

TOP HOSPITAL

TOP HOSPITAL LEVEL 5

TOP HOSPITAL LEVEL 8

1 April 2009



Contents

About your cover	2
• What you're covered for	2
• Where you're covered.....	2
• Pre-existing conditions.....	2
• Waiting periods	3
• What isn't covered.....	3
Going to hospital	4
Looking after your broader health	8
Terms and definitions.....	12
Important information about your health insurance policy	17
ahm privacy policy.....	19

About Top 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.

ahm's hospital covers give 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
- Health management programs
- Chronic disease management programs
- Hospital substitute services

If you have **Top Hospital Level 5 or Level 8**, a co-payment will apply when admitted to a hospital or day surgery.

There are no exclusions or extended waiting periods.

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 (the 'tick of approval'). 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 Member Services Officers on 134 246 or go to www.ahm.com.au



Printed on FSC certified paper

About your 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)

- ✓ Midwife assisted home births

- ✓ Male and female sterility reversals

- ✓ Hip and knee joint replacements

- ✓ Major eye surgery

- ✓ 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

- ✓ Travel and accommodation related to a hospitalisation (see page 11)

- ✓ Disease prevention, health management, chronic disease management and hospital substitute programs

* 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 benefit only (see Default benefit definition, page 13)

Restricted services

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

- ✗ Podiatric surgery

- ✗ Cosmetic surgery where not considered medically necessary

- ✗ Services not covered by Medicare unless otherwise specified

- ✗ Services where Medicare do not pay a benefit (eg. where patient is not Medicare eligible)

Exclusions

There are **no exclusions** on any of ahm's hospital covers.

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.

About your cover

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 • Disease prevention programs • Chronic disease management programs • Travel and accommodation
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) • Doctor health checks and Healthy Heart checks • Hospital substitute services (except obstetric related or if a pre-existing condition)
12 months	<ul style="list-style-type: none"> • Pre-existing conditions • Obstetrics, pregnancy and birth related conditions in a public or private hospital • Disease management appliances • Pregnancy Support program • Hospital substitute services that are obstetric related or if a pre-existing condition • Midwife delivery services

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 do not 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.

Your ahm policy also provides benefits for support services in the home, so if your situation allows, you may be able to get out of hospital early to recover in your own home or avoid a hospitalisation altogether.

See 'Looking after your broader health' (page 8) for information about these services and the programs available.

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 (subject to any waiver that may apply). <p>Private hospital</p> <ul style="list-style-type: none">• Check our list of partner hospitals by calling us or visit our web site www.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 (subject to any waiver that may apply). <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 (subject to any waiver that may apply). <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 benefit (see page 13). <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 those not paid by Medicare (in which case the accommodation benefit would be the equivalent of the Commonwealth declared benefit for a shared room).</p> <p>If you have Top Hospital Level 5 or Level 8, the co-payment applies (subject to any waiver that may apply).</p>

Going to hospital

Before going to hospital continued...

How long will you be in hospital?	<p>Day only</p> <ul style="list-style-type: none">You'll be admitted and discharged on the same day. <p>More than 2 nights</p> <ul style="list-style-type: none">We may be able to help you leave hospital early or prevent a longer stay with support services in your home. See 'Looking after your broader health' section (page 8) for information about these services and the programs available or call 134 246 for more details. <p>More than 1 night after the birth of your baby</p> <ul style="list-style-type: none">ahm's Total Health for Hospital program means you can choose to recover at home instead of hospital after the birth of your baby. We'll work with your doctor to provide all the clinical services you need at home. Extra benefits such as domestic services may also be available. See 'Looking after your broader health' section (page 8) for information about this program or call 134 246 for more details. <p>NOTE: Early discharge isn't available at all hospitals.</p>
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; andHow 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 web site www.ahm.com.auAsk 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 web site at www.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 alternate no gap arrangements.

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're admitted to hospital for an accident and you have a co-payment with your policy, where possible we'll waive the co-payment upfront. This is only for the first admission in relation to a non-compensable accident (see page 12).
- 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 web site 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.
- You might also be able to take advantage of our hospital substitute services, so ask the hospital staff to call our Total Health for Hospital team on 1800 653 316 to find out if the program is appropriate for you.

