Australian Government
Private Health Insurance Ombudsman

An explanation for consumers of how and why waiting periods operate including the rules on pre-existing conditions

WAITING PERIODS

FOR PRIVATE HEALTH INSURANCE

This brochure provides consumers with information on the waiting periods that apply to private health insurance in Australia.

what are waiting periods?

A waiting period is an initial period of health fund membership during which no benefit is payable for certain procedures or services.

Waiting periods can also apply to any additional benefits when you change (upgrade) your health insurance cover.

why do waiting periods apply?

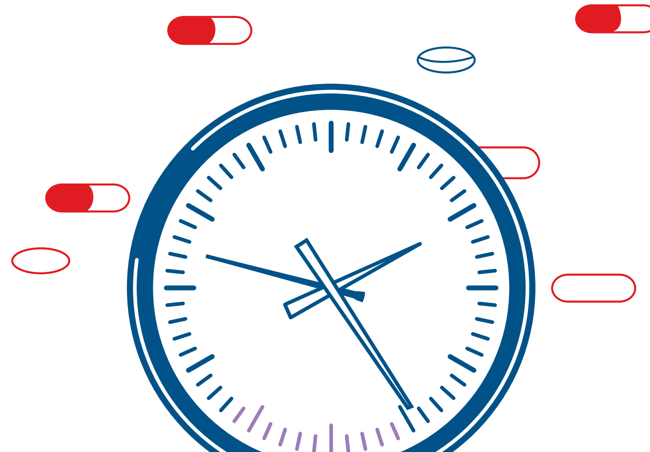
In Australia, all health funds are required by law to provide health insurance for Australian residents regardless of their health status and cannot charge higher premiums based on whether a person is more likely to require treatment.

If there were no waiting periods, people could take out hospital cover or upgrade to a higher cover only when they knew or suspected they might need hospital treatment. Their hospital costs would then have to be paid by the long-term members of the fund. This would lead to much higher premiums for all fund members and would not be fair.

do all health funds apply the same waiting periods?

Most funds apply the same waiting periods for hospital cover, but waiting periods do differ between funds for general treatment (extras) and overseas visitor cover.

Some funds also apply *Benefit Limitation Periods* for some types of treatment on some of their hospital covers.



waiting periods for hospital cover

Most health insurance funds will apply the following waiting periods to new members taking out a hospital cover product:

- a general two month wait for any benefits.
- a two month wait for psychiatric care, rehabilitation or palliative care (whether or not for a pre-existing condition).
- a twelve month wait for any benefits for pre-existing conditions.
- a twelve month wait for benefits for obstetric treatment (pregnancy).

(These are the maximum waiting periods allowed by law for hospital cover.)

These waiting periods also apply to any additional benefits on your new product if you transfer to a higher level of hospital cover, with your existing fund or with a different fund.

does membership of general treatment (extras) cover count towards waiting periods for hospital cover?

No. Sometimes people take out general treatment (extras) cover only, and then take out hospital cover later. Membership of a general treatment product does not cover you for a hospital stay. Nor does it count towards waiting periods on a hospital cover.

Benefit Limitation Periods

Some funds include *Benefit Limitation Periods* as a feature of some of their hospital products. These are initial periods of membership during which only a minimal benefit is paid for some types of treatment.

These benefit limitation periods may be from one to three years, depending on the product chosen. Your fund should clearly explain whether any benefit limitation periods apply to your product, their duration and effect on the benefits you might be paid.

Benefit limitation periods will not apply to you if you are transferring from another hospital product (with the same or another fund).

waiting periods for general treatment cover

Most extras products have different waiting periods for the different types of services that the products cover. They vary significantly but some examples of typical waiting periods are:

- two months for benefits for general dental services and physiotherapy
- six months for benefits for glasses or lenses
- twelve months for benefits for major dental procedures such as crowns or bridges
- one, two or three years for some high cost procedures such as orthodontics.

Some funds may apply additional waiting periods for some extras services if the condition being treated is considered to be pre-existing.

If you change to another fund
If you are changing your extras cover to another fund, most funds will not make you serve waiting periods again for the benefits you had on your previous cover.

All funds operate their extras covers quite differently so you should always recheck the benefits as well as any annual limits and how they work. Many funds will reduce any annual benefit limits for extras services by the amount of benefit already paid to you under your previous product.

