



Member Guide

Important information about your health insurance

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Important note: The information contained in this document is current at the time of issue (April 2024) 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 which are summarised in this document. Premiums, benefits, Fund Rules and policies change from time to time. 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 for all ahm 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. You can download product guides at **ahm.com.au** or call **134 246** and we'll send you a copy.

Please read this Member Guide and your product guide(s) carefully.

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.

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 to the best of your knowledge and belief having made reasonable enquiries 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'll 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, let us know by live chat at [ahm.com.au](https://www.ahm.com.au) or by calling us on **134 246**.

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 a transfer certificate(s) from them to determine if any comparable Waiting Periods for benefits you've already served can be recognised. We'll only recognise Waiting Periods where you join ahm within 30 days of leaving your previous insurer. You may not be able to claim benefits for certain services until we've received your transfer certificate.

We'll request a transfer certificate on your behalf if you've given us permission to do so.

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.

It's important to note your annual limits in the first financial year of your membership and any sub-limits or lifetime limits may be reduced by the benefit amount/s you have received from your previous insurer.

We also need the transfer certificate to verify whether a Lifetime Health Cover (LHC) loading (page 35) or a Youth Discount (page 37) applies to anyone on your membership, as this could affect your premiums.

Without the transfer certificate, we cannot verify whether anyone listed above is required to have LHC applied to their policy. As a result, if we do not receive a Transfer Certificate from your previous insurer, we'll provide you with notice as soon as reasonably practicable that we'll be calculating and applying the loading to all members over 31, in accordance with applicable requirements in the Act, from their cover start date with ahm, and your premium may change. If you leave ahm without us receiving a transfer certificate, we'll issue any transfer certificate to you/your new insurer on this same basis.

When you switch to ahm from your previous 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.

Levels of Medicare eligibility are:

- Full Medicare (green card)
- Interim Medicare (blue card)
- Reciprocal (RHCA) Medicare (yellow card)
- No 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, we may not be able to pay benefits as set out in your cover, and you may end up with large Out-of-pocket Expenses if you receive hospital treatment.

If this is you, or any member on your policy, you must call us and let us know that you have limited Medicare eligibility. We'll be able to 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

Starting your cover

You can choose to start your cover now or any date in the future.

If you're switching health insurers, you may ask us to backdate your Hospital 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 38 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 (this is the cooling-off period).

If you change your mind during that period, and no claims have been made, we'll either transfer you to a more appropriate cover from the original commencement date or cancel it altogether and refund your premiums.

During the cooling-off period, you cannot return to a cover that ahm has closed.

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

Overseas claims

ahm doesn't pay benefits for any claims for services provided outside Australia or for items purchased or hired from overseas suppliers.

You may want to consider ahm 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. Visit ahm.com.au/travel-insurance for more information.

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 Accident Override.

We may agree to pay provisional benefits in some cases. We may, acting reasonably, 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 which are reasonably requested by ahm.

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.

Private Health Information Statements

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

You should review the PHIS in conjunction with your product guide, this Member Guide and the Fund Rules available at ahm.com.au as they provide a full overview of the benefits available to you. You can download the PHIS 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 go to **ahm.com.au**
Once you're logged in to your account you can:

- Make extras claims and view your remaining annual limits
- View your extras claims history
- Use our benefit calculator to find out how much you might get back on an extras claim
- Check your extras Waiting Periods
- 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 and update your account details no matter where you are.

You can download the ahm app from your app store.

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

Partner Authority

If the Principal Member adds their Partner, the Partner will be given authority to manage most aspects of the membership, unless the Principal Member tells us otherwise. This means ahm may disclose membership details to both the Principal Member and their Partner.

Partner Authority means Partners can:

- Make claims
- Add or remove dependants
- Change cover
- Suspend and reinstate the membership
- Change bank account details
- Change payment methods
- Request and receive premium refunds

However the Partner cannot remove the Principal Member or cancel the entire membership.

If the Principal Member would like their Partner to access their claims and personal information, they can provide their Partner with Claims and Information Consent (see below).

Third Party Authority

ahm provides two levels of authority, where you can nominate a third party to deal with ahm on your behalf.

