straightforward health insurance

Important Information about your membership

gmf 60 YEARS

CANSTAR outstanding value
Hospital Cover
Western Australia

Claiming

We make it as quick and easy to claim benefits as we possibly can. Claim forms are available from gmfhealth.com.au or call us on 1300 653 099 and we will send some forms to you.

Claims Postal Address: PO Box 513, Kalgoorlie WA 6433

Extras Claims

GMF Health members can now claim on the spot using their GMF Health member card. This means you can receive your benefit on the spot for services like dental and optical and you only need to pay for any out-of-pocket cost you may incur.

Electronic claiming is available at dental, optical, physiotherapy, chiropractic, podiatry, osteopath, speech pathology, clinical psychology and dietetic providers who have electronic claiming facilities and are registered with GMF Health.

To make an electronic claim at a provider you need to ensure your card is swiped through the electronic claim terminal. Once the claim has been approved, all you need to do is pay your out-of-pocket cost to the provider.

This means you don't need to fill out any forms or wait to receive your benefit. Contact your provider to find out if they have electronic claiming facilities.

Alternatively, complete a claim form, attach your provider's original account and receipt (if paid) and send to us. Scanned, faxed and photocopied documents are acceptable.

If you have fully paid the account, you have the option of using our 'EasyClaim' service or receiving a cheque.

'EasyClaim' directly credits the benefit amount to your bank account (excluding credit cards), so there's less waiting before you receive your benefit. If you would like to use 'EasyClaim', make sure you complete the 'EasyClaim' section on your claim form.

Hospital Claims

In most cases, hospital in-patient and day-patient accounts will be forwarded directly to GMF Health for payment. If you do receive an account, complete a claim form, attach the original account and send to us.

Medical Claims

Please do not send medical accounts for in-patient or day-patient hospital services to Medicare. You must send these accounts directly to GMF Health to enable us to process any Gap Benefits that you may be entitled to. We will electronically claim your Medicare benefit on your behalf.

Hospital cover – the details

Benefits explained

Limited benefits
Limited accommodation benefits apply which are similar to the cost of a shared room in a public hospital. GMF Health Medical Gap, theatre fees and pharmacy costs are not payable.

Cosmetic surgery and other treatment without an MBS item number
Procedures that do not attract a Medicare benefit only receive accommodation benefits which are equivalent to the cost of a shared room in a public hospital. No other benefits are payable.

No benefit is payable for Bronze Hospital members.

Long stay patients
If you are covered by GMF Health Hospital cover and you require continuous hospitalisation for 35 days or more, (which may include a break of up to seven days), the treating hospital will be required to provide GMF Health with an acute care certificate from your treating hospital, otherwise only a basic benefit will apply.

Medical Gap cover

What is the medical gap?

The medical gap is the difference between the Medicare Benefit Schedule (MBS) fee set by the Federal Government and the amount Medical Practitioners charge private patients when they are admitted to a hospital or day hospital facility.

Some Medical Practitioners only charge the MBS fee. In these cases, there is no medical gap to pay (providing treatment is not excluded from your level of cover).

However, many Medical Practitioners charge more than the MBS fee. It is the amount above the MBS fee that is known as the medical gap.

Will GMF Health cover my medical gap?

GMF Health Hospital policies all include GMF Health's Medical Gap cover (Bronze Hospital cover does not include Medical Gap cover).

GMF Health's Medical Gap cover could either eliminate or reduce your medical gap for in-hospital treatment provided by a wide range of Medical Practitioners in Australia.

Medical Gap cover only applies for treatment provided when you are admitted to a hospital. Limitations and exclusions apply for some cosmetic and reconstructive surgery items and for treatment that is excluded from your level of cover.

GMF Health is unable to pay benefits for medical fees charged for services provided out-of-hospital, such as consultations in Medical Practitioners' rooms, or pathology/radiology services performed where you're not admitted as a patient in a hospital.

