Important Information Guide

GMHBA Health Insurance

Effective 24 November 2025

GMHBA

Contents

The information within this guide should be read carefully and retained in conjunction with GMHBA's Fund Rules and your specific product information. GMHBA's Fund Rules can be found online at: gmhba.com.au/fund-rules

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

About your membership

Who can be covered under your GMHBA policy?

The policyholder

The policyholder is the person who holds the policy (we also call them the 'main member' or 'contributor').

The policyholder is:

- Responsible for the payment of premiums
- Nominates who's covered by the policy
- Able to log in to the member area or mobile app to view and manage the membership, as per the GMHBA Privacy Policy
- Advises GMHBA of any changes to membership details
- Entitled to access and provide authority for others (client, spouse or power of attorney) to access all records, claims history and tax statements relating to the membership.

Singles cover

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

Couples cover

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

- The policyholder and their partner.

A 'couple', for the purposes of couples cover, includes anyone who's married, in a registered relationship, or in a recognised de facto relationship. There's no minimum time duration for the relationship to be considered a 'couple'.

Family cover

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

- The policyholder, their partner and one or more dependants.

Single parent cover

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

- The policyholder and one or more dependants.

Dependants (including child and student dependants)

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

Child dependants will be removed from the membership on their 21st birthday, unless they qualify as a student dependant.

Student dependant criteria

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

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

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

- Their new cover starts* within 30 days of coming off the family cover (*Backdating of the policy may be required if cover is taken out between 31 and 60 days after a dependant is removed from the family cover); and
- Chosen level of cover is equal to or lower than the family cover.

Note: to claim benefits, their cover must be active *on or before* the day of treatment.

Student dependants – other fund members

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

An official clearance certificate and claims history must be provided to GMHBA by the former dependant's previous health fund.

Age-based discount

The age-based discount is designed to get more young people into private health insurance. It's a government-backed 2% reduction on premiums for each year that a person is aged under 30 when they purchase eligible hospital cover. The highest age-based discount that can be applied is 10% for 18 to 25 year olds.

The discount is available on all GMHBA hospital covers to new and existing members.

If you're eligible, it's applied to your premium until you turn 41 (as long as you keep your hospital cover). The discount is then gradually phased out after you turn 41, declining by 2% each year until there is zero discount remaining.

Please note: age-based discounts only apply to hospital cover premiums.

Managing your membership

Changing your details

Changing your details with GMHBA is easy. The policyholder can change their details at any time in their member area (when accessing via our website), by calling us, or visiting a branch.

A partner, client or power of attorney with authority can also change the membership details by contacting us.

Your member card

When you join GMHBA, you and your partner (if on a couples or family cover) will each be given a physical member card. This shows your member number, and outlines the people covered on the policy. GMHBA's contact details are listed on the back. It's a good idea to have your member card on hand when you arrange admission to hospital as a private patient, visit a service provider, or when you contact GMHBA with any questions.

Member cards can be requested for any dependant/s via the app, member area or by contacting us.

A new card may be issued when you make changes to your membership. Please note that an existing card becomes invalid whenever a new member card is issued. Keep your card safe, and please let us know if your card is lost or stolen.

In addition to a physical member card, which is sent soon after joining, the policyholder can also access a digital member card in the GMHBA app.

Member area

You can view and manage your membership in the GMHBA member area at a time that suits you. Use your secure member area to:

- View your cover details
- Submit a claim
- Check your extras limits (if applicable)
- Make a payment
- And more!

To log in, you'll need to use the email and mobile number that GMHBA has on file for your membership (if you don't have a valid email or mobile number, you'll need to contact us so we can validate your identity). When registering for the first time, you'll also need your member number which is listed in your welcome email and on your member card.

The member area can be accessed via gmhba.com.au or the GMHBA mobile app. Please note that some services are only available in the member area when accessing via our website.

Remember, only the policyholder has login access for the member area and app.

The GMHBA app

Access your membership, digital card (policyholder only) and make a claim while on the go with the GMHBA app. Log in or register using the same details as your member area.

Product fact sheets

If you have private health insurance, it's important to understand what's covered – and what's not – and any waiting periods that may apply. This and other important information is provided in the fact sheet for each individual policy.

Your fact sheet is included in your welcome email when you join GMHBA. You can view this in your member area or the GMHBA app at any time or request a copy if needed. We recommend referring to this information for specific details regarding your hospital and/or extras cover.

Changing your cover

A policyholder or partner with authority can change their level of cover at any time by contacting us, or by visiting a branch. The policyholder can also do this in the member area (when accessing via our website).

Please note that if you change your level of cover, waiting periods will apply for services not previously covered, for reduced hospital excess amounts, and for higher benefits available on an upgraded cover.

Planning for a child

Preparing to start or expand your family? If you want the option of choosing your obstetrician and giving birth as a private patient in a private hospital, you'll need to have pregnancy and birth included as a clinical category on your hospital cover. Note that any outpatient appointments (regular obstetrician appointments, blood tests etc.) are not covered by private health insurance.

If you upgrade your hospital cover to include pregnancy and birth, you'll need to do this at least 12 months before you plan to give birth. This is to make sure that all waiting periods have been served before you claim for pregnancy and birth-related hospital admissions. If a baby is born early, waiting periods are assessed from the baby's estimated due date.

In a standard delivery, your newborn baby will not be admitted as a patient in hospital. Any medical expenses for a newborn not admitted to hospital will be deemed outpatient services and are claimable through Medicare only. If you have complications and your newborn baby is admitted to hospital and requires any separate accommodation or medical attention, they will be covered for accommodation or medical services, provided:

Managing your membership (continued)

- waiting periods have been served by the parent, and
- the baby is added to the policy within 6 months of their date of birth, and
- change to family status (from couple to family, for example) is backdated to their date of birth.

When a newborn is added to a policy, a single policy automatically becomes a single parent policy, and a couples policy becomes a family policy.

Note: cover changes, including a change to family status, may result in a change to your premiums.

Suspending your cover

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

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

To arrange the suspension of your membership, please contact GMHBA before your departure. Memberships will be automatically reactivated based on the reactivation date provided by the policyholder or partner with authority who requested the suspension. If your reactivation date changes while overseas, it's up to you to inform GMHBA.

And don't worry. Fund-approved overseas travel will not impact the amount you pay for your Lifetime Health Cover (LHC) loading, since you're still considered to be maintaining your fund membership.

However, paid hospital days do not accrue on suspended memberships, and your LHC loading end date (when loading is removed following 10 continuous years of cover) will be extended for the length of the suspension period.

