Important Information

Before you join or transfer your health insurance to GMHBA, we recommend you read the following important information.

If you have any questions give us a call on 1300 446 422 or visit a branch.

We remind you to contact us for a benefit estimate before commencing any treatment to confirm the benefit payable and that our premiums may vary for each state/territory. Please retain this member guide with any other GMHBA documents.

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Application for membership with GMHBA

You will be asked to complete a membership application when you join GMHBA or make changes to your membership. For example, when you change your level of cover or add/remove a person covered by your membership. You can make changes to your membership anytime.

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. Like most health funds, GMHBA uses the terms 'fund member', 'spouse/partner' and 'dependant' to define the people covered by a membership. Only the person nominated as the 'fund member' can authorise changes to the membership unless the fund member has previously authorised the spouse/partner to make such changes.

Similarly, correspondence issued by GMHBA will be addressed to the fund member and it is the fund member'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 in force at that time or as they may be amended from time to time.

GMHBA reserves the right to refuse admission to membership of any level of health insurance, except Bronze Hospital cover.

In the event of any member or person named on the members' membership being convicted in a court of law of assault or similar offence against a staff member related to that staff member's performance of their duties, has obtained or attempted to obtain an improper advantage, for themselves or for any other member or is convicted in a court of law of fraud against the fund, the Board may in its discretion, declare the members' membership void.

The status of the members' membership will be assessed with any outstanding claims being honoured and any premiums refunded. Any other rights accrued to the member will be forfeited.

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.

Audits

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 and will be treated in a completely confidential manner.

Benefit limitation periods

During your first 24 months of cover – after the standard hospital waiting periods have been served – Gold Hospital, Silver Hospital Single Parents and Silver Hospital covers are subject to benefit limitations on selected services. This means that the benefits payable on these services are limited to receive the public hospital default benefits only, during the 24 month benefit limitation period. Once the waiting period and benefit limitation period has been served, you will have access to the benefits applicable on your level of cover. Applicable benefit limitation periods can be found in product descriptions under the hospital tab of this member guide.

Claiming

Claims may be made personally at any GMHBA branch, by post, electronically, by fund-approved hospitals or health care providers, or online at **gmhba.com.au**. In order to assess your claim and calculate your benefit, GMHBA needs the following information:

- A completed claim form when remitted by post or via a provider.
- The fully itemised health care account/s and, if you have paid the account/s, the original receipt/s (photocopies/facsimiles of accounts and/or receipts cannot be accepted).

Important Information

Registered members can now also claim for select services online at gmhba.com.au/members:

1. Members need to be registered for web services.
2. Member needs to agree to terms and conditions which include agreeing to keep receipts for two years as they will be audited.
3. Costs for these services must have already been paid.

You will also be required to provide additional documentation with claims for the services/ items including:

- A doctor's letter of recommendation is required to be lodged with claims for the following items/ services: blood glucose monitor, extremity pump, nebuliser pump, appliances, sleep apnoea monitor, pressure garments, GMHBA approved orthopaedic appliances, non-surgical prostheses, oxygen, tens monitor, medical aids, home and domestic nursing aids, respite care, nicotine replacement therapy patches, learn to swim lessons, blood pressure monitors and joint supports.
- An orthodontic treatment plan certificate, completed by the treating orthodontist/dentist is required before orthodontic benefits can commence. You can obtain an orthodontic treatment plan certificate by calling our customer service centre on 1300 446 422 or from any GMHBA branch. 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.
- Weight loss program is only payable when recommended in writing by a doctor for the purpose of preventing or improving a specific health condition/s. The Weight Loss provider must be a member of the Weight Management Council of Australia and agree to abide by the Weight Management Code of Practice, including: Weight Watchers Australia – Jenny Craig Weight Loss Centres Pty Ltd – Fernwood – Simplicity Weight Loss. Benefits are only payable for weight loss program fees and not meals or exercise components. Upon claiming GMHBA members are required to provide the following in support of their claim for weight loss program benefits:
  - A report from the weight loss provider or photocopy of your membership record of fees paid at the time that the milestone is reached.
  - A report from the weight loss provider or photocopy of your membership record of weight loss achieved from commencement on the program. An initial benefit of $100 is payable upon members achieving a 10% loss of their start weight. Another benefit of up to $100 is payable on members achieving their goal weight where achieved within 24 months and up to the total of programs fees not already reimbursed. Where program fees are less than $100 at each of these milestones, GMHBA will pay the total of the program fees only and not $100. A two-month waiting period for commencement of weight loss program applies.
- GMHBA reserves the right to take the following actions against any policy holder or persons where improper, fraudulent or indiscretion occurs whilst making claims against the fund. Actions that may be taken are:
  - Suspension of electronic claiming with the period of time determined by the fund depending on the severity of the incident.
  - Restitution (voluntary or negotiated).
  - Prosecution.
- No extras benefit will be payable unless a medical reason/condition is present
- 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.

