# Silver Everyday Package cover

## *SHEPSAE (Closed to new members)*

**This information is important, please read and retain for future reference.**
Silver Everyday Package cover is the ideal cover for young healthy couples who would prefer to be covered in a private hospital. This option excludes a range of services and treatments that young couples may not need to help reduce the premium.

**What is covered in a participating private hospital?**
For services not listed under 'exclusions', Silver Everyday Package provides cover[1] at participating private hospitals for:

- ✓ Hospital accommodation^ in a shared room.
- ✓ Partial cover in a single room (a co-payment of $100 per day, capped at seven days per admission applies).[2]
- ✓ Medical Gap.
- ✓ Delivery suite.
- ✓ Theatre.
- ✓ Intensive and coronary care.
- ✓ Same day treatment.
- ✓ Surgically implanted prostheses (Government Prosthesis List group benefits).[3]
- ✓ Other agreed charges.

**What is covered in a public hospital?**
For services not listed under 'exclusions', Silver Everyday Package provides cover[1] as a private patient in a public hospital for accommodation in a shared room or partial cover in a single room (co-payments of $100 per day apply for single rooms, capped at seven days per admission).

**Hospital Exclusions**
You are not covered (excluded) for:

- × Joint replacement.
- × Cosmetic surgery.
- × Cataract surgery and corneal transplants.
- × Haemodialysis.
- × Gastric banding and all obesity surgeries.
- × Dental implants.

**Benefit limitation periods**
A 24 month benefit limitation period applies to the following service:

- Psychiatric services

**Excess options**
The Silver Everyday Package is only available with a calendar year excess. This excess reduces your premium and you will not pay the excess unless you are admitted to hospital.

| Admission type | Level 1 Excess |
|---|---|
| Admission excess (private hospital - overnight) | $250 |
| Admission excess (public hospital or day stay) | $125 |
| Maximum annual excess – per person | $250 |
| Maximum annual excess – singles | $250 |
| Maximum annual excess – families | $500 |
| Waived for dependants under 21 | No |

1. Limited benefits may apply to cosmetic surgery and high cost drugs. Drugs purchased outside of the hospital are not included. You may be subject to doctor's waiting lists in a public hospital. Default benefits are paid for all public hospital episodes.
2. Please note: Some Private Hospitals only have single rooms and co-payments will apply.
3. Benefits are no higher than the No Gap Government prescribed benefit.

^ Fixed benefits are payable in non-participating private hospitals. Contact GMHBA for further details.


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Excess - Hospital only - An excess is deducted from the benefit paid by GMHBA Health Insurance. For example, if GMHBA Health Insurance'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.

Where one member of a couple, 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.

**What is medical gap cover?**
GMHBA's medical gap cover is a billing system that provides higher benefits than the scheduled fee which will reduce or even eliminate your out-of-pocket costs for doctor or specialist fees when treated in hospital.

**Silver Everyday Package medical gap**
In the event that your doctor chooses to use GMHBA's medical gap cover and where the actual fee for the anticipated service is greater than the Medicare Benefits Scheme (MBS) fee, an additional medical gap benefit will be paid equal to 20% of the MBS fee for each service. Additional medical gap benefits may not be payable towards the cost of imaging or pathology services.

**Our medical gap cover options**
If your doctor or specialist is one of more than 14,000 who choose to participate in GMHBA's medical gap cover system, two options are available for our hospital products:

*Option 1 – Known Gap*
Your doctor chooses to use GMHBA's medical gap cover system and charges a known patient gap (an amount higher than the scheduled fee). To participate, your doctor must inform you in writing of the cost of the anticipated services, the Medicare and GMHBA benefits and the patient gap before any treatment commences. They must bill us directly for the GMHBA and Medicare benefits. We will arrange to pay these benefits direct to your doctor and all you will need to pay is the known gap.

*Option 2 – No Gap*
If your doctor chooses to use our medical gap cover and not charge a patient gap, your GMHBA benefit and the Medicare benefit will fully cover the doctor's charges. In these instances, your doctor will bill us directly and you will pay nothing.

**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 an ailment 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 2 months.
- Existing GMHBA memberships, and transfers to GMHBA from another fund where the level of cover and/or benefit entitlement is upgraded or increased and/or where the waiting periods have not been completed.

**Pre-existing conditions and waiting periods**
Waiting periods apply to new members who have a pre-existing condition. 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.
- Members transferring/upgrading to a higher hospital cover must wait 12 months to get the higher hospital benefits. 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.

**Benefit limitation periods**
During your first 24 months of cover – after the standard hospital waiting periods have been served you are subject to benefit limitations on selected services. This means that the benefits payable on these services are limited to receiving 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.


