Standard Cover

Standard Cover is a hospital and extras package that includes cover for heart-related procedures, and offers 60% back of what you pay on included extras services (up to $1,000 per person per financial year).

This document is a summary only. For more information please refer to our Standard Cover policy document, which is available on our website at ahm.com.au/download-form

Why choose ahm Health Insurance?

You don't have to wait

We don't have any 2 or 6 month waiting periods on popular extras services like Physiotherapy and Routine Dental.*

Cover that fits like a glove

From time to time our Cover Specialists contact members to review whether the cover they have now, is the cover they need now.

Talk about responsive!

When you call us, you'll get individual advice and assistance when you need it. Your needs are important to us.

Solid as a rock

We've been looking after the health insurance of Australians for more than 40 years, so why not let us look after yours?

Manage your health insurance 24/7

View your claims history, search for a doctor or provider, or pay your premiums online. These are just some of the things you can do when you sign up for our online member services.

** Other waiting periods apply.*

Hospital

What's covered?

You can claim benefits for many things on Standard Cover but here is a list of the most common services covered.

- Heart-related procedures including open heart and bypass surgery and other invasive cardiac procedures such as angiograms and stents
- Ambulance Transportation
- Removal of tonsils/adenoids/ appendix
- Surgical removal of wisdom teeth in hospital
- All joint investigations and reconstructions (not replacements)
- Colonoscopies

What you can claim

- benefits towards theatre fees and hospital accommodation in a private or shared room
- surgically implanted prostheses up to the minimum benefit listed on the Federal Government's Prostheses Schedule
- medical gap for doctors', specialists' and surgeons' medical fees

What's partially covered?

The services below are restricted. This means we will only pay a limited benefit which won't cover the full cost of treatment.

- Psychiatric services
- Rehabilitation
- Podiatric surgery

What you can claim

- benefits towards shared accommodation at a public hospital or a reduced level of accommodation benefits at a private hospital
- surgically implanted prostheses up to the minimum benefit listed on the Government's Prostheses List
- medical gap for doctors', specialists' and surgeons' medical fees

What's not covered? (excluded services)

- Obstetrics and pregnancy related services
- Assisted reproductive services
- All joint replacements
- Spinal fusion
- Dialysis
- Major eye surgery
- All obesity surgery including gastric banding and bypass
- Male and female sterility reversals
- Services not covered by Medicare
- Cosmetic Surgery

Extras

With Standard Cover you can get 60% back of what you pay for the extras services listed below, until you reach your limit for the year. You're free to use your limit on one or all of the included extras.

What's covered?	Waiting period	Benefit	Financial year limit per person
Routine Dental* eg examinations, scale and clean, x-rays, mouthguards, fillings	None	60% of the charge	$1,000
Complex Dental eg Endodontics, Periodontics	12 months		
Optical Frames, lenses, contact lenses and repairs (only payable for scripted sight correcting products)	None		
Therapies** Physiotherapy, Chiropractic, Osteopathy	None		
Alternative & Complementary Therapies Remedial Massage, Acupuncture, Naturopathy, Exercise Physiology, Homeopathy, Chinese Medicine, Reflexology	None		

** Some dental benefits (eg clean and polish) are limited to a number of services each year*
*** 1 initial consultation per therapy per person per financial year*

Important information

Your hospital waiting periods

1 day	› Hospital treatment as a result of an accident › Ambulance Transportation
2 months	› Hospital treatment (where there are no pre-existing conditions) › Rehabilitation, psychiatric and palliative care (regardless of whether the condition is pre-existing)
12 months	› Pre-existing conditions

What does this mean?

A waiting period is a set amount of time you must serve before being eligible to claim for benefits on your cover.

Waiting periods apply when you first join, if you rejoin after not having had health insurance for some time, or if you change to a level of cover that has additional services or higher benefits on services where a waiting period applies.

If you're switching from another private health insurer, we'll generally recognise any waiting periods you've already served for comparable benefits.

Your hospital excess

To help keep your premium down, Standard Cover has an excess.

What you pay:	$500 per person on the first admission to hospital in a membership year
Limits per membership year:	$500 per person / $1,000 per family

What does this mean?

At ahm Health Insurance, an excess is an up front lump sum payment that you agree to pay towards your hospital treatment before benefits are paid.

Limits

Per person limits	Each person on your cover can claim up to the 'per person' limit for the claiming period.

What does this mean?

A limit is the total amount you can claim towards that service in a financial year (1 July – 30 June).

ahm recognised providers

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

Recognising a provider means we get specific details and credentials from them to make sure they meet both legislative and our criteria for benefit payment. All service providers must be recognised by ahm Health Insurance before we can pay benefits.

To find out if your service provider is recognised by us call 134 246 or use the online provider search tool at ahm.com.au

...Important information continued

Restricted services – partially covered

If a service is restricted on your cover, it means that we'll only pay a limited benefit if you're treated at a private hospital or as a private patient at a public hospital.

This benefit won't cover the full cost of treatment and you may be left with significant out-of-pocket expenses.

There are restricted services on Standard Cover.

Excluded services – not covered

If a service is excluded on your cover it means that we won't pay a benefit towards it and you will be significantly out-of-pocket.

There are excluded services on Standard Cover.

