.

ahm pays 100% of the cost

Chronic and complex care

Benefit

A chronic disease means a disease that has been, or is likely to be, present for at least six months. It can include but isn't limited to asthma, cancer, cardiovascular illness, diabetes, a mental health condition, arthritis and a musculoskeletal condition.

This 12 month program is for chronically ill individuals with such conditions and is designed to help you learn how to better manage your condition.

- You'll receive a written plan with agreed goals and activities developed by a qualified clinician
- It will help you to make the changes needed to improve or manage your condition through motivation and behavioural changes
- You'll be provided with information specific to your health goals and needs
- You can also use ahm's online diary for setting and tracking goals and access a library of health features and recipes.

Services include:

- Telephone support from a registered nurse
- Co-ordination of services to manage the condition
- Phone in and email service
- Educational material and online resources
- Health coaching.

Participation: If you've been diagnosed as having a chronic disease or you have been identified as having multiple risk factors for chronic disease, call us on 134 246 to enrol in the program. You must be 18 years or older to participate.

ahm pays
100%
of the cost

<i>Health checks</i>		<i>Financial year limit</i>	<i>Benefit</i>
Doctor health checks and Healthy Heart checks (where not claimable through Medicare, an employer or another party)		1 per person	\$50
<i>Disease management appliances</i>		<i>Financial year limit</i>	<i>Benefit</i>
Blood pressure monitor		1 per policy every 3 continuous financial years	\$80
CPAP machine or BiPAP respirator		1 per policy every 5 continuous financial years	\$500
CPAP machine or BiPAP respirator mask and/or rental		Combined per policy per financial year	\$80
Blood glucose testing machine		1 per policy every 3 continuous financial years	\$80
Instant injector or insulin pen		1 per policy every 3 continuous financial years	\$80
Nebuliser		1 per policy every 2 continuous financial years	\$80
Peak Flow Meter		1 per policy every 2 continuous financial years	\$40
Spacer		1 per policy every 2 continuous financial years	\$40
TENS machine		1 per policy every 3 continuous financial years	\$60
Lymphoedema	Garments	3 items per person, per financial year	(per item) \$40
	Consultations	4 consultations per person, per financial year	(per consult) \$30

NOTE: ahm reserves the right to check eligibility for benefits and verify payment. Proof of need for an appliance will be required before a benefit can be paid eg. specialist or doctor's letter, script, enrolment in a ahm health management program relating to the condition (see page 24).

Insulin pump and speech processor replacements

Benefit

You'll be able to claim these as an 'outpatient' service which means that the replacement is fitted in a doctor's surgery or rooms rather than in hospital. These items are part of your hospital cover and are paid in the same way as other prostheses. This means we'll pay benefits according to the listed minimum price on the Government's Prostheses List. We'll only pay a benefit where your specialist verifies that the replacement is medically necessary and it's not a replacement for a processor or pump that is still within warranty.

In almost all cases, we'll cover the cost of the item in full so you won't need to pay for the item first and then claim a refund from ahm. If your doctor charges more than the listed minimum price on the Prostheses List, we'll only pay the listed minimum price and you will have to pay the difference.

ahm pays 100% up to the listed minimum price on the Government's Prostheses List

Travel and accommodation

Benefit

We'll pay a travel and accommodation benefit related to a hospitalisation where either:

- the patient has to travel more than 200 kilometres return in relation to a hospitalisation; or
- in life or death situations for a partner or next of kin to accompany the patient; or
- for a parent to accompany a child dependent under the age of 18.

This benefit is only payable where both the patient and the supporter are covered under an ahm hospital policy and for travel or accommodation relating to a hospitalisation. The combined benefit per day includes both travel and accommodation. We won't pay benefits for both the patient and supporter for the same dates.

Accommodation for a patient who travels greater than 200km return in relation to a hospitalisation is only payable for one night before and one night after the admission, unless supported by medical certification of a genuine need for an extended stay.

We'll pay for accommodation for the supporter during the patient's hospital admission only.

NOTE: Proof of travel and accommodation costs will be required eg. petrol docket, bus or train tickets, hotel receipts. (Petrol docket will be accepted when dated up to 3 days prior to hospitalisation and 1 day after discharge from hospital.)

