



Member Guide

Important information about your
health insurance

August 2018

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Important note: The information contained in this document is current at the time of issue (August 2018) and supersedes previously published material. Please ensure you read this document thoroughly and retain a copy for your reference. Membership of ahm is subject to our Fund Rules and policies which are summarised in this document. Premiums, benefits, Fund Rules and policies change from time to time. The information in this document only applies to ahm branded products. Insurance covers 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.

How to use our Member Guide

We've prepared this Member Guide to help you understand the important things about your health insurance. It summarises our Fund Rules and policies for all members, except Overseas Student Health Cover holders. You can download our Fund Rules at **ahm.com.au**

This Member Guide should be read with the product guide(s) for your cover. The product guide outlines what services are included under your cover and how much you can get back. You can download product guides at **ahm.com.au** or call **134 246** and we'll post you a copy.

Please read this Member Guide and your product guide(s) carefully and keep them in a safe place so you can refer to them when you need to.

If you've just joined us, the Member Guide and your product guide(s) go hand in hand with all the other information in your welcome pack.

Remember, if you have to go to hospital or have any other treatment, get in touch before your treatment to confirm what benefits you're entitled to. And don't forget to tell us if any of your details change.

ahm's Joining Statement

You are applying for an ahm health insurance private health insurance policy with Medibank Private Limited ABN 47 080 890 259 under its Health Benefits Fund and agree to be bound by the Fund Rules. You declare that all of the statements made in this application are true and complete and understand we may refuse payment of benefits, and that Lifetime Health Cover loading may be affected, if any statements are false in any respect. We reserve the right to vary our premiums, our private health insurance products or benefits payable, subject to the *Private Health Insurance Act 2007* and Rules. If you have paid premiums in advance, you will not be exempt from such changes. You consent to the collection, use and disclosure of personal information in accordance with the ahm Privacy Policy. You warrant that each named beneficiary has also given that consent. This includes consent to collect any personal information about a named beneficiary from you, any other named beneficiary, medical practitioner or health insurer. You completely indemnify us, our related parties, our officers, employees and agents for any losses, damages or expenses that arise from any allegation by any named beneficiary that any conduct, in acting in accordance with the ahm Privacy Policy, is without consent or otherwise amounts to an interference with privacy.

I've joined. What now?

Member card

When you join ahm you will get a card that includes your member number.

You'll need to use this card when you visit extras providers, arrange an admission to hospital or when you contact us. Make sure the details on the card are 100% correct.

If the details on your card aren't correct, you can let us know by live chat at **ahm.com.au** or by calling us on **134 236**.

Keep your member card safe and let us know straight away if it's lost or stolen. We don't accept any liability for the misuse of a lost or stolen member card.

Tip: Use your ahm member card to claim benefits on the spot at any recognised extras provider who has the electronic claiming service.

Switching private health insurers

If you're switching to ahm from another Australian private health insurer, we need Transfer Certificate(s) from them to make sure any comparable Waiting Periods for benefits you've already served are recognised. You may not be able to claim benefits for certain services until we've received your Transfer Certificate.

It's important to note any extras benefits you received from previous insurer/s may reduce the extras benefits you're entitled to under your ahm cover. Your annual limits for your first year of membership and any sub-limits or lifetime limits may be reduced by the amount/s you have received from your previous insurer.

We also need the Transfer Certificate(s) to verify whether a Lifetime Health Cover loading (page 35) applies to anyone on your membership, as this could affect your premiums.

If you choose a hospital cover with a lower excess, the excess of the equivalent cover will apply until you have served the relevant Waiting Period.

We'll request a Transfer Certificate on your behalf if you've authorised us to do so.

If you've switched from another health insurer, make sure you cancel any premium payment arrangements you may have with them.

Medicare eligibility

The colour of your Medicare card indicates your eligibility for Medicare. If you hold a Yellow (Reciprocal) Medicare card or if you don't have a Medicare card, this will affect the benefits we can pay under your cover. In some instances, the benefits set out in your cover won't be able to be paid, and you may end up with large Out-of-pocket Expenses.

If this is you, you must call us and let us know that you have limited Medicare eligibility. We'll be able to tell you the details and check that the cover you've chosen is the most appropriate for your circumstances.

If you have limited access to Medicare, we strongly recommend that you only purchase an ahm cover in conjunction with an Overseas Visitors Health Cover, which is more suitable for your needs. ahm offers Overseas Visitors Health Cover through Medibank Private. For more information, visit [medibank.com.au](https://www.medibank.com.au)

Starting your cover

You can start or change your cover at any time.

If you're switching health insurers, you may ask us to backdate your cover to the day after you left your previous health insurer (provided this period is 30 days or less) to ensure you have continuous cover (see page 37 for more details).

Cooling off period

We give you 30 days from the date your new or changed cover commences to review your cover and make sure you're happy with it.

If at that time, you want to change the cover in any way, or cancel it altogether, give us a call on **134 246**. We can either change you to a more appropriate cover or cancel the cover totally and refund your premiums, as long as you haven't made any claims during the cooling off period.

If you choose to increase your level of cover, you'll need to pay any difference in premiums from the date you increased it and you'll be subject to Waiting Periods and any other restrictions or exclusions associated with the new cover.

Overseas claims

Your ahm cover doesn't cover you for any claims for services provided outside Australia or for items purchased or hired from overseas suppliers.

You may want to consider travel insurance when you are travelling overseas. Without adequate travel insurance you could find yourself paying a lot of money if you're hospitalised or need to visit a doctor overseas.

Compensable claims

We won't pay benefits for a claim if you've received, or are entitled to receive, compensation or damages (including under an insurance scheme such as workers' compensation, motor vehicle accident or other third party insurance). This applies even if your cover includes Accidents.

We may agree to pay provisional benefits in some cases. We may withhold benefits until you've enquired into your rights to compensation.

When you make a claim for compensation, you'll need to provide us with timely information and copies of the claim documents.

If you receive any ahm benefits and you subsequently receive third party compensation in relation to the same claim, you must refund the benefits to ahm from the compensation.

Standard Information Statements

A Standard Information Statement (SIS) is an overview of key benefits and product features of your cover that we're required by legislation to provide. We'll send you a copy of your SIS at least once every 12 months and at other times when we are required to.

You should review the SIS in conjunction with your product guide and this Member Guide, to provide a full overview of the benefits available to you. You can download the SIS at any time at privatehealth.gov.au or get a copy by calling us on **134 246**.

Managing your cover

Log in to your account

You can manage your ahm cover online. To register for access, go to **ahm.com.au**

Once you're logged in to your account you can:

- View your extras claims history
- Make extras claims
- Use our benefit calculator to find out how much you might get back on an extras claim
- Request a replacement member card
- Search for Partner Private hospitals and Recognised Providers
- View and update your details
- Manage and make payments

Download the app

With the ahm app you can make most extras claims, check your account details and get in touch with us, no matter where you are.

You can download the ahm app at the App Store (iPhone) or Google Play (Android).

Make sure you keep your ahm mobile app updated as we'll be releasing new functionality along the way.

Partner Authorisation

This section applies to partners on the policy. When you [the partner] submit a paper claim form on your own behalf, you agree to the Terms and Conditions at **ahm.com.au/terms-and-conditions** and the terms of this Member Guide, which has been made available to you or the Principal Member. Unless you tell us otherwise (opt out), by making a claim you consent to the Principal Member viewing your extras claims history.

You agree that the Principal Member is authorised to otherwise manage the cover, including viewing the policy-wide usage of extras services (such as the dollar usage of dental or physio services for the whole policy) against annual limits. The Principal Member can't view your hospital claims history.

Adult/Student Dependant Authorisation

This section applies to Adult or Student Dependents on the policy. When you [the Adult/Student Dependant] submit a paper claim form on your own behalf, you agree to the Terms and Conditions at **ahm.com.au/terms-and-conditions** and the terms of this Member Guide, which has been made available to you or the Principal Member. Unless you tell us otherwise (opt out), by making a claim you consent to the Principal Member viewing your extras claims history.

You agree that the Principal Member is authorised to otherwise manage the cover, including viewing the policy-wide usage of extras services (such as the dollar usage of dental or physio services for the whole policy) against annual limits. The Principal Member can't view your hospital claims history.

Child Dependants under the age of 16

This section applies to Child Dependants on the policy. You [the Child Dependant under 16] may submit a paper claim form on your own behalf without the Principal Member or any Partner's authority. When you submit a paper claim form on your own behalf, you agree to the Terms and Conditions at ahm.com.au/terms-and-conditions and the terms of this Member Guide, which has been made available to you or the Principal Member.

When you submit an extras or hospital claim, the Principal Member may view your extras and hospital claims history and make claims on your behalf. When you turn 16, if you remain on the policy as a Student or Adult Dependant, you may be able to opt out of the Principal Member viewing your extras claims history.

You also agree that the Principal Member is authorised to otherwise manage the cover, including viewing the policy-wide usage of extras services (such as the dollar usage of dental or physio services for the whole policy) against annual limits.

Third Party Authorisation

A Principal Member's rights can be given to another person either by calling us or completing a Third Party Authority form. This will be registered on the membership until it is removed by the Principal Member.

By nominating a Third Party Authority, the Principal Member allows the nominated person to do anything that they would be able to do on the cover, such as have benefits paid to them, change bank account details and cancel the cover.

To nominate a Third Party Authority, download the Third Party Authority form at ahm.com.au or get in touch.

ahm also recognises other legal arrangements for third parties (e.g. Power of Attorney). In such cases, we may also need further information for identification purposes.