Other hospital things that aren't covered

The following list outlines things that you won't be covered for on any of our hospital covers.

- Charges above the Medical Benefits Schedule (MBS) fee unless your doctor agrees to participate in GapCover. If your doctor participates in GapCover, we'll pay up to the GapCover agreed fee
- Charges above the minimum benefit for surgically implanted prostheses
- The full cost of your accommodation or theatre fees if you attend a non-agreement hospital or for restricted services in either a private or public hospital. Check with us on 134 246 before you go to hospital
- Any benefit at all for any excluded service including (but not limited to) accommodation, theatre fees, intensive care, prosthesis, medication, allied health and medical gap
- Labour ward
- Private room accommodation, operating theatre charges and intensive care accommodation for restricted services
- Treatment that is subject to a waiting period if you haven't served the relevant waiting period
- Personal items including phone calls, faxes, TV, internet and newspapers
- Take home bandages and dressings or 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. You may be entitled to some benefits for physiotherapists on the extras component of your cover.
- Some high cost Non PBS drugs – the hospital should advise you if these drugs won't be paid for by us. This is part of their responsibility to obtain your Informed Financial Consent.
- Medical costs for services not covered by Medicare or excluded services
- Any medical, hospital or ambulance services received overseas or purchased outside Australia, including online purchases from overseas companies
- Cosmetic Surgery
- A claim payable or subsidised by a third party (such as workers compensation or traffic accident schemes)

Things you need to know

Where you'll be covered

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

Partner hospitals and day surgeries
If you're treated as a private patient, ahm Health Insurance has agreements in place with the majority of private hospitals and day surgeries throughout Australia. These agreements detail agreed theatre and accommodation charges for services covered under your policy. This doesn't apply to restricted or excluded services.

If you receive treatment for a restricted service in a partner hospital, we'll only pay limited benefits and you'll be significantly out-of-pocket. If you receive treatment for an excluded service, no benefits will be paid.

To find a partner hospital visit ahm.com.au

Non agreement hospitals and day surgeries
In some instances, we haven't reached an agreement with a private hospital. These hospitals are referred to as non agreement hospitals.

If you receive treatment at a non agreement hospital we'll only pay a limited benefit and you'll be significantly out-of-pocket.

Pre-existing conditions

Any kind of condition or illness that you had the signs or symptoms of (in the opinion of ahm's appointed Medical Practitioner) in the 6 months before you joined private health insurance or changed your cover.

Medical gap

The benefit we pay towards medical services is based on the Medicare Benefits Schedule (MBS). This is a list of fees that has been issued by the Australian Government to set out the minimum amounts that Medicare and private health funds should pay towards each medical service listed. If a service is listed on the MBS and included in your cover, Medicare will pay 75% of the MBS fee and we'll pay the remaining 25%.

In some cases a doctor may choose to charge more than the MBS fee which may leave you with an out-of-pocket expense that you'll have to pay.

This is known as the medical gap and is the difference between the fees you're charged by the medical providers and the MBS fees for the services they provide.

GapCover
GapCover is designed to help remove or reduce the medical gap so that you pay less for your treatment or nothing at all. If your doctor participates in GapCover we'll provide benefits up to an agreed fee and then you'll have to pay the difference. Under GapCover, the maximum gap that you'll have to pay is $500 per claiming provider (i.e. doctor's account).

A doctor can choose to participate on a case by case basis, so you should always check with them prior to agreeing to treatment and ask them to provide you with an estimate of medical fees.

Note: We don't pay any GapCover benefits for excluded services.

If your doctor chooses not to participate in GapCover, we'll only pay up to the MBS fee and you'll have to pay the difference between the MBS fee and what your doctor charges you.

Search for a doctor
You can access a doctor search facility at ahm.com.au/find-a-doctor to find a list of doctors who have previously registered to participate in GapCover.

Cooling off period

If you terminate your cover within 30 days of joining and haven't claimed a benefit during this period, you're entitled to a full refund.

Important information

The information contained in this document is current at the time of issue (May 2013). Please ensure you read this document thoroughly and retain a copy for your reference. Membership of ahm Health Insurance is subject to our Fund Rules and policies which are summarised in our Standard Cover policy document. Premiums, benefits, Fund Rules and policies change from time to time.

Policies of insurance issued under, or on the terms of, any products described in this publication are referable to the Medibank Private Limited (ABN 47 080 890 259) health benefits fund.

Complaints

If you have a complaint related to your cover, please let us know straight away so that we can work to resolve matters as soon as possible. Where possible, we'll resolve your issue on the spot. However, if we're unable to resolve your issue immediately, we'll refer it to our Customer Advocacy Team who'll undertake a detailed investigation. Our Customer Advocacy Team will aim to find a solution for you by investigating your complaint and then letting you know the result.

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

Phone: 1800 640 695
Email: info@phio.org.au
Address: Suite 2,
Level 22 580 George Street
Sydney NSW 2000
Website: phio.org.au

Privacy Policy

To obtain a copy of the ahm Health Insurance Privacy Policy go to ahm.com.au, email info@ahm.com.au or call ahm Health Insurance on 134 246.

Private Health Insurance Code of Conduct

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

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

ahm Health Insurance is a business of Medibank Private Ltd ABN 47 080 890 259.

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