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

Unpaid accounts (other than hospital accounts)

Claims for unpaid accounts will be paid by direct credit (where available) or cheque. The benefit cheque will be 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:

- In cash at any GMHBA branch for claims of less than $500, when claimed in person.
- By cheque, made payable to the fund member for larger claims, and mail claims.
- Directly into the members' financial institution account where these arrangements are in place.
- To GMHBA, where the member requests that the benefit refund is, either in part or full, used to pay GMHBA premiums.

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 medical gap cover – see page 26-27 for details) and your claim for hospital benefits has been assessed and paid. GMHBA benefits are not payable for services rendered when the patient is not a hospital inpatient.

Agent's authority

You 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.

Item numbers included under Preventative Dental limit:

Item number	ADA Schedule	Simplified definition
011	Comprehensive oral examination	Evaluation of all teeth, also includes recording medical history
012	Periodic oral examination	Follow up consult, records all changes to patients teeth since previous consult
013	Oral examination – limited	A "problem-focused" consult done immediately prior to required treatment
014	Consultation	A consult to seek advice/discuss treatment regarding a specific condition
015	Consultation – extended (30 minutes or more)	A consult to seek advice/discuss treatment regarding a specific condition which lasts 30 minutes or more
016	Consultation by referral	A consult with a patient referred by a dental or medical practioner for the management/opinion of a specific dental condition
017	Consultation by referral – extended (30 minutes or more)	A consult with a patient referred by a dental or medical practitioner for the management/opinion of a specific dental condition which lasts 30 minutes or more
018	Written report (not elsewhere included)	A written report of the patients care
111	Removal of plaque and/or stain	Removal of plaque/stain from all surfaces of the teeth
113	Recontouring of pre-existing restoration(s)	Reshaping/repolishing of existing fillings
114	Removal of calculus – first visit	Removal of tartar from the surfaces of the teeth
115	Removal of calculus – subsequent visit	Is the follow up consult to remove all tartar from the surfaces of the teeth
121	Topical application of remineralising and/or cariostatic agents, one treatment	An application of an agent to the surfaces of the teeth eg calcium salts, fluoride

Important Information

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 had 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 Ageing 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 with 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.php

Community Rating

GMHBA is a strong supporter of the principles of community rating. As such, GMHBA will not discriminate between members on the basis of their health or any other reason described below.

When making decisions in relation to members, GMHBA will disregard the following:

1. The suffering by the member of a chronic disease, illness or any other medical condition.
2. The gender, race, sexual orientation or religious belief of a person.
3. The age of a member, except in relation to Lifetime Health Cover loadings.
4. Any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that are likely to result in an increased need for extras or hospital treatment.
5. The frequency with which a person needs hospital treatment or general treatment.
6. The amount, or extent, of the benefits to which a member becomes, or has become, entitled during a period.