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| Extras Service | Waiting Periods | Benefit |
|---|---|---|
| **Ambulance**[1] | N/A | |
| Annual subscription refund | | 100% |
| Transport benefit (per trip) | | $300 |
| Annual limit per person each calendar year | | $500 |
| **Audiology**[2] | 2 months | |
| Initial visit | | $25 |
| Subsequent visit | | $20 |
| Annual limit per person each calendar year | | $400 |
| **Blood glucose monitor**[3] | 12 months | |
| Benefit | | $150 |
| **Chiropractic / Osteopathy**[4] | 2 months | |
| Initial visit | | $25 |
| 2-10 subsequent visits | | $17 |
| Further visits | | $15 |
| Chiropractic x-ray (1 per person) | | $40 |
| Annual limit per person/single membership each calendar year | | $350 |
| Annual limit per family membership each calendar year | | $600 |
| **Dental** | | |
| **Major Dental** (see important note for dental) | 12 months | |
| **Orthodontic –** Benefits example: Fixed appliance treatment – upper and lower jaw treatment by a registered specialist | 12 months | |
| Maximum benefits per calendar year | | 75% up to $320 per year incrs to $570 at 6 years. |
| Maximum benefit per course of treatment | | $1,710 |
| Lifetime benefit limit | | $1,900 |
| **Dentures** (see important note for dental) | 12 months | |
| New full upper and lower dentures per 2 years | | $420 |
| **Combined crown and bridgework** (see important note for dental) | 12 months | |
| Annual limit per person each calendar year | | $450 |
| **Indirect restorations** (see important note for dental) | 12 months | |
| Annual limit per person/single membership each calendar year | | $350 |
| Annual limit per family membership each calendar year | | $700 |
| Implants (see important note for dental) | 12 months | |
| Annual limit per person each calendar year | | $400 |
| **General dental** (For more information see general dental note) | 2 months | |

**Important note: The table opposite must be read along with the footnotes below**

1. **Ambulance** – To be fully covered for Ambulance services, we recommend that you take out an ambulance subscription in your state or territory. You can claim a refund on one ambulance subscription per membership each calendar year. A transport benefit per trip is claimable (see table opposite) however this will not cover the entire cost and therefore will result in significant out of pocket costs. Publicly funded ambulance services and State Government Ambulance transport schemes are excluded.

2. **Audiology –** The annual limit of $400 per person each calendar year includes combined benefits for audiology, speech therapy and eye therapy.

3. **Blood glucose monitor –** Benefits are limited to one monitor per membership every three years. A doctor's letter of recommendation must accompany each claim for benefits.

4. **Chiropractic/Osteopathy –** There is a limit of one chiropractic x-ray per person/single membership each calendar year. Benefits will be paid for one consultation and/or treatment per provider per day.

   The annual limit of $350 per person/single membership and $600 per family membership each calendar year includes combined benefits for chiropractic (including chiropractic, x-rays), osteopathy, naturopathy, homeopathy and acupuncture.

   **Important note for Dental:** The benefits shown are the annual limits for each type of dental service. There are further sub limits within some of these dental services e.g. the individual benefit for one crown on Silver Everyday Package is $225.

   **General Dental –** There are a range of dental procedure that cannot be claimed when provided on the same day e.g. a filling on a tooth that has been removed. There are also limits on the number of dental procedures you can have e.g. periodic examinations are limited to two per calendar year. Dental benefits for some procedures cannot be paid unless tooth identifications (ID) are supplied by the provider.

   The general dental limits for dental examinations and scale and clean procedures are available per person on a calendar year basis

   For services other than dental, benefits for one initial consultation are available each calendar year.

   **Preventative Dental –** Benefits are based on specific item numbers. Please call 1300 446 422 for a benefit estimate before commencing treatment to confirm the benefit payable.