\$75 per day combined up to \$750 per person every membership year



Who's on your cover?

We have a range of different policy options designed to suit the different lifestyle needs of our members. So depending on your circumstances, the scale (level) of your cover will be one of the three below:

Single policy – a policy that only includes one person, the principal member

Single parent policy – a policy that includes two or more people, one insured adult (the principal member) and the other insured persons are dependants of the insured adult

Family policy – a policy that includes an adult who is the principal member, their partner and any dependants of the principal member or their partner.

The **principal member** is the first named member of a policy. This person is responsible for the payment of premiums under a policy issued by ahm. This person has the authority to terminate the policy and add or delete persons from the policy.

A **partner** of a person is the person's husband or wife or a person who, although not married to the person, lives with that person on a bona fide domestic basis and includes a same-sex partner.

Dependants on your cover

If you have a family or single parent policy, your kids can be covered on your policy as dependants as long as they fit the following criteria:

Child dependant – your child is under the age of 18 and single

Adult child dependant – your child is aged 18 and over and under 21 years and they're single and not working full-time

Student dependants – your child is aged 21 and over and under 25 and they're single, studying full-time and not working full-time

Adult dependants – your child is aged 18 and over and under 25 and they're single and not a full-time student. An additional premium applies to keep your child covered as an adult dependant and it is not available on all our cover types. Please call us on 134 246 for more information and a list of eligible policies. If your child has a partner then they will need to take out their own insurance cover.

Adding dependants to your policy

Any partners or dependants added to your policy will need to serve waiting periods unless they've previously held a comparable cover and join with no gap in their cover.

Newly born infants

To be eligible for benefits towards the hospitalisation of your newborn child you must have a family or single parent family policy.

So if you're having a baby and you have a single policy, you'll need to change to a single parent family or family policy at least 2 months before the baby's birth. This rule also applies to premature births.

If you wait until less than 2 months prior to birth or after the birth of your baby to change your cover, then your baby will have to serve all waiting periods.

If the baby is added to the policy more than 12 months after their birth date, waiting periods must be served.

A newborn won't be charged for accommodation for the first 10 days of life unless they're admitted to a special care nursery.

If there are multiple births, the first baby isn't charged for accommodation unless admitted as an inpatient. All other babies will be charged for accommodation so you need to ensure they are covered.

Your co-payment will apply for the mother and admitted babies up to the per person limit.



Changing your cover

We all make changes from time to time and that includes changing your health insurance. It's important to know when changing your level of cover you may be required to serve waiting periods for any additional services or lower co-payments or excesses that were not on your previous cover.

Where limits apply, any benefits already paid on your previous cover within the current benefit year will be taken into account.

Changing your cover may affect your eligibility or participation in an ahm health management program.

Transferring from another private health insurer

If you've transferred from another private health insurer, we'll recognise the waiting periods you've already served for comparable benefits.

In accepting a transfer from another private health insurer, we reserve the right to treat any benefits paid by the previous insurer in the current financial year as already being used under the limits of your new cover.

Suspending your policy

At ahm, we recognise that we all need to get away sometimes, so if you're travelling overseas for more than 30 days, you can suspend your policy (to a maximum of 2 years at any one time) without it affecting your loyalty. The period of suspension will still count towards the years of continuous cover.

To suspend your policy just send us a written or email request before your holiday with a copy of your official itinerary or e-ticket which includes the dates of travel. We'll get back to you before you leave to confirm the suspended period. We'll contact you on your return to confirm reinstatement of your policy and reactivating your premiums.

NOTE: You'll still need to serve any waiting periods you may have had before leaving the country and no benefits will be paid for services provided during the suspension period.

Suspending your policy may result in you being charged the Medicare Levy Surcharge. We suggest you speak to your accountant, tax agent or the Australian Taxation Office for further advice.

Overseas claims

Your hospital policy doesn't cover you for any medical, hospital or ambulance services received overseas or goods purchased outside of Australia, including online purchases from overseas companies.

As your hospital policy doesn't cover you for any medical, hospital or ambulance services while you're overseas we recommend you call us so that we can help you arrange travel insurance at discounted rates. Without adequate travel insurance you could find yourself paying a lot of money if you're hospitalised or need to visit a doctor overseas.

