IMPORTANT INFORMATION GUIDE

EFFECTIVE MAY 2024

GMHBA

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The information within this guide should be read carefully and retained in conjuction with GMHBA's Fund Rules and your specific product information.

GMHBA may make changes to products and benefits from time to time, including adding or reducing the benefits or services available to members. Notice of such changes will be provided in accordance with the Private Health Insurance Act 2007, Code of Conduct and Australian Consumer Law.

WHO CAN BE COVERED UNDER YOUR GMHBA POLICY?

THE POLICYHOLDER

The policyholder is the name of the person the health insurance policy is held under (also known as the contributor).

The policyholder is:

- Responsible for the payment of premiums
- Nominates who's covered by the policy
- Advises GMHBA of any changes to membership details
- Is entitled to access all records and claims history and tax statements relating to the membership

SINGLES COVER

A single membership only covers one person, the person covered is referred to as the policyholder.

COUPLES COVER

If you choose couples cover, the following people can be covered under your policy:

- The policyholder and their partner

FAMILY COVER

If you choose family cover, the following people can be covered under your policy:

- The policyholder, their partner and one or more dependants

SINGLE PARENT COVER

If you choose single parent cover, the following people can be covered under your policy:

- The policyholder and one or more dependants.

DEPENDANTS INCLUDING CHILD AND STUDENT DEPENDANTS

Child dependants can be covered on a family or single parent membership until they turn 21 years of age regardless of their student or employment status.

Child dependants will be removed from the membership on their 21st birthday unless at this time they qualify to remain on the membership as a student dependant.

STUDENT DEPENDANT CRITERIA

If the child dependant is single and a full time student, apprentice or trainee at an eligible educational institution, or completing a life skills course through an approved provider, they can continue to be covered on a family or single parent membership until they turn 25, provided that a student declaration is submitted before their 21st birthday and again each year by 31 March.

End of year school, apprenticeship, traineeship, and university leavers are covered under their parent's family or single parent membership until 31 March the following year, or their 25th birthday, whichever is earlier.

Dependants coming off a family policy who take out their own cover within 60 days can transfer any waiting periods already served across to their new membership with us, provided:

- their new cover starts within 30 days of coming off the family cover; and
- chosen level of cover is equal to or lower than the family cover.

Depending on the date that the new cover is taken out, backdating may be required to maintain continuity. Note that to claim benefits their cover must be active on or before the day of treatment.

STUDENT DEPENDANTS – OTHER FUND MEMBERS

Student dependants whose parents are fund members of another registered health fund may join GMHBA within 30 days of ceasing to be a dependant, on a level of cover equal to or less than that held by their parents, without re-serving waiting periods previously served. An acceptable clearance certificate and claims history must be provided to GMHBA.

AGE-BASED DISCOUNT

All GMHBA hospital products include a discount based on your age. This means Australians aged 18-29 will be eligible to receive up to 10% discount on their premiums for hospital cover.

The discount will be available on all GMHBA hospital products and is available to new and existing members.

You can retain your age-based discount until you're 41 providing you remain on a hospital product. These discounts will then be gradually phased out after you turn 41.

To receive the discount, new eligible members can sign up to one of our hospital products and it will be applied automatically to your premium.

MANAGING YOUR COVER

CHANGING YOUR DETAILS

A policyholder or partner with authority can change your details at any time in their online Member Area, by calling us or visiting a branch.

YOUR MEMBERSHIP CARD

When you first join GMHBA, you receive a membership card that identifies you as a member. The card shows your membership number and who is covered. GMHBA's contact details are listed on the back of the card. Have your membership card on hand when you arrange admission to hospital, visit a service provider or when you call GMHBA with any questions.

A new card may be issued when you make changes to your membership. Please note that an existing card will become invalid whenever a new membership card is issued. Keep your card safe and please advise GMHBA if your card is lost or stolen.

CHANGING YOUR COVER

A policyholder or partner with authority can change their level of cover at any time in your Online Member Area, by calling us or visiting a branch. Please note that waiting periods will apply for services not previously covered, for reduced hospital excess amounts and for higher benefits available on the upgraded cover.

PLANNING A CHILD

If you are preparing to start a family and your hospital cover does not include pregnancy you will need to ensure you upgrade your hospital cover to include pregnancy at least 12 months before you have a child to ensure all waiting periods have been served.

If all goes well, a newborn baby is not admitted as a patient in hospital, but if you have complications and your baby requires any accommodation or medical attention, your newborn baby will be covered for accommodation or medical services provided they are added to the policy within 6 months of their date of birth.

A single policy will become a single parent policy, and a couples policy will be come a family policy when the newborn is added to the policy.

PRE EXISTING CONDITIONS

If you have been a member for less than 12 months on your current hospital cover, make sure you contact us before you are admitted to hospital and to find out whether the waiting period for pre-existing conditions (refer to page 18-20 for definition) applies to you. We need about five working days to make the pre-existing condition assessment, subject to the timely receipt of information from your treating medical practitioners. Make sure you allow for this time frame when you agree to a hospital admission date. If you proceed with the admission without confirming benefit entitlements and we subsequently determine your condition to be pre-existing, you'll have to pay all outstanding hospital charges and medical charges not covered by Medicare.

SUSPENDING YOUR COVER

A policyholder or partner with authority can suspend their GMHBA membership for periods of overseas travel provided you:

- Have at least 12 months continuous unsuspended membership with GMHBA since joining
- Have had a minimum of six months active cover since any previous suspension for overseas travel
- Plan to be overseas for at least four weeks
- Have paid premiums to the date of departure

- Apply for suspension of your membership prior to departure

To arrange the suspension of your membership, please contact GMHBA prior to your departure. Memberships will be automatically reactivated based on the reactivation date provided by the fund member. If your reactivation date changes while overseas it is your responsibility to inform GMHBA.

Fund approved overseas travel will not impact on your Lifetime Health Cover (LHC) loading as you are still considered to be maintaining your fund membership.

A three-year maximum cover suspension period for overseas travel applies. Only the balance of outstanding waiting periods need to be served upon resumption of your membership.

Please see GMHBA's Fund Rules for additional information.

CANCELLING YOUR HEALTH COVER

You may cancel your GMHBA membership:

- From the date you notify GMHBA of the cancellation in writing or over phone (a clearance certificate will be provided to the insured person within 14 days of request) or your current premium due date, whichever is earlier.
- Within 60 days of joining and you will receive a full refund of any premiums received provided you have not made a claim.

EXTRAS RULES

ANNUAL LIMITS

An annual limit is the maximum amount that can be claimed for a service in a calendar year.

Some annual limits also include a sub-limit, which is the maximum amount that can be claimed for a particular service within an overall annual limit.

Lifetime benefit limits are the maximum amount that can be claimed for a service over the lifetime of a policy.

MEDICARE

Where you are entitled to receive a rebate from Medicare for any extras service, you cannot claim the out of pocket through your GMHBA membership.

PHYSIOTHERAPY CLAIMS

Physiotherapy consultations must be for a minimum of 15-20 minutes to qualify for one on one physiotherapy benefits.

DOCTORS LETTER OF RECOMMENDATION

The following services require a Doctor's Letter of Recommendation in support of claims: blood glucose monitor, blood pressure monitor, extremity pump, GMHBA Limited approved orthopaedic appliances, nebuliser pump, non-surgical prostheses, pressure garments, sleep apnoea monitor, approved quit smoking programs, and tens monitors. GMHBA does not pay benefits for the hire of any health appliance or equipment.

ORTHODONTICS

For the purpose of benefit payments, orthodontic treatment is regarded as commencing on the date the appliance is originally fitted. Limits apply every calendar year.

ORTHOTIC APPLIANCES (FOOT)

Must be custom made by a registered podiatrist or orthotist. For an orthosis to be custom made, a plaster cast, mould or a postive model must be created. Customising, heat moulding, trimming or adjusting an existing 'off the shelf' appliance does not involve this process and therefore does not constitute a custom made appliance.