Your premiums

Paying your premiums

Premiums need to be paid in advance and can be paid up to a maximum of 12 months in advance. There are several ways to pay your premiums, and you can choose whichever works best for you. A surcharge may apply if you choose to pay your premiums by Visa or Mastercard. Get in touch to find out more.

Direct debit – You can set it up with your preferred frequency and payment date and we'll withdraw the premiums from your nominated bank account when the premiums are due. Set up regular payments by logging in to your account at ahm.com.au or getting in touch.

Visa or Mastercard – Set up with your preferred frequency and payment date and we'll withdraw the premiums from your nominated card when they are due. Set up regular payments by logging in to your account at ahm.com.au or getting in touch.

BPAY – Make payments via BPAY using the biller code 57430 and your member number as the customer reference number.

Online – One-off payments can be made using your Visa or Mastercard. Just log in to your account at ahm.com.au and go to the payment options.

Phone – Pay your premiums by Visa or Mastercard over the phone on **134 246**.

Mail – Write a cheque to 'ahm health insurance' and clearly print your name and member number on the back. Then send it to ahm health insurance, Locked Bag 4, Wetherill Park NSW 2164.

Premium protection

Premiums can change from time to time, subject to approval from the Minister of Health. We'll let you know if we're going to change the premium on your cover.

If you've paid your premiums in advance, any premium changes won't apply until your next payment is due.

However, if you make any changes to your membership, such as changing your level or category of cover, reactivating your cover after a suspension or moving to another State or Territory, the new premium will apply from the date of the change or the date you resume your membership. The date you have paid up to will then be adjusted accordingly.

Premium arrears

You can't receive a benefit for items or services provided during the period in which your membership is in arrears.

The Principal Member is responsible for ensuring that premiums are paid in advance at all times and, if paying by direct debit, that there are enough funds in the nominated account.

If your premiums are in arrears for more than two months, your cover will lapse and your membership will be terminated. We'll attempt to contact you during this time to let you know, and we'll also advise you in writing if the membership is terminated.

Premium refunds

If you cancel your cover, you're entitled to a refund of any prepaid premiums. Your refund will generally be calculated from the date of application. An administration fee may apply.

Adding/removing members

As your circumstances change you may need to add or remove members on your cover.

Only the Principal Member or other Authorised Person can add or remove a Partner or a Dependant or cancel the whole membership.

Anyone on the cover aged 16 and over can enquire about and change their personal details on the cover, or cancel their own membership.

Adding or removing a member may also mean that you need to change the category of cover you're on to suit your situation. It can also affect the premiums you'll need to pay.

Here's a list of the people who can be on your cover:

Principal Member – the first person listed on the membership; the one who is responsible for the membership and the payment of premiums.

Partner – a person who lives with the Principal Member in a marital or de facto relationship.

Child Dependant – a child of the Principal Member or their Partner, who is not married or living in a de facto relationship and is under the age of 21.

Student Dependant – a child of the Principal Member or their Partner, who is not married or living in a de facto relationship, has reached the age of 21 but is under the age of 25 and is undertaking full-time education.

Adult Dependant – a child of the Principal Member or their Partner, who is not married or living in a de facto relationship, has reached the age of 21 but is under the age of 25, and is not a Student Dependant. Adult Dependents can only be included on selected covers for an additional premium.

Glossary

Full-time education: a course of study being undertaken at an Australian educational institution, requiring a full-time study workload.

Categories of cover

Single – one person only: the Principal Member.

Couple – the Principal Member and their Partner.

Single Parent Family – the Principal Member and any of their Child or Student Dependants.

Family – the Principal Member, their Partner and any of their Child or Student Dependants.

We also provide an option for families with Adult Dependants, where, for an additional cost, some covers can be extended to also include an Adult Dependant/s. Not all membership categories are available for all covers. Get in touch to find out more.

Anyone you add to your cover will need to serve Waiting Periods (page 13), unless they've previously held cover for the same benefits and have not had a break in cover for more than 30 days between their old and new cover.

Having a baby?

If you're thinking about starting a family, make sure your cover includes Obstetrics- related services. There is a 12-month Waiting Period for these services that the mother will need to have served before receiving any benefits.

In addition, once the baby is born, you'll want to make sure they're added to your cover.

If you're on a single cover and want to add your baby, you'll need to change your cover to either a family or single parent family cover within **two months** of the baby's birth.

This change to your cover will take effect from the date of birth, and any difference in premiums will be payable from that date. This will ensure the baby only has to serve any Waiting Periods not already served by the Principal Member.

If you already hold a family or single parent family cover when your baby is born, all you need to do is add your baby to your cover within 12 months of the birth. The child will be included under the cover from birth and only have to serve those Waiting Periods not already served by the Principal Member.

You won't be charged for hospital accommodation for your baby for the first 10 days of their life unless the baby is admitted to hospital in their own right (e.g. a special care nursery or intensive care). Generally, a newborn isn't separately admitted to hospital as an Inpatient (this is because the baby comes under the mother's admission).

With multiple births, you won't be charged hospital accommodation for the first baby unless one or more is admitted as an Inpatient. You *will* be charged for hospital accommodation for your second and any subsequent babies so you need to ensure they're covered from birth.

Remember that your hospital Daily Charge and/or Excess (page 21) will apply for the mother and any admitted babies, up to the applicable limit. Check your product guide to confirm what limits apply to your cover.

Adding your Partner or Dependants

Your Partner or Dependants (other than newborn babies - see above) can generally only be added from the date you advise us. Waiting Periods may apply (page 13).

Changing your cover

There are many reasons you might need to change your cover as your life changes. For instance, you may decide you need additional services for older children, or a different type of cover after the kids leave home.

Whatever the case, changing your level of cover has several implications:

- You may be required to serve Waiting Periods for any additional services or items not previously included under your cover or that have an increased benefit.
- You may have a different Daily Charge and/or Excess on your hospital cover to your previous cover.
- In some instances, certain services may become unavailable.

If you change your cover, keep in mind that where any limits apply to your cover, any benefits previously paid under your old cover will be taken into account.

Changing contact details

You are required to pay the premium that applies to the State or Territory that you live in. So if you're moving interstate, you must let us know as soon as you can so we can calculate your new premium amount.

If you move interstate, your premiums will be adjusted to reflect the change and to ensure you receive the benefits applicable to your State or Territory.

If you move, let us know your new residential and/or mailing addresses as soon as possible so we can ensure you continue to receive any important mail. Don't forget to tell us if you change your phone number or email address.

Glossary

Financial Date: the date to which the Principal Member has fully paid the premiums in respect of the Policy.

Suspending your cover

You can ask to put your cover on hold for up to two years at a time if:

- you're travelling overseas (for more than 30 days), or
- you or your Partner become unemployed.

No benefits will be paid during any period of suspension.

Overseas trip

If you're going overseas for more than 30 days, you can request to suspend your cover for up to two years at a time. This won't affect any Loyalty Limits as the period of suspension will still count towards the years of continuous cover. However, the suspension time doesn't count towards any applicable Waiting Periods.

Just send us a written or email request in advance of your holiday. If anything changes, you need to let us know as soon as possible. Don't forget to notify us of your new return date within 30 days of arriving back in Australia.

For your suspension to be approved, your premiums must be paid up until the date of your departure. We'll then confirm the suspension to you in writing, and we'll even contact you on your return to reactivate your cover and remind you that you need to pay your premiums.

Unemployment

If you and your Partner are on the same cover, and either of you are unemployed, you can suspend your cover for up to two years.

Simply provide us with proof of you or your Partner's receipt of a Newstart Allowance, Sickness Allowance or any other similar allowance relating to unemployment under the *Social Security Act 1991*.

When either you or your Partner returns to work, you'll need to advise us within 30 days of the employment start date.

Tax implications

If you hold hospital cover, suspending your cover may mean you're subject to the Medicare Levy Surcharge for the time of your suspension. This is because the Australian Taxation Office (ATO) sees you as not holding appropriate private hospital cover for the period. Contact your Accountant, Financial Advisor or call the ATO on **13 28 61** for more details.

Cancelling your cover/membership

Only the Principal Member, or their Authorised Third Party, has the right to cancel a whole membership.

To cancel your membership you'll need to call us on **134 246**.

We'll cancel your membership from the date that we receive your notice (or any future date you nominate) and forward you a refund of any excess premiums. An administration fee may apply. Any surcharge paid in relation to your method of payment (page 8) will not be refunded.

Membership terminations

We reserve the right to terminate a membership in the following circumstances:

- the membership premiums have not been paid for more than two consecutive months,
- we believe there has been an attempt to obtain an improper advantage,
- we believe a fraud or attempted fraud has been committed,
- information contained in your membership application or change of cover application is found to be incorrect or incomplete,
- the circumstances of anyone on the cover has changed and you have not advised us,
- the Principal Member falsely agreed to the Joining Statement or change of cover declaration.

If we decide to terminate your membership, we'll let you know in writing.

Waiting Periods

A Waiting Period is a set amount of time you must wait before any benefits are payable for items and services that are included under your cover. Benefits are not payable for items and services received during a Waiting Period.

Waiting Periods apply when you first join private health insurance. They may also apply if you cancel and then rejoin or change insurers with a gap of more than 30 days or if you change to a level of cover that has additional services or higher benefits on services where a Waiting Period applies. This includes changing cover to reduce any Excess and/or Daily Charge that applies.

If you're switching from another private health insurer with a gap in cover of 30 days or less, we may recognise the Waiting Periods you've already served for comparable benefits.