Compensation or damages

Where you or your dependants have a right to claim damages or compensation from any other person or body, you are required to pursue that entitlement prior to lodging a claim for benefits with GMHBA. A claim should only be lodged with GMHBA if action at law is unsuccessful. A letter of denial is required. This includes WorkCare, TAC, public liability and third party claims.

Connect Rewards Plus

The Connect Rewards Plus program pays reward dollars to members on combined hospital and extras cover according to the level of hospital cover and number of years members have been with GMHBA.

- GMHBA does not recommend or endorse any health or medical program, therapy or appliance in respect of which connect rewards plus benefits are offered or paid. Some programs, treatments or appliances should not be undertaken or used without medical advice.
- In circumstances where family/couples/single parents memberships change to a single membership, the existing membership may retain the connect rewards accrued.
- Connect rewards plus is a membership reward. Connect rewards plus entitlements cannot be transferred from one membership to another.
- When you have a hospital admission which results in out-of-pocket expenses, we'll write to you within 60-90 days of your hospital discharge to ask if you would like to use your connect rewards plus dollars towards the cost of the inpatient medical gap. In the letter, we'll include your current connect rewards plus balance. You must have a connect rewards balance and an out-of-pocket medical

expense of at least $50 at the time of discharge to qualify for benefits. You can only claim connect reward benefits for inpatient medical gap by producing a copy of the letter and completing the form attached to it. These types of claims cannot be processed in branches on the spot without the member having received a letter from GMHBA first.

– Swimming lessons, Orthopaedic shoes, joint supports, Melanoma surveillance photography, nicotine replacement therapy patches and blood pressure monitor claims must be accompanied by a written recommendation by a doctor including a health management plan and approved by GMHBA.

Customer Service Charter

As testament to our commitment to you, we have developed the GMHBA Customer Service Charter which is our written assurance to you that we take our service delivery seriously. The charter details our promises and guarantee to you as well as what happens in the event something goes wrong.

To view GMHBA's Customer Service Charter visit **gmhba.com.au**

Dependants

1. GMHBA membership

Child dependants: are covered up until they turn 21 years of age if they no longer meet the criteria for student dependants.

Child dependants that do not meet the criteria (of a student dependant) will be terminated off the membership from the date they turned 21. They have two months to organise health insurance from this date, however their new membership will commence from the date they turned 21. They won't have to serve waiting periods when transferring to an equivalent or lower level of health insurance.

Student dependants – are covered up until they turn 25 years of age. They have two months to organise health insurance from this date however, their new membership will commence from the date they turned 25. They will not be required to serve waiting periods when transferring to an equivalent or lower level of health insurance.

Student dependants – mid-year school/ apprenticeship and traineeship leavers: who transfer from their parent's GMHBA membership within two months of leaving school or finishing an eligible apprenticeship or traineeship through a registered training group are not required to serve waiting periods when transferring to an equivalent or lower level of cover. A letter from their school or registered training group confirming the date of completion is required.

Student dependants – end of year school/ apprenticeship and traineeship leavers: are covered under their parent's family or single parent membership until the 31st of March the following year. They will not be required to serve waiting periods when transferring to an equivalent or lower level of health insurance.

Group Training is an employment and training arrangement whereby an organisation employs apprentices and trainees under an Apprenticeship/ Traineeship Training Contract and places them with host employers. A registered Group Training Organisation undertakes the employer responsibilities for the quality and continuity of the apprentices' and trainees' employment and training. To qualify as a traineeship and be eligible to attract Commonwealth Government incentives, there must be a registered training contract between the trainee and the employer. Please contact us on 1300 446 422 or visit a branch for more information.

2. Other funds

Student dependants whose parents are fund members of another registered health fund may join GMHBA within two months of ceasing to be a dependant, on a level of cover equal to or less than that held by their parents, without serving waiting periods. An acceptable transfer certificate and claims history must be received.

3. Previously uninsured

Previously uninsured dependants may join GMHBA within two months of leaving school or on completion of a full-time apprenticeship/traineeship, and receive immediate Bronze Hospital cover benefits, except for any pre-existing condition/illness (other than for psychiatric, rehabilitation and palliative care) and maternity cases for which a waiting period of 12 months will apply.