A three-year maximum cover suspension period applies per instance for overseas travel.

Only the balance of outstanding waiting periods need to be served upon resumption of your membership.

Please see GMHBA's Fund Rules for additional information.

Cancelling your cover

You may cancel your GMHBA membership:

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

Waiting periods

A waiting period is the time between when you first take out health insurance or upgrade your cover and when you are actually covered for a treatment or service. Waiting periods exist to deter people from joining the fund or increasing their level of cover only when they have a condition or illness that may require immediate treatment. Doing this places pressure on premiums for all members of the fund.

Waiting periods will apply to:

- New members to health insurance (members who have never held hospital or extras cover with a health fund). If you receive a service or treatment during a waiting period, you are not eligible to receive a benefit payable from us, regardless of when you submitted the claim.
- Existing GMHBA members who upgrade to a higher level of cover or reduce their excess payable. Note: waiting periods will apply only for those services not previously covered, and for higher benefits available or reduced excess on the upgraded cover. Provided waits have previously been served, you'll still receive benefits applicable to your existing level of cover during the new waiting period.
- Former child or student dependants who take out their own cover 61 or more days after coming off the family cover or whose chosen level of cover is higher than the family cover.
- Members who transfer from another health fund who have not fully served the required waiting periods for equivalent or higher benefits (see Transferring from another health fund).
- Additional members added onto a policy (unless they've already served their relevant waiting periods). Exceptions apply for newborns, adopted and permanent foster children (where the family membership has been in existence for at least two months).

Refer to hospital waiting periods (page 15) and extras waiting periods (page 32) for further information relevant to each cover type.

Transferring from another health fund

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

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

GMHBA recommends that your cover starts immediately after your previous cover ends.

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

If you are transferring hospital cover to GMHBA from another fund and have already fully paid the policy excess in the current calendar year, this will not need to be paid again with GMHBA for any subsequent admissions in the current calendar year.

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

Under Lifetime Health Cover (see page 19), continuity of a member's/partner's Certified Age at Entry (CAE) is possible when transferring from another Australian registered health fund.

How to claim and information on claiming

Before you can claim

Before you can claim you must serve the relevant waiting periods detailed on your product's fact sheet or on pages 15 and 32.

We recommend you call GMHBA or visit a branch for a benefit estimate before commencing treatment, to confirm what's payable under your policy.

Claiming

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

Electronic claiming

When you have GMHBA extras cover you can use your member card to claim electronically on the spot when this facility is available at your healthcare provider. After the service has been provided and claim details entered, tap or swipe your member card at the terminal and your claim will usually be processed electronically within seconds. You just pay any difference to the provider.

Online or via the GMHBA mobile app

The policyholder can also submit claims for most extras services via the GMHBA app and member area.

Please note that, in order to use online claiming:

- The policyholder needs to be registered for online services.
- The policyholder needs to agree to terms and conditions, which include keeping receipts for two years, as they may be audited.
- The services must have been provided no more than two years ago.

Claim by post

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

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

- A completed claim form when submitting your claim by post; and
- The fully itemised account. If you've already paid the account, we need the original itemised receipt.

Visit a branch

You can also make claims at your local GMHBA branch. Search gmhba.com.au/find-a-branch to find a location near you.

Unpaid accounts (other than hospital accounts)

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

Paid accounts

Benefits for paid accounts will be paid:

- Directly into the policyholder's claims refund account, where these arrangements are in place; or
- By cheque, made payable to the policyholder when direct credit account details have not been provided.

This is in accordance with arrangements determined by the fund, which may change from time to time. If you have any questions about payment, it's always best to give us a call.

Claim limitations

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

- You have already claimed the maximum allowable benefits during a specified period.
- You have transferred to GMHBA from another fund and have previously claimed benefits and reached the annual limit for the service/treatment (until the benefits reset each year, unless otherwise specified).
- Services or treatment are rendered more than two years prior to the date of claiming.
- The health care account has been incompletely, incorrectly or inappropriately itemised.
- You have an excess to pay on your chosen level of hospital cover.
- The fund believes that a patient, following a review of the case (on the basis of information provided by the hospital either internally or using an agreed independent source), is not receiving acute care after 35 days of continuous hospitalisation, GMHBA benefits will be reduced to Nursing Home Type Patients and will be paid in accordance with the default benefit determined by the Health Department. All Nursing Home Type Patients are required to pay part of the cost of hospital accommodation.
- The service is subject to a waiting period or other limit.
- You cannot claim benefits for a service that has not yet taken place.
- No MBS item number is provided by the doctor/specialist.
- The MBS item number is being performed for a cosmetic reason and not medical (refer to page 22 for a cosmetic surgery definition).

How to claim and information on claiming (continued)

- More than one consultation and/or treatment type per day has been claimed and performed by the same provider within a group of chiropractors (excluding X-Ray), acupuncturists, osteopaths, physiotherapists, myotherapists and if eligible, remedial massage therapists.
- The medical service is provided by a medical practitioner employed full-time in the public sector.

Benefits available

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

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

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

Claims from recognised providers

Benefits are not payable where:

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

Australian Government Rebate on private health insurance

The Australian Government Rebate on private health insurance is an income-tested rebate to help people meet the cost of their premiums. The idea is to encourage more Australians to take out private health insurance, and reduce demand on the public system.

This rebate is available to anyone who is eligible for Medicare and holds a complying health insurance product (CHIP)* for hospital and/or extras cover.

This is a tiered system, and the rebate amount you may be eligible to receive is determined by income threshold, as well as the age of the oldest person on the policy. The private health insurance rebate rates are based on the Rebate Adjustment Factor and are generally updated on 1 April each year. Income thresholds are subject to change on 1 July each year.

An outline of the current income thresholds and rebate rates, as set by the Australian Government, can be found at gmhba.com.au/phi-rebate or on the Australian Taxation Office (ATO) website at: ato.gov.au

You can claim the Australian Government Rebate on private health insurance as either:

- A premium reduction through GMHBA, or
- A lump sum payment when lodging your annual tax return.

*All GMHBA hospital and extras covers are classed as complying health insurance products.

Hospital cover

Hospital rules

Hospital cover

We recommend referring to your product fact sheet (see page 6) for specific details regarding your hospital cover, and contacting us prior to any hospital admission.

Clinical categories

All Australian health funds are required by the government to use standard clinical categories and definitions across all medical services, including references to inclusions and exclusions. The full list of these categories and definitions is available on pages 24-28.