Going to hospital

After hospitalisation

<p>What about the doctor's bills?</p>	<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.
<p>What about the hospital charges?</p>	<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 services not covered or paid by Medicare, unless specified (after your co-payment amount is paid – Top Hospital Level 5 or Level 8) 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>
<p>What about the prostheses charges?</p>	<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. 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>
<p>What about hospital substitute services charges?</p>	<p>ahm's Total Health for Hospital Programs</p> <p>ahm fully covers you for all services provided through either the Assisted Discharge or Alternative to a Hospital Admission program. There is no need to complete a claim form, ahm pays the provider direct.</p> <p>Services by an ahm recognised provider</p> <p>In most cases, any benefits associated with the services used 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. Should you receive a bill, please call ahm on 134 246 for advice on what to do.</p>

Looking after your broader health

ahm hospital policies provide 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 and health coaching, early discharge from hospital, avoiding hospitalisation and help with managing chronic conditions.

We've detailed the components available to you for each ahm health management program in this policy. 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.

ahm pays 100% of the cost for services delivered through an ahm program or by an ahm recognised provider.

You'll also see a range of other benefits under broader health designed to help you (and your family) with your ongoing good health. This includes disease management appliances, a travel and accommodation benefit, midwife delivery services for home births, doctor health checks and Healthy Heart checks.

ahm's Total Health programs

The following programs and services form part of your hospital cover so you can access them at any time when you need them. Some of the programs are subject to eligibility, hospital participation and your doctor's approval. There are no waiting periods for the disease prevention and chronic disease management programs, normal waiting periods apply to other programs. ahm pays 100% of the cost for all eligible programs and services. You must be 18 years or older to participate in these programs.

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

NOTE: Falling into arrears (having a policy that is unfinancial) may affect your eligibility or participation in any of these programs.

Disease prevention programs		Benefit
ahm's Health Risk Assessment (HRA)	<p>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 preventive measures.</p> <ul style="list-style-type: none"> 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. <p>Participation: The HRA can only be completed online and you must be 18 years or older to complete the assessment.</p>	ahm pays 100% of the cost
ahm's Health Coaching	<p>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.</p> <ul style="list-style-type: none"> 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 tracking and setting goals and access a library of health features and recipes. <p>Services include:</p> <ul style="list-style-type: none"> Consultation to set health goals Over the phone support. <p>Participation: If you're 18 years or older, just call us on 134 246 to enrol in the program.</p>	ahm pays 100% of the cost

Looking after your broader health

Health management programs		Benefit
ahm's Total Health for Pregnancy	<p>Pregnancy support</p> <p>This program is for new and expecting mothers. It involves regular telephone discussions by registered midwives throughout your pregnancy on pre and post natal health issues including healthy eating, exercise and baby care.</p> <ul style="list-style-type: none"> • We'll contact you at regular intervals through your pregnancy and after your baby is born, to help answer your questions and provide information on all the important topics • You can call or email a midwife with unexpected questions anytime throughout your pregnancy right up until your child is 12 months old • The program offers phone support, educational books on pregnancy, birth and child care • ahm's comprehensive web site features articles and health content customised for pregnancy and parenting, plus, a pregnancy calendar that shows you what to expect week by week. <p>Services include:</p> <ul style="list-style-type: none"> • Telephone support • Phone in and email service • Educational material • Online resources. <p>Participation: If you're pregnant or have a child under the age of 12 months, you can enrol online or have the enrolment form mailed to you at your request. You must have served your 12 month waiting period.</p> <p>NOTE: <i>To facilitate in the safe, early discharge of mothers from hospital and the provision of care services in the home, an extension to this program can include ahm's Total Health for Hospital program.</i></p>	ahm pays 100% of the cost

Chronic disease management programs		Benefit
ahm's Total Care	<p>Chronic and complex care</p> <p>This 12 month program for chronically ill individuals with conditions such as circulatory system disease, digestive system disease, neurological disease, respiratory disease, diabetes, chronic pain, cancer/palliative care or multiple medical conditions will help you learn how to better manage your condition.</p> <ul style="list-style-type: none"> • 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 to aid in goal setting and tracking and access a library of health features and recipes. <p>Services include:</p> <ul style="list-style-type: none"> • 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. <p>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 in this program.</p>	ahm pays 100% of the cost

Looking after your broader health

Hospital substitute services

Hospital substitute services can help you avoid a hospitalisation or reduce your time in hospital. ahm pays 100% of the cost for services delivered when part of an ahm program or when provided by an ahm recognised provider. These providers have a contract with ahm and will bill ahm directly for services.