ORTHOPAEDIC APPLIANCES

Must be custom made. For an orthosis to be custom made, a plaster cast, mould or positive model must be created. Customising, heat moulding, trimming or adjusting an existing 'off the shelf' appliance does not involve this process and therefore does not constitute a custom made appliance.

WEIGHT MANAGEMENT PROGRAMS

Weight management benefits are claimable towards the costs or fees associated with membership to a weight management provider. Benefits are not payable towards the purchase of food and/or dietary supplements or exercise components. Approved weight management providers are Jenny Craig, Weight Watchers and Fernwood Food Coaching.

RECEIPTS

Benefits are only payable on itemised receipts. Receipts which have been altered in any way will not be accepted. Providers are required to re-issue any receipts or endorse any alterations.

REPLACEMENT RULE

A benefit replacement rule applies to a number of items/services covered by GMHBA's extras covers. The rule requires that after you claim for such an item, you must wait a specified period of time before you can lodge another claim for the same type of item. The replacement rule applies to the following items/services: dentures, crowns and hearing aids, blood glucose monitor, blood pressure monitor, extremity pump, GMHBA Limited approved orthopaedic appliances, nebuliser pump, non-surgical prostheses, pressure garments, sleep apnoea monitor, and tens monitors.

INDIVIDUAL TELEHEALTH CONSULATATIONS

One on one Telehealth Consultations are covered with a GMHBA recognised provider, for services as approved by GMHBA. A list of recognised modalities is available and may be changed periodically. Telehealth services are considered a substitutional service, and meet the requirements, to what would otherwise be undertaken as a standard face to face consultation, are covered in accordance with industry association guidelines by using appropriate telehealth delivery services that satisfy the requirements of the patient/condition to be treated. Telehealth consultations may not be appropriate for all situations. Benefits are subject to your level of cover, waiting periods and annual limits or sub limits.

EXTRAS SERVICES PURCHASED OVER THE INTERNET

Benefits will be paid for extras services purchased online from Australian providers (optical and pharmaceutical only) where a script is provided. For a company to be considered an Australian provider, an ABN needs to be visible on the company's website. Consistent with current GMHBA rules, benefits for services or treatment received or purchased overseas are excluded.

EXCLUSIONS ON EXTRAS

You cannot claim for the following:

- Services or treatment for which anyone covered has a right to claim damages or compensation from any other person or body
- Treatment where the member and/or dependant is eligible for fully or partially subsidised treatment under any Commonwealth or State Government Act
- Services or treatment rendered more than two years prior to the date of claiming
- Services or treatment not covered by your membership and/or is rendered while the membership is in arrears or is suspended
- Services or treatment rendered by a practitioner not in private practice and/or not recognised by bodies approved by GMHBA
- Cosmetic services or treatment rendered by a practitioner.

Pharmacy exclusions

- The supply of contraceptives, fertility and IVF drugs and items available through the Pharmaceutical Benefit Scheme (PBS)
- Food supplements
- Pharmacy items, where they are available over the counter and purchased with or without a prescription
- Supply of liquid filled Temazepam capsules
- Pharmaceuticals purchased overseas and not listed on the Australian Register of Therapeutic Goods (TGA)
- Immunisation services rendered in the course of the carrying out of a mass immunisation
- Non PBS pharmaceutical items that are not considered either an S4 or S8 drug (as per the TGA)

Dental exclusions

- Dental procedures where a limit on the number you can have has been exceeded
- Dental procedures unless tooth identifications (ID) are supplied by the provider
- Dental procedures carried out and charged by a dental mechanic, other than an advanced dental technician
- A range of dental procedures when provided on the same day eg. a filling on a tooth that has been removed. Please contact us for further information relating to these exclusions

Foot orthotic exclusions

- Foot orthotics provided by a physiotherapist or chiropractor

Orthopaedic appliance exclusions

- GMHBA specified and approved orthopaedic appliances purchased for support purposes only

Optical

- Optical claiming includes prescription glasses (frames and lenses) and contact lenses.
- Excludes purchases of frames only, non prescription glasses and repairs.

HOSPITAL RULES

HOSPITAL COVERS

If you have hospital cover, it's important to understand what's covered and not covered under your level of cover. GMHBA has created Fact Sheets on each individual product which you will automatically be provided with anytime you change your cover or at any other time upon request. We recommend referring to this information for specific details regarding your hospital cover.

CLINICAL CATEGORIES

GMHBA is required to use standard clinical categories and definitions across all services, including references to inclusions and exclusions. The full list of these categories and definitions is available on pages 32-36.

MEDICAL BENEFITS

Claims for medical benefits can only be paid after your claim for medical services has been assessed by Medicare (except in the case of claims made through GMHBA's Access Gap Cover Scheme) and your claim for hospital benefits has been assessed. Benefits are not payable for medical services rendered when the patient is not a hospital **inpatient**.

PARTICIPATING PRIVATE HOSPITALS

GMHBA has contracts with hundreds of private hospitals across the country. To ensure that your hospital is a **participating private hospital**, you can request a copy of this directly from us or download a copy of the most recent list from our website. Please note that **public hospital**s are not listed specifically as benefits are paid towards all public facilities, provided you are admitted as a private **inpatient**.

NON PARTICIPATING PRIVATE HOSPITALS

If you are admitted to a private hospital that is not on our participating hospital list, please be aware that you may not be covered in full for your accommodation or theatre costs for these admissions. We recommend you contact us prior to your admission in these instances for further information on what types of benefits you will receive and information on your out of pocket costs.

PUBLIC HOSPITAL

You will be covered for hospital accommodation costs when you are admitted to a shared room, as a private patient in a public hospital. If you elect to be admitted to a public hospital as a private patient, you are entitled to the minimum benefits payable by private health insurers for a shared room in a public hospital. Electing to be a private patient in a public hospital could result in significant out-of-pocket costs to you. Ensure you receive written informed financial consent for any hospital admission.

EXCESS

GMHBA's range of hospital covers often feature an excess to let members share some of the cost of hospital admissions in return for lower premiums. Members will often have the choice between a no excess product or opting for a cheaper premium in exchange for paying an excess in the event of a hospital admission. The excess is calendar year based.

An excess is deducted from the benefit paid by us. For example, if GMHBA's full benefit for a hospital stay was $5,000 and the member has a $250 excess on their hospital cover, the benefit would reduce by the amount of the excess and an adjusted benefit of $4,750 would be paid to the hospital as the member has paid their $250 excess directly to the hospital.

Where one member on a couples, family or single parent excess cover is admitted to hospital they will only pay the maximum amount per person as opposed to the maximum amount per membership.

CHILD DEPENDANT EXCESS

A range of products have no excess for child dependents under 21. Please see your product fact sheet for more information.

INSULIN PUMPS

GMHBA does not pay a benefit for replacement of insulin pumps still under manufacturer's warranty.

REGIONAL TRAVEL AND ACCOMMODATION BENEFITS

If you live in a regional area and need to travel to a larger urban centre to receive specialist hospital treatment not available within 100km of where you live, GMHBA will pay a benefit towards private car transport (0.15c per km) and accommodation ($150 per night for nights 1, 2, 3 and $50 per night thereafter). This benefit is available to members on eligible products. Please see your product fact sheet for information regarding eligibility.

TRAVEL CONDITIONS - MEMBER

- This benefit only applies when an inpatient hospital procedure has taken place.
- All calculations and rules apply based on the applicants primary place of residence.
- Primary Place of Residence is defined as the residential address as listed on the GMHBA policy.
- Service provider must be located more than 100kms from applicants primary place of residence.
- Private car travel - benefit calculated based off the most direct route as per Google Maps.
- Travel benefits are available for private/personal car only. This excludes the use of taxis, rideshare services (i.e. Uber), public transport and fees incurred on toll roads.
- Benefits are available per member per episode.
- This benefit will not be payable until a corresponding hospital account has been received and processed on the patients membership.