In certain cases such as maternity, you may have substantial out-of-pocket expenses for visits to your Medical Practitioner, before and after hospitalisation.

It is important that you ask your Medical Practitioner to explain all of the out-of-pocket expenses that you may be responsible for, including all expenses for treatment and services which are provided while you are not in hospital.

How do I find out if I am covered for the medical gap?

We can tell you if your referred Medical Practitioner is fully covered by GMF Health.

Simply call us on 1300 653 099 BEFORE you arrange a hospital stay.

Newborn babies

Newborn babies are not considered to be patients in a hospital for the first nine days after their birth unless they are admitted to a special care facility, or if the baby is part of a multiple birth.

If a newborn baby is added to the membership within 30 days of birth, the baby will be credited with the length of membership of the parent with the longest served policy and will be deemed to have served the same waiting periods. To change your level of cover from Single to Family call GMF Health on 1300 653 099.

GMF Health cannot pay benefits unless the baby has been admitted to hospital. Medicare will pay 85% of the MBS for babies not admitted to hospital.

Pre-Existing Ailments and Conditions

What is a pre-existing condition or ailment?

An ailment, illness or condition, the signs or symptoms of which, in the opinion of an independent medical practitioner appointed by GMF Health, existed at any time during the six months before you became a member or transferred to a higher level of cover.

It is not necessary for the ailment, illness or condition to have been diagnosed in the six month period prior to taking out hospital cover or upgrading – only that signs or symptoms were, or would have been evident. These signs or symptoms should have been reasonably apparent to either the member, or a reasonable general practitioner had the member been examined in the six month period.

Pre-existing conditions or ailments do not apply for psychiatric, rehabilitation and palliative care.

When to contact the health fund

If you have less than 12 months membership on your current hospital product, make sure you contact us before you are admitted to hospital and find out whether the pre-existing ailment waiting period applies to you.

Please allow at least five days for us to make an assessment of the pre-existing ailment.

If you proceed with the admission without confirming benefit entitlements and GMF Health subsequently determine your condition to be pre-existing, you will be required to pay all hospital charges and medical charges not covered by Medicare.

Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing ailment rule before your admission. Consequently if you have less than 12 months membership on your current hospital product you might have to pay for some or all of the hospital and medical charges if you are admitted to hospital and choose to be treated as a private patient and GMF Health later determines that your condition was pre-existing.

Prostheses

What are prostheses?

Prostheses are the surgically implanted devices you may need if you have an operation. There are many types of prostheses which are required during surgery. Some of the most common procedures needing prostheses are joint replacements, cataract surgery and some heart procedures.

Am I covered for prostheses?

All levels of GMF Health Hospital cover entitle you to a benefit for prostheses as long as you are admitted to hospital for the procedure and the item is listed on the Federal Government Prosthesis List. No benefit is payable for prostheses implanted during a procedure that is specifically excluded from your level of cover or if your procedure does not have a MBS item number.

Most prostheses are fully covered, however there are some prostheses that may attract an out-of pocket expense. Please be assured that there is at least one fully covered prosthesis available for every surgical procedure that you may need, so We suggest you discuss the choice of prosthesis with your Medical Practitioner.

How do I find out if I am fully covered for my prosthesis?

It is important to talk to your Medical Practitioner to find out whether a prosthesis will be used during your procedure. Once you have confirmed this, you will need to know the item number of the prosthesis you need and the item number of the procedure you will be having. When you have this information, simply call a Member Service Consultant on 1300 653 099 so we can confirm the amount of any gap you may need to pay.

Psychiatric care

Private hospital benefits for psychiatric patients are only available for approved programs in hospitals that have contracts with GMF Health for the provision of these programs. Limited benefits apply for Family Choice, Young Singles Choice and Bronze Hospital members.

Default benefits are paid on all other non-approved programs. Contact us for details on 1300 653 099 as benefits may vary by State.

Public Hospitals – can GMF Health members choose to be admitted as public patients?

