The Law Handbook

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Insurance

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[29.10] Most people during a lifetime will take out numerous insurance policies to protect themselves against situations in which they may suffer financial loss.

In spite of this, very few people really understand the cover offered under their policies or how to take action to get a claim paid.

This chapter focuses on:

- matters to consider when buying insurance;
- the relationship between insured and insurer;
- getting a claim paid;
- dispute resolution schemes;
- the law about health insurance.

UNDERSTANDING INSURANCE

Insurance policies

[29.20] Insurance policies are contracts regulated by both federal legislation and the common law.

[29.30] Legislation

The main federal Acts regulating insurance are:

- the *Corporations Act 2001* (Cth);
- the *Life Insurance Act 1995* (Cth);
- the *Insurance Contracts Act 1984* (Cth).

This legislation applies to almost all consumer insurance policies.

The *Australian Securities and Investments Commission Act 2001* (Cth) also applies to insurance products (and all other financial services and products) at a general consumer protection level, prohibiting misleading, deceptive or unconscionable conduct.

Health insurance is subject to different legislation and is discussed in detail at [29.180].

[29.40] Types of insurance

Different rules apply depending on whether the insurance is classified as general or life insurance.

This is because life insurance policies can run for many years provided the premiums are paid, while general insurance policies typically last for only one year.

General insurance

General insurance means all insurance except life insurance. The most common types are:

- home and contents;
- motor vehicle;
- travel;
- personal accident;
- income protection;
- public liability.

Life insurance

Life insurance companies sell products that are:

- investment only;
- a mixture of investment and insurance;
- insurance only.

What life insurance policies may cover

Life insurance policies cover not only death but also disability, trauma and income protection.

This chapter discusses only the insurance aspect of these products. People interested in the investment aspect should seek financial advice.

[29.50] Cover notes

Most insurance companies will give *interim* (temporary) cover in the form of a cover note until a formal policy is issued.

A cover note is usually issued for a limited time only and is enforceable like any other policy. When the formal policy is issued, it is usually backdated to when the interim cover began.

The General Insurance Code of Practice

The General Insurance Code of Practice is a voluntary code of practice to which most insurers are signatories. The Code of Practice sets out various standards applying to the conduct of the insurer and is binding on the insurer. The current version of the General Insurance Code of Practice commenced on 1 July 2014. The drafting of an updated version is currently underway.

Nearly all types of general insurance, from home insurance and travel insurance to business insurance, are covered by the Code of Practice.

General principles contained in the Code of Practice include the following:

- All customer services (including product information, sales procedures, claims handling and the management of complaints or disputes) will be conducted in a fair, transparent and timely manner.
- If an error is made in assessing applications, deciding on claims or investigating complaints, the insurer will take immediate action to correct it.
- Claims will generally be determined within 10 business days of receipt provided the insurer has received all necessary information and provided no further assessment or investigation is required. Where further time is needed by the insurer, they will notify customers as to what information is required and provide an estimate as to the time required to make a decision. Unless exceptional circumstances apply, all claims will be determined within four months.
- Customers will have access to any information that has been used to assess applications, claims or complaints and will have the opportunity to correct any mistakes or inaccuracies in this information.
- Insurers will make sure that not only their employees but also their authorised representatives and service providers meet the standards in the Code.
- Where the customer demonstrates that they are in urgent financial need of the benefits under the policy, the insurer will fast-track the assessment of the claim and/or make an advance payment within five days of the customer demonstrating their urgent financial need.
- How complaints between the customer and the insurer will be handled, including escalation procedures and applicable time limits for the insurer to respond.
- The right to request a review of a decision following a catastrophe or disaster, including where the customer has signed a release in relation to the claim.

The Code of Practice sets higher standards of conduct for insurers than those required by law.

If the Code is breached

If you believe your insurer has breached the Code, you should first make a complaint to the insurer. If the response is not satisfactory, the complaint can be taken to the Code Governance Committee or Australian Financial Complaints Authority (AFCA).

The Code Governance Committee is an independent body responsible for monitoring and enforcing compliance with the General Insurance Code of Practice. AFCA, a free service for consumers, can enforce the code of practice including by requiring the insurer to take steps to rectify the breach (see [29.160]).

Legal rights and responsibilities

[29.60] The duty of utmost good faith

The *Insurance Contracts Act* writes into every insurance contract a statutory obligation on both parties to act with the utmost good faith (s 13).

Responsibilities of the insurer

The duty of utmost good faith requires an insurance company to:

- assess claims promptly;
- not delay paying claims without proper cause;
- not refuse to pay claims without proper cause (eg, by inappropriately preferring a GP's medical opinion over that of a specialist);
- in some circumstances, specifically advise the consumer of what risks the policy covers.

Responsibilities of the insured

The duty of utmost good faith requires an insured person to:

- disclose all information relevant to the insurer's decision to accept the risk;
- not make false or exaggerated claims;
- cooperate with insurers when making claims.

[29.70] The insured's duty of disclosure

Under the duty of disclosure, a person applying for insurance must disclose relevant information to the insurer before a contract is entered into.

The importance of proper disclosure

It is extremely important to understand the extent of the duty of disclosure because someone who fails to comply with it could find that they are in fact uninsured when they make a claim.

Completing the proposal form

A person applying for insurance must:

- fully and completely answer all the questions on the proposal form;
- answer questions asking for detailed information precisely (see The insurer's responsibility in asking questions at [29.70]);
- include additional information if a "tick the box" question does not offer an answer that applies to the person's situation.

If there is not enough space on the form

A page with additional information can be attached if there is not enough space on the form.

For example …

A person may not be sure whether anything has been missed if the application asks for all traffic offences, or reasons for all visits to the doctor, in the last five years.

In this case, the person should write on the application form that they are not sure that the answer is complete and then, if required, obtain the details from the traffic authority or the doctor.

Issues in non-disclosure

Many disputes about insurance policies arise because the consumer is alleged to have not disclosed information to the insurer when the policy was taken out. The following are issues to consider in checking whether the insurer can correctly reject a claim.

Is it a material non-disclosure?

Where the non-disclosure is innocent, the insurance company can only rely on it if they would have charged a higher premium or rejected the application had they had the information.

It can be difficult to test an insurer's assertion that it would not have issued a policy except by complaining to the AFCA or by issuing court proceedings.

Was there actually non-disclosure?

The person has not breached the duty of disclosure if:

- they only become aware of a matter after taking out the policy (eg, discovering termites in a house when renovating it after purchase); or
- the company was already aware of the matter (eg, it may know the person's medical history through a claim on an earlier policy).

Disclosure made to a third party

Where insurance is sold through a third party (particularly a car dealer, mobile phone dealer or travel agent), the proposal form is often completed as one of a series of documents, and the third party may not record all the information they are given. Since the third party is usually taken to be the insurer's agent, any statement made to them qualifies as disclosure to the insurer even if there is no record of it in the application form.

However, if the information was given to an insurance broker and the broker failed to tell the insurance company, the remedy is against the broker (see [29.170]).

Failure of insurer to seek further information

Under s 21 of the *Insurance Contracts Act*, where a person fails to answer a question, or gives an obviously irrelevant answer, and where the insurer nevertheless accepts the response, it is taken to have waived the person's duty to disclose the information requested.