TRAVEL CONDITIONS - SUPPORT PERSON

- Benefits payable for 1 support person to accompany the patient.
- Support person must travel together with the patient to be eligible to claim benefits.
- All benefits relating to Travel & Accommodation claims will be paid against the patients membership.
- There is no benefit available for a support person travelling to the member.

ACCOMMODATION CONDITIONS

- Accommodation provider must be an approved Tourist Accommodation property i.e. hotel or motel.
- Proof of accommodation required including cost per night and must show ABN details of the property.
- Benefits are payable towards Accommodation for the night prior, duration of, and night after discharge. For same day procedures, benefits for accommodation are payable towards the night before and the night of the admission.
- Benefits not payable towards GST (where applicable).
- This benefit cannot be claimed against boarder fees payable in a private hospital.

RELEVANT STATE BASED SCHEMES

- Australian States and Territories offer assistance for Regional Travel and Accommodation. Please contact the Department of Health in your State or Territory for further information.
- If you're entitled to receive a State or Territory benefit on your Travel & Accommodation expenses, you cannot claim your out of pocket expenses with GMHBA. Once you are no longer eligible to claim with your State or Territory, eligible claims can be processed by GMHBA.

HOW TO CLAIM AND INFORMATION ABOUT CLAIMING

BEFORE YOU CAN CLAIM

Before you can claim you must serve the relevant waiting periods detailed on pages 18-20.

We recommend you call us or visit a branch for a benefit estimate before commencing treatment to confirm what is payable under your policy.

CLAIMING

There are a number of ways you can claim your benefits including:

Electronic claiming

When you have GMHBA extras cover you can use your membership card to claim electronically on the spot when this facility is available at your health care provider. After the service has been provided, your membership card will be swiped and your claim will usually be processed electronically within seconds. You just pay any difference to the provider.

Online

Visit our website at gmhba.com.au and make your claims for most extras services online through the Online Member Area.

Please note that in order to use online claiming:

- Members need to be registered for web services
- Members need to agree to terms and conditions which include keeping receipts for two years as they may be audited
- Services must have been provided no more than two years ago.

Claim by post

- Complete a claim form and post to GMHBA along with your itemised receipt and/or account
- Lodge your medical claims with Medicare first via a two-way claim which will then be forwarded to GMHBA for processing

In order to assess your claim and calculate your benefit, we need the following information:

- A completed claim form when submitting your claim by post
- The fully itemised account or, if you have paid the account, the original itemised receipt

UNPAID ACCOUNTS (OTHER THAN HOSPITAL ACCOUNTS)

Claims for unpaid accounts will be paid by direct credit (where available) or by cheque made payable to the health care provider. The cheque should be immediately forwarded to the health care provider, together with your payment for any account balance.

PAID ACCOUNTS

Benefits for paid accounts will be paid:

- Directly into the policyholder's financial institution account where these arrangements are in place
- By cheque, made payable to the fund member for larger claims or when direct credit account details have not been provided

This is in accordance with arrangements determined by the fund which may chnage from time to time.

AGENT'S AUTHORITY

The policyholder may authorise another person to collect benefits on your behalf by completing the agent's authority section of the claim form. The fund member and the agent (the person who is being authorised to collect the benefits) must sign the authority. The agent will be requested to sign the claim form again when benefits are paid.

CLAIM LIMITATIONS

Benefits may not be paid or may be paid at a lower level where:

- You have already claimed the maximum allowable benefits during a specified period
- You have transferred to GMHBA from another fund and have previously claimed for the service/treatment
- Services or treatment are rendered more than two years prior to the date of claiming
- The health care account has been incompletely, incorrectly or inappropriately itemised
- You have an excess to pay on your chosen level of cover
- The fund believes that a patient, following a review of the case (on the basis of information provided by the hospital either internally or using an agreed independent source), is not receiving acute care after 35 days of continuous hospitalisation, GMHBA benefits will be reduced to Nursing Home Type Patients and will be paid in accordance with the default benefit determined by the Health Department. All Nursing Home Type Patients are required to pay part of the cost of hospital accommodation.
- The service is subject to a waiting period or other limit
- You cannot claim benefits for a service that has not yet taken place.
- No MBS item number is provided by the GP/specialist
- The MBS item number is being performed for a cosmetic reason and not medical (refer to glossary for a cosmetic surgery definition)
- More than one consultation and/or treatment type per day has been claimed and performed by the same provider within a group of chiropractors (excluding X-Ray), acupuncturists, homeopaths, osteopaths, physiotherapists, myotherapists and if eligible remedial massaeuse.
- The medical service is provided by a medical practitioner employed full-time in the public sector.

CLAIMS FROM RECOGNISED PROVIDERS

Benefits are not payable where:

- Treatment is provided to themselves, a member of the provider's family and/or to a provider's business partner and their family members or any other people not independent from the practice. In the case of the GMHBA health related and primary care practices, this rule only applies in this instance where professional services are provided to themselves.
- Family members receive services including: wife/husband, brother/sister, children, parents, grandparents, grandchildren of the provider/business partners', spouse/partner.
- Services/treatment are received overseas
- For lifestyle related services that primarily take the form of sport, recreation or entertainment
- Under a hospital or extras cover they exceed the fees and/or charges raised for any treatment and/or services covered for benefits under the relevant cover, after taking into account benefits paid from any other source.
- Services are not rendered in person (with exception of approved Telehealth services).

MANAGING YOUR BENEFITS

GMHBA undertakes audit activities in order to protect members' assets and contain costs. From time to time, in the general interest of members, a GMHBA representative may contact you with a request for assistance to monitor costs – whether relating to benefits paid or charges raised by health care providers. Your co-operation with such requests is critical to our cost containment efforts.

Services for both extras and hospital benefits must be validated by clinical notes. No benefit is payable where there are no clinical notes outlining the service provided. The clinical notes must be legible, written in English and be understandable by a peer.

GMHBA reserves the right to take the following actions against any policy holder or persons where improper, fraudulent or inappropriate conduct occurs whilst making claims against the fund:

- Suspension of electronic claiming with the period of time determined by the fund depending on the severity of the incident
- Cancellation of a policy
- Restitution (voluntary or negotiated).
- Prosecution

LIABILITIES OF FUND MEMBERS TO GMHBA

- A fund member can be liable to GMHBA for unpaid premiums and for overpayments. Overpayments can be made by GMHBA to a fund member, either through an error in completing a claim, or an error in processing a claim. If an overpayment is made, the fund member is liable to repay the amount of the overpayments to GMHBA on demand.
- If a fund member is liable to GMHBA for unpaid premiums or overpayments then GMHBA has the right to deduct the amount of that liability from any monies due by GMHBA to the fund member on any account.

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Ambulance

AMBULANCE CLAIMS

Ambulance cover is important as you never know when an emergency may happen. Ambulance coverage in Australia is different from state to state, so we encourage you to read below to find out what you need to do to be fully covered.

VICTORIA

If you hold an eligible extras product, you can claim back up to 100% of the cost of one Ambulance Victoria Subscription per calendar year.

If you hold a GMHBA Hospital product, you are covered for emergency ambulance services Australia Wide.

TASMANIA

Tasmanian residents are covered by a State based scheme. Please contact the Tasmanian Ambulance Service for more details regarding coverage.

NEW SOUTH WALES

Take out any GMHBA hospital cover and you're automatically covered for emergency transportation within NSW. Ambulance in NSW is a Levy Based Scheme which is why it operates under your hospital cover.

If an ambulance is called, you will receive a bill. If you have a hospital product with GMHBA you can send this bill on to GMHBA and we'll let the NSW Ambulance service know you're covered.

Benefits are paid for emergencies Australia wide if you are in other states and have hospital cover with GMHBA.

AUSTRALIAN CAPITAL TERRITORY

Take out any GMHBA hospital cover and you're automatically covered for emergency transportation within ACT. Ambulance in ACT is a Levy Based Scheme which is why it operates under your hospital cover.

If an ambulance is called, you will receive a bill. If you have a hospital product with GMHBA you can send this bill on to GMHBA and we'll let the ACT Ambulance service know you're covered.

