

Will the
pre-existing
ailment waiting
period affect you?

information for
consumers

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important

If you (or anyone covered by your health insurance policy) need to be admitted to hospital, but you have been on your current hospital table for less than 12 months, you might not get health fund benefits due to the waiting period for pre-existing ailments.

You should check with your health fund about your eligibility for benefits before being admitted to hospital for treatment as a private patient.

What this brochure explains

This brochure explains how the waiting period for pre-existing ailments can affect you.

If you have a pre-existing ailment when you first take out hospital cover the law allows health funds to make you wait twelve months before they will pay any benefits to treat this pre-existing condition. This waiting period also applies when you upgrade to a higher level of hospital cover. This means that if you have hospital treatment for a pre-existing ailment in your first twelve months of membership of your current hospital table, you might not be covered.

Health funds are also allowed to impose:

- a two month waiting period for benefits for all hospital treatment; and
- a twelve month waiting period for benefits for obstetrics (pregnancy) services in hospital.

You can get information about other waiting periods for benefits from your health fund.

Why does the pre-existing ailment waiting period apply?

People choose to take out private hospital insurance for many different reasons. If there was not a pre-existing ailment waiting period people could take out hospital cover or upgrade to comprehensive cover only when they know or suspect that they might need hospital treatment and immediately make an expensive hospital claim. If these new members then left the fund or downgraded to a low premium table, their hospital costs would have to be paid for by the long-term members who remain on these hospital tables. This would not be fair.

Remember, new members who do have pre-existing ailments can still seek treatment for these conditions in a public hospital under Medicare.

What is a pre-existing ailment?

A pre-existing ailment is:

- An ailment,
- An illness, or
- A condition

where there were signs or symptoms present during the six months before you joined a hospital table or upgraded to a higher hospital table.

It is not necessary that you or your doctors knew what your condition was. The only question is whether there were any signs or symptoms.

The pre-existing ailment rule can still apply even if you haven't seen your doctor about the ailment before joining the hospital table or upgrading to a higher hospital table. If you knew you weren't well, or had signs of an ailment that a doctor would have detected if you had seen one during the six months prior to joining the hospital table, then the rule may still apply.

If I joined when waiting periods were waived, will the pre-existing ailment rule apply to me?

Sometimes health funds waive certain waiting periods for new members. Usually, they waive only the general two month waiting period for hospital benefits. Funds do not normally waive the twelve month waiting period for pre-existing ailments and obstetrics (pregnancy) services in hospital. This means that the twelve month waiting period for pre-existing ailments might still apply to you. Make sure you check with your health fund.

Does membership of an ancillary table count towards waiting periods on a hospital table?

Sometimes people take out ancillary (or extras) cover only, and then take out hospital cover later. Membership of an ancillary table does not count towards waiting periods on a hospital table. You will need to have membership of a hospital table for twelve months to be eligible for hospital benefits for pre-existing ailments.

How do I know if I have a pre-existing ailment?

A doctor appointed by the health fund decides whether your ailment is pre-existing, not you or your doctor.

The health fund doctor must consider information from your treating doctors when making this decision. The health fund doctor must also consider your treating doctors' opinions on the signs and symptoms of your ailment, but is not bound to agree with them.

Health funds cannot impose a waiting period for hospital benefits on particular ailments just because these ailments are often pre-existing. Each case must be considered on its own merit. The health fund doctor must look at your circumstances and decide whether you had signs or symptoms in the six months before joining the health fund or upgrading to a higher level of hospital cover.

Is my family medical history relevant?

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

What should I do if I need hospital treatment in my first year of joining or upgrading my hospital cover?

If you need to be admitted to hospital you should contact your health fund straight away to check that you will get hospital benefits. If you joined your current hospital table less than 12 months ago, the fund will check whether or not your ailment is pre-existing.

Health funds will need a number of working days to make this assessment. It is important that you contact your health fund as soon as you know you may need to go to hospital.

If you need to be admitted to hospital urgently, the health fund might not be able to tell you before you are admitted whether you will get benefits. A section later in this brochure called "What if I require urgent treatment?" tells you what to do if this happens.

When you contact your health fund, they will need to know your membership number, the date you are to be admitted to hospital and the reason you are going to hospital.