Please check your product guide for information about Waiting Periods that apply to your ahm cover.

Hospital Waiting Periods

1 day

- Hospital treatment as a result of an Accident
- Ambulance Services
- Travel and Accommodation

2 months

- Hospital treatment (where there are no Pre-Existing Conditions)
- Rehabilitation, Psychiatric services and Palliative care (regardless of whether it is a Pre-Existing Condition)
- Doctor's health checks and Healthy Heart checks

12 months

- Pre-Existing Conditions (page 15)
- Obstetrics-related services
- Disease Management Appliances
- Speech Processors and Insulin Pump Replacements

Extras Waiting Periods

Extras Waiting Periods can vary depending on the cover you hold. Check your product guide to see the Waiting Periods that apply to your cover.

1 day

- Emergency Ambulance

2 months

- All other services (applies to some covers - check your product guide)

6 months

- Optical Appliances (applies to some covers - check your product guide)

12 months

- Complex dental
- Major dental
- Orthodontics
- Podiatric Surgery
- Orthotics and orthopaedic shoes
- Hearing aids
- Pre and post natal services
- Medical gases
- Joint fluid replacement injections
- Midwife-Assisted Home Births

2 years

- Refractive sight-correcting laser eye surgery (you need to have held lifestyle extras or super extras cover for two years before you're entitled to this benefit)

Mental Health Waiver

The Mental Health Waiver allows members who have served their two month waiting period for Restricted in-hospital Psychiatric Services to upgrade to a cover with Included in-hospital Psychiatric Services and elect to have the two month waiting period for those higher benefits waived.

Members can elect to use their waiver at the point of upgrading or after upgrading, prior to serving the two month waiting period for Included Psychiatric Services. Members need to have held hospital cover without a break of more than 30 days to be eligible to use the waiver.

The waiver only applies to the two month waiting period for the higher Included benefits for in-hospital Psychiatric Services. All other applicable waiting periods will continue to apply.

Members will only be able to use the Mental Health Waiver once in their lifetime.

Pre-Existing Conditions (PEC)

Pre-Existing Conditions (PEC) are subject to a 12-month Waiting Period from the time you became insured under or changed your cover. A PEC is an ailment, illness or condition that, in the opinion of a Medical Practitioner appointed by ahm, the signs or symptoms of which existed at any time in the period of six months before you became insured under or changed your cover.

Our appointed Medical Practitioner is the only person authorised to decide if an ailment, illness or condition is pre-existing. They must consider any information that was provided by the medical practitioner who treated the ailment, illness or condition.

Assuming that we receive all the information required from your treating medical practitioner(s), we'll need up to 10 working days to make the assessment, so you should consider this when you agree to a hospital admission date. If you're admitted into hospital without confirming your benefit entitlements and your condition is subsequently determined to be pre-existing, you'll be required to pay any hospital and medical charges not covered by Medicare.

If you're admitted to hospital for an emergency, we may not have time to assess if the PEC rule applies. As a result, you may have to pay for all or some of the hospital and medical charges if:

- you've held your current hospital cover for less than 12 months; or
- you've changed your cover to include a new or upgraded treatment and haven't had that treatment included under your cover for 12 months, and
- you're admitted to hospital and choose to be treated as a private patient, and
- your condition is later determined to be pre-existing.

Hospital cover

What's covered?

This depends on what cover you have. Check your product guide or our website for a list of services and procedures included under your cover.

If you need to go to hospital, get in touch to confirm your cover, Waiting Periods, Daily Charge and/or Excess and to check whether the hospital has an agreement with us.

ahm hospital covers pay benefits towards the following, provided the service is an Included Service under your cover

Note: the benefit we pay for these services may not be enough to cover all of the costs associated with your treatment.

- Ambulance Services
- Partner Private hospital
 - Agreed charges for accommodation in private or shared room
 - Same day admissions
 - Intensive care
 - Theatre fees
- Public hospital accommodation as a private patient
 - Accommodation in a shared room
 - Same-day admissions (shared room only)
- Doctors' fees for in-hospital medical services when you're treated as a private patient
- Intensive care
- Surgically implanted prostheses to the minimum benefit listed on the government's Prostheses List
- Medical gap for doctors' and surgeons' in-hospital medical fees if they participate in GapCover for your claim forming part of your treatment.

No benefits are payable for Excluded Services.

If a service is Restricted, then some of these benefits won't be paid and you'll be significantly out of pocket.

Tip: Check your product guide for a list of the Included services and any Restricted or Excluded Services under your cover. Don't forget to get in touch before commencing treatment or going to hospital to confirm what benefits will be paid and potential Out-of-pocket Expenses you might incur.

The hospital and doctors treating you should tell you about their costs before you go to hospital, so it's important to ask before you are admitted. This will enable you to provide informed financial consent.

Glossary

Inpatient: someone who is admitted to a hospital as an overnight or day patient.

Outpatient: a person who receives treatment while not admitted to a hospital, such as treatment in an emergency department, visits to a general practitioner (GP) or a specialist.

Default Benefit: an amount set by the government as the minimum amount that a health fund must contribute towards hospital accommodation charges for an Included or Restricted service or treatment. Also known as a Minimum Benefit. Where a Default Benefit applies a member may have significant Out-of-pocket Expenses.

Agreed charge: to help you know your costs and benefits up front, we've contracted with most private hospitals which includes an agreement on how much they can charge.

Ambulance Services

ahm hospital covers include Medically Necessary ambulance transportation and services provided by an ahm approved ambulance provider. This includes transport to the nearest hospital that's able to provide the level of care you need. Some covers limit the number of ambulance services we'll pay benefits towards per financial year. Check your product guide to see if any limits apply to your cover.

We don't pay benefits towards any ambulance services that aren't Medically Necessary. This includes general patient transport or any transport after you're discharged from hospital (e.g. hospital to home).

Some State governments, however, have their own schemes in place, so if you live in NSW, the ACT, QLD or TAS, please take note of the following.

If you live in NSW or the ACT, your hospital cover includes a levy to the ambulance service. Pensioners/Concession Card holders are exempt from this levy – so if you hold any of the following cards you're entitled to a lower premium:

- Concession Card
- Health Benefits Card
- Pension Health Benefits Concession Card and Social Security Card
- Veteran Affairs Pension Card.

To be eligible for the lower premium, every person on your cover must be listed on the concession card.

You'll need to provide us with your concession card details, including the expiry date. You'll also need to provide us with new card details when your concession card expires.

If your circumstances change, and you lose access to the benefits under your Concession Card, let us know as soon as possible so we can make sure ambulance services are included under your cover.

If you live in TAS or QLD, you're already covered by your State's scheme. However, we do meet the costs for any interstate ambulance if not covered by the State scheme.

Note: your Daily Charge and/or Excess doesn't apply to ambulance claims and we don't pay benefits towards ambulance subscriptions.

Disease management appliances

Some ahm hospital covers pay benefits towards a number of disease management appliances.

Check your product guide to see if you're eligible for benefits for these items.

If you wish to make a claim for one of these appliances, you'll need to provide us with:

- a letter from a medical practitioner that recommends the relevant appliance for the condition being managed, or
- a prescription for the appliance relevant to the condition.

Insulin pump and speech processor replacements

Some ahm hospital covers pay benefits towards these items. Check your product guide to see if it's included.

You'll be able to claim benefits for these items where the replacement is done as an Outpatient service, which means that the replacement is fitted in a doctor's surgery or rooms rather than in hospital. You won't be able to claim benefits for the doctor or specialist's Outpatient medical fees.

These items are paid in the same way as other prostheses. This means we'll pay in accordance with the minimum benefit listed on the government's Prostheses List.

We'll only pay a benefit where your specialist verifies that the replacement is medically necessary and it's not a replacement for a processor or pump that's still within warranty.

In almost all cases, we'll cover the cost of the item in full so you won't need to pay for the item first and then claim a refund from us.

If you're charged more than the minimum benefit listed on the government's Prostheses List, we'll only pay the listed minimum benefit and you will have to pay the difference. We won't pay benefits for devices not included on the government's Prostheses List.

Travel and accommodation benefits

Some ahm hospital covers pay benefits towards travel and accommodation. Check your product guide to see if it's included.

We'll pay a travel and accommodation benefit related to a hospitalisation where:

- the patient has to travel more than 200km return in relation to a hospitalisation, or
- in life or death situations, for a partner or next of kin (supporter) to accompany the patient, or
- a parent accompanies a Child Dependant under the age of 21.

This benefit is only payable where both the patient and the supporter hold an ahm hospital cover that includes this benefit 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.

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.

We'll pay for accommodation for the supporter during the patient's hospital admission only.

Proof of travel and accommodation costs will be required.

What's partially covered?

This depends on your particular ahm hospital cover.

Check your product guide for a list of services you're partially covered for.

Restricted Services

If a service is Restricted under your cover, it means that we'll only pay the Default Benefit if you're treated at a private hospital or as a private patient at a public hospital.

Default Benefits may not cover the full cost of your hospital accommodation and you may be left with large Out-of-pocket Expenses.

Restricted Services include benefits towards the following:

- Default Benefit for shared room accommodation at a public hospital or a reduced level of accommodation benefits at a private hospital (Default Benefit, page 17)
- Surgically implanted prostheses up to the minimum benefit listed on the government's Prostheses List
- Doctors' fees for in-hospital medical services when you're treated as a private patient
- Medical Gap for doctors' and surgeons' in-hospital medical fees if they participate in GapCover for your claim forming part of your treatment.