Benefits are paid for emergencies Australia wide if you are in other states and have hospital cover with GMHBA.

SOUTH AUSTRALIA

If you hold an eligible extras product, you can claim back up to 100% of the cost of one South Australian Ambulance Service Subscription per calendar year.

If you hold a GMHBA Hospital product, you are covered for emergency ambulance services Australia Wide.

QUEENSLAND

Queensland residents are covered by a State based scheme. Please contact the Queensland Ambulance Service for more details regarding coverage.

NORTHERN TERRITORY

If you hold an eligible extras product, you can claim back up to 100% of the cost of one St Johns Ambulance Service Subscription per calendar year.

If you hold a GMHBA Hospital product, you are covered for emergency ambulance services Australia Wide.

WESTERN AUSTRALIA

If you hold an eligible extras product and reside outside of Metropolitan Perth, you can claim back up to 100% of the cost of one St Johns Ambulance Service Subscription per calendar year.

If you live in Metropolitan Perth and hold an eligible extras product, you can claim back up to 100% of the cost of an Ambulance Service Subscription

If you hold a GMHBA Hospital product, you are covered for emergency ambulance services Australia Wide.

THINGS YOU NEED TO KNOW

APPLICATION FOR MEMBERSHIP WITH GMHBA

When you complete a membership application, it is important that you provide us with all the information requested to allow us to maintain an accurate record of your membership. It is also important that the information you provide is true and correct.

GMHBA will consider your membership void if you provide false or incorrect information on your membership application and premiums received in advance for coverage beyond the termination date will be refunded. GMHBA uses the terms ‘policyholder’, ’partner’ and ‘dependant’ to define the people covered by a membership. Only the person nominated as the ‘policyholder’ can authorise changes to the membership unless the policyholder has previously authorised the spouse/partner to make such changes.

Similarly, correspondence issued by GMHBA will be addressed to the policyholder and it is the policyholder's responsibility to notify GMHBA of any change of address. The signing of the membership application and the payment of any premium constitutes an acceptance of any conditions in the regulations of the fund enforced at that time or as they may be amended from time to time.

PRIVACY

We value the relationship between GMHBA and our members. An important part of this relationship is our commitment to protecting the personal information entrusted to us by our members. A copy of our privacy statement is provided to new members upon joining, or if you would like to access our privacy statement or our privacy policy you can pick up a copy at one of our branches, visit our website or call us.

MEMBERSHIP FOR NON RESIDENTS OF AUSTRALIA

GMHBA hospital covers are designed for people who have full Medicare eligibility. These covers will not meet the cost of **public hospital** treatment, medical treatment or diagnostic services for people who do not have full Medicare eligibility. Temporary residents of Australia who do not have full Medicare eligibility should consider alternative health insurance arrangements.

OVERSEAS TRAVEL

GMHBA does not provide benefits for services or treatment received overseas. GMHBA advises that you take out travel insurance for the set period of your travel and that it’s suitable to the destinations you’re visiting.

You can purchase a range of travel insurance options from gmhba.com.au

PROOF OF AGE

When you join GMHBA and you are not transferring from another fund, you (and your partner and family members) may need to provide one of these acceptable forms of proof of age:

- Current passport
- Current photo driver's licence
- Original birth certificate

PRIVATE HEALTH INFORMATION STATEMENTS

A Private Health Information Statement (PHIS) is available for all health insurance policies in Australia and gives a summary of the key product features. Health funds are required to provide PHIS by law so you can review and compare health insurance products.

An up to date PHIS will be forwarded to anyone on request and, at the very least, to members once every year (without the need to be requested). If more than one adult is insured under a single policy GMHBA will only provide a PHIS to the policyholder.

A policyholder will be given an up to date copy of the relevant PHIS, details about what the policy covers and how benefits are provided and a statement identifying the referable health benefits funded when they join.

STATE OF THE HEALTH FUNDS REPORT

Every year the Private Health Insurance Ombudsman publishes a State of the Health Funds Report. The aim of this report is to give people extra information to help them make decisions about taking up private health insurance. The report provides general independent comparative information on the performance and service delivery of all health funds. It does not provide detailed information on health fund products. A copy of this report can be downloaded from www.ombudsman.gov.au/about/private-health-insurance.

TERMINATION OF MEMBERSHIP

GMHBA may terminate a membership in the following circumstances:

- Where information provided to GMHBA is false or misleading;
- where a member has acted improperly in any way which has, or is likely to, result in loss or damage to GMHBA;
- materially or repeatedly breached any fund rules or any other term of membership.

Where the person who has acted improperly is a partner or dependent, GMHBA reserves the right to terminate only that person from a membership.

GMHBA fund members are responsible for ensuring their premiums are up to date. Membership will cease when premiums fall into arrears of more than two months after the premium due date. To claim benefits, a fund member must be financial at the time of incurring the expense for the service or treatment.

WAITING PERIODS

WAITING PERIODS

A waiting period is the time between joining GMHBA and when you are covered for a treatment or service. If you receive a service or treatment during a waiting period, you are not eligable to receive a benefit payable from us, regardless of when you submit the claim. Waiting periods exist to protect members from claims made by those who join the fund or increase their level of cover because they have a condition or illness that may require treatment.

Waiting periods will apply to:

- New members to health insurance (members who have never held hospital or extras cover with a health fund)
- Existing GMHBA members who upgrade to a higher level of cover or reduce their excess payable
- Members who transfer from another health fund who have not fully served the required waiting and/or for equivalent benefits
- Additions to a membership (unless the addition/s has already served all waiting periods with GMHBA or another fund) except newborns, adopted and permanent foster children and where the addition/s has already served all waiting periods with GMHBA or another fund

Limited benefits may apply on hospital covers for cosmetic surgery, depending on the medical justification for the surgery.

For treatment that was covered under the old policy, at the same or higher level than the new policy, waiting periods are no longer than the balance of any unexpired waiting periods for the benefit that applied to the person under the policy.

For treatment that was covered under the old policy but at a lower level, the member is entitled to the lower benefits on their old cover during the waiting period.

Existing members with at least 12 months membership in total across their old and new cover are entitled to the lower benefits on their old cover during the waiting period.

The mental health waiver allows members who have served their 2 month waiting for restricted psychiatric benefits to upgrade their cover to a product which includes in-hospital psychiatric treatment without serving an additional 2 month wait.

Members can use the Mental Health Waiver once in their lifetime.

The waiver applies only to the 2 month waiting for in-hospital psychiatric treatment. Any other applicable waiting periods will still need to be served.

Refer to opposite page for hospital and extras waiting periods.

HOSPITAL SERVICES (WHEN INCLUDED ON COVER)	WAITING PERIOD
Accidents – An unforeseen event occurring by chance and caused by an external force or object, which results in involuntary injury to the body. Treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury. Accident must occur after joining.	No waiting period
Pregnancy related services.	12 months
Pre-existing ailment, illness or condition (other than psychiatric, rehabilitation and palliative care)	12 months
Psychiatric, rehabilitation or palliative care	2 months
Any other benefit for hospital (or hospital substitution) treatment.	2 months
Ambulance benefits	0 days

EXTRAS SERVICES (WHEN INCLUDED ON COVER)	WAITING PERIOD
Ambulance benefits	0 days
All benefits except as specified below	2 months
Optical	6 months
Major dental services (including full & partial dentures, orthodontics, crown & bridgework, endodontic services such as root canal, gold fillings, indirect restorations, surgical extractions of a tooth/teeth including wisdom teeth).	12 months
Health appliances including nebuliser pump, blood glucose monitor, blood pressure monitors, pressure garments, sleep apnoea monitor, extremity pump, hearing aids, orthopaedic appliances (GMHBA approved), prostheses (GMHBA approved non-surgical), tens monitor, podiatry surgical procedures and orthotic appliances (foot).	12 months

WAITING PERIODS (CONTINUED)

PRE-EXISTING CONDITIONS (PEC)

A pre-existing condition is one where signs or symptoms of your ailment, illness or condition, in the opinion of a **medical adviser** appointed by GMHBA (not your own doctor), existed at any time during the six months preceding the day on which you purchased your hospital insurance or upgraded to a higher level of hospital cover and/or benefit entitlement.