- **Authorised Person:** If you are the Principal Member, you can nominate a third party to manage the membership on your behalf. Once appointed, an Authorised Person can do everything the Principal Member can do, including close the membership. This does not allow them to access personal information.
- **Claims and Information Consent:** Claims and Information Consent provides a third party with access to a member's sensitive information (such as claiming information) and contact details when contacting ahm over the phone or through live chat. Claims and Information Consent must be provided by each member specifically, someone cannot do this on their behalf. Once appointed, someone with Claims and Information Consent can contact ahm and enquire/request details of the consenting member's claims – including services claimed, the date, the provider and cost of each service, as well as enquire about any upcoming claims. A person with Claims and Information Consent can also access and change the consenting member's personal information. Claims and Information Consent also applies to claims that can be viewed in your online account (see 'Claims information on your online account' below).

There are three ways a member can nominate someone as their authorised third party:

- Verbally over the phone;
- By completing an ahm Third Party Authorisation form – the form can be downloaded at **ahm.com.au**; or
- By giving ahm valid Power of Attorney/guardianship documentation.

A third party can be nominated for a specific timeframe or for the duration of the membership. You can revoke this authority at any time.

Claims information on your online account

Extras claims

The Principal Member can submit extras claims through their online account for anyone on the membership. To view extras claims history online for Members aged 16 and older on their policy, the Principal Member will need to provide ahm with the contact details for each such Member. ahm will then contact the Member(s) to check if they're happy with the Principal Member viewing their extras claims history online. Unless the Member(s) contact us to opt out, their consent will be assumed 30 days after they received the SMS/email.

Hospital and medical claims

The Principal Member can only view your hospital and medical claims history online when you have provided them with Claims and Information Consent.

If you have authorised the Principal Member under Claims and Information Consent, they can access all claims information including extras by contacting ahm via phone or web enquiry regardless of whether the member has opted out of the Principal Member viewing their extras claims history online.

Dependants turning 16

If a dependant is over 16 years old, or when a dependant turns 16 years old, they must provide their consent to us sharing their personal information with you, including any claims information (Claims and Information Consent).

Your premiums

Paying your premiums

Premiums must be paid in advance and you can prepay up to 12 months. 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 – Set 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 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.

Mail – Write a cheque to 'ahm health insurance' and 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 for Health. Where this occurs we'll provide written notice to the Principal Member to let them know what the new premium will be. If you do not agree to the increased premium, you may cancel your cover by notifying us.

If you've paid your premiums in advance, any premium changes won't apply until your next payment is due, this is known as premium protection. 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 protection doesn't protect you against any other changes made to the terms and conditions of your membership.**

Premium arrears

You can't receive a benefit for items or services while 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 may lapse and your membership may be terminated. We'll attempt to contact you during this time to let you know. We'll advise you in writing if the membership is terminated.

Canceling your membership and obtaining 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 request and will not be backdated. Refunds will generally be refunded to the account from which they were deducted. We may apply a reasonable and proportionate administration fee and refund all remaining monies - we'll tell you in advance what this is.

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 remove themselves from the 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 31 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 31, 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 as determined by ahm.

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 14), unless they've previously held cover for the same benefits and have not had a break in cover of more than 30 days between their old and new cover.

Having a baby?

If you're thinking about starting a family, you may want to consider cover that includes Pregnancy and birth. There is a 12-month Waiting Period for these services that the mother will need to serve before being admitted to hospital for these services. The good news is that you can serve part of this Waiting Period while you're pregnant, so as long as your expected due date falls outside of this 12-month Waiting Period you'll be eligible for benefits for the birth of your baby.

In addition, once the baby is born, you may want to consider adding them 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 couple, 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 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 added to your policy from birth.

Remember that your hospital Daily Charge and/or Excess (page 20) 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 or a future date as nominated by you. Waiting Periods may apply (page 14).

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 or limit.
- 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 excluded or will have their benefit reduced.

If you change your hospital cover, your Membership Year for the purposes of Daily Charge/ Excess will be reset.

Also, 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're 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. The adjustment will apply from the date you contact us.

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.

Suspending your cover

You can ask to put your cover on hold if:

- you are travelling overseas (for more than 30 days), or
- you or your Partner become unemployed, or
- you are experiencing temporary financial hardship

No benefits will be paid during any period of suspension.

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.

Overseas trip

If you're going overseas for more than 30 days, you can request to suspend your cover for the days you're outside of the country – up to two years at a time.

You should request your suspension in advance of your trip. 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.

If you have paid your premiums in advance, premium protection will be lost.

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 your or your Partner's receipt of a JobSeeker Payment or other similar allowance relating to unemployment under the Social Security Act 1991 and we'll start your suspension from the date we receive these.