In other words, if the insurer does not seek further information when it assesses the risk, it cannot later rely on an irrelevant or missing answer to refuse a claim.

It is important to obtain a copy of the proposal form to check whether there was, in fact, failure to disclose information or whether, for example, a box has simply been left blank, which is not a failure to disclose.

The insurer's responsibility in asking questions

For most types of insurance for consumers, it is enough for the person to correctly answer the questions on the application form. Section 21A of the *Insurance Contracts Act* provides that an insurer cannot rely on an incorrect answer to an open-ended or vaguely worded question (eg, by requesting that the individual disclose "all relevant matters") if the information it wanted could have been the subject of a specific question.

In practice this means that, unless there is something exceptional about the person's individual circumstances that should have been disclosed, the insurer cannot rely on a breach of the duty of disclosure to reject a claim if the person answered the questions correctly.

Renewals of insurance

An insurer can only rely on a non-disclosure by a person in connection with the renewal of an insurance policy if the insurer either:

- requests that the individual answer a set of specific questions; or
- gives the individual a copy of previous matters disclosed by the individual and requests that the individual either confirm that those matters are unchanged or disclose any changes.

If the insurer fails to take either of these actions, the insurer is taken to have waived the consumer's duty of disclosure in relation to the renewal. The insurer cannot ask open-ended questions and to do so has the effect of causing the insurer to have waived the duty of disclosure. The individual can satisfy their obligation under the duty of disclosure by correctly answering the questions put to them at the time of the renewal. If, however, the individual failed to satisfy their duty of disclosure in relation to the *original* insurance contract, the insurer can rely on that failure in relation to the renewal.

The effect of this is that where a matter has changed between the time of the original insurance contract and the renewal, the insurer can only rely on the non-disclosure of the changed matter in relation to the renewal of insurance if the insurer has specifically made a separate set of enquiries at that time and the individual has failed to correctly answer those questions.

For example ...

Between the time of taking an original car insurance policy and its renewal the customer is involved in an accident in which they were at fault. They do not disclose this to the insurer. Had the insurer been aware of the accident at the time, they may have either charged higher premiums or refused to renew the insurance. The insurer can only rely on this non-disclosure if at the time of the renewal, they made specific inquiries as to whether the consumer had been in an accident or alternatively had the consumer confirm their previous statement that they had had no accidents.

Fraudulent and innocent non-disclosure

The insurer may say it has rejected a claim because the person did not disclose information correctly in the application form. It is important to determine whether non-disclosure is innocent or fraudulent, as different consequences follow.

Fraudulent non-disclosure

Non-disclosure is fraudulent if the person knew a fact was relevant and still failed to disclose it.

Innocent non-disclosure

Non-disclosure is innocent if the person honestly fails to disclose a fact that they thought was irrelevant (or, more likely, have simply not thought about at all).

Consequences of fraudulent non-disclosure

Under s 28 of the *Insurance Contracts Act*, if non-disclosure was fraudulent, the insurance company can cancel the policy and refund the premium.

This is the case even if two people applied for joint insurance, and one of them lied on the application without the other realising it.

Consequences of innocent non-disclosure

If the insurer would have accepted the risk

The insurer cannot reject a claim on the basis of non-disclosure if:

- the non-disclosure was innocent; and
- the insurer would have accepted the risk and entered into a contract even if full disclosure had been made.

However, if the insurer would have charged a higher premium or larger excess if full disclosure

had been made, it can reduce its payment of the claim by that amount.

If the insurer would not have accepted the risk

The insurer can reject a claim on the basis of non-disclosure if:

- the non-disclosure was innocent, but
- the insurer would have rejected the proposal had it had the information.

However, it must prove that it would have rejected the proposal; for example, by showing that it has rejected similar applications.

Life insurance

A number of special rules apply to life insurance (ss 29, 30, 31).

The main effect is that the insurance company cannot cancel the policy in the case of an innocent non-disclosure that is discovered three years or more after the contract was entered into, unless the applicant's age was misstated. The insurer can however within the first three years of the formation of the insurance contract reduce the sum insured under a life insurance policy by an amount proportionate to the difference in premiums between those charged and those that the insurer would have charged had the duty of disclosure been complied with.

Where the applicant's age is misstated, the insurer is entitled to reduce the sum insured by an amount proportionate to the difference in premiums between those charged and those that the insurer would have been charged had the applicant correctly stated their age.

Ongoing nature of the duty of disclosure

Many people do not realise that every renewal of an insurance policy is a new policy – that is, a new contract requiring disclosure. If an annual policy is paid in monthly or quarterly instalments, this is still an annual policy.

The person insured must, if asked, disclose anything that has arisen in the preceding 12 months that will be material to the insurance company's assessment of the risk of renewing the policy. For example, if the person has had a motor vehicle claim after taking out a home and contents policy, they must – if requested by the insurance company – disclose that fact when the home and contents policy is renewed.

[29.80] Exclusion clauses

Insurance policies do not provide cover against all losses, and they contain exclusion clauses limiting the insurer's liability.

For example, a car insurance policy commonly does not cover damage from an accident that occurred when the car was unsafe or unroadworthy or the driver had an excessive blood alcohol content. Similarly, many home and contents policies exclude damage caused by floodwater.

Proving excessive blood alcohol levels

In New South Wales, there is specific legislation that prevents insurance companies from relying on the results of a police breath test analysis. If an insurer wants to refuse a claim because it alleges that a driver was influenced by alcohol, it must establish this through other means; for example, the statements of witnesses.

Can the insurer reject the claim?

Insurers cannot always rely on an exclusion clause to reject a claim. Before accepting the situation, the insured person should consider a number of issues.

Has the clause been properly applied?

The insurer must apply the wording of any exclusion clause very carefully.

For example ...

In one case before the Insurance Ombudsman Service (as it then was), an insurer had refused a claim under a disability policy on the basis that it was for a pre-existing injury. The panel noted that the policy only excluded pre-existing injuries for which treatment had been received in the three years before the policy was taken out. A review of the facts showed that the person had not received treatment for the injury during this period, and the claim was allowed.

Did the person's conduct cause the loss?

An insurance company can refuse a claim if the loss was caused by the insured person's conduct (*Insurance Contracts Act*, s 54). If, however, the person can prove that there is no connection between their conduct and the loss or damage, the insurance company cannot refuse to pay.

For example ...

The insurer cannot refuse to pay a claim after an accident in which a car with bald tyres and driven by a drunk driver was hit from behind by another car while it was stationary at a red light, because neither the bald tyres (a breach of a condition that the car be properly maintained) nor the driver's inebriated state (also a breach of the insurance contract) caused the accident.

If part of the loss was caused by the person's conduct, the amount of the claim can be reduced proportionally.

Was the person aware of a pre-existing defect?

Under ss 46 and 47 of the *Insurance Contracts Act*, the insurer cannot rely on exclusions for a pre-existing defect or disability if, when they took out the policy (either at application or renewal):

- the person was unaware of it; and
- a reasonable person in their position would not have been aware of it.

