

Hospital Cover Level 5 & Ancillary Cover

Information about your policy



▶ **Effective 1 July 2011**

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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.

If you have **Hospital Cover Level 5**, a co-payment will apply 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.

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 your hospital cover

What you're covered for

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.

- ✓ Medical gap
 - the difference between Medicare Benefits and the Schedule fee for inpatient services
 - if your doctor participates in our Access Gap Cover scheme and charges the agreed fee, we'll cover the difference between the Medicare Benefits Schedule fee and the agreed amount.
- ✓ Accommodation* – private or shared room
- ✓ Operating theatre*
- ✓ Intensive care*
- ✓ Obstetrics
- ✓ Labour ward
- ✓ Fertility treatments – eg. IVF and GIFT programs (inpatient services only)
- ✓ Hip and knee joint replacements
- ✓ Major eye surgery
- ✓ Dialysis
- ✓ Psychiatric services
- ✓ Rehabilitation
- ✓ Palliative care
- ✓ Cardio-thoracic procedures, including open heart and bypass surgery and invasive cardiac procedures such as angiograms
- ✓ Surgically implanted prostheses – we'll cover the cost of any No Gap prostheses, and the minimum benefit for Gap Permitted prostheses
- ✓ Ambulance transport

* 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 13)

Restricted services

We pay the default (minimum) benefit only for restricted services and services not covered by Medicare. Restricted services include:

- ✗ 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

There are **no exclusions** on Hospital Cover and Ancillary Cover or Hospital Cover Level 5 and Ancillary Cover.

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 must have regard to any information in relation to the ailment, illness or condition that the Medical Practitioner who treated the ailment, illness or condition provides or that ahm provides.

What you're covered for

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	<ul style="list-style-type: none">• Hospital treatment as a result of an accident• Ambulance
2 months	<ul style="list-style-type: none">• Hospital treatment (where there's no pre-existing conditions)• Rehabilitation, psychiatric and palliative care (regardless of whether pre-existing)
12 months	<ul style="list-style-type: none">• Pre-existing conditions• Obstetrics, pregnancy and birth related conditions in a public or private hospital• Speech processor and insulin pump replacements

What isn't covered

- ✗ Charges above the Schedule fee (unless your doctor agrees to participate in our Access Gap Cover scheme)
- ✗ Charges above the Access Gap Cover scheme agreed fee
- ✗ Charges above the minimum benefit for Gap Permitted prostheses
- ✗ Private room accommodation for restricted services
- ✗ Operating theatre charges for restricted services
- ✗ Personal items including STD phone calls, faxes and newspapers
- ✗ Take home bandages and dressings
- ✗ Any medication that you take home or that wasn't related to your hospitalisation
- ✗ 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
- ✗ 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 13)
- ✗ Charges for medical services where Medicare doesn't pay a benefit (eg. for a person without a Medicare entitlement or restricted entitlement)

Going to hospital

Not everyone needs to go to hospital but if you do, we can help you prepare for your hospitalisation by providing you with the information you need to know.

Before going to hospital

Make sure your policy is paid in advance so that you know you're covered for the treatment you'll be having. Benefits paid will be determined by your choice of doctors, where you're being treated and the treatment you'll be receiving.