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

Temporary financial hardship

If you're experiencing temporary financial hardship but are not eligible for an unemployment suspension and you have been an ahm member for at least 12 months, you can suspend your cover for up to three months. If you suspend your cover due to temporary financial hardship, you won't be able to suspend it again for this reason for 12 months (from the date your cover reactivates).

Tax implications

If you hold hospital cover, depending on your income, suspending your cover may mean you're subject to the Medicare Levy Surcharge for the period you're suspended. This is because you're not considered by the Australian Taxation Office (ATO) to hold 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 an 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 refund any excess premiums. We may apply a reasonable and proportionate administration fee and refund all remaining monies - we'll tell you in advance what this is. Any surcharge paid in relation to your method of payment (page 9) 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. If you have a gap of more than 30 days between cancelling and re-joining or switching to ahm from another insurer, Waiting Periods may apply. They also apply if you change to a level of cover that has additional services or higher benefits on services, or where changing cover to reduce any Excess and/or Daily Charges.

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 (page 4).

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

Mental Health Waiver

The Mental Health Waiver allows members who have served their two-month Waiting Period for Restricted Hospital psychiatric services to upgrade to a cover with Included 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 Hospital 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 Hospital psychiatric services. All other applicable Waiting Periods will continue to apply.

Each member 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(s) 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 by our appointed medical practitioner acting reasonably 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 included?

Hospital cover pays benefits towards hospital accommodation, intensive care and medical services that you receive when you're treated in hospital as a private Inpatient.

What's included under your cover depends on the 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.

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're admitted. This will enable you to provide informed financial consent.

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.

Glossary

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

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.

Minimum 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 Minimum 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 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
- Pension Health Benefits Concession Card and Social Security Card
- Health Benefits 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.

In WA, aged pensioners are entitled to free primary ambulance services provided by St John Ambulance Australia. All other WA senior citizens aged 65 or over are entitled to receive a 50% subsidy on the cost of ambulance transport provided by St John Ambulance Australia. The remaining 50% of the cost may be claimable from ahm if the member is entitled to ambulance benefits under their cover.

Please visit health.wa.gov.au for more information.

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 selected disease management appliances (check your product guide available at ahm.com.au). 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 available at ahm.com.au 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 medical devices and human tissue products. This means we'll pay in accordance with the minimum benefit listed on the government's Prescribed List of Medical Devices and Human Tissue Products.

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 most 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 Prescribed List of Medical Devices and Human Tissue Products, we'll only pay the listed minimum benefit and you'll have to pay the difference. We won't pay benefits for devices not included on the government's Prescribed List of Medical Devices and Human Tissue Products.

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, 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.

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

This depends on your particular ahm hospital cover. Check your product guide for a list of Restricted Services.

Restricted Services

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

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

There are no benefits payable towards theatre fees for Restricted Services. Restricted Services include benefits towards the following:

- Minimum Benefit for shared room accommodation at a public hospital or a reduced level of accommodation benefits at a private hospital (page 16)
- Medical devices and human tissue products, up to the minimum benefit listed on the government's Prescribed List of Medical Devices and Human Tissue Products.
- 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 20) applicable to your cover will be charged even where only a Minimum 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's Excluded?

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'll have to pay all costs yourself.

Check your product guide(s) available at ahm.com.au for a list of Excluded services.

Other excluded procedures, charges and items

- 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 21 for information on GapCover)
- Charges above the minimum benefit for surgically implanted medical devices and human tissue products set out in the government's Prescribed List of Medical Devices and Human Tissue Products
- The full cost of your 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, medical devices and human tissue products, medication, allied health and the medical gap
- Any accommodation charges above the Minimum Benefit for Restricted Services
- Treatment that's either subject to a Waiting Period, provided while premiums are in arrears or while your membership is suspended
- Personal items such as 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 any purchases from outside Australia, including online purchases from overseas companies
- 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

Hospital cover benefits are generally payable only for treatment for which a Medicare benefit is payable. However, under some Hospital covers we pay limited benefits towards the following treatments when provided to a hospital Inpatient, even though no Medicare benefit is payable (check your product guide):

- Surgical removal of wisdom teeth: We'll pay benefits towards hospital accommodation charges. We don't pay any benefits towards the dentist's fees under hospital cover. This means you could incur Out-of-pocket Expenses for those charges. Some benefits (up to applicable limits) may be claimable for the dentist's fees if you hold an appropriate level of extras cover.
- Podiatric surgery: We only pay benefits towards hospital charges for podiatric surgery. There are no Medicare benefits payable for podiatric surgery, which means we also don't pay any benefits towards the podiatric surgeon's fees under Hospital cover and you could incur significant Out-of-pocket Expenses. Some benefits (up to applicable limits) may be claimable for the podiatric surgeon's fees if you hold an appropriate level of extras cover.