All waiting periods must be served for extras benefits and hospital benefits which are higher than those available from the Bronze Hospital cover.

Child dependant excess

No excess applies for child dependants under 21 on GMHBA's Platinum, Gold and Silver Hospital Single Parents family hospital covers listed in this member guide.

Electronic claiming

When you have GMHBA extras cover you can use your GMHBA 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

Important Information

within seconds. Once your claim is authorised by GMHBA, you simply pay any difference between the full fee for the treatment and the amount claimed by GMHBA.

If there is an unexpected rejection of your claim at point of service, your provider should contact GMHBA on 1300 446 422 to clarify the issue at the time of the service taking place.

Excess

GMHBA's range of hospital covers often feature an excess to let GMHBA members share some of the cost of hospital admissions in return for lower premiums. The excess is calendar year based.

Excess – Hospital only

An excess is deducted from the benefit paid by GMHBA. 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.

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

No excess applies for child dependants under 21 on GMHBA's Platinum, Gold and Silver Hospital Single Parents family hospital covers listed in this member guide.

Exclusions

You cannot claim for the following:

- Benefits are only payable on itemised and original account/s. Account/s which have been altered in any way will not be accepted. Providers are required to re-issue any account/s or endorse any alterations.
- The supply of contraceptives, fertility and IVF drugs and items available through the Pharmaceutical Benefit Scheme (PBS).
- Natural remedies (includes Modifast & Optifast).
- 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.
- Dental procedures carried out and charged direct to the fund member/dependant 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.
- 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.
- Services/treatment for which the member and/or dependant has a right to claim damages or compensation from any other person or body.
- Treatment where the member and/or dependant is eligible for free treatment under any Commonwealth or State Government Act.
- Services/treatment rendered more than two years prior to the date of claiming.
- Services/treatment not covered by your membership and/or is rendered while the membership is in arrears or is suspended.
- Services/treatment rendered by a practitioner not in private practice and/or not recognised by bodies approved by GMHBA.
- Pressure garments purchased for reasons other than treatment of burns, lymphoedema or for postoperative surgery up to 60 days from hospital discharge only.
- GMHBA specified and approved orthopaedic appliances purchased for support purposes only.
- Hiring of equipment (unless otherwise stated).
- Mass immunisation, services rendered in the course of the carrying out of a mass immunisation.
- Services not rendered face to face (eg remotely over the phone).
- Foot orthotics provided by a physiotherapist or chiropractor.
- Additional medical gap benefits where the medical service is rendered by a medical practitioner employed full-time in the public sector.
- Treatment is provided to themselves, a member of the providers family and/or to a providers business partner and their family members or any other people not independent from the practice. Family members include: wife/husband, brother/sister, children, parents, grandparents, grandchildren of the provider/business partners' and their spouse/partner.
- Benefits for lifestyle related services that primarily take the form of sport, recreation or entertainment.
- Fund benefits, payable under a hospital or extras cover shall not 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

– Benefits for services on treatment received overseas.

Extras services purchased over the internet

Benefits will be paid for extras services purchased over the internet from Australian providers (optical and pharmaceutical) where a script is provided. Consistent with current GMHBA rules, benefits for services on treatment received overseas are excluded.

Healthy Start Benefit

GMHBA's Healthy Start Benefit has been introduced to help cover the obstetrician's medical gap (inpatient service only). For Gold Hospital product level 0/1/2, an additional benefit of $500 (up to the actual fee less the standard medical benefit and additional gap medical benefit) is payable where the episode is for the birth of a child. This benefit will be paid per episode and not per child (ie the additional benefit is up to $500 for multiple births as well as single births). When you have a hospital admission which results in an out-of-pocket expense for the birth of a child, we'll send you a payment of up to $500 within 60-90 days of your hospital discharge. For further information on the Healthy Start Benefit we recommend you call us on 1300 446 422.