Hospital substitute services		Benefit
ahm's Total Health for Hospital	<p>Assisted Discharge or home recovery</p> <p>With the permission of your treating doctor, you can elect to recover at home rather than in hospital. Our health consultants will tailor a package of care services to assist your recovery.</p> <p>Services include:</p> <ul style="list-style-type: none"> • General and specialist nursing services • Personal care • Domestic services • Transport. <p>Participation: Call us for a referral form on 1800 653 316.</p> <ul style="list-style-type: none"> • You need your doctor's permission to be treated at home • Your hospital stay has to be more than two nights or you've given birth at one of our program participating hospitals • You must be over 18 years old • Your waiting periods must have been served • Your doctor and the hospital staff must consider it appropriate for you to leave hospital earlier than expected. 	ahm pays 100% of the cost
	<p>Alternative to a Hospital Admission</p> <p>Where clinically appropriate, we can help you avoid a hospitalisation altogether. ahm's health consultants tailor a package of care services to be provided in your home under the supervision of your treating doctor. Telephone support is available throughout the episode of care.</p> <p>Services include:</p> <ul style="list-style-type: none"> • Home nursing • Personal care • Domestic services • Transport • Carer for children. <p>Participation: Call us for a referral form on 1800 653 316.</p> <ul style="list-style-type: none"> • You need your doctor's permission to be treated at home • You must be over 18 years old • Your waiting periods must have been served. 	ahm pays 100% of the cost

NOTE: These programs are only available in participating hospitals so call us to check eligibility before you need to be admitted. The care programs tailored by ahm's health consultants only include ahm recognised providers.

Looking after your broader health

More health benefits

Health checks	Financial year limit	Benefit
Doctor health checks and Healthy Heart checks (where not claimable through Medicare, an employer or another party)	1 per person	\$50
Disease management appliances	Financial year limit	Benefit
Blood pressure monitor	1 per policy every 3 continuous financial years	\$100
CPAP machine or BiPAP respirator Mask and/or rental	1 per policy every 5 continuous financial years Combined per policy per financial year	\$600 \$100
Blood glucose testing machine	1 per policy every 3 continuous financial years	\$100
Instant injector or insulin pen	1 per policy every 3 continuous financial years	\$100
Nebuliser	1 per policy every 2 continuous financial years	\$100
Peak Flow Meter	1 per policy every 2 continuous financial years	\$50
Spacer	1 per policy every 3 continuous financial years	\$50
TENS machine	1 per policy every 3 continuous financial years	\$80
Lymphoedema Garments Consultations	3 items per person, per financial year 4 consultations per person, per financial year	(per item) \$50 (per consult) \$40

NOTE: ahm reserves the right to check eligibility for benefits and verify payment.

Travel and accommodation	Benefit
<p>We'll pay a travel and accommodation benefit related to a hospitalisation where either:</p> <ul style="list-style-type: none"> 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. <p>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.</p> <p>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.</p> <p>We'll pay for accommodation for the supporter during the patient's hospital admission only.</p> <p>NOTE: Proof of travel and accommodation costs will be required eg. petrol docket, bus or train tickets, hotel receipts. (Petrol docket will be accepted up to 3 days prior to hospitalisation and 1 day after discharge from hospital.)</p>	<p>\$75 per day combined up to \$750 per person every membership year</p>

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.

If you have a co-payment with your policy and you're admitted to hospital for an accident (as defined by the hospital and ahm – see ahm's definition* below), where possible we'll waive the co-payment upfront. The co-payment will only be waived for the first admission in relation to a non-compensable accident.

Please see page 13 for more information on how the waiver works.

**An accident is defined as an unplanned or unforeseen event resulting in bodily injury that requires immediate medical treatment in a hospital. We don't waive the co-payment where it's a compensable claim.*

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 web site 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 web site at www.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.

Broader health cover

The Federal Government introduced legislation in 2007 that allows health insurers to provide more benefits to policy holders for disease management and prevention as well as services that substitute or avoid a hospitalisation. ahm has led the industry in offering health and disease management programs.

Terms and definitions

Broader health management

ahm offers a range of programs to help you manage your health and get the right support and advice when you need it. (See 'Looking after your broader health', pages 8-11 for an overview of programs and services covered by this policy).

NOTE: Changing your cover or allowing your policy to fall into arrears may affect your eligibility or participation in an ahm broader health management program.

Chronic disease

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

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, excluding child, adult child and student dependants, and for admissions as a result of non-compensable accidents. 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
Top Hospital	No co-payment	Does not apply
Top Hospital 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
Top Hospital Level 8	\$400 for same day or 1 night stay per person or \$800 for two or more nights stay per person	\$800 per person \$1,600 per family

If you reduce your co-payment amount, for example, Level 8 to 5, you've changed your cover and will have to serve normal waiting periods for the lower or no co-payment to apply.

Waiver of co-payments

If you have Top Hospital Level 5 or Top Hospital Level 8, we'll waive the co-payment in certain cases:

- as a result of an accident (as defined on page 12 – Accidents); and
- for child, adult child and student dependants on your policy who require a hospitalisation.