Hospital benefits

If you are admitted to hospital as a private patient, for a service that is included on your cover, hospital benefits will help to cover the cost of your accommodation, operating theatre fees, and surgically implanted medical devices or human tissue products, up to the approved benefits on the Australian Government's Prescribed List of Medical Devices and Human Tissue Products.

Medical benefits

These contribute toward the cost of receiving inpatient medical treatment and services, such as doctor or surgeon's fees, anaesthetic, imaging and pathology services.

Claims for medical benefits can only be paid after your claim for medical services has been assessed by Medicare (except in the case of claims made through GMHBA's Access Gap Cover scheme, see page 16) and your claim for hospital benefits has been assessed. Benefits are only payable for treatment rendered while the patient is admitted to hospital (inpatient medical claims) for services included on their hospital cover and provided:

- The patient's cover is active on or before the day of treatment; and
- All waiting periods have been served.

Participating private hospitals

GMHBA has agreements with over 500 private hospitals across Australia. You can find a list of our participating private hospitals and search for a provider on our website, or contact us to make sure that we have an agreement with your preferred hospital. Please note that public hospitals are not included on our participating private hospital list, as benefits are paid towards all public hospitals (provided you are admitted as a private inpatient – see Public hospitals).

Non-participating private hospitals

If you're admitted to a private hospital that is not on our participating hospital list, please be aware that you may not be covered in full for your accommodation or theatre costs for these admissions. It's always a good idea to contact us prior to your admission for further information on what types of benefits you will receive, and information on potential out-of-pocket costs.

Public hospitals

If you choose to be admitted to a public hospital as a private patient, you are entitled to the minimum hospital accommodation benefits payable by private health insurers for a shared room in a public hospital (*except in NSW public hospitals).

*For NSW public hospitals, GMHBA will pay hospital accommodation benefits for a single room where a member has:

- Signed the Inpatient Election form to be treated as a private patient; and
- Ticked 'yes' to a single room if one is available on the Inpatient Election form.

Be aware, though, electing to be a private patient in a public hospital could result in significant out-of-pocket costs. Make sure you get written informed financial consent for any hospital admission.

Excess

GMHBA's current range of open hospital covers feature an excess to let members share some of the cost of hospital admissions in return for lower premiums. Think of it like a gap payment. The excess is only payable in the event of a hospital admission and has an annual cap, meaning that it is only payable once per person (if applicable) per calendar year.

An excess is deducted from the hospital benefit paid by us. For example, if GMHBA's full benefit for a hospital stay was $5,000 and you had a $500 excess on your hospital cover, the benefit would shrink by the amount of the excess, and an adjusted benefit of $4,500 would be paid to the hospital. You, as the member, would pay your $500 excess to the hospital directly, usually on the day of admission or prior.

When one member on a couples, family or single parent excess cover is admitted to hospital they will only pay the maximum amount per person, as opposed to the maximum amount per membership. And they only have to pay this once per calendar year, even if admitted to hospital multiple times.

Hospital rules (continued)

Child dependant excess

Some of our covers have no excess for child dependants under 21. Please see your product fact sheet for more information.

Insulin pumps

Unfortunately, GMHBA does not pay a benefit for replacement of insulin pumps still under manufacturer's warranty or for pumps supplied in telehealth settings.

Single Room Guarantee

If your cover includes the Single Room Guarantee (available on select covers only) and you request a single room in a private hospital, but this is not available, GMHBA will pay you $100 per night, up to a maximum of $300 for three nights. Please contact us following your admission to claim the Single Room Guarantee payment.

The following conditions apply to the Single Room Guarantee:

- You will need to request a single room from the hospital prior to your admission;
- Your admission must be covered under your policy for the treatment you received during your stay;
- Does not apply for same-day admissions or admissions for sleep studies, or where your doctor specifically requests a shared room for clinical reasons.

Hospital waiting periods

Refer to page 8 for waiting periods definitions and details, and the following information about waiting periods specific to hospital covers.

Hospital services (when included on cover)	Waiting period
Accidents – An unforeseen event occurring by chance and caused by an external force or object, which results in involuntary injury to the body. Treatment must be sought through a doctor or an emergency department within 48 hours of sustaining the injury. Accident must occur after joining.	No waiting period
Pregnancy and birth-related admissions	12 months
Pre-existing ailment, illness or condition (other than psychiatric, rehabilitation and palliative care)	12 months
Psychiatric, rehabilitation or palliative care	2 months
Any other benefit for hospital (or hospital substitution) treatment	2 months
Ambulance benefits	0 days

Mental Health Waiver

The Mental Health Waiver allows members who have served their 2 month waiting period for restricted psychiatric benefits to upgrade their hospital cover to include inpatient psychiatric treatment without serving an additional 2 month waiting period.

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

The waiver applies only to the 2 month waiting period for in-hospital psychiatric treatment. Waiting periods for any other newly included services will still need to be served.

Cosmetic surgery

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

Pre-existing conditions (PEC)

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

GMHBA will ask that you provide information from both your GP and treating specialist in order for an external medical adviser to determine whether your condition is deemed pre-existing or not.

The process can take some time and it's best to get this done as soon as possible to confirm whether GMHBA can cover your procedure.

Be aware, the pre-existing condition rule still applies even if your ailment, illness or condition was not diagnosed prior to joining the hospital cover. If your condition is found to have been pre-existing, you will not be covered for the admission, and must wait until after the waiting periods have been served for benefits to be payable.

The only test is whether or not, in the six months prior to joining your current hospital cover signs and symptoms:

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

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.

Going to hospital and using your cover

Informed Financial Consent

You should always get a written estimate of fees from your medical provider/s and have them provide you with Informed Financial Consent (IFC) before being admitted to hospital. This will detail any out-of-pocket costs you might be facing. It's also a good idea to get an estimate of fees from the hospital where your procedure will be conducted. If you have any questions during this time, just call GMHBA and we'll guide you through the process.

Understanding fees

What is a medical gap?

The Australian Government has set a schedule of fees, called the Medicare Benefits Schedule (MBS). The MBS covers all services that can be provided by doctors and specialists. When you're admitted to hospital as an inpatient, Medicare will pay 75% of the MBS fee for your medical treatment – GMHBA pays the other 25%.

In Australia, doctors and specialists are allowed to set their own fees. This means, in some cases, they'll charge more than the MBS can cover. This higher fee is generally referred to as a "medical gap" fee or "out-of-pocket" cost. As a patient, you must pay any out-of-pocket costs towards your treatment.