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 visiting a branch, calling 1300 446 422 or emailing **service@gmhba.com.au**. We respond to all our phone calls immediately, and will follow up all e-mail and telephone messages within 24 hours.

2. **Write to us**
   We will provide an acknowledgement within five 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). We have appointed a panel of highly experienced employees, including Subject Matter Experts, First Line Leaders, a Senior and Executive Manager who meet regularly to discuss any issues received from members. 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 acknowledgement of your correspondence within five working days of the committee's weekly meeting.

   You are welcome to write to the MSRC at PO Box 761, Geelong, Vic 3220.

4. **Contact our Member Satisfaction Manager**
   If you require further clarification about the decision made at the MSRC, please write to the Member Satisfaction Manager at PO Box 761, Geelong, Vic 3220. We will acknowledge your correspondence within five 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. You can contact the Ombudsman on freecall 1800 640 695 or Suite 2, Level 22, 580 George Street, Sydney, NSW 2000.

Insure? Not sure?

If you need more information about private health insurance, please refer to the Private Health Insurance Administration Council (PHIAC) guide "Insure? Not sure?" which can be downloaded from our website gmhba.com.au or **phiac.gov.au/for-consumers/insure-not-sure**.

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.

Important Information

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.

Medicare levy surcharge

The Medicare Levy Surcharge (MLS) is an additional tax which Australians need to pay if they are without private health insurance hospital cover and are earning over $84,000 as a single or $168,000 as a couple/family. If you do not hold an eligible hospital cover (or if you drop your hospital cover) you will have to pay additional tax on top of the standard Medicare Levy that applies to all Australian taxpayers.

On 1 July 2012 the Federal Government increased the MLS for higher income earners to encourage people to maintain their private health insurance, rather than adding to the already long waiting lists for public hospitals. The surchage payable is now based on income tiers. Please refer to the table on page 58 for more details.

For more information at **privatehealth.gov.au** or **ato.gov.au**.

Membership card

When you join GMHBA, you'll 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 participating 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.

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 contact GMHBA on 1300 446 422 or visit a branch to discuss appropriate health insurance arrangements.

Migrants

Migrants who join GMHBA within two months of arriving in Australia shall receive the following concessions:

- No two month waiting period for any level of hospital cover.
- No 12 month waiting period for pre-existing conditions/illnesses will apply to Bronze Hospital cover.

All other waiting and benefit limitation periods for hospital and extras will apply. Proof of residency must be presented to GMHBA. Lifetime health cover regulations also apply to migrants. Contact GMHBA for details.

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**.

Participating providers

A participating provider is a health care provider, with whom GMHBA has entered into an agreement relating to direct billing and/or fees and benefits. These agreements aim to maximise your cover and minimise your out-of-pocket costs.

Details of participating private hospitals can be obtained from any GMHBA branch, by calling 1300 446 422 or from **gmhba.com.au**.

a. Participating private hospitals

1. Members of GMHBA's Platinum and Gold Hospital covers, who are admitted to a participating private hospital and have served all waiting and benefit limitation periods are entitled to cover for accommodation, theatre, delivery suite, intensive and coronary care and other agreed hospital charges – less any excess (if applicable). Members should present their GMHBA membership card when attending a participating private hospital.

   Public hospitals: Platinum Hospital and Gold Hospital cover provides cover for hospital accommodation costs when you are admitted to a single or shared room (subject to bed availability) as a private patient in a recognised public hospital.
2. Coverage for Silver Hospital, Silver Hospital Single Parents, Silver Everyday Package and Silver Young Singles Package includes:

– Co-payments applied for single room accommodations of $100 per day, up to $700 per hospital admission.
– Benefit exclusions and restrictions for a range of services as outlined in the table opposite.