Check your cover!	<p>Less than 12 months' cover</p> <ul style="list-style-type: none">• A 12 month waiting period has to be served before obstetrics or pregnancy related benefits appropriate to your level of hospital cover apply. This also applies to premature birth and whether you're pregnant or not at the time of joining ahm or changing your cover.• Make sure you understand what pre-existing conditions are and confirm that your waiting periods have been served. You should call us to ensure you'll be covered for your treatment. <p>More than 12 months' cover</p> <ul style="list-style-type: none">• You should have already served your waiting periods but it's a good idea to call us to get more information and check on your level of cover. <p>BLUE interim, YELLOW reciprocal or no Medicare card</p> <ul style="list-style-type: none">• 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 14). Please call us to check your cover before going to hospital.
Where will you be treated?	<p>Day only surgery</p> <ul style="list-style-type: none">• If you have chosen a co-payment on your policy, it will apply in a day only surgery. <p>Private hospital</p> <ul style="list-style-type: none">• Check our list of partner hospitals by calling us or visit our website ahm.com.au• Sometimes day only surgery is performed in a private hospital.• If you've chosen a co-payment on your policy, it will apply in a private hospital. <p>Public hospital</p> <ul style="list-style-type: none">• You can ask to be treated as a public patient in a public hospital at no charge but you may have to go on a waiting list and you won't be able to have the doctor of your choice. The doctor is appointed by the hospital.• You can ask to be treated as a private patient with the doctor of your choice. Day only surgery is sometimes performed in a public hospital.• If you've chosen a co-payment on your policy, it will apply in a public hospital. <p>Non-agreement hospital</p> <ul style="list-style-type: none">• Some hospitals don't have a contract with ahm so if you're treated in a non-agreement hospital, you'll only receive the default (minimum) benefit (see page 13).• If you've chosen a co-payment on your policy, it will apply in a non-agreement hospital. <p>NOTE: Private cover in a public hospital</p> <p>If you choose to be treated as a private patient in a public hospital we'll cover the cost of accommodation in a private or shared room for all procedures except restricted services and those not paid by Medicare (in which case the accommodation benefit would be the equivalent of the Federal declared benefit for a shared room).</p>

Going to hospital

Before going to hospital continued...

What treatment are you having?	<p>It's important that you understand your treatment</p> <p>Informed Consent is your right to know exactly what is involved with your treatment. Make sure you ask for:</p> <ul style="list-style-type: none">• 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 about the doctor's charges?	<p>Ask your specialist if they can tell you who else will be involved in your treatment</p> <ul style="list-style-type: none">• Provide them with a copy of our Access Gap Cover scheme and 'Estimate of Medical Fees' form. You can call us for your copy or download a copy from our website ahm.com.au• Ask how much you will have to pay. 'Informed Financial Consent' is your right to know how much your treatment will cost and how much you will have to pay towards it.• You can access a doctor search facility on the ahm website at ahm.com.au which informs you of doctors who have previously participated or have indicated their intention to participate in Access Gap Cover, as well as those who've agreed to other no gap arrangements.

Going to hospital

Hospital admission

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 you need to be admitted, you can ask your doctor about choice of hospital but check with us to make sure it's a partner hospital.

If your doctor referred you to a specialist for treatment

- Ask your doctor to refer you to a specialist who participates in our Access Gap Cover scheme. You can check our website to find out which doctors in your area participate in the scheme.
- Make sure you give your doctor the 'Estimate of Medical Fees' form to fill in so you know your costs up front.

If you admitted yourself into the hospital

- The hospital will confirm your cover with us (or may do so prior to your admission).
- If you have a co-payment on your policy, the hospital usually requires you to pay it on the day of your admission. Make sure you have your credit card or money to pay this on the day.
- The hospital will also provide you with 'Informed Financial Consent'. 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.

Going to hospital

After hospitalisation

What about the doctor's bills?	<p>Your doctor/specialist participates in the Access Gap Cover scheme</p> <ul style="list-style-type: none">• They'll usually send the bill directly to us and then we pay the bill and send you a statement.• You can refer to your 'Estimate of Medical Fees' form for any differences you may have to pay. <p>Your doctor/specialist doesn't participate in the Access Gap Cover scheme</p> <ul style="list-style-type: none">• You'll have to pay any difference between the Medicare Benefits Schedule fee and the doctor's charge. This is called 'the gap'.• To make claiming easier for you, call us and we'll send you a 'Two Way Claim Form'. Then all you need to do is take the account to Medicare who'll then forward it to us.
What about the hospital charges?	<p>Your hospital cover means you are covered in full for agreed theatre and accommodation charges, except for restricted services as outlined on page 2 and not covered or paid by Medicare, unless specified (after your co-payment amount is paid – Hospital Cover Level 5) at:</p> <ul style="list-style-type: none">• all partner private hospitals; and• public hospitals. <p>The hospital will bill ahm directly and we'll send you a statement showing you the benefits we've paid.</p>
What about the prostheses charges?	<p>ahm covers you for all surgically implanted No Gap prostheses on the Government's Prostheses List</p> <p>We'll also cover the minimum benefit towards the prostheses charge for any Gap Permitted prostheses (after any applicable co-payment is paid).</p> <p>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.</p> <p>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.</p>
Insulin pump and speech processor replacements	<p>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.</p> <p>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 Federal 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.</p> <p>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.</p>

About Ancillary Cover

Ancillary Cover allows you to take charge of your wellbeing by paying benefits for services that help you lead a healthier lifestyle.