Access Gap Cover

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

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

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

a) No Gap – this is where there will be no gap for you to pay following the procedure. It's all covered by Medicare and GMHBA.

b) Known Gap – this is where you will be charged a maximum gap of $500 per specialist, per admission to hospital, and $800 for obstetrics services.

It's up to your doctor whether they want to participate in Access Gap Cover, and they can do that on a patient-by-patient basis. If they do participate, they'll need to provide you with a written estimate of fees for your treatment. If you choose a doctor that does not participate in the Access Gap Cover scheme, you'll still be covered for the MBS fee, but you will need to pay any gap.

Remember, there may still be out-of-pocket costs, even if your doctor uses Access Gap Cover. These vary from service to service, but they are capped for peace of mind.

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

Please contact GMHBA prior to treatment to check your eligibility.

Regional travel and accommodation

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

Travel conditions – member

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

Travel conditions – support person

- Benefits are also available for 1 support person to accompany the patient.
- The support person must travel together with the patient to be eligible to claim benefits.
- All benefits relating to travel and accommodation claims will be paid against the patient's membership.
- There is no benefit available for a support person travelling to the member. Only from the member's place of residence to the service provider.

Accommodation conditions

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

Relevant state-based schemes

- Australian states and territories sometimes offer their own assistance for regional travel and accommodation. Please contact the Department of Health in your state or territory for further information.
- If you're entitled to receive a state or territory benefit on your travel and accommodation expenses, you cannot also claim your out-of-pocket expenses with GMHBA. Once you are no longer eligible to claim with your state or territory, eligible claims can be processed by GMHBA.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is an additional tax imposed on people who do not hold eligible private health insurance hospital cover, and who have a taxable income above the threshold set by the Australian Government for singles and families. In other words, if you earn over a certain amount, and have no hospital cover, you may have to pay extra at tax time.

If you or your family do not have an appropriate level of hospital cover for the full financial year, or you choose not to maintain your cover, and your annual taxable income places you in Tier 1, Tier 2 or Tier 3, you may have to pay the Medicare Levy Surcharge. The amount you may have to pay is based on your income tier which is subject to change on 1 July each year.

An outline of the current income thresholds and MLS rates can be found at: gmhba.com.au/medicare-levy-surcharge

For more information, as well as any relevant exemptions, visit:

www.privatehealth.gov.au/health_insurance/surcharges_incentives/medicare_levy.htm

Lifetime Health Cover

The Lifetime Health Cover (LHC) loading is an Australian Government loading (i.e. an extra cost) on your private health insurance hospital cover premiums. It was introduced on 1 July 2000 to encourage people to take out private health insurance hospital cover earlier in life.

How does LHC work?

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

From the date LHC was introduced, anyone who joins a hospital cover of a registered health fund will be given a Certified Age at Entry (CAE) status.

This CAE represents the age you were when you first joined a hospital cover. If you joined a hospital cover before 1 July 2000 and were over the age of 30, you would have been assigned a CAE of 30 meaning you'd pay the base rate (the lowest premium) for your hospital cover. Since 1 July 2000, if you join and you're over 31, you're assigned a CAE based on the age you were on the previous 1 July. If you join with a CAE of over 30, you will pay a 2% loading for each year your CAE is above 30 to a maximum loading of 70% at age 65.

In other words, the younger you are when you take out hospital cover, the cheaper it will be. Ideally, cover should be taken out before turning 31, to avoid the LHC loading altogether.

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

Note that members can have a cumulative total of 1094 days without hospital cover (known as 'allowable absence days') before this impacts their loading percentage. Keep in mind that allowable absence days do not count as paid hospital days and will not be counted towards your 10 continuous years of cover.

How much extra will I have to pay?

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

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

For example: If you take out hospital cover for the first time when you are 35, you would need to pay a 10% loading (that's 2% a year times 5 years). After you've paid the LHC for 10 continuous years, this loading would be removed from your cover.

Note that the Australian Government Rebate on private health insurance does not apply to any LHC loading on your premium.

How is LHC applied for couples and families?

For couple and family policies, the LHC loading is applied as an average of the LHC loading applicable for each adult on the policy. Keep in mind that child and student dependants aged over 18 are not classed as adults for LHC purposes. Here are some examples:

- If one adult on a couple policy has a loading of 16% and the other adult has a loading of 12%, the LHC loading applied to the policy would be 14%.
- If one adult on a family policy has a loading of 6% and the other adult does not have any applicable LHC loading, the LHC loading applied to the entire policy would be 3%.

Age-based discount

As part of the Australian Government private health insurance reforms, health funds were given the option to offer discounts to members aged 18-29 years holding hospital cover.

The age-based discount is available to eligible members on all GMHBA hospital products.

How does the discount work?

These discounts are tiered based on age and set by the Government. They range from 2% to 10% of your private health insurance hospital premium.

If you're eligible for an age-based discount, we'll apply it until you turn 41 (providing you retain your hospital cover). After you turn 41, the discount is gradually phased out and will decline by 2% of your private health insurance hospital premium each year until the discount no longer remains.

Age-based discounts are optional for health insurers to implement, meaning not all health funds offer them. GMHBA is proud to offer our members age-based discounts on all our hospital covers.

If you'd like more information about how it works, please visit gmhba.com.au/age-based-discount or contact us.

Discount % that health insurers can offer:

Members under 30 years old may be eligible to receive a discount on hospital cover based on the table below. The level of discount you're eligible for is based on your age when you first take out hospital cover.

Where there are one or two adults eligible for an age-based discount on a couple or family policy, the discount is applied as an average of the two.

Age	% discount that a health insurer can offer
18-25 years old	10%
26 years old	8%
27 years old	6%
28 years old	4%
29 years old	2%
30+ years old	0%

Ambulance

Emergency ambulance

All GMHBA hospital covers (and some eligible extras policies) cover emergency ambulance services by recognised providers Australia-wide.

Just note that this doesn't include cover for non-emergency ambulance transport (i.e. from a hospital to your home, or ambulance transfers between hospitals) or call-out fees. Publicly funded ambulance services and State Government transport schemes are also excluded.

Ambulance claims

Ambulance cover is important, as you never know when an emergency may happen.

In Australia, ambulance trips are not covered by Medicare, and how you're covered for ambulance services varies from state to state.

To avoid unexpected out-of-pocket costs, it's a good idea to read below and check your state's coverage details.

Victoria

Victorian residents are recommended to purchase an Ambulance Victoria subscription to be covered for all ambulance services, not just emergencies.

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

Tasmania

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

New South Wales

If you have GMHBA hospital cover, you're automatically covered for emergency transportation within NSW. Ambulance services in NSW are provided as part of a levy-based scheme, which is why it operates under your hospital cover.