Hospital cover	Benefit exclusions and restrictions
Silver Hospital Single Parents	Dental implants, obstetrics, IVF and related services, gastric banding and all obesity surgeries, haemodialysis (excluded).
Silver Hospital	Dental implants, obstetrics, IVF and related services, joint replacement, gastric banding and all obesity surgeries, haemodialysis, cosmetic surgery, cataract surgery and corneal transplants (excluded).
Silver Everyday Package	Dental implants, joint replacement, cataract surgery and corneal transplants, gastric banding and all obesity surgeries, haemodialysis and cosmetic surgery (excluded).
Silver Young Singles Package	Dental implants, obstetrics, IVF and related services, joint replacement, cataract surgery and corneal transplants, gastric banding and all obesity surgeries, haemodialysis and cosmetic surgery (excluded). Restrictions apply to benefits for psychiatric and rehabilitation services are payable at the basic (default) level of benefits, which means you'll have significant out-of-pocket costs.

These excluded services do not attract any benefits

Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included.

b. Non-participating hospitals
Fixed benefits are payable for hospitalisation in non-participating private hospitals. Please contact GMHBA on 1300 446 422 or visit a branch for further details.

Members of Platinum Hospital, Gold Hospital, Silver Hospital Single Parents, Silver Hospital, Silver Everyday Package and Silver Young Singles Package cover who are to be admitted to a non-participating private hospital should contact GMHBA at least three business days before admission. GMHBA will then contact the hospital and negotiate fee and benefit arrangements on the members' behalf with the aim of minimising out-of-pocket costs.

Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included.

c. Bronze hospital
Members of Bronze Hospital cover, who are admitted to a public hospital and have served all waiting periods are covered for accommodation costs.

Bronze Hospital and Bronze Young Singles Package contains exclusions as follows:

Hospital cover	Benefit exclusions
Bronze Hospital	Gastric banding and all obesity surgeries, haemodialysis.
Bronze Young Single Package	Cataract surgery and corneal transplants, gastric banding and all obesity surgeries, haemodialysis, obstetrics, joint replacement and IVF and related services.

Please note: Benefits for a single room in a public hospital or for treatment in a private hospital when using Bronze hospital cover will result in significant out-of-pocket expenses. For further information on private patient benefits on Bronze Hospital cover, please call on 1300 446 422 or visit a branch.

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.

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 practitioner 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.

The only person authorised to decide that a condition is pre-existing is the medical practitioner appointed by GMHBA. However, the fund medical

Important Information

practitioner must consider any information regarding signs and symptoms provided by your treating medical practitioner/s.

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 table signs and symptoms:

– Were evident to you; or
– Would have been evident to a reasonable general practitioner if a general practitioner had been consulted.

When to contact GMHBA

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

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; and
– We later determine that your condition was pre-existing.

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.

This commitment is documented in our privacy policy and summarised in our privacy brochure. You can pick up a copy of our privacy brochure from any GMHBA branch, by calling our customer service centre on 1300 446 422 or by visiting **gmhba.com.au**

Proof of age

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

– Current passport.
– Current photo driver's licence.
– Original birth certificate.
– Statutory declaration (if you have none of the above).

Recommendation or endorsement

GMHBA is a registered health insurance fund and does not offer health or medical services or advice. GMHBA does not recommend or endorse any medical practitioner, dentist, therapist, hospital, health or medical service provider, treatment, therapy or the use of any appliance or prosthetic. GMHBA does not endorse or make any representation whatsoever as to the appropriateness or effectiveness of any service or goods for which a benefit or reward is paid.

Refunds

You may cancel your GMHBA membership from:

– The date you notify GMHBA, in writing of the cancellation (a transfer 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 get a full refund of any premiums received provided you have not made a claim.

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, all appliances, hearing aids, nebuliser pumps, blood glucose monitors, blood pressure monitors, sleep apnoea monitors, extremity pumps, tens monitor, pressure garments, GMHBA specified orthopaedic appliances and non-surgical prostheses.