If you're admitted to hospital for an accident, where possible we'll waive the co-payment upfront. However, due to the way we receive claims for hospitalisations relating to accidents, the hospital may require you to pay the co-payment on the day of admission. We'll then reimburse this amount, subject to eligibility for the waiver. The co-payment will only be waived for the first admission in relation to a non-compensable accident.

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 (subject to any waiver that may apply).

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 (subject to any waiver that may apply).

Default benefit

We'll pay the default benefit for accommodation as set by the Commonwealth Government for restricted services. The default benefit covers the cost of:

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

Dependents

Child dependents – 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 dependents – 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, not working full-time and living at home.

Student dependents – 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 dependents have stopped or suspended their study, have a partner, live away from home or have entered the workforce, they should have their own health insurance policy.

Terms and definitions

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.

Exclusions

Some health insurers exclude certain hospital services, but you'll be pleased to know that all ahm's hospital covers are exclusion free!

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.

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

Single parent policy – a policy that includes two or more persons, of whom only one is an insured adult (the principal policy holder) and the other insured persons are dependents of the insured adult.

Family policy – a policy that includes an adult who is the principal policy holder, their partner and any dependents of the principal policy holder 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 Commonwealth 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 Commonwealth 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 www.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 policy holder or dependant joins a policy with ahm or changes to a new policy covering hospital treatment and renews every year on that date.

Midwife assisted home births

As some policy holders choose to have a home birth, Top Hospital, Top Hospital Level 5 and Top Hospital Level 8 will pay a benefit towards midwife assisted deliveries with a registered midwife. This benefit is \$600 for each home birth. The benefit doesn't apply if there's a hospitalisation related to the birth.

Terms and definitions

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 only up to the per person limit (subject to any waiver that may apply).

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 benefit. The default 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.

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.

Principal policy holder

Is the first named policy holder 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 Commonwealth Government has produced a Private Patients' Hospital Charter to inform health insurance policy holders of their rights. You can view the charter online or download a copy from www.health.gov.au

Terms and definitions

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.

Commonwealth 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 register 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 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 www.ahm.com.au

Restricted services

We pay the default benefit only (see definition on page 13) for accommodation for restricted services and services not covered or paid by Medicare in either a private or public hospital.

Top Hospital, Top Hospital Level 5 and Top Hospital Level 8 have restricted services as outlined on page 2.

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 benefit only will be paid.

Sterility reversal procedures

We'll pay a theatre and accommodation fee for male and female sterility reversals (if you are charged). We'll also pay a benefit to assist towards paying your doctor's fee, but you may still be significantly out-of-pocket depending on what your doctor charges you.

Please call us before your procedure to confirm how much you may be out-of-pocket.

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 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 broader health 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.

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.

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 out of the country for more than 30 days, you can suspend your policy for the time you're away (see Policy suspension at right). 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 policy holders to be at least one premium payment in advance.

NOTE: If a policy holder is more than two months in arrears then the policy will be terminated by notice in writing from ahm to the principal policy holder, 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.

To suspend your policy just send us a written or email request before your holiday including the dates of travel. We'll get back to you before you leave to confirm the suspended period.

To reactivate your policy you need to provide proof of the date of entry back into Australia within 30 days of your return.

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.

Policy termination

Only the principal policy holder 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 policy holder 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 cannot terminate the policy.

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

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.

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 web site.
- **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 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 credit card. Just log in to the members' section and select 'Make a payment'.
- **Over the COUNTER** – We accept credit cards, cheques and cash over the counter at our head office: 77 Market Street Wollongong NSW.

ahm fund rules require that all policy holders 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.

Using ahm's online services

The ahm web site has been recognised as the number one web site in the health insurance industry for more than three years.

You'll find information around healthy living, dental and eyecare health, monthly 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 Total Health web site. You will need your membership number to log in to the members' section.

Emergency Service Helpline

Your hospital cover gives you access to the Emergency Medical & 24 hour doctor/medical referral service. If you need assistance in a medical emergency and don't know what to do, call **1800 006 745**.

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 ahm (134 246)

Fax: 1300 fax ahm (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

Web site: www.phio.org.au

Phone: 1800 640 695

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 policy holder (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 policy holder. We send all communications on policies that cover more than one person to the address supplied by the principal policy holder.
- 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 ahm (134 246)

Call centre hours: Monday to Friday

8.00am – 6.00pm (Eastern Standard Time)

Fax: 1300 fax ahm (1300 329 246)

Web: www.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. Policy holders 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.