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

Benefits are paid for emergencies Australia-wide if you are an NSW resident with GMHBA hospital cover and require emergency ambulance services in other states or territories.

Australian Capital Territory

Take out any GMHBA hospital cover and you're automatically covered for emergency transportation within ACT. Ambulance in ACT is a levy-based scheme, which is why it operates under your hospital cover.

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

Benefits are paid for emergencies Australia-wide if you are an ACT resident with GMHBA hospital cover and require emergency ambulance services in other states.

South Australia

South Australian residents are recommended to purchase a South Australian Ambulance Service (SAAS) subscription to be covered for all ambulance services, not just emergency.

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

Queensland

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

Northern Territory

Northern Territory residents are recommended to purchase a St John NT Ambulance subscription to be covered for all ambulance services, not just emergency.

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

Western Australia

Western Australian residents are recommended to purchase an ambulance service subscription to be covered for all ambulance services, not just emergency. Ambulance services depend on whether you live within the Perth metropolitan area or regional WA.

If you live in Metropolitan Perth and hold an eligible extras product, you can claim back up to 100% of the cost of an ambulance service subscription per calendar year.

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

Important information about some hospital services

Cosmetic surgery

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

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

Hospital & psychiatric admissions

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

*See Mental Health Waiver on page 15 for details of the once-in-a-lifetime exemption that allows members to upgrade their existing cover to include psychiatric benefits once they have served the minimum 2 month waiting period.

Podiatric surgery

This service covers hospital treatment for conditions affecting the foot and/or ankle, provided by a registered podiatric surgeon. However, these benefits are limited to hospital accommodation and the cost of a prosthesis as laid out in the Private Health Insurance (Medical Devices and Human Tissue Products) rules.

Other medical services, like your anaesthetist or surgeon's account, for example, are not covered under any hospital cover.

Benefits may be payable towards podiatric surgery if you hold an appropriate level of extras cover. Check your extras fact sheet for more details.

Dental surgery

If included on your hospital cover, then you would receive benefits towards the hospital and associated medical fees (bed, theatre, anaesthetists etc.) for inpatient dental surgery.

Remember, this doesn't cover the dental treatment itself – for that you'll need the right level of extras cover (look for anything that includes major dental).

Accidents and Accident Protection

Accidents

An 'accident' is an unforeseen event occurring by chance and caused by an external force or object, which results in involuntary injury to the body requiring immediate treatment.

You are covered for accidental injuries sustained after joining GMHBA (your policy must include the clinical category related to the treatment of the injury). For an accident to be covered, treatment must be sought through a doctor or an Emergency department within 48 hours of sustaining the injury. An Accident Declaration form must also be supplied to GMHBA.

Accident Protection (selected covers)

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

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

Accident Protection covers accidental injuries occurring by chance and caused by an external force or object, which results in involuntary injury to the body sustained after joining GMHBA. For an accident to be covered, treatment must be sought through a doctor or an emergency department within 48 hours of sustaining the injury, and any hospital admission must occur within 90 days. An Accident Declaration form must also be supplied to GMHBA in order for benefits to be paid.

Following the initial hospital admission, if you require a follow up procedure that's directly related to the accident, this will also be covered under your Accident Protection.

Note: benefits are limited to inpatient hospital treatment for services with a valid Medicare Benefits Schedule item. Be aware, there are also some services that are not eligible to be considered an accident.

GMHBA's definition of accident excludes:

- Medical conditions (disease or illness that is not immediately due to an external injury).
- Pre-existing conditions.
- Pregnancy, birth and IVF procedures.
- Accidents arising from surgical procedures.
- Elective cosmetic surgery.
- Podiatric surgery by an accredited podiatrist.
- Sudden illness.
- Injuries due to alcohol or drug use, or drugs not prescribed by a registered practitioner.
- Aggravation of an existing condition.
- Damage to teeth caused by eating or drinking.
- Claims covered by third parties (such as Workcover and TAC).

Clinical category definitions

Clinical categories are set by the Australian Government and provide standardised groupings for hospital and medical treatments like 'Ear, nose and throat', 'Bone, joint and muscle' and 'Heart and vascular system'. Each clinical category has its own set of MBS item numbers. For further information visit: privatehealth.gov.au

Assisted reproductive services

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

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

Back, neck and spine

Hospital treatment for the investigation and treatment of the back, neck and spinal column, including spinal fusion.

For example: sciatica, prolapsed or herniated disc, and spine curvature disorders such as scoliosis, kyphosis and lordosis.

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

Blood

Hospital treatment for the investigation and treatment of blood and blood-related conditions.

For example: blood clotting disorders and bone marrow transplants

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

Bone, joint and muscle

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

- Chest surgery is listed separately under Lung and chest.
- Spinal cord conditions are listed separately under Brain and nervous system.
- Spinal column conditions are listed separately under Back, neck and spine.
- Joint reconstructions are listed separately under Joint reconstructions.
- Joint replacements are listed separately under Joint replacements.
- Podiatric surgery performed by a registered podiatric surgeon is listed separately under Podiatric surgery (provided by a registered podiatric surgeon).
- Management of back pain is listed separately under Pain management. Pain management that requires a device is listed separately under Pain management with device.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Brain and nervous system

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

Treatment of spinal column (back bone) conditions is listed separately under Back, neck and spine.

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

Clinical category definitions (continued)

Breast surgery (medically necessary)

Hospital treatment for the investigation and treatment of breast disorders and associated lymph nodes, and reconstruction and/or reduction following breast surgery or a preventative mastectomy.

For example: breast lesions, breast tumours, asymmetry due to breast cancer surgery, and gynecomastia.

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

Cataracts

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

Chemotherapy, radiotherapy and immunotherapy for cancer

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

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

Dental surgery

Hospital treatment for surgery to the teeth and gums. For example: surgery to remove wisdom teeth, and dental implant surgery. When included on a hospital cover, this pays benefits towards the hospital and associated medical fees (bed, theatre, anaesthetists etc.).

Note: this doesn't cover the dental treatment itself – for that you'd need extras cover with major dental as an inclusion.

Diabetes management (excluding insulin pumps)

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

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

Dialysis for chronic kidney failure

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

Digestive system

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

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

Ear, nose and throat

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

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

Eye (not cataracts)

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

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

Clinical category definitions (continued)

Gastrointestinal endoscopy

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

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

Gynaecology

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

- Fertility treatments are listed separately under Assisted reproductive services
- Pregnancy and birth-related conditions are listed separately under Pregnancy and birth
- Miscarriage or termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.
- Chemotherapy and radiotherapy for cancer is listed separately under Chemotherapy, radiotherapy and immunotherapy for cancer.

