

## **Important information**

Before you join or transfer your health insurance to GMHBA please read the following important information. If you have any questions about your health insurance please call our trained Customer Service Advisors on 1300 4 GMHBA (46422) or visit a branch. We remind you to contact us for a benefit estimate before commencing any treatment just 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.

## **Application for membership with GMHBA**

You'll 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's 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 may not pay claims or continue to provide health insurance if you provide false or incorrect information on your membership application. Like most health funds, GMHBA uses the terms 'fund member' 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 contribution constitutes an acceptance of any conditions laid down 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 Public Hospital cover.

## **Arrears**

GMHBA fund members are responsible for ensuring their contributions are up to date. Membership will cease when contributions fall into arrears of more than 2 months after the contribution 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.

## **Check your cover**

GMHBA offers a wide range of health insurance options each providing a different level of benefits. We recommend that you contact us to confirm your exact benefit entitlement before you go to hospital or get treatment.

## **Claiming**

Claims may be made personally at any GMHBA branch, by post or by the assignment of your benefit entitlement to a hospital or health care provider. 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, and
- 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.

You'll also be required to provide additional documentation with claims for the services/items listed below.

- 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, medical aids, home and domestic nursing aids, defined accommodation (respite), 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 4 GMHBA (46422) 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.

### **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 contributions.

### **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 pages 11-12 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.

### **Code of conduct**

GMHBA is a fully compliant member of the private health insurance code of conduct. The Australian Health Insurance Association (AHIA) 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 AHIA 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. You can download a copy of the Code at [www.privatehealth.com.au/codeofconduct.php](http://www.privatehealth.com.au/codeofconduct.php)

### **Connect rewards plus**

- GMHBA does not recommend or endorse any health or medical program, therapy or appliance in respect of which connect rewards 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 (with connect rewards accumulated in excess of the single membership limit) changes to a single membership, the existing membership may

retain the connect rewards accrued. However, you'll not accrue any further connect rewards until your accruals return to within the single membership limit of benefit entitlements.

- Connect rewards is a membership reward. Connect rewards 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.

### **Damages or compensation**

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.

### **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 2 months to organise health insurance from this date however, their new membership will commence from the date they turned 21. They will not be required 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 2 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 & traineeship leavers:** who transfer from their parent's GMHBA membership within 2 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 & 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 4 GMHBA (46422) 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 2 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 clearance form and claims history must be received.

#### **3. Previously uninsured**

Previously uninsured dependants may join GMHBA within 2 months of leaving school or on completion of a full-time apprenticeship/traineeship, and receive immediate Public Hospital cover benefits, except for any pre-existing ailment/ illness 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 Public Hospital cover.

### **Child dependant excess**

No excess applies for child dependants under 21 on the GMHBA hospital covers listed in this member guide.

### **Dispute resolution process**

GMHBA operates entirely for its members and our mission is to provide access to quality private health care. We receive many letters of praise about our services and staff. However like any organisation we aren't perfect and on occasions we also receive complaints. If you have an issue you want resolved we encourage you to contact us through the following channels.

#### **Step 1. Talk to a GMHBA representative**

GMHBA staff are well trained in our products and services and are here to listen to you. You can talk to a representative by visiting a branch, calling 1300 4 GMHBA (46422) or emailing [service@gmhba.com.au](mailto:service@gmhba.com.au)

#### **Step 2. Write to the Member Services Review Committee (MSRC)**

GMHBA has appointed a panel of highly experienced employees including team leaders, a senior manager and an executive manager who meet regularly to discuss any issues received from members. The aim of the MSRC is to listen to you and provide a decision that is fair and equitable for all members. You're welcome to write to the MSRC at PO Box 761, GEELONG VIC 3220.

#### **Step 3. Contact our Member Satisfaction Manager**

If you need further clarification about the decision made at the MSRC please write to GMHBA's Member Satisfaction Manager at PO Box 761, GEELONG VIC 3220.