GMHBA will ask that you provide information from your GP and your treating specialist in order for the medical advisor to make a decision regarding a pre-existing condition

The pre-existing condition rule still applies even if your ailment, illness or condition was not diagnosed prior to joining the hospital cover. The only test is whether or not, in the six months prior to joining your current hospital cover signs and symptoms:

- Were evident to you
- Would have been evident to a reasonable medical practitioner if a medical practitioner had been consulted.

EMERGENCY ADMISSIONS

In an emergency, we may not have time to determine if you are affected by the pre-existing condition rule before your admission. Consequently if you have less than 12 months membership on your current hospital cover you might have to pay for some or all of the hospital and medical charges if:

- You are admitted to hospital and you choose to be treated as a private patient
- We later determine that your condition was pre-existing

TRANSFERRING FROM ANOTHER HEALTH FUND

You can transfer your health insurance from another health fund to GMHBA without serving any new waiting periods for the equivalent cover provided that you:

- Have served all waiting periods with your previous fund
- Transfer to any equivalent or lower level of cover within 30 days of your membership ceasing with your previous fund
- Provide GMHBA with an acceptable transfer certificate and claims history issued by your previous fund within 14 days of transferring your cover. GMHBA recommends that your cover starts immediately after your previous cover ends

If your new cover with GMHBA provides higher benefits or benefits for services not covered by your previous fund, you'll be regarded as a new member for those higher benefits, and/or additional services.

If you transfer to GMHBA from another fund before completing the waiting and benefit limitation periods with your previous fund, you'll need to serve the balance of the waiting and benefit limitation periods with GMHBA (Please call 1300 446 422 for further information).

When you transfer to GMHBA your benefit entitlements may be adjusted by benefits already paid by your previous fund.

Under Lifetime Health Cover, continuity of a member's/partner's Certified Age at Entry (CAE) is possible when transferring from another Australian registered health fund.

ACCESS GAP COVER

WHAT IS A MEDICAL GAP?

In Australia, medical services provided by doctors have a Medicare Benefits Schedule (MBS) fee, set by the Government. This is called the 'scheduled fee'.

For medical services provided by a specialist doctor while you are admitted as an inpatient in hospital, Medicare pays 75% of the scheduled fee and your health insurer pays the remaining 25%.

Specialists are free to charge whatever fee they deem appropriate for their services. If this fee is more than 100% of the scheduled fee, you will need to pay the difference. This is called a medical 'gap' and is sometimes also called an out of pocket cost.

WHAT IS ACCESS GAP COVER?

The Australian Health Service Alliance (AHSA) Access Gap Cover scheme is a billing system that provides higher benefits than the Government's scheduled fee. It can reduce or even eliminate any gap for medical fees when treated as an inpatient in hospital.

Specialist doctors who are registered for, and use, the Access Gap Cover scheme get a higher fee from GMHBA (more than the standard 25%), in exchange for limiting the gap they charge to you.

There are 2 scenarios for how you may be billed by your specialist doctor when they use the Access Gap Cover scheme:

1. No Gap – this is where there will be no gap for you to pay following the procedure
2. Known Gap – this is where you will be charged a maximum gap of $500 per specialist, per admission to hospital, and $800 for obstetrics services

IS YOUR DOCTOR REGISTERED FOR ACCESS GAP COVER BENEFITS?

If your specialist doctor is registered for Access Gap Cover, the gap may be reduced or eliminated for medical services they provide while you are an inpatient in hospital.

Specialists are free to choose to opt in or out of the Access Gap Cover scheme on a patient by patient and procedure by procedure basis – just because they are registered for the scheme doesn't mean they always use it. If you choose a doctor that does not participate in the Access Gap Cover scheme for your procedure, you will be covered by Medicare and GMHBA for the scheduled fee, but will need to pay any gap.

Before deciding to have a procedure, you should discuss the cost of treatment with your specialist doctor. Your specialist must advise of any gap that you will have to pay and provide a written estimate of the fees for treatment, before you go into hospital.

You may also receive services from an assistant surgeon and anaesthetist for your procedure – they can also choose whether or not to participate in the Access Gap Cover scheme. You may have separate gaps to pay for their services.

MEDICARE LEVY SURCHARGE AND AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

	BASE TIER	TIER 1	TIER 2	TIER 3
SINGLES	<$93,000	$93,001-$108,000	$108,001-$144,000	>$144,001
FAMILIES	<$186,000	$186,001-$216,000	$216,001-$288,000	>$288,001
PRIVATE HEALTH INSURANCE REBATE JULY 1 2023 - JUNE 30 2024				
UNDER 65	24.608%	16.405%	8.202%	0%
65-69	28.710%	20.507%	12.303%	0%
70+	32.812%	24.608%	16.405%	0%
MEDICARE LEVY SURCHARGE				
ALL AGES	0.00%	1.00%	1.25%	1.50%

MEDICARE LEVY SURCHARGE

The Medicare Levy Surcharge (MLS) is a surcharge (additional tax) on people who do not hold eligible private hospital cover and who have a taxable income above the threshold for singles and families.

If you or your family do not have hospital cover, or you choose not to maintain your cover, you may have to pay the Medicare Levy Surcharge based on the new income test.

AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

This rebate is available to anyone who is eligible for Medicare; depending on your income and the age of the oldest person on your policy, the government may pay a percentage of your premium.

The rebate applies to all of GMHBA's covers. You can claim the Australian Government Rebate either:

- **As a premium reduction through GMHBA**
- **A lump sum payment when lodging your annual tax return**

LIFETIME HEALTH COVER

The Lifetime Health Cover (LHC) loading is a Government loading on your private hospital cover premiums. It was introduced on July 1, 2000 to encourage people to take out private hospital cover earlier, and to maintain their cover.

HOW DOES LHC WORK?

LHC is a 2% loading for every year you don't have hospital cover after you turn 30.

From the date it was introduced, anyone who joins a hospital cover of a registered health fund will be given a Certified Age at Entry (CAE) status. This CAE represents the age when they first joined a hospital cover after July 1, 2000. If you joined a hospital cover before this date you are assigned a CAE of 30 and you will pay the base rate (the lowest premium) for your hospital cover. If you joined after this date with a CAE of over 30, you will pay a 2% loading for each year your CAE is above 30 to a maximum loading of 70% at age 65.

Where you have had to pay a LHC loading, and have done so for a continuous period of 10 years, the loading will no longer apply on the day after the last day of the 10 year period. People born on or prior to July 1, 1934 are exempt from the CAE requirement.

Members can have a cumulative total of 1094 days days without hospital cover without impacting their loading percentage.

HOW MUCH EXTRA WILL I HAVE TO PAY?

If you take out hospital cover before July 1, following your 31st birthday, you won't have to pay any LHC loading.

If you take out cover after July 1, following your 31st birthday, you will need to pay an extra 2% loading for every year your CAE is above 30 (2% if you're 31, 4% if you're 32, and so on).

For example: If you take out private hospital cover for the first time when you are 35, you would need to pay a 10% loading. After you've paid the LHC for 10 continuous years, the loading is removed from your cover.

IF THINGS GO WRONG

Our mission to be your trusted partner in the provision of private health insurance goes beyond providing quality affordable products and high levels of customer service.

While we receive many letters of praise about our products and customer service advisors, like any organisation, we aren't perfect and, on occasions, we also receive complaints. We believe that your complaints are of equal or greater importance than praise.

As such, we have stringent guidelines in place to ensure we acknowledge you in the most efficient and timely manner.

So, in the unfortunate circumstance that you have a concern or complaint you can contact us through the following channels and can expect an acknowledgement as indicated below:

1. TALK TO A GMHBA REPRESENTATIVE

You can talk to a representative by calling 1300 446 422, visiting your local branch or emailing service@gmhba.com.au.