Restrictions

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.
– 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 continuous hospitalisation, GMHBA benefits will be reduced to Nursing Home Type Patients benefits 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/s is subject to a waiting period or other limit.
– Surgery is performed in hospital by a registered podiatrist/podiatric surgeon. Contact GMHBA for details.
– When no MBS item number is provided by the GP/specialist eg cosmetic surgery.
– Where professional services are provided to themselves, the provider or members of the provider's family or to a provider's business partner's family members or any other people not independent from the practice, only wholesale material costs involved in the provision of the service are subject to benefits.
– Additional medical gap benefits where the medical service is rendered by a medical practitioner employed full-time in the public sector.

Single room guarantee

We will pay you $50 per day (up to a maximum of $150 for three days) if you stay in a shared room when you requested a single room. This is only available for overnight accommodation in a Private Hospital. Day stays are ineligible for this payment.

Standard Information Statements

A Standard Information Statement (SIS) is available for every product available to new and existing members of the fund. The content of the SIS will be as outlined in the private health insurance (complying product) rules.

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

A newly insured member will be given an up to date copy of the relevant SIS, details about what the policy covers and how benefits are provided and a statement identifying the referable health benefits funds 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 our website **gmhba.com.au** or **phio.org.au**.

Suspension

You can suspend your GMHBA membership for periods of overseas travel provided you:

– Have at least 12 months continuous unsuspended membership with GMHBA prior to departure; and
– Plan to be overseas for at least two months; and
– Have paid premiums to the date of departure; and
– Apply for suspension of your membership prior to departure.

You'll be required to resume your suspended membership within two months of returning to Australia and premiums must be paid from the date of re-entry. Your passport, boarding pass or a statutory declaration may be required to be presented to GMHBA as proof of travel.

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

If you apply to GMHBA to suspend your hospital cover for a short period of time and we agree, this period of suspension does not impact on your LHC loading, you are considered to be maintaining your cover.

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 and benefit limitation periods with your previous fund;

Important Information

– Transfer to any equivalent or lower level of cover providing you transfer 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 seven 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 and will be required to serve the waiting and benefit limitation periods – but only for the higher benefits/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 (see waiting periods page 11 and below under the heading 'waiting periods').

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.

Waiting periods

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 memberships (previously uninsured).
– 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 where the family membership has been in existence for at least two months, and where the addition/s has already served all waiting periods with GMHBA or another fund.
– Existing GMHBA memberships, and transfers to GMHBA from another fund where:
    i The level of cover and/or benefit entitlement is upgraded or increased.
    ii Any hospital or extras service was not covered by the previous fund; and/or
    iii The waiting and benefit limitation periods have not been completed.

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

Where a member is transferring from another product or from another health fund, waiting periods for hospital (or hospital substitute) treatment that was not covered under the old policy are:

– 12 months – Obstetric or pre-existing condition (other than for psychiatric, rehabilitation or palliative care).
– 2 months – Psychiatric, rehabilitation or palliative care.
– 2 months – Any other benefit for hospital (or hospital substitution) treatment.

For hospital (or hospital substitution) where a member is transferring from another product or from another health insurer, waiting periods for extras that were not covered under the old policy are:

– 12 months – Major dental, podiatric surgery, orthotics and health appliances.
– 6 months – Optical benefits, medical aids and nursing benefits.
– 2 months – Any other extras benefit.

The above waiting periods also apply to previously uninsured members.

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 period 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.

Waiting periods – Pre-existing condition (PEC)

A special waiting period applies to obtain benefits for hospital treatment for new members who have pre-existing conditions. The waiting period also applies to existing members who have recently upgraded their level of hospital cover. If the ailment, illness or condition is considered pre-existing:

– New members must wait 12 months for any hospital benefits (other than psychiatric, rehabilitation and palliative care).

– Members transferring/upgrading to a higher hospital cover must wait 12 months to get the higher hospital benefits (other than psychiatric, rehabilitation and palliative care).

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.