This section includes important information about your Ancillary Cover and lists your benefit entitlements. If you're unsure of anything, just call us on 134 246.

Here's a snapshot of the services this policy covers:

Dental

- General dental
- High cost dental
- Orthodontics

Optical

- Frames, lenses and contact lenses

Therapies

- Physiotherapy
- Chiropractic
- Psychology and hypnotherapy
- Speech therapy
- Podiatry
- Natural therapies

Pharmacy

- Pharmaceutical items
- Preventive treatments

Other benefits

- Dietary
- Hearing aids
- Orthotics/orthopaedic shoes

NOTE: Ancillary Cover is only available with Hospital Cover or Hospital Cover Level 5.

Waiting periods

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

The good news is that there are no 2 or 6 month waiting periods on any of ahm's extras covers so you'll be able to start claiming straight away on many benefits including routine dental, optical, physio, chiro and osteo and natural therapies including naturopathy and remedial massage.

If you change your cover and if your new level of cover has additional or higher benefits on services where waiting periods of 12 months or more apply, you will still have to serve these waiting periods.

12 months

- Major dentistry (crowns, bridges, implants, veneers, dentures and orthodontics)
- Specialist dental benefits provided by Periodontists, Oral Surgeons, Endodontists and Prosthodontists
- Orthotics
- Hearing aids

Ancillary benefits table

Your benefit

Ancillary benefits table		Your benefit
Natural Therapies		
Osteopath, naturopath, acupuncture, remedial massage, herbalist, rolling, alexander technique, kinesiology, orthoptist, reflexology, one-on-one pilates, homeopath, feldenkrais, bowen therapy and biochemist		100% up to \$45
	Combined Financial Year Limit per person	\$600
	Financial Year Limit per family	\$1,200
Physiotherapy and Associated Services		
Physiotherapy, occupational therapy, hand therapy, one-on-one hydrotherapy		100% up to \$45
	Combined Financial Year Limit per person	\$600
	Financial Year Limit per family	\$1,200
Chiropractic Services		
Chiropractic		100% up to \$40
Chiropractic x-rays		\$90
	Combined Financial Year Limit per person	\$500
	Financial Year Limit per family	\$1,000
Podiatry and Associated Services		
Podiatry, biomechanical assessment and cast		100% up to \$40
	Combined Financial Year Limit per person	\$400
	Financial Year Limit per family	\$800
Orthotics/Orthopaedic shoes (Purchased from a registered Podiatrist or Orthopaedic supplier only. Excludes sporthotics and formthotics)		100% up to \$200
	Combined Financial Year Limit per person	\$200
	Financial Year Limit per family	\$400
Pharmaceutical Items		
Pharmaceutical (Excludes PBS scripts, patented medicines, contraceptives and herbal medicines)		100% of balance above general patient PBS amount, up to \$50 per item prescribed
Preventive Treatments		
Nicobate patches, Hepatitis A/B injections, flu and travel vaccines		Up to \$30 per item
	Combined Financial Year Limit per person	\$650
	Financial Year Limit per family	\$1,300
Dietary		
Dietitian, nutritionist consultation		100% up to \$40
	Combined Financial Year Limit per person	\$300
	Financial Year Limit per family	\$600

Ancillary benefits table

Your benefit

Psychology and Hypnotherapy

(Provided by registered psychologists only)

Psychology

Hypnotherapy

Group psychology

Combined Financial Year Limit per person
Financial Year Limit per family

100% up to \$70
100% up to \$70
\$15 per person
\$400
\$800

Speech Therapy

Speech therapy

Combined Financial Year Limit per person
Financial Year Limit per family

100% up to \$50
\$300
\$600

Hearing Aids

Hearing aids

Hearing aid repair

Combined Financial Year Limit
(per person per 3 years)
Limit per family per 3 years

100% up to \$600
100% up to \$100
\$600
\$1,200

Optical

Single vision glasses, bifocal glasses, multi-focal glasses, contact lenses,
disposable contacts (prescription – sight correcting lenses only)

Combined Financial Year Limit per person
Financial Year Limit per family

100% up to \$300
\$300
\$600

Dental benefits table

Your benefit

These are examples of the most common benefits we pay for dental services and their item numbers. We pay benefits for more than we can include here so make sure you call us before you have any treatment to confirm the benefits you'll receive.