As a patient in a public hospital, you can choose to be treated as a private or public patient. As a public patient, there is no direct charge to the patient as all of your accommodation and treatment costs are paid for by Medicare.

However, if you choose to be a public patient, you will be treated by a Medical Practitioner assigned by the hospital and you may not have a say in when your treatment will occur. You should also be aware that the allocation of private rooms in public hospitals is decided according to clinical need.

Should you choose to be admitted to a public hospital as a private patient, you may incur some out-of-pocket expenses for medical services. Limited accommodation benefits apply which are similar to the cost of a shared room in a public hospital.

Treatment in a Contracted Private Hospital

GMF Health has agreements with most private hospitals that are likely to be accessed by members. These agreements ensure that an agreed schedule of fees (including in-patient accommodation, theatre and special unit accommodation fees as appropriate) is charged by the hospital and paid by GMF Health on the member's behalf. Please note that a member's benefit entitlements will be affected by factors such as their level and type of cover and the financial status of their membership. This will affect the amount GMF Health will reimburse to the hospital.

GMF Health strongly recommends you contact us on 1300 653 099 to confirm their benefit entitlement prior to receiving hospital treatment.

Treatment in Non-Contracted Private Hospitals

For private hospitals not contracted by GMF Health, we will pay a benefit equivalent to the lowest amount we would pay a contracted hospital in the State the treatment was received.

Rehabilitation

Private hospital benefits for rehabilitation patients are only available for approved programs in hospitals that have contracts with GMF Health for the provision of these programs. Limited benefits apply for Bronze Hospital members.

Default benefits are paid on all other non-approved programs. Contact us for details on 1300 653 099 as benefits may vary by State.

Respite care

GMF Health Hospital benefits are not payable for respite care.

Preparing for a Hospital Stay

A hospital stay can be expensive and often the range of services provided to you during your stay can become quite complex.
To ensure you are fully aware of any out-of-pocket expenses that you may be responsible for paying following your treatment, it's important that you do the following:

Before treatment

- Obtain a detailed quotation from your Medical Practitioner/Specialist, including Anaesthetist charges.
- Forward the quotation to GMF Health by either calling us on 1300 653 099, faxing us on 1300 653 098, emailing welcome@gmfhealth.com.au. We will provide you with confirmation of your benefit entitlements and advise you of any out-of-pocket expenses.
  If you are satisfied with the quotation and services to be provided by your Medical Practitioner/Specialist, you need to provide him/her with 'informed financial consent' to go ahead with the treatment.
- Your Medical Practitioner/Specialist will provide you with an 'informed financial consent' authorisation form to complete. This form should detail all expected expenses. By authorising this form you are indicating that you are aware that you're responsible for paying any amount not covered by GMF Health or Medicare.

After treatment

When you or your family have in-patient or day-patient hospital treatment you could receive up to four different types of accounts:

Hospital accounts cover items such as theatre and room fees. These accounts are normally sent directly to GMF Health for payment. If you do receive a Hospital account, submit a claim for benefits directly to GMF Health.

Medical accounts cover surgeon, anaesthetist, pathology and radiology fees. To claim benefits, complete a claim form, attach the Provider's original account, a copy of your informed financial consent and submit the form to GMF Health. Important note: please do not send any medical accounts directly to Medicare.

Pharmaceutical items that are applicable to your hospital stay are included on your hospital account so you will not receive a separate account. Drugs prescribed for discharge and drugs not associated with the reason for admission are not covered by GMF Health.

Prosthetic accounts – provided that the surgically implanted prosthesis is on the Fully Covered Schedule, you won't have an out-of-pocket expense. In most cases prostheses are included on your hospital account so you won't get a separate account. If you do receive an account, to claim benefits complete a Claim form, attach your Provider's original account and submit to GMF Health. Please refer to page 3 for more prostheses information.

Contact us

If you think you may need to go to hospital, contact us for a brochure 'Preparing for your hospital stay' which will answer many of your questions. You can download a copy from gmfhealth.com.au or call us on 1300 653 099 to obtain a copy.