What you pay when you go to hospital

Although hospital cover helps reduce the cost of a hospital visit, your Out-of-pocket Expenses will be your excess and/or Daily Charge (if you have one - check your product guide available at ahm.com.au) as well as any difference between what the hospital or doctor charges and the benefit we pay.

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

Daily Charge

A Daily Charge or Co-payment is a 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, depending on your cover (check your product guide available at ahm.com.au). Please note, 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 is an upfront lump sum payment that you agree to pay towards the cost of your hospital stay or day surgery on admission. An excess will help to reduce your premiums.

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

The Excess may not apply to dependants on family policies (check your product guide available at ahm.com.au).

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 available at ahm.com.au to see if a Daily Charge (Co-payment) and/or Excess applies to your hospital cover before undertaking treatment. Alternatively, you can contact us to check whether an excess applies to your cover, which we recommend you do before undergoing treatment if you're unsure.

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's 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. These changes may include:

- the removal of items (with or without replacement),
- the addition of new items,
- the addition or modification of conditions associated with such items (including in relation to circumstances in which benefits might be payable), or
- changes to the corresponding MBS fee(s).

The MBS is available at **mbsonline.gov.au**

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 (check your product guide available at **ahm.com.au**) 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're 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 — we refer to these as Partner Private hospitals.

These agreements include 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 Minimum Benefits and you'll have significant Out-of-pocket Expenses. If you receive treatment for an Excluded Service, no benefits will be paid by ahm.

Our Partner Private hospitals, and our agreements with Partner Private hospitals may change from time to time without notice to you. 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 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 Minimum Benefit and you'll have significant Out-of-pocket Expenses. If you receive treatment for an Excluded Service, no benefits will be paid by ahm.

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 Minimum Benefit for same-day admissions and overnight accommodation in a shared room. You'll need to pay any difference between the Minimum Benefit we pay and the amount the hospital charges.

This means you may need to pay significant Out-of-pocket Expenses.

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:

- 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)?
- 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?
- 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.

Call us to check your cover and benefit entitlements

We'll 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)
- whether a Daily Charge and/or Excess applies to your cover.

Medical Devices and Human Tissue Products

Medical devices and human tissue products are surgically-implanted items such as a stent (for coronary arteries), grommets or titanium plates and screws. Except for Excluded Services, we'll pay you up to the minimum benefit listed on the government's Prescribed List of Medical Devices and Human Tissue Products.

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

If you do choose an item that costs more than the minimum benefit, you'll have to pay the difference between the minimum benefit and the charge. We won't pay benefits for items not included on the Prescribed List of Medical Devices and Human Tissue Products.

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.

Benefits for pharmaceuticals

The Pharmaceutical Benefits Scheme (PBS) is funded by the government and makes subsidised prescription medicines available to Australian residents. Residents eligible for the PBS contribute to the cost of subsidised medicines by paying a co-payment for each item (set by the government).

Government legislation prevents health insurers from paying benefits for medications covered by the PBS unless provided under an agreement with the hospital.

This means ahm will only pay benefits towards PBS medications where:

- you're admitted to a Partner Private hospital for an Included service (refer to your product guide available at **ahm.com.au**); and
- the pharmaceutical is directly related to the treatment of the condition for which you're admitted; and
- the pharmaceutical isn't prescribed for cosmetic purposes.

No benefits are payable for PBS pharmaceuticals that do not meet the above requirements, including pharmaceuticals provided on discharge from hospital and pharmaceuticals provided at a non-Partner Private hospital.

Under Hospital cover, benefits are not payable for non-PBS pharmaceuticals.

Further details about the PBS are available at **pbs.gov.au**

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 can lodge the bill with Medicare as a paid or unpaid claim using its two-way claim form (available online). This is the quickest and easiest way to claim from both us and Medicare. Alternatively, you can make a claim with Medicare, then with us, by providing us with the Medicare Statement of Benefit. Whatever isn't paid for by Medicare or us is what you'll have to pay to your doctor and is considered your Out-of-pocket Expense.