Please note, any Daily Charge and/or Excess (page 21) applicable to your cover will be charged even where only a Default Benefit is paid.

Nursing home type patients (NHTP)

If you're admitted to hospital for more than 35 days in succession, you'll be regarded as a nursing home type patient, unless your doctor certifies your need for ongoing acute care. This means we'll pay a lower benefit towards the daily hospital accommodation charge which could result in significant Out-of-pocket Expenses.

What isn't covered?

Excluded Services

If a service is Excluded on your cover it means that we won't pay a benefit towards it and you'll be significantly out of pocket if you choose to be treated as a private patient.

For these services, you won't receive anything from us towards the costs of treatment so you will have to pay all costs yourself.

Check your product guide(s) for a list of services which are Excluded.

Other procedures, charges and items that aren't covered

- Charges above the Medicare Benefits Schedule (MBS) fee unless your doctor chooses to participate in GapCover. If your doctor participates in GapCover for your claim forming part of your treatment, we'll pay up to the GapCover agreed fee (see page 22 for information on GapCover)
- Charges above the minimum benefit for surgically implanted prostheses set out in the government's Prostheses List
- The full cost of your accommodation or theatre fees if you attend a non-Partner Private hospital for an Included service

- Any benefit at all for Excluded services under your cover, including (but not limited to) accommodation, theatre fees, intensive care, prostheses, medication, allied health and the medical gap
- Any accommodation charges above the Default Benefit for Restricted services
- Treatment that's subject to a Waiting Period, provided while premiums are in arrears or while your membership is suspended
- Personal items such as phone calls, 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) who aren't directly employed by the hospital you're treated in. You may be entitled to receive a benefit towards these services if you have an ahm extras cover
- Most Non Pharmaceutical Benefits Scheme (PBS) drugs – the hospital should advise you if these drugs won't be paid for by us through 'Informed Financial Consent'
- Medical Costs for services not covered by Medicare
- Any medical, hospital or ambulance services received overseas or purchased outside Australia, including online purchases from overseas companies
- Cosmetic Treatment
- Claims for services in respect of which you have received, or are entitled to receive, compensation (page 6)
- Claims that are fully covered by a third party.

Services for which a Medicare benefit isn't payable

We'll only pay benefits if Medicare considers the procedure to be medically necessary and pays a benefit for the doctor.

To make a claim, we need a Medicare statement that informs us of their payment.

If you go into hospital to have a procedure for which a Medicare benefit isn't payable then you'll be paying a lot more.

If Medicare doesn't pay a benefit, no benefit is paid towards medical costs, theatre fees or intensive care fees.

Podiatric Surgery

Medicare benefits are not payable for podiatric surgery so your hospital cover won't pay any benefits for the doctors' charges, but some extras covers may pay benefits towards doctors' charges for podiatric surgery. Check your product guide(s) for information and benefits.

Cosmetic Treatment

Cosmetic Treatment is any treatment which is not medically necessary and aims to revise or change the appearance, colour, texture, structure or position of normal bodily features.

No benefits are payable towards procedures or hospital costs associated with Cosmetic Treatment.

Here are some examples of procedures that ahm doesn't pay benefits for:

- breast augmentation (except following a mastectomy, as a Medicare benefit is payable for this procedure)
- laser eye surgery to remove the need for glasses
- blepharoplasty (eyelid reduction)
- dermabrasion (abrasive therapy, chemical face peels).

Nursing homes

We don't pay benefits towards the cost of residential aged care (e.g. nursing homes or aged care facilities) or for associated respite care.

What you pay when you go to hospital

Although hospital cover helps reduce the cost of a hospital visit, you'll still have Out-of-pocket Expenses for things like your Excess, Daily Charge and any difference between what the hospital or doctor charges and the benefit we pay for the services or items.

Any Daily Charge and/or Excess on your hospital cover will apply even where only the Default Benefit is paid.

Daily Charge (Co-payment)

At ahm, a Daily Charge (also known as a Co-payment) is the daily amount that you agree to pay towards the cost of treatment if you're admitted to hospital (including same-day procedures).

It applies to each person on your cover and there is a maximum amount each person on your cover has to pay - either each hospital admission or each Membership Year (check your product guide). The Daily Charge is a separate amount you'll need to pay the hospital, in addition to any applicable Excess (up to your limit).

Excess

An Excess helps to reduce your premiums. At ahm, an Excess is an upfront lump sum payment that you agree to pay towards the cost of your hospital stay or day surgery on admission.

It applies to each person on your policy and there is a maximum amount for each person per Membership Year.

If the charge for your first admission is less than the Excess amount, any remaining Excess must be paid if you're admitted to hospital again in the same Membership Year. The Excess applies in addition to any applicable Daily Charge (up to your limit).

Tip: Check your product guide to see if a Daily Charge (Co-payment) and/or Excess applies to your hospital cover.

Glossary

Membership Year: the annual period commencing on the date that the member joins an ahm cover, or changes to a new ahm cover for hospital treatment, and renews every year on that date.

Out-of-pocket Expenses: any expense for a hospital, medical or extras service or item for which you will not be reimbursed by either us or Medicare. It is the amount you have to pay.

There might be a gap

The benefit we pay towards in-hospital medical services is based on the Medicare Benefits Schedule (MBS).

Items on the MBS are subject to change from time to time in accordance with changes made by the Department of Health.

The MBS lists all of the medical services subsidised by the Australian government through Medicare, including:

- doctors' services, e.g. GPs and specialists
- diagnostic services, e.g. blood tests, x-rays and ultrasounds provided by pathologists and radiologists.

Each service listed in the schedule has an item number and a corresponding fee that's been set by the government. If a service is listed in the MBS and Included or Restricted under your cover Medicare will pay 75% and we will pay 25% of the MBS fee.

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 'gap'.

How GapCover can help

GapCover is a scheme designed to help eliminate or reduce your out-of-pocket expenses for in-hospital specialists' charges.

If your doctor chooses to participate in GapCover for your claim forming part of your treatment and meets the terms and conditions associated with the scheme, we'll provide benefits up to an agreed fee and then you'll have to pay the difference.

Under GapCover, the maximum gap you'll have to pay is \$500 per claim and per provider (i.e. each doctor's account).

A doctor can choose to participate on a per claim, per treatment and per patient basis, so you should always check upfront with them prior to agreeing to each claim forming part of your treatment and ask them to provide you with an estimate of medical fees. If you are being treated by more than one doctor (e.g. surgeon and anaesthetist), participation is at each individual doctor's discretion.

GapCover doesn't apply to diagnostic services such as blood tests and x-rays provided by pathologists and radiologists, out-of-hospital medical services, or services not included under your cover. GapCover also doesn't apply to things such as Excess and Daily Charges. You may still have Out-of-pocket Expenses.

If your doctor chooses not to participate in GapCover, we will only pay 25% of the MBS fee (for Included and Restricted services) and you'll have to pay the difference between the MBS fee and what your doctor charges you.

Search for a doctor

Search online for doctors who've previously registered to participate in GapCover at ahm.com.au/find-a-doctor. Just because a doctor has previously participated in GapCover doesn't mean they'll do so for your procedure, so again, it's important to ask prior to each claim forming part of your treatment.

Doctors' admitting rights

Not all doctors can admit you to all hospitals. Your doctor will be able to tell you which hospitals they can admit you to.

Where you'll be treated

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, in conjunction with your doctor or specialist.

Partner Private hospitals and day surgeries

If you're treated as a private patient, we have agreements in place with the majority of private hospitals and day surgeries throughout Australia.

These agreements detail agreed theatre and accommodation charges for Included Services under your cover. This doesn't apply to Restricted or Excluded Services.

If you receive treatment for a Restricted Service in a Partner Private hospital, we'll only pay Default Benefits and you'll be significantly out of pocket. If you receive treatment for an Excluded Service, no benefits will be paid.

Our agreements with Partner Private hospitals are subject to change. You should confirm prior to receiving treatment whether your hospital provider is part of our network as this may affect your Out-of-pocket Expenses.

To find a Partner Private hospital, use our Find a provider search at ahm.com.au

Non-Partner Private hospitals and day surgeries

In some instances, we don't have an agreement with a Partner Private hospital or day surgery. These are referred to as non-Partner Private hospitals.

If you receive treatment for a service that's Included or Restricted under your cover at a non-Partner Private hospital we'll only pay the Default Benefit and you'll be significantly out of pocket. If you receive treatment for an Excluded Service no benefits will be paid.

We recommend you call us before being treated to clarify your benefit entitlements. The hospital and doctors treating you should tell you about their costs before you go to hospital, so it's important to ask.

Public hospitals

If you're treated as a private patient in a public hospital for Included services, we'll pay the Default Benefit for same-day admissions and overnight accommodation in a shared room. You'll need to pay any difference between the Default Benefit we pay and the amount the hospital charges.

This means you may need to pay significant Out-of-pocket Expenses. You should ensure you obtain all the information about hospital and medical charges so you can give Informed Financial Consent before you are treated.

Going to hospital

Going to hospital can be a daunting experience so to help you prepare we've provided you with details of what you need to know over the next few pages.

Before you receive treatment you're entitled to ask your doctor, your health insurer and your hospital about any Out-of-pocket Expenses you'll need to pay. Being fully aware of how much your treatment will cost will allow you to give Informed Financial Consent.

We've included a checklist of the important questions that you should ask before you're admitted, a section on the different costs involved and what happens after you leave hospital. We've also prepared a Hospital benefits table (page 26) to help you understand what benefits we'll pay under hospital covers and where Out-of-pocket Expenses can occur.