2. WRITE TO US

Write to us at GMHBA, PO Box 761, Geelong, Vic 3220 We will provide an acknowledgement within 5 working days for written correspondence. Where the matter is complex we will attempt to finalise within a month. However where the difficulty of the matter precludes this, we will inform you of the progress.

3. WRITE TO THE MEMBER SERVICES REVIEW COMMITTEE (MSRC)

If after receiving our response you are still not satisfied, you can write to the Member Services Review Committee (MSRC). The MSRC consists of a panel of senior managers.

The aim of the MSRC is to listen to you and to provide decisions that are fair and equitable for all our members. You will receive an acknowledgment of your correspondence within 5 working days of the committee's weekly meeting.

You are welcome to write to the MSRC at PO Box 761, Geelong, Vic 3220 or email service@gmhba.com.au.

4. CONTACT OUR CUSTOMER RELATIONSHIP TEAM

If you require further clarification about the decision made at the MSRC, please write to the Customer Relationship Team at PO Box 761, Geelong, Vic 3220 or email service@gmhba.com.au.

We will acknowledge your correspondence within 5 days of receipt. Where the matter is complex we will attempt to finalise within a month, however where the complexity of the matter precludes this, we will keep you informed of the progress.

If you're still dissatisfied with the outcome, free independent advice is available from the Private Health Insurance Ombudsman.

To make a complaint, contact the Commonwealth Ombudsman at www.ombudsman.gov.au or call 1300 362 072.

PAYMENT METHOD OPTIONS

CREDIT CARD

When you choose this option, your premiums are automatically debited from your MasterCard or Visa credit card each month, quarter, half-year or year – which ever you prefer. Please note that automatic payments from a credit card do not attract the direct debit discount. Billing and reminder notices are not sent if you pay by automatic direct debit.

DIRECT DEBIT

You can save 2% on eligible products by having your premiums deducted directly from your bank, credit union or building society account. Billing and reminder notices are not sent if you pay by automatic direct debit.

DIRECT TO GMHBA

Your premiums can also be paid using any of the following payment method options:

- **GMHBA branches –** payments can be made in cheque or by EFTPOS
- **Australia Post –** payments can be made in cash, cheque or EFTPOS when you present your billing notice at any Australia Post office with BPay facility
- **Pay online –** payments can be made by credit card through NAB's Secure on-line payment facility
- **Simply visit gmhba.com.au** and select the 'pay by web' option. Alternately use the BPay facility of your financial institution
- **Pay by phone –** payments can be made by credit card over the phone using NAB Transact, simply phone 1300 238 959. Alternately you can use the BPay facility of your financial institution
- **Mail –** payments must be made by cheque or money order. Please do not send cash by mail. When making a direct payment either in person or by mail, you must present your billing notice. A billing notice will be sent to you if your premium is paid direct to GMHBA, either monthly, quarterly, half-yearly or yearly in advance

PAYMENT IN ADVANCE

A fund member (or person paying on their behalf) may not make a payment of premiums that would cause the period of cover to exceed 12 months in advance of the contribution due date.

DIRECT DEBIT SERVICE AGREEMENT

Terms and conditions of our direct debit service agreement can be found in the Documents and Forms section on our website.

ARREARS

GMHBA fund members are responsible for ensuring their premiums are up to date. Membership will cease when premiums fall into arrears of more than two months after the premium due date. To claim benefits, a fund member must be financial at the time of incurring the expense for the service or treatment.

RATE REVIEW

Private health insurers are approved to make premium changes on April 1 each year. You will be advised of any changes to your premium and/or your policy in accordance with the requirements as set out in the Private Health Insurance Act.

OTHER IMPORTANT INFORMATION

COSMETIC SURGERY

Please note that depending on the level of hospital cover you have with GMHBA, you may have **exclusions** for cosmetic surgery or limited benefits may apply for cosmetic surgery procedures. GMHBA's definition of cosmetic surgery is as follows:

- 'Cosmetic service' means an operation, procedure or treatment undertaken for the dominant purpose of improving appearance or improving self-esteem where:
  - (a) there is no disease, deformity, injury or disorder; or
  - (b) the deformity is the result of a normal physiological process such as pregnancy and ageing

HOSPITAL & PSYCHIATRIC ADMISSIONS

Hospital benefits are only payable when the member has served waiting periods, is on an eligible product and is being admitted to hospital for medical reasons. For certain types of hospital admissions, we may require clinical notes from the admitting doctor to support the reason for admission. Where a medical reason cannot be ascertained, benefits may not be payable.

BENEFITS AVAILABLE

Fund benefits, payable under a hospital or extras (general) table shall not exceed the following amount:

(a) the fees and/or charges raised for any treatment and/or services rendered, being treatment and/or services covered for benefits under the relevant table; less

(b) any compensation, damages or benefits paid or payable from any other source including by way of compensation in relation to the treatment and/or services rendered.

RIGHTS OF GMHBA LIMITED

Where at the time at which benefits are claimed it appears to the Fund that the Fund member and/or dependant may be entitled to receive a payment by way of compensation for a good, service or treatment but the Fund member and/or dependant has not established their right to that compensation, benefits are not payable for that good, service or treatment.

Where a Fund member and/or dependant establishes their right to a payment by way of compensation and accepts a settlement in respect of such compensation, whether such settlement later is approved by a duly constituted Court or Tribunal or not, wherein the term of such settlement specifies that the sum of money paid under the settlement does not relate to expenses past or future in respect of which Fund benefits are otherwise payable, or the Fund member and/ or dependant abandons or compromises any part of the claim so that such expenses are excluded, then benefits are not payable.

The Fund member and/or dependant shall be required to establish their right to receive payment by way of compensation for a good, service or treatment before submitting a claim to the Fund in respect of that good, service or treatment. Should it be established that the Fund member and/or dependant has no right to payment by way of compensation then Fund benefits shall be payable in respect of that good, service or treatment.

OBLIGATION OF FUND MEMBERS

Where the Fund is of the opinion that a condition, injury or ailment is one which may give rise to a claim for compensation or where benefits have been paid by the Fund which relate to such a claim, the Fund at its absolute discretion may require the Fund member in respect of whom benefits are otherwise payable to sign an irrevocable undertaking and authority in favour of the Fund, in a form acceptable to the Fund, pursuant to which the Fund member undertakes to make such a claim for compensation.

A Fund member who has, or may have, a right to receive compensation in respect of a good, service or treatment, must:

- include in any claim for compensation all hospital, paramedical and related expenses in respect of which benefits otherwise are or may be payable by the Fund
- not withdraw the claim for compensation for hospital, paramedical and related expenses
- prosecute the claim for compensation with diligence and take all reasonable steps to pursue the claim for compensation
- disclose to the Fund and its legal advisers all matters relevant to the prosecution of the claim for compensation
- notify the Fund forthwith upon payment of the claim for compensation or any part thereof and direct that from any such claim that it is first deducted and paid to the Fund by way of reimbursement an amount equal to the amount of benefits paid by the Fund in respect to such condition, injury or ailment

CODE OF CONDUCT

GMHBA is a fully compliant member of the Private Health Insurance Code of Conduct. Private Healthcare Australia in conjunction with the Health Insurance Restricted Membership Association of Australia (HIRMAA) has developed codes of practice called the Private Health Insurance Practice Codes to reinforce existing regulatory obligations and to establish a minimum standard of business practice applicable to all participants in such codes. The first code to be established is the Private Health Insurance Code of Conduct.