Floods

Particular issues arise where an insurance claim is rejected because the insurer alleges the damage was caused by floodwater, which is not covered under the policy. The NSW Legal Aid Commission publishes a number of resources to assist consumers with their claims. They are available through the commission's website (www.legalaid.nsw.gov.au).

Flood damage

In response to a series of natural disasters in Queensland, Victoria and New South Wales and the inconsistent and potentially confusing ways that different insurers provided cover for such events, changes were made to the *Insurance Contracts Act* to standardise the definition of "flood" and to restrict insurers from selectively covering certain flood events and not others.

Although insurers are not obliged to provide cover in relation to loss and damage from flooding, the *Insurance Contracts Act* now expressly requires insurers to clearly inform customers in writing as to whether a home, contents, small business effects or strata title insurance contract provides insurance cover in respect of loss or damage resulting from floods (s 37C).

"Flood" is defined as the covering of normally dry land by water that has escaped from the normal confines of lakes, rivers, creeks, reservoirs, canals and dams. Insurers are prohibited from applying a different meaning to the term "flood" (or such derivative terms such as "flooding").

Where the insurer provides cover for any type of flood event in relation to home, contents, small business effects or strata title insurance policies, the insurer is required to provide cover for loss and damage from all events covered by the standard definition of flood. An insurer cannot therefore refuse to pay a claim on the basis that the policy terms only covered a more narrow set of flooding events than are covered by the standard definition.

Additionally where a policy provides for different levels of cover depending on the type of flood event, the insurer is subject to the maximum amount stated in relation to all flood events. For example:

- A policy provides that cover for flood events caused by water escaping from rivers is capped at $150,000, but cover for flood events caused by water escaping from reservoirs is capped under the policy at $75,000. The insurer is obliged to cover all flood events at a maximum of $150,000.

[29.90] The insurer's duty of disclosure

Informing the insured person of restrictions

Section 35 of the *Insurance Contracts Act* provides certain standard levels of cover for particular events occurring under certain types of insurance contract. These standard coverage levels may be modified, reduced or disapplied by the insurer only if the insurer clearly informs the insured that a lower level of cover shall apply. The insurer must clearly inform consumers of these restrictions before the contract is entered into.

What contracts are covered by s 35?

Section 35 applies to:

comprehensive car insurance;
home building and contents insurance;

- sickness and accident insurance;
- consumer credit insurance;
- travel insurance.

If the insurer fails to disclose restrictions

If the required information is not given, the terms of the contract will be set by law.

The terms of this statutory contract are invariably more generous and less restrictive than those in the insurer's policy document. The insured person may be able to claim more than the insurer's contract allows or to claim where the contract does not allow it.

If there is dispute, the insurer must prove that it clearly informed the person of the restrictions.

For example ...

In one case, the Insurance Ombudsman Service (as it then was) found that the insured was not clearly informed of a restriction, and s 35 therefore applied, because the restriction was inconsistent with other terms of the contract, and the change in the policy (which was advised at renewal) did not refer to the earlier broader wording of the policy, so it was not obvious that the risks covered had been restricted.

Duty to disclose unusual provisions

Section 37 requires that the insurer must clearly inform the insured in writing of any unusual provisions (compared to other insurance policies) of the insurance contract.

What is "clearly informing"?

The NSW Supreme Court has held that the obligation to "clearly inform" may not be satisfied just by giving a person a copy of the policy. The wording and layout of the policy should also be examined.

A breach of the duty of utmost good faith

Sometimes the insurer's duty to act in the utmost good faith may oblige it to specifically draw the insured person's attention to an exclusion clause.

In *AAMI v Ellis* (1990) 6 ANZ IC 60-957, the South Australian Supreme Court held that the insured had breached the contract by modifying the insured motor vehicle and that on a strict view, the insurance company was entitled to deny the claim.

However, the court then held that, considering the insured's age and inexperience, the company could rely on the exclusion clause only if it had specifically drawn that clause to the person's attention. The company had breached its duty of good faith by not doing so and therefore could not rely on the exclusion clause.

Purchase, renewal and cancellation

[29.100] Buying insurance

Insurance can be bought either:

- from the insurance company, over the counter, by phone or through the internet; or
- through an intermediary.

Buying through an intermediary

A number of different types of intermediaries sell insurance. These include:

- insurance brokers;
- insurance agents;
- car dealers;
- travel agents;
- banks;
- finance companies.

Insurance brokers

Insurance brokers will generally act as your agent, not the insurer's agent (there are limited exceptions, depending on the facts). This means that your remedy is against the broker, not the insurer, if you suffer a loss because, for example, the broker did not arrange cover against the risks you wanted or delayed in obtaining the insurance. Insurance product comparison websites are likely to be treated as your broker rather than the insurer's agent.

If the intermediary is not a broker

Most other intermediaries are considered to be agents of the insurance company, not the insured. This means that:

- anything you tell the intermediary is treated as information disclosed to the insurer;
- the insurance company is bound by statements made by the intermediary.

Is your insurance broker licensed?

If you are using a broker to arrange your insurance, you should check that they hold an Australian financial services licence or are an authorised representative of a licence holder. When an insurance broker or agent first has contact with you, they should provide you with a financial services guide outlining what financial services they provide and how you can complain if you need to. If they proceed to recommend an insurance policy, they may give you a statement of advice. You will also be given copies of the product disclosure statements for any insurance policies that they recommend to you.

Checklist for buying insurance

The following checklist covers a few major points:

- Before deciding on an insurer, check the speed of the company's claims processing procedures and, if possible, their industry reputation. Try to get at least three quotes – this will give you a good basis for a comparison.
- If you are insuring a car, decide whether you want to insure it for an agreed amount (where a claim will enable you to upgrade any replacement car) or for its market price, which will depreciate over time.
- In the case of home building insurance, you should insure your property for its full replacement value. If you underinsure the property and your home is badly damaged or destroyed, you may be out-of-pocket for tens of thousands of dollars. Go to www.moneysmart.gov.au for information about avoiding underinsurance. Some insurers sell "total replacement" policies which remove the risk of underinsurance.
- If you are buying a car, it may be more expensive to buy insurance through the car yard – the dealer will get a commission from the sale of the insurance, and you may pay interest on the premiums.
- Review the amount your goods are insured for when you renew your policy;
- You have 14 days after receiving the policy to cancel it and get a full refund of the premium unless you make a claim on the policy in the meantime. During this period, you should read it carefully and make sure it covers what you want to insure. For example, you may wish to check that it includes flood cover.
- Keep a copy of your original contract and copies of correspondence with the insurance company and any other documents relating to the policy.
- In the case of home and contents insurance, keep accurate records of your valuables so you can show proof of ownership.
- Contents insurance may not automatically cover all your valuables and may not cover items taken outside the home. Expensive items (such as jewellery) may need to be individually disclosed to be insured.
- Many car insurance policies offer discounts for drivers with good driving records (often called "no-claim discounts" or "ratings"), and some insurers even offer good drivers a "maximum no-claim discount" or "rating one" for life. It's worth shopping around and comparing how insurers offer this feature – depending on your policy, even if you have a maximum no-claim discount for life, your premium could still rise if you make an at-fault claim.