This information will provide you with a good summary of what you need to know; however, you should always call us before you go to hospital so we can confirm what benefits you're entitled to.

Before you go to hospital

Things to ask your GP/Specialist:

- where you'll be treated (if it's not a Partner Private hospital we'll only pay the Default Benefit and you'll be significantly out of pocket)?
- how long you will be in hospital?
- who will be treating you and will they participate in GapCover for each claim forming part of your treatment (to keep your costs to a minimum)?
- what other costs are involved?
- will there be any other specialists involved, e.g. assistant surgeon or anaesthetist, and will they participate in GapCover for each claim forming part of your treatment?
- will you need any prostheses?
- what are the total costs involved? Your specialist should provide you with an estimate of medical fees prior to your treatment so you're fully aware of what you'll have to pay. This will enable you to provide Informed Financial Consent.

Understand your treatment

Make sure you ask for:

- a full explanation of the procedure and any likely complications or prostheses involved
- if there are other treatment options
- how long you'll take to recover
- how long you'll have to wait for test results.

Call us to check your cover and benefit entitlements

We will check:

- if the service is Included or Restricted under your cover
- whether you have served your Waiting Periods (including the 12-month Waiting Period for Pre-Existing Conditions)
- what Daily Charge and/or Excess applies to your cover.

Prostheses charges

A prosthesis is a surgically-implanted item such as a stent (for coronary arteries), grommets or titanium plates and screws. Except for Excluded Services, we'll cover you up to the minimum benefit listed on the government's Prostheses List (the Prostheses List).

There may be more than one clinically appropriate prosthesis available for your procedure, including some that cost more than the minimum benefit.

You should talk to your doctor prior to your treatment so that you can make a fully informed decision about the cost of your treatment.

If you do choose a prosthesis that costs more than the minimum benefit, you'll have to pay the difference between the minimum benefit and the prosthesis charge. We won't pay benefits for prostheses not included on the Prostheses List.

Benefits for pharmaceuticals

The Pharmaceutical Benefit Scheme (PBS) is a government scheme that subsidises the cost of prescription medicine. The PBS sets the amount a Patient pays towards the cost of a subsidised drug. We'll pay the PBS amount if you're an Inpatient and the drug is prescribed for your treatment.

After hospital

Hospital and doctors' bills

If you're treated in a Partner Private hospital for a service that is included under your cover, the hospital will send the bill directly to us. You'll receive a statement showing the benefits that we've paid, for your information.

If your doctor/specialist participated in GapCover for your claim forming part of your treatment, they'll also send their bill directly to us and we'll send you a statement showing how much we've paid. This means that you don't have to worry about filling in any claim forms.

If your doctor didn't participate in GapCover, they'll send the bill to you. You'll need to take this to Medicare to claim from them first, and then fill in a claim form and send it to us with the Medicare Statement of Benefits attached. Whatever isn't paid for by Medicare or us is what you'll have to pay to your doctor.

Out-of-hospital treatment

To assist in your recovery, your doctor may recommend that you see other healthcare providers after you've left hospital.

Out-of-hospital treatment, such as physiotherapy, isn't included in ahm hospital covers; however, you may be able to claim benefits if you have an ahm extras or packaged cover.

Outpatient services

Medicare covers 85% of the MBS fee when you receive medical services outside hospital, such as GP visits, visits in a specialist's room, or in an accident and emergency room, or as a non-admitted patient in a hospital.

Under government legislation, health insurers are not generally allowed to pay benefits for Outpatient services. This is why we won't pay any benefits where you're not admitted to hospital. A rebate may be claimable from Medicare for Outpatient services.

Hospital Benefits table

We've prepared this table to help you understand what benefits we'll pay under our hospital covers (for Included and Restricted services) and where Out-of-pocket Expenses can arise. We don't pay any benefits for Excluded Services (check your product guide).

		Partner Private hospital	Non-Partner Private hospital	Public hospital
Accommodation and Intensive Care Unit (ICU) charges	Included service	<ul style="list-style-type: none"> • ahm pays the cost of shared or private room accommodation in hospital or same-day facility. • Your Out-of-pocket Expenses- any hospital Excess and/or Daily Charge applicable to your cover. 	<ul style="list-style-type: none"> • ahm pays the Default Benefit set by the Australian Government. • Your Out-of-pocket Expenses - any charge above the Default Benefit and any Excess and/or Daily Charge applicable to your cover. 	
	Restricted service	<ul style="list-style-type: none"> • ahm pays the Default Benefit set by the Australian Government. • Your Out-of-pocket Expenses - any charge above the Default Benefit in addition to any Excess and/or Daily Charge applicable to your cover. 		
Theatre fees	Included service	<ul style="list-style-type: none"> • ahm pays costs as per our agreement with the hospital. • Your Out-of-pocket Expenses- any hospital Excess and/or Daily Charge applicable to your cover. 	<ul style="list-style-type: none"> • ahm pays no benefits. • Your Out-of-pocket Expenses - any charge raised by the hospital and any Excess and/or Daily Charge applicable to your cover. 	
	Restricted service	<ul style="list-style-type: none"> • ahm pays no benefits. • Your Out-of-pocket Expenses - any charge raised by the hospital and any Excess and/or Daily Charge applicable to your cover. 		
Surgically implanted prostheses	Included or Restricted service	<ul style="list-style-type: none"> • ahm pays the minimum benefit set out in the government's Prostheses List. • Your Out-of-pocket Expenses - any charge above the minimum benefit OR the full cost of the prosthesis if it's not on the Prostheses List. 		
In-hospital doctors' medical services	Included or Restricted service	<ul style="list-style-type: none"> • ahm pays 25% of the MBS fee. • Your Out-of-pocket Expenses - where your doctor/s charge more than the MBS fee and: <ul style="list-style-type: none"> • participates in our GapCover - limited expense of no more than \$500 per provider account. • does not participate in our GapCover - any charge above the MBS fee per provider. 		
In-hospital diagnostics (e.g. bloods tests, scans etc.)	Included or Restricted service	<ul style="list-style-type: none"> • ahm pays 25% of the MBS fee. • Your Out-of-pocket Expenses - any charge above the MBS fee per service. 		

Extras cover

Extras cover helps with the costs of services and items for which a Medicare benefit isn't payable, like dental, prescription glasses or physio.

What's included?

The services, and benefits you'll receive for these services, depend upon the type of ahm extras cover you have. We'll either pay a percentage or a fixed benefit, up to your annual limit, towards the services you're insured for, so your Out-of-pocket Expenses will depend on what the provider charges. Use our claims calculator in Member Services, or contact us before your treatment to get an idea of how much you'll get back and what your Out-of-pocket Expenses might be.

Check your product guide for a list of the services included under your cover. You would have received one in your welcome pack and these are also available at ahm.com.au. Benefits are subject to limits (page 31) and Waiting Periods (page 13).

Consultations

You're able to claim for one face-to-face consultation with a provider on a given day.

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

Benefits are not payable for telephone consultations; however, consultations for some services delivered via video conference are claimable.

Some covers include separate benefits for an initial and subsequent consultation. Benefits for an initial consultation are payable once per therapy per person each financial year, up to your limit (check your product guide).

Broken appointments

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

Emergency Ambulance

If you have ahm extras cover on its own, we only pay benefits for Emergency Ambulance services provided by an ahm approved ambulance provider. This means a sudden or unexpected need for hospitalisation where the only practical way of getting to a hospital is by ambulance.

We don't pay benefits for ambulance subscriptions and we don't pay benefits for other ambulance services such as:

- transfers between hospitals
- travelling from home to hospital for tests
- any transport on discharge from hospital (e.g. hospital to home).

Travel and accommodation

Travel and accommodation benefits are available on some ahm extras covers if you need to travel more than 200km return for a specialist medical appointment or an Outpatient procedure and there's no ahm Recognised Provider near where you live.

This doesn't include travel and accommodation related to hospitalisations, dental or extras services and IVF treatment.

To claim for travel and accommodation benefits you need to complete a claim form and supply an invoice for your accommodation, which includes the date, plus one of the following:

- a statement of attendance from a doctor, or
- a copy of a Medicare statement or bulk billing statement, or
- a copy of the doctor's account, or
- a copy of a completed form for a State-based travel and accommodation subsidy scheme (e.g. IPTAAS in NSW, PTSS in QLD etc.).

Pharmacy

The Pharmaceutical Benefit Scheme (PBS) is a government scheme that subsidises the cost of prescription medicine.

The PBS sets the amount a Patient pays towards the cost of a subsidised drug.

If your ahm extras cover includes benefits for Pharmacy, we'll pay benefits for non-PBS pharmacy items that are prescription-only and prescribed by a medical practitioner as being essential to treat your condition. We'll pay benefits up to a set amount per item, up to your limit. Before we'll pay any benefits, we'll deduct an amount equal to the non-concessional PBS co-payment.

We won't pay any benefits where your non-PBS item costs less than the co-payment amount.

Benefits are not payable for oral contraceptives (unless they're prescribed for purposes other than contraception) or for pharmaceuticals prescribed for cosmetic purposes. No benefits are payable for items available without a prescription, herbal medicines, vitamins or any over-the-counter preparations.

The PBS is only available to persons with Medicare eligibility and a prescription will be required for all claims.

Orthotics and orthopaedic footwear

We'll pay benefits for orthotics and orthopaedic footwear only if custom made and supplied by an ahm recognised podiatrist or orthopaedic footwear supplier.