Funds will not normally transfer any additional limits or entitlements you may have built up with your previous fund under a *loyalty bonus* scheme.

what if the fund is offering to waive the waiting periods?

Sometimes funds will waive some waiting periods as part of a promotion to attract new members. Usually, they only waive the general two-month waiting period for hospital benefits, or some of the waiting periods for general treatment services. Always check which waiting periods will still apply.

HOSPITAL WAITING PERIODS EXPLAINED

general two month waiting period

Most funds apply a two month waiting period before any benefits are payable under hospital cover. Some funds will pay benefits for treatment immediately following an accident in the first two months, but you need to check with the fund, as not all funds do.

psychiatric and rehabilitation waiting period

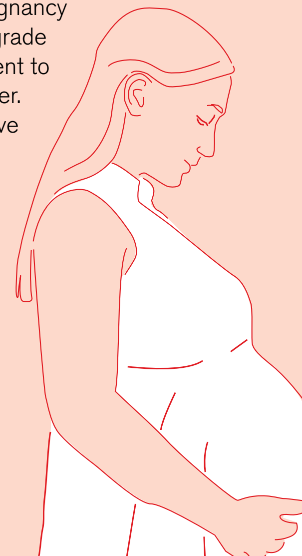
To be covered as a private patient for psychiatric treatment or drug and alcohol rehabilitation in hospital, you can purchase a private hospital policy. Unlike other pre-existing conditions, which normally require you to complete twelve months of membership before you can be covered for a hospital admission, psychiatric services and rehabilitation only require a two month waiting period, even if the condition is pre-existing. This means you can be covered two months after commencing or upgrading your policy.

obstetric (pregnancy) waiting period

Almost all funds apply a twelve-month waiting period to hospital benefits for pregnancy services. Funds are usually strict in applying this waiting period and you may not be covered if your baby comes early and you have not served the waiting period.

If you think you will need cover for pregnancy services, you need to take it out or upgrade well before you fall pregnant. Entitlement to obstetrics benefits rests with the mother. She needs to have served the full twelve months to be able to claim benefits.

Many less expensive hospital covers do not cover obstetrics, or pay restricted benefits that only cover you for obstetrics as a private patient in a public hospital.
If you want to be covered for your baby's birth in a private hospital, you need to take out a hospital cover that allows you to do this well before you fall pregnant.



You may also need to upgrade from single cover to family cover to ensure your baby is covered at birth. Funds have different rules about when you need to do this, so make sure you check with your fund as soon as possible.

pre-existing conditions waiting period

If you are a new member of a hospital cover, you may not receive any benefits for a pre-existing condition in the first twelve months of membership.

If you already have hospital cover but have transferred to a higher level of cover, you may only receive the (lower) benefits that you had on your previous level of cover for a pre-existing condition in the first twelve months on your new cover.

what is a pre-existing condition?

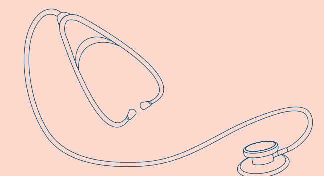
A pre-existing condition is defined by law as any condition, illness, or ailment that you had signs or symptoms of during the six months before you joined a hospital policy or upgraded to a higher hospital policy. It is not necessary that you or your doctor knew what your condition was or that the condition had been diagnosed.

A condition can still be classed as pre-existing even if you hadn't seen your doctor about it before joining the hospital policy or upgrading to a higher hospital policy.

If you knew you weren't well, or had signs of a condition that a doctor would have detected (if you had seen one) during the six months prior to joining the hospital table, then the condition would be classed as pre-existing.

is my family medical history relevant?

Risk factors, including family history of a condition, are not signs or symptoms of a pre-existing condition. The health fund doctor should not consider these risk factors when deciding whether a condition is pre-existing.



who decides if I have a pre-existing condition?

A doctor appointed by the health fund decides whether your condition is pre-existing, not you or your doctor. He or she must consider your treating doctors' opinions on the signs and symptoms of your condition, but is not bound to agree with them.

Health funds cannot impose a waiting period for hospital benefits on particular conditions just because these conditions are often pre-existing. Each case must be considered on its own merit.

what if I need hospital treatment in my first year of joining?