Getting information

The Australian Securities and Investments Commission has detailed information on its website at www.moneysmart.gov.au, covering:

- how to understand your policy;
- how to compare different wording;
- important things to consider before buying your policy.

[29.110] Renewal

Many insurance policies are renewed every year.

Notice

The company must give at least 14 days' notice in writing of the expiry date of a policy.

If notice is not given

If the insurance company does not give the required notice, insurance cover continues at no cost to the policy holder unless and until:

- the person receives notice; or
- a claim arises. In this case, the policy holder will only have to pay the premium from the date of the claim.

[29.120] Cancellation

Cancellation by the insurer

Life insurance

The insurance company can only cancel a life insurance policy in certain specified circumstances:

- if the insured has made a fraudulent claim (*Insurance Contracts Act*, s 59A); or
- the insured has failed to pay premiums, provided that:
  - the insured has not paid at least three years' premiums; and
  - the surrender value of the policy does not exceed the total amount of the overdue amount of the premium and any other money owed to the insurer under the policy (*Life Insurance Act*, s 210).

General insurance

The insurance company can only cancel a general insurance policy in certain specified circumstances (*Insurance Contracts Act*, s 60). This can happen if the insured has:

- failed to comply with the duty of utmost good faith;
- failed to comply with the duty of disclosure;
- broken a condition of the contract;
- made a fraudulent claim.

Notice

The insurer must give the insured person at least:

- three business days' notice before cancelling a general insurance policy (unless the cancellation relates to the non-payment of an instalment premium – see below);
- at least 20 business days' notice before cancelling a life insurance policy.

Instalment premiums

An insurer may cancel a contract of general insurance immediately if any instalment premium is overdue for at least one month or more and before entering into the contract of insurance the insurer clearly disclosed to the insured its right to do so.

Refunds

When it cancels the policy, the insurance company usually refunds any premium for the unexpired period of insurance.

Cancellation by the insured person

Notice

Most policies give an insured person the right to cancel a policy by giving written notice.

Refunds

Usually only a percentage of the unexpired premium will be refunded when a person cancels their insurance policy, unless they do so during the *cooling-off period* – that is, within 14 days of receiving the policy documents. An administration fee may be charged.

Claiming on insurance

[29.130] Before claiming

Before making a claim on an insurance company – especially an at-fault claim – it is worth considering that:

- you may have to pay an excess before the insurance company contributes anything;
- for motor vehicle insurance, you may lose part or all of your no-claim bonus or have your driving rating reduced, so that the next year's premium could cost more (it could go up even if you have a maximum no-claim discount (or rating one) for life, depending on how your insurer provides this feature).

[29.140] Making the claim

There are a number of things you can do to help the insurer process your claim quickly and efficiently and to reduce the possibility of complications.

In particular, you should:

- cooperate with the insurer's loss assessors;
- fully notify the insurer promptly;
- provide as much information and evidence as you can in support of your claim.

Notification

You should notify the insurance company of the event as soon as possible. Notification by phone

should be followed up in writing, and the letter should include all relevant details of the incident.

Supporting documents

If possible, you should include documents to support the claim.

Keep records for insurance purposes

It is a good idea to keep records – receipts, valuations, serial numbers, photos and so on. Accurate records help in getting a claim paid promptly.

For example ...

Someone who has been burgled should take photos, contact neighbours for statements and arrange for a third party to witness the scene if there will be a delay in the police attending. A list of items stolen must be provided. If you later need to add any items to the list originally submitted to the insurer, you should explain why these items were missed off the first list.

[29.150] Motor vehicle accidents

If your car has been damaged in an accident, you may need to arrange to:

- store the damaged car at a repair shop while it is decided who will pay for the repairs;
- hire a replacement car.

You may not be able to recover these costs from your insurer or from the other driver or their insurer (even if they were at fault).

You should not arrange to store your car or hire a replacement without getting your insurer to agree to it, preferably in writing, unless you can afford to pay for it yourself.

The Insurance Reference Service

The Insurance Reference Service is Australia's only national database of insurance claims. It offers an easily accessible record of insurance claims by individuals. Some insurance companies use this database in deciding whether to accept an insurance proposal or as part of the investigation process when a claim is made.

Most people don't know that the service exists. Consumers have a right of free access to the database and can correct inaccurate information on it.

Where to take disputes

[29.160] Dispute resolution

Every insurer selling insurance to consumers and every licensed broker is required to be a member of an ASIC-approved external dispute resolution (EDR) scheme under the terms of their Australian financial services licence. The ASIC-approved scheme for insurance is the Australian Financial Complaints Authority (AFCA) which replaced the previous two main schemes, the Financial Ombudsman Service and Credit and Investments Ombudsman.

Advantages of using AFCA

The advantages of using this service rather than going to court are:

- they are familiar with insurance law;
- it is free;
- you do not need a lawyer to use it;
- it will help investigate the complaint;
- the decision made by the scheme is binding on the company, but not on you; and
- whether the company wins or loses, they are required to pay AFCA's costs in determining the matter, providing the company with an incentive to resolve matters promptly.

The complaints process

Before making a formal complaint

Before going to AFCA, the person must try to resolve the complaint with the insurer.

The insurer's internal review

The internal review by the insurer is not window dressing. If a complaint is taken to AFCA, the insurer will have to pay a fee regardless of whether the complaint is upheld by the scheme, so it has an economic incentive to establish proper internal complaint resolution procedures.

Complaining to AFCA

If the matter cannot be resolved with the insurer, it may be taken to AFCA, which will conduct an investigation. If the complaint is not settled or conciliated at this stage, it is referred to an AFCA panel.

What the panel will consider

The terms of reference of AFCA require the panel to give consideration to what is fair in all the circumstances having regard to each of the following:

a) legal principles
b) applicable industry codes or guidance as to practice
c) good industry practice, and
d) previous relevant decisions of AFCA or one of the previously established external dispute resolution schemes.

It may thus be possible to argue that a claim should be paid because the conduct of the insurer was unreasonable or unfair or contrary to good industry practice even if it was legal.

Making a submission to AFCA

The following should be addressed in a submission to AFCA:

- the letter of complaint should be clear about why the claim should be paid. It should specifically address any reasons the insurance company has given for refusing the claim or rejecting the complaint;
- if the claim depends on what was said between the consumer and the insurer, the conversations should be reported as precisely as possible. Any supporting details should also be provided, such as information that would make it more likely that the consumer should be believed (eg, the person relied on oral statements because they could not read English);
- if it is being argued that the person did not receive various documents (and that, eg, the insurer should pay because it breached *Insurance Contracts Act*, s 35), the history of the sale of the policy should be set out in detail, identifying what documents were received.

The panel's decision

The decisions of AFCA are not binding precedents. Each case is considered on its facts.

The panel's decisions are not binding on consumers either – a person who is dissatisfied can reject the decision and pursue court action. But insurers are bound by AFCA's decisions – they cannot appeal.

Australian Financial Complaints Authority Insurance Division

What matters can be heard?

AFCA can hear disputes in the following areas:

- life insurance (including income protection insurance, funeral insurance, TPD and trauma insurance);
- motor vehicle insurance (not compulsorily third-party insurance);
- home insurance (buildings and contents);
- sickness and accident insurance;
- consumer credit insurance;
- travel insurance;
- some other policies such as for personal property and some small business insurance.