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|---|---|---|
| a) Diagnostic services | 2 months | Set benefits apply |
| b) Preventative services e.g. periodic examination 2 per calendar year, removal of plaque 3 per calendar year. Annual limit per person per calendar year. See preventative dental note. | 2 months | Up to $200 per person |
| c) Simple extractions (not including surgical extractions of wisdom teeth) | 2 months | Set benefits apply |
| d) Restorative services (limited benefits apply to precious restorations) | 2 months | Set benefits apply |
| **Annual limit** (see important note for dental) | | |
| Annual limit per person each calendar year | | $1,000 |
| **Dietetics** | 2 months | |
| Initial visit | | $27 |
| Subsequent visit | | $21 |
| Class attendance | | $10 |
| Annual limit per person each calendar year | | $350 |
| **Extremity pump**[5] | 12 months | |
| Benefit | | $300 |
| **Eye therapy and speech therapy**[6] | 2 months | |
| Initial visit | | $27 |
| Subsequent visit | | $21 |
| Annual limit per person each calendar year | | $400 |
| **Fluoride dietary supplement**[7] | 2 months | |
| Benefit of up to | | 85% |
| Maximum benefit per person each calendar year | | $45 |
| **Hearing aids** | 12 months | |
| Benefit up to | | 80% |
| Maximum benefit per person every 3 years | | $400 |
| **Naturopathy/Homeopathy/Acupuncture**[8] | 2 months | |
| Initial visit | | $19 |
| 2-10 subsequent visits | | $17 |
| Further visits | | $14 |
| Annual limit per person/single membership each calendar year | | $350 |
| Annual limit per family membership each calendar year | | $600 |
| **Nebuliser pump**[9] | 12 months | |
| Benefit | | $150 |
| **Nursing – Visiting/Home/Registered Nurse (Private Practice)**[10] | 2 months | |
| Home (bush) nursing benefit for each visit | | $8 |
| Visiting/Registered nurse (private practice) benefit per hour | | $8 |
| Maximum benefit each day | | $48 |
| Annual limit per person each calendar year | | $1,000 |

5. **Extremity pump –** Benefits are limited to one extremity pump per membership every three years. A doctor's letter of recommendation must accompany each claim for benefits

6. **Eye therapy and speech therapy –** The annual limit of $400 per person each calendar year includes combined benefits for audiology, eye therapy and speech therapy.

7. **Fluoride dietary supplement -** Benefits are only payable towards the cost of dietary fluoride supplements (tablet or liquid form) dispensed by a chemist or dentist in private practice.

8. **Naturopathy/Homeopathy/Acupuncture** –Benefits will be paid for one consultation and/or treatment per provider per day.

   The annual limit of $350 per person/single membership and $600 per family membership each calendar year includes combined benefits for naturopathy, homeopathy, acupuncture, chiropractic and osteopathy.

9. **Nebuliser pump -** Benefits are limited to one nebuliser pump per membership every three years. A doctor's letter of recommendation must accompany each claim for benefits.

10. **Nursing –** Visiting/home/registered nurse (private practice) – The annual limit of $1,000 per person each calendar year includes combined benefits for home (bush) nursing and visiting/registered nurse. Visiting nurse benefits apply towards a registered nurse in private practice on recommendation from a medical practitioner.



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|---|---|---|
| **Occupational therapy**[11] | 2 months | |
| Initial visit | | $31 |
| 2-10 subsequent visits | | $21 |
| Further visits | | $17 |
| Annual limits per person /single membership each calendar year | | $350 |
| Annual limit per family membership each calendar year | | $600 |
| **Optical**[12] | 6 months | |
| Prescription spectacles, contact lenses and frames – benefit of up to | | 80% |
| Annual limit per person each calendar year | | $170 |
| **Orthopaedic appliances**[13] | 12 months | |
| Benefit of up to | | 80% |
| Maximum benefit per item | | $115 |
| Limit per person every 3 years | | $400 |
| **Orthopaedic appliance repairs** | 2 months | |
| Annual limit per person each calendar year | | $40 |
| **Orthotic appliances** (foot)[14] | 12 months | |
| Benefit of up to | | 80% |
| Maximum benefit per item | | $115 |
| Annual limit per person/single members each calendar year | | $400 |
| **Pharmacy – private script**[15] | 2 months | |
| Members pay the first maximum PBS contribution then the following benefit is paid towards the balance | | $40 |
| Annual limit per person/single membership each calendar year | | $250 |
| Annual limit per family membership each calendar year | | $400 |
| **Physiotherapy/Myotherapy/Hydrotherapy**[16] | 2 months | |
| Initial visit | | $31 |
| 2-10 subsequent visits | | $21 |
| Further visits | | $17 |
| Class attendance | | $10 |
| Annual limit per person/single membership each calendar year | | $350 |
| Annual limit per family membership each calendar year | | $600 |
| **Podiatry**[17] | 2 months | |
| Initial visit | | $27 |
| Subsequent visit | | $21 |
| Comprehensive treatment – initial visit | | $35 |
| Comprehensive treatment – subsequent visit | | $25 |
| Video analysis | | $25 |
| Plaster of paris | | $25 |

11. **Occupational therapy -** The annual limit of $350 per person/single membership and $600 per family membership each calendar year includes combined benefits for physiotherapy, myotherapy, occupational therapy and hydrotherapy.

12. **Optical -** Non-prescription sunglasses and repairs are excluded.