If you need to be admitted to hospital you should contact your health fund straight away to check if you will be entitled to hospital benefits. Health fund staff should give you some general advice about the pre-existing condition rule but, at this stage, they cannot tell you whether or not your condition is pre-existing.

Your health fund will send you a letter about the pre-existing rule and medical certificates for your treating doctors to complete. You will be asked to sign the consent portion of the medical certificates to allow the release of clinical information relating to your hospital stay. Your treating doctors can send the completed medical certificates to your health fund or the certificates can be returned to you to send to your health fund.

If you have not heard back from the fund within 5 working days of sending them the information, you should contact the fund and ask if they have made a decision.

If you proceed with your admission before the health fund has advised you whether you are entitled to benefits, you may become responsible for all costs associated with the admission.

what if I need urgent treatment in my first year of membership?

If you need to go to hospital urgently, your health fund might not have enough time before you are admitted to decide whether your condition is pre-existing. This means that you may not know, before you are admitted, whether you will get any health fund benefits.

One option is for you to go to a public hospital and seek treatment as a public patient.

If you choose to be treated as a private patient despite the uncertainty, the hospital should tell you how much you will have to pay if the health fund decides you are not eligible for benefits because your condition is pre-existing. The hospital might ask you to pay some or all of the cost of your hospital treatment when you are admitted. If the health fund later decides that it will pay benefits, you can reclaim these costs.

If the health fund decides, while you are still in hospital, that you are not entitled to benefits, you can ask the hospital staff about other options for the rest of your treatment, such as transferring to a public hospital.

what can I do if I think the decision that my condition is pre-existing is wrong?

If you think the decision is not right after reading all the information the health fund sends you, contact the health fund first and ask for a review of their decision. You might also want to discuss it with your doctor. Take this pamphlet with you, as your doctor may not fully understand how the pre-existing condition rule is applied.

If you are still not satisfied, after requesting a further explanation and review, you can contact the Private Health Insurance Ombudsman. The Ombudsman's staff can investigate the fund's decision and give you an independent view. Contact details for Ombudsman are at the end of this brochure.

pre-existing conditions - examples

Example 1

Pre-existing condition rule applies

- Pam was experiencing nausea and abdominal pain one month before she took out hospital cover with a health fund.
- She consulted her doctor about the problem shortly after joining the fund. Her doctor referred her to a specialist for further investigation. The specialist diagnosed gallstones and recommended surgery.
- The doctor appointed by the health fund determined that symptoms of Pam's condition were in existence in the six months before she joined the fund.
- In reaching this decision, the doctor relied on information from Pam's treating doctor that, although he had not diagnosed gallstones initially, the symptoms (nausea and pain) had been present for some time before Pam saw him or joined the health fund.
- The fund advised Pam she would not be eligible for benefits for treatment of the gallstones for the first twelve months of her membership.

Example 2

The new product has some better benefits (no restricted treatments)

- Jim had 12 months membership on a product that had restricted benefits for some treatments including any cardiac procedures (benefits were limited to less than half the hospital's charges). He changed to a product that had no restrictions.
- Jim suffered a heart attack three months after changing his cover.
- As Jim had previously had some symptoms of heart disease, the heart condition was deemed pre-existing and he was still only entitled to his previous (restricted) benefits for this problem for a further nine months

pre-existing conditions - examples

Example 3

Pre-existing condition rule does not apply

- Warren had held his hospital cover for three months, when he suffered a stroke and was rushed to hospital.
- Warren's treating doctor indicated he had a number of risk factors for stroke, including high blood pressure, but had suffered no signs or symptoms of stroke prior to joining the fund.
- The doctor appointed by the health fund determined that Warren was eligible to receive benefits for his treatment, because he did not have any signs or symptoms of the stroke prior to joining the fund.

(Please note that these examples are intended as a guide only. Each case will depend on the individual's particular circumstances.)

more information & complaints

The Private Health Insurance Ombudsman has a number of other brochures and publications that may help you to better understand your health insurance. These are available on our website or can be provided on request.

Our 'Right to Change' brochure contains more information about changing health funds or upgrading your cover.

If you need our help with private health insurance arrangements or have a complaint telephone our **Hotline: 1800 640 695**
email us at: **info@phio.org.au**
or check out our websites at: **www.phio.org.au and www.privatehealth.gov.au**

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