The terms of reference of AFCA are available at www.afca.org.au.

Disputes about other types of policy

The panel can hear a dispute about other types of policy if the insurer agrees. It is worth asking the insurer if it will consent to the matter being referred to the panel.

What the panel cannot hear

The panel is restricted to disputes concerning:

- advice that was not provided to you or advice that you have received about the policy which may have been inappropriate or misleading;
- premiums that were incorrectly charged;
- the cancellation of a policy;
- a refusal to pay a claim (including for reasons of an alleged failure to disclose a relevant matter to the insurer);
- the amount that should be paid under a claim;
- a breach of privacy by the insurer;
- a failure by the insurer to follow an instruction given to them (such as increasing the sum insured);
- certain non-claim disputes (such as an insurer's sales and marketing conduct).

It cannot generally hear disputes about an insurer's commercial judgment, policy or assessment of

risk, the level of premiums or the rejection of an insurance proposal (there are exceptions).

AFCA does not consider matters relating to private health insurance or workers compensation. These are considered by the Private Health Insurance Ombudsman and Fair Work Ombudsman respectively.

Monetary limit

AFCA's ability to award compensation is subject to certain monetary limits as set out in the AFCA Rules which are available at www.afca.org.au. Examples of these limits are:

- general insurance broking: $250,000 per claim;
- life insurance (other than income protection): $500,000 per claim.

If the value of your claim exceeds these limits, you should consider whether pursuing the complaint via AFCA is appropriate.

Time limit

AFCA's ability to consider disputes is also subject to time limits. For insurance-related complaints, they must be submitted to AFCA on the earlier of:

- six years from the date that the person became aware (or should have been aware) of the loss; and
- two years after the person receives notice of the insurer's "final decision" – the decision made after an internal review at the person's request.

Costs

In general, your legal costs in pursuing a complaint via AFCA are not recoverable, but AFCA may decide that the financial firm is to contribute to such costs. Unless special circumstances apply, the award of a contribution to legal costs will not exceed $5,000.

A decision by the Financial Ombudsman Service #1

A person's house was damaged in a fire started by equipment used to cultivate marijuana, indoors, for his own use. His claim was denied on the basis that when he applied to insure the house, he failed to disclose that he was growing marijuana in it. The insurer argued that this entitled it to cancel the policy.

The panel found that the marijuana cultivation needed only to be disclosed if it increased the risk of damage to the property. It found that where marijuana was grown for sale, there was an increased risk due to the possibility of violence associated with drug use. This did not apply where marijuana was grown for personal use, and the company was ordered to pay the claim.

A decision by the Financial Ombudsman Service #2

A person took out an income protection insurance policy that, among other things, paid if the person lost "the sight of one eye". The insurer argued that it only had to pay if there was a complete loss of vision in one eye. The panel rejected this, saying it was sufficient if damage was such that the eye was ineffective or virtually useless, even without 100% loss of sight. The insurer was ordered to pay the claim.

[29.170] Complaints about brokers

AFCA will consider disputes between consumers and insurance brokers subject to the applicable monetary limits. Disputes may arise where, for example, a claim is rejected because the broker failed to pass on information to the insurance company or misunderstood the consumer's needs.

The Consumer, Trader and Tenancy Tribunal

The NSW Civil and Administrative Tribunal (NCAT) can hear disputes about insurance policies, though not about "cover in respect of a person's life" (*Consumer Claims Act 1998* (NSW), s 3) up to the value of $40,000.

If the dispute is about a general insurance policy, or about a life insurance policy such as income protection or trauma (that does not relate to a death claim), and AFCA cannot hear your case, or you are dissatisfied with the decision of AFCA, NCAT is a no-cost forum that may be able to hear it.

HEALTH INSURANCE

Overview of the health insurance system

[29.180] Australia has two health insurance regimes: Medicare, which is universal public insurance covering certain services, and private health insurance.

[29.190] Medicare

Medicare is a taxpayer-funded insurance scheme that gives all permanent residents health insurance covering most necessary health care services. It provides:

- access to free treatment as a public patient in a public hospital;
- a rebate on the medical costs of being a private patient in a public or private hospital (75% of the recommended schedule fee) through the Medicare Benefits Schedule (MBS);
- a rebate on fees charged by GPs and specialists (typically 85% of the scheduled fee) through the MBS;
- a rebate on some allied health and dental care services, for people with complex care needs and chronic conditions and only when supported by a doctor's referral, through the chronic disease management (CDM) program;
- subsidised access to prescription medications purchased from pharmacies, and when prescribed to private hospital patients or to public hospital outpatients, through the Pharmaceutical Benefits Scheme (PBS).

Consultations with a doctor

If a doctor bulk-bills the Government, there is no charge to the patient for that doctor's service.

If the doctor does not bulk-bill, the patient is responsible for any shortfall between what the doctor charges and what Medicare pays. Medicare will pay 85% of the MBS scheduled fee for out-of-hospital services, and the remaining 15% of the scheduled fee, plus any additional charge beyond that scheduled fee, represents the amount to be paid by the patient. However, there is a safety net that covers these out-of-pocket costs. The safety net operates on a calendar year, so that once an individual or a family reaches a certain level of out-of-pocket costs, the safety net comes into effect. For all Medicare eligible recipients, the Original Medicare Safety Net (OMSN) covers 100% of the schedule fee for out-of-hospital services, and the Extended Medicare Safety Net (EMSN) pays 80% of any subsequent out-of-pocket costs. The threshold to be eligible for the OMSN is based on gap payments (the difference between the Medicare rebate and schedule fee) and was $470 in 2019. For the EMSN, there are two thresholds, one for individuals or families covered by a Commonwealth concession card, or who receive Family Tax Benefit Part A ($680.70 in 2019), and one for other Medicare eligible individuals and families ($2,133 in 2019). Since 1 January 2010, there have been a number of services for which benefits payable under the EMSN are subject to an annual cap. Caps apply to assisted reproductive technology, obstetrics and some services for cataract surgery, hair transplantation and varicose veins. Caps were also added to a range of consultations (including some GP and referred attendances) and procedural services in November 2012.

While the safety net applies to a family, the family must register with Medicare Australia for all services received and paid for by individuals in the family to count towards the EMSN.

When a patient is treated by a doctor in hospital as a private patient (in a public or private hospital), 75% of the scheduled fee will be subsidised by Medicare. The remaining 25% is paid by either the patient or private health insurance company (see [29.200]). The patient also pays any amount the doctor charges above the scheduled fee. Further details are available online at the Department of Human Services (see www.humanservices.gov.au).

Pharmaceuticals

The PBS is a Commonwealth-funded program that provides access to subsidised medicines when these are purchased from private community-based pharmacies or when prescribed to private hospital patients or public hospital outpatients. The subsidy applies to medicines that have been

listed on the PBS to be prescribed for a particular condition. Medicines are generally listed for a restricted set of conditions and indications and may not be available on the PBS for every possible condition that medicine can be used to treat. For a PBS-listed medicine, the patient pays a set amount (the co-payment), and the government pays the remainder of the cost of the medicine directly to the pharmacist. The co-payment is the same for all medicines, but there are different levels of co-payment for different categories of patients.