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 under 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 potential Out-of-pocket Expenses – any hospital Excess and/or Daily Charge applicable to your cover. 	<ul style="list-style-type: none"> • ahm pays the Minimum Benefit set by the Australian Government. • Your potential Out-of-pocket Expenses – any charge above the Minimum Benefit and any Excess and/or Daily Charge applicable to your cover. 	
	Restricted service	<ul style="list-style-type: none"> • ahm pays the Minimum Benefit set by the Australian government. • Your potential Out-of-pocket Expenses - any charge above the Minimum Benefit and 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 potential 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 potential 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 potential Out-of-pocket Expenses - any charge raised by the hospital and any Excess and/or Daily Charge applicable to your cover. 		
Medical devices and human tissue products	Included or Restricted service	<ul style="list-style-type: none"> • ahm pays the minimum benefit set out in the Prescribed List of Medical Devices and Human Tissue Products. • Your potential Out-of-pocket Expenses – any charge above the minimum benefit OR the full cost of the item if it's not on the Prescribed List of Medical Devices and Human Tissue Products. 		
In-hospital doctors' medical services	Included or Restricted service	<ul style="list-style-type: none"> • ahm pays 25% of the MBS fee. • Your potential 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. blood tests, scans etc.)	Included or Restricted service	<ul style="list-style-type: none"> • ahm pays 25% of the MBS fee. • Your potential 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 (refer to your product guide). 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 online claims calculator, 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 14).

Consultations

You're only 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 or video consultations (telehealth), except for the following services (where they are included on your cover): psychology and counselling, physiotherapy, diet and nutrition, occupational therapy, podiatry, exercise physiology, speech therapy and lactation consultants. Refer to your product guide which is available at ahm.com.au to see what's included on your cover.

Some covers include separate benefits for an initial and subsequent consultation. Benefits for an initial face-to-face consultation are payable once per therapy per person each financial year, up to your limit. Benefits for an initial telehealth consultation are payable once per therapy per person each financial year, up to your limit.

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 also pay towards attendance fees where transportation is not required.

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. Limits apply. Refer to your product guide available at ahm.com.au.

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

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(s) of your accommodation, 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 Benefits 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 only pay benefits for orthotics and orthopaedic footwear if they are 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 physiotherapists, chiropractors, podiatrists and osteopaths 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 (available at ahm.com.au) 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 without notice to you.

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 (available at ahm.com.au) 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
- Exercise physiology
- Swimming lessons for children 0-17 years
- Gym membership.

Swimming lessons (age 0-17 years) – benefits may be claimed towards swimming lessons for children aged 0-17 years provided by an Austswim® or Swim Australia™ accredited swim school or instructor, where a medical practitioner confirms the service is required for the purpose of managing or preventing a disease, injury or condition.

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 you need to:

- 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 Acupuncture Therapy, courses including hypnotherapy, and nicotine replacement therapy (patches, gum, lozenges and inhalers) where you can't claim benefits under the PBS.

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.

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 (e.g. 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 where 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 (refer to your product guide available at ahm.com.au to see what's included under your cover)
- Items or services purchased/provided prior to joining
- Items or services received overseas or purchased outside Australia, including online purchases from overseas companies
- Where two or more 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 supplied or service/treatment received over two years prior to the date the claim is lodged with ahm
- 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

Extras benefits are subject to limits. There are different types of limits that apply depending on your type of extras cover. Refer to your product guide (available at ahm.com.au) to confirm which limits apply to you.

Annual limit

An annual limit is the maximum amount of benefits we pay towards services and/or items included on your cover within a financial year. Annual limits are subject to per person limits.

Family limit

A family limit is the total amount that can be claimed by all members on your cover within a financial year. Family limits are subject to per person limits.

Per person limit

Each person on your cover can claim up to the per person limit within a financial year – except where a family limit applies and has already been reached by other members on the cover, or where a lifetime limit applies and has already been reached by that person.

Bundle limit

A bundle limit is the maximum amount of benefits we pay across all of the services included in that bundle, within a financial year. Bundle limits are subject to per person limits and family limits. Bundle limits apply to ahm's choosable extras covers only.

Flexi limit

A flexi limit is the maximum amount of benefits we pay towards a group of services or items included on your cover within a financial year. Flexi limits are subject to per person limits.

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 higher your limits will be (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.

Lifetime limit

A lifetime limit is the total benefit you can receive for an item or service, or group of items or services, over your lifetime. When you reach this limit, you can no longer claim that benefit again, even if you change your cover with ahm or move between health insurers.

Rolling year limit

A rolling year limit is the maximum benefit you can claim within a rolling 12-month period. The rolling year starts on the date the service is first provided, with the limit renewed 12 months later. Rolling limits are subject to per person limits.