Development of the codes commenced in 2003 with a committee formed by Private Healthcare Australia and HIRMAA. That committee has broad representation from funds, so the development has had detailed and expert input from a cross section of the industry and from stakeholders. The Minister for Health and the Treasurer have endorsed the Code. The Code is designed to sit beside the current Government acts and regulations within which the industry operates and underlines the intent of the industry to show its commitment to consumers. The Private Health Insurance Code of Conduct is designed to help you by providing clear information and transparency in your relationships with health insurers. The Code covers four main areas of conduct in private health insurance ensuring:

- You receive the correct information on private health insurance from appropriately trained staff
- You are aware of the internal and external dispute resolution procedures within GMHBA Health Insurance
- Policy documentation contains all the information you require to make a fully informed decision about your purchase and all communications between you and GMHBA Health Insurance are conducted in a way that ensures appropriate information flows between the parties
- All information between you and GMHBA is protected in accordance with national and state privacy principles

You can download the code at: privatehealth.com.au/codeofconduct

GLOSSARY

ACCIDENT

An unforeseen event occurring by chance and caused by an external force or object, which results in involuntary injury to the body requiring immediate treatment.
You are covered for accidental injuries sustained after joining the fund (Policy must include the clinical category related to the treatment of the injury). For an Accident to be covered, treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury. An Accident Declaration form must be supplied to the fund.

ACCIDENT PROTECTION (SELECTED COVERS)

Accident Protection means temporarily upgraded cover. You may be eligible to access treatments usually reserved for the highest levels of hospital cover for up to 90 days following an accident.

We understand that no one sees an accident coming, so you might not have thought to include some services on your cover. That's why, on eligible products, we'll cover you in a participating private hospital for services that are normally excluded or restricted on your cover if you need them because of an accident. Please see your fact sheet to determine if Accident Protection is included on your cover.

Accident Protection covers accidental injuries occurring by chance and caused by an external force or object, which results in involuntary injury to the body sustained after joining GMHBA. For an accident to be covered, treatment must be sought through a Doctor or an Emergency Department within 48 hours of sustaining the injury and the hospital admission must occur within 90 days. An Accident Declaration form must be supplied to GMHBA in order for benefits to be paid. There are some services that are not eligible to be considered an accident.

Following the initial admission that has occurred within 90 days, if you require a follow up procedure that is directly related to the accident, this will be covered under your accident protection

Benefits are limited to inpatient hospital treatment for services with a valid Medicare Benefits Schedule item.

GMHBA's definition of Accident excludes:

- Medical Conditions (disease or illness that is not immediately due to an external injury)

- Pre-Existing Conditions

- Pregnancy, birth and IVF procedures

- Accidents arising from surgical procedures

- Elective Cosmetic Surgery

- Podiatric Surgery by an accredited podiatrist

- Sudden Illness

- Injuries due to alcohol or drug use, or drugs not prescribed by a registered practitioner

- Aggravation of an existing condition

- Damage to teeth caused by eating or drinking

- Claims covered by third parties (such as Workcover and TAC)

CALENDAR YEAR

A calendar year is 1 January to 31 December

COMPENSATION

This includes:

- A payment by way of damages;
- A payment under a scheme of insurance or compensation provided by the Commonwealth or State law (for example, workers compensation insurance or compulsory third party motor vehicle accident insurance);
- Settlement of a claim for damages

(with or without admission of liability);

- A payment for negligence;
- A benefit paid by another private health insurer; or
- Any other payment that in the Fund's reasonable opinion is a payment in the nature of compensation or damages.

EMERGENCY AMBULANCE

Emergency Ambulance definition: E.g. as defined by your state or territory ambulance scheme (i.e. generally does not cover you for transportation between hospitals or rehabilitation centres)

EXCLUSIONS

Services you are not covered for. If you need treatment for a service listed as an exclusion under your policy, you are not entitled to any benefits and will have significant out-of-pocket expenses.

INFORMED FINANCIAL CONSENT

The provider should advise you in writing of any out-of-pocket costs before you undergo any treatment.

INPATIENT

Any person covered who is formally admitted to hospital as an inpatient with a doctor's order. The day you are discharged is your last inpatient day. Treatment in a hospital emergency department is not considered an inpatient service.

MAXIMUM PBS AMOUNT

The maximum PBS amount is set by TGA (Therapeutic Goods Administration), and the amount changes every year on Jan 1st.

MEDICAL ADVISER

A medical practitioner appointed by GMHBA to decide if a condition is pre-existing. The medical adviser must consider any information regarding signs and symptoms provided by your treating medical practitioners.

NON-PARTICIPATING HOSPITAL

Hospitals with which GMHBA currently does not have an agreement in place. Fixed benefits are available however significant out of pocket expenses are likely to be incurred. Please contact us for further details.

PRIVATE PRACTICE

All general treatment (extras cover) services must be provided by practitioners in a private practice who are appropriately registered with recognised bodies approved by GMHBA.

PUBLIC HOSPITAL

If you are admitted as a private patient in a public hospital you will only be covered for a shared room. Electing to be a private patient in a public hospital could result in out-of-pocket costs to you. Ensure you receive written informed financial consent for any hospital admission. Our public hospital coverage (e.g. Bronze Hospital) does not help you avoid public hospital queues. The length of a public hospital queue is determined by the hospital and is not determined by GMHBA.

RECOGNISED PROVIDER

GMHBA will pay benefits for extras services provided by a GMHBA recognised provider. Extras services include but are not limited to dental, optometrist and physiotherapist.

CLINICAL CATEGORY DEFINITIONS

REHABILITATION

Hospital treatment for physical rehabilitation for a patient related to surgery or illness.

HOSPITAL PSYCHIATRIC SERVICES

Hospital treatment for the treatment and care of patients with psychiatric, mental, addiction or behavioural disorders. For example: psychoses such as schizophrenia, mood disorders such as depression, eating disorders and addiction therapy.

PALLIATIVE CARE

Hospital treatment for care where the intent is primarily providing quality of life for a patient with a terminal illness, including treatment to alleviate and manage pain.

BRAIN AND NERVOUS SYSTEM

Hospital treatment for the investigation and treatment of the brain, brain-related conditions, spinal cord and peripheral nervous system. For example: stroke, brain or spinal cord tumours, head injuries, epilepsy and Parkinson's disease.

- Treatment of spinal column (back bone) conditions is listed separately under Back, neck and spine.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

EYE (NOT CATARACTS)

Hospital treatment for the investigation and treatment of the eye and the contents of the eye socket. For example: retinal detachment, tear duct conditions, eye infections and medically managed trauma to the eye.

- Cataract procedures are listed separately under Cataracts.
- Eyelid procedures are listed separately under Plastic and reconstructive surgery.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

EAR, NOSE AND THROAT

Hospital treatment for the investigation and treatment of the ear, nose, throat, middle ear, thyroid, parathyroid, larynx, lymph nodes and related areas of the head and neck. For example: damaged ear drum, sinus surgery, removal of foreign bodies, stapedectomy and throat cancer.

- Tonsils, adenoids and grommets are listed separately under Tonsils, adenoids and grommets.
- The implantation of a hearing device is listed separately under Implantation of hearing devices.
- Sleep studies are listed separately under Sleep studies.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

TONSILS, ADENOIDS AND GROMMETS

Hospital treatment of the tonsils, adenoids and insertion or removal of grommets.

BONE, JOINT AND MUSCLE

Hospital treatment for the investigation and treatment of diseases, disorders and injuries of the musculoskeletal system. For example: carpal tunnel, fractures, hand surgery, joint fusion, bone spurs, osteomyelitis and bone cancer.

- Chest surgery is listed separately under Lung and chest.
- Spinal cord conditions are listed separately under Brain and nervous system.
- Spinal column conditions are listed separately under Back, neck and spine.
- Joint reconstructions are listed separately under Joint reconstructions.

- Joint replacements are listed separately under Joint replacements.
- Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).
- Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

JOINT RECONSTRUCTIONS

Hospital treatment for surgery for joint reconstructions. For example: torn tendons, rotator cuff tears and damaged ligaments

- Joint replacements are listed separately under Joint replacements.
- Bone fractures are listed separately under Bone, joint and muscle.
- Procedures to the spinal column are listed separately under Back, neck and spine.
- Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).

KIDNEY AND BLADDER

Hospital treatment for the investigation and treatment of the kidney, adrenal gland and bladder. For example: kidney stones, adrenal gland tumour and incontinence

- Dialysis is listed separately under Dialysis for chronic kidney failure.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

MALE REPRODUCTIVE SYSTEM

Hospital treatment for the investigation and treatment of the male reproductive system including the prostate. For example: male sterilisation, circumcision and prostate cancer.

- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

DIGESTIVE SYSTEM

Hospital treatment for the investigation and treatment of the digestive system, including the oesophagus, stomach, gall bladder, pancreas, spleen, liver and bowel. For example: oesophageal cancer, irritable bowel syndrome, gall stones and haemorrhoids.

- Endoscopy is listed separately under Gastrointestinal endoscopy.
- Hernia and appendicectomy procedures are listed separately under Hernia and appendix
- Bariatric surgery is listed separately under Weight loss surgery.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

HERNIA AND APPENDIX

Hospital treatment for the investigation and treatment of a hernia or appendicitis.

- Digestive conditions are listed separately under Digestive system.

GASTROINTESTINAL ENDOSCOPY

Hospital treatment for the diagnosis, investigation and treatment of the internal parts of the gastrointestinal system using an endoscope. For example: colonoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography (ERCP).

- Non-endoscopic procedures for the digestive system are listed separately under Digestive system.

GYNAECOLOGY

Hospital treatment for the investigation and treatment of the female reproductive system. For example: endometriosis, polycystic ovaries, female sterilisation and cervical cancer.

- Fertility treatments are listed separately under Assisted reproductive services
- Pregnancy and birth-related conditions are listed separately under Pregnancy and birth
- Miscarriage or termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.

CLINICAL CATEGORY DEFINITIONS (CONTINUED)

- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

MISCARRIAGE AND TERMINATION OF PREGNANCY

Hospital treatment for the investigation and treatment of a miscarriage or for termination of pregnancy.

CHEMOTHERAPY, RADIOTHERAPY AND IMMUNOTHERAPY FOR CANCER

Hospital treatment for chemotherapy, radiotherapy and immunotherapy for the treatment of cancer or benign tumours

- Surgical treatment of cancer is listed separately under each body system."

PAIN MANAGEMENT

Hospital treatment for pain management that does not require the insertion or surgical management of a device. For example: treatment of nerve pain and chest pain due to cancer by injection of a nerve block.

- Pain management using a device (for example an infusion pump or neurostimulator) is listed separately under Pain management with device."

SKIN

Hospital treatment for the investigation and treatment of skin, skin-related conditions and nails. The removal of foreign bodies is also included. Plastic surgery that is medically necessary and relating to the treatment of a skin-related condition is also included. For example: melanoma, minor wound repair and abscesses.

- Removal of excess skin due to weight loss is listed separately under Weight loss surgery.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

BREAST SURGERY (MEDICALLY NECESSARY)

Hospital treatment for the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy.
For example: breast lesions, breast tumours, asymmetry due to breast cancer surgery, and gynecomastia.

- This clinical category does not require benefits to be paid for cosmetic breast surgery that is not medically necessary
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

DIABETES MANAGEMENT (EXCLUDING INSULIN PUMPS)

Hospital treatment for the investigation and management of diabetes. For example: stabilisation of hypo- or hyper- glycaemia, contour problems due to insulin injections

- Treatment for diabetes-related conditions is listed separately under each body system affected. For example, treatment for diabetes-related eye conditions is listed separately under Eye.
- Treatment for ulcers is listed separately under Skin.
- Provision and replacement of insulin pumps is listed separately under Insulin pumps.

HEART AND VASCULAR SYSTEM

Hospital treatment for the investigation and treatment of the heart, heart-related conditions and vascular system. For example: heart failure and heart attack, monitoring of heart conditions, varicose veins and removal of plaque from arterial walls.

- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy,

radiotherapy and immunotherapy for cancer.

LUNG AND CHEST

Hospital treatment for the investigation and treatment of the lungs, lung-related conditions, mediastinum and chest. For example: lung cancer, respiratory disorders such as asthma, pneumonia, and treatment of trauma to the chest.

- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

BLOOD

Hospital treatment for the investigation and treatment of blood and blood-related conditions. For example: blood clotting disorders and bone marrow transplants

- Treatment for cancers of the blood is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

BACK, NECK AND SPINE

Hospital treatment for the investigation and treatment of the back, neck and spinal column, including spinal fusion.
For example: sciatica, prolapsed or herniated disc, and spine curvature disorders such as scoliosis, kyphosis and lordosis.

- Joint replacements are listed separately under Joint replacements.
- Joint fusions are listed separately under Bone, joint and muscle.
- Spinal cord conditions are listed separately under Brain and nervous system
- Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

PLASTIC AND RECONSTRUCTIVE SURGERY (MEDICALLY NECESSARY)

Hospital treatment which is medically necessary for the investigation and treatment of any physical deformity, whether acquired as a result of illness or accident, or congenital. For example: burns requiring a graft, cleft palate, club foot and angioma.

- Plastic surgery that is medically necessary relating to the treatment of a skin-related condition is listed separately under Skin
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

DENTAL SURGERY

Hospital treatment for surgery to the teeth and gums. For example: surgery to remove wisdom teeth, and dental implant surgery.

PODIATRIC SURGERY (PROVIDED BY A REGISTERED PODIATRIC SURGEON)

Hospital treatment for the investigation and treatment of conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon, but limited to cover for:

- accommodation; and
- the cost of a prosthesis as listed in the prostheses list set out in the Private Health Insurance (Prostheses) Rules, as in force from time to time.

Note: Insurers are not required to pay for any other benefits for hospital treatment for this clinical category but may choose to do so.

IMPLANTATION OF HEARING DEVICES

Hospital treatment to correct hearing loss, including implantation of a prosthetic hearing device.

- Stapedectomy is listed separately under Ear, nose and throat.

CATARACTS

Hospital treatment for surgery to remove a cataract and replace with an artificial lens.

JOINT REPLACEMENTS

Hospital treatment for surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of prostheses. For example: replacement of shoulder, wrist, finger,

CLINICAL CATEGORY DEFINITIONS (CONTINUED)

hip, knee, ankle, or toe joint, spinal disc replacement.

- Joint fusions are listed separately under Bone, joint and muscle.
- Spinal fusions are listed separately under Back, neck and spine.
- Joint reconstructions are listed separately under Joint reconstructions.
- Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).

DIALYSIS FOR CHRONIC KIDNEY FAILURE

Hospital treatment for dialysis treatment for chronic kidney failure. For example: peritoneal dialysis and haemodialysis.

PREGNANCY AND BIRTH

Hospital treatment for investigation and treatment of conditions associated with pregnancy and child birth.

- Treatment for the baby is covered under the clinical category relevant to their condition. For example, respiratory conditions are covered under Lung and chest.
- Female reproductive conditions are listed separately under Gynaecology.
- Fertility treatments are listed separately under Assisted reproductive services
- Miscarriage and termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.

ASSISTED REPRODUCTIVE SERVICES

Hospital treatment for fertility treatments or procedures. For example: retrieval of eggs or sperm, In vitro Fertilisation (IVF), and Gamete Intra-fallopian Transfer (GIFT).

- Treatment of the female reproductive system is listed separately under Gynaecology.
- Pregnancy and birth-related services are listed separately under Pregnancy and birth.

WEIGHT LOSS SURGERY

Hospital treatment for surgery that is designed to reduce a person's weight, remove excess skin due to weight loss and reversal of a bariatric procedure. For example: gastric banding, gastric bypass, sleeve gastrectomy.

INSULIN PUMPS

Treatment for the provision and replacement of insulin pumps for treatment of diabetes.

PAIN MANAGEMENT WITH DEVICE

Hospital treatment for the implantation, replacement or other surgical management of a device required for the treatment of pain. For example: treatment of nerve pain, back pain, and pain caused by coronary heart disease with a device (for example an infusion pump or neurostimulator).

- Treatment of pain that does not require a device is listed separately under Pain management.

SLEEP STUDIES

Hospital treatment for the investigation of sleep patterns and anomalies. For example: sleep apnoea and snoring.

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