General Dentistry		80% of actual charge up to:
Diagnostic Procedures		
GP comprehensive examination or consultation (011) } GP recall examination or consultation (012) Single intra-oral x-ray (022) Panoramic x-ray (037)	combined 2 per person per financial year	\$28.80 \$28.00 \$21.60 \$44.80
Preventive Procedures		
Clean and polish (111) } Scale and clean (114) } Topical fluoride application (121) Custom-made mouthguard (151) Fissure sealing (161)	combined 3 per person per financial year 2 per person per financial year 2 per person per financial year	\$25.60 \$47.20 \$18.40 \$75.20 \$24.00
Oral Surgery		
GP simple extraction (311)		\$64.80
Endodontics (Root Canal Therapy)		
GP preparation of one root canal (415)		\$119.20
Restorative Services		
Metal filling (511/513)	1 surface/3 surfaces	\$56/\$83.20
Anterior (front) tooth coloured filling (521/523)	1 surface/3 surfaces	\$61.60/\$88
Posterior (back) tooth coloured filling (531/533)	1 surface/3 surfaces	\$65.60/\$101.60
GP occlusal splint (965)	1 per person per financial year	\$266.40
	Combined Financial Year Limit per person	\$800
	Financial Year Limit per family	\$1,600
High Cost Dentistry		60% of actual charge up to:
Periodontics		
Specialist root planing (per tooth) (2225)		\$8.40
Oral Surgery		
(Benefits vary according to the complexity of the procedure) Specialist surgical removal of a tooth (eg wisdom tooth) (3245)		\$178.50
Endodontics (Root Canal Therapy)		
Specialist preparation of one root canal (4155)		\$159.00
General Services		
Specialist occlusal splint (9655)	1 per person per financial year	\$267.00
Crowns/Bridges/Dentures		
Porcelain metal crown (615)		\$571.80
Full metal crown (618)		\$532.80
Bridge pontic (643)		\$471.00
Full upper or lower denture (711/712) Partial metal chrome upper or lower (727/728) }	1 upper and lower per person per 3 financial years	\$355.80 \$451.80
Orthodontic		
(Benefits vary dependent on item numbers) Specialist full upper and lower banding (831B)	Financial Year Limit per person	\$540*
Note: Orthodontic services performed by a general dentist attract a lower benefit	Combined Financial Year Limit per person	\$800
	Combined Financial Year Limit per family	\$1,600

Terms and definitions

Trying to understand health, medical and insurance terminology can be quite frustrating, so to help you understand these terms, we've included the following explanations. If you still need a helping hand, just call us.

Accidents

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.

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

Access Gap Cover scheme

In most cases, your health insurance will cover the majority of your costs but you may face extra expense if your specialist or doctor charges above the Medicare Benefits Schedule (MBS) fee for their services.

The Access Gap Cover scheme helps remove or reduce these costs so that you pay less for your specialist treatment in hospital, or pay nothing at all.

If your doctor participates in the scheme

1. Ask your doctor to fill in an 'Estimate of Medical Fees' form so that you can see upfront exactly how much you'll have to pay before your treatment begins. (You can download a copy from our website or call us to have one sent out to you). This estimate enables you to make a fully informed decision about the cost of your treatment prior to giving consent to your doctor. This is called 'Informed Financial Consent'.
2. We'll pay up to the Access Gap Cover Schedule fee.
3. Doctors usually send the bills directly to us and we send you a statement detailing how much we've paid. Some doctors may bill you direct.