Co-payment levels depend on whether patients are classified as concessional or general. Concessional patients are those who are eligible for Medicare *and* hold one of the following Commonwealth cards: Pensioner Concession Card, Commonwealth Seniors Health Card, Health Care Card, Repatriation Health Card for All Conditions (gold), Repatriation Health Card for Specific Conditions (white), Repatriation Pharmaceutical Benefits Card (orange), Safety Net Concession Card or Safety Net Entitlement Card. Holders of Repatriation Concession Cards are considered concessional patients for the Repatriation PBS only (a companion scheme to the PBS offering additional subsidised medicines to current and past members of the armed forces and their families) and are general patients under the PBS.

In 2019, co-payments for access to PBS medicines are $6.50 for concessional patients, $40.30 for general patients and free for those who have reached the safety net threshold. As of January 2016, pharmacists have the option to discount the patient co-payment by $1 for items dispensed under the PBS (this does not apply to the early supply of an item; within 20 days of the supply of the previous item of the same pharmaceutical). Public hospital outpatients may be charged the standard PBS co-payments (for general and concessional patients as may be applicable) per item. Some medicines are cheaper than the set levels of co-payment, in which case the patient pays the full cost of the medicine.

Safety net thresholds for PBS expenditure in 2019 are $1,550.70 for general patients and $390.00 for concessional patients. Once a general patient reaches the relevant threshold, the concessional patient co-payment applies. Similarly, concessional patients face no PBS co-payment once they reach the concessional threshold.

For all pharmaceuticals for which multiple brands are available, generic substitution is possible if accepted by the patient and provided it has not been prohibited on the prescription by the doctor. Generic substitution means that the pharmacist can substitute a named brand of a medicine with a cheaper alternative brand of the same medicine. If the medicine is cheaper than the co-payment, the patient benefits from generic substitution by paying a lower price. Generic substitution may reduce costs to the Federal government (and the taxpayer) for medicines that are more costly than the co-payment. Some brands of some medicines are subject to a "brand-price premium". Where a brand-price premium applies, the patient will have to pay this cost in addition to the PBS co-payment.

[29.200] Private health insurance

Private health insurance provides cover for:

- treatment as a private patient in a public or private hospital;
- some out-of-hospital services not covered by Medicare, such as physiotherapy, dental care and other health services; and
- suitably qualified and accredited health service providers of Outreach Hospital in the Home services, which prevent or substitute for hospital services.

Private health insurance does not cover treatment by a medical practitioner that is not provided in a hospital. These services are covered by Medicare. Private health insurance may also cover some medicines that are not listed on the PBS or that are prescribed for a condition other than the PBS indication.

[29.210] The right to choose

Everyone has the right to choose to be treated as a public or a private patient, whether they have private health insurance or not. When a person is admitted to a public hospital, the hospital should:

- ask the person whether they wish to be treated as a public or private patient; and
- explain the difference.

[29.220] Admission as a public patient

A person who chooses to be a public patient does not have to pay fees and is appointed a doctor by the hospital (ie, the patient cannot choose).

[29.230] Admission as a private patient

Hospital fees

A person who wants to be treated by a doctor of their choice may choose to be a private patient. The hospital then charges a daily fee.

Privately insured patients in public hospitals

In a public hospital, accommodation fees are fully covered by private health insurance if the patient has this cover.

Privately insured patients in private hospitals

Private hospitals can be very expensive, and there may be additional fees such as theatre fees. Even the highest level of private health insurance may not cover the whole cost, and patients may face expenses above those covered by their insurance.

It is important to check before going into a private hospital what the fees will be and what is covered by your private health insurance.

No gap and known gap policies

The medical "gap" is the amount the doctor charges above the MBS scheduled fee for care provided in a hospital. For medical procedures performed in hospital, doctors have the choice of participating in the health fund's "no gap" or "known gap" policies:

- No gap policies mean that patients do not incur any out-of-pocket expenses for their medical procedures.
- Known gap policies imply that patients will be charged a known or "capped" amount for each medical procedure.

Alternatively, doctors may elect not to participate in either of these policies, in which case all out-of-pocket expenses for the amount charged above the MBS schedule fee will be met by the patient.

Uninsured private patients in hospitals

Someone who chooses to be treated as a private patient will be billed for accommodation by the hospital and for medical services by the doctor, even if they do not have private health insurance.

Medical fees

As well as hospital fees, private patients in both public and private hospitals are charged fees by the treating doctor (and there may be more than one doctor for treatment such as surgery).

Medical fees are covered up to the government-recommended scheduled fee (ie, the MBS fee), with Medicare covering 75% of the schedule fee and private health insurance covering 25%.

Gap payments

Many doctors charge above the scheduled fee, and the patient must pay the extra (ie, the gap). Patients should check with their doctors what fees will be charged.

In some cases, private health insurers, private hospitals and doctors have established agreements that mean there are no gap payments (ie, a "no gap" policy), or gap payments that are known in advance (ie, a "known gap" policy), for patients being treated in some private hospitals.

Patients should check whether their private insurer has any such agreement and whether there will be additional expenses in the hospital where they are planning to be treated.

Gap cover schemes

Many private health insurers offer gap cover schemes. They may be included as a standard in hospital cover, but patients should check whether their insurance includes a gap cover scheme. Details of gap cover schemes are available online at the Private Health Insurance Consumer Information website (see www.privatehealth.gov.au).

Private health insurance

[29.240] Private health insurance can be purchased for a single person, a couple, a single parent family or a couple with children (family membership).

Private health insurance can be divided into three main types: hospital, general and ambulance cover.

[29.250] Hospital cover

Private insurance coverage of hospital expenditure is currently undergoing reform. From 1 April 2019, private insurers were required to categorise their policies into four tiers based on the extent of cover offered: gold, silver, bronze or basic. These changes are set to become mandatory from 1 April 2020.

These tiers are described at www.privatehealth.gov.au. The four tiers are differentiated by the clinical categories for which insurance coverage is offered, and within those categories, the procedures may be classified as a minimum requirement (meaning all procedures in that category must be covered), a minimum requirement for which there is restricted cover (see below) or a restricted cover category (which is not a minimum requirement). For example, coverage for diabetes management is offered as restricted cover for the basic tier cover but is a minimum requirement (unrestricted for all other levels of cover).

Exclusions

Some tiers will exclude cover for certain treatments or conditions, and in return, the member pays a lower premium. For example, a fund could offer a package that does not cover obstetrics, or hip and knee replacement surgery or major eye surgery.

Front-end deductable (excess) cover

In return for lower premiums, the member agrees to pay a certain amount upfront if they use their private health insurance.

For example, a member with a $400 front-end deductable will have to pay the first $400 if they use their insurance.

Co-payment policies

With these policies, the member contributes an agreed amount per day for their care while in hospital.

For example, a patient might agree to pay the first $100 for each day in hospital.

Restricted benefits cover

With this policy, members' expenses are covered while being treated in a public hospital for certain conditions, but members will face out-of-pocket expenses when treated in a private hospital for the same condition.