Heart and vascular system

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

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

Hernia and appendix

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

- Digestive conditions are listed separately under Digestive system.

Hospital psychiatric services

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

Implantation of hearing devices

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

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

Insulin pumps

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

Joint reconstructions

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

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

Joint replacements

Hospital treatment for surgery for joint replacements, including revisions, resurfacing, partial replacements and removal of medical devices and human tissue products. For example: replacement of shoulder, wrist, finger, hip, knee, ankle, or toe joint, spinal disc replacement.

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

Kidney and bladder

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

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

Clinical category definitions (continued)

Lung and chest

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

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

Male reproductive system

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

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

Miscarriage and termination of pregnancy

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

Palliative care

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

Pain management

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

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

Pain management with device

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

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

Plastic and reconstructive surgery (medically necessary)

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

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

Podiatric surgery (provided by a registered podiatric surgeon)

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

- Accommodation; and
- The cost of any item listed in the Federal Government's Medical Devices and Human Tissue Schedule set out in the Private Health Insurance (Medical Devices and Human Tissue) Rules.

Note: Insurers are not required to pay for any other benefits for hospital treatment for this clinical category, but may choose to do so. Check with GMHBA for more information.

Pregnancy and birth

Hospital treatment for investigation and treatment of conditions associated with pregnancy and childbirth.

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

Rehabilitation

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

Clinical category definitions (continued)

Skin

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

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

Sleep studies

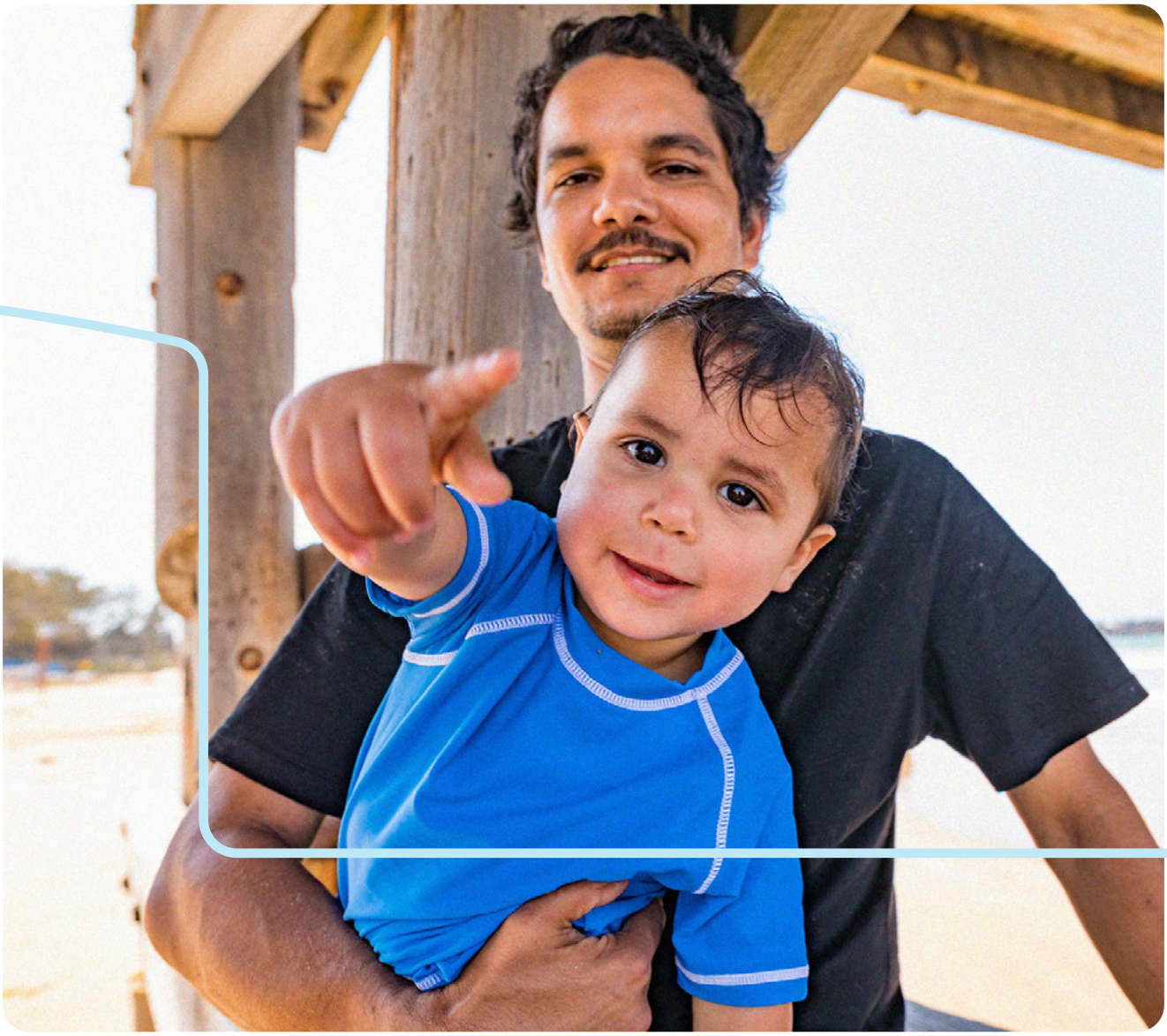
Hospital treatment for the investigation of sleep patterns and anomalies. For example: sleep apnoea and snoring.

Tonsils, adenoids and grommets

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

Weight loss surgery

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



Extras cover

Extras rules

Benefit limits

These are listed on your product fact sheet and show the type of limit for each service covered on your extras policy (see Limit types on page 33).

Medicare

Where you are entitled to receive a rebate from Medicare for any extras service, you cannot also claim the out-of-pocket expense through your GMHBA membership. For example, if you have a care plan from your doctor that includes physiotherapy and you receive a Medicare benefit for your physiotherapy appointment, you cannot then claim for this service and any out-of-pocket expenses under your extras cover physiotherapy benefits.

Doctor's letter of recommendation

The following services require a doctor's letter of recommendation in support of claims prior to claiming: blood glucose monitor, blood pressure monitor, extremity pump, GMHBA Limited approved orthopaedic appliances, nebuliser pump, non-surgical medical devices and human tissue products, pressure garments, sleep apnoea monitor, quit smoking programs, and tens monitors. GMHBA does not pay benefits for the hire of any health appliance or equipment.