How it works

Medicare Benefits Schedule fee		Above MBS	Above Access Gap Cover Schedule fee
Medicare pays 75%	Your health insurer pays 25%	Your health insurer pays up to the agreed Access Gap Cover Schedule fee	Patient pays the balance

Important to know

To ensure the Access Gap Cover scheme maintains some control over costs, a cap of \$400 per item above the Access Gap Cover fee has been put into place. If you're quoted a charge in excess of this amount, then the Access Gap Cover scheme can't be used and you'll have to pay the amount between the MBS fee and the doctor's charge. Obstetricians may charge a gap of up to \$800 for prenatal care and delivery.

If your doctor/s decline to participate in the scheme:

- you should still give your doctor the 'Estimate of Medical Fees' form and ask for 'Informed Financial Consent', prior to your treatment
- we'll only be able to 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.

Medicare Benefits Schedule fee		Above MBS
Medicare pays 75%	Your health insurer pays 25%	Patient pays the balance

You can access a doctor search facility on the ahm website at ahm.com.au

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.

Terms and definitions

Broken appointments

ahm doesn't pay benefits towards broken appointments, so if you've been charged for not attending or cancelling an appointment, you won't be able to claim for it.

Consultations

You're able to claim for one face to face consultation with a provider on a given day. This means that if you have two or more consultations with the same provider on the same day, even if they're for different types of services, you'll only be able to claim for one.

Telephone or video consultations are not eligible for benefits except where approved by ahm.

Co-payments

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?

Level	What you pay	Limits per membership year
Hospital Cover	No co-payment	Does not apply
Hospital Cover Level 5	\$250 for same day or 1 night stay per person or \$500 for two or more nights stay per person	\$500 per person \$1,000 per family

If you reduce your co-payment amount, for example, Level 5 to no co-payment, you've changed your cover and will have to serve normal waiting periods for no co-payment to apply.

Day only admission

This is when you're admitted to a hospital and discharged on the same day. If you've chosen a co-payment on your cover, you'll need to pay your co-payment in this situation.

Day only surgery

This is a facility where you're admitted, treated and discharged on the same day. If you've chosen a co-payment on your cover, you'll need to pay your co-payment in this situation.

Default (minimum) benefit

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

- shared accommodation at a public hospital; or
- a reduced level of accommodation benefits and no theatre fee benefits in a private hospital; plus
- medical gap
 - if your doctor participates in our Access Gap Cover scheme and charges the agreed fee, we'll cover the difference to the agreed amount;
 - the difference between Medicare benefits and the Schedule fee for inpatient services; and
- surgically implanted prostheses – we'll cover the cost of any No Gap prostheses and the minimum benefit for Gap Permitted prostheses.

For services not covered or not paid by Medicare, the default benefit for accommodation only is payable. Any co-payment applicable to your cover will be charged even where a default benefit only is paid.

Dentistry - high cost

High cost dentistry includes all crown and bridgework, implants, veneers, dentures and orthodontics regardless of who performs the work.

Orthodontics – We'll pay benefits for orthodontic services by a General Practitioner (GP) or specialist dentist provided claims are accompanied by a detailed treatment plan.

Dependants

Child dependants – Your child can be covered by a family or a single parent family policy until the age of 18 if they're single.

Adult child dependants – Your child aged 18 and over and under 21 years can be covered on a family or a single parent family policy if they're single and not working full-time.

Student dependants – Your child aged 21 and over and under 25 can be covered on a family or a single parent family policy if they're single, studying full-time and not working full-time.

NOTE: If your dependants have a partner they should have their own health insurance policy.

Exclusions

We pay no benefits for excluded services. There are no excluded services on Hospital Cover and Ancillary Cover or Hospital Cover Level 5 and Ancillary Cover.

Terms and definitions

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 or ancillary cover with another private health insurer.

Single policy – a policy that includes only one person (the principal member).

Single parent policy – a policy that includes two or more persons, of whom only one is an 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.

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 Benefits Schedule (MBS)

The Medicare Benefits Schedule is a list of medical services provided by doctors. The Federal Government established the national Medicare scheme to pay benefits for these services. Medicare pays 75% of the MBS fee for inpatient hospital related medical services and health insurers pay the remaining 25%. A doctor can charge more than the MBS fee.