The health fund must advise you that you might be affected by the pre-existing ailment rule. Health fund staff will give you some general advice about the rule, but at this early stage they cannot tell you whether or not your ailment is pre-existing.

Whenever you call your health fund for advice, ask the staff member to write to you with the advice they have given over the telephone. You should also write down the name of the staff member you spoke to and the date and time of your call.

The health fund will send you some written information about the pre-existing ailment rule and medical certificates for your treating doctors to fill in. The health fund will give you one medical certificate for each doctor who has seen you about the ailment (usually your general practitioner and specialist).

The medical certificate asks for your signed consent for the doctor to give medical information about you to the health fund. This information is only about the ailment that needs to be treated in hospital. The information will be the diagnosis (name) of the ailment, the signs and symptoms of the ailment and when you first noticed them or knew about them. The health fund doctor will only use this information to decide whether your ailment is pre-existing. It is in your interest to sign this consent as you could be disadvantaged if you don't.

Ask your treating doctor(s) to fill these forms in and send them promptly to the health fund.

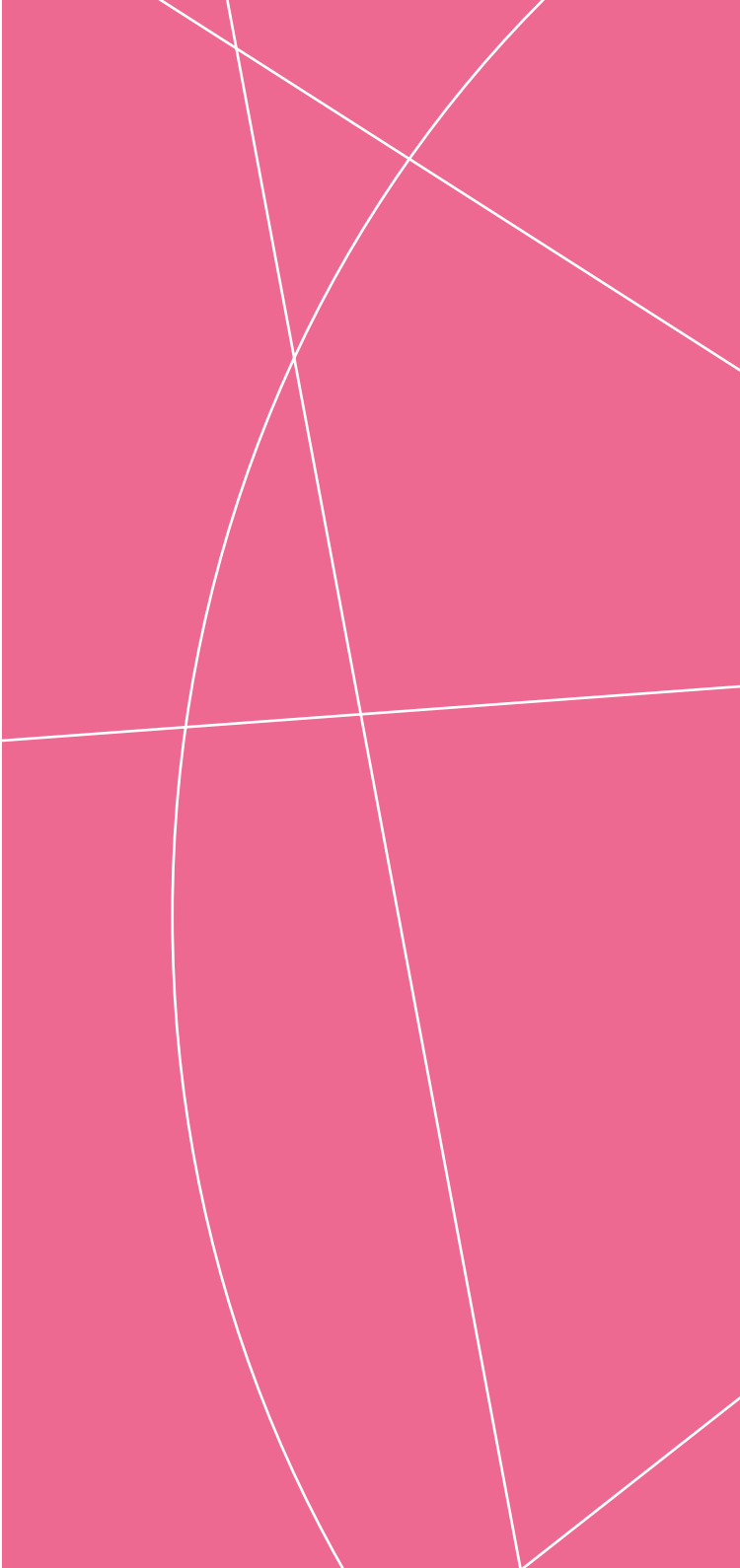
Remember, it is in your financial interest not to proceed with your hospital admission until the health fund has decided whether you can get hospital benefits. Otherwise you risk having to pay the whole hospital bill and some out-of-pocket medical costs if the health fund decides that you cannot get benefits.