Extras cover – the details

GMF Health Extras provides benefits towards a wide range of day-to-day health care services not covered by Medicare.

Conditions

When using this guide as a reference for your Extras cover, please keep in mind that GMF Health benefits are only paid for services provided by professionals who are registered with GMF Health. These conditions apply to all levels of GMF Health Extras cover.

Please ask your provider to confirm they are a registered GMF Health provider, or contact GMF Health on 1300 653 099. Remember, not all providers are GMF Health registered, so be sure to check BEFORE you commence your treatment.

Annual maximums

Maximum benefits for treatment and services are calculated and based on calendar years.

As a member, your dental entitlements are based on the continuous length of your membership on Extras cover. Maximums cannot be advanced from future years nor can unused entitlements be carried forward to the following year.

Benefit quotations

When high cost treatment is proposed, we recommend that you obtain an itemised quotation from your provider BEFORE you commence any treatment.

By submitting an itemised quotation to us, we will be able to provide you with written confirmation of your benefit entitlements. This will help you to know exactly what your out-of-pocket expenses will be for the proposed treatment before it begins.

Your GMF Health quotation is valid for two months from the date that it's issued. If you do not submit your claim within two months, the amount of benefit payable may change.

You may also wish to consider obtaining quotes from two or three providers to compare the price of the treatment required.

To obtain a benefit quotation simply call 1300 653 099 or fax your itemised quotation to us on 1300 653 098 and we will forward written confirmation to you.

Benefits explained

Accommodation and Travel costs

A benefit is payable if the specialist service is not available either permanently or on a visiting basis, within 200kms (return journey) of your usual place of residence.

Benefits for travel and accommodation must be initially claimed from your home State Government's relevant transport subsidy scheme and GMF Health may pay a benefit for further out-of-pocket expenses. GMF Health does not pay a benefit for private accommodation.

The maximum amount of benefit you can claim on travel costs is $350 per membership. The total amount of benefit available from both GMF Health and your home State Government's subsidy scheme will not exceed these maximums.

A completed and signed government approval form together with your home State Government's relevant transport subsidy scheme remittance advice must be presented in order to claim this benefit.

Ambulance cover

GMF Health provides all Extras members with road ambulance cover if they are not already covered by their home State Government ambulance scheme, so long as ambulance services are provided by the principal providers of ambulance services in each Australian State or Territory.

GMF Health provides 100% cover for emergency road ambulance transport, as often as it is required. Every GMF Health member is also entitled to one fully paid non-emergency service per calendar year. All subsequent use of non-emergency ambulance services will require you to pay a co-payment of $40 toward the cost of each service. All services must be medically necessary

Dental

GMF Health pays a benefit for medically necessary dental services provided by a Dentist who is registered with GMF Health. Benefits are also paid for some medically necessary services provided by a fully qualified and registered Dental Prosthetist. Listed below are the categories of dental treatment.

Dental – general

General Dental includes routine dental care – regular checkups, consultations, all extractions, restorations, x-rays and mouthguards.

Dental – major

Major Dental includes more extensive treatments such as restorative services, dentures, crowns, bridges and orthodontic treatment. Orthodontic treatment is excluded from some levels of cover.

We can only pay a benefit for partial dentures and other services provided through a Dental Prosthetist where the particular State Legislation permits.

Benefits for full arch banding is included in the orthodontic maximum. A benefit is not paid for full arch banding orthodontic treatment which is commenced during the waiting period.

The benefit for full arch banding is for the full course of treatment.

The full benefit for full arch banding is only paid once banding is fitted and when the first claim for the course of treatment is made and additional benefits are not paid from any subsequent years' orthodontic dental entitlement.

If the full benefit is not paid due to the maximum entitlement being reached (as a result of the benefits being paid for other treatments) the balance is payable in the subsequent year providing the course of treatment is ongoing.

Dental benefit restrictions

The benefit on some dental items may be restricted if performed in conjunction with other specific dental services, or if a service is received more than once in a specified period of time.