Public hospital table

Members electing this policy have restricted benefits for all conditions. As with the restricted benefits cover, members' expenses are covered for treatment as a private patient in a public hospital, but members will incur out-of-pocket expenses when treated in a private hospital.

Hospital-substitute treatment

This is a form of general treatment that involves the provision of patient treatment in a proxy setting outside the hospital environment. This is also referred to as "broader health cover" (see [29.260]). The member should discuss the viability of this treatment option with their doctor.

Discounts on premiums

Insurers are able to offer discounts on insurance premiums to members under certain conditions (eg, premiums are paid three months in advance, paid upfront by direct salary deduction, by automatic transfer, by employer contribution etc). In addition, from 1 April 2019, individuals 18–29 will be eligible for a discount of up to 10% on their insurance premium (2% for each year that a person is under 30, up to a maximum of 10%), with the discount to be retained until the age of 41 when it will then be phased out.

[29.260] General treatment cover

General treatment cover, also referred to as extras or ancillary, assists with the cost of treatments provided by ancillary health service providers such as dental, physiotherapy, speech therapy, podiatry, optometry, home nursing and prostheses.

Broader health cover

Insurers are able to offer cover for a broader range of services that prevent, substitute for or are part

of hospital treatment (ie, Outreach Hospital in the Home services). This policy aims to eliminate the boundary between hospital and ancillary cover. Examples are renal dialysis, chemotherapy and programs for the management of chronic diseases such as asthma and diabetes. Previously, these services were only covered by private health insurance if they were provided in a hospital.

Packaged products

While health insurance can be purchased solely as either hospital or general treatment cover, most health insurance funds also offer a "packaged product" comprising both forms of health cover.

Comparing costs

The main difference between most private health insurance products is in terms of the trade-off between premiums and excesses. That is, the choice is largely between:

- paying lower premiums but paying an excess when the cover is used; and
- paying higher premiums but not having to pay an excess when the cover is used.

[29.270] Ambulance cover

Medicare does not subsidise the cost of ambulance transportation. The costs and inclusions of ambulance cover differ with each state, territory and health insurer.

In Queensland and Tasmania, residents are charged a levy, and the state government pays the full cost of ambulance transportation. In the other Australian states, ambulance cover can be purchased from a private health insurer. An ambulance levy will be included in the fund's basic hospital cover; however, some funds also offer "ambulance only" cover. It is also important to determine the level of ambulance cover provided by the health insurance fund since some funds cover all ambulance services whereas others provide only basic cover. Fully subsidised transport costs are also available to pensioners, veterans' affairs and Health Care Card holders in New South Wales and the Australian Capital Territory.

As an alternative to private health insurance, residents have the option of purchasing an ambulance subscription through their state ambulance service.

[29.280] Advantages of private cover

The main benefits of having private health insurance are:

- cover for some or all of the expenses associated with choosing a particular doctor or a particular hospital;
- better accommodation in some private hospitals (eg, a better standard of meals and a private room);
- access to private hospitals for non-urgent (elective) care. There are usually waiting lists for non-urgent treatment in public hospitals; and
- cover for services not available under Medicare, such as physiotherapy and dental care. These are called *ancillaries* or *extras*.

[29.290] Surcharges and financial incentives

The 30% rebate

Since January 1999, the federal government has offered a rebate on premiums paid for private health insurance. The rebate covers all private health insurance cover (hospital, extras and combined cover). Since 2013, the private health insurance rebate has been means tested which means that the amount of the rebate depends on the income of the individual or family and does not apply once the individual's or family's income is beyond the means test threshold level. The table below shows how the rebate varies by age and income, with the thresholds that will apply from 1 April 2019 to 31 March 2020 (source: https://privatehealth.gov.au/health_insurance/surcharges_incentives/insurance_rebate.htm). The thresholds for eligibility for the rebate are indexed annually. The levels of the threshold also vary for single parents and couples (including de facto couples). For families with children, the thresholds increase by $1,500 for each child after the first.

	Annual income (before tax)			
Singles	$90,000	$90,001–$105,000	$105,001–$140,000	$140,001
Families	$180,000	$180,001–$210,000	$210,001–$280,000	$280,001

	Rebate			
	Standard	*Tier 1*	*Tier 2*	*Tier 3*
Age 65	25.059%	16.706%	8.352%	0%
Age 65–69	29.236%	20.883%	12.529%	0%
Age 70+	33.413%	25.059%	16.706%	0%

How is the rebate claimed?

The rebate can be claimed:

- as a reduction on the premium, by registering this choice with the fund; or
- as a tax rebate on a person's income tax return.

Individuals who choose the rebate as a premium reduction will be asked to nominate which income tier applies, based on estimated income.

If the nominated tier results in a lower rebate than would apply based on the actual income, the individual will receive a tax offset through their tax return at the end of the financial year.

If the nominated tier results in a higher rebate than would apply based on the actual income, the individual will incur a tax liability at the end of the financial year, which may result in a tax debt. There are no additional penalties for estimating incorrectly.

Eligibility

All Australians who are eligible for Medicare and who are members of a registered health fund are eligible for the rebate.

The Medicare levy surcharge

Higher income earners (singles with an income of $90,001 and above and families with an income of $180,001 and above) face a surcharge that must be paid on top of the normal 1.5% Medicare levy if they do not take out private health insurance for hospital cover. The surcharge varies by income; those who fall into Tier 1 income levels (see Table above) pay 1%, Tier 2 pay 1.25% and Tier 3 pay 1.5%.

Lifetime health cover

What it does

Lifetime health cover, introduced by the federal government on 1 July 2000, allows health funds to charge different premiums according to a person's age when they first took out hospital cover. Members who join early in life pay a lower premium than those who join later in life.

Lifetime health cover is essentially a financial loading that must be paid in addition to the usual premium and applies only to hospital cover, not ancillary cover.

The certified age of entry

A person's certified age of entry (ie, their lifetime health cover age) is the age they are considered to be when they take out hospital cover. A person's certified age of entry is:

- their actual age on the day they first take out hospital cover, if purchased prior to 23 April 2004;
- their actual age on 1 July before they first take out hospital cover, if purchased on or after 23 April 2004 and their birthday is not 1 July; or
- their actual age (less one year) on the day they first take out hospital cover, if purchased for the first time on or after 23 April 2004 (and their birthday is 1 July).

People born on or before 1 July 1934 are not affected by lifetime health cover. They can take out private health insurance at any time and receive a certified age of entry of 30.

Effect on premiums

There is a 2% loading on the base rate premium for every year that a person's age at entry exceeds 30, up to a maximum of 70%.

Thus, in order to avoid paying the lifetime health cover loading, hospital cover must be taken out by 1 July following the consumer's 31st birthday.

Once you have paid a lifetime health cover loading on your private hospital insurance for 10 continuous years, the loading is removed as long as you retain your hospital cover.

Breaks in cover

A person can drop their hospital cover for up to 24 months (cumulative) without affecting their certified age of entry. After 24 months, their

certified age of entry increases by one year for every year they do not have cover.

Effect on ancillary products

Ancillary products (ie, "extras") are not affected by lifetime health cover.

Loyalty bonuses

Health insurers are able to offer loyalty bonuses to members based on length of membership.