Planning a child

If you are preparing to start a family and your hospital cover does not include obstetrics, you will need to ensure you upgrade your hospital cover to include obstetrics 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, you will not be covered for accommodation or medical services unless your child has served the waiting period. So, if you are currently on a singles membership, you will need to change to a family membership at least two months before your baby is born. GMHBA recommends that you change to family membership three months before your baby is due (you can add an unborn child as an additional person) in case your baby arrives prematurely.

Direct Debit Service Agreement

Terms:

1. This agreement relates only to the Direct Debit Scheme and method of premium payments and does not affect the conditions of membership laid down in the regulations in force at this time or as amended from time to time.
2. All communication issued by GMHBA in relation to the Direct Debit Request and Agreement for Payment of Premiums by Direct Debit will be issued to the GMHBA member irrespective of whether it is the members, or another person's/party's financial institution account to which the Direct Debit Request and Agreement for Payment of Premiums by Direct Debit relate.
3. The frequency of direct debit deductions will be as specified in the Direct Debit Request.
4. The GMHBA membership should be paid to the date of the direct debit deduction. If the membership is not paid to this date, the direct debit deduction may include all arrears owing.
5. A cancellation of the Direct Debit Request must be received by GMHBA in writing on the prescribed form at least seven days prior to the stated cancellation date. The request is to be signed and dated by the account holder. Faxed cancellations will be accepted.

   Cancellations notified by telephone will not be accepted. The cancellation of the Direct Debit Request does not constitute cancellation of the GMHBA membership.
6. Alterations to membership or account details must be received in writing, on the prescribed form/s at least 7 days before the next scheduled direct debit deduction date.
7. GMHBA will notify the member in the event of any alteration to the Direct Debit Request Service Agreement, at least 14 days prior to the direct debit deduction date.
8. A refund of premiums cannot be issued within 14 days of the direct debit deduction date. This allows sufficient time for the Financial Institution to advise GMHBA of any direct debit deduction dishonour.
9. Direct debit deductions through 'BECS' is not available on all accounts and it is the responsibility of the member to check the suitability of the account for direct debit deductions.
10. It is the responsibility of the member to ensure that sufficient funds are held in the account to cover the direct debit deduction. If there are not sufficient funds in the account to cover the direct debit deduction any resulting Financial Institution fees are the responsibility of the member.
11. Direct debit deductions will take place on the date/frequency specified in your Direct Debit Request unless those dates fall on a non working day (i.e. weekend or public/bank holiday) in which instance the direct debit deduction will occur on the first working day following the scheduled date. Members must contact the Financial Institution if they are uncertain of the direct debit deduction date.
12. If a direct debit deduction is dishonoured, GMHBA may attempt to make subsequent deductions at any time, including arrears of premium and any financial institution fees incurred on the dishonour.
13. After three consecutive direct debit deduction dishonours GMHBA will remove the membership from the direct debit scheme.
14. Details of the Financial Institution account will be treated confidentially. The account holder agrees that GMHBA may supply to the member, or any Financial Institution with which GMHBA has entered into an agreement to enable participation in the direct debit scheme, or the Financial Institution specified by the account holder on the direct debit request, any information relating to the member's account with GMHBA, or any credit or debit to the member's account with GMHBA, or any credit or debit to GMHBA's account with a Financial Institution.
15. Dispute Resolution Process
    i. It is the responsibility of the member to contact GMHBA in the event of a member claim or complaint.
    ii. GMHBA will promptly investigate the claim and advise the member if the claim is accepted as a valid claim or, if it is disputed by GMHBA, the reasons why it has been disputed (including without limitation details of the authority given to GMHBA by the customer, including a copy of the original record of the Direct Debit Request and Agreement for Payment of Premiums by Direct Debit).
16. GMHBA is unable to accept direct debits on the 29th, 30th and the 31st of any month.
17. If a frequency is not selected GMHBA will default the frequency to monthly debits. If a date is not selected GMHBA will default the date to the next available date for your frequency.