Home Nursing

If you require medical treatment at home for an acute illness which would ordinarily be treated in a GMF Health contracted hospital, we will pay a benefit for a registered private practice nurse approved by GMF Health, provided the nurse is in attendance for more than four hours a day and the treatment was ordered by a Medical Practitioner.

Please note that obstetrics is not considered to be an acute illness.

Optical

We will pay a benefit for prescription glasses (frame and lenses) and contact lenses when supplied by an Optometrist or Optical Dispenser registered with GMF Health.

Please note that your glasses or contact lenses are recorded against your entitlement for the calendar year in which the optical item is ordered, which may not necessarily be when you collect them.

Pharmacy

GMF Health pays a benefit for most therapeutic prescriptions (including repeats) for any medicine or drug listed on the current GMF Health Schedule of Pharmaceutical Benefits. Benefits are not payable on Government PBS (Pharmaceutical Benefit Scheme) items, nor will we pay a benefit for prescription items such as contraceptives and items prescribed to enhance mental or physical prowess.

All items must be prescribed by a Medical Practitioner, however some drugs require a prescription from a Specialist Medical Practitioner before a benefit can be paid. Speak to a GMF Health Member Service Consultant for more details.

You normally pay no more than a charge, which is equivalent to the fee listed under the National Health Act per item. GMF Health generally pays the balance of the cost, but for some items an additional member co-payment may apply.

Other important information about your GMF Health membership

Overseas Travel

Away for more than three months? Suspend your membership
If you have been a GMF Health member for more than two months and you are going overseas for three months or more you can suspend your membership until you return to Australia. This enables you to retain any length of membership benefits you have earned prior to your departure overseas.

If you suspend your cover, you will also need to consider whether the Federal Government's Medicare Levy Surcharge will apply to you while you are overseas. The additional levy applies if you earn over a certain income threshold. To find out more contact us on 1300 653 099.

If you wish to suspend your membership you will need to complete a Membership Suspension application. You will also need to be sure to resume your membership within two months of returning to Australia, otherwise you may lose your length of membership benefits and may be required to reserve waiting periods.

Terms and conditions apply. They are available along with Membership Suspension and Resumption forms in the GMF Health Membership Suspension Guide. Ask your GMF Health Member Service Consultant for a Guide by calling 1300 653 099, or visit gmfhealth.com.au

Will I be covered for overseas treatment?
We don't pay benefits for treatment provided outside Australia, including general treatment such as dental and glasses and any hospital or medical treatment. In this case, it might be best to consider taking out travel insurance.

Holders of 'New Start' or 'Sickness Allowance' cards

If you have been a GMF Health member for more than two months and you hold a New Start or Sickness Allowance entitlement card you can suspend all, or part of your membership for the duration indicated on the card. Your premiums must be paid up to date for your suspension to be effective and no benefits will be paid for treatments or services during the period of your suspension.

By suspending your cover instead of cancelling your membership, you will be able to reinstate your cover when your New Start or Sickness Allowance entitlements cease without any loss of long term entitlements. You will need to ensure that you reinstate your cover within two months of the date that your New Start or Sickness Allowance entitlements cease.

It is important to remember that if you do suspend your Hospital cover while you hold a New Start or Sickness Allowance entitlement you will only be able to obtain health care provided by the Public Health system. This may mean that you won't have access to your choice of doctor and you may also have to join waiting lists for any surgery which is not considered to be an emergency.

Terms and conditions do apply. They are available along with Membership Suspension and Resumption forms in the GMF Health Membership Suspension Guide. Ask your GMF Health Member Service Consultant for a Guide by calling 1300 653 099 or visit gmfhealth.com.au

Frequently asked questions

Why isn't there a No Claim Bonus?

Unfortunately GMF Health is not legally permitted to provide a 'no claim bonus'. Under the provisions of the Private Health Insurance Act 2007, health insurers are prohibited from charging a lesser premium based on a person's state of health or history of claiming. This system, called community rating, aims to ensure that groups with a higher level of claims are not disadvantaged.