Such bonuses can take the form of either:

- higher benefits paid;
- lower premiums charged; or
- in the form of goods and services.

No-claim bonuses

Offering no-claim bonuses is still prohibited.

Weighing up the cost

While lifetime health cover provides an incentive to take out private health insurance at the age of 30 or as soon as possible thereafter in order to avoid paying the additional loading later on, it is important to weigh up the cost of paying premiums from the age of 30 onwards against the cost of joining later and paying the loading.

Effect on higher income earners

The combined effect of the Medicare levy surcharge, the 30% rebate and lifetime health cover means that some high-income earners may find it cheaper to take out private health insurance cover even if they never intend to be treated as a private patient.

[29.300] Choosing between packages

There are many different health insurance packages available, tailored to the needs of different consumers. This range can make it difficult to understand what is covered and to compare different funds and packages.

Before taking out insurance, it is important to be clear about what is covered by the package being considered and to check whether there are limits on the benefits paid, whether an excess applies, what the waiting periods are and any other conditions that might apply.

Limits on benefits for ancillary services

Most health insurance funds limit the benefit payable for each service (as a percentage of the service price) and the maximum annual benefit payable. For example, a fund might offer to pay 50%–75% of the price of ancillary services, depending on the level of cover. Hence, the remaining 50%–25% is paid out-of-pocket by the consumer.

Waiting periods

All funds have waiting periods before benefits will be paid for some services.

For pre-existing ailments and conditions, and obstetric care, the period is 12 months. People planning a family and intending to join a health fund should do so as early as possible to ensure they are covered if the baby is born prematurely.

For other services, the waiting period varies, depending on the fund and the type of service.

The waiting period for pre-existing ailments and conditions is rarely waived, even in special promotions that waive other waiting periods.

[29.310] Privately insured patients in public hospitals

In general, state and territory health departments require public hospitals to treat patients on the basis of need, regardless of their status as public or private patients. This means that having private health insurance does not (and is not intended, or designed to) give a person priority of treatment over public patients in public hospitals.

In both the National Health Reform Agreement and the Australian Health Care Agreements, the Australian and State governments agreed that an individual can choose to be a private patient in a public hospital and that the public hospital can charge for these private patients at a fee set by each State. The National Health Reform Agreement (2011) stipulates that an eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient. The Reform Agreement also permits the State governments to introduce incentives to encourage public hospitals to recruit private patients. Many public hospitals employ staff whose task is to recruit private patients at their hospital.

Self-insuring

Some people choose to self-insure. Given that private health insurance may cost a family almost $3,000 a

year, setting this amount aside each year in a term deposit account may be cheaper. It is, of course, more risky, because people have little control over the timing of major medical expenses. The person must also be sure not to spend the saved amount for other purposes.

[29.320] Getting help

Sources of information

Health insurance is regulated by the federal Department of Health and Ageing, which maintains a website with up-to-date information regarding private health insurance (see the Department of Health at www.health.gov.au). The Private Health Insurance Ombudsman website (see https://www.ombudsman.gov.au/How-we-can-help/private-health-insurance) is also a good source and contains an interactive database enabling users to search for and compare different health insurance policies (see www.privatehealth.gov.au).

The *Private Patients' Hospital Charter* is also available to explain your rights and responsibilities as a private patient in hospital and outline what you can expect from your doctor, hospital and health insurer (see https://beta.health.gov.au/resources/publications/private-patients-hospital-charter).

If there is a dispute

People who have problems with private health insurance fees or claims for refunds should first try to resolve the matter with their health insurance fund.

The Private Health Insurance Ombudsman

If the matter is not resolved with the fund, the person should contact the Private Health Insurance Ombudsman. The Ombudsman has been established to deal with complaints about private health insurance arrangements and is independent of the private health funds, public and private hospitals and the government.

Contact points

[29.330] If you have a hearing or speech impairment and/or you use a TTY, you can ring any number through the National Relay Service by phoning **133 677** (TTY users, chargeable calls) or **1800 555 677** (TTY users, to call an 1800 number) or **1300 555 727** (Speak and Listen, chargeable calls) or **1800 555 727** (Speak and Listen, to call an 1800 number). For more information, see www.communications.gov.au.

Non-English speakers can contact the Translating and Interpreting Service (TIS National) on **131 450** to use an interpreter over the telephone to ring any number. For more information or to book an interpreter online, see www.tisnational.gov.au.

Changes are expected to the websites for many NSW government departments that were not available at the time of printing. See www.service.nsw.gov.au for further details.

Administrative Appeals Tribunal
www.aat.gov.au
ph: 1800 228 333 or 9276 5101

Australian Financial Claims Authority
www.afca.org.au
ph: 1800 931 678

Australian Prudential Regulation Authority
www.apra.gov.au
ph: 1300 55 88 49 or 8037 9015

Australian Securities and Investments Commission (ASIC)
www.asic.gov.au
ph: 1300 300 630 or 03 5177 3988

Australian Taxation Office
www.ato.gov.au
ph: 13 28 65
Branches
Albury-Wodonga
Centrelink Service Centre,
430 Wilson St, Albury, NSW 2640
Chatswood
Centrelink Service Centre,
56-64 Archer St, Chatswood, NSW 2067
Newcastle
279 King St, Newcastle, NSW 2300
Parramatta
2-12 Macquarie St, Parramatta, NSW 2123
Penrith Centrelink
Penrith Service Centre
598 High St, Penrith, NSW 2750
Rockdale Centrelink
Rockdale Service Centre
75 Railway St, Rockdale, NSW 2216
Sydney CBD
Shop 1, 32 Martin Pl, Sydney, NSW 2000
Wollongong/Corrimal
Centrelink Service Centre
Cnr Underwood St and Collins St, Corrimal, NSW 2518
Postal address
PO Box 9990 in the locations above.

Health, Department of
www.health.gov.au

Health, Department of (Private Health Insurance)
www.health.gov.au/internet/main/publishing.nsf/Content/private-1

HIV/AIDS Legal Centre (NSW)
www.halc.org.au
ph: 19206 2060

Information Commissioner, Office of the Australian (formerly Privacy Commissioner)
www.oaic.gov.au
ph: 1300 363 992

Information and Privacy Commission NSW
www.ipc.nsw.gov.au
ph: 1800 472 679

Law and Justice Foundation of NSW
www.lawfoundation.net.au

Legal Aid NSW
www.legalaid.nsw.gov.au
ph: 1300 888 529 or 9219 5000
For information on specialist services and regional offices, see Contact points of Chapter 4, Assistance with Legal Problems.

Medicare Australia
www.humanservices.gov.au

MoneySmart (formerly known as FIDO)
www.moneysmart.gov.au
ph: 1300 300 630

NSW Civil & Administrative Tribunal
www.ncat.nsw.gov.au
ph: 1300 006 288

Office of State Revenue
www.osr.nsw.gov.au
ph: 9689 6200
Payment
Office of State Revenue
GPO Box 4042, Sydney, NSW 2001

Private Health Insurance Ombudsman
www.ombudsman.gov.auHow-we-can-help/private-health-insurance
ph: 1300 362 072

Private Health Insurance Consumer Information (PrivateHealth.gov.au)
www.privatehealth.gov.au