AUSTRALIAN DENTAL ASSOCIATION

Choosing a policy
Essential questions

Quite apart from government incentives, many people take out private health insurance because it gives them more options that public cover alone and grants them access to items that may not be covered by Medicare. But assessing whether you need hospital (cover all or part of private or public hospital costs), ambulance or ancillary (otherwise known as "extras", it covers dental, physio et al) cover or a combination of them, can be an overwhelming proposition. To help make this decision a little easier, we've assembled a list of important questions you should ask yourself before you sign on the dotted line.

Please keep in mind that the main focus of this fact sheet is the validity and worth of extras cover, specifically coverage for dental treatments. It is not advisable to change your policy on the strength of your extras cover alone until you are able to fully assess the impact on your overall policy needs.

Do you need extras cover?

When it comes to dental treatment, extras cover, also known as general treatment cover, should be the starting point of your policy evaluations. For the most part, extras cover doesn't really offer value for money if you're only an infrequent user of these services. On average, your rebate (the amount you receive back from your fund) only compensates you for about 50% of the cost of dental treatment (although some of the smaller not-for-profit funds return anywhere up to 75%). Even the one time head of the government organisation which oversees private health insurance in Australia has expressed doubts about its value, pointed out you would be better off putting money aside for these services should you eventually need them.

What kind of insurer do I want?

At first glance, every private health insurer looks roughly the same. But on closer examination, some fairly significant differences emerge between them which may influence which policy you choose. One of the main things you need to consider is whether you want to sign up with a not-for-profit or for-profit fund, or whether you're eligible for membership of a restricted fund.

Not-for-profit private health insurers are usually owned by their members and primarily channel their excess funds into the operation of the business and into providing a higher level of benefits to their members in the form of increased rebates.

For-profit insurers by contrast have a primary responsibility to return a profit to their shareholders and may return lower rebate amounts. They do, however, have the same requirement as not-for-profit funds to set aside sufficient funds to maintain their business and provide benefits to their members.

Restricted funds are generally only open to a particular group or industry i.e. Defence Health is only open to current or former members of the ADF, the Defence Community and their families. Determining if you can join these funds should therefor be a fairly quick and straightforward exercise.

Do I have to take all my policies out with the same insurer?

Not at all. While the popular perception is that you must have your general and extras cover with the same fund, the reality is that you can split your policies between insurers. Keep in mind that to avoid tax penalties from the government that you must have a hospital policy; extras cover is however entirely optional.

Are their premium increases high or low?

Every year on the 1 April, the funds increase their premiums by a government-approved percentage. While the average increase is 6%, a number of funds routinely charge in excess of this so it's worth checking the percentage by which your fund increases its premiums each year.

For more information visit **ada.org.au**

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Does the policy offer the coverage you need?

Funds are required by law to have what is known as a Standard Information Statement (SIS) for each policy which provides you with broad details about waiting periods, benefit limits and services covered by the policy. You can obtain a copy of the SIS ahead of signing on the dotted line by going to privatehealth.gov.au or by asking the fund for a copy. If you have any specific questions about whether the policy you're considering covers the specific treatments and procedures you want, it's advisable to check with your prospective insurer prior to taking out the policy.

How long do you have to wait before making a claim?

While insurers' advertising campaigns may give the impression that you can claim immediately on joining, the reality is each policy has pre-existing illness clauses and exclusions that determine when you can make a claim and for which treatments. Again, double checking when you can begin to make claims should be something you verify ahead of signing up with an insurer.

Can you see your regular dentist?

Continuity of care, which is another way of saying ongoing care by the one dentist over many years, is something that should matter to you. Your long-term dentist, who knows you and your treatment history well, is best placed to offer you the oral healthcare you need. So continuing to see them is very important. But many funds are increasingly attempting to divert policyholders to their own clinics or to see their contracted dentists with promises of 'no gap' or higher rebates on certain treatment. While this may sound like a good thing from a financial perspective, the downside is that you may pay more for other treatments in the long run. Private health insurance is all about having choice of provider so you shouldn't have to compromise on continuity of care; rebates should be linked to the policy itself, not who provides the care.

What kind of rebate amounts does the fund offer?

It's easy to assume that rebates will cover the majority of the costs you incur, but, in reality, they rarely do. So it pays to check how much of the "gap", which is the difference between the treatment cost and the rebate, you will have to cover. Complicating this is the fact that insurers are not always transparent about how the rebate amounts are calculated.

Are people complaining about the fund to the Private Health Industry Ombudsman?

The number of complaints made about private health insurance has increased year-on-year. To ensure you are taking out a policy with a fund that experiences a low level of complaints, go to **ombudsman.gov.au**

To help you decide if your current policy is suitable, or whether you need to find another insurer, keep these 5 key questions in mind when you're evaluating your options.

1. Are you happy with your rebate amounts?
2. Is the wait time before making claims acceptable to you?
3. Has your fund pressured you to use their dentist?
4. Is your fund not-for-profit or for-profit?
5. Are you getting value for money from your policy?

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