Benefits don't cover pre-moulded, pre-fabricated or off-the-shelf orthotics such as sporthotics or formthotics. If you're purchasing from an orthopaedic manufacturer or supplier, make sure you include a referral from an ahm Recognised Provider with your claim.

We accept referrals from ahm recognised Physiotherapists, Chiropractors and Podiatrists for orthotic devices.

Prenatal and postnatal services and birthing courses

We'll pay benefits towards consultations, classes and birthing courses provided by a registered midwife. We also pay benefits towards pregnancy compression garments, provided they've been approved by the Therapeutic Goods Administration (TGA) and you have a supporting letter from a Medical Practitioner. Prenatal and postnatal services and birthing courses aren't available on all covers, and some covers have limits on the number of pregnancy garments that can be claimed. Please check your product guide to see what's included under your cover.

Dental benefits

There are some restrictions on dental benefits. This includes some items we don't pay for. It also includes some item numbers that cannot be claimed in combination with each other.

Some dental items (e.g. scale and clean) have a limit on the number of services allowed each year. Contact us to find out more.

Item numbers are subject to change in accordance with the Australian Dental Association Schedule of Dental Services and Glossary.

Health Improvement Benefits

In Australia, private health insurers can only pay benefits towards health improvement benefits that form part of a health management program. The health management program must be intended to manage a specific health condition(s) identified by a Health Provider before you start the class or program.

Health Improvement Benefits aren't available on all ahm extras covers. Please check your product guide to see what's included under your cover.

A Health Improvement Benefit Approval Form must be completed by a Health Provider for the following classes or programs:

- Exercise classes or Personal training
- Pilates
- Yoga
- Exercise physiology
- Swimming lessons for children 0-17 years
- Gym membership
- Weight loss classes and courses

Swimming lessons (age 0-17 years) – if a child 0-17 years of age has asthma, diabetes or an unhealthy Body Mass Index (BMI), benefits may be claimed towards swimming lessons provided by an Austswim® or Swim Australia™ accredited swim school or instructor.

Weight loss –benefits may be claimed towards classes and courses provided by an approved weight loss provider. You'll need to provide medical evidence of a Body Mass Index of 26 or over or an unhealthy BMI for a child as determined by a Health Provider. This can be in the form of a doctor's certificate, or a Health Improvement Benefit Approval Form. Benefits are payable for weight loss classes and courses, not food.

The Health Improvement Benefit Approval Form must be completed by a Health Provider stating what condition the exercise class or program is intended to manage. A Health Provider for the purposes of this form means a Medical Practitioner, Dietitian, Exercise Physiologist,

Physiotherapist, Osteopath, Chiropractor, Occupational Therapist, Psychologist, Diabetes Educator or Aboriginal Health Worker.

To be eligible to receive any benefits for Health Improvement Benefits:

- 1 Print the Health Improvement Benefit Approval Form
- 2 Take it to your Health Provider to complete
- 3 Submit the form by logging in online and uploading it via 'Make a claim'

The Health Improvement Benefit Approval Form lasts for 2 years and will need to be renewed after that time.

The following Health Improvement Benefits **DO NOT** require completion of a Health Improvement Benefit Approval Form:

Quit smoking – benefits towards laser therapy, hypnotherapy and nicotine replacement therapy (patches, gum, lozenges and inhalers) where you can't claim benefits under the PBS.

Disease management association fees – benefits towards association fees for the Arthritis Foundation, Asthma Foundation, Coeliac Society, Diabetes Australia, Australian Breastfeeding Association, Heart Foundation, Crohn's and Colitis Association, and Ostomy Associations.

Cancer Council UV products – benefits towards the following Cancer Council UV sun protection products only: sunscreen, hats, swimwear and sunglasses ranges. You can't claim benefits from the cosmetics, clothing, shade or accessories ranges. Your receipt must identify that the item has been approved by the Cancer Council.

Stress management courses – benefits towards courses to manage and prevent health conditions associated with high levels of stress. The courses must be provided by an ahm-recognised Psychologist.

Preventive tests, scans and screenings – benefits towards some services that assist with early diagnosis and/or to prevent an illness or condition. We don't pay benefits towards preventative tests, scans or screenings that are claimable through Medicare

Health checks – benefits towards doctor's health checks and Healthy Heart checks to assist with early diagnosis and/or prevent an illness or condition. We don't pay benefits towards health checks that are claimable through Medicare, are related to employment (such as pre-employment health checks) or when you can claim it through a third party insurer.

What isn't included?

With ahm extras covers, there are no benefits paid for the following:

- Items or services not included under your cover or in excess of any applicable Limits
- Items or services purchased/provided overseas or prior to joining
- Where two or more of the same services are supplied on the same date by the same provider to the same member
- Goods or services supplied during a Waiting Period or while the membership is suspended or in arrears
- When goods or services have been incompletely or inadequately itemised or described on the account or claim documentation
- Any item or service supplied over two years prior to the date of claim
- Claims for services in respect of which you have received, or are entitled to receive, compensation (see page 6)

- Claims that are fully covered by a third party
- Where treatment is rendered by a provider to themselves, their partner, Dependant, business partner, business partner's partner or Dependant
- If the provider is not an ahm Recognised Provider
- Where the claim form or other claim application contains any false or inaccurate information (this may in some circumstances also lead to your membership being terminated by ahm)
- Pharmaceuticals that are contraceptives prescribed for contraceptive purposes only, prescribed for cosmetic purposes, supplied under the PBS, available without a prescription or any over-the-counter preparations
- For extras services provided at a public hospital or other publicly funded facility
- Where the claim can be made from Medicare
- Where the service is provided in an aged care service.

Limits

Annual limits

Benefits are subject to annual limits. An annual limit is the maximum amount of benefits payable towards services, items or groups of services and/or items within a financial year (1 July to 30 June).

Benefits that have been paid under your previous cover will be taken into account in determining the benefits payable under your ahm cover.

Per family limit

This is the total amount that can be claimed by all members on your cover.

Per person limits

Each person on your cover can claim up to the 'per person' limit, except where a family limit applies and has already been reached by other members on the cover.

Lifetime limit

A lifetime limit is the total benefit you can claim for this service in a lifetime.

Rolling year

A rolling year begins on the date a service was first provided, with the limit applying to the 12-month period following the date of service.

Loyalty limit

Some of our covers include loyalty limits as a way of rewarding you for staying with us.

The longer you're a member, the more you can claim (up to a maximum limit - refer to your product guide).

These loyalty limits are calculated by using the number of full financial years the Principal Member has continuously held an ahm cover.

Check your product guide to see if loyalty limits apply to your cover.

Tip: Check your product guide to see if a Daily Charge (Co-payment) and/or Excess applies to your hospital cover.

Claiming extras

We've made claiming easy by providing a range of options so that you can choose the claiming method that best suits you.

There are some requirements though, so we've provided you with details of these and how to claim on the following pages.

We can only pay a claim if:

- the service is performed by an ahm Recognised Provider
- the service date on the receipt is less than two years old
- your claim is not payable or subsidised by a third party (such as workers' compensation)
- your membership is paid up to date on the date of service.

How to claim

On-the-spot

If your ahm Recognised Provider has a HICAPS machine, you can use your ahm member card and the claim benefit will be processed on the spot. You'll only need to pay the difference between the total amount charged by your provider and any benefit we pay.

The amount you'll have to pay will depend on your level of cover, limits and waiting periods. If you've reached the limit for that service, you'll have to pay the full amount.

Online

- 1 Log in to your account at **ahm.com.au** and go to 'Claims'. Make sure you have your receipt with you.
- 2 Select the service you want to claim for from the list and select 'Start claim'
- 3 Enter the provider name or number, who went, the date of the service, item number and the amount paid.

Please note:

- You need to enter each item number separately with the corresponding cost.
- You'll be shown what benefit you'll get for each item.
- Any benefits will be paid into your nominated bank account in 2 to 5 business days.
- You'll need to keep original receipts for 3 years for audit purposes.

App

- 1 Download the ahm app from your app store.
- 2 Log in to the app and go to the 'Claims' tab. Make sure you have your receipt with you.
- 3 Select 'Start claim'.
- 4 Enter the provider name or number, who went, the date of the service, item number and the amount paid.

Please note:

- You'll be shown what benefit you'll get for each item.
- Not all extras services are claimable via the ahm mobile app.
- Any benefits will be paid into your nominated bank account in 2 to 5 business days.
- You'll need to keep original receipts for 3 years for audit purposes.

Email

- 1 Download the claim form from **ahm.com.au**
- 2 Email your completed form and a scan or photo of your receipt/s to **info@ahm.com.au** with your name and ahm member number in the subject line.

Postal – If you've paid

- 1 Fill in a Claim form and post it to us
- 2 Make sure you attach your original receipts (these aren't returned so make sure to keep a copy)

Any benefit will be deposited in your bank account.

Postal – If you haven't paid

- 1 Fill in a Claim form, attach the bill and post it to us
- 2 We'll send you a cheque for any benefit that's payable to your ahm Recognised Provider
- 3 When you receive the cheque, you must send it to the ahm Recognised Provider and include any additional amount that you may be required to pay.

Claim forms can be downloaded from **ahm.com.au** or call us on **134 246** to have them posted to you.

ahm Recognised Providers

All service providers must be recognised by ahm before we can pay benefits. ahm Recognised Providers include hospitals and extras providers. Recognition of providers is at ahm's discretion. ahm Recognised Providers must meet criteria set by ahm, and ahm may at its discretion cease to recognise a provider it has previously paid benefits for.