Orthodontics

For the purpose of benefit payments, orthodontic treatment is regarded as commencing on the date the appliance is originally fitted.

Limits apply every calendar year and benefits may be claimed as long as the treatment is still ongoing, up to the person's lifetime limit (see Limit types on page 33).

Orthotic appliances (foot)

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

Orthopaedic appliances

Required immediately following an injury or surgery as a result of an injury. Must be custom-made or approved by GMHBA for benefits to be payable. Adjustments to an existing 'off the shelf' appliance does not constitute a custom-made appliance.

Weight management programs

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

Receipts

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

Replacement rule

A benefit replacement rule applies to a number of items/services covered by GMHBA's extras covers. The rule requires that, after you claim for such an item, you must wait a specified period of time before you can lodge another claim for the same type of item. See your fact sheet for further details.

The replacement rule applies to the following items/services: dentures, crowns, hearing aids, blood glucose monitor, blood pressure monitor, extremity pump, GMHBA Limited approved orthopaedic appliances, nebuliser pump, non-surgical medical devices and human tissue products, pressure garments, sleep apnoea monitor, and tens monitors.

Individual telehealth consultations

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

Extras rules (continued)

Extras services purchased over the internet

Optical and pharmaceutical benefits will be paid for extras services purchased online from Australian providers where a script is provided.

For a company to be considered an Australian provider, an ABN needs to be visible on the company's website. Consistent with current GMHBA rules, benefits for services or treatment received or purchased overseas are excluded.

Exclusions on extras

You cannot claim for the following:

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

Pharmacy exclusions

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

Dental exclusions

- Dental procedures where a limit on the number you can have has been exceeded.
- Dental procedures where tooth identifications (ID) are not supplied by the provider.
- Dental procedures carried out and charged by a dental mechanic, other than an advanced dental technician.
- A range of dental procedures when they're provided on the same day e.g. a filling on a tooth that has been removed.

Please contact us for further information relating to these exclusions.

Foot orthotic exclusions

- Foot orthotics provided by a physiotherapist or chiropractor.
- Customised heat moulded, trimmed or adjusted 'off the shelf' orthotics.

Orthopaedic appliance exclusions

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

Optical

- Excludes purchases of frames only, non-prescription glasses and repairs.

Extras waiting periods

Refer to page 8 for waiting periods definitions and details, and the following information about waiting periods specific to extras covers.

Extras services (when included on cover)	**Waiting period**
Ambulance benefits	0 days
All benefits except as specified below	2 months
Optical	6 months
Major dental services (including full and partial dentures, crown and bridgework, endodontic services such as root canal, gold fillings, indirect restorations, surgical extractions of a tooth/teeth including wisdom teeth) and orthodontics.	12 months
Health appliances including nebuliser pump, blood glucose monitor, blood pressure monitors, pressure garments, sleep apnoea monitor, extremity pump, hearing aids, orthopaedic appliances (GMHBA approved), medical devices and human tissue products (GMHBA approved non-surgical), tens monitor, podiatry surgical procedures and orthotic appliances (foot).	12 months

Different types of limits and benefits

Limit types

Annual limits

Most benefit limits are annual limits, which reset each calendar year on 1 January. This means if you use all of your limit in one year, you'll have to wait until 1 January the *following* year to start claiming benefits again. Annual limits apply to each individual on the membership, unless otherwise specified. Keep in mind, some services also have a multi-year limit.

Smart Limits are flexible annual limits that members on SmartCare Extras covers can choose to spend across included services (excluding optical) each calendar year, either with or without sub-limits depending on the cover.

Membership limits

Membership limits are the maximum amounts that can be claimed in a calendar year, and they're shared between all people on the membership. No one person can claim more than the per person limit each calendar year.

Sub-limits

A sub-limit is the maximum amount that can be claimed for a particular service or treatment within an overall annual limit. These vary from service to service.

Combined limits

This is a single limit that can be used across a collection of services as specified in your cover fact sheet.

Multi-year limits

This is a rolling limit that resets after the specified number of years on the anniversary date for each claim from this service category.

Lifetime limits

This applies for orthodontic treatment only, per person on the membership. Once you have claimed the maximum lifetime limit, you will not be eligible to claim any further orthodontic benefits during your lifetime at this level of cover, and your benefits won't re-accrue or reset. This information is shared between health funds, and your lifetime limit will not reset if you transfer your policy to a cover with equivalent benefits.

Note that your lifetime limit can increase if you choose a policy with a higher lifetime limit.

Annual limit rollover

This feature is offered on SmartCare Boost Extras covers only, available when taken out with eligible hospital covers, and allows members to carry over any unused annual limits for included extras services (excluding optical) into the next calendar year. Members must hold active, continuous GMHBA SmartCare Boost Extras cover at the same level (Starter, Everyday or Complete) for a minimum of 12 months before they become eligible for annual limit rollover. Once a member is eligible, their unused annual limit will rollover at the next effective annual limits reset date. Annual limits reset and/or rollover on 1 January each year. The current calendar year's annual limit must be reached first before you can access the remaining annual limit rolled over from the previous calendar year.

Benefit types

Extras cover can help you get money back on common health expenses that aren't generally covered by Medicare.

Set benefits

Set benefits means that when you claim on an eligible service, you will receive a set amount back from your health insurance to cover part of your cost (up to your limit). Therefore you only pay the difference between what you get back from GMHBA and the cost set by your provider.

Percentage back

Percentage back means that every time you claim, until you reach the limit for the service, you'll receive a certain percentage of that amount back in benefits. Therefore you only pay the difference between what you get back from GMHBA and the cost set by your provider.

Estimate your refund

If you want more specific information about what you can expect your out-of-pocket costs to be, we recommend you obtain a quote from your provider before undergoing treatment, along with a list of item numbers. You can then contact us for details of the benefits payable, and make an informed decision before proceeding with the treatment or service.

Other info

Things you need to know

Application for membership with GMHBA

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's also important that the information you provide is true and correct.

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

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

Privacy

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

Membership for non-residents of Australia

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

Overseas travel

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

Proof of age

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

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

In line with our data retention and destruction processes, these documents will only be sighted and not retained.

Private Health Information Statements

A Private Health Information Statement (PHIS) is available for all health insurance policies in Australia and gives a summary of the key product features. Health funds are required to provide PHIS by law, so you can review and compare health insurance products more easily. The policyholder will be given an up-to-date copy of the relevant PHIS, details about what the policy covers and how benefits are provided and a statement identifying the referable health benefits funded when they join GMHBA.