What information will the health fund give me if they have decided my ailment is pre-existing?

Once the assessment is finalised the fund will advise you of the outcome. If your ailment is considered pre-existing, the health fund will write you a letter that clearly explains why the health fund doctor decided your ailment is pre-existing.

The letter will include a summary of the evidence the doctor considered to make the decision. If the health fund doctor's opinion about your signs and symptoms is different to the opinion of your treating doctor, the health fund doctor will explain why the opinion of your treating doctor has been disregarded.

If you have not already been to hospital, the health fund will tell you about other options that you and your doctor can discuss. This may include putting your admission off until you are eligible for benefits, or being treated as a public patient, or you may wish to go ahead with the admission and pay the hospital and out of pocket medical costs yourself.



What can I do if I think the decision that my ailment is pre-existing is not appropriate?

When you receive the decision from the health fund, you might want to discuss it with your doctor.

If you think the decision is not appropriate after reading all the information the health fund sends to you, contact the health fund first.

If you are still not satisfied after talking to the health fund, you can lodge a complaint with the Private Health Insurance Ombudsman by:

- Telephoning the Complaints Hotline on 1800 640 695; or
- Writing a letter to
Suite 1201, Level 12
St Martin's Tower,
31 Market Street,
SYDNEY NSW 2000, or
- faxing a letter to (02) 9261 5937 or
- emailing your complaint to info@phio.org.au
or
- Lodging your complaint at the Ombudsman's website at www.phio.org.au/lodgecomplaint.php .

Staff of the Ombudsman will tell you what information they need.

What if I need urgent treatment?

If you need to go to hospital urgently, your health fund might not have enough time before you are admitted to decide whether it will pay benefits. While some health funds can confirm important membership details out of normal business hours, funds need some time to assess pre-existing ailments. This means that if you have less than twelve months membership on your current hospital table you will not know whether you can get benefits before you are admitted.

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 will contact your health fund as soon as possible to check what benefits will be paid.

The hospital will tell you as soon as possible how much you might have to pay if the health fund decides you cannot get benefits because your ailment 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 will not get benefits, the hospital staff will talk to you about other options for the rest of your treatment, such as transferring to a public hospital.

I have been a member of my health fund for 5 years. How does the pre-existing ailment rule affect me if I transfer to another health fund or upgrade my hospital cover?

If you have had hospital cover for twelve months, you will have already served the twelve month waiting period for pre-existing ailments on that level of cover. That means you are already entitled to the benefits provided on that level of cover.

If you upgrade to a higher level of hospital cover, or transfer to a higher level of cover with another health fund, you will need to wait twelve months before you can get the higher benefits of your new cover if you need hospital treatment of any pre-existing ailments. You will be able to get the benefits of the lower table you were on before, though.

More information about upgrading your hospital cover or transferring to another health fund is in a brochure called "The Right to Change", which is published by the Private Health Insurance Ombudsman. You can get a copy of the brochure from your health fund or by visiting the Ombudsman's web-site at www.phio.org.au.

You should always check with the health fund about what benefits you might be entitled to before you are admitted to hospital.

Does the pre-existing ailment rule apply to my ancillary (extras) cover?

The law about the pre-existing ailment rule applies only to hospital cover and not ancillary cover. Some health funds apply similar rules to their ancillary cover, and they can do this if they wish.

Information about waiting periods applied to ancillary cover is available from each health fund.

You should know, though, that health funds can apply the pre-existing ailment waiting period to ancillary treatment if it is to be provided in hospital (for example, removal of wisdom teeth).