You should check whether your provider is recognised by ahm prior to treatment. 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**

Where ahm recognises a provider, to the fullest extent allowed by the law, such advertising or reference should not be construed as:

- an endorsement by ahm; or
- an acknowledgement or representation by ahm as to fitness for purpose; or
- a recommendation or warranty by ahm about the product and/or service of the ahm Recognised Provider. Accordingly, to the fullest extent allowed by law, ahm neither takes nor assumes any responsibility for the product and/or services provided.

Members should make and rely on their own enquiries and seek any assurance or warranties directly from the Recognised Provider of the services or product.

Government surcharges and incentives

Lifetime Health Cover (LHC)

Lifetime Health Cover (LHC) is an Australian Government initiative designed to encourage people to take out and maintain private health insurance before the age of 31.

A LHC loading is applied to people who haven't taken out hospital cover by 1 July following their 31st birthday. This is known as their LHC base day.

If you don't hold hospital cover after your LHC base day, you'll pay a 2% loading on top of the base rate of your hospital cover premium, up to a maximum of 70%, for each year (or part year) you're aged over 30.

The LHC loading is removed once you've held hospital cover and paid the loading for 10 continuous years.

Permitted days without hospital cover

The following are considered permitted days without hospital cover and won't affect your LHC loading (in most cases, you need to have held hospital cover on and/or after your LHC base day to be eligible to access these permitted days without hospital cover):

- Days where your hospital cover is suspended under our Fund Rules.
- Days when you're overseas for a continuous period of more than one year (which can include periods of return to Australia of less than 90 days each time).
- The first 1,094 days of not having hospital cover.

Special rules

People who were born on or before 1 July 1934 can take out hospital cover at any time without incurring an LHC loading.

Special rules also apply to Australians returning from overseas, Norfolk Islanders, Veterans' Affairs Gold Card Holders, former members of the Australian Defence Force, staff of the Australian Antarctic Division, refugees and all other categories of migrants to Australia.

For more information about LHC and to use the LHC calculator to find out if you'll need to pay a loading, visit privatehealth.gov.au

Medicare Levy Surcharge (MLS)

The MLS is a levy that high income earners have to pay if they don't have an appropriate level of private hospital cover.

It's calculated based on 'income for Medicare Levy Surcharge purposes' which includes things like taxable income, exempt foreign employment income, reportable fringe benefits, reportable superannuation contributions and total net investment losses.

If you hold any ahm hospital cover you'll be exempt from paying the MLS.

For more information about the MLS and the income thresholds that apply, visit the Australian Taxation Office at ato.gov.au

Australian Government Rebate on Private Health Insurance

The Australian Government Rebate (AGR) on private health insurance helps make health insurance more affordable by giving you a rebate on your premiums. Your eligibility for the AGR depends on your age and income tier. The AGR does not apply to the LHC component of hospital cover premiums.

From 1 April 2014, the Australian Government will review the AGR percentages annually for all health insurers. The review is based on a calculation that incorporates any changes to the average health insurance premium and cost of living.

This means the Australian Government will continue to review the AGR for all health funds based on this calculation on 1 April every year.

Income tiers are based on 'income for Medicare Levy Surcharge purposes' which includes things like taxable income, exempt foreign employment income, reportable fringe benefits, reportable superannuation contributions and total net investment losses.

You'll need to tell us what income tier you think you should be on, so if you're not sure, speak to your accountant or financial advisor. Once you've advised us of your chosen income tier, your premium will be adjusted according to the level of AGR you've nominated.

Members may be eligible to continue to receive one of the higher age-based AGR levels even if the person aged 65 or older leaves the membership, for example, due to death, divorce or separation. If your membership currently receives an increased AGR due to age and you're considering removing a member from, or adding a member to the membership, please contact us to discuss the potential effect on your AGR entitlement.

Receiving the AGR

You can receive the AGR in one of two ways:

- as a reduction in premiums, or
- as a tax offset in your annual tax return.

If you'd like to claim the AGR as a reduced premium and have not yet applied for the AGR, please contact us.

If you don't do something, the tax office might

Nominating an AGR tier helps ensure you're receiving the correct AGR based on your circumstances. Not nominating an AGR tier could mean having to repay any amounts you've received above your entitlement at tax time.

Remember it's important to maintain hospital cover or you may incur a Medicare Levy Surcharge. To find out how this affects you go to ato.gov.au/privatehealthinsurance

Nominate your AGR tier now

Get better control of your health insurance costs by nominating your AGR tier now. And if you'd like more information simply visit ahm.com.au or ato.gov.au/privatehealthinsurance

Important legal information for the Principal Member

The Principal Member is first person listed on the membership; the one who is responsible for the payment of premiums and has full authority to make any changes to the membership.

Please note Principal Members must be over the age of 16 to hold cover with ahm.

For more info, please also see page 9. The Principal Member:

- receives all correspondence and benefits for this membership on behalf of every person included on this membership
- agrees to our Privacy Policy (page 38) and warrants that every person included on this membership also agrees to our Privacy Policy
- agrees to the Joining Statement or change of cover declaration, and so agrees to abide by the Fund Rules and policies and to provide us with correct information required under the membership at all times
- agrees to let us know as soon as possible if any circumstances of anyone on the membership change, or if any of the details we hold change or are incorrect
- understands that if you're switching to ahm from another Australian health insurer, your ahm cover will start on the date your cover commences with us. This means you may have a gap in your private health insurance cover. Provided you join us within 30 days of leaving your former fund, we'll recognise any Waiting Periods for services included under your new ahm cover that you've already served on your previous level of cover. You'll just need to serve the balance of any Waiting Periods not fully served on your former cover or those for any new or upgraded services.

However, it also means you may not have continuous cover for the purposes of:

- LHC loading - so any days without private hospital cover may count towards your 'permitted days without hospital cover'. If you have exhausted your permitted days without hospital cover, you may need to pay additional LHC loading.
- MLS - if you fall within the applicable income brackets you may need to pay the MLS for any days you were without private hospital cover.

For more information about LHC and the MLS see page 35.

Our Privacy Statement

For the purpose of this Privacy Statement, we are Medibank Private Limited (Medibank) and Australian Health Management Group Pty Ltd (ahm), a subsidiary of Medibank and other Medibank subsidiaries (collectively Medibank Group Companies).

We collect and use your personal and sensitive information to enable us, other Medibank Group Companies and our third party suppliers and partners to provide you with products and services, including insurance, health-related services and partner offerings and to give you information on other products and services.

If we do not collect this information, we may not be able to provide you with these services. It is your responsibility to keep your contact details up to date with us, to assist in protecting your privacy.

We may collect your information from you, another person on your membership, a person authorised to provide us this information on your behalf, or another Medibank Group company or a third party.

Where you give us personal information about others, you must ensure that you let them know what information you are giving us and that you have their consent to do so. You should also let them know about this Statement.

We may disclose your personal information to persons or organisations in Australia or overseas including other Medibank Group Companies, our service providers and professional advisers, health service providers, our suppliers and partners, government agencies, financial institutions, your employer (if you have a corporate product) and your educational institution, migration agent or broker (if you have Overseas Student Health Cover or a visitors cover). We may also disclose your information to other persons included on your membership or your agents and advisers.

Our Privacy Policy contains more information about our privacy practices, including how we use your information and how you may opt out of receiving promotional material from us. The Policy also details how you may request access to, or correction of, personal information we hold about you, how you can lodge a privacy complaint and how we manage such complaints. You can obtain the latest version of our Privacy Policy by contacting us or by visiting **ahm.com.au**

You can also write to our Privacy Officer:

Privacy Officer
ahm health insurance
Locked Bag 4
Wetherill Park NSW 2164

or email **privacy@ahm.com.au**

Feedback

Tell us what you think

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 is important to us.

If you have a suggestion about how we can improve our products or service, please let us know. If you're unhappy about something we've done – or perhaps not done – please give us the opportunity to put things right.

We use your de-identified feedback for training and coaching purposes so we can improve our products and services.

Email feedback@ahm.com.au

Phone Call us on **134 246**

Mail ahm health insurance
Locked Bag 4, Matraville NSW 2036

Complaints

If you have a complaint, please let us know straight away so 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 do this immediately, we'll refer it to our Customer Advocacy Team who'll carry out an investigation.

Customer Advocacy Team

Our Customer Advocacy Team will aim to find a solution for you by investigating your complaint and then letting you know the result. They will:

- investigate the issue
- keep you informed
- aim to resolve the issue within 10 working days.

To assist in this process, please provide as much information as possible about your complaint. Please include your name and member number (if applicable), on all correspondence.

What if I'm not satisfied?

If you're not satisfied with the steps we've taken to resolve your complaint or with the result of the investigation, you can request a review of your complaint by the Private Health Insurance Ombudsman.

Private Health Insurance Ombudsman

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 for free, independent advice.

Phone Health Insurance Complaints: **1300 362 072**

Health Insurance Advice: **1300 737 299**

Website ombudsman.gov.au/about/private-health-insurance

Private Patients' Hospital Charter

The Australian government has produced a Private Patients' Hospital Charter to inform health insurance members of their rights. You can view the charter online or download a copy from health.gov.au

Private Health Insurance Code of Conduct

ahm is a signatory to the Private Health Insurance Code of Conduct. The code was developed by the health insurance industry and aims to promote the standards of service to be applied throughout the industry.



The code is designed to help you by ensuring that:

- information we provide to you is written in plain language
- ahm employees are competently trained to deal with your enquiries
- ahm protects the privacy of your information in line with Privacy principles
- you have access to a reliable and free system of addressing complaints with ahm.