How to pay

We offer a number of convenient options to make sure you're covered when you most need it. All you need to do is pick the one that's right for you.



Direct debit – We think this is the easiest way to pay, and our members must think so too because this is our most popular payment method. There's no need to think about when your premium is due because we'll just withdraw the premiums from your nominated bank account or credit card at a frequency chosen by you. Simply call us on 134 246 to set this up or download a Payment Form from our website ahm.com.au.



BPAY – You can pay any time of day, over the phone or online if you're registered for phone or internet banking with your financial institution. Simply use the biller code 57430 and your membership number as the customer reference number.



Online – One off payments can be made using your Visa or MasterCard credit card. Just log in to the members' section and select 'Make a payment'.



Phone – You can pay your premiums by Visa or MasterCard credit card over the phone on 134 246.



Mail – Cheques can be sent to: ahm, Locked Bag 1006, Matraville NSW 2036. Please ensure your name and membership number is clearly printed on the back of the cheque.



Over the counter – We accept Visa and MasterCard credit cards, EFTPOS, cheques and cash over the counter at our head office: 77 Market St, Wollongong NSW.

Our fund rules require that all members who pay their premiums by direct debit, cheque, cash or by BPAY must pay their premium at least one premium frequency in advance at all times.

If you pay by group payroll deductions, you must be paid up to the same date as your group.

Payments in advance

You can pay your premiums up to a maximum of 12 months in advance of the date you make the payment even if you're already paid in advance.



Important information you need to know

Accidents

An accident is defined as an unplanned or unforeseen event resulting in bodily injury that requires immediate medical treatment in a hospital.

We understand that accidents do happen, so if you recently joined ahm and are still serving your waiting period you should call us to discuss whether your benefits apply.

Agreed charge

To help you know your costs and benefits up front, ahm has contracts with most private hospitals which include an agreement on how much they can charge.

Ambulance transportation

You're covered for medically necessary ambulance transport and services including air ambulance such as CareFlight, to the nearest hospital that's able to provide the level of care you need. Some state governments however, have their own schemes in place, so if you live in NSW, ACT, Queensland or Tasmania, please take note of the following.

If you live in NSW or ACT your cover includes a levy to the ambulance service. Pensioners are exempt from this levy – so if you hold a pension or health care card, you're entitled to a lower premium. Just send us a copy of your card and we'll reduce your premiums from the date we receive the copy.

If you live in Tasmania or Queensland you're already covered by your state's scheme. However we do cover the costs for any interstate ambulance transport if not covered by the state scheme.

NOTE: Co-payments don't apply to ambulance transportation and we don't pay benefits towards ambulance subscriptions.

Claims

Claims are only payable if:

- the service is performed by an ahm recognised provider
- the service date on the receipt is less than two years old
- an original receipt or invoice is submitted to and kept by ahm
- your claim is not payable or subsidised by a third party such as workers compensation unless an authority has been completed
- your policy is financial on the date of service.

Default (minimum) benefit

We'll pay a default (minimum) benefit as set by the Federal Government for restricted services. The default benefit covers the cost of:

Accommodation

- shared accommodation at a public hospital; or
- a reduced level of accommodation benefits (including special care) in a private hospital.

Medical Gap

- if your doctor participates in our GapCover scheme and charges the agreed fee, we'll cover the difference between the Schedule Fee and the agreed fee;
- the difference between Medicare benefits and the Schedule fee for inpatient services.

Surgically implanted prostheses

- we'll cover the cost of any No Gap prostheses and the minimum benefit for Gap permitted prostheses.

Theatre fees and intensive care accommodation

- no benefits are payable in a private hospital.
- For services not covered or not paid by Medicare, we'll only pay the default benefit on accommodation.

NOTE: Any co-payment applicable to your cover will be charged even where only a default benefit is paid.

Disease management appliances

Proof of the diagnosis of your condition and the recommendation for a relevant appliance by a medical practitioner must accompany a claim to receive benefits. The following forms of proof are accepted:

- a doctor's or specialist's letter relating to management of the condition;
- a doctor's referral to a specialist for the management of the condition;
- prescription for an appliance relevant to the condition;
- if you're currently enrolled in an ahm disease prevention or chronic disease management program relevant to the condition.