#### **Step 4. Contact the Private Health Insurance Ombudsman**

If you're still unhappy with the outcome of your issue, free independent advice is also available from the Private Health Insurance Ombudsman. You can contact the Ombudsman on Freecall 1800 640 695 or Level 7, 362 Kent Street, SYDNEY NSW 2000.

### **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 through the terminal, your claim details entered and your claim will usually be processed electronically 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 4 GMHBA (46422) 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 contributions. 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. No excess applies for child dependants under 21 on the GMHBA hospital covers listed in this member guide. Excess amounts apply to the overall membership not to each individual covered by the membership.

### **Exclusions**

You cannot claim for the following:

- 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.
- 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 2 years prior to the date of claiming.
- Where more than one consultation and/or treatment type per day has been claimed regardless of provider within the group of chiropractor (excluding x-ray), naturopath, homeopath and osteopath.
- Where more than one consultation and/or treatment type per day has been claimed regardless of provider within the group of physiotherapy, myotherapy and if eligible, remedial massage.
- Services/treatment which is 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.
- Dental treatment not rendered face to face (e.g. 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 provided to 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.

### **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 [www.phiac.gov.au/insurenotsure](http://www.phiac.gov.au/insurenotsure)

### **Liabilities of fund members to GMHBA**

A fund member can be liable to GMHBA for unpaid contributions and for overpayments. Overpayments can be made by GMHBA to a fund member, either through an error in completing a claim, or an error in processing a claim. If an overpayment is made, the fund member is liable to repay the amount of the overpayments to GMHBA on demand.

If a fund member is liable to GMHBA for unpaid contributions 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 is a surcharge on individuals and families on higher incomes who don't have eligible private patient hospital cover (eligible cover). The surcharge is 1% of taxable income in addition to the normal 1.5% Medicare Levy. People may have to pay the Medicare levy surcharge if they or any of their dependants do not have eligible cover and they are:

- A single person - without dependent children - with a taxable income (including any reportable fringe benefits of \$1,000 or more) greater than \$50,000.
- A family - including a couple and single parent - with a combined taxable income (including any reportable fringe benefits of \$1,000 or more) greater than \$100,000 (increasing by \$1,500 per dependent child, after the first child).

Contact your tax adviser or GMHBA for further details about the Medicare levy surcharge.

## 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 4 GMHBA (46422) or visit a branch to discuss appropriate health insurance arrangements.

## Migrants

Migrants who join GMHBA within 2 months of arriving in Australia shall receive the following concessions.

- The 2 month waiting period will not apply to any level of hospital cover.
- The 12 month waiting period for pre-existing ailments/ illnesses will not apply to Public Hospital cover.

All other waiting 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

Benefits for treatment rendered overseas will be paid at the level that would apply if the treatment was rendered in Australia. Before claiming, accounts must be paid in full, itemised and translated into English at the cost of the member.

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 4 GMHBA (46422) or from GMHBA.com.au

### a) Participating private hospitals

#### 1. Great Value Gold Hospital covers

Members of GMHBA's Great Value Gold Hospital covers, who are admitted to a participating private hospital and have served all waiting 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: Great Value Gold Hospital cover provides cover for hospital accommodation costs when you are admitted to a private or shared room (subject to bed availability) as a private patient in a recognised public hospital.

#### 2. Young Couples Hospital cover, Single Parents Hospital cover and Better Singles Saver Hospital cover.

These covers have benefit exclusions and restrictions for a range of services:

| Hospital Cover               | Benefit exclusions and restrictions  |
|------------------------------|--|
| Single Parents Hospital (MN) | Obstetrics, IVF and related services (excluded).   |
| Young Couples Hospital (MC)  | Obstetrics, IVF and related services, joint replacement, cosmetic surgery and cataract surgery (excluded). |

|   |  |
|---|--|
| Better Singles Saver Hospital (EE, EEZ) | Obstetrics, IVF and related services, joint replacement, cataract surgery 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 4 GMHBA (46422) or visit a branch for further details.