13. **Orthopaedic appliances (GMHBA approved) –**Must be custom made or approved by GMHBA. A doctor's letter recommending the appliance must accompany each claim for benefits. Orthopaedic appliances attract benefits where the application of which has resulted from, and is required immediately following the injury or surgery to the injury necessitating the appliance, for purposes other than or additional to support. For an appliance to be custom made, a plaster cast or mould must be taken. 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. There are some conditions therefore we recommend you call 1300 446 422 for a benefit estimate to confirm the benefit payable.

    The limit of $400 per person is available every three years. This limit includes combined benefits for orthopaedic appliances and pressure garments.

14. **Orthotic appliances (foot) –** Orthotic appliances must be custom made. For an orthosis to be custom made, a plaster cast or mould must be taken. 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.

    The annual limit of $400 per person each calendar year includes combined benefits for podiatry visits, orthotic appliances (foot) and podiatric surgical procedures.

15. **Pharmacy** - Private Script Benefits are only payable towards the cost of prescription pharmaceuticals dispensed via a provider in a private practice. Benefits are not payable towards the cost of contraceptives or NHS (PBS) prescriptions, food supplements, natural therapies (including Modifast/Optifast), over the counter items purchased with or without a prescription and pharmaceuticals purchased overseas and not listed on the Australian Register of Therapeutic Goods.

16. **Physiotherapy/Myotherapy/Hydrotherapy** – For physiotherapy and hydrotherapy only class attendance is limited to $240 per person each calendar year and this limit in included with your annual limit. Benefits will be paid for one consultation and/or treatment per provider per day. Physiotherapy consultation must be for a minimum of 15 – 20 minutes to qualify for one-on-one physiotherapy benefits.

    The annual limit of $350 per person/single membership and $600 per family membership each calendar year includes combined benefits for physiotherapy, myotherapy, occupational therapy and hydrotherapy.

17. **Podiatry** – The annual limit of $400 per person each calendar year includes combined benefits for podiatry visits, podiatric surgical procedures and orthotic appliances (foot).



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| | | |
|---|---|---|
| Surgical procedures – benefit of up to | 12 months | 80% |
| Maximum benefit per surgical procedure | | $115 |
| Annual limit per person each calendar year | | $400 |
| **Pressure garments**[18] | 12 months | |
| Benefit of up to | | 80% |
| Maximum benefit per item | | $115 |
| Limit per person every 3 years | | $400 |
| **Prostheses (non-surgical)**[19] | 12 months | |
| Benefit of up to | | 80% |
| Maximum benefit per item | | $300 |
| Maximum benefit per person every 3 years | | $400 |
| **Psychology** | 2 months | |
| Initial visit | | $40 |
| Second visit | | $25 |
| Subsequent visit | | $25 |
| Group therapy initial visit | | $20 |
| Group therapy second visit | | $12.50 |
| Group therapy subsequent visit | | $12.50 |
| Annual limit per person/single membership each calendar year | | $350 |
| Annual limit per family membership each calendar year | | $600 |
| **Sleep apnoea monitor**[20] | 12 months | |
| Benefit | | $200 |
| **Tens monitor**[21] | 12 months | |
| Benefit | | $100 |

18. **Pressure garments** – Are used for the treatment of burns, lymphodaema or for post-operative surgery up to 60 days from hospital discharge. For benefits to be payable garments must be supplied through a private company or therapist in private practice. A doctor's letter recommending the appliance must accompany each claim for benefits. We recommend you contact GMHBA for a benefit estimate to confirm the benefit payable.

    The limit of $400 per person is available every three years. The limit includes combined benefits for orthopaedic appliances (GMHBA approved) and pressure garments.

19. **Prostheses** (non-surgical) – Prostheses includes a range of approved non-surgically implanted prostheses (eg wigs). A doctor's letter of recommendation must accompany each claim for benefits. We recommend you contact GMHBA for a benefit estimate to confirm the benefit payable.

20. **Sleep apnoea monitor –** Benefits are limited to one sleep apnoea monitor per membership every three years. A doctor's letter of recommendation must accompany each claim for benefits.

21. **Tens monitor –** Benefits are limited to one tens monitor per membership every three years. A doctor's letter of recommendation must accompany each claim for benefits.

***Silver Everyday Package cover is only available within a combined hospital and extras package.**

**Important**
All extras services must be provided by practitioners in a private practice who are appropriately registered with recognised bodies approved by GMHBA. We recommend you contact us for a benefit estimate before commencing treatment to confirm the benefit payable. For services other than dental, benefits for one initial consultation per therapy type are available each calendar year.

**Find out more**
If you're planning treatment or a hospital admission, please call us to discuss your options to ensure you're covered and have served all relevant waiting and benefit limitation periods.

For further information please call 1300 446 422, visit your local branch or gmhba.com.au.



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