Please check with the health fund before you are admitted whenever you need to go to hospital for any treatment.

Your rights

As a consumer of private health insurance you have the right:

- To expect your health fund to give timely, clear and accurate advice about your eligibility for benefits.
- To expect your health fund to clearly explain the pre-existing ailment rule to you.
- To expect your health fund to clearly explain waiting periods to you.
- To expect the medical practitioner appointed by the health fund to apply the pre-existing ailment rule to your case fairly according to the law, and according to your specific circumstances.
- To contact your health fund for further explanation of the decision that you have a pre-existing ailment.
- To complain to the Private Health Insurance Ombudsman if you think the health fund doctor's decision is not appropriate.

Your responsibilities

As a consumer of private health insurance you have the responsibility:

- To understand the limitations, waiting periods and other conditions that apply to your health insurance cover.
- To know that the health fund can make you wait for twelve months after you join or upgrade your hospital cover before they pay hospital benefits for pre-existing ailments.
- To be honest and open in providing information about your medical history and other matters relevant to enable your health fund to assess your entitlements to benefits fairly and promptly.
- To check your eligibility for health fund benefits before you are admitted to hospital for private treatment, wherever possible.
- To pay any costs of your private health care not covered by your private health insurance policy or Medicare.
- To know that information about your medical history relevant to the proposed hospital treatment may be provided to a doctor appointed by the health fund, but only with your signed consent.

case studies

The following case studies are provided to help you to understand how the pre-existing ailment rule can be applied. They are examples only. You should check with your health fund before being admitted to hospital to see if the pre-existing ailment rule applies to you.

Case study 1

Mr Green noticed some rectal bleeding one month before he joined his health fund. Two weeks after joining the fund, he consulted his doctor about the problem for the first time. His doctor referred him to a specialist for further investigation. The specialist diagnosed colon cancer, which required surgery.

The health fund doctor determined that symptoms of Mr Green's ailment were in existence in the six months before he joined his fund. In reaching the decision the health fund doctor relied on information from Mr Green's treating doctor that Mr Green had reported that the symptoms (rectal bleeding) had been present for two weeks before Mr Green joined the health fund.

Case study 2

Mr Gold had been treated for bone cancer, but the cancer had been in remission for one year when he joined his health fund. Six months after joining the fund, Mr Gold required hospitalisation because the cancer had re-appeared.

The health fund medical adviser determined that the hospitalisation was required for a pre-existing ailment because Mr Gold's treating doctor indicated that this type of cancer was not considered cured until it had been in remission for five years.

Case study 3

Mrs Blue had been a member of her health fund for five years, on a cover which had a \$500 excess.

Mrs Blue decided to upgrade to a cover without any excess. Three months after upgrading her cover, Mrs Blue suffered a heart attack and required cardiac surgery.

If the fund doctor was satisfied that Mrs Blue had signs or symptoms of her heart attack, such as chest pain, in the six months before she upgraded her cover, the pre-existing ailment rule would apply and Mrs Blue would be required to pay the \$500 excess, but would be otherwise entitled to benefits under the lower level of cover.

If, however, the fund doctor was not satisfied that signs or symptoms of Mrs Blue's heart attack were in existence in the six months before she upgraded her cover, the pre-existing ailment rule would not apply. Mrs Blue would not be required to pay the excess, and benefits at the higher level of cover would be payable.

Case study 4

Mrs Orange had been a member of her health fund for six months when she visited her doctor because of rectal bleeding of recent onset. Mrs Orange told her doctor that her mother had suffered from colon cancer some years earlier. The doctor referred Mrs Orange to a specialist for further investigation of the problem. One month later, the specialist diagnosed colon cancer that required surgery.

The health fund doctor determined that Mrs Orange's colon cancer was not pre-existing, because there were no signs or symptoms of the colon cancer in the six months before joining the health fund. He noted Mrs Orange's family history of colon cancer, but considered that this was a risk factor only, not a sign or symptom of the colon cancer.

Information in other languages is available on the
Department of Health and Aged Care website at:
www.health.gov.au/privatehealth/consumer/pea/language.htm
Contact the Department of Health and Aged Care toll free on
1800 676 296



Commonwealth Department of
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