Members of Great Value Gold Hospital, Young Couples Hospital, Single Parents Hospital and Better Singles Saver Hospital cover who are to be admitted to a non-participating private hospital should contact GMHBA at least 3 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.

**Please Note:** Benefits for a private room in a public hospital or for treatment in a private hospital when using public hospital cover will result in significant out-of-pocket expenses. For further information on private patient benefits on Public Hospital cover, please call us on 1300 4 GMHBA (46422) or visit a branch.

**Participating dentists** - dental plus scheme GMHBA has arranged agreements with many dentists throughout Victoria. These agreements relate to fees and benefits for a number of different preventative and diagnostic dental services. To maximise your cover, dental plus members receive benefits of 70% - 100% of the GMHBA schedule fee for these services, depending on the level of extras cover selected.

GMHBA members also receive substantial benefits for all other services. However these are paid at a fixed amount per service, rather than as a percentage of the GMHBA schedule fee. You can claim benefits from GMHBA at participating dentists using their electronic claiming systems (if available). Simply show your GMHBA membership card to the dentist for processing and then pay the balance (if any) of the claim. Remember, your membership must be paid up to at least the date of service when electronically claiming.

If your dentist does not participate in the Dental Plus scheme, you'll still be able to use electronic claiming systems if available however, the dental services benefits will be paid at a fixed amount per service. Participation by a dentist in the Dental Plus Scheme is not a recommendation or endorsement by GMHBA of the dentist.

**Payment in advance**

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

**Pre-existing ailments (PEA)**

A pre-existing ailment 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 an ailment is pre-existing is the medical practitioner appointed by GMHBA. However, the fund medical practitioner must consider any information regarding signs and symptoms provided by your treating medical practitioner(s). The pre-existing ailment 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 6 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 find out whether the pre-existing ailment waiting period applies to you. We need about 5 working days to make the pre-existing ailment 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 ailment 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 4 GMHBA (46422) or by visiting [GMHBA.com.au](http://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 or
- Current photo driver's licence or
- Original birth certificate or
- 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, or
- your current contribution due date, whichever is the earlier.

### **Replacement rule**

A benefit replacement rule applies to a number of items/services covered by GMHBA's Great Value 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.
- after 35 days of continuous hospitalisation a certificate as specified in Section 3B of the Health Insurance Act is not received. Where such a certificate is not received benefits will be reduced to the nursing home type patient benefits and will be paid in accordance with Health Department direction.
- 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 CMBS item number is provided by the GP/specialist e.g. cosmetic surgery.
- where professional services are provided to 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.

### **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](http://GMHBA.com.au) or [www.phio.org.au](http://www.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 2 months, and,
- have paid contributions 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 2 months of returning to Australia and contributions must be paid from the date of re-entry. Your passport, boarding pass or a statutory declaration must be presented to GMHBA as proof of travel. A 3 year maximum cover suspension period for overseas travel applies. Only the balance of outstanding waiting periods need to be served upon resumption of your membership.

### **Transferring from another health fund**

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

- have served all waiting periods with your previous fund and,
- transfer to any equivalent or lower level of cover providing you transfer within 30 days of your membership ceasing with your previous fund and,
- provide GMHBA with an acceptable clearance form and claims history issued by your previous fund.

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 periods - but only for the higher benefits/additional services.

If you transfer to GMHBA from another fund before completing the waiting periods with your previous fund, you'll need to serve the balance of the waiting periods with GMHBA (see waiting periods page 50 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 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, 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 the level of cover and/or benefit entitlement is upgraded or increased and/or where the waiting periods have not been completed.

For new memberships (no previous extras cover) or where 12 months continuous dental cover has not been in existence, all dental benefits will be limited to \$200 per person/single membership and \$400 per family membership during the first 12 months of membership with GMHBA.

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

### **Waiting periods – Pre-existing ailment (PEA)**

A special waiting period applies to new members of hospital tables who have pre-existing ailments. 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.

### **Direct Debit Request 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 persons/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 7 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.