Emergency hospital admission

No matter how sudden or unexpected your hospital admission, if we have not had time under the Pre-existing condition rules to determine if you are affected by these rules, you may still have to pay for some or all of the hospital and medical charges related to your hospital admission.

Health insurance policy

Acceptance of a policy application and continued eligibility for health insurance is conditional on the requirement that no person on the policy also has an active hospital cover with another private health insurer.

Inpatient

An inpatient is someone who is:

- admitted to a hospital; and
- allocated a bed; and
- treated or uses the hospital's facilities and is then discharged following treatment.

Medicare eligibility

If you have a blue interim, yellow reciprocal or no Medicare card, some of the benefits outlined in this policy document may not be available to you.

In particular, because you may not be eligible for benefits paid under the MBS you may incur significant out-of-pocket expenses if you're admitted to any hospital as a private patient.

If you have limited access to Medicare, we strongly recommend that you only purchase this cover in conjunction with an Overseas Visitors Health Cover policy, which is more suitable to your needs.

Many private health insurers offer Overseas Visitors Cover. For more details on who provides this cover:

- Visit health.gov.au and search for "overseas visitors health cover"
- Freecall 1800 020 103.

Medicare Levy Surcharge (MLS)

The Medicare Levy Surcharge is an additional 1% surcharge of taxable income imposed on high income earners, who are eligible for Medicare but who don't have an applicable hospital policy with a registered private health insurer. The MLS is in addition to the normal 1.5% Medicare levy.

You can call the Australian Taxation Office for more information on 132 861.

Membership year

Means the annual period commencing on the date that the member or dependant joins a policy with ahm or changes to a new policy covering hospital treatment and renews every year on that date.

Nursing home patients

We don't pay benefits for patients of nursing homes, aged care facilities or for associated respite care.

Nursing home type patients (NHTP)

The Government has set specific benefits for persons who are admitted to hospital for more than 35 days when not for an acute reason.

Patient co-payments apply and will be charged directly by the hospital.

Obstetrics

Obstetrics is the term used for services or treatment relating to pregnancy and delivery of a baby.

A twelve month waiting period has to be served before applicable benefits can be claimed on your level of hospital cover. This also applies to premature birth and whether you're pregnant or not at the time of joining the policy or changing your cover.

NOTE: Essential Hospital only pays the default (minimum) benefit for obstetrics.

Outpatient services

Medicare covers 85% of the MBS fee when you receive medical services outside hospital, such as visits in a specialist's room, or in an accident and emergency room, or as a non-admitted patient in a hospital.

Health insurance benefits don't apply to public hospital accident and emergency department fees or outpatient medical services when Medicare pays 85% of the benefit and where the service provider doesn't have an agreement with ahm.

Palliative care

Palliative care is a type of health care that provides support to people with a life-limiting illness. Palliative care aims to comfort, not to cure; to relieve pain and distress for people who are dying, and to support parents, families and friends in approaching death and dealing with grief.

Pharmaceutical Benefits Scheme (PBS)

The PBS is the national pharmaceutical benefits scheme funded by the Federal Government where patients pay a set amount towards the cost of a subsidised drug. We'll pay the PBS amount if you're an inpatient and the drug is relevant to your treatment.

The PBS is only available to persons with Medicare eligibility.

Policy in arrears (unfinancial)

Benefits are not payable for services provided during the period in which a policy is in arrears until the premium is fully paid and accepted by ahm. ahm fund rules require members to be at least one premium payment frequency in advance.

ahm has the right to refuse to accept premiums if more than two months have elapsed since the financial date of the policy.

NOTE: If a member is more than two months in arrears then the policy will be terminated by notice in writing from ahm to the principal member, effective from the last financial date of the policy.

Policy termination

Only the principal member and ahm have the right to terminate a policy. Notice of termination must be given in writing, effective from the date specified in the notice (being a date no earlier than the date of the notice).

You're entitled to a refund of any premiums paid in advance of the date of termination.

Any member or dependant over the age of 16 covered by a policy can terminate their own individual cover by giving notice in writing to ahm, effective from the date specified in the notice (being a date no earlier than the date of the notice) but can't terminate the policy.

Cooling off period – If the principal member terminates their policy within 30 days of joining and hasn't claimed a benefit during this period, they're entitled to a full refund.