Medical gap

The medical gap is the difference between what Medicare pays, the MBS fee and the fee your doctor charges. Health insurers pay the gap up to the MBS fee for inpatient hospital related medical services. Charges above the MBS fee are usually paid by the patient. The Access Gap Cover scheme 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.

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 Federal Medicare Benefits scheme 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.

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 two months before the baby's birth. This rule also applies to premature births.

If you wait until after the birth of your baby to change your cover, then your baby will have to serve all waiting periods.

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.

If you've chosen a co-payment on your policy, it will apply for the mother and admitted babies up to the per person limit.

Non-agreement hospitals

Agreements with hospitals are based on agreed charges and quality of care. In some instances, we haven't been able to reach an agreement with a private hospital, or the hospital has defaulted on their existing agreement. These hospitals are referred to as non-agreement hospitals and will only be paid the default (minimum) benefit. The default (minimum) benefit for accommodation is prescribed in the Private Health Insurance Act.

If you elect to use the services of a non-agreement hospital, you may be significantly out-of-pocket. We recommend you call us before being treated to clarify your exact benefit entitlements. We can't guarantee what you might have to pay.

Nursing home patients

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

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 benefits appropriate to your level of hospital cover apply. This also applies to premature birth and whether you're pregnant or not at the time of joining the policy or changing your cover.

Terms and definitions

Orthotics and orthopaedic footwear

We'll pay benefits for orthotics and orthopaedic footwear only if custom made and supplied by a recognised podiatrist or orthopaedic footwear supplier. Make sure you include a referral from a recognised provider with your claim.

ahm accepts referrals from recognised physiotherapists and chiropractors for orthotic devices.

NOTE: We don't pay benefits for prefabricated orthotics including sporthotics or formthotics.

Outpatient services

Medicare will only cover 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 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.

Partner

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.

Private hospitals and day surgeries

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 as outlined in your policy.

This doesn't include restricted services. If you have a co-payment with your policy, you need to pay this first.

Pharmaceutical Benefits Scheme (PBS)

The PBS is the national pharmaceutical benefits scheme funded by the Commonwealth 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.

Pharmacy

We'll pay benefits on pharmacy items that are:

- prescription only and prescribed by a medical practitioner; and
- essential to treat a particular illness or injury.

A co-payment equal to the PBS general patient amount will be deducted from each eligible pharmacy item.

Items available without a prescription including over the counter, off the shelf, herbal medicines and vitamins can't be claimed.

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.

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 (less any applicable co-payment) and there's at least one clinically appropriate No Gap prosthesis for any procedure you may require.

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

At ahm, we're required to ensure that our members receive quality services from recognised providers.

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 registered with 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

Restricted services

We pay the default (minimum) benefit only (see definition on page 13) for accommodation for restricted services and services not covered or paid by Medicare.

Hospital Cover and Hospital Cover Level 5 have restricted services as outlined on page 2.

Important information about your health insurance policy

Change of cover

When changing your level of cover, you may be required to serve waiting periods for any additional items, increased benefits 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.

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.

Limits

Most ancillary benefits will have a limit which is a maximum amount you can claim in a specified period of time (see Claiming periods below). Limits are outlined in the benefits table of this policy and are per financial year unless otherwise stated. You can check your benefit limits online at any time.

NOTE: Limits not used in a claiming period don't roll over to the next claiming period.

Claiming periods

Financial year – 1 July to 30 June. Your ancillary benefit entitlements are renewed at the beginning of each financial year.

Limit types

Per person limits – Where applicable, each person on a policy can claim up to the 'per person' limit for the claiming period except where the family limit has already been used by other members on the policy.

Family limit – Benefits are payable up to the family limit indicated in the benefits table for the claiming period. Per person limits also apply.

Online and telephone claiming

There's a \$500 limit on ancillary claims made online or over the phone and you can only claim for paid extras and general dental services, not medical gap or high cost dentistry.

If you reach the \$500 limit, you can't make any more claims online or over the phone until we have received your receipts.

Once we have your receipts, and verified the claims, you can claim up to \$500 again.

Overseas claims

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

If you're travelling overseas, 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 overseas.

NOTE: If you're planning to be out of the country for more than 30 days, you can suspend your policy for the time you're away up to a maximum of 2 years at any one time (see Policy suspension below). However, by doing this, you could be subject to the Medicare Levy Surcharge (MLS).