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 the service was for, 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 can attach the receipts to your online claim – just make sure the image(s) are clear and show the full receipt details. Otherwise, you'll need to keep the 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 the service was for, 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 can attach the receipts to your online claim – just make sure the image(s) are clear and show the full receipt details. Otherwise, you'll need to keep the original receipts for 3 years for audit purposes.

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 you 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, acting reasonably in its legitimate interests. ahm Recognised Providers must meet criteria set by ahm, and ahm may, from time to time, cease to recognise a provider it has previously paid benefits for. You can find out more about ahm's "Recognition Criteria" in the Fund Rules.

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**

ahm may recognise a provider, advertise on behalf of a provider, or appear (by reference to its logo or otherwise) in an advertisement of any provider. You may have rights under Australian laws which cannot be excluded. Otherwise, to the fullest extent allowed by law, and provided ahm has not engaged in negligence, fraud or wilful misconduct, such advertising or reference about third parties 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 rely on their own enquiries and seek any assurance or warranties directly from the provider in relation to the service or product, or from the relevant registration body (e.g. AHPRA) regarding any conditions or restrictions associated with the provider's registration.

Government surcharges and incentives

Lifetime Health Cover (LHC)

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

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.

The Australian Government reviews 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.

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.

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

Age-based discounts (Youth Discount)

The Youth Discount is available on most of ahm's hospital covers and applies to members who are aged between 18 and 29 when they take out an eligible hospital cover. The discount ranges from 10% (if you take out hospital cover before the age of 26) to 2% (if you take out hospital cover at the age of 29).

To be eligible for a Youth Discount you need to have your own policy or a policy with your partner; you can't be a dependant on your parents' policy.

If you're on a couple or family policy, the discount is calculated by taking an average of any discount applied to each adult on the hospital cover.

The discount is ongoing, which means if you keep your eligible hospital cover your discount remains until you turn 41. From then, the discount will reduce by 2% per year until it reaches zero.

Important legal information for the Principal Member

The Principal Member is the 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.

The Principal Member:

- receives all correspondence and benefits for this membership on behalf of every person included on this membership
- will ensure that all members on the membership are aware of ahm's policies, including its Privacy Policy (refer to page 39 or **ahm.com.au**)
- agrees to the Joining Statement or change of cover declaration, and so agrees to abide by the Fund Rules (available at **ahm.com.au**) 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.
- understands that if you're switching to ahm from another Australian health insurer with a gap of more than 30 days, any aged-based discount (known as Youth Discount at ahm) you were entitled to will not be retained. If you join an eligible ahm hospital cover, your Youth Discount will be calculated based on your age at this time. However, it also means you may not have continuous cover for the purposes of:
 - LHC loading — 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're 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@medibank.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 feedback for training and coaching purposes so we can improve our products and services but don't worry, it's always de-identified first.

Email feedback@ahm.com.au

Phone Call us on **134 246**

Mail ahm health insurance
Locked Bag 4, Wetherill Park NSW 2164

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**

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**

For general information about private health insurance, see **privatehealth.gov.au**

Fund Rules

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 in a manner that is reasonable and consistent with the Act. An up-to-date copy of the Fund Rules is always available at **ahm.com.au**

If any changes will or might have a detrimental effect on a member's entitlement to benefits, we'll provide the Principal Member with reasonable notice in writing about the changes (including any changes to premiums and an updated product guide if required) a reasonable time before the changes are due to take effect unless the changes are required by law in which case we will endeavour to provide notice as soon as reasonably practicable.

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.

After we've notified you and provided an updated product guide, 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.

After we've notified you and provided an updated product guide, if we make a change to your cover and you choose to continue your membership (under the new or changed cover), you'll be taken to have accepted the changes and will 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 your membership by notifying us, and we'll refund premiums paid in advance.

Terms and descriptions

Here is a list of some 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 under Accident Override for the initial hospital treatment for injuries resulting from the Accident. Benefits are also payable for ongoing hospital treatment but only where the services are required to continue the initial course of treatment paid under Accident Override. You can download the form at ahm.com.au

"**Act**" means the Private Health Insurance Act 2007 (Cth) and, where the context requires, includes any Private Health Insurance Rules made by the Minister under section 333-20 or by the Private Health Insurance Council under 333-25 of the Act.

Body Mass Index (BMI): an estimate of your total amount of body fat to determine whether you're 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.

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 17 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.

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

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 a Podiatrist or orthopaedic footwear supplier (for more details see page 28).

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

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

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)