Private Patients' Hospital Charter

The Federal Government has produced a Private Patients' Hospital Charter to inform health insurance members of their rights. You can view the charter online or download a copy from health.gov.au

Prostheses

This term refers to surgically implanted items such as stents (for coronary arteries), grommets, artificial hips and knees, or titanium plates and screws (used in reconstructions or bone breaks).

The majority of prostheses listed on the Government's Prostheses List are No Gap prostheses. These are fully covered by ahm and there's at least one clinically appropriate No Gap prosthesis for any procedure required.

Federal legislation allows for a Prostheses Gap payment for a small number of prostheses. These prostheses are referred to as Gap Permitted prostheses and aren't fully covered. This means if there is a gap, you'll have to pay it.

If you need a prosthesis, please discuss the choices with your doctor prior to giving your doctor consent. This will allow you to make a fully informed decision about the cost of your treatment.

If you choose a Gap Permitted prosthesis that costs more than the minimum benefit, you'll have to pay the difference between the minimum benefit and the prosthesis charge.

Recognised providers

It's important for ahm to recognise service providers so that you receive quality health care from the providers you choose.

Recognising a provider means we get specific details and credentials from them to make sure they meet legislative and ahm criteria for benefit payment. All service providers must be recognised by ahm before we can pay benefits. Recognition of a provider means that ahm may check with the provider on the goods or services supplied to any person on a policy to ensure that appropriate claims and benefits are being paid.

Benefits won't be paid for services performed or goods supplied by unrecognised practitioners or by a provider on themselves, their partner or dependants, business partners or business partners' partner or dependants.

Call 134 246 to find out if your service provider is recognised by ahm or use ahm's online provider search tool at ahm.com.au

Services not covered by Medicare

If you go into hospital to have a procedure that isn't covered by Medicare then you'll be paying a lot more. We'll only pay benefits if Medicare considers the procedure to be medically necessary and pays a benefit for the doctor (unless specified otherwise). To make a claim, we need a Medicare statement that informs us of their payment.

If Medicare doesn't pay a benefit we'll pay the default (minimum) benefit for your accommodation only and no benefit for theatre or intensive care fees.

Here are some examples of procedures that Medicare don't pay benefits for and where we only pay the default benefit for your accommodation:

- breast enlargement (except following a mastectomy, as this is covered by Medicare);
- laser eye surgery to remove the need for glasses;
- blepharoplasty (eyelid reduction); and
- dermabrasion (abrasive therapy, chemical face peels).

Where a Medicare benefit is not paid due to the patient having restricted or no Medicare cover, the default (minimum) benefit only will be paid.

Standard Information Statements

A Standard Information Statement (SIS) is an overview of key benefits and product features of your policy. We send you a copy of your SIS at least once every 12 months and sometimes at other times as we are required to.

You should review the SIS in conjunction with your cover's policy document to provide a full overview of the benefits available to you.

If you'd like a copy of your SIS, you can download a copy from privatehealth.gov.au or call us on 134 246.

Feedback

At ahm Health Insurance, we work hard to make sure you always get the best service when you need it and we welcome your feedback.

Whether you're making a suggestion, paying a compliment or making a complaint, your feedback is important to us.

If you have a suggestion about how ahm can improve our products or service, please let us know. If you're ever unhappy about something we've done - or perhaps not done - please give us the opportunity to put things right.

We use your de-identified feedback for training and coaching purposes so that we can improve our products and services.

Online: Use the contact us form – choose your subject at the top of the form

Phone: Call our friendly staff in the Member Service Centre on 134 246

Email: feedback@ahm.com.au

Mail: ahm member feedback
Locked Bag 1006
Matraville NSW 2036

Fax: 1300 329 246

Complaints

If you have a complaint related to your policy, please let us know straight away so that we can work to resolve matters as soon as possible.

Where possible, we'll resolve your issue on the spot. However, if we're unable to resolve your issue immediately, we'll refer it to our Customer Advocacy Team who'll undertake a detailed investigation.

Customer Advocacy Team

Our Customer Advocacy Team will aim to find a solution for you by investigating your complaint and then letting you know the result. They will:

- investigate the issue
- keep you informed
- aim to resolve the issue within 21 days

To help us in this process, please provide as much information as possible about the nature of your complaint. Please include your name, and membership number (if applicable), on all correspondence.