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

ahm fund rules require members to be at least one premium payment frequency in advance.

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 suspension

If you're travelling overseas for more than 30 days, you can suspend your policy up to a maximum of 2 years at any one time.

To suspend your policy just send us a written or email request before your holiday with 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 payments.

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 (see Medicare Levy Surcharge, page 14). Consult your accountant, tax agent or the Australian Taxation Office for further advice.

Important information about your health insurance 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.

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 benefit for your accommodation only and no benefit for theatre 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);
- liposuction (in some cases); 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.

Transferring from another private health insurer

If you've transferred from another private health insurer, we'll acknowledge 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 benefit year as already being used under the limits of your new cover.

Standard Information Statements

A Standard Information Statement (SIS) is a general guide to key benefits and product features of your policy. We send you a copy of your SIS at least once every 12 months when we advise you of changes to your policy and premiums and also whenever there is a detrimental change to a benefit that is listed on the document. 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.

Payment methods

How to pay for your cover

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

- **DIRECT DEBIT** – This is our most popular payment method because you don't have to think about when your insurance is due. We'll draw your premiums at a frequency you choose from your nominated account or credit card. Simply call us on 134 246 to set this up or download a Payment Form from our website.
- **BPAY** – Pay any time of day, over the phone or online. If you're registered for phone or internet banking with your financial institution, pay your premiums using the biller code 57430 and your membership number as the customer reference number.
- **PHONE payments** – You can pay your premiums by Visa or MasterCard credit card over the phone on 134 246 or use the BPAY option.
- **By 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.
- **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'.
- **Over the COUNTER** – We accept Visa or MasterCard credit cards, cheques and cash over the counter at our head office: 77 Market Street Wollongong NSW.

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

Payments by Group Payroll Deductions must be paid 'in line' (ie to the same date) with their group.

Payments in advance

Paying in advance: You can pay your premiums to a maximum of 12 months in advance. This applies from the date you make a payment (not the date your premiums are currently paid to). If your premiums are already in advance, ahm will accept further payments to pay your membership up to 12 months in advance from the day you paid.

Using ahm's online services

You'll find information around healthy living, dental and eyecare health, regular health updates to keep you in the know, online services so you can make online extras claims, check your benefit limits, change your level of cover and view or update your personal details. You can also register for our e-newsletter, search for a Doctor or Hospital and access our health information, recipes and more. You will need your membership number to log in to the members' section.

Feedback and complaints

Feedback

At ahm, 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 provides a valuable contribution to our business.

If you have a suggestion about how ahm can improve our service or products, please let us know so that we can address it as soon as possible.

You can contact us in the following ways:

Phone: 134 246

Fax: 1300 329 246

Email: feedback@ahm.com.au

Mail: ahm member feedback,
Locked Bag 1006,
Matraville NSW 2036

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.

If we're unable to resolve your complaint immediately, we'll investigate the matter and aim to resolve it within 21 days.

Most issues can be addressed at the first point of contact. If it takes longer, it will be referred to our Customer Advocacy Team for follow up.

Customer Advocacy Team

Our Customer Advocacy Team will aim to find a solution for you by investigating your complaint and then advising you of the outcome.

- Your complaint will be acknowledged.
- You'll be kept informed of the progress of our investigation.
- We'll 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 and also how you would like it resolved. Please include your name, and membership number (if applicable), on all correspondence. Telephone conversations with ahm may be recorded and used for resolving disputes and monitoring of service standards.

Not happy with the outcome?

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

If you have a complaint about any private health insurer, the Private Health Insurance Ombudsman can be contacted for free independent advice as follows:

Address: Level 7, 362 Kent Street, Sydney NSW 2000

Email: Info@phio.org.au

website: phio.org.au

Phone: 1800 640 695

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

Contacting us

All enquiries: 134 246

Call 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

The information contained in this document was accurate at the time of publication. All information is subject to the rules of ahm, and premiums and claims will be accepted and paid in accordance with these rules.

ahm reserves the right to vary its premiums and benefits during the year, with premiums being subject to approval by the Minister of 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.