An up-to-date PHIS will be provided on request and to members once every year (without the need to be requested). If more than one adult is included on the policy, GMHBA will only provide a PHIS to the policyholder.

State of the health funds report

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

Termination of membership

GMHBA may terminate a membership in the following circumstances:

- Where information provided to GMHBA is false or misleading;
- Where a member has acted improperly in any way which has, or is likely to, result in loss or damage to GMHBA;
- Materially or repeatedly breached any fund rules or any other term of membership;
- Where the person who has acted improperly is a partner or dependant, GMHBA reserves the right to terminate only that person from a membership.

Things you need to know (continued)

GMHBA 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 GMHBA member must be fully paid (financial) at the time of incurring the expense for the service or treatment.

Managing your benefits

GMHBA does undertake 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. This doesn't mean you've done anything wrong, it's just how we ensure our services are working correctly.

Your cooperation with such requests helps keep health insurance costs down for everyone (including you!).

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

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

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

Liabilities of fund members to GMHBA

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

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. To be honest, we value these even more than the praise, and we've got strict guidelines in place to make sure we get back to complaints in a timely manner.

So, if you have a concern or complaint, please don't hesitate to contact us. We genuinely want to make your GMHBA experience as positive as possible.

How to make a complaint

Call 1300 446 422 Monday to Friday, 8:30am-5pm AEST to talk to a GMHBA representative

Webchat via gmhba.com.au/contact-us Monday to Friday, 9am-4:30pm AEST

Visit a branch. Search gmhba.com.au/find-a-branch to find a location near you

Email service@gmhba.com.au

Log in to the member area via our website at gmhba.com.au/members or the GMHBA app to make an enquiry and submit your feedback

Write to us at PO Box 761, Geelong VIC 3220

We will respond to phone calls, branch visits, and webchats immediately during our operating hours, and we will follow up on all other contact methods within 5 business days. Where the matter is complex, we will attempt to finalise within 20 business days. However, where the difficulty of the matter precludes this, we will inform you of the progress.

For more information on how to make a complaint and our complaints handling process, visit: gmhba.com.au/complaints

If you're still dissatisfied with the outcome of your complaint, you can receive free, independent advice from the Private Health Insurance Ombudsman.

Hotline: 1300 362 072

Website: www.ombudsman.gov.au

Post: Commonwealth Ombudsman, GPO Box 442, Canberra ACT 2601

Payment method options

There are several ways you can pay your GMHBA premiums. Feel free to choose a method and a frequency (weekly, fortnightly, monthly, quarterly, half-yearly or yearly) that suits you.

Just note that not all payment methods and frequencies are available on all products.

Credit card

When you choose this option, your premiums are automatically debited from your MasterCard or Visa credit card. Please note that automatic payments from a credit card do not attract the direct debit discount. We won't send you billing and reminder notices if you pay by automatic credit card debit.

Direct debit

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

Direct to GMHBA

Your premiums can be paid direct to GMHBA using any of the following payment method options:

- GMHBA branches – payments can be made in cheque or by EFTPOS at any GMHBA branch. Please note we do not accept cash payments.
- Australia Post – payments can be made in cash, cheque or EFTPOS when you present your billing notice at any Australia Post office with Post Billpay facility.
- Pay online – one-off payments can be made by credit card in the member area, GMHBA app or via the BPay facility of your financial institution.
- Pay by phone – payments can be made by credit card over the phone using NAB Transact, simply phone 1300 238 959.
- Mail – payments must be made by cheque or money order. Please do not send cash by mail.

Alternatively, you can use the BPay facility of your financial institution.

Billing notice

When making a direct payment to GMHBA, either in person or by mail, you must present your billing notice.

A billing notice will be sent to you if your premium is paid directly to GMHBA, either monthly, quarterly, half-yearly or yearly in advance.

Payment in advance

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

Direct Debit Service Agreement

Terms and conditions of our Direct Debit Service Agreement can be found on our website at: gmhba.com.au/documents

Arrears

GMHBA 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 member must be fully paid (financial) at the time of incurring the expense for the service or treatment.

Premium review

Private health insurers are approved to make premium changes once per year. This usually occurs on 1 April. You will be advised of any changes to your premium and/or your policy in accordance with the requirements as set out in the Private Health Insurance Act 2007. Find out more at: gmhba.com.au/premium

Other important information

Rights of GMHBA Limited

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

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

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

Obligation of fund members

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

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

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

Private Health Insurance Code of Conduct

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

Development of the codes commenced in 2003 with a committee formed by Private Healthcare Australia and HIRMAA. That committee has broad representation from funds, so the development has had detailed and expert input from a cross section of the industry and from stakeholders.

The Minister for Health and Aged Care and the Treasurer have endorsed the Code. The Code is designed to sit beside the current Government acts and regulations within which the industry operates and underlines the intent of the industry to show its commitment to consumers. The Private Health Insurance Code of Conduct is designed to help you by providing clear information and transparency in your relationships with health insurers. The Code covers four main areas of conduct in private health insurance ensuring:

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

You can download the code at: privatehealthcareaustralia.org.au/codeofconduct/documents

Glossary

Calendar year

A calendar year is 1 January to 31 December.

Compensation

This includes:

- A payment by way of damages;
- A payment under a scheme of insurance or compensation provided by the Commonwealth or State law (for example, workers compensation insurance or compulsory third party motor vehicle accident insurance);
- Settlement of a claim for damages (with or without admission of liability);
- A payment for negligence;
- A benefit paid by another private health insurer; or
- Any other payment that in the fund's reasonable opinion is a payment in the nature of compensation or damages.

Emergency ambulance

As defined by your state or territory ambulance scheme (i.e. generally does not cover you for transportation between hospitals or rehabilitation centres).

Exclusions

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

Informed financial consent

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

Inpatient

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

Maximum PBS amount

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

Medical adviser

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

Non-participating hospital

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

Outpatient

Any person who receives medical treatment or services without being formally admitted to a hospital. This can include GP or specialist appointments, attendance at an emergency department, diagnostic tests and imaging such as pathology and radiology as well as outpatient appointments after being formally discharged from hospital.

Private practice

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

Recognised provider

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

Important Information Guide

GMHBA Health Insurance

Private Health Insurance Code of Conduct™

GMHBA Health Insurance
Level 3, 60 Moorabool St, Geelong VIC 3220
PO Box 761 Geelong VIC 3220

gmhba.com.au
T 1300 446 422
ABN 98 004 417 092

GMHBA HEALTH INSURANCE