What if I'm not satisfied?

If you're not satisfied with the steps taken by ahm to resolve your complaint or with the result of our investigation, you can request a review of your complaint by the Private Health Insurance Ombudsman.

Private Health Insurance Ombudsman

We will do our best to resolve the issue to your satisfaction. If you're unhappy with the result, you can contact the Private Health Insurance Ombudsman (PHIO) for free independent advice.

Phone: 1800 640 695

Email: Info@phio.org.au

Address: Suite 2, Level 22
580 George Street
Sydney NSW 2000

Web site: phio.org.au

ahm privacy policy

Your privacy is important to us

Australian Health Management Group Pty Limited (ahm) is subject to the Privacy Act 1988 and complies with the principles for handling your personal information.

You can contact us anonymously. However, if you choose not to be identified, we are very limited in our ability to insure you, pay claims or offer you services.

Your privacy and personal information is important to us and we will do each of the following:

- only collect, use and disclose personal information about you that is required in the provision of information about or the promotion or delivery of our products and services to you; administration of ahm's business; business analysis; or to meet any legal obligations imposed on ahm (Purpose).
- only disclose your personal information to third parties for a Purpose and with whom we have entered into an agreement that gives you (or that the law requires to give you) at least the same level of protection to your personal information as we do.
- only use de-identified information for any statistical or other analysis or similar research purposes.
- only disclose your information to a third party in connection with a product or service offered by that third party with your prior consent.
- only transfer your personal information outside Australia or health information outside New South Wales if it is in accordance with the law and is necessary for any of the following:
 - to prove your cover with another private health insurer and to confirm waiting periods have been served.
 - to investigate claims.
 - for the administration or delivery of health insurance, health management programs, dental services and related products and services.
- use only fair and lawful ways to collect personal information. Sometimes we may need to collect sensitive information from third parties such as doctors or hospitals so we can assess risks or process claims. We may also need to ask for it from another private health insurer, if you are looking

to transfer your policy. We may contact a service provider who has treated you in the past, if the information is likely to be relevant to your current treatment.

- collect personal information directly from you if it is reasonable and practicable to do so.
- allow the principal member (the person who is responsible for paying the premium) to have complete information on all aspects of the policy, including benefits claimed under the policy. This may include disclosing your sensitive information. This is required under our contract with the principal member. We send all communications on policies that cover more than one person to the address supplied by the principal member.
- take reasonable steps to ensure the personal information that ahm collects, uses or discloses is accurate, complete and up-to-date. If you need to update your contact details, please let us know.
- take reasonable steps to protect your personal information from misuse, loss and unauthorised access, modification or disclosure.
- take reasonable steps to destroy or permanently de-identify personal information if we no longer need it for any purpose.
- on request, we will give you access to the personal information we hold about you. If any personal information we hold about you is out of date or inaccurate, we encourage you to let us know, and ask us to correct it. If we cannot deal with your request, you will receive our reasons in writing.

If you want to complain about an interference with your privacy by ahm, you can visit an ahm office, call 134 246, write to Locked Bag 1006, Matraville, NSW 2036 or email info@ahm.com.au. We will do our best to resolve your complaint as quickly as possible.

If you are not satisfied with our response to your complaint, you can refer the matter to the Federal Privacy Commissioner.

Director of Complaints

Office of the Federal Privacy Commissioner
GPO Box 5218, Sydney NSW 1042
Telephone: 1300 363 992

Notes:

Notes:

All enquiries: 134 246

Customer service centre hours:

Monday to Friday
8.00am – 6.00pm (Eastern Standard Time)

Fax: 1300 329 246

Web: ahm.com.au

Email: info@ahm.com.au

Postal Address:

ahm, Locked Bag 1006, Matraville NSW 2036



**Find us
on Facebook**

facebook.com/ahm.health.insurance

The information contained in this document was accurate at the time of publication.

ahm reserves the right to vary its premiums and benefits during the year, with premiums being subject to approval by the Minister for Health and Ageing. Members who pay premiums in advance won't be exempt from such changes. This means that changes to benefits or premiums may take effect during your payment period, prior to the date that your policy is financial.