A copy of the code is available online at privatehealth.com.au/codeofconduct

Fund Rules and policies

All members of ahm health insurance are subject to our Fund Rules, which set out the terms and conditions of their cover, as well as the services we pay benefits for. The Fund Rules can be changed from time to time. An up-to-date copy of the Fund Rules is always available at ahm.com.au. If any changes will have a detrimental effect on a member's entitlement to benefits, we'll provide the Principal Member with reasonable notice in writing before the changes are due to come into effect.

Occasionally, we may need to make changes to a health insurance cover. These changes will apply regardless of whether premiums have been paid in advance and may include:

- closing a cover
- removing a service or item from a cover
- reducing or removing a benefit or benefits under a cover.

If we close a cover you're on:

- we may allow you to stay on the cover, but not make any changes (e.g. adding or removing a member or component of cover). If you want to make a change to your membership, you'll need to select a new cover, or
- we may not permit you to stay on this cover and will move you to a cover as similar as possible to your existing cover. We'll advise you in writing if this occurs.

If we make a change to your cover and you choose to continue your membership (under the new or changed cover), you'll be bound by its terms and conditions. If you don't wish to continue under the new or changed cover you have the option of transferring to a different cover or cancelling the membership.

Medical terms and service descriptions

Here is a list of some medical terms and service descriptions used in this Member Guide and ahm's product guides.

Accident: an unplanned or unforeseen event resulting in bodily injury that requires immediate medical treatment in a hospital.

Accident override: Services which are normally Restricted or Excluded Services will be treated as Included Services where you require hospital treatment as the result of an Accident that occurred after joining the cover. Benefits are payable for the initial hospital treatment for injuries resulting from the Accident. Benefits are also payable for ongoing hospital treatment where the services form part of your initial course of treatment payable by ahm under Accident override. Accident override is only available under some ahm hospital covers (check your product guide). To make a claim under Accident override, you will need to submit an Accident claim form for assessment. You can download the form at ahm.com.au

Assisted reproductive services (e.g. IVF and GIFT): treatment in hospital for infertility. It includes retrieval and implantation of eggs and collection of semen. In Vitro Fertilisation (IVF) treatment and Gamete Intra Fallopian Transfer (GIFT) are two of the most common procedures. Benefits are only payable for parts of the treatment where a member is admitted to hospital.

Body Mass Index (BMI): an estimate of your total amount of body fat to determine whether you are overweight, obese, or underweight for your height. To calculate your BMI, divide your weight in kilograms by your height in metres squared. The BMI for a person under age 18 needs to be corrected for their age and sex.

Cancer therapies and treatment: includes in-hospital chemotherapy and radiotherapy. Also includes surgery to remove cancer where that surgery is included under your cover. Procedures and drugs must be on the Medicare Benefit Schedule (MBS) or Pharmaceutical Benefit Scheme (PBS).

Complex dental: includes periodontics (root planing, oral surgery for prostheses, jaw injuries or non tooth-related oral surgery) and endodontics (root canal therapy).

Disease management appliances: items that assist in the management of chronic health conditions, such as blood pressure monitors, respirators, nebulisers, TENS machines and special garments (see page 18 for more details).

Emergency hospital admission: an unexpected admission to hospital. No matter how sudden or unexpected your hospital admission, if we've not had time under the Pre-Existing Condition rules to determine if you're affected by these rules, you may still have to pay some or all of the hospital and medical charges related to your hospital admission.

Gastric banding surgery: gastric banding or lap banding surgery is a procedure to treat obesity that involves placing a band around the upper stomach to create a small stomach pouch that limits and controls the amount of food you're able to consume. This is different to gastric sleeve or bypass surgery.

Gynaecological Procedures: an operation to remove or repair major parts of the female reproductive system. This includes treatment of endometriosis, laparoscopy and vaginal repair. Does not include hysterectomy or surgery associated with childbirth.

Heart-related procedures: medical and surgical admissions to investigate, diagnose, monitor and/or treat heart-related conditions. It includes medical admissions for heart-related conditions, angiograms, insertion of stents, pacemakers and defibrillators, open heart surgery, valve replacement or repair and other invasive cardiac procedures.

Hip and knee replacements: joint replacement surgery of the hip or knee joint.

Hospital treatment as the result of an accident: urgent and immediate treatment in a hospital for an injury caused to your body by an unplanned or unforeseen event.

Hysterectomy: an operation to remove some or all of the uterus (womb). It may also involve removal of the cervix, ovaries, fallopian tubes and other associated structures. Includes vaginal, open, laparoscopic and robot-assisted hysterectomy. ahm does not meet the additional costs associated with robot-assisted surgery.

Joint fluid replacement injections: fluid injections into joints including the knee, hip and shoulder, to alleviate the pain of osteoarthritis.

Joint investigations and reconstructions: surgery to investigate and repair damage to a joint as a result of injury or illness. This may include an arthroscopy, repair of ligaments and tendons, removal of loose bodies, repair of the joint surface, meniscus or other joint structures. Includes medication such as visco-supplemental injections.

Joint replacement surgery: surgery to replace all or part of a joint with a prosthesis. It includes revision of previous joint replacement surgery. Any prosthesis provided must be on the government's Protheses List for benefits to be payable.

Major dental: includes indirect restorations, all crowns, bridgework and implants and dentures.

Major Eye Surgery: surgery to treat conditions and disorders associated with the eye. This includes cataract surgery as well as surgery to the cornea, retina, eyelid, tear duct and muscles of the eye. Major eye surgery does NOT include laser eye surgery for the correction or improvement of vision instead of wearing glasses or contact lens.

Midwife assisted home births: a home birth assisted by a registered Midwife. A benefit is not payable if there's a hospitalisation related to the birth.

Minor Gynaecological Procedures: specific procedures such as insertion of an intrauterine contraceptive device (IUD), or hysteroscopy (a procedure using an instrument to examine the lining of the uterus) or colposcopy (using a microscope to examine the cervix). Does not include laparoscopy or major surgery that involves general anaesthetic with respiratory assistance.

Obstetrics-related services: services and treatment provided in hospital that deal with the care of women during pregnancy, childbirth and following delivery. It includes delivery of the baby and complications of pregnancy. This does not include any treatment that the baby may require.

Optical: prescription sight-correcting products, such as glasses, frames, lenses and repairs, and contact lenses.

Orthodontics: specialist dental treatment to correct misaligned teeth and jaws. Treatments include braces, plates and retainers. We'll pay benefits towards orthodontic services by a General Dental Practitioner or specialist dentist provided claims are accompanied by a detailed treatment plan.

Orthotics and orthopaedic shoes: custom-made shoe inserts, alterations, and their repairs (orthotics), made and supplied by an ahm recognised Podiatrist or orthopaedic footwear supplier (for more details see page 28).

Palliative care: providing care, comfort, and relief of pain and distress for people who are dying. Benefits are only payable where included under a member's cover and the member is admitted to a palliative care unit in a hospital.

Pharmacy: non-Pharmaceutical Benefits Scheme pharmacy items that are prescription only and prescribed by a medical practitioner (for more details see page 28).

Podiatric Surgery: the surgical treatment in a hospital of conditions affecting the foot, ankle and lower leg by qualified and registered podiatric surgeons. Medicare benefits are not payable for podiatric surgery so ahm doesn't pay benefits for the podiatric surgeon's charges.

Prosthesis: a surgically implanted item such as a stent (for coronary arteries), grommets or titanium plates and screws which is listed on the government's Prosthesis List.

Psychiatric services: inpatient treatment with medications and/or psychotherapy for mental health conditions such as: depression, anxiety, personality disorders, eating disorders and addiction. Where included under a person's cover, treatment must be provided at an approved psychiatric facility for benefits to be payable. Conditions such as dementia and Alzheimer's are not generally considered to be psychiatric conditions.

Rehabilitation: therapy which assists in recovery following a major health event. It aims to assist people to manage activities of daily living without the assistance of another person.

It may include physical therapy and exercise programs to assist in the recovery from stroke, after a joint replacement or following a heart attack. These services can consist of overnight or day therapy programs. Where included under a cover, rehabilitation must be provided at an approved rehabilitation facility and under an approved program for benefits to be payable. It does not include treatment for substance addictions.

Renal dialysis: inpatient treatment which replaces the function of the kidneys. It can include both haemodialysis (circulating the blood through a machine) and peritoneal dialysis (infusing and draining a sterile solution into the abdomen). Where Included under a persons cover, treatment must be provided in hospital.

Routine dental: includes x-rays, examinations or consultations, preventive procedures such as clean and polish, oral surgery for tooth extractions and minor restorative services.

Sterility Reversal procedures: inpatient treatment to restore fertility. If your ahm hospital cover includes benefits for Sterility Reversal procedures, and Medicare benefits are not payable for your procedure, we'll pay a theatre and accommodation benefit and a benefit towards your doctor's fee, but you may still be significantly out of pocket depending on what your doctor charges you. Please contact us before your procedure to confirm how much you will be out of pocket.

Weight Loss Surgery: surgery to the stomach to treat obesity. Surgery may involve reducing the size of the stomach (gastric banding or stapling), removing a portion of the stomach (sleeve gastrectomy) or bypassing the stomach (gastric bypass).

Got questions? We're here to help

Monday to Friday



Chat at ahm.com.au



Call 134 246

or ask anytime



facebook.com/ahm.health.insurance



[@ahmhealth](https://twitter.com/ahmhealth)