Why doesn't GMF Health pay 100% of health costs?

If we were to pay 100% of all services, members' premiums would increase dramatically. For example, if we were to give a 100% rebate on all dental fees, the extra cost to GMF Health would run into the millions.

We set our benefits by equitably distributing funds amongst our members. Our objective is to return the highest possible benefit to our members on each item, taking into account the various levels of cover.

What does 'medically necessary' mean?

The treatment is medically necessary in the opinion of a medical practitioner or other suitably qualified person appointed by GMF Health.

Up to what age are my children covered?

Children are covered on their parents policy until their 21st birthday, unless they are married or living in a de-facto relationship. Children under 25 who are not married or living in a de-facto relationship and not earning more than $20,500 taxable income per annum are also eligible to remain on their parent's policy.

If I transfer from another health fund, do I receive immediate cover?

If you have health insurance with another fund you may not have to meet any waiting periods. GMF Health will provide immediate cover so long as you have already met the relevant waiting periods and have transferred within two months of your financial date with your previous fund.

If you're switching from another Australian health insurer and you've used some or all of your annual Extras benefits, your Extras benefits with GMF Health will be adjusted accordingly.

In order for your entitlements to be transferred, you must pay from the financial date of your previous health fund. This means there isn't any gap between being covered by your previous fund and being covered by GMF Health.

Cooling off period

If you decide that the health cover you've chosen isn't right for you, you can transfer to a different level of cover at any time. Keep in mind that you may have to serve additional waiting periods if you transfer up to a higher level of cover. Alternatively, if you have taken out your cover within the last 30 days, GMF Health have a 'cooling off period' which means you can cancel your policy and receive a full refund provided that you haven't made a claim.

Where do I find the GMF Health General Terms and Conditions?

General Terms and Conditions are contained in our Fund Rules. To obtain the Fund Rules visit gmfhealth.com.au or contact one of our GMF Health Member Service Consultants on 1300 653 099.

What are my payment obligations?

GMF Health asks that all members pay their premiums in advance. Benefits cannot be claimed for treatment received after the date to which premiums have been paid. If your payment is more than two months overdue, your membership may lapse. Agents for GMF Health are **not** able to accept premiums that are more than two months overdue. If you are having difficulties making payments, talk to us by calling 1300 653 099.

Are there any exclusions on benefits?

There are a few circumstances under which GMF Health will not pay a benefit. These include:

1. Treatment received during a waiting period, or for a pre-existing condition during the first 12 months of membership or transfer to a higher level of cover.
2. If your membership is unfinancial at the time of treatment or service.
3. If you have received treatment that is excluded on your level of cover.
4. Where the provider of the service is not registered by GMF Health.
5. On claims covered by Workers' Compensation, Third Party or other compensation or insurance.
6. A benefit will not be paid until after treatment or service has been received.
7. No benefit will be paid that is greater than the fee charged.
8. A benefit is not be payable unless the claim is lodged within two years of the date of service.
9. Where you have reached your maximum benefit entitlement.
10. Where an item is not payable with another item.
11. When you transfer from another fund to a level of GMF Health cover that provides benefits towards services that were excluded from your previous fund and you have not served the relevant waiting period.
12. GMF Health does not pay a benefit for telephone or Internet consultations.
13. No payment will be paid on Medicare claims where Medicare do not pay a benefit.

Straightforward health insurance

GMF Health Head Office
130 Egan Street,
Kalgoorlie WA 6430

Postal Address
PO Box 513,
Kalgoorlie WA 6433

T 1300 653 099
Monday to Friday
7am to 5pm (WST)

F 1300 653 098

E welcome@gmfhealth.com.au

gmfhealth.com.au

HealthGuard Health Benefits Fund Limited ABN 26 054 321 274, carrying on business as GMF Health and under other business names.

